

AGENDA
FOR
COUNCIL OF ACADEMIC SOCIETIES

BUSINESS MEETING

Wednesday, March 28, 1973

9:00 am - 4:00 pm

Morning Session - Pennsylvania Room
Afternoon Session - Ballroom

Mayflower Hotel
Washington, D.C.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

One Dupont Circle

Washington, D. C.



ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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

AGENDA
COUNCIL OF ACADEMIC SOCIETIES
BUSINESS MEETING

Wednesday, March 28, 1973
Mayflower Hotel
Washington, D. C.

	<u>PAGE</u>
I. Roll Call	
II. Adoption of Minutes, CAS Meeting November 3, 1973.	3
III. Chairman's Report	
IV. <u>Action Items:</u>	
1. Programs in the Basic Medical Sciences	7
2. Policy Statement on Professional Standard Review Organizations	13
3. A Legislative Proposal for RMP-CHP	17
4. New Membership Applications:	
a. American Academy of Orthopedic Surgeons	29
b. American College of Chest Physicians	30
c. American Society of Therapeutic Radiologists	31
d. American Urological Association	32
V. <u>Information Items:</u>	
1. Graduate Medical Education Committee Report	33
2. Continuing Medical Education Committee Report	63
3. Actions of the Liaison Committee on Medical Education - Dr. Knobil	77
4. Coordinating Council on Medical Education and the Liaison Committee on Graduate Medical Education - Dr. Swanson	81
5. Status of the development of regulations for implementation of new Medicare-Medicaid legislation - Dr. Relman	85

Business Meeting
Wednesday, March 28, 1973

	<u>PAGE</u>
6. Biomedical Research Committee - Dr. Estabrook	87
7. Committee on Financing Medical Education - Dr. Weil	89
8. Division of Educational Resources Development - Dr. William G. Cooper	91
9. Primary Care	93
10. Medical College Admission Assessment Program	95
11. Statement from the Association for Medical School Pharmacology	97
VI. <u>Discussion Items:</u>	
1. The Future Outlook for Federal Research in Med- ical Education Financing - Dr. John A. D. Cooper and Staff. Dr. John Sherman, Acting Director of The National Institutes of Health and members of his staff will join in the Council for this dis- cussion.	
VII. 1. <u>Agenda</u> for the Conference on the Impact of Large Center Categorical Grants on the Academic Health Centers, Thursday, March 29, 1973, Mayflower Hotel, Washington, D. C.	99

MINUTES

COUNCIL OF ACADEMIC SOCIETIES

BUSINESS MEETING

November 3, 1972

Hotel Fontainebleau
Miami Beach, Florida

I. Roll Call

Dr. William B. Weil, CAS Secretary, called the roll. Forty-three of the fifty-one constituent societies were represented. Member societies not represented were:

American Association of Neuropathologists
American Association of Pathologists and Bacteriologists
Association of Medical School Pediatric Department Chairmen, Inc.
Society of Surgical Chairmen
American College of Obstetricians and Gynecologists
American College of Surgeons
American Gastroenterological Association
American Society for Clinical Investigation, Inc.

The Secretary verified the voting delegation from the CAS for the November 4 meeting of the AAMC Assembly to insure that the 35 seats allotted to the CAS would be filled.

II. Approval of Minutes

The minutes of the meeting held February 4, 1972 were approved as circulated.

III. Chairman's Report

Supplementing the Chairman's report which was printed in the Agenda, Dr. Clark noted the following:

1. The committee authorized by the CAS Administrative Board to study salary arrangements and income levels for clinical faculty was not

activated. A committee of the AAMC is undertaking this.

2. The matter of faculty representation in the AAMC remains unresolved.
3. Interest in a CAS-sponsored Institute was explored. Some possible topics named were educational technology for medicine; education for primary medical care; and political or economic issues related to medical education. Additional suggestions were invited.
4. Special attention was called to the Report of the Ad Hoc Committee to Consider Medical School Admissions Problems.

IV. Action Items

1. CAS Dues Increase

Upon motion, duly seconded, the CAS adopted the annual dues increase according to the schedule presented in the Agenda on p. 12. Six abstentions were noted.

2. Interaction of Basic and Clinical Sciences

Upon motion, duly seconded, the CAS unanimously adopted the Resolution on the Interaction of Basic and Clinical Sciences that appeared in the Agenda on p. 19.

3. Membership Applications

Upon motion, duly seconded, the CAS Membership voted unanimously to recommend to the AAMC Executive Council the following applications:

- a. American Academy of Neurology
- b. Association of Orthopaedic Chairmen
- c. Central Society for Clinical Research
- d. American College of Psychiatrists
- e. Biophysical Society
- f. American College of Radiology

4. Election of Officers and Administrative Board Members

By written ballot the CAS Membership elected the following:

Ronald W. Estabrook, Ph.D. - Chairman-Elect; and
Robert M. Blizzard, M.D.,
David R. Challoner, M.D., and
Rolla B. Hill, Jr., M.D.,

two-year terms to the Administrative Board. Names, addresses, and terms of office of the Council of Academic Societies Administrative Board for 1972-73 are shown on the attached.

At the close of the meeting Dr. Robert G. Petersdorf was installed as Chairman of the Council of Academic Societies succeeding Dr. Sam L. Clark, Jr., who will continue ex officio on the Administrative Board of the CAS. On behalf of the CAS, Dr. Petersdorf expressed appreciation to Dr. Clark for the vigorous leadership which has characterized his term as Chairman.

V. Discussion Items

The Council of Academic Societies heard a number of special reports and had an opportunity for discussion on each:

- a. Jonathan Rhoads - Programs and Progress in the Conquest of Cancer.
- b. Robert Q. Marston - The Heart and Lung Bill.
- c. Michael Ball - Present and Future Policy Trends of NIH and NIMH Training Grant Programs; and recent developments in NIH and NSF grants to VA-employed faculty.
- d. James Warren - Student and Faculty Participation in Educational Exercises Involving "Private Patients."
- e. James Schofield - Accreditation of Medical Schools and the Future of Accreditation of Graduate Clinical Education.
- f. Robert Weiss - Subcommittee on Quality of Care of the AAMC Health Services Advisory Committee.

- g. August Swanson - AAMC Committee on Graduate Medical Education; Committee on Educational Technology for Medicine; Committee on Continuing Education; and CAS Spring Workshop.
- h. John Cooper - AAMC Committee on Biomedical Research to be chaired by Eugene Braunwald.

VII. Other Business

1. Dr. D.C. Tosteson urged that the CAS Administrative Board consider the organization of a CAS committee on accreditation whose primary function would be to develop a mechanism for involvement of the CAS in institutional accreditation.

2. Dr. Frank Newell introduced a motion, which was duly seconded, that the CAS recommend that there NOT be established a Council of Faculties within the AAMC at this time. The motion was defeated with 26 for and 30 against.

3. Dr. Ralph Wedgwood introduced the following motion, which was duly seconded, and passed unanimously:

that the CAS establish an ad hoc committee to study and report, at the next meeting, on mechanisms for the development of appropriate support and funding for advanced graduate clinical specialty and biomedical research training.

VIII. Next Meeting

The CAS will hold an all-day meeting in March immediately preceding the CAS Workshop.

IX. Adjournment

The meeting stood adjourned at 5:20 p.m.

MHL:smc
11/17/72
ATTACHMENT: 1

Document from the collections of the AAMC Not to be reproduced without permission

III. Action Items:

1. Programs in the Basic Medical Sciences:

The Liaison Committee on Medical Education has developed an appendix to the "Structure and Functions of a Modern Medical School" describing the essential qualities of schools of basic medical sciences. This document will be presented to the Assembly of the Association and to the House of Delegates of the AMA for approval and will become the working basis for accreditation of schools of this type.

APPENDIX* (To Functions and Structure of a Medical School)

Programs in the Basic Medical Sciences

I. Introduction

Since undergraduate medical education is but a part of the continuum of the life long education of the physician, a program in the basic medical sciences merits special comment. The continuum of medical education consists of a series of sequential learning experiences available to the student of medicine at the same or different institutions. Premedical education leading to the baccalaureate degree is the institutional responsibility of the college or undergraduate division of a university. Undergraduate medical education, including both the basic medical sciences and clinical science, with an increasing integration of the components leading to the doctor of medicine degree is the responsibility of a medical school. Graduate medical education, following the granting of the doctor of medicine degree, by means of residency programs prepares the physician for practice and is a responsibility of the medical school or teaching hospital. Completing the continuum, continuing education affords the physician varied learning experiences appropriate for his clinical responsibility and is provided by professional associations, medical schools, and teaching hospitals.

In the past, the several program components of this continuum were offered as discrete and isolated segments. Now, efforts should continue to achieve greater integration of the several elements despite the possible diversity of their sponsoring organizations and their geographic locations. A recognition of this continuum by institutions having a responsibility for undergraduate medical education is of special significance because integration is particularly necessary in the conduct of undergraduate medical education. The study of the basic medical sciences and the study of clinical science cannot be separated. A single curricular pattern for the attainment of this integration cannot be prescribed.

II. Definition and Mission

Programs in the basic medical sciences are of less than 32 months duration, do not culminate with the award of the M.D. degree, provide the initial part of undergraduate medical education, and must be affiliated with an approved medical school. Although primarily concerned with the sciences which are basic to the study of medicine, these programs must include the opportunity for the simultaneous study of clinical medicine. This appendix modifies the preceding statement so that it is applicable to the evaluation for accreditation of programs in the basic medical sciences.

*Adopted by the LCME, January 10, 1973.

Adopted by the House of Delegates of the American Medical Association on _____, and the Assembly of the Association of American Medical Colleges on _____.

Document from the collections of the AAMC. Not to be reproduced without permission.

1 If undergraduate medical education is divided between a program in the
2 basic medical sciences and the program of a degree-granting institution,
3 it is ultimately the responsibility of the degree-granting institution
4 to assure the continuity and integration of the curriculum.
5

6 A program in the basic medical sciences has the same inherent responsibili-
7 ties as described in Section II of the preceding statement. The extent of
8 these responsibilities, especially as they involve responsibility for the
9 care of patients, may be abridged providing they are appropriate for the
10 attainment of stated and acceptable objectives of the commitment to under-
11 graduate medical education.
12

13 III. Educational Programs

14
15 The educational program in the basic medical sciences assumes that the
16 students will have completed the premedical program. It offers them an
17 education which will prepare them adequately for entrance with advanced
18 standing into an approved medical school.
19

20 It is of utmost importance that instruction not be conducted exclusively in
21 the basic sciences without any experience in clinical medicine. Instruction
22 in clinical medicine is necessary to facilitate the correlation of the scien-
23 tific and clinical aspects of medical knowledge as well as to reinforce the
24 students' motivation for medicine and provide the opportunity to acquire
25 necessary attitudes, skills and techniques and to begin the acquisition of
6 a professional identity. The experience requires careful planning with
27 participation by qualified teachers of clinical medicine who are competent
28 in both the basic and the clinical sciences.
29

30 This usually requires that there be a program of graduate medical education
31 at an affiliated hospital where faculty and house staff can serve as role
32 models for the student.
33

34 IV. Administration and Governance

35
36 Programs in the basic medical sciences must be conducted by a college or
37 university. Whether the program does or does not constitute a separate
38 college or school, there should be a recognizable organization of faculty
39 including a committee structure similar to the organization of a degree-
40 granting medical school.
41

42 Administrative responsibility for the program must rest with a dean or
43 director who has adequate authority with respect to the necessary resources
44 such as faculty, budget, space, library, learning resources, and research
45 facilities.
46

47 The governance of the program in basic medical sciences should include
48 substantive representation from the affiliated medical school in order to
49 assure coordination of the program with the objectives of that institution,
50 particularly in the area of admissions, curriculum, student evaluation,
51 promotion and transfer and faculty recruitment and promotion.
52
53
54

1 Provision for this representation must be by means of a formal affiliation
2 which acknowledges the responsibility of the medical school which will
3 award the M.D. degree for the adequacy of the continuum of undergraduate
4 medical education. It is recognized that several currently approved pro-
5 grams do not have such an affiliation. For these programs this require-
6 ment is deferred, if there is evidence that development of such an affil-
7 iation is in progress.

8
9 V. Faculty

10 The faculty must consist of a sufficient number of skilled teachers and
11 investigators from the biological, behavioral, and clinical sciences to
12 achieve the objectives of the particular program. The specific fields to
13 be represented will be determined in part by the prerequisites set by the
14 affiliated clinical program and do not have to be structured in any set
15 pattern of departmental or divisional organization. A significant portion
16 of faculty effort should be devoted to the facilitation of learning by those
17 who enroll as students. In addition to the educational efforts of the faculty
18 scholarly productivity should be encouraged. Depending on the discipline
19 involved, the basic science faculty in the program will find it important
20 to retain strong ties with their counterparts in the arts and sciences pro-
21 grams. Thus, the program in the basic medical sciences will draw academic
22 sustenance from the more basic as well as the more applied portions of
23 their disciplines. It will depend on the skills of the academic and admin-
24 istrative leaders of the program to provide conditions which permit this
25 integration.
26

27
28 Nominations for faculty appointment should involve participation of faculty,
29 the dean or director, and the M.D. degree-granting institution, the role of
30 each customarily varying somewhat with the rank of the appointee and the
31 degree to which administrative responsibilities may be involved.

32
33 Physicians practicing in the community may contribute significantly to the
34 educational program but do not obviate the need for full time physician-
35 teachers on the faculty.

36
37 VI. Students

38
39 The affiliation between the institution responsible for a program in the
40 basic medical sciences and the medical school awarding the M.D. degree
41 should assure the transfer to the medical school of the student whose pro-
42 gress in the program is satisfactory.

43
44 There must be a well defined mechanism for student selection and formal
45 acceptance into the program, evaluation of student performance, and deter-
46 mination of qualification for transfer into a clinical program offering the
47 M.D. degree. At a specific point in the program the student must be iden-
48 tified and formally registered as a medical student.
49
50
51
52
53
54

1 VII. Finances

2
3 Although the amount of financial support necessary for a program in the
4 basic medical sciences will be less than the amount required for a com-
5 plete program of undergraduate medical education, the qualitative re-
6 quirements are the same.
7

8 VIII. Facilities

9
10 The qualitative requirements for facilities are described in the preceding
11 statement; the quantitative requirements will be determined by the extent
12 of the program in the basic medical sciences.
13

14 IX. Accreditation

15
16 Section IX of the preceding statement is applicable to programs in the
17 basic medical sciences.
18

19 The Liaison Committee has categorized the types of basic medical science
20 programs that it will consider for accreditation as follows:
21

- 22 1) Existing two-year programs accredited or provisionally
23 accredited;
24
25 2) New basic science programs in institutions with a commitment
26 to establish a full M.D. degree program with their own
27 resources or as part of a consortium, and
28
29 3) New basic science programs in institutions which are
30 formally affiliated with one or more already established
31 medical schools. In this case, the program will be
32 accredited as a component of the M.D. degree-granting
33 institution or institutions.
34

35 It is the policy of the Liaison Committee to discourage the establishment
36 of programs in the basic medical sciences for medical students that do not
37 have a clearly defined pathway leading to the M.D. degree. Recognizing
38 the need for mobilizing additional university resources for the benefit of
39 medical education, the Committee may approve a basic medical science pro-
40 gram through the degree-granting school with which it is affiliated. In
41 this case the program will be surveyed initially upon request and subse-
42 quently as part of the regular review process of the affiliated medical
43 school.
44

45 An institution planning a program should seek detailed information about
46 accreditation early in the planning process.
47
48
49
50
51
52
53
54

III. Action Items:

2. Policy Statement on Professional Standards Review Organization:

The Association has developed the following policy statement which was acted upon by the Executive Council on March 16. The Executive Council action will be reported at the CAS Business Meeting.

Policy Statement of the AAMC on PSROs

TITLE XI of Public Law 92-603, the Social Security Amendments of 1972, calls for the establishment of PSROs nationwide to monitor and evaluate the costs and quality of health care for Medicare and Medicaid patients. At present, the Federal responsibility for developing this program has been divided among three agencies. HSMHA has been assigned the task of developing norms and standards as well as designing methodologies for collecting the necessary data in a uniform manner; SSA, because of its operational experience in administering the Medicare program, will assimilate the data through its EDP facilities, utilizing the capabilities of its carriers and intermediaries.

The PSRO office under the direction of the Secretary of HEW will have overall policy determination over both HSMHA and the SSA.

\$10M this fiscal year and \$30M next fiscal year have been requested for PSRO activities. Most of these funds will be utilized for contracts to prototype PSROs with some monies for central office operations and a small amount for research. The majority of the PSRO staff positions will be within the BHI of the SSA.

Although PSRO regulations will not be developed anytime within the near future, it is anticipated that some preliminary guidelines will be distributed for the use of "early" PSRO programs, as well as those organizations with plans to become PSROs (under Section 1169 of the Law, funds are provided for feasibility and planning grants to PSRO prototype projects).

By January 1, 1974, the Secretary of HEW will have designated the geographical areas for PSROs. Nationally there will be approximately 150-200 PSROs which will be established mostly below the state level.

The PSRO will be required to develop a series of profiles on institutions, physicians and patients. Although rudimentary patient and physician profiles now exist in the computer tapes of the intermediaries and carriers, they must be expanded to include additional data and must be collated to produce the requisite information.

Utilizing EDP techniques, matrices will be developed by PSROs which will facilitate the evaluation of practitioner and institutional performance in multiple areas of health care services.

The preparation, distribution and validation of data, starting at the local level and channelled through the PSRO central office and back to the local organizations will constitute a substantial administrative task to be performed by the 100 carriers and intermediaries for Medicare and a large number of different carriers and intermediaries for Medicaid. Changes will also have to be made in the present EDP system of the SSA to accommodate the demand for additional and different types of data.

Within the teaching hospital, the U.R. Committee could be used as a mechanism for developing an internal review system to meet the operating requirements of the local PSRO. If the norms, criteria and standards developed by the U.R. Committee are judged to be acceptable to the PSRO, the hospital can then be made responsible for reviewing its own health

care services subject to periodic sample auditing by the PSRO. In such cases, the U.R. Committee can make decisions in regard to patient care which are binding upon the carrier as well as the SSA.

Records and data will have to be reviewed to determine such things as appropriateness of admission, parameters of acceptable care for various disease states and perhaps comparison of surgical rates, for example, of hysterectomies and tonsillectomies with those of other hospitals in the area.

With the realization that the PSRO legislation needs to be more clearly interpreted, the Federal Government may develop a PSRO Model Review System to describe how a PSRO could be organized. This package would include a model charter, by-laws, membership guidelines, a budget, an appropriate data system and a reporting mechanism. The early directives to be distributed with this package could suggest the types of activities that should be conducted by a PSRO, e.g. pre-admission certifications program, development of a model treatment plan, etc.

In developing their programs, PSROs will be assisted by the technical and regional staffs of HSMHA and SSA. Once geographical areas have been designated, it is recognized that institutions such as teaching hospitals will require additional staff and resources to assist their U.R. Committees in meeting the requirements of the local PSROs.

The Association's Subcommittee on Quality of Care (Dr. Robert Weiss, Chairman; Dr. Clement Brown; Dr. David Challoner; Dr. Christopher Fordham; Dr. Richard Meiling; and Mr. John Westerman) will meet in April to develop further the AAMC's relationship to the evolving federal presence in quality and cost review.

The Subcommittee intends to meet with Dr. Bauer, Director of PSRO, and the Senate Finance Committee staff, and develop recommendations for teaching hospitals to meet PSRO criteria through multiple mechanisms. In addition, the dissemination of information, where teaching hospitals have successfully worked out mechanisms with prototype PSROs, will be one of the major goals of the Subcommittee.

Approval by the EC of a policy statement on the appropriate involvement of the AAMC membership in the development of PSROs is desirable at this time.

RECOMMENDATION

It is recommended that the Executive Council approve the following statement as an AAMC policy on PSROs:

The AAMC believes that the development and implementation of norms and standards for assessing the quality of health care is a vital responsibility of the medical schools and teaching hospitals. A major part of this responsibility is the incorporation of quality-of-care assessment into clinical educational programs to develop in medical students a life-long concern for quality in their practice.

The AAMC, therefore, strongly recommends that its member institutions become intimately involved in the development and operation of Peer Standards Review Organizations.

AAMC RMP-CHP LEGISLATIVE PROPOSAL

At a May 1972 meeting of the Association's Health Services Advisory Committee, John A.D. Cooper, M.D., AAMC President, proposed the establishment of an ad hoc committee to consider the implications for the Association in connection with the legislative authorizations for the Regional Medical and Comprehensive Health Planning programs, which expire June 30, 1973.

Committee membership included Dr. Stuart Sessoms, chairman; Dr. William S. Jordan Jr.; Dr. Alexander M. Schmidt; Dr. William Stewart; Dr. James V. Warren; Dr. William R. Willard; and Dr. Andrew Hunt. The committee was asked to give consideration to the following issues:

1. What do RMP and CHP do now, and how does that affect the Association constituency;
2. What does the Association think RMP and CHP should do, and how should that affect the Association constituency; and
3. What steps would be necessary to achieve this, with particular reference to a possible legislative proposal.

The committee has held a number of meetings, has questioned numerous experts in the field, and has received assistance from the Association staff, including reports on site visits to a number of CHP and RMP programs or agencies. Among the persons who appeared before the committee were John R.F. Ingall, M.D., Director, Regional Medical Program of Western New York, representing the RMP Coordinators Association; and Mr. Larry Newell and Mr. William Hiscock, representing the American Association of Comprehensive Health Planning. The major findings and conclusions of the committee are represented in the accompanying Outline of Proposed Legislation.

In essence, the Association's legislative proposal is based on the following principles:

1. There should be established a Council of Health Advisers in the Executive Office of the President to advise him on national health policy, on preparation of appropriate legislative proposals, and on preparation of a biennial Report on the Nation's Health. The Council should be assisted by a National Advisory Commission on Health Planning.
2. There should be established a program of grants to states for health planning and services which would be carried out by state health agencies which, in turn, would be comprised of a planning unit (providing comprehensive health planning at both the state and area level) and a health services unit (combining a number of existing federal health service development programs, the most important of which is RMP). The principal function of the health services unit should be to support programs to transfer more effectively the advancing knowledge in medicine and biomedical technology from the academic health centers to the practicing community. Block-grant financing should be provided through allotments to states of federal funds for health planning and health services. Public participation should be provided through appropriate advisory groups. State health planning and services should be required to meet federal standards

Document from the collections of the AAMC Not to be reproduced without permission

which the HEW Secretary would develop with the review and approval of a National Advisory Council on Health Planning and Services.

3. There should be a focus at the federal level on health services research and development which would be accomplished by providing for a permanent, open-ended authorization of appropriations for the National Center for Health Services Research and Development, whose authority is to expire June 30, 1973.

It is hoped that the Executive Council will study and comment on the Outline of Proposed Legislation, which follows, and take the following action.

RECOMMENDATION

It is recommended that the Executive Council adopt the principles listed above as Association policy on the extension of RMP-CHP legislation.

Outline of Proposed Legislation

Title I

Council of Health Advisers

Require the President to submit to Congress a biennial Report on the Nation's Health which shall include information on the status of the nation's health; on trends in the quality, management and utilization of health services; on the adequacy of the nation's health care resources; on the effect of government programs in the nation's health; and on methods or legislation for meeting identified deficiencies.

Establish in the Executive Office of the President a three-person Council of Health Advisers, comparable to the Council on Environmental Quality.

Authorize the Council to employ necessary officials and to fix their salaries, and also to employ necessary experts and consultants.

Specify the duties and functions of the Council --

(1) to assist and advise the President in the preparation of the Report on the Nation's Health;

(2) to gather timely and authoritative information concerning the conditions and trends in the nation's health both current and prospective, to analyze and interpret such information for the purpose of determining whether such conditions and trends are interfering, or are likely to interfere, with the improvement of the nation's health and to compile and submit to the President studies relating to such conditions and trends;

(3) to review and appraise the various programs and activities of the federal government for the purpose of determining the extent to which such programs and activities are contributing to the improvement of the nation's

health, and to make recommendations to the President with respect thereto;

(4) to develop and recommend to the President national policies to foster and promote the improvement of the nation's health to meet the social, economic, health, scientific, ethical, and other requirements and goals of the Nation;

(5) to conduct investigations, studies, surveys, research, and analyses relating to health care resources and health services delivery;

(6) to document and define changes in the health of the nation and to accumulate necessary data and other information for a continuing analysis of these changes or trends and an interpretation of their underlying causes;

(7) to report in alternate years to the President on the state and condition of the nation's health; and

(8) to make and furnish such studies, reports thereon, and recommendations with respect to matters of policy and legislation as the President may request.

Establish a 19-person National Advisory Commission on Health Planning to assist and advise the Council, which shall be composed of five members appointed by the President pro tempore of the Senate, five members appointed by the Speaker of the House, and nine members appointed by the President.

Require the Council to consult with the National Advisory Commission on Health Planning and to utilize other, nongovernment resources as appropriate.

Provide that the members of the Council shall be full-time employees and fix their pay rate in the Executive Schedule.

Authorize appropriations to carry out the title of \$300,000 in fiscal 1974, \$700,000 in fiscal 1975, and \$1,000,000 in fiscal 1976.

Title II

Health Planning and Services

Findings and Declaration of Purpose

Describe the general need for the legislation and the purposes for it --

(1) promote the establishment of more efficient and effective health service systems, assure coordination among all federal health programs, as well as with other health related programs and activities, and with particular attention to the relationship between improved organization and delivery of health services and the planning thereof;

(2) assist in the support of state programs of health planning, public health services, the initial support of new health services, and the support of health services meeting particular needs;

(3) provide support for research and development (including demonstration and training) related to improving the organization, planning, and delivery of health services; and

(4) provide support for demonstrations and experiments in the integration and coordination of federal health programs, and appropriate related programs, leading to the development of improved health systems extending high quality care to all, improving efficiency in the use of resources, and promoting the effective interrelationship of assistance provided by federal health programs.

Grants to States for Health Planning and Services

Describe conditions to be met in order for a state to be eligible for assistance under the section: designation of a state agency to carry out the state's health planning and health service assistance functions (with

the option at the Secretary's discretion of separate agencies being so designated); provision for a state health planning and service assistance advisory council, a majority of whose membership shall be health care consumers; provision of assurances to the Secretary that the state agency will have authority to carry out its functions and that federal funds will increase state health spending rather than supplant it; provision of appropriate methods of administration, fiscal controls and reporting procedures. Provide that interstate compacts may also qualify for assistance.

State Health Planning

Describe the state health planning function. Planning shall be conducted according to criteria established by the Secretary and shall give first consideration to identification of acute problems and development of means to overcome them. State health planning shall be carried on in cooperation with education, welfare and rehabilitation agencies. State health planning shall include the relationship between the health needs of the people and the capability of the health care system to deliver health services; the development and distribution of health personnel; the establishment of methods of measuring the quality of health care provided in the state; and the evaluation of health care planning and services in the state. The state health planning agency shall review and approve applications for all health related projects in the state to be assisted under the Public Health Service Act, the Social Security Act, or other appropriate provisions of law, except that it shall not consider applications related to biomedical research or health professions education. Require the state planning agency to review its plans at least annually. Require the state health planning agency to work with health care facilities in the state on a capital expenditure program. Require the Secretary to carry on a continuous program of health service planning in consultation with state planning agencies and provide for federal takeover of state health planning if the

state agency does not carry out its responsibilities. Exclude planning with respect to the national supply of professional health personnel from the general emphasis on state-by-state planning.

State Health Service Assistance

Describe the state health service assistance function. The state health service agency shall be responsible for providing adequate health services to the people of the state. Services assisted or provided shall meet criteria as to their scope and quality prescribed by the Secretary and shall be in accordance with state health plans. If a state designates separate planning and assistance agencies, then the approval of the planning agency must be obtained prior to approval of a project by the service assistance agency. The priority of projects to be assisted is to be based on the relative need as determined in the state health plan. Except for assistance with respect to the national supply of professional health personnel, health services assistance shall proceed primarily on a state-by-state basis. If the designated state agency does not carry out its responsibility, the Secretary shall assume responsibility for coordinating the service assistance functions within the state. Applications for health services assistance may be made by any public or nonprofit private entity or combination. No application shall be disapproved by the state action agency until the agency has afforded the applicant an opportunity for a hearing. The state health service assistance agency may make grants or enter into contracts for any of the purposes currently provided for in existing Public Health Service Act sections 304 (health services research and development); 314(e) (health services development); 904 (establishment and operation of RMPs); 910 (multiprogram services); 314(d) (public health services)

State Allotments and Payments to States

Provide for the allotment of appropriated funds to states on the basis of the population, per capita income, and the extent of the need for

health service assistance, provided that no state would receive less than one percent of the appropriation. Funds may be reallocated by the Secretary if not fully used by the state to which they were initially allotted. From each allotment, the state shall be paid from time to time the federal share of expenditures incurred in carrying out the state's health planning and health service assistance functions. The federal share is to be 90 percent for states which designated a single agency to carry out the two functions, 75 percent for states which designated separate agencies, and 80 percent for states with separate agencies but also with certificate of need legislation.

Project Grants for Areawide Health Planning

Provide for project grants by the state health planning agency to other public or nonprofit private agencies or organizations for areawide health planning, similar to the planning currently authorized in existing section 314(b). There must be an areawide health planning council, a majority of whose membership must be health care consumers; and the areawide health planning agency is to assist health care facilities in the development of a capital spending program.

Project Grants for Training, Studies and Demonstrations

Provide permanent, open-ended authorization for project grants by the state health planning agency to any public or nonprofit private agency, institution, other organization, or combination to cover all or any part of the cost of projects for training, studies, or demonstrations looking toward development of improved or more effective comprehensive health planning.

Withholding of Payments

Provide for the withholding of funds by the Secretary when he determines after reasonable notice and opportunity for hearing that there is a failure to comply substantially with either the applicable provisions of the law, the state health plan, or applicable regulations.

-25-
Definitions

Define terms used, including the terms regional medical program, medical center, clinical research center, hospital, nonprofit, and construction.

Annual Report

Provide for an annual report to the Congress from the Secretary on the effectiveness of the activities carried out under the legislation, on the relationship between federal and nonfederal financing for activities undertaken under this legislation, and on recommended changes in the law.

Authorization of Appropriations

Authorize appropriations of \$600 million in fiscal 1974, \$700 million in fiscal 1975, and \$800 million in fiscal 1976 for this program of grants to states for health planning and services, and provide that no funds shall be available to pay for hospital care except in connection with research, demonstration or training carried out under the program.

General Provisions

Provide such general provisions as are necessary to make the new program of grants to states for health planning and services conform to routine Public Health Service Act and DHEW legislative requirements.

Federal Standards

Provide a mechanism under which the Secretary, with the participation and approval of the newly established National Advisory Council on Health Planning and Services, shall provide for the development of federal standards for health planning and services, in cooperation with appropriate regional, state and local review organizations as determined by the Secretary. Require state health planning and health service agencies to meet such standards. Provide for the development of interim standards, pending the development of permanent standards.

National Advisory Council on Health Planning and Services

Establish a 23-member National Advisory Council on Health Planning and Services to advise and assist the Secretary in the preparation of general regulations

for, and as to policy matters arising with respect to, the administration of this program of grants to states for health planning and services, with particular attention to the relationship among comprehensive health planning, the improved organization and delivery of health services, and the financing of such services. The Council shall review at least annually the grants made under the program to determine their effectiveness in carrying out their purposes. The Council is to be comprised of four ex-officio members -- the Secretary, the Chairman of the Council of Health Advisers, the chief medical officer of the VA, and a medical officer designated by the Defense Secretary -- and 19 members appointed by the Secretary, a majority of whom are to be representatives of health care consumers. The appointed members are to be selected from among leaders in the fields of the fundamental sciences, the medical sciences, or the organization, delivery and financing of health care, officials in state and areawide health planning agencies, leaders in health care administration, or state or community or other public affairs, who are state or local officials, or representatives of consumers of health care. The Secretary is to be chairman of the Council, and it is to meet at least four times a year. Appointed members of the existing National Advisory Council on Comprehensive Health Planning Programs (which the new Council replaces) may serve at the Secretary's discretion as additional members of the new Council until their existing terms expire.

Title III

Other Amendments to the Public Health Service Act

Amend section 304(a) (research and demonstrations relating to health facilities and services) to provide a permanent, open-ended authorization for the National Center for Health Services Research and Development.

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: ~~Mary H. L. ...~~ Connie Choate

NAME OF SOCIETY: AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS

MAILING ADDRESS: 430 North Michigan Avenue
Chicago, Illinois 60611

PURPOSE: See Appendix I - attached

MEMBERSHIP CRITERIA:

Fellowship - See Appendix II attached (Article IV, Sections 1-6)

Membership - See Appendix III attached (Article VI, Sections 1-6)

NUMBER OF MEMBERS: 5,516 Fellows and 222 Members (Total 5,738)

DATE ORGANIZED: October 1933

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

- Enclosed 1. Constitution & Bylaws
Enclosed 2. Program & Minutes of Annual Meeting

(CONTINUED - OVER)

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: ~~Mary H. Little~~ Connie Choate

NAME OF SOCIETY: American Society of Therapeutic Radiologists

MAILING ADDRESS: c/o Luther W. Brady, M.D., President
American Society of Therapeutic Radiologists
Hahnemann Medical College and Hospital
230 North Broad Street
Philadelphia, Pennsylvania 19102

PURPOSE: The American Society of Therapeutic Radiologists is an organization of physicians specializing only in therapeutic radiology. Its efforts are directed to benefit the patient by promoting the highest possible standards of therapeutic radiology, by improving the training of therapeutic radiologists and by providing clinical and laboratory researches into the frontiers of knowledge of the specialty.

MEMBERSHIP CRITERIA: Active membership is available to physicians in the Americas who specialize fulltime in therapeutic radiology. Associate membership is available for qualified radiation physicists, radiobiologists, and other specialists with recognized interest in the aims of the Society. Junior membership is offered to residents in training in therapeutic radiology. Corresponding membership shall be open to residents of foreign countries who fulfill the requirements for active or associate membership but cannot attend regularly the functions of the Society.

NUMBER OF MEMBERS: 700

DATE ORGANIZED: In 1958, the society was originally organized as a club and assumed status as a separate society in 1966.

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

March 1971 1. Constitution & Bylaws

October 1971 2. Program & Minutes of Annual Meeting

(CONTINUED - OVER)

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: ~~Max K. Dittler, M.D.~~ Connie Choate

NAME OF SOCIETY: AMERICAN UROLOGICAL ASSOCIATION, INC.

MAILING ADDRESS: 1120 North Charles Street
Baltimore, Maryland 21201

- PURPOSE:
- (a) To encourage research, experiments, investigations and analyses of diseases, abnormalities and other conditions of the genito-urinary tracts, their treatments and corrections, and to make the results known to physicians and the public.
 - (b) To develop, and assist in developing, scientific methods for the diagnosis, prevention and treatment of such diseases and to make the results known to physicians and the public.
 - (c) To benefit the general public by encouraging the study and maintaining the highest possible standards of urological education, practice and research
 - (d) To promote the publication of and encourage contributions to, medical and scientific literature pertaining to urology.

MEMBERSHIP CRITERIA:

See pages 8 - 14 of the Constitution and Bylaws, May 1972

NUMBER OF MEMBERS: 3,125
~~# of specialty societies:~~
DATE ORGANIZED: 1902

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

- | | |
|-----------------|--|
| <u>May 1972</u> | 1. Constitution & Bylaws |
| <u>May 1972</u> | 2. Program & Minutes of Annual Meeting |

(CONTINUED - OVER)

GUIDELINES FOR ACADEMIC MEDICAL CENTERS
PLANNING TO ASSUME INSTITUTIONAL RESPONSIBILITY
FOR GRADUATE MEDICAL EDUCATION

CONTENTS

Foreword 30

I. Introduction 31

II. Historical Summary 31

III. Guidelines 39

 A. Definitions. 39

 1. Graduate medical education 40

 2. Graduate medical students. 40

 3. A graduate medical education program 40

 4. The graduate medical education faculty 40

 5. Academic medical centers with institu-
 tional responsibility for graduate medi-
 cal education. 41

 B. The Institutional Setting. 41

 1. Introduction 41

 2. Governance 42

 a. Role of the Governing Board. 42

 b. Role of the Faculty. 43

 c. Role of the Residents and Fellows. 43

 3. Administrative Arrangements. 44

 C. Resident Selection, Evaluation of Progress
 and Graduation 45

 1. Selection. 45

 2. Evaluation of Progress 45

 a. General. 45

 b. Evaluation of Readiness for Increased
 Patient Care Responsibilities. 46

 3. Graduation 47

 4. Resident Counseling. 48

 D. Curriculum and the Learning Environment. 48

 1. Curriculum Development 48

 2. Balancing Service and Education. 49

 3. Continued Intellectual Growth. 49

 E. Financing. 50

 1. Institutional Financing. 50

 2. Resident Financing 51

 F. Guidelines Concerned with Related Issues 52

 1. Patient Records. 52

 2. Attitudinal Development. 53

 3. Education with Other Health Professionals. 53

 4. Primary Patient Care 54

 5. Manpower Distribution by Specialty and
 Geographic Location. 55

FOREWORD

The Assembly of the AAMC approved a statement in November of 1971 urging that the academic medical centers assume institutional responsibility for graduate medical education. These guidelines have been developed to assist faculties seeking to develop a plan for institutional assumption of responsibility for the various internship and residency programs in their academic centers.

In developing this document, the Graduate Medical Education Committee and the staff drew heavily upon earlier committee reports. These are mentioned in the Historical Summary and should be referred to by faculties and their planning committees. The Historical Summary also sets forth the rapid and accelerating change in graduate medical education in the United States.

Because the rate of change in graduate medical education has been paralleled by an increasing complexity of academic medical centers, it has been necessary to keep these guidelines broad. Major conceptual ideas for which policies and administrative detail must be developed are set forth. It was not intended that a single best solution be promulgated.

The value of these guidelines will be enhanced if the specific problems which are met and resolved (or not resolved) by the institutions as they attempt to meet the Assembly's challenge are communicated on a national level. From the aggregate experience plans for specific studies in national policy development can be derived.

I. INTRODUCTION

Graduate medical education is the process that differentiates the multipotential holder of the M.D. degree into a competent, professional physician who has the requisite knowledge, skills and judgement to begin a lifelong career of service and learning in a delimited area of medical practice.

This document sets forth guidelines for the development of overall institutional responsibility for graduate medical education. It is particularly directed towards academic medical centers with medical schools conducting undergraduate programs leading to the M.D. degree, but it has broad applicability to all institutions conducting programs for the graduate education and training of medical specialists.

II. HISTORICAL SUMMARY

Attaining the M.D. degree now signifies that the recipient is prepared for further education rather than for an independent professional career. The degree is a benchmark of transition from the first phase of formal medical education to the second. In the first phase the goal is to educate and train students in the basic and clinical sciences to the point that they are capable of obtaining clinical, social, and cultural data from a variety of patients; are able to assimilate and record these data in a logical and coherent fashion and

correlate this information, to a limited degree, with the existing body of biomedical, scientific knowledge in arriving at diagnostic and therapeutic decisions. As the body of knowledge has grown and the skills for collecting data and providing therapy have become more and more complex, the undergraduate phase of medical education and training has been complemented by a formalized graduate phase.

This phase, largely based upon direct responsibility for patient care, has developed as an apprenticeship system, supervised and controlled by each specialty discipline. National standards for accreditation of graduate programs and for certification of individuals by examination have been evolved by each specialty. Directors for each specialty graduate program are principally guided by these national standards.

In general the system has been successful and has produced highly trained and skilled specialists. However, the reliance on national policies, established solely by specialists in each discipline, for accreditation and certification has not been optimally responsive to societal needs and has produced a relatively inflexible graduate medical educational system which tends to neglect the variations in residents, institutional characteristics, institutional missions and national and regional health service needs.

The nation's medical schools are now providing staff and facilities for the graduate education of 80% of their M.D.

recipients. Therefore, these institutions and their affiliated teaching hospitals should properly assume a larger degree of responsibility for the conceptual development of the graduate phase of medical education and for setting the standards of accomplishment for the students whom they educate and train.

Granting the M.D. degree has been the responsibility of academic institutions for the past fifty years. The assumption of this responsibility terminated the era when medical education was controlled largely by the practicing profession. As a result, new standards derived from the broad perspective of the universities promoted an adherence to excellence in scientific and clinical education and created institutions capable of scientific investigation and the application of new biomedical knowledge to medicine.

Medical schools, as they became components of universities, established their medical educational programs by achieving a consensus of the entire faculty of the school. This involved both basic scientists and clinicians. Criteria for student selection and standards for promotion and graduation also were considered to be a responsibility of the entire faculty. While constrained to a degree by state licensure laws, accreditation standards, and the "conventional wisdom" of the medical establishment, schools could develop special curricula and instructional techniques peculiarly suited to their students, their resources, and the needs of their communities or regions. Until the mid-50's, few schools made sig-

nificant experiments in modifying the conventional (i.e., 2 basic science years, 2 clinical years) mode of the traditional four-year undergraduate education for the M.D. degree. During the past fifteen years, and particularly during the past five, new approaches to undergraduate education have been common. The forces promoting curricular experimentation are complex, and they vary from one institution to another. The opportunity to depart from tradition is in large measure afforded by the willingness of the accrediting agency (the Liaison Committee on Medical Education), state examining boards and other public agencies to trust that the "corporate wisdom" of the entire faculty of a medical school will assure maintenance of basic and fundamental academic standards. This trust has been enhanced by the emergence of large full-time faculties in both the clinical and basic science departments. These faculties are considered to be of such high quality that they can be permitted a large degree of institutional self-determination for undergraduate medical education.

During the period when undergraduate education was traditional and essentially standardized, and most M.D. recipients entered practice after one year of internship, the purpose of graduate medical education was to produce a few qualified specialists in those clinical areas which required detailed knowledge and skills not ordinarily provided in the formal medical education program. It is not surprising that the first four boards established during the period from 1916

to 1932 were in Ophthalmology, Otolaryngology, Obstetrics and Gynecology, Dermatology and Syphilology. Individuals in these disciplines, concerned with assuring high standards of education and training for those who called themselves specialists, promoted the establishment of Boards to lay down national standards for program length and content and national examinations to assure the competence of those certified as specialists.

Reliance upon rather rigid standards for program characteristics and individual certification was necessitated by the diversity of settings for graduate medical education. Hospitals, both those affiliated with and not affiliated with medical schools, were the institutions for graduate medical education; and in either setting, the program for each specialty discipline was considered the sole responsibility of the specialists involved in that discipline. A broad institutional responsibility for graduate education, similar to that taken by the entire faculty for undergraduate medical education, did not evolve, even as the number of specialty Boards increased and as the setting for graduate medical education moved more and more into the academic environment of the medical schools.

While initially graduate education was largely conducted by full-time practitioner-specialists in the context of their own practice, the development of full-time, clinician-academicians in medical schools gradually moved the major responsibility for graduate medical education into the province

of academic medicine. Students promoted this transition by preferentially choosing programs established in academic settings over those lacking academic affiliations. During the past decade, Board members have been increasingly drawn from physicians in the academic environment.

In 1966 the AMA-sponsored Citizens' Commission on Graduate Medical Education, recognizing the significant engagement of academic medical centers with graduate medical education, recommended that the universities assume full responsibility for all of graduate medical education in the nation.¹ In 1968 the Council of Academic Societies of the AAMC published a report of a major conference on "The Role of the University in Graduate Medical Education." This report pointed out that although the setting for graduate medical education had shifted into the academic medical centers, there was insufficient recognition that these graduate programs were now a major responsibility of these institutions.² In 1971 the Assembly of the AAMC approved a statement urging the constituent members of the Association to assume responsibility for graduate medical education in a manner analogous to their assumption of responsibility for undergraduate medical education.^{3,4}

The foregoing has related the movement of graduate medical education into the academic environment largely to the development of full-time clinical faculties and to student preference for the academic setting. Several other factors have been operant in this evolution.

The explosion in biomedical knowledge and technology largely is a product of the university-based medical school, and the most comprehensive exposure to this new information can be gained at the university centers. University centers have also commanded more resources for procuring advanced equipment and specialized personnel. While such expenditures have generally been for research purposes, the opportunity to learn the latest methodologies for patient care has been provided to graduate medical students in these settings.

Training programs supported by federal funds have largely gone to university-based medical centers. Thus, direct support for individuals seeking graduate education has been more available in programs directed by full-time, academic clinicians.

The ascendancy of graduate programs in the academic institutions has been significantly related to external forces, particularly those promoting research and increased specialism in medicine. The institutions, either individually or in the aggregate, have only recently realized that they must become concerned with the impact of their large graduate medical education commitments, on their resources and upon the characteristics and quality of medical practice in their communities and the nation.

During the past several years, significant changes have begun to develop in the national approach to accreditation of graduate programs and the certification of specialists.

These changes can provide opportunities for the faculties of graduate medical educational institutions to move toward a broader responsibility.

In the accreditation arena, the formation of the Coordinating Council on Medical Education and the Liaison Committee on Graduate Medical Education has established for the first time an opportunity for five major national organizations to participate in remodeling the accreditation of both undergraduate and graduate medical education. The parent organizations are: the American Medical Association, the Association of American Medical Colleges, the American Board of Medical Specialties, the American Hospital Association and the Council of Medical Specialty Societies. These provide for broad input into both the Coordinating Council and the Liaison Committee on both undergraduate and graduate medical education. It is likely that proposals for innovative improvements in educational programs will receive interested and sympathetic attention by these newly-formed bodies.

During the past decade, the specialty Boards have been seeking to improve their certification procedures for individuals. Increasingly they have turned to the National Board of Medical Examiners for advice and assistance. The National Board, recognizing that rapid changes are occurring in both undergraduate and graduate medical education, is in the process of reorganizing itself so that it can provide more effec-

tive service for certifying that recipients of the M.D. degree are prepared for entering graduate education and also assisting the Boards in developing assessment systems of high quality and validity.

In the discussion and debates which have led to the establishment of a new accrediting system and the reorganization of the National Board of Medical Examiners, it has been repeatedly emphasized by many who participated that the institutions of higher education which conduct programs for the education of physicians must assume greater responsibility for the quality of all programs conducted under their aegis. Further, there is general recognition that in a complex, pluralistic society, national agencies cannot effectively oversee either accreditation or certification without delegating responsibility to institutions which are dedicated to maintaining and improving quality.

At this point in time, the reorganization which has been accomplished on the national scene provides both an opportunity and a challenge to the academic medical centers to assume greater responsibility for and greater authority over graduate medical education.

III. GUIDELINES

A. DEFINITIONS

1. Graduate medical education is that period in the formal education and training of a physician which usually fol-

lows the granting of the M.D. degree and culminates in qualifying for certification in a specific clinical discipline. Certification is obtained by the satisfactory completion of a program of education and training, and passing an examination or examinations conceived and administered by a national body (Board) representing the discipline.

2. Graduate medical students are individuals, usually with an M.D. degree, who are enrolled in a graduate medical institution and are pursuing education and training in a program leading to certification in a clinical discipline. The traditional titles "intern", "resident", "clinical fellow" or "house officer" recognize the hospital-physician role of these individuals. Although such titles do not convey their semi-student status or their role in health care delivery outside the conventional hospital setting, the titles "resident" or "clinical fellow" are widely understood and are preferable to "student" or "trainee".

3. A graduate medical education program is a complete educational and training experience which prepares residents to assume independent responsibility for patient care in a specific clinical discipline.

4. The graduate medical education faculty in an institution ordinarily should include all the full-time and part-time faculty normally responsible for undergraduate medical education. The need to incorporate learning opportunities in the basic sciences into graduate programs will provide a

special challenge to the basic science faculty and their clinical colleagues. Institutions utilizing part-time clinician-teachers are encouraged to provide these individuals with appropriate input into program planning and appropriate recognition.

5. Academic medical centers with institutional responsibility for graduate medical education are institutions or institutional consortia which provide the spectrum of scientific and clinical faculty, the facilities, and the administrative capability necessary to plan, conduct and evaluate graduate education and training based upon policies and goals derived on an institution-wide basis.

B. THE INSTITUTIONAL SETTING

1. Introduction

Graduate medical education requires a special institutional setting. Academic medical centers planning to assume responsibility for graduate medical education must recognize the need for an institutional system capable of delivering health-care services, ranging from primary to tertiary, in a variety of settings.

In developing the health services appropriate for graduate programs, the centers will need to encourage the participation of individuals, institutions and agencies having primarily a service commitment, but willing to make a commitment to the academic mission. The new institutional form

derived from this amalgamation will have both special characteristics and special problems which may require changes in the conventional management and governing policies of either the academic or the health service institution. The academic programs and the service programs must be blended. The faculty must be composed of individuals with a variety of academic and professional capabilities; and as a faculty, must be capable of recognizing the contribution of all its segments to the common goals of education, service, and research.

Financing, although derived from multiple sources, must be apportioned to assure that the various missions of the institution remain in dynamic and effective balance.

2. Governance

a. Role of the Governing Board. The academic medical center which broadens its responsibilities to include graduate medical education must be cognizant of the need for a governing board made up of individuals who can understand its special problems and make policy decisions which range from those related to academic governance to those required in the institutional delivery of health care services. Where the academic center is a consortium of institutions with their own governing boards, a governance mechanism representing all institutions should be established to implement policy decisions related to the overall educational mission of the center and to articulate these policies with the service missions of the several constituent institutions.

The provision of health services to the community is essential for accomplishing the graduate medical education mission, and the board must be sensitive to the needs of the community for health services. There should be provisions made for input to the board from recipients of these services.

b. Role of the Faculty. Faculty should be responsible for policy development and program review of all facets of graduate medical education. Faculty from both basic and clinical academic departments should expect to contribute to the teaching programs of the various disciplines. In most institutions, mechanisms for ensuring that the faculty exercises this responsibility have been well developed for the undergraduate program leading to the M.D. degree. Because of the greater complexity of graduate education, it is particularly important that broad participation of members of the faculty, ranging from basic scientists to practicing clinicians, be engaged in setting standards for student selection, reviewing and approving curriculum plans, assessing the validity of resident evaluation procedures, and ratifying the graduation of residents from various graduate medical programs. This will necessitate establishing a multidisciplinary review system for each graduate program. An overall faculty committee for broad policy development and the adjudication of disagreements will surely be needed.

c. Role of the Residents and Fellows. Because residents and fellows are expected to educate and train those junior to

them and are also expected to share in the supervision of patient care provided by those with lesser experience, they should be provided appropriate involvement in the affairs of the institution. This involvement should be particularly directed toward enhancing their teaching and supervisory skills.

3. Administrative Arrangements

Administrative systems will vary depending upon the size and complexity of the academic medical center. The importance of providing for the following relationships is emphasized:

a. The ultimate responsibility and authority for the educational programs of the academic center should be lodged with an individual who has direct access to, and is also responsible to, the governing board. When the graduate medical institution is a consortium of institutions, the relationship of this administrative officer to each institutional member should be explicitly stated.

b. The undergraduate and graduate medical education programs should be administratively linked.

c. Because of the differential nature of graduate medical education, the specific programs leading to different disciplinary careers should be planned and implemented by faculty members specifically responsible for each program. However, the autonomous discretion of these program directors should be limited. The individual with overall responsibility for the center's educational programs should have administrative authority over each program director and should assure

that the selection of students, appointment of faculty, development of curricula, assessment of residents, evaluation of the educational process and outcomes and the commitment of resources for all programs are commensurate with the policies for graduate medical education established by the entire faculty.

d. Because administering a health services delivery system is a complex task, it is likely that an individual with particular skills will be delegated this task. It is extremely important that this individual and his staff understand the interdependence of the service and educational programs of the center and that he be a member of the team of individuals responsible for the educational mission.

C. RESIDENT SELECTION, EVALUATION OF PROGRESS AND GRADUATION

1. Selection

Residents selected should ordinarily have achieved the M.D. degree or its equivalent. This is not to be construed to interdict programs which coordinate their curricula with the undergraduate medical school curricula of students who have made early career decisions for a specific discipline. Specific criteria for selection for each program should be developed and approved by the general faculty or a representative body of the faculty.

2. Evaluation of Progress

a. General. Procedures for evaluation and reporting the progress of residents in each program should be developed.

These procedures should include an assessment of knowledge, skills, performance and judgement in the particular discipline pursued and an overall assessment of attitudinal development. No specific examination or rating system is recommended but evaluation should be carried out by faculty members both within and without the resident's discipline. There should be clear evidence that progress is periodically evaluated (at least annually) and reports of these evaluations should be on file in a central office of the institution. Provision should be made for regularly apprising residents of the faculty's evaluation of their progress. This feedback is essential. Evaluation reports should be utilized to verify that residents are ready to graduate and be certified as prepared for Board examinations.

b. Evaluation of Readiness for Increased Patient Care Responsibility. A fundamental educational technique of graduate medical education is caring for patients in a carefully supervised setting. As residents achieve increasing knowledge, skills and judgement, increased responsibility for making decisions and providing services is necessary. Faculty supervision of residents is an important and intricate matter. On one hand, failure to allow residents to grow into increasing responsibility inhibits their professional development, while on the other hand, permitting premature assumption of responsibility endangers patients and may encourage the development of undesirable attitudes and behaviors which will

prove detrimental far beyond the training years. This difficult problem of matching responsibility with achievement cannot be resolved by arbitrarily assuming that after fixed periods of time in a program, all residents are ready for similar levels of responsibility. Verifiable and auditable methods of determining readiness for the next level of patient-care responsibility should be developed. These may include reports of direct observations of residents in the patient-care setting by several faculty members, audits of a resident's patient records, the use of simulation techniques, and written or oral examinations to determine knowledge. Specific and measurable criteria should be determined in advance in order to achieve optimal evaluation.

3. Graduation

Certification that an individual is prepared for independent patient-care responsibility is a dual function shared by the graduate medical institution and the Boards. Graduation should be acknowledged by the awarding of a certificate which signifies that the entire faculty recognizes that the individual awarded the certificate has met all of the requirements set forth by that faculty. The institution should place the same stress on its public accountability for the awarding of such a certificate as do institutions of higher education in awarding advanced degrees.

Examination by the appropriate specialty board completes the certification procedure.

4. Resident Counseling

An advising and counseling service should be available to graduate medical residents.

D. CURRICULUM AND THE LEARNING ENVIRONMENT

1. Curriculum Development

It is recognized that each graduate discipline in medicine has its special body of knowledge and skills. Nevertheless, it is not necessary that all graduate programs in a discipline have either identical content or identical requirements for length of training. Broad guidelines indicating the expectations of achievement for professionals in each discipline are achieved through a national consensus and promulgated by the Boards. Program directors, faculty and residents are encouraged to develop their own curriculum for each discipline taught within the institution and to experiment with the development of new disciplines which can provide patient care more effectively.

In developing curricula, careful attention should be paid to the special distinctions which make each resident unique. These include prior educational background and cognitive, perceptual and manual skills. Opportunities should be provided to residents to plan a significant portion of their programs with the advice and counsel of faculty.

Effective performance in any specialized discipline of medicine is founded upon general knowledge and skills common

to all physicians. Undergraduate medical school curricula are designed to provide students with these basic skills. However, if residents have not had a sufficiently broad experience in the general clinical areas relevant to their specialty, this type of experience should be provided. The timing when residents in various disciplines achieve optimal basic knowledge and clinical skills is of lesser importance than ensuring that these skills are achieved before the residents are certified for graduation.

2. Balancing Service and Education

It has been repeatedly emphasized that graduate medical education is based upon the provision of personal health care services to patients. A willingness to serve patients is an important professional attitude for physicians. The obligation to provide patient services must be a part of the learning experience for all residents. Graduate medical residents are expected to assume increasing service loads as they grow and mature into their full professional roles, and must therefore willingly accept the responsibility of serving the needs of patients in all settings. This emphasis on patient service must not be construed as condoning excessive dependence by institutions upon residents and clinical fellows for the provision of patient services.

3. Continued Intellectual Growth

While learning in the setting of direct patient care is important in graduate medical education, it is essential to

balance the educational strategy with a similar emphasis on continued intellectual growth in biomedical knowledge. Residents should be taught how to continue to expand their fund of knowledge in an organized fashion while fulfilling the demands of accepting increasing responsibility for patient care.

The development of a learning environment which maintains residents' interest in the basic biomedical sciences during the graduate years is both an opportunity and a challenge for the faculties of academic medical centers. Basic scientists and clinicians should work together to maintain and stimulate the intellectual curiosity of these older, now differentiating residents. The instructional techniques for this group must be especially tailored. Adherence to the techniques which are effective for undifferentiated, undergraduate medical students frequently will not succeed.

Centers assuming responsibility for graduate medical education should plan to support enlarged basic science faculties and should seek to recruit basic scientists who can teach effectively in the clinical setting.

E. FINANCING

1. Institutional Financing

Institutions seeking accreditation for graduate medical education must develop sufficient financial resources for supporting educational programs to ensure that administrators

and faculty with primary responsibility for education can devote their principal energies to conducting the various programs.

Because teaching and practicing clinical medicine are inextricably related, it is expected that faculty having teaching responsibilities will also care for patients. Payment for patient services delivered in the teaching setting by both faculty and advanced residents is appropriate and essential. Funds so generated should be collected and managed in such fashion that the financial needs of faculty, residents and educational programs are met effectively and fairly. This plan should be formally established, agreed to by the faculty, and its administration should be periodically reviewed by the governing board.

Residents and faculty both contribute to the services provided patients by hospitals. Hospitals providing facilities for graduate medical education must, therefore, contribute to the budget for graduate medical education.

2. Resident Financing

Because the graduate education and training of residents is long and the intensity of their responsibility precludes their earning extra income, the costs cannot be borne solely by most residents.

Residents, as they advance through their training, provide essential services to patients both on behalf of hospitals and their physician-teachers. The financing of resi-

dents should recognize these services, and income derived from both hospital charges and professional fees should be budgeted for their stipends.

F. GUIDELINES CONCERNED WITH RELATED ISSUES

1. Patient Records

Effective learning and effective evaluation of the learner in the clinical setting are dependent upon the excellence of patient record systems. Academic medical centers should make every effort to maintain high quality patient record systems. The goals should be:

a. To make the patient record an effective instrument for ensuring excellence in the provision of care to each individual patient.

b. To make the patient record an effective instrument for learning by displaying all data legibly and in a manner which assures that the rationale for each decision is clearly evident.

c. To make the patient record an effective instrument for evaluating the quality of performance of the resident by making the records auditable. Accomplishing an audit should not require extraordinary investment of time by the reviewer.

An optimal learning environment requires that the learners and their teachers participate directly in patient care and record their observations, opinions and decisions directly in the patient record.

2. Attitudinal Development

Graduate medical education has developed because of the need to provide specialized knowledge and skills to physicians in delimited areas of medical practice. This thrust has placed an emphasis on the attainment of such knowledge and skills, often to the exclusion of cultivating a professional awareness of the emotional needs and cultural characteristics of patients as individuals or as members of specific populations. Graduate medical institutions should be aware that an essential portion of their educational mission is the maintenance and cultivation of helping attitudes in their residents. Many institutions have available to them faculties in the behavioral sciences. These faculties are showing an increasing interest in participating in medical education and they should be encouraged. However, the faculty responsible for graduate medical education must assume primary responsibility for maintaining and cultivating an awareness of the physician's responsibility for encompassing all facets of patients' needs--physical, emotional and cultural.

3. Education With Other Health Professionals

Increasingly, physicians are dependent upon the knowledge and skills of other health professionals. Optimal provision of personal health services to an expanding population with increasing expectations for health care can only be met by the efficient utilization of all available talent. The period of graduate medical education provides special opportu-

nities for training physicians to work with other health professionals. Most academic medical centers are educating several types of health professionals other than physicians. In developing educational policy, curriculum, and instructional plans, members of the faculty responsible for other health professional programs should be consulted; and mechanisms for their meaningful input should be developed. In the graduate setting, differentiating physicians should learn to work with students in other health professions in the real context of patient care. Having residents develop an understanding of the special abilities of other health professionals, coupled with learning how to delegate responsibilities to those colleagues, should be a major goal.

4. Primary Patient Care

An emphasis on specialism in American medicine has resulted in a graduate medical education system focused principally on educating and training physicians for highly specialized roles in the treatment of disease. The generalist, prepared to assume primary responsibility for patients, has not received major attention. Institutions for graduate medical education are encouraged to experiment with the development of delivery systems and educational programs which will encourage a significant proportion of their residents to develop careers as primary care physicians.

5. Manpower Distribution by Specialty and Geographic Location

a. Specialty distribution:

Academic medical centers should plan their program in graduate medical education in accord with specialty manpower needs of both their regions and the nation. In a nation which is undergoing significant changes in its health care delivery system, projecting manpower needs requires complex planning technology. The geographic mobility of physicians further complicates local and regional forecasting. Institutions are urged to utilize resources available locally in developing manpower projections and to cooperate in national efforts to estimate the types of specialists needed in medicine.

b. Geographic distribution:

Solving the problems of getting physicians to settle and work in medically underserved areas is complicated. While there are many financial and cultural factors which influence physicians in their decisions for location, the professional experiences provided during their graduate education may be influential. Learning while caring for patients in well-run ambulatory settings remote from the acute-care teaching hospital may provide insights into the feasibility of establishing a practice in more remote areas. By extending graduate education opportunities into remote settings, academic medical centers will also provide opportunities for continued participation in medical education by physicians who choose to establish their practices in these areas.

REFERENCES

1. Millis, J. S. (Chairman). The Graduate Education of Physicians. Report of the Citizens Committee on Graduate Medical Education. Chicago: American Medical Association, 1966.
2. Smythe, C. McC., Kinney, T. D., Littlemeyer, M. H. (Eds.). The Role of the University in Graduate Medical Education. Evanston, Illinois: Association of American Medical Colleges.
3. Bulletin of the Association of American Medical Colleges, VI: 9: 3, 1971.
4. Kinney, T. D. (Chairman). Implications of Academic Medical Centers Taking Responsibility for Graduate Medical Education. Report of the Ad Hoc Committee on Graduate Medical Education. J. Med. Educ., 47: 77-84, 1971.

THE GRADUATE MEDICAL EDUCATION COMMITTEE

William G. Anlyan, M.D., CHAIRMAN
Vice President for Health Affairs
Duke University
School of Medicine

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

William J. Grove, M.D.
Executive Dean
University of Illinois
College of Medicine

William D. Holden, M.D.
Chairman, Department of Surgery
Case Western Reserve University
School of Medicine

Thomas D. Kinney, M.D.
Director of Medical Education
Duke University
School of Medicine

Julius R. Krevans, M.D.
Dean
University of California, SF
School of Medicine

Christian Ramsey, M.D.
President
Institute for the Study of
Health and Society

Arnold S. Relman, M.D.
Chairman, Department of Medicine
University of Pennsylvania
School of Medicine

David B. Wilson, M.D.
Asst. Dir. of the Medical Center
(For Special Projects and Health
Care Planning)
University of Mississippi
School of Medicine

Dr. Dael L. Wolfle
Professor
University of Washington
Graduate School of Public Affairs

Prepared by:

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

Document from the collections of the AAMC Not to be reproduced without permission

FOREWORD

The Ad Hoc Committee on Continuing Medical Education was charged with advising the Association of American Medical Colleges regarding the role that the Association and its constituents should play in continuing education in the future. Implicit in that charge was the view that continuing education has not been effective in accomplishing its imputed purpose--to make physicians of all ages optimally effective in the performance of their professional duties.

Data on performance of physicians (including those holding full- and part-time academic appointments) are difficult to acquire, but the information available suggests that there are significant defects in performance. In the opinion of the committee, there are two main reasons for these deficiencies which are of importance to medical faculties.

The first is that the behaviors imparted during the academic years do not, apparently, persist long into the practice years. The pressures of practice envelop the physician before he has an opportunity to adapt to the discipline required to continue his learning.

Secondly, despite a complete lack of evidence of effectiveness, the "shotgun" approach continues to be the pattern of continuing education as provided by medical faculties and associations. The committee questions the effectiveness of short courses, audio-tapes, video-tapes, and even books and

journals when they are considered in the light of the documented behavioral changes experienced by the majority of physicians after they become involved in the delivery of health care.

Measurements of continuing education, such as certificates of attendance, recognition rewards, and possibly recertification and relicensure by examination, are not measurements of the end objective--improving patient care by changing the behavior of physicians--and have no greater correlation with this objective than do grades and class rankings in medical school with performance during clinical graduate training.

Therefore, it is the thesis of this committee that continuing education cannot and should not be separated from the initial formal education and that medical faculties must strive to incorporate into the basic and graduate training years those continuing education methods which have been shown to be effective.

The committee report develops this position and also emphasizes that the AAMC and its constituents must make plans for instituting educational policies which bear directly on the problem of making physicians continually responsive to the changing knowledge and technology of medicine in the context of their daily responsibilities for patient care.

INTRODUCTION

The committee determined that fulfilling its charge required that it consider continuing education not in the context of the past or present but in the context of future. There was a consensus that there will be increasing expectations by the public for professional accountability (that is, that high quality care be obtainable at reasonable cost).

A modified Delphi technique was utilized to obtain opinions of the entire committee regarding the trends and characteristics of the health care delivery system during the next 10 years.

In the aggregate the committee believes that:

1. Physicians will continue to have the major responsibility for patient care, although they will be increasingly associated with and assisted by other health professionals.
2. Group practice will increase until by the end of the decade at least 50%--and perhaps as high as 80%--of all physicians will be members of organized medical groups.
3. These groups will increasingly be associated with a specific hospital.
4. Forty to seventy percent of physicians will receive at least three-fourths of their professional incomes from salaries.
5. There will be systematized methods of assuring an acceptable quality of physician performance. The responsibility for defining accountability will be shared by:

- (a) practicing physicians and medical educators,
- (b) the federal government,
- (c) third-party insurance carriers, and
- (d) consumers.

The committee believes that the definition of the parameters of quality will be predominantly initiated by practicing physicians and medical educators.

6. Efforts to control quality of medical practice will include:

(a) Audit systems such as the Professional Standards Review Organizations already enacted into law.

(b) Relicensure and recertification with recertification being distinctly favored.

(c) Periodic updating as a condition for continued employment in both private and public clinics.

(d) Requirement for continuing education credit even though there is little evidence that this is effective in assuring that physicians will responsibly modify their practice as knowledge and technology advance.

7. With increased demand for public accountability, there will be an increasing emphasis on educational programs for physicians by hospitals and clinics.

The committee's recommendations must then be interpreted with the knowledge that medical practice in the future is expected to be conducted by physicians predominantly working in organized groups with the majority rewarded through a salary in a social system demanding accountability for control

of quality and with hospitals and professional organizations placing an increasing emphasis on staff education.

RECOMMENDATIONS

1. *The medical faculty has a responsibility to impress upon students that the process of self-education is continuous and that they are going to be expected to demonstrate that they are competent to deliver care to patients throughout their professional lives.*

The form in which students and physicians will be asked to demonstrate competence will vary as their careers evolve. Initially, written cognitive examinations will play an important part in evaluation; but these will become less frequent as skills, attitudes, and ability to deduce appropriate conclusions from given data are tested. In practice the quality of care actually being delivered may be the method by which physician competence is constantly monitored.

2. *Medical faculties must cooperate with practicing physicians in their communities or regions to develop acceptable criteria of optimal clinical management of patient problems. Having established criteria, faculty and practitioners must devise and agree upon a system to ensure that deficiencies in meeting these criteria are brought to the attention of physicians who are performing below the expected norm.*

Before educational goals can be defined and plans laid, it is essential that the real educational needs of physicians be identified. Needs must relate to specified deficiencies

in knowledge, skills, attitudes, and medical care delivery organizational structures which are impairing optimal patient care. This effort cannot be unilateral. The academic staff must be as willing to examine and correct its own deficiencies in patient management as it is to criticize management by members of the nonacademic community of physicians. Students must see that their mentors are willing to participate in rigorous criticism of their own clinical activities. The development of positive and responsive attitudes of open dialogue among physicians must be imprinted as early as possible. Faculty examples of disregard of criticism may be a significant factor in imprinting and molding later regressive behaviors in physicians, impairing their willingness to participate in lifelong learning.

In developing criteria, both the processes of patient care and outcomes must be scrutinized. Although the patient population and the mission of academic hospitals vary from nonacademic hospitals, the committee urges that equivalent standards for ensuring optimal quality be required for all health providers in a community.

Initially, both the establishment of criteria and the development of a feedback system must be modest in scope, but ultimately criteria for all disciplines and subdisciplines of clinical medicine should have a systematized methodology. The areas where the efficacy of two or more approaches to the same problem is unresolved must be identified and flexible allowance made for differing professional opinions.

3. *Educational programs must be specifically directed toward improving deficiencies in knowledge, skills, attitudes, and organizational structures detected through systems developed for accomplishing recommendation 2. These programs should be geared to the need for immediate feedback and should be no more complex than needed to accomplish their goals and objectives, namely the improvement of patient care.*

There is too often an undue preoccupation with form which obscures function in continuing education. The development of educational programs should be directed toward fulfilling the physician's own desire to improve his performance as rapidly and as effectively as possible. Consideration should be given to principles of adult education concerning variations of learning styles, objective-directed learning, and the necessity for interchange of ideas during the learning process. Where learning new skills requires an on-the-job setting, provisions should be made to bring physicians to the appropriate site for the needed period. This may require the provision of substitute personnel in the physician's practice; the academic centers are urged to work particularly with organized groups that have planned for this need.

4. *Evaluation of the effect of educational programs should be planned from their first inception. Evaluations should be directed toward specific intended modifications of physician behavior and/or patient management in the setting of day-to-day practice. Depend-*

ence upon subjective evaluation of participants and/or cognitive evaluation may be spurious and misleading.

Experimental protocols and research applications failing to provide methods for data collection would not survive any current scientific review process. So too, with educational exercises at undergraduate, graduate, and continuing education levels, there should be methods for assessing objectively that specific desired learning outcomes have been achieved. As the student progresses in his professional education and career, these methods become increasingly sophisticated, time-consuming, and expensive but are, nevertheless, critical to the success of the educational system. Continuing education should be looked upon as a pragmatic effort to improve professional practice and can thus only be evaluated in the real practice setting. If the deficiencies toward which an educational program was directed persist, the content, mode of presentation, and motivational impetus for the learners must be re-examined.

Recommendations 1 through 4 set forth the broad principles upon which the committee believes the Association and its constituents should base their efforts in continuing education. The subsequent recommendations are directed toward specific areas of concern.

5. Medical faculties should evolve auditable records.

Assessment of both the process and outcomes of patient

management requires a written clinical record which clearly sets forth the problems identified and attacked, the logic of the diagnostic and therapeutic decisions made, and the outcomes of these decisions. Academic faculties are encouraged to evolve clinical record systems which meet these needs. Students should learn from their very first clinical experience how to develop such records and should grow to expect that their records will be reviewed throughout their professional lives. Faculty willingness to accept review and criticism from colleagues in their own and other disciplines is essential for inculcating responsible professional attitudes in the students whom their attitudes influence. A uniform patient record system involving all affiliated institutions in a center would greatly assist in education and in the measurement of the quality of patient care.

6. Medical faculties should endeavor to apply computer technology to patient record systems, diagnostic and therapeutic decision-making, and educational feedback systems.

Computers have undeveloped potential for clinical data management in a real time sense. Notable experiments are in process, and much can be learned from these. Resistance to the application of computers to clinical problems and adherence to the handwritten records of the past is a position which must be carefully reassessed. Because of high costs for both developmental and operational computer applications, resource sharing among centers will be essential.

7. *Educational planning and implementation should be carried out with the direct involvement of individuals skilled in educational methodologies.*

The development of systems for establishing patient management criteria and educational goals and objectives and for evaluating the impact of education on the learner require skills not necessarily inherent in all medical academicians. Both initial and continuing education require the assistance of individuals who may or may not be physicians but who have had the necessary training to develop and implement modern, goal-directed educational programs. The services of these individuals will do much to improve medical education throughout its continuum.

8. *Whenever appropriate, the members of a health team should be educated together.*

As the team concept of patient care grows, management and skills of delegation are becoming more important. Educational programs directed toward the improved attainment of team care should be developed and directed toward the activities of the entire team. Interdisciplinary development of criteria of quality of care is a method by which educational programs in which the team members learn together may be encouraged.

9. *Financing of continuing education must be based on a policy which recognizes its essential contribution to the progressive improvement of health care delivery.*

Continuing education must be financed from several sectors. Traditionally, these programs have been self-supporting. The process of evaluation of the efficacy of programs in terms of altered physician behavior and/or improved patient care is sophisticated, time-consuming, and expensive. As with any other sector of education, stable base funding from states, professional societies, and the federal government is essential in order to ensure the development of a skilled cadre of individuals to direct, lead, and evaluate such programs.

The committee believes that education of health professionals, and particularly their continuing education, must be directed toward the goal of the constant improvement of health care throughout the nation. Special funds, obtained on a competitive basis, are necessary in order to stimulate the development and implementation of new ideas in this area. Tuition derived from the students must also be continued in order to both provide support for ongoing programs of proven worth and to create an attitude of personal investment by the learner.

CONCLUSION

These nine recommendations do not represent extraordinary departures. All of them have been developed and implemented to varying degrees both in academic centers and in community hospitals. They do not set continuing education apart from the formal academic programs for students still in their

medical school or clinical graduate years but rather attempt to meld these years into the full professional life span.

The recommendations are pragmatic and are based upon defensible predictions of the characteristics of the health care system during the next decade. If the AAMC and the academic centers embark upon policy development which implements these recommendations in a spirit of cooperation with practicing physicians, much of the criticism currently being leveled at the health care system may be allayed.

AD HOC COMMITTEE ON CONTINUING EDUCATION

Thomas C. Meyer, M.D., F.R.C.P., Chairman
University of Wisconsin Center for Health Sciences
Department of Postgraduate Medical Education

Clement R. Brown, M.D.
Mercy Hospital and Medical Center
Chicago, Illinois

Joseph Hamburg, M.D., Dean
School of Allied Health Professions
University of Kentucky

John N. Lein, M.D.
Associate Dean
Division of Continuing Medical Education
University of Washington
School of Medicine

Phil R. Manning, M.D.
Associate Dean for Postgraduate Education
University of Southern California
School of Medicine

Lewis A. Miller, President
Miller and Fink Corporation
Darien, Connecticut

George Shapiro, Ph.D.
Professor of Communications
University of Minnesota

Donald Shropshire, M.A., Administrator
Tucson Medical Center

Frank R. Woolsey III, M.D.
Department of Postgraduate Medical Education
Albany Medical College
Albany, New York

AAMC STAFF:

August G. Swanson, M.D.
Director
Department of Academic Affairs

Connie Choate

IV. Information Items:

3. Actions of the Liaison Committee on Medical Education:

The Liaison Committee on Medical Education (LCME) actions are approved by the Executive Council of the AAMC and the Council of Medical Education of the AMA. The actions during the past six months are enclosed for your information. The activities of the LCME will be commented upon by Dr. Ernst Knobil.

ACTIONS OF THE
LIAISON COMMITTEE ON MEDICAL EDUCATION

<u>Fully Developed Schools</u>	<u>Survey</u>	<u>Years Approved</u>
Cornell University Medical College	6/72	7
SUNY-Upstate Med. Ctr. College of Medicine	5/72	7 (entering class 120)
University of Laval Faculty of Medicine	5/72	5 (entering class 200)
Duke University School of Medicine	2/72	7 (entering class 114)
 <u>Developing Schools</u>		
University of Massachusetts Medical School	5/72	Provisional Accreditation: Entering class 64-1973; 80-1974; 96-1975, pending next survey during 1973- 1974.
Southern Illinois University School of Medicine	7/72	Provisional Accreditation to enroll a charter class of 48 entering students in June 1973; up to 24 third year students; annual resurveys.
 <u>Conversion to Degree Granting Medical School</u>		
University of Hawaii School of Medicine	8/72	Continued full Accreditation for the Basic Science Curriculum; Provisional Accreditation for the MD degree granting program; 66 students per class.
Brown University, Division of Biological and Medical Sciences	8/72	Continued full Accreditation for the Basic Science Curriculum; Provisional Accreditation for the MD degree granting program; 60 students in each year of the curriculum; resurvey during 1974-75

Document from the collections of the AAMC Not to be reproduced without permission

LIAISON COMMITTEE ON MEDICAL EDUCATION

Council on Medical Education, AMA

Warren L. Bostick, M.D.
University of California, Irvine
California College of Medicine
Irvine, California 92664

(714) 833-5925

Bland W. Cannon, M.D.
Special Advisor to the Chancellor
The University of Tenn. Medical Units
62 South Dunlap Street
Memphis, Tennessee 38103

(901) 527-6641 Ext. 855

Francis L. Land, M.D.
Associate Dean for Clinical Affairs
University of Nebraska
College of Medicine
42nd and Dewey Streets
Omaha, Nebraska 68105

(402) 541-4283

E. Bryce Robinson, Jr. M.D.
3526 Lenox Road
Birmingham, Alabama 35213

(205) 322-5391

William A. Sodeman, M.D.
Commission on Foreign Medical Graduates
116 South Seventh Street
Philadelphia, Pennsylvania 19106

(215) WA 3-8282

Joseph M. White, Jr., M.D.
University of Texas Medical Branch
Galveston, Texas 77550

(713) 765-2671

Assn. of American Medical Colleges

Ralph J. Cazort, M.D.
Dean
Meharry Medical College
School of Medicine
1005 18th Avenue North
Nashville, TN 37208

(615) 256-3631

Kenneth R. Crispell, M.D.
Vice President for Health Affairs
University of Virginia
School of Medicine
Charlottesville, VA 22901

(703) 924-5239

T. Stewart Hamilton, M.D.
Executive Director
Hartford Hospital
80 Seymour Street
Hartford, CT 06115

(203) 524-3011

Thomas D. Kinney, M.D.
Director of Medical Education
Duke University
Medical School
Durham, NC 27706

(919) 684-8111

Ernst Knobil, M.D.
Chairman, Dept. of Physiology
University of Pittsburgh
School of Medicine
Pittsburgh, PA 15213

(412) 683-1620

C. John Tupper, M.D.
Dean
University of California, Davis
School of Medicine
Davis, CA 95616

(916) 752-0331

(Continued Liaison Committee Membership)

Federal Member

Public Members

Harriet Simmons Inskip (Mrs.)
4930 Takoma Avenue
Ft. Wayne, Indiana 46807

(219) 745-3111

Nathan Stark
Vice President
Hallmark Cards, Inc.
2501 McGee
Kansas City, Missouri 64108

(816) 274-5906

Association of Canadian Medical Colleges

John B. Firstbrook, M.D.
151 Slater Street
Ottawa 4, Ontario
Canada

(613) 237-0700

IV. Information Items:

4. Coordinating Council on Medical Education and the Liaison Committee on Graduate Medical Education:

The newly established CCME and LCGME have now met on two occasions. The problems to be addressed and their modes of operation are still being established. A report of the developments in these meetings will be made by Dr. August G. Swanson.

COORDINATING COUNCIL ON MEDICAL EDUCATION

Representatives Named by Participating Organizations

AMERICAN BOARD OF MEDICAL SPECIALTIES:

John F. Roach, M.D.	Albany, New York
John P. Hubbard, M.D.	Philadelphia, Pennsylvania
Robert A. Chase, M.D.	Palo Alto, California

AMERICAN HOSPITAL ASSOCIATION:

Thomas Ainsworth, M.D.	Chicago, Illinois
Donald J. Caseley, M.D.	Chicago, Illinois

AMERICAN MEDICAL ASSOCIATION:

Merrill O. Hines, M.D.	New Orleans, Louisiana
Tom E. Nesbitt, M.D.	Nashville, Tennessee
Bernard J. Pisani, M.D.	New York, New York

ASSOCIATION OF AMERICAN MEDICAL COLLEGES:

William G. Anlyan, M.D.	Durham, North Carolina
Clifford Grobstein, Ph.D.	La Jolla, California
T. Stewart Hamilton, M.D.	Hartford, Connecticut

COUNCIL OF MEDICAL SPECIALTY SOCIETIES:

C. Rollins Hanlon, M.D.	Chicago, Illinois
William A. Sodeman, M.D.	Philadelphia, Pennsylvania
J. Jerome Wildgen, M.D.	Kalispell, Montana

PUBLIC MEMBER - To Be Selected

MEMBER REPRESENTING FEDERAL GOVERNMENT - To Be Selected

Staff of the organizations represented may attend meetings on an ex officio basis, without vote.

12/72

LIAISON COMMITTEE ON GRADUATE MEDICAL EDUCATION

Representatives Named by Participating Organizations

AMERICAN BOARD OF MEDICAL SPECIALTIES:

John Anderson, M.D.	Minneapolis, Minnesota
Robert A. Chase, M.D.	Palo Alto, California
Gordon W. Douglas, M.D.	New York, New York
Jack D. Myers, M.D.	Pittsburgh, Pennsylvania

AMERICAN HOSPITAL ASSOCIATION:

Samuel P. Asper, M.D.	Baltimore, Maryland
Bruce W. Everist, M.D.	Ruston, Louisiana

AMERICAN MEDICAL ASSOCIATION:

Perry J. Culver, M.D.	Boston, Massachusetts
James W. Haviland, M.D.	Seattle, Washington
Bernard J. Pisani, M.D.	New York, New York
William A. Sodeman, M.D.	Philadelphia, Pennsylvania

ASSOCIATION OF AMERICAN MEDICAL COLLEGES:

William G. Anlyan, M.D.	Durham, North Carolina
John Danielson	Chapel Hill, North Carolina
William D. Holden, M.D.	Cleveland, Ohio
Julius R. Krevans, M.D.	San Francisco, California

COUNCIL OF MEDICAL SPECIALTY SOCIETIES:

Edward C. Rosenow, M.D.	Philadelphia, Pennsylvania
Rubin Flocks, M.D.	Iowa City, Iowa

PUBLIC MEMBER - To Be Selected

MEMBER REPRESENTING FEDERAL GOVERNMENT - To Be Selected

Staff of the organizations represented may attend meetings on an ex officio basis, without vote.

11/1/72

IV. Information Items:

5. An ad hoc committee of the Association has been working in an advisory capacity with the Social Security Administration in drawing up the rules and regulations for Medicare-Medicaid. The status of this committee's activities will be reported by Dr. Relman.

IV. Information Items:

6. Biomedical Research Committee - Dr. Estabrook

The Committee on Biomedical Research and Research Training has met several times since its activation, January 1, 1973. The Committee has decided to approach the question of the cost of the biomedical research contribution to medical education by developing data as to the view of the students and the faculty regarding the importance of biomedical research in the education of a physician. A first questionnaire will attempt to develop an understanding of the view of the medical student regarding the contribution of biomedical research to his education. A second questionnaire will be distributed to faculty and will attempt to ascertain the view of the faculty regarding the relationship between biomedical research and medical education. A third aspect of this study may involve questions being distributed to the cohort of the medical student class of 1960, who are participating in the AAMC Longitudinal Study.

The Committee is also beginning to concern itself with the role of the AAMC in long-term development of biomedical research policy. In this regard, the Committee has endorsed the concept of the National Diabetes Act of 1973 and requests that staff of the Association work with voluntary nonprofit organizations which support these types of legislation to ensure that adequate provision is made for investigator-initiated project research.

IV. Information Items:

7. Committee on Financing Medical Education:

The Association has been conducting an intensive study of eight paired schools to determine the range of costs for undergraduate medical student education. The report of the committee is expected in early summer. Dr. William Weil will report on the current state of this study.

IV. Information Items:

8. Division of Educational Resources Development:

This Division has been established in the Association to facilitate the development and utilization of multimedia teaching materials. An extension of the Division is located on the Emory Campus in Atlanta where two staff members (one from AAMC and one from the American Association of Dental Schools) are working with the staff of the National Medical Audiovisual Center to begin a program for accession, review, indexing and cataloguing of available multimedia materials. Dr. William Cooper, head of the Division, and Deputy Director of the Department of Academic Affairs, will report on the plans for this Division.

IV. Information Items:

9. Primary Care:

The Executive Committee has given highest priority to furthering the development of viable models for the provision of primary care and facilitating their introduction into the educational programs of the institutions. Dr. Thomas Piemme, Chairman, Division of General Medicine at George Washington University, has been working on a part-time basis with Dr. Robert Kalinowski, Director of the Division of Health Services, to implement this program. Dr. Piemme will report on progress and plans.

Status Report on

MCAT DEVELOPMENT ACTIVITY

A provisional name has been designated - Medical College Admission Assessment Program (MCAAP). The key word is "assessment". This word was deliberately chosen to suggest a broader range of data collection beyond that ordinarily implied by a testing format, e.g. biographical information. The purpose of the program is to update and expand the MCAT and increase the amount of useful information available during the admissions process.

A systematic effort is suggested for obtaining constituent input and consensus on instrument construction and research and development activity. This effort began in a serious way about a year ago when your response to a "Proposal for a Program of Pre-enrollment Assessment" was requested. Some concrete topics for discussion were identified which hopefully will provide a departure point for discussion at the spring meetings of the appropriate councils and subcouncilar units of the Association. Jim Angel, program director of MCAAP, will be working with the various regional chairmen to identify a regional representative who will facilitate discussions within regions where possible, organize the regional input, and supply continuity in later discussions.

Following regional meetings, the current plan is to organize regional conferences in June sponsored by MCAAP and devoted exclusively to discussion of plans and priorities for program development. Participation would be open to all interested representatives from all constituent bodies of the AAMC within that region. The various regional representatives previously identified would play a major role in transmitting the concerns of their organization at these discussions and in representing a synthesis of these concerns at a task force to take place in July. Invitation to the task force sessions would include the regional representatives and a few at-large members. The primary objective of the task force sessions would be consensus on immediate plans and priorities for test construction activities and research effort.

Concurrently, a contractor will be identified to interact with the constituency at these various opportunities and draw up a set of specifications which will also include its independent recommendations.

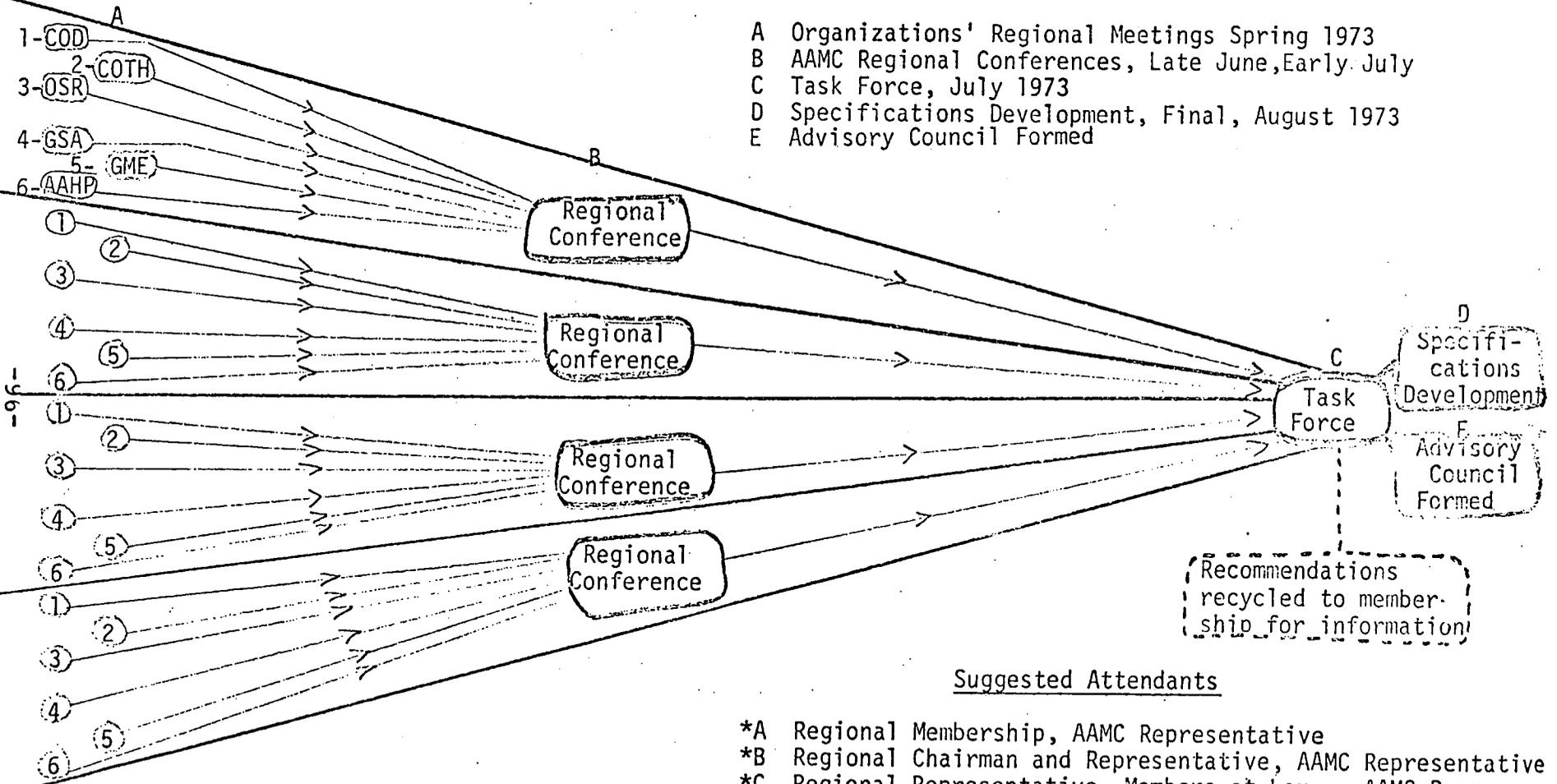
Finally, an advisory body will be identified from those contributing to the ultimate consensus in order to provide continuing guidance to the developing program.

EXHIBIT I. Medical College Admissions Assessment Program, Division of Educational Measurement and Research
 AAMC
 2/73

DIAGRAM OF COUNCIL/GROUP AND TASK FORCE INVOLVEMENT¹

MCAT Revision Planning

Meetings



- A Organizations' Regional Meetings Spring 1973
- B AAMC Regional Conferences, Late June, Early July
- C Task Force, July 1973
- D Specifications Development, Final, August 1973
- E Advisory Council Formed

Suggested Attendants

- *A Regional Membership, AAMC Representative
- *B Regional Chairman and Representative, AAMC Representative
- *C Regional Representative, Members-at-Large, AAMC Repr.
- D AAMC Staff, Contractors, Review by Representatives
- E Persons recommended by task force, AAMC Exec. Council
- *Some meetings possibly attended by contractor representative

- 1 Council of Deans
- 2 Council of Teaching Hospitals
- 3 Organization of Student Representatives
- 4 Group on Student Affairs
- 5 Group on Medical Education
- 6 Association of Advisors to the Health Professions

¹ Plans being formulated for CAS participation also.

Not named is Council of Academic Societies, which may have involvement of some dimension.

Document from the collections of the AAMC. Not to be reproduced without permission.

Association for Medical School Pharmacology

Office of the President
Department of Pharmacology and Therapeutics
University of Florida College of Medicine
Gainesville, Florida 32601
(904) 392-3544

OFFICERS

Thomas H. Maren, President
H. George Mandel, Treasurer
George Washington University
Paul L. Munson, Secretary
University of North Carolina
Edward J. Cafruny, Councillor
University of Toledo
James F. Ashmore, Councillor
University of Indiana

November 22, 1972

THE ROLE OF PHARMACOLOGY IN THE EDUCATION OF THE PHYSICIAN

Pharmacology is the basic science concerned with the interactions of chemicals and biological systems. Its principal role in medicine is to provide the scientific basis for the rational application of those chemical agents commonly known as drugs to the diagnosis, prevention and treatment of disease. This science also should provide an understanding of the nature of all effects, including harmful ones, of chemicals on the organism. It is, therefore, quite possible and indeed important to define the role of pharmacology in the education of the physician.

The medical student's first experience with pharmacology must provide comprehensive consideration of the interactions of drugs and the normal organism. Consideration must be given to the principal actions at all levels of biological organization. These provide the basis for therapeutic application and the means of understanding secondary effects which may be the basis of adverse responses. Physical and chemical properties of drugs must be presented because of their great theoretical importance which in turn has a bearing in their therapeutic application. Other aspects of pharmacology which must now be taught include absorption, distribution, metabolism and excretion of drugs, toxic effects, possible interactions with other drugs, tolerance and dependence where they may occur, and genetic variables which can affect the response to the drug. Only with such a background can the student understand the use of, and rationally employ, drugs in the disease state. It should also be emphasized that training in these areas can be provided most effectively by pharmacologists with

Association for Medical School Pharmacology

a diversity of backgrounds, including those dominantly physiological, chemical and medical, and with either Ph.D. or M.D. degrees.

In addition to the toxicology of drugs employed in the practice of medicine, increasing emphasis must be placed on alerting medical students to the hazards of dangerous environmental agents. These include industrial pollutants and chemical agents used indiscriminately to stimulate or to depress the nervous system. These latter drugs are commonly considered the agents of drug abuse.

Having established a base in pharmacology, training should proceed by its natural extension into the clinical years. Armed with fundamentals and the impact of the clinical pharmacologist, students can orient their thinking to the patient and to the disease process. Their knowledge has extended from single systems to encompass the entire array of drugs which might be employed in therapy. To meet the optimal requirement for education in this broad field, it is essential to include strong parallel programs in toxicology and clinical pharmacology.

Upon graduation from medical school, the new physician is required to make prompt, rational, life or death decisions regarding drugs in the management of patients. A strong, comprehensive training in pharmacology is the beginning which leads toward the dual capacity to practice and to invoke knowledge of principles that will serve when compounds and theories come to light at a later time, long after the days of formal education. Pharmacology and its practical counterpart, therapeutics, must then be part of the continuing education of the physician during the residency and throughout practice.

At a time when the physician's need for knowledge of drugs has never been greater and indeed is increasing steadily, there has been a paradoxical and irrational trend to deemphasize programs in basic medical education. Accrediting agencies for medical schools, medical administrators, and faculty committees responsible for curricula should be concerned with the decreasing emphasis on drug education and should make every effort to see that physicians are better prepared in pharmacology and toxicology than they have been in the past.

FINAL PROGRAM

CONFERENCE ON THE IMPACT OF
LARGE CENTER CATEGORICAL GRANTS ON THE ACADEMIC HEALTH CENTERS

Sponsored by the Council of Academic Societies of the
Association of American Medical Colleges and the
National Heart and Lung Institute

Thursday, March 29, 1973
Mayflower Hotel
Washington, D. C.

MORNING SESSION - 8:30 a.m. - Chairman, Robert Petersdorf, M.D., University of Washington

- 8:30-8:40 a.m. Introduction and Welcome - John A. D. Cooper, M.D.,
Ph.D., Association of American Medical Colleges
- 8:40-9:20 a.m. The relationship between the source of funding and
the institution being funded - Thomas Kennedy, Jr.,
M.D., NIH
- 9:20-9:50 a.m. The impact of center grant programs on the institution -
Linda Wilson, Ph.D., Washington University
- 9:50-10:30 a.m. Discussion and Coffee
- 10:30-12:00 noon Experience and concerns from two medical centers
- 10:30-11:00 a.m. Impact on the institution - Julius Comroe, M.D.,
University of California, San Francisco
- 11:00-11:30 a.m. Impact on medical education - A. McGhee Harvey, M.D.,
Johns Hopkins University
- 11:30-12:00 noon Discussion
- 12:00-1:30 p. m. Luncheon
- Speaker - The Honorable Paul G. Rogers, U. S. House
of Representatives
- Presentation on changing patterns in federal funding
of biomedical research as viewed by the legislature

Document from the collections of the AAMC Not to be reproduced without permission

CONFERENCE PROGRAM ON LARGE CENTER
CATEGORICAL GRANTS, Continued...
Page two

AFTERNOON SESSION - 1:30 p.m. - Chairman, Ronald Estabrook, M.D., University of Texas,
Southwestern

- 1:30-4:00 p.m. Center grants versus investigator-initiated research
- 1:30-2:00 p.m. The challenge of center research - Robert Ringler,
Ph.D., National Heart and Lung Institute
- 2:00-2:30 p.m. Preparation for a center research program - J. Palmer
Saunders, Ph.D., National Cancer Institute
- 2:30-3:00 p.m. Presentation on the effect of large center programs
on investigator-initiated research - Russell Ross,
D.D.S., Ph.D., University of Washington
- 3:00-4:00 p.m. Discussion and Coffee
- 4:00-4:30 p.m. Implications of large program grants for institutional
management and fiscal responsibility - Robert Stone,
M. D., University of New Mexico
- 4:30-5:00 p.m. Peer review, quality control and performance guarantee -
Kenneth Brinkhous, M.D., The University of North
Carolina
- 5:00-5:30 p.m. General discussion
- 5:30 p.m. "No host reception"