



AGENDA
FOR
COUNCIL OF ACADEMIC
SOCIETIES

“ISSUES IN GRADUATE MEDICAL EDUCATION”

Interim Meeting
March 22-23, 1979
Washington Hilton Hotel
Washington, D.C.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

*One Dupont Circle
Washington, D.C. 20036*

AGENDA
COUNCIL OF ACADEMIC SOCIETIES
INTERIM MEETING

March 22 - 23, 1979
Washington Hilton Hotel
Washington, D.C.

TABLE OF CONTENTS

MEETING SCHEDULE	(1)
GRADUATE MEDICAL EDUCATION WORKSHOPS	
Background and Workshop Format	(3)
Proposed Revision of the <u>General Requirements</u> for Graduate Medical Education	(8)
The <u>transition</u> between undergraduate and graduate medical education	(42)
The <u>accreditation</u> of graduate medical education	(60)
Graduate medical education and <u>specialty distribution</u>	(82)
 <u>BUSINESS MEETING</u>	
Action Item: Rules and Regulations Amendment on Election of Officers	(91)

ISSUES IN GRADUATE MEDICAL EDUCATION

Thursday March 22, 1979

9:00 am - 10:00 am

Registration

10:00 am

Convene -- Monroe Room

Keynote: Graduate Medical Education: A Challenge to the Academic Societies

-- Thomas K. Oliver, M.D., Chairman of the Council

-- A Report of the AAMC Task Force on Graduate Medical Education--Jack S. Myers, M.D., Chairman of the Task Force

-- The Liaison Committee on Graduate Medical Education: Its Progress after Six Years. William K. Hamilton, M.D., Former Chairman of the LCGME.

12:00 noon

Lunch -- International Ballroom West

2:00 pm

Workshop Discussions

-- The Proposed Revision of the General Requirements for Graduate Medical Education (Grant Room)

-- The Transition Between Undergraduate and Graduate Medical Education (Hamilton Room)

-- The Accreditation of Graduate Medical Education (Independence Room)

-- Graduate Medical Education and Specialty Distribution (Kalorama Room)

5:00 pm

A Report on the Graduate Medical Education National Advisory Committee--Alvin R. Tarlov, M.D., Chairman of the Committee (Conservatory)

6:00 pm - 7:00 pm

Cocktails (no host) -- Lincoln West

ISSUES IN GRADUATE MEDICAL EDUCATION

Friday, March 23, 1979

8:30 am

Reconvene -- Lincoln West

--Reports from Workshops and General Discussion
by the Council

BUSINESS MEETING

10:30 am

Call to Order

--Action item: Rules and Regulations Amendment
on Election of Officers

--Discussion of Current Public Policy Issues
Relating to Biomedical Research and Education

12:30 pm

Adjourn

GRADUATE MEDICAL EDUCATION WORKSHOPS

Background:

The Council at its Annual Meeting in New Orleans expressed concern about the mounting pressures for change in graduate medical education. The program is organized to provide an opportunity for thorough discussion of the many issues in graduate medical education. The AAMC established a Task Force on Graduate Medical Education in 1977 and much of the material in the agenda is derived from discussions of the Task Force and its Working Groups. (See page 6 for a list of members of the Task Force.) At the annual meeting of the Assembly of the AAMC in November, 1979, the report of the Task Force will be presented and acted upon. This interim meeting of the CAS will provide input to the Task Force and assist greatly in its development and recommendations.

Format:

Representatives to the Council will be distributed evenly among the 4 workshops. Selection of workshops will be on a first come basis at the time of registration on Thursday the 22nd.

The Liaison Committee on Graduate Medical Education and the Residency Review Committees:

Liaison Committee on Graduate Medical Education (LCGME)

Established in 1972

Membership - Association of American Medical Colleges (AAMC)
4 Representatives

- American Board of Medical Specialties (ABMS)
4 Representatives

- American Medical Association (AMA)
4 Representatives

- American Hospital Association (AHA)
2 Representatives

- Council of Medical Specialty Societies (CMSS)
2 Representatives

- Public Representative (1)

- Resident Representative (1)

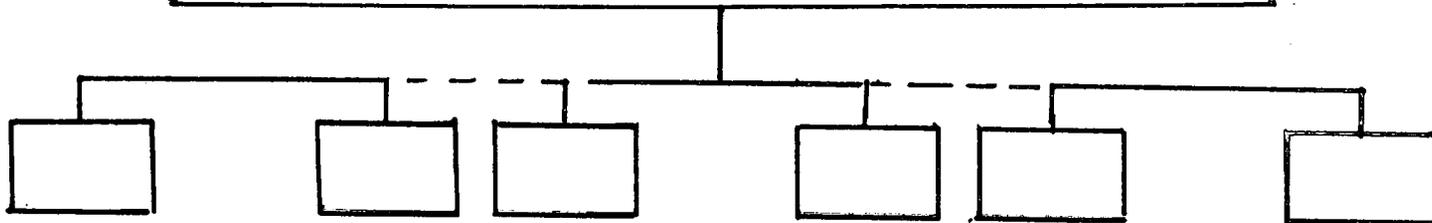
- Federal Representative (1)

Residency Review Committees (RRCs)

There are 22 RRCs (see page 66 for their names and sponsors). The RRCs in internal medicine and surgery were the first two and were established in their present form in 1949. The pathology RRC was the last and was established in 1972.

LCGME

- 1) Develops General Requirements which must be approved by all 5 sponsors.
- 2) Approves Special Requirements of each RRC.
- 3) Establishes operating policies and procedures for all RRCs.
- 4) Reviews RRC actions and accredits programs.



22 R R C s

- 5) Develops Special Requirements which must be approved by each RRC's sponsor.
- 6) Reviews and approves programs and recommends accreditation status to the LCGME.

REPRESENTATIVES TO THE LCGME

American Board of Medical Specialties

Robert B. King, M.D.
Frank Moody, M.D.
Victor C. Vaughan, III, M.D.
James Hansen, M.D. (Staff, ex-officio, without vote)
Glen Leymaster, M.D. (Staff, ex-officio, without vote)

American Hospital Association

Mr. Irvin G. Wilmot
Mr. Eugene L. Staples
Nancie Noie (Staff, ex-officio, without vote)
Mr. Raymond O. Nordquist (Staff, ex-officio, without vote)

American Medical Association

Clarence S. Livingood, M.D.
Richard G. Connor, M.D.
Russell S. Fisher, M.D.
Gordon H. Smith, M.D.
E. Lovell Becker, M.D. (Staff, ex-officio, without vote)

Association of American Medical Colleges

Thomas K. Oliver, Jr., M.D.
Robert Petersdorf, M.D.
Richard Janeway, M.D. Dean
*August G. Swanson, M.D. (*Voting Staff Member)

Council of Medical Specialty Societies

Truman G. Schnabel, Jr., M.D.
Anne M. Seiden, M.D.
Frank W. Masters, M.D. (Alternate representative)
Mr. L. Jack Carow (Staff, ex-officio, without vote)
Richard S. Wilbur, M.D. (Staff, ex-officio, without vote)

Federal Government Representative

David McNutt, M.D.

House Staff Representative

Russell Kridel, M.D.

AAMC TASK FORCE ON GRADUATE MEDICAL EDUCATION*

- MYERS, JACK D., M.D., Chairman; University Professor of Medicine, University of Pittsburgh School of Medicine, 1291 Scaife Hall, Pittsburgh, Pennsylvania 15261/(412) 624-2649
- BEERING, STEVEN C., M.D.; Dean, Indiana University, School of Medicine, 1100 West Michigan Street, Indianapolis, Indiana 46202/(317) 264-8157
- CLAWSON, D. KAY, M.D.; Dean, University of Kentucky, College of Medicine, 800 Rose Street, Lexington, Kentucky 40506/(606) 233-5119
- DOUGLAS, GORDON W., M.D.; Professor and Chairman, Department of Obstetrics and Gynecology, New York University, School of Medicine, 550 First Avenue, New York, New York 10016/(212) 683-1624
- FOOTE, SANDRA, M.D.; Clinical Associate, Laboratory for Tumor Cell Biology, National Cancer Institute, Bethesda, Maryland 20014/(301) 496-4567; Mailing Address (Residence)--6352 12th Place North, Arlington, Virginia 22205/(703) 534-9310
- FOREMAN, SPENCER, M.D.; Executive Vice President, Sinai Hospital of Baltimore, Baltimore, Maryland 21215/(301) 367-7800
- GOULET, CHARLES; Executive Vice President, Health Care Services, Illinois Blue Cross/Blue Shield, 233 North Michigan Avenue, Chicago, Illinois 60601/(312) 661-2940
- GUTMANN, CHERYL M., M.D.; First-Year Resident, Department of Psychiatry, Rush-Presbyterian-St. Luke's Medical Center, Chicago (312) 942-7277 page #3190; Mailing Address (Residence)--351 Dickens Street, Chicago, Illinois 60614/(312) 248-5112
- GUZE, SAMUEL B., M.D.; President of the Medical Center, Vice Chancellor for Medical Affairs, Chairman, Department of Psychiatry, Washington University, 660 South Euclid Avenue, St. Louis, Missouri 63110/(314) 454-3013
- JOKLIK, WOLFGANG K., Ph.D.; Chairman, Department of Microbiology, Duke University Medical Center, School of Medicine, P.O. Box 3005, Durham, North Carolina 27710/(919) 684-5138
- MEDEARIS, DONALD N., JR., M.D.; Wilder Professor of Pediatrics, Harvard Medical School, Chief, Children's Service, Massachusetts General Hospital, Boston, Massachusetts 02114/(617) 726-2900
- *DUSTAN, HARRIET P., M.D.; Director, Cardiovascular Research and Training Center, University of Alabama, Ziegler Building (10th Floor), University Station, Birmingham, Alabama 35294/(205) 934-2580, member from June 1977-May 1978
- *HOMAN, WILLIAM P., M.D.; Chief Resident in Surgery, New York Hospital, 1977-78, member from June 1977-June 1978, currently Research Fellow, the Nuffield Department of Surgery, Radcliffe Infirmary, Oxford OX2 6 HE, England

(AAMC Task Force on Graduate Medical Education--Continued)

MILLER, DAN; Fourth-Year Medical Student, University of California, San Diego, School of Medicine; Mailing Address--4528 19th Street, San Francisco, California 94114/(415) 861-5884

NELSON, STANLEY R.; Executive Vice President, Henry Ford Hospital, 2799 West Grand Boulevard, Detroit, Michigan 48202/(313) 876-1244

NEUHAUSER, DUNCAN, Ph.D.; Associate Professor of Health Services Administration, Department of Health Services, Harvard University, School of Public Health, 677 Huntington Avenue, Boston, Massachusetts 02115/(617) 732-1070

PETERSON, ANN S., M.D., Associate Dean for Student Affairs, Columbia University College of Physicians and Surgeons, Columbia University, 630 West 168th Street, New York, New York 10032/(212) 694-2500

REYNOLDS, RICHARD C., M.D.; Professor of Medicine and Associate Dean for Clinical Affairs, Director of Ambulatory Care, Department of Medicine Rutgers Medical School, University Heights, Piscataway, New Jersey 08854/(201) 564-1966

SPELLMAN, MITCHELL W., M.D., Ph.D.; Dean for Medical Services, Office of the Dean, Harvard Medical School, 25 Shattuck Street, Boston, Massachusetts 02115/(617) 732-1760

OBSERVERS/PARTICIPANTS

MATHER, JOHN, M.D.; Chief, Medical/Dental Division, Education Service, Department of Medicine and Surgery, Veterans Administration, Room 414-D, 810 Vermont Avenue, N.W., Washington, D.C. 20420/(202) 389-5171

MAYER, WILLIAM D., M.D.; Assistant Chief Medical Director of Academic Affairs (14), Department of Medicine and Surgery, Veterans Administration, 810 Vermont Avenue, N.W., Washington, D.C. 20420/(202) 389-5093

GRAHAM, ROBERT, M.D.; Executive Secretary, Graduate Medical Education National Advisory Committee, Deputy Director, Bureau of Health Manpower, Division of Medicine, Center Building, 4th Floor, 3700 East-West Highway, Hyattsville, Maryland 20782/(301) 436-6430

PROPOSED REVISION OF THE GENERAL REQUIREMENTS FOR
GRADUATE MEDICAL EDUCATION

When the Liaison Committee on Graduate Medical Education was formed, its bylaws gave it the responsibility for establishing the general rules and requirements under which residency programs are established and conducted. This proposed revision is the first brought forward by the LCGME. It is based upon a 1974 statement on the responsibilities of institutions sponsoring programs in graduate medical education. The Coordinating Council on Medical Education (CCME) has forwarded the proposal to the LCGME's five sponsoring organizations for review and comment.

In late May, an ad hoc committee of representatives from both the CCME and LCGME will meet to resolve differences and prepare a final version to be ratified by all five sponsors of the LCGME. The Council's discussion of the proposal will provide guidance to the AAMC representatives on the Committee. The Council of Deans and the Council of Teaching Hospitals will also review and comment on the revision at their spring meetings.

On the following pages are (1) the proposed "Essentials of Accredited Residencies in Graduate Medical Education" and (2) the existing version of "Essentials of Accredited Residencies."

THE ESSENTIALS OF ACCREDITED RESIDENCIES
IN GRADUATE MEDICAL EDUCATION

1 Graduate medical education in the United States is the second
2 phase in the continuum of medical education. Physicians enter pro-
3 grams in graduate medical education after completing their undergra-
4 duate phase in order to prepare themselves to be practitioners. The
5 graduate phase is essential as indicated in this statement in the
6 Liaison Committee on Medical Education's (LCME) "Structure and
7 Functions of a Medical School":

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

8 During the undergraduate phase, students gain knowledge of the
9 sciences basic to medicine and learn to apply that knowledge to clini-
10 cal problems. Skills in collecting data are developed by interviewing
11 and examining patients and selecting and applying laboratory procedures
12 under the guidance and supervision of the faculty and residents. Stu-
13 dents learn to utilize these data to arrive at diagnostic hypotheses
14 and make therapeutic decisions. These basic skills are learned by
15 rotations through a variety of clinical disciplines in both inpatient
16 and outpatient settings. Undergraduate medical students have limited
17 opportunities to assume personal responsibility for patient care, and
18 generally do not participate in the care of individual patients for an
19 extended period of time.

1 Physicians in graduate medical education are, by convention, called
2 resident physicians or residents. During the graduate phase, the know-
3 ledge and skills acquired in medical school are expanded through the
4 progressive assumption of personal responsibility for patient care in
5 supervised, clinical, educational environments which provide op-
6 portunities to learn about the variability of human beings in health
7 and disease and about their biological, psychological and social problems.
8 As residents progressively gain more knowledge and skill they are provided
9 greater latitude to make decisions and treat patients, but always under
10 supervision.

11 Graduate medical education is organized programmatically. For each
12 specialty of medicine there are programs which concentrate on providing
13 education and training in that specialty. Institutions vary in the number
14 and variety of the specialty programs they provide. Some may offer programs
15 in nearly all of the specialties, while others sponsor only a limited
16 number, consistent with their clinical resources and mission. Each pro-
17 gram is organized and directed by a program director and has an identified
18 staff which is responsible for the education, training and supervision
19 of its residents. Each institution is responsible for the provision of
20 sufficient resources and internal supervision to assure the proper
21 conduct of all of its programs.

22 During the graduate phase of their education most residents, in
23 addition to attaining the knowledge and skills needed to be practitioners,
24 seek to complete training requirements for certification by a specialty
25 board. Each board generally requires that graduate medical education be

1 obtained in a program reviewed and approved by the Residency Review
2 Committee (RRC) for that specialty and accredited by the Liaison Com-
3 mittee on Graduate Medical Education (LCGME).

APPROVAL AND ACCREDITATION

4 Approval and accreditation of training programs are voluntary
5 efforts of all parties involved in graduate medical education. By this
6 process the quality of training programs is upgraded and assurance is
7 provided medical students, residents, specialty boards, and the public
8 that programs are of high quality.

9 To be approved and accredited, graduate medical education programs
10 must meet the Special Requirements for a specialty and be sponsored by
11 an institution which meets the General Requirements for graduate medical
12 education. The Special and General Requirements are the standards
13 against which programs and institutions are judged by Residency Review
14 Committees (RRCs) and the Liaison Committee on Graduate Medical Education
15 (LCGME) in the process of review, approval and accreditation.

16 There is an established Residency Review Committee for each of
17 the specialties in medicine for which certification is provided by a
18 specialty board.

19 RRC
20 Allergy & Immunology

Represented Organizations
American Board of Allergy & Immunology
(A Conjoint Board of the American Board
of Internal Medicine and the American
Board of Pediatrics)
AMA Council on Medical Education

RRC

Represented Organizations

1	Anesthesiology	American Board of Anesthesiology AMA Council on Medical Education
2	Colon & Rectal Surgery	American Board of Colon & Rectal Surgery AMA Council on Medical Education American College of Surgeons
3	Dermatology	American Board of Dermatology AMA Council on Medical Education
4	Family Practice	American Board of Family Practice AMA Council on Medical Education American Academy of Family Physicians
5	Internal Medicine	American Board of Internal Medicine AMA Council on Medical Education American College of Physicians
6	Neurological Surgery	American Board of Neurological Surgery AMA Council on Medical Education American College of Surgeons
7	Nuclear Medicine	American Board of Nuclear Medicine <i>(A Conjoint Board of the American Board of Internal Medicine, the American Board of Pathology and the American Board of Radiology)</i> AMA Council on Medical Education
8	Obstetrics-Gynecology	American Board of Obstetrics & Gynecology AMA Council on Medical Education American College of Obstetricians and Gynecologists
9	Ophthalmology	American Board of Ophthalmology AMA Council on Medical Education
10	Orthopaedic Surgery	American Board of Orthopaedic Surgery AMA Council on Medical Education American Academy of Orthopaedic Surgeons
11	Otolaryngology	American Board of Otolaryngology AMA Council on Medical Education American College of Surgeons
12	Pathology	American Board of Pathology AMA Council on Medical Education

RRC

Represented Organizations

1	Pediatrics	American Board of Pediatrics AMA Council on Medical Education American Academy of Pediatrics
2	Physical Medicine & Rehabilitation	American Board of Physical Medicine & Rehabilitation AMA Council on Medical Education
3	Plastic Surgery	American Board of Plastic Surgery AMA Council on Medical Education American College of Surgeons
4	Preventive Medicine	American Board of Preventive Medicine AMA Council on Medical Education
5	Psychiatry & Neurology	American Board of Psychiatry & Neurology AMA Council on Medical Education
6	Radiology	American Board of Radiology AMA Council on Medical Education
7	Surgery	American Board of Surgery AMA Council on Medical Education American College of Surgeons
8	Thoracic Surgery	American Board of Thoracic Surgery AMA Council on Medical Education American College of Surgeons
9	Urology	American Board of Urology AMA Council on Medical Education American College of Surgeons

10 The Liaison Committee on Graduate Medical Education is composed
 11 of representatives of the following national professional organiza-
 12 tions which are concerned with and involved in graduate medical educa-
 13 tion:

- American Board of Medical Specialties
- American Hospital Association
- American Medical Association
- Association of American Medical Colleges
- Council of Medical Specialty Societies

1 In addition there is a resident representative, there is a federal repre-
2 sentative, and there is a public representative.

3 Each RRC develops Special Requirements for training programs in
4 its specialty. These Special Requirements, which have been approved by
5 the RRC's sponsoring organizations and the LCGME, set forth the require-
6 ments for the essential educational content, instructional activities,
7 patient care responsibilities, supervision, and facilities that should
8 be provided by programs in a particular specialty. Guides to assist
9 program directors in interpreting the Special Requirements are also
10 prepared by RRCs.

11 The General Requirements delineate the responsibilities of insti-
12 tutions that sponsor graduate medical education programs. The General
13 Requirements also delineate training program requirements and respon-
14 sibilities which are common to all RRCs, institutions, and programs
15 regardless of specialty. The General Requirements have been established
16 by the LCGME in collaboration with the RRCs and approved by the Coordi-
17 nating Council on Medical Education and each of its five sponsoring
18 organizations.* An assessment of whether institutions fulfill these
19 General Requirements is made in the process of review of their graduate
20 programs prior to action by the RRCs and the LCGME.

*The Coordinating Council on Medical Education (CCME) is composed of representatives of the same five professional organizations which sponsor the LCGME. It is responsible for the development and consideration of major policies for all three phases of medical education. The CCME also oversees the Liaison Committee on Medical Education (LCME accredits undergraduate medical education) and the Liaison Committee on Continuing Medical Education (LCCME accredits continuing medical education).

1 Actions by the RRCs are based upon information gained through
2 written submissions by program directors and assessments made on
3 site by assigned visitors. Actions of the RRCs, after review and
4 approval by the LCGME, determine the accreditation status of programs.
5 The LCGME is also responsible for adjudication of appeals of adverse
6 decisions and has established policies and procedures for appeal.
7 Current operating policies and procedures for review, approval, accredi-
8 tation and appeal are contained in the *Manual of Structure and Functions*
9 *for Residency Review Committees*, which is revised and updated annually.**
10 Information concerning the accreditation status of any program may be
11 obtained by communication with the Secretary of the LCGME.

PART I. GENERAL REQUIREMENTS.

12 Programs in graduate medical education are sponsored by organiza-
13 tional units involved in providing medical care and health services.
14 These units are referred to as institutions. The principal institutions
15 for graduate medical education are hospitals. In order to provide the
16 complete education and training experience established by the Special
17 Requirements of a specialty, programs may involve more than one
18 institution and various types of settings, which can include clinics,
19 medical schools and various health agencies. Whatever the institutional
20 form, providing health services of the highest quality as well as education
21 and training must be a major mission. Graduate medical education requires

**General Requirements, Special Requirements, Guides, and the *Manual of Structure and Functions for Residency Review Committees* can be obtained from: The Secretary, Liaison Committee on Graduate Medical Education, 535 North Dearborn, Chicago, Illinois 60610

1 that residents be directly involved in the provision of excellent patient
2 care under supervision in an environment which stresses scholarly pursuits
3 and inquiry. The educational mission must not be compromised by an exces-
4 sive reliance on residents to fulfill institutional service obligations.
5 The need for an institutional commitment to education is expressed in this
6 policy statement which was promulgated by the Coordinating Council on
7 Medical Education and approved by its sponsoring organizations in 1974:

"Institutions, organizations and agencies offering programs in graduate medical education must assume responsibility for the educational validity of all such programs. This responsibility includes assuring an administrative system which provides for management of resources dedicated to education and providing for involvement of teaching staff in selection of candidates, program planning, program review and evaluation of participants.

While educational programs in the several fields of medicine properly differ from one another, as they do from one institution to another, institutions and their teaching staffs must ensure that all programs offered are consistent with their goals and meet the standards set forth by them and by voluntary accrediting agencies.

The governing boards, the administration, and the teaching staff must recognize that engagement with graduate medical education creates obligations beyond the provision of safe and timely medical care. Resources and time must be provided for the proper discharge of these obligations. The teaching staff and administration, with review by the governing board, must (a) establish the general objectives of graduate medical education; (b) apportion residency and fellowship positions among the several programs offered; (c) review instructional plans for each specific program; (d) develop criteria for selection of candidates; (e) develop methods for evaluating, on a regular basis, the effectiveness of the programs and the competency of persons who are in the programs. Evaluation should include input from those in training.

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

1 Implementation of these General Requirements requires that the
2 program directors and teaching staffs of sponsored programs work
3 with each other and the institutional administration and governing
4 authorities to provide an operating system for educational resource
5 allocation and quality control which ensures that sponsored programs
6 can fully meet the Special Requirements set forth in Part II of these
7 Essentials. In order to prevent duplication of effort and needless
8 reiteration, many of the resources provided by institutions for their
9 training programs are not specifically mentioned in this document. They
10 do appear in the current *Accreditation Manual for Hospitals* issued by
11 the Joint Commission on Accreditation of Hospitals.*

12 1. Responsibilities of Institutions

13 Ensuring that each specialty program fully meets the Special Require-
14 ments for approval by its RRC is an overall institutional responsibility.
15 The specifications set forth in this section make necessary an institu-
16 tional system for the allocation of educational resources and the main-
17 tenance of the quality of all sponsored programs.

*The *Accreditation Manual for Hospitals* can be obtained from: The Joint Commission on Accreditation of Hospitals, 875 North Michigan Avenue, Chicago, Illinois 60611

1 1.1. The LCGME expects institutions sponsoring programs in graduate
2 medical education to provide documentary evidence of a commit-
3 ment to medical education by:

- 4 a) The governing board,
5 b) The administration
6 c) The clinical departments.

7 This evidence should consist of:

8 1.1.1 A written statement setting forth the reasons why the
9 institution sponsors graduate medical education:

10 There should be evidence of agreement to this statement
11 by the clinical departments, the administration, and the
12 governing board.

13 1.1.2 A detailed plan which sets forth how institutional re-
14 sources are organized and distributed for educational
15 purposes:

16 Such resources include teaching staff, patients, physical
17 facilities, and financial support. There should be clear
18 evidence that the plan is agreed to by the administration,
19 program directors, and the governing board. Those respon-
20 sible for administration of the plan should be identified
21 by name and title in the institution's table of organization.

22 1.1.3 An operational system, based on institutional policies,
23 establishing how the sponsored programs provide for:

- 24 a) The appointment of teaching staff,
25 b) The selection of residents,
26 c) The apportionment of residents among programs
27 d) The evaluation and advancement of residents

- 1 e) The dismissal of residents whose performance
- 2 is unsatisfactory, and
- 3 f) The assurance of due process for residents
- 4 and teaching staff.

5 These policies should be agreed to by the administration
6 and clinical departments, incorporated in a manual of
7 policies and procedures, and reviewed and approved by the
8 governing board. There should be clear evidence of adher-
9 ence to these policies and procedures by program directors.

10 1.1.4 An operational system for periodic internal analysis of
11 each sponsored program by representatives of clinical
12 departments, residents, and administration. Such analysis
13 should include the appraisal of:

- 14 a) The goals and objectives of each program,
- 15 b) The instructional plans formulated to achieve
- 16 these goals,
- 17 c) The effectiveness of each program in meeting its
- 18 goals, and
- 19 d) The effectiveness of utilization of the resources
- 20 provided.

21 There should be evidence that these analyses are effective,
22 and that mechanisms exist to correct identified deficiencies.

23 Accomplishing the requirements set forth in Sections 1.1.1 through
24 1.1.4 may be delegated to a committee composed of program directors
25 or their representatives and others concerned with or involved in an

1 institution's educational mission. However, once a system is estab-
2 lished and agreed to, it is essential that all programs comply with
3 the accepted policies and procedures. Failure by a program to comply
4 may jeopardize the approval of that program by its RRC. Failure of
5 an institution to establish or implement the necessary policies
6 and procedures set forth in these General Requirements may jeopardize
7 the accreditation status of all of its programs.

8 1.2 Interinstitutional Agreements: When the resources of two or more
9 institutions are utilized for the conduct of one or more programs,
10 each participating institution or organizational unit is expected
11 to demonstrate a commitment to graduate medical education as set
12 forth in 1.1.1 through 1.1.4. Documentary evidence of agreements,
13 approved by institutional governing boards, should be available for
14 inspection by assigned site visitors. The following items should
15 be covered in such interinstitutional agreements.

16 1.2.1 Items of Agreement:

- 17 a) Designation of program director: A director for each
18 specialty program should be agreed to and designated.
19 The scope of the director's authority to direct and
20 coordinate the program's activities in all participating
21 institutions should be clearly set forth in a written
22 statement.
- 23 b) Teaching staff: The teaching staff responsible for
24 providing the educational program and supervising the
25 residents in each institution should be designated.

- 1 c) Educational contribution: The expected contribu-
2 tion to the educational objectives to be provided
3 by each institution to each program should be deline-
4 ated.
- 5 d) Assignment of residents: The period of assignment
6 of residents to the segment of a program provided
7 by each institution, and any priority of assignment,
8 should be set forth.
- 9 e) Financial commitment: Each institution's financial
10 commitment to the direct support of each program
11 should be specifically identified. Compensation and
12 other benefits for residents should be as consistent
13 as possible from institution to institution.

14 1.2.2 When several institutions or organizational units participate
15 in sponsoring multiple programs, mechanisms should be developed
16 to coordinate the overall educational mission and facilitate
17 the accomplishment of the policies and procedures set forth
18 in sub-sections 1.1. and 1.2.

19 1.3 Facilities and Resources: Institutional facilities and resources
20 should be adequate to provide the educational experiences and oppor-
21 tunities set forth in the Special Requirements for each sponsored
22 program. These include, but are not limited to, an adequate library
23 providing access to standard reference texts and current journals,
24 sufficient space for instructional exercises, adequate facilities
25 for residents to carry out their patient care and personal educa-
26 tional responsibilities, and a medical record system which facili-
27 tates both quality patient care and education.

1 1.4 Hospital Accreditation: Hospitals sponsoring or participating in
2 programs of graduate medical education are expected to be accredited
3 by the Joint Commission on Accreditation of Hospitals. If a hospital
4 is not so accredited, the reasons why accreditation was not sought
5 or was denied should be explained and justified.

6 2. Program Organization and Responsibilities

7 Programs in graduate medical education usually are developed by individual
8 specialty groups or departments. Program content and organization should
9 be delineated by a statement of goals and objectives, supplemented by a
10 statement outlining the scope of clinical experience and rotations pro-
11 vided, its duration, and any special features, such as opportunities for
12 investigation, ambulatory care experience in different settings, etc.

13 All programs are encouraged to place an emphasis on the development of
14 their residents' teaching and interpersonal skills. Teaching about the
15 socio-economics of health care and demonstrating cost consciousness in
16 the provision of medical services should be incorporated into all programs.

17 The educational effectiveness of a residency training program depends
18 largely on the quality of its supervision and organization. The respon-
19 sibility for these important functions lies with the department heads who
20 in most instances are also the program directors. The program directors
21 should have qualifications and breadth of experience which will enable them
22 to carry out an effective training program. Each program director accepts
23 the responsibility of resident selection, evaluation and promotion within
24 the framework of the policies of the sponsoring institution. The develop-
25 ment of program curriculum and goals, the integration of resident physicians

1 into departmental activities including patient care, research and teaching
2 of other members of the health care team, as well as the extent to which
3 various evaluation techniques employed are additional responsibilities of
4 the program director.

5 The fundamental conceptual framework for curriculum, programmatic goals
6 and evaluation standards should be to enable resident physicians to
7 practice their specialties in a compassionate, scientific, and cost-effective
8 manner upon completion of their training programs.

9 The sponsoring institution is expected to assist program directors in
10 carrying out their responsibilities through the development of appropriate
11 institutional policy to assure excellence in resident physician education.
12 When a Residency Review Committee reviews a program prior to making recom-
13 mendations to the Liaison Committee on Graduate Medical Education regarding
14 its accreditation status, the extent to which the sponsoring institution is
15 supporting the efforts of the program director through its institutional
16 policies will be taken into consideration.

17 2.1 Qualifications of Program Staff: The individuals who have responsi-
18 bility for the conduct of graduate medical education programs should
19 be specifically identified.

20 2.1.1 The Program Director: The director of each program should
21 have the qualifications set forth in the Special Requirements
22 for that program. Each director should have the authority
23 and time needed to fulfill administrative and teaching
24 responsibilities in order to achieve the educational goals
25 of the program and to participate with other program directors
26 in maintaining the quality of all institutional programs.

1 2.1.2 Teaching Staff: The teaching staff should have the quali-
2 fications set forth in the Special Requirements for the
3 program in which they are primarily involved. The staff
4 should be selected for their willingness and ability to
5 contribute to the educational objectives of their own pro-
6 gram and to the overall educational mission of the institution.

7 Teaching physicians should be mindful of the important role
8 that other members of the health care team play in patient
9 care and should involve them, as appropriate, in accomplishing
10 the educational objectives of their programs.

11 2.2 Relationships Between Medical Staff and Graduate Programs: In some
12 institutions the program staff and the non-teaching staff are differ-
13 entiated. Where this is the case, the institutional educational plan
14 (1.1.2) should clearly delineate the agreements reached regarding the
15 utilization of institutional resources for education. This should
16 include agreement as to whether residents and teaching staff may
17 have contact with the patients of members of the medical staff not
18 involved in the teaching programs and what responsibilities residents
19 have for such patients.

20 3. Eligibility and Selection of Residents

21 Physicians with the following qualifications are eligible to enter graduate
22 medical education programs accredited by the LCGME:

23 3.1 Unrestricted Eligibility: Unrestricted eligibility is accorded to
24 those with the following qualifications:

25 3.1.1 Graduates from the institutions in the U.S. and Canada ac-
26 credited by the Liaison Committee on Medical Education,

1 3.1.2 Graduates from institutions in the U.S. accredited by
2 the American Osteopathic Association, unless prohibited
3 by Special Requirements,

4 3.1.3 Graduates of medical schools which are not accredited by
5 the LCME who meet the following additional qualifications:

6 a) Have fulfilled the educational requirements to practice
7 in the country in which they have had their medical
8 education, or, if a national of the country concerned,
9 have obtained an unrestricted license or certificate
10 of full registration to practice in that country, have
11 passed examinations designated as acceptable by the
12 LCGME for determination of professional preparedness
13 and capability to comprehend and utilize the English
14 language, and have had their credentials validated by
15 an organization or agency acceptable to the LCGME, or

16 b) Have a full and unrestricted license to practice medi-
17 cine in a U.S. jurisdiction providing such license.

18 3.1.4 U.S. citizen graduates from institutions not accredited by
19 the LCME who cannot qualify under Section 3.1.3, but who
20 meet the following qualifications:

21 a) Have successfully completed the licensure examination
22 in a U.S. jurisdiction in which the law or regulations
23 provide that a full and unrestricted license to practice
24 will be granted after successful completion of a specified
25 period of graduate medical education; or

26 b) Have completed in an accredited U.S. college or univer-
27 sity undergraduate premedical education of acceptable

1 quality; have successfully completed all of the for-
2 mal educational requirements of a foreign medical
3 school, but have not been granted the privilege to
4 practice medicine by the country in which the medical
5 school is located by reason of not having completed a
6 period of required service; and have passed an examina-
7 tion designated as acceptable by the LCGME for deter-
8 mination of professional preparedness.

9 3.2 Restricted Eligibility: Restricted eligibility for foreign nationals
10 to enroll in LCGME programs is accorded under the following circum-
11 stances:

- 12 a) When a U.S. medical school and one or more of its affiliated
13 hospitals have a documented bilateral agreement, approved by
14 an agency recognized for that purpose by the LCGME, with an
15 official agency or recognized institution in the physician's
16 country of origin to provide an educational program designed
17 to prepare the physician to make specific contributions in a
18 health field upon return to the country in which the sponsoring
19 agency or institution is located; and
- 20 b) The physician has been granted an unrestricted license or
21 certificate of full recognition to practice medicine in the
22 country wherein the agency or institution making the agreement
23 referred to in (a) is located; and

- 1 c) The physician has passed examinations designated as accept-
2 able by the LCGME for determination of professional prepared-
3 ness and capability to comprehend and utilize the English
4 language; and
- 5 d) The physician has made a formal commitment to return to the
6 country in which the sponsoring agency or institution is
7 located; and
- 8 e) The credentials of the physician and the existence of a suit-
9 able agreement have been validated by an organization or
10 agency acceptable to the LCGME.

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

15 3.3 The Enrollment of Non-Eligibles: The enrollment of non-eligible
16 residents may be cause for withdrawal of approval and accreditation.

17 3.4 Special Educational Provisions for Residents Who Are Not Graduates
18 of LCME Accredited Medical Schools: Institutions and programs provid-
19 ing education and training to residents eligible under Sections 3.1.3,
20 3.1.4, and 3.2 should make special educational provisions to correct
21 deficiencies these residents may have in their professional prepara-
22 tion and their knowledge of the United States health care system,
23 medical practices and ethics, and United States culture and cultural
24 values.*

**The Role of the Foreign Medical Graduate, a Report of the Coordinating Council on Medical Education, 1978* (for copies, address: Secretary, CCME, P. O. Box 7586, Chicago, Illinois 60680)

1 3.5 Selection, Recruitment and the Transition between Undergraduate
2 and Graduate Medical Education: Eligible physicians may enter
3 graduate medical education at any time after they have attained the
4 M.D. degree. Institutions and their sponsored graduate programs
5 are expected to select residents with due consideration of their
6 preparedness to enter into the program they have selected. Criteria
7 for their selection should include personal characteristics and
8 aptitude as well as academic credentials.

9 In selecting residents from medical schools accredited by the LCME
10 for first graduate year positions, institutions and all of their
11 sponsored programs are expected to participate in the National
12 Residency Matching Program (NRMP*) and abide by its policies and
13 procedures (certain programs sponsored by the federal uniformed
14 services may be exempt). Programs which select residents to begin
15 their first residency year at the second graduate year level should
16 not offer appointments to students prematurely, and certainly not
17 before the beginning of their final year of medical school.

18 4. Types of Programs

19 Graduate programs of two types may be provided to residents by institutions:

- 20 4.1 Categorical Programs: Categorical (C) are programs in a specialty
21 which meets the Special Requirements of the RRC for that specialty.
22 Some specialties require that residents have complementary educational

*The NRMP is an agency sponsored by: American Hospital Association, American Medical Association, American Protestant Hospital Association, Association of American Medical Colleges, Catholic Hospital Association, American Medical Student Association, American Board of Medical Specialties, and Council on Medical Specialty Societies.

1 experiences in other disciplines. Whether it is required that
2 such experiences precede or be interwoven into the education and
3 training for the specialty, institutions sponsoring such programs
4 should make the necessary arrangements for residents to gain these
5 complementary experiences in programs approved by the RRC of the
6 specialty providing the experience.

7 Categorical programs which require educational experience in a
8 variety of clinical disciplines may be conducted in any educational
9 setting which meets the General Requirements and the Special Re-
10 quirements of the RRC for such specialties.*

11 4.2 Transitional Programs: Transitional (T) are programs for residents
12 ordinarily in their first graduate year who desire a broad experience
13 in several specialties before entering further training.**

14 Institutions or consortia of institutions which sponsor an accredited
15 program in internal medicine and at least two other accredited programs
16 from amongst the following: family practice, obstetrics and gynecology,
17 pathology, pediatrics, psychiatry, radiology or surgery; may offer a
18 transitional year if the following conditions are met:

- 19 a) There is a qualified director (or associate director) on site re-
20 sponsible for planning the program, counseling the residents, and
21 coordinating their evaluation;
- 22 b) There is an institutional committee, composed at least of the rep-
23 resentatives of the accredited programs providing the components
24 of the transitional year, charged to assist the director in program
25 development and evaluation;

* This merges what have been termed Categorical and Categorical* designations.

** These programs are intended to replace those previously designated as Flexible programs.

- 1 c) At least three quarters of the education and training of the
2 transitional year is provided by staff assigned to the accredited
3 programs sponsored by the institution. The balance of the year
4 is spent in educational settings selected by the director and
5 approved by the institutional transitional program committee;
- 6 d) The residents in each of their assignments are associated with
7 senior residents in the participating specialties.

8 5. Relationships between Institutions, Programs, and Residents

9 5.1 Responsibilities of Institutions and Programs

10 5.1.1 Teaching and Learning: An environment wherein both the teaching
11 staff and the residents are seeking to improve their knowledge
12 and skills is essential. Residents may be assigned by program
13 directors to assume responsibility for teaching more junior resi-
14 dents and students. Special attention should be given to assisting
15 residents to acquire skills in teaching and evaluating those for
16 whom they are responsible. The clinical departments are expected
17 to organize formal teaching sessions tailored to meet the Special
18 Requirements of their programs. Participation in these sessions
19 by teaching staff from other clinical departments and by teaching
20 staff from the basic science disciplines is encouraged.

21 5.1.2 Participation in Policy Development and Review: Residents should
22 be involved by institutions and programs in the development of
23 policies. Their day-to-day involvement with institutional and
24 departmental activities may provide unique perspectives which
25 can be of significant value in improving education and patient
26 care.

- 1 5.1.3 Supervision: There must be institutional and program
2 policies and procedures that ensure that all residents are
3 supervised in carrying out their patient care responsibilities.
4 The level and method of supervision must be consistent with
5 the Special Requirements for each program. Supervision
6 should promote the professional growth of each resident
7 while maintaining the quality of the care of patients.
- 8 5.1.4 Counseling and Support Services: Program directors and
9 teaching staff should be sensitive to the need for the
10 timely provision of counseling and psychological support
11 services to residents. Graduate medical education places
12 increasing responsibilities on residents and requires sus-
13 tained intellectual and physical effort. For some, these
14 demands will, at times, cause physical or emotional stress.
15 Institutional awareness, empathy, and responsiveness towards
16 these problems are vital to the educational process.
- 17 5.1.5 Evaluation and Advancement: As set forth in Section 1.1.3 (d),
18 there should be an institutional policy for the evaluation and
19 advancement of residents. Evaluation criteria for each speci-
20 alty should meet the standards set by the RRC of that specialty.
21 The institutional system should assure that each program:
22 a) Periodically, and at least annually, evaluates the
23 knowledge, skills, and professional growth of its
24 residents, using appropriate criteria and procedures.
25 b) Provides to residents an assessment of their perfor-
26 mance, at least annually.

- 1 c) Advances residents to positions of higher responsi-
2 bility only on the basis of an evaluation of their
3 readiness for advancement.
- 4 d) Recommends acceptance of residents for certification
5 by a specialty board only after an evaluation to estab-
6 lish that their clinical skills and professional atti-
7 tudes are consistent with the standards for that
8 specialty, and
- 9 e) Maintains a personal record of evaluation for each
10 resident which is accessible to the resident.

11 5.1.6 Due Process: As set forth in Section 1.1.3 (f), there
12 should be institutional policies and procedures which pro-
13 vide for due process when actions are contemplated which
14 will result in dismissal or will significantly threaten a
15 resident's intended career development or when there are
16 grievances against a program or institution. These policies
17 and procedures should be agreed to by the residents, program
18 directors, teaching staff, and administration, and approved
19 by the governing board. The details of their implementation
20 should be made known to the residents, program directors, and
21 adhered to by all programs sponsored by the institution.

22 5.1.7 Reporting Requirements: Institutions sponsoring accredited
23 programs in graduate medical education must report annually
24 the names of individuals enrolled in their programs, the
25 institutions from which they received the M.D. degree (or
26 equivalent), the program in which they are currently enrolled,

1 and the program in which they were enrolled for the
2 previous year; in addition, institutions must report
3 those individuals successfully completing their spon-
4 sored programs. These reports shall be supplied to the
5 LCGME and the agencies designated by it as having respon-
6 sibility for the recording of credit and the collection
7 and analysis of data on physician manpower development.

8 **5.2 Resident Physician Responsibilities:** Resident physicians are
9 expected to:

10 5.2.1 Participate in safe, effective, and compassionate patient
11 care under supervision, commensurate with their level of
12 advancement and responsibility.

13 5.2.2 Participate fully in the educational activities of their
14 program and, as required, assume responsibility for teach-
15 ing and supervising other residents and students.

16 5.2.3 Participate in institutional programs and activities in-
17 volving the medical staff and adhere to established prac-
18 tices, procedures, and policies of the institution.

19 5.2.4 Participate in institutional committees and councils, and

20 5.2.5 Develop a personal program of self study and professional
21 growth with guidance from the teaching staff.

22 **5.3 Agreement with Residents:** There should be a written agreement with
23 each resident. Parties to this agreement should be the program
24 director, the individual designated as having institutional author-
25 ity, and the resident. The agreement should encompass the following:

26 5.3.1 The educational experience to be provided to the resident, in-
27 cluding the nature of assignments to other programs or institu-
28 tions.

- 1 5.3.2 Resident's responsibilities as set forth in Section 5.2.
- 2 5.3.3 Compensation
- 3 5.3.4 Vacation, professional leave, and sick leave
- 4 5.3.5 Practice privileges and other activities outside the
- 5 educational program.
- 6 5.3.6 Malpractice coverage and other insurance benefits.
- 7 5.3.7 Individual educational plans, such as a reduced schedule
- 8 or educational opportunities tailored to meet a resident's
- 9 personal needs or career plans.
- 10 5.3.8 Guarantee of Due Process as set forth in Section 5.1.6
- 11 in case of disciplinary action or contemplated dismissal
- 12 or grievance against a program or the institution.

o0o

13 All institutions and programs are expected to comply with the foregoing General

14 Requirements. Recognizing that implementation of these requirements by most

15 institutions will necessitate considerable modification of present policies

16 and procedures, the LCGME intends to develop a phased program which will provide

17 sufficient time to permit institutions to adapt to these requirements.

18 The Special Requirements, which follow, apply to programs in each specialty and

19 set forth the standards which must be met in order to gain approval by the

20 Residency Review Committees and accreditation by the LCGME.

PART II. SPECIAL REQUIREMENTS

NOTE: The Special Requirements of Residencies in individual specialties are not being revised at this time.

Essentials of Accredited Residencies*

REVISED TO JULY 30, 1978
INTRODUCTION

Residencies in the clinical divisions of medicine, surgery, and other special fields provide advanced training in preparation for the practice of a specialty. Approval for residency training in the clinical specialties is limited to programs conducted in general or special hospitals. However, the term residency training is also applied to certain non-clinical programs in graduate medical education which may be conducted in organized medical facilities outside of a hospital.

It is desirable, for the purpose of clarification, to differentiate between two terms commonly used in referring to higher medical education. Graduate training, as used in these Essentials, refers to the various recognized plans of training which lead to qualification in a specialty. Postgraduate training in contrast, refers to formally organized shorter courses, offered by medical schools, hospitals, clinics and medical organizations which provide advanced instruction in a limited field, primarily designed for physicians in practice. Residencies in the following branches of medicine are approved by the Liaison Committee on Graduate Medical Education (LCGME).

- | | |
|-------------------------------|--|
| 1. Allergy and Immunology | 16. Pediatrics |
| 2. Anesthesiology | Pediatric Allergy |
| 3. Colon and Rectal Surgery | Pediatric Cardiology |
| 4. Dermatology | 17. Physical Medicine and Rehabilitation |
| Dermatopathology | 18. Plastic Surgery |
| 5. Family Practice | 19. Preventive Medicine |
| 6. General Surgery | General Preventive Medicine |
| Pediatric Surgery | Aerospace Medicine |
| 7. Internal Medicine | Occupational Medicine |
| 8. Neurological Surgery | Public Health |
| 9. Neurology | 20. Psychiatry and Neurology |
| 10. Nuclear Medicine | 21. Radiology |
| 11. Obstetrics and Gynecology | Diagnostic Radiology |
| 12. Ophthalmology | Therapeutic Radiology |
| 13. Orthopedic Surgery | Nuclear Radiology |
| 14. Otolaryngology | 22. Thoracic Surgery |
| 15. Pathology | 23. Urology |
| Blood Banking | |
| Dermatopathology | |
| Forensic Pathology | |
| Neuropathology | |
| Radioisotopic Pathology | |

It is recognized that while some hospitals may be unable to meet the educational standards for graduate training in the specialties, as set forth in the Essentials, they may be able to offer experience of value to young physicians. These hospitals may well consider the appointment of paid house physicians to assist in conducting the professional work of the hospital. Experience of this type does not ordinarily carry credit towards certification in the specialties or towards qualification for membership in special societies.

I. GENERAL REQUIREMENTS

Hospitals conducting or applying for approved residency programs should be accredited by the Joint Commission on Accreditation of Hospitals.

This implies that the hospital must be properly organized, staffed, and equipped and that its activities are conducted primarily for the welfare of the patient. While the educational program is supplementary to the primary purpose of the hospital, i.e., the care and management of patients, it is directly related to this function in that it serves to improve the quality of medical care offered.

Size and Type.—The size of the institution is not a primary consideration. The clinical material, however, should be of sufficient scope and diversity to enable residents to observe the principal manifestations of the disease conditions, in the understanding and management of which they are acquiring additional experience. The number of service or ward beds,

rather than the total bed capacity, is of significance in this connection. In hospitals admitting principally private patients, the availability of these patients for teaching purposes is an essential consideration.

Official approval is extended to general and special hospitals offering acceptable programs in the various specialty fields. Programs conducted in hospitals associated with medical schools are ordinarily of three or more years in duration and offer special facilities for progressively graded, comprehensive training. A number of hospitals not directly affiliated with medical schools, have organized programs of graduate training which comply with all the requirements of the Essentials of Approved Residencies. Some of these hospitals, utilizing their own facilities to the fullest extent, have developed acceptable, fully approved programs. Other hospitals of this type, have supplemented their educational program through affiliation with medical and graduate schools, or with other hospitals which are able to augment the resident's training in those phases which might otherwise be considered deficient. The rotation of residents from an approved hospital to an affiliated institution which is able to provide experience lacking to the parent hospital is often desirable, when properly supervised.

Plant and Equipment.—The physical plant should be adequately constructed and planned to assure proper medical and hospital care as well as safety and comfort for the patient. Equipment, appliances, and apparatus such as are commonly employed in the practice of modern, scientific medicine, should be available. In those departments in which residencies are being offered, space and equipment should be made available for the use of the resident staff in addition to that ordinarily required by the service.

1. STAFF

The teaching staff should be composed of physicians and other health professionals qualified on the basis of educational background and professional accomplishment, oriented to the requirements and responsibilities of the teaching appointment, and motivated to assign acceptable priority to teaching duties. A well organized and well qualified staff is one of the most important requisites in a hospital assuming responsibility for residency training. It may well be the determining factor in the development and approval of a graduate training program. There should be an educational committee of the staff which is responsible for the organization of the residency program, for the supervision and direction of the residency program, and for correlating the activities of the resident staff in various departments of the hospital. The committee might well include the pathologist, the radiologist, and other department heads who, because of the inherent relationship of the departmental work will be called on to assist in the training program.

The particular specialties in which residents are being trained should be represented in the staff by well qualified, experienced, and proficient physicians, whether or not they hold membership in special societies and colleges or are certified in their specialty. Adequate organization of the medical staff presupposes careful selection of the head of the department and of the chiefs of the various services. In addition to their qualifications in the specialty, they should have high professional standing, and possess the attributes of the teacher. Being responsible for the training of residents, they should be chosen on the basis of ability, aptitude, and interest.

Members of the attending staff should be assigned by the department head to specific responsibility as far as the work

*Previous versions of this document were entitled "Essentials of Approved Residencies" and "Essentials of Approved Residencies and Fellowships." Because of the multiple meanings of "Fellowship," this part of the title was deleted a number of years ago. The word "Accredited" has recently been adopted instead of "Approved."

of the services is concerned. The service of each attending physician should include an adequate number of patients and extend over a sufficient period to elicit his full interest and attention while on service. On the other hand the service should not be so large as to be a burden to the attending staff and thus result in reduced attention to the educational program. In all instances, it is imperative that the head of the department be available to assume full responsibility for supervision of the work of the department.

The staff must hold an adequate number of regularly scheduled clinical pathological conferences and other staff conferences, in addition to meetings of the staff at which the histories, clinical observations, laboratory studies, and pathology of selected cases are reviewed. Scientific meetings at which papers are presented by members of the staff or guest speakers are considered commendable but do not serve to meet the requirements of these scheduled conferences. In addition to meetings of the staff as a whole, it is expected that departmental conferences will be conducted in which residents should take an active part, so that the quality of the service given by that department to its patients may be recurrently evaluated. Other educational activities requiring the full support and cooperation of the staff are described under Training Program, and Applied Basic Sciences (Section I-7, I-9) and under Special Requirements (Section VI).

2. DEPARTMENT OF RADIOLOGY

The department of radiology should be under the direction of a qualified radiologist proficient in the various functions of his specialty. He must cooperate fully in the training of all hospital residents and supervise any direct contact which they may have with the work of the department. This supervision, if not full time, necessitates at least daily visits to the hospital during which the radiologist is expected to be available for consultation with the resident staff in addition to supervising the work of the department.

The department should contain modern roentgenographic, roentgenoscopic, and where indicated, therapeutic equipment and radium adequate for the needs of the hospital. The department should be properly organized to carry out its functions in an effective manner. It should keep adequately indexed records, including cross indices, to assure efficient operation and to facilitate investigative work. These requirements are essential in institutions offering residency programs in any field.

3. DEPARTMENT OF PATHOLOGY

The department of pathology should be under the direction of a qualified pathologist who shall be prepared to cooperate fully in the training of all hospital residents and supervise any direct contact they may have with the laboratory. There should be continuous supervision of the laboratory by the pathologist who, preferably, should have no responsibilities outside the hospital that would prevent his being available for consultation and for guidance of the resident's work.

The department should provide adequate space and equipment for the resident's use in addition to that required for the proper functioning of the service. Apparatus, reagents, and materials necessary for the operation of a modern clinical and pathological laboratory should be available. The department should be organized to provide a high quality of service for the clinical departments and to permit of its active participation in the educational program. An efficient system of records including cross indices should be maintained, to assure proper functioning of the laboratory and to facilitate investigative work. This department should assume much of the responsibility for the clinical pathological conferences and other educational activities of the staff.

The facilities of the autopsy room should be ample enough to permit participation by the resident staff. Thoroughness in postmortem examination should be emphasized. Complete

necropsy records should be kept on file and each should contain a summary of the clinical record and detailed description of both the gross and microscopic observations. Residents of all departments should attend postmortem examinations unless other important duties prevent. They may, with value, participate in the performance of necropsies, including the preparation of the protocol, and in the review of microscopic findings on materials derived from their own and other services.

It is expected that hospitals assuming responsibility for resident training will maintain a high autopsy rate. It is felt that the autopsy rate is a reliable gauge of the staff's interest in scientific advancement. (A description of the special requirements for an approved residency in pathology is given in Section VI.)

4. BIOMEDICAL INFORMATION

Institutions offering approved residencies should provide access to biomedical information including carefully selected, authoritative medical textbooks and monographs, recent editions of the Index Medicus, and current medical journals in the various branches of medicine and surgery in which training is being conducted, as well as other learning resources (e.g. audiovisuals). The information resources should be properly supervised.

5. MEDICAL RECORDS DEPARTMENT

The record department should be adequately supervised, preferably by a qualified medical record librarian. An efficient record system should be maintained, including alphabetical and diagnostic patient indices. Operative reports, roentgenological, and pathological records should be properly classified, permitting a ready reference. The employment of the Standard Nomenclature of Diseases and Operations is recommended for all medical records, although Current Medical Terminology may provide an additional useful tool in the management and utilization of clinical records. For coding or indexing, either the Standard Nomenclature of Diseases and Operations (SNDO) or the International Classification of Diseases, Adapted for Indexing Hospital Records by Diseases and Operations (ICDA) may be used.

Clinical records must be completed and include the patient's chief complaint, case history, physical examination on admission, a provisional diagnosis, record of laboratory examinations, therapy employed, descriptions of operations if performed, adequate progress notes, consultation remarks, a final diagnosis, condition on discharge, necropsy observations in case of death if postmortem examination is performed, and an appropriate summary. The records should show by signatures or at least initials, the names of all physicians writing the record in whole or part, as well as the names of the staff members by whom the records are verified. Each completed record should be verified by a responsible staff member.

In a hospital assuming responsibility for graduate training, it is expected that the clinical records be sufficiently comprehensive to permit of their use for teaching purposes. While responsibility for the preparation of parts of the record, such as the admission work-up, may be delegated to the intern or resident assigned to the case, the ultimate responsibility for the completed record lies with the staff member in charge.

There should be a records committee of the staff which will meet periodically with the record librarian to review the clinical charts and report their findings. This committee may be empowered to make recommendations concerning the disciplinary measures necessary to assure the maintenance of adequate clinical records on a current basis. Satisfactory records can be maintained only through the continuous and cooperative efforts of the staff, the medical records department, and the hospital administration.

6. SELECTION OF RESIDENTS

The development of a satisfactory program requires, first of all, a careful selection of applicants for appointment to the resi-

dent staff. The hospital administration and medical staff, through appropriate review of credentials, should ascertain that the personal and medical qualifications of applicants selected for residency positions are satisfactory. There should be confidence that the residents appointed have the high standards of integrity, motivation, industry, resourcefulness, health and basic medical knowledge necessary to take full advantage of the further educational experience offered. This should include assignment of carefully graded and progressive responsibility for patient care. The qualifications of the resident staff should leave no doubt as to their competence to accept this assignment, since the primary obligation of the hospital must be for the patients' welfare.

For those applicants who have had their prior medical training in the United States or Canada, evaluation of qualifications is usually not difficult. Personality characteristics can be assessed through interview, letters of recommendation, and communication with the hospital where internship was served, and the dean's office of the medical school. The medical school accreditation and internship review programs of the Council on Medical Education of the American Medical Association renders reasonable assurance in regard to medical qualifications which can be augmented through communication with the hospital and school concerned. Such candidates for appointment should be graduates of approved schools. (See pertinent sections under Special Requirements.)

Since similar sources and kinds of information have not been readily available for graduates of foreign medical schools, the Educational Commission for Foreign Medical Graduates, 3624 Market St., Philadelphia, Pa., 19104, has been established to provide as comparable knowledge of qualifications as possible. The Council recommends that hospitals considering foreign medical school graduates for residency positions acquire reasonable assurance in regard to their medical qualifications through utilization of the program of the Educational Commission.

[Beyond July 1, 1961, no hospital should expect to maintain an approved residency program unless its appointees who are graduates of foreign medical schools either:

1. Have a full and unrestricted state license to practice, or
2. Have secured a standard certificate from ECFMG.
3. In the case of United States citizens, have successfully passed the complete licensure examination in any state or other licensing jurisdiction in which the law or regulations provide that a full and unrestricted license to practice medicine in that state or jurisdiction will be issued to the physician after satisfactory completion of his internship or residency in that state, without further examination.
4. In the case of students who have completed, in an accredited American College or university, undergraduate pre-medical work of the quality acceptable for matriculation in an accredited U.S. medical school, have studied medicine at a medical school located outside the United States, Puerto Rico, or Canada but which is recognized by the World Health Organization, have completed all of the formal requirements of the foreign medical school except internship and/or social service, may substitute for an internship required by a foreign medical school, an academic year of supervised clinical training (such as a clinical clerkship or junior internship) on or after July 1, 1971, prior to entrance into the first year of AMA approved graduate medical education. The supervised clinical training must be under the direction of a medical school approved by the Liaison Committee on Medical Education. Before beginning the supervised clinical training, also known as the "Fifth Pathway," students must have their academic records reviewed and approved by the medical schools supervising their clinical training and must attain a score satisfactory to the sponsoring medical school on a screening examination acceptable to the Council on Medical Education.

After July 1, 1961, the Council will recommend to the Residency Review Committees the disapproval of those training programs whose rosters contain graduates of foreign medi-

cal schools who do not satisfy requirement 1, 2 or 3 above.

Even though a foreign medical graduate may possess a full and unrestricted state license, ECFMG certification may be necessary if he expects to be licensed in another state by reciprocity or endorsement; furthermore, such certification may be necessary as a requirement for qualification for specialty certification by the majority of American specialty boards.]

Graduates of schools of osteopathy who hold only the D.O. degree are eligible for appointment to residencies only in those specialties for which the corresponding specialty board has established conditions under which the D.O. will be acceptable to the Board for examination for certification. (Most, but not all, specialty boards have an established policy under which they will accept former Doctors of Osteopathy who now hold an M.D. degree from the University of California College of Medicine, Irvine.)

7. TRAINING PROGRAM

Duration.—Graduate training in the various branches of medicine should be of sufficient duration and educational content to enable the resident on completion of his training, to begin the practice of his specialty in a scientific manner. With the exception of a few specialties, e.g., pediatrics, a fully organized, comprehensive program should include three or more years of formal residency training. Not all hospitals, however, are able to develop programs of this type. A given approved residency may not provide complete training in a specialty field but if properly organized can make a substantial contribution to the resident's advanced training. It is desirable that hospitals, which cannot, for one reason or another, develop a fully approved program, integrate their training plan with that of other approved hospitals to assure the resident of the opportunity of completing his training, during which he is given progressively graded responsibility.

Part-Time Programs.—While internship and residency programs have ordinarily been considered as full-time activities, there are particular circumstances under which physicians can undertake graduate medical education programs only on a part-time basis. It is highly desirable that these physicians be encouraged to proceed as far as possible with the necessary training to prepare them for licensure and medical practice.

It is incumbent upon the responsible program director to arrange a program which meets the educational needs of the trainee and at the same time includes in its total extent the sum of clinical experience and responsibilities acquired by a trainee on a normal schedule. Such a part-time plan must be fair to the other trainees and fully compatible with the hospital's training program and responsibilities in the care of patients.

The responsible program director must be prepared to justify to the appropriate review committee, as well as to state boards of licensure and specialty boards, the manner in which the program will be arranged so as to provide the equivalent of a full-time appointment, and the manner in which the trainee's experience and responsibilities will be documented. Of great importance is documentation of the manner in which the trainee's patient-care responsibilities will be discharged during those periods off duty. If two half-time trainees were to assume responsibility for the care of the same group of patients, this would not be unlike the manner in which patient care is delivered in some private practice situations.

Supervision.—The educational effectiveness of a residency depends largely on the quality of its supervision and organization. The responsibility for these important functions lies with the department heads and a representative committee of the medical staff. Heads of departments should be responsible for their own services, the committee assuming a larger role in directing and correlating the various aspects of the educational program. The department head should have qualifications and breadth of experience which will enable him to carry out an effective training program. Those members of the attending staff who assist in supervising the resident's work should also have had acceptable training in the specialty and

ESSENTIALS OF ACCREDITED RESIDENCIES

should demonstrate an interest and ability in teaching. In some hospitals, where the number of men on the staff who have had advanced training in the specialty is limited, it may be desirable to assign responsibility for the supervision of the training program to physicians recognized in their field, on a consulting basis. In such instance, it is expected that the consultant assuming this responsibility will devote sufficient time to the residency program to assure the close and continuing supervision of all phases of the resident's work.

Resident Responsibility.—Aside from the daily contact with patients and the attending staff, and participation in the organized educational program, the assumption of responsibility is a most important aspect of residency training. Accordingly, as ability is demonstrated, an increasing amount of reliance should be placed in the judgment of residents in diagnosis and in treatment, as well as in the teaching of interns and medical students. In surgery and the surgical specialties, the resident should be given ample opportunity to perform major surgical procedures under supervision, particularly in the later stages of his training, in order that he may acquire surgical skill and judgment.

Methods of Instruction.—It is important that methods of instruction be employed in the training program which are best suited to the special field. Emphasis should be placed on personal instruction at the bedside, in the operating room and in the delivery room, on related laboratory studies, teaching rounds, departmental conferences or seminars, clinical-pathological conferences, demonstrations and lectures.

Clinical-pathological conferences should be held preferably each week for the general staff, or, in larger hospitals it may be advisable to arrange separate meetings for each of several departments in order that all of the available material may be presented properly. The program should include the demonstration of pathological material from the operating room and from autopsies. The amount of material to be reviewed will usually require a weekly meeting and permit the more extensive use of the fresh and frozen specimens which are preferred to fixed specimens for demonstration and study. Details of the program and its manner of presentation may vary but the following procedure represents the plan followed in many hospitals:

- a. Presentation of abstract reports of selected cases.
- b. Demonstration of gross and microscopic pathology.
- c. Correlation of clinical and pathological findings.
- d. Comparison of reports with the literature.
- e. Summary of findings and conclusions.

The success of the clinical-pathological conference lies chiefly in the ability of the pathologist to teach and to interpret pathological lesions in terms of clinical manifestations of the disease.

A record of all conferences of the medical staff should be kept by every hospital for both current and future reference.

Journal Club.—Familiarity with the critical analysis of pertinent medical literature is an important feature of medical training. The journal club or seminar is an excellent means of stimulating interest in scientific literature. In smaller hospitals, it may be conducted as a joint activity of several departments. Particularly in larger hospitals where the number of residents justify, separate meetings of this type for each service is considered advantageous. There are several methods of conducting a successful journal club. Each member of the resident staff can be requested to make a comprehensive review of the important articles contained in one or more current medical journals, reporting regularly at these meetings. The plan may be supplemented by assignment of a specific subject or disease entity to one or more of the participants for a complete review of the related past and current literature. Other plans for stimulating study of this nature may be arranged in conjunction with medical staff conferences, or through clinical research pertaining to problems under discussion, or in connection with patients under treatment in the hospital. A successful journal club will prove stimulating not only to the resident staff, but to the attending staff as well.

Resident Assignments, Hospital Service.—The resident staff should be assigned to a sufficient number and variety of hospital patients to assure a broad training and experience. However, hospital duties should not be so extensive as to prevent giving ample time for other important phases of the training program. The completeness of the preliminary study of all patients, necessary in arriving at a correct diagnosis, should be emphasized. The variety of the pathological conditions encountered are also of primary importance.

Outpatient Department.—The importance of the outpatient department and its role in the training of the resident staff should be emphasized. Here there is opportunity for acquiring further knowledge and experience, particularly in differential diagnosis and follow-up observation. Study of end results in patients operated upon is of primary importance. The resident staff should have a definite assignment to the scheduled clinics. They should be required either to attend all clinics of the hospital service to which they are assigned or, to devote full or part time to a series of clinics during a certain period of their training. The former plan is considered more satisfactory because it provides a longer contact with the same patients, including the periods before and after hospitalization. Other activities should not be allowed to conflict with the work of the resident staff in the outpatient department.

The major responsibilities of carrying on outpatient department work should not be given over entirely to the resident staff. The educational value of work in the outpatient department is largely dependent on the amount of interest displayed by heads of departments and high ranking members of the attending staff. In any acceptable plan of graduate training, they should be in regular attendance at the diagnostic and follow-up clinics for supervision and instruction of the assigned personnel working under their direction.

Emergency Service.—All hospitals are called on to care for a certain number of patients who present themselves for treatment in case of accidents or other emergencies. The service may vary from a few patients seen in emergency in the outpatient department to the extensive and well organized accident wards which care for traumatic cases in connection with the ambulance services of larger hospitals. Regardless of the size of the service, advantage should be taken of this opportunity for the resident staff to obtain experience in the care of these types of cases. Being available in the hospital at all times, they may be called on to take the initiative in making differential diagnosis, rendering first aid treatment, and assuming the major responsibility for the immediate care of a variety of traumatic conditions. They must also decide when patients should be admitted to the hospital. Under proper supervision of the attending staff, assignment to the emergency service is a valuable experience for the residents.

Operating Room Assignment.—In surgery and the surgical specialties, work in the operating room constitutes an important part of the resident's responsibility. During the course of his training, the resident should be given sufficient operating responsibility to acquire surgical skill and judgment. This experience should be progressively graded to the end that, on completion of his training, the resident is able to assume individual responsibility for major surgical procedures. A more detailed discussion of this phase of the resident's training is found under the appropriate sections of the specialties concerned.

Teaching and Investigation.—Residents should be assigned to teaching responsibilities as their experience increases. The stimulating teacher-student relationship should be part of the resident's experience, not only as a student of the attending physician, but as a teacher of interns and nurses and, in hospital affiliated with medical schools, of junior and senior medical students.

When the facilities of an institution permit, and when the residents are competent and interested, they should be encouraged to engage in investigative work. Such investigation may take the form of research in the hospital laboratories or wards, comprehensive summaries of medical literature, or the prepara-

ESSENTIALS OF ACCREDITED RESIDENCIES

tion of statistical analyses based on clinical case records. The interests of the various members of the resident staff should be carefully considered when arranging assignments to this activity, inasmuch as ability and desire to do this type of work differ widely. Intelligent direction and supervision should be provided in selecting the project to be undertaken and in its development. It is realized that only an occasional individual will make contributions or discoveries of lasting value to the medical profession. However, those who undertake and pursue a research problem receive a stimulus which can be obtained in no other way. An understanding of the methods and problems involved in research leads to a better interpretation of the great mass of current scientific literature which must be constantly reviewed by the progressive physician or surgeon.

When feasible each member of the resident staff, either individually or in collaboration with other members of the department, should be encouraged to prepare a formal paper suitable for publication.

It is not essential, or even desirable, that all hospital residencies should adopt exactly the same program, or that they should offer a rigidly uniform sequence of experience. It is essential, however, that all hospitals participating in graduate training should be able to meet the fundamental essential requirements for an approved program and either alone or in collaboration should attain comparable results in the quality of training and amount of experience obtained.

Preparation for Practice.—It is essential that the house officer before completing his period of formal graduate medical education in the hospital and its ambulatory facilities be exposed to the variety of methods by which he will apply his knowledge in the practice situation. If adequate models do not exist within the hospital environment, then a formal plan must be developed to expose the house officers to meaningful experience in health and medical service under a representative variety of patterns now developing throughout the nation. Inherent in this experience is an opportunity to become oriented to the social and economic aspects of medical practice. Preceptorial experience, seminars, or investigative projects on the relationship of medicine to the needs of society should be an essential part of the house officer's experience before he is considered to have completed his graduate medical education.

Special Requirements for Programs of International Educational Exchange in Medicine.—In addition to the foregoing requirements for all residents, those programs which accept graduates of foreign medical schools should contain certain special additional features which are essential to the effective education and training of such individuals.

(a) An orientation program for the foreign medical graduate should include thorough familiarization with patterns of American hospital and clinical practice, organizational responsibilities of hospital personnel, legal as well as moral and ethical concepts of physician-patient relationships, and the varying patterns of graduate medical education which lead to competence in practice.

(b) While the ECFMG resources described in Section 6, "Selection of Residents," are intended to provide reasonable assurance regarding the medical qualifications of foreign medical school graduates, many such individuals have deficits in background education and experience not ordinarily found in graduates of United States or Canadian medical schools. Special educational activities should be designed to correct these deficits in the area of professional medical knowledge, and in some cases in the use of the English language.

(c) Effective participation in the medical management of patients is impossible without an appropriate degree of appreciation by the foreign trained physicians of the cultural backgrounds of their patients. Such appreciation is unlikely to develop in the absence of carefully planned and conscientiously conducted programs of contact with a wide cross-section of American family life and of other non-medical activities characteristic of the American way of life.

(d) The countries of origin of foreign medical graduates have widely-varying needs for health and medical care, and the programs for individual foreign physicians should reflect an interest in those features of clinical practice most essential to the foreign physician upon return to his own country.

8. COLLABORATING AND AFFILIATING PROGRAMS

Some hospitals that have excellent facilities and clinical material for the greater part of an approved training program may be deficient in some particular phase of the work that can be well provided in another hospital of graduate training caliber. In such instances the hospital which has the greater part of the required clinical material and facilities may become the parent institution and collaborate with the second institution to provide a well rounded and complete program of training in a given specialty.

In other instances, especially on university connected services, the chief of an approved service may elect to augment the opportunity afforded his trainees for clinical experience by rotating them to a smaller affiliated institution for short periods of service. Such short-term services need not be independently approved. However, their contribution to the resident's training is taken into consideration and recognized when evaluating the over-all program of which it is a part. The departmental staff of the parent institution sponsoring the program must assume responsibility for the resident's training during the period he is assigned to the affiliating service, as well as when he is serving at the parent hospital. Under arrangements of this nature, it is not intended that the resident be assigned to affiliating services without supervision even though he may obtain extensive experience in this way. The resident's work must be properly supervised at all stages of his training. In general, affiliated services should not constitute more than a third of the training period. Hospitals which can offer satisfactory training for more than this period can probably develop acceptable programs of their own.

9. BASIC SCIENCE TRAINING

Competence in any of the various specialties in clinical medicine requires a knowledge of the basic medical sciences as related to that specialty. Therefore, acceptable residency programs must provide for training in the applied basic medical sciences. Such training does not necessitate formal course work, specific assigned laboratory exercises, or affiliation of the residency hospital with a medical school; it should be distinctly of an applied nature, closely integrated with the clinical experience of the resident.

Any resident seeking competence or certification in a specialty must be able to apply at least the following basic sciences to his special field of medicine: anatomy, bacteriology, biochemistry, pathology, pharmacology, and physiology.

Undergraduate education in an approved medical school provides a background for an understanding of these sciences. In a graduate training program, therefore, training in basic sciences should stress reviews of their clinical application and not constitute primarily a review of undergraduate work.

Anatomy.—Anatomy at the residency level may be taught, reviewed or learned from the living body, on the operating or examining table, or from the fresh tissues in the pathological laboratory. More important in anatomical instruction of residents than an available anatomical laboratory is the attitude and enthusiasm of the hospital staff in availing themselves of opportunities to teach and learn applied gross and microscopic anatomy from clinical and pathological material. Opportunities of anatomical dissection, when available, may be utilized for supplementary training.

Bacteriology.—Hospital laboratories should have adequate facilities and personnel qualified to carry out diagnostic bacteriological studies, and those in the allied fields of parasitology, mycology, immunology, and serology. The resident staff should make use of the educational opportunity provided through the study of bacteriological material from the

hospital services, correlating the laboratory study with its clinical application. Members of the resident staff who exhibit a particular interest in this field might well be assigned to the department for additional investigative work.

Biochemistry.—The hospital biochemistry laboratory should provide the resident with opportunities to broaden his knowledge of biochemistry as related to such clinical problems as he may encounter in his specialty; for example, water balance, acid-base equilibrium, glucose tolerance, and blood or urine levels of significant metabolic, nutritional, or therapeutic element. Such applied basic science work in biochemistry is far more valuable than a formal review course in the field.

Pathology.—In a well conducted department of pathology of an approved hospital there is opportunity for correlating much basic medical science material with problems of clinical medicine. Applied gross and microscopic anatomy may be effectively learned from necropsy and surgical specimens. The clinical-pathological conference should and can be one of the most effective devices for correlation of the basic sciences with clinical medicine.

Pharmacology.—Since the principles of pharmacology are involved in every therapeutic administration of chemical substances to patients, the wards of the residency hospitals provide very suitable opportunities for the resident to apply and expand the knowledge of pharmacology previously gained in medical school.

Physiology.—Historically, one of the most fruitful fields of investigation into the normal functions of the body has been the study of abnormality of function to which the resident in clinical medicine is constantly exposed. Clinical medicine affords a rich field for the study of physiology and a potent stimulus to the resident to apply the basic principles of this science. Much of the equipment and special apparatus employed in clinical studies of the patient are likewise used in physiology, so that clinical studies provide ample opportunity and stimulation for the resident to supplement his knowledge of physiology with applications of the science to clinical problems. Encouragement and opportunity for an enlarged understanding of body function in health and disease should be part of the experience of the resident in any of the specialities in the course of his clinical work.

10. HOSPITAL-RESIDENT AGREEMENT

A formal agreement in which mutual obligations are defined should be entered into between the hospital and the applicant at the time of his appointment. This agreement must be honorably fulfilled by both parties and when terminated by mutual consent, the hospital should provide a statement of release from the agreement or contract. Contracts for one year, renewable by mutual consent, are preferable.

The Council urges that all inducements, representations, and agreements made with respect to the offer and acceptance of a residency be embodied in the terms of a written agreement which should specify at a minimum the following:

1. The term of the residency.
2. The salary.
3. The conditions under which living quarters, meals, and laundry or their equivalent are to be provided.
4. Whether the hospital will provide professional liability (malpractice) insurance for the resident, or whether he will be expected to provide such insurance at his own cost if he desires this coverage.
5. Whether the hospital will provide hospitalization and health insurance for the resident and his family.
6. Vacation periods.
7. Hours of duty, or the method by which this is to be determined.
8. The content of the educational phase of the residency,

including duration and sequence of the specified assignments to clinical, laboratory or ambulatory care facilities.

The residency agreement imposes ethical, moral and legal obligations upon both the hospital and the resident. No residency should be terminated prior to its expiration date without the opportunity for both parties to discuss freely any differences or grievances that may exist.

Under particular circumstances, the hospital or the resident may be justified in terminating a residency prior to the expiration of its term. If the resident fails to perform the normal and customary services of a residency or fails to comply with the reasonable rules that are necessary in the orderly operation of the hospital, the hospital may be justified in taking such action. Likewise, a physician should be entitled to rely upon representations with respect to opportunity for educational experience, conditions of service, living quarters, agreed vacation periods, etc., that are made to induce him to apply for the residency.

A breach of the agreement by either a hospital or a resident is not condoned by the Council.

Whenever complaint of such a breach is made, it is the policy of the Council to ask each of the parties involved to submit an explanatory statement. Such statements become a part of the physician's and hospital's records, and are made available upon request to authorized agencies.

11. EMPLOYMENT RELATIONS OF HOUSE OFFICERS

The primary purpose of intern and resident programs is professional education. Supervised service to patients is an essential part of intern and resident training, and it benefits both trainee and patient.

The accreditation process should include evidence that the employment agreements with interns and residents provide appropriate safeguards for the educational component of the program as follows:

1. There must be a mechanism for satisfactory intra-institutional communication between the governing board, the professional staff, and house officers with respect to service, research, and educational problems.
2. There must be a clearly-stated basis for annual reappointment. This must be based on evidence of progressive scholarship and professional growth of the trainee as demonstrated by his ability to assume graded and increasing responsibility for patient care. This determination is the responsibility of the program director, with advice from members of his teaching staff, and cannot be delegated to a professional or non-professional staff member who is primarily concerned with the service needs of the institution. A primary objective of the accreditation process is determination of the excellence of the experience as an exercise in professional education. Since supervised service to patients is an essential part of intern and resident training, these aspects of the program as measured by satisfactory performance of service functions should be considered in determining continued tenure.
3. There must be an equitable and satisfactory mechanism, involving the participation of the medical staff, for the redress of grievances. Although final responsibility rests with the institution's governing body, the latter should rely upon the determinations of the medical staff in professional and educational matters.

It is inappropriate that house officers be expected to assume increasing responsibility for patient care, while not at the same time participating effectively in communications which contribute ultimately to policy-making decisions. The intern and resident must be integrated into the medical staff as true colleagues in order that effective programs of medical education and patient care be carried out.

ESSENTIALS OF ACCREDITED RESIDENCIES

II. PERSONAL RECORD

It is considered desirable that a personal record of the resident be maintained by the department responsible for his training. This should include a record of his assignments, results of examinations, personal evaluation by attending staff members who intimately supervise his work, and such detailed information as may be necessary in rating the resident's total accomplishment at the end of his training. The close personal contact which exists between department heads and resident staff is usually sufficient of itself to make possible an accurate evaluation of the resident's judgment and professional progress. All records relating to the resident's work in the hospitals should be preserved and should be made available to examining boards and other responsible agencies if requested.

III. MISCELLANEOUS

Intern-Resident Relationships.—Those hospitals training both residents and interns should recognize their obligation to both groups and should plan their programs so that both interns and residents have opportunities for training and experience. The residents should participate in the teaching of the interns and in the supervision of their activities. Residents should not, however, act so as to diminish the contact of the interns with the attending men or assume the supervisory or disciplinary functions of the staff.

IV. RECORDING OF CREDIT

The successful completion of a residency is recorded in the biographic files of physicians maintained by the American Medical Association. It is important, therefore, that all institutions approved for residencies in specialties make an annual report to the Council on Medical Education of the American Medical Association. Periods of service in institutions approved by the Council for residencies in specialties are given full credit in the biographic files without further inquiry. Services in unapproved institutions are recorded as unclassified assignments.

There is an extensive interchange of information and close collaboration between the Council on Medical Education, the various American Boards responsible for the examination and certification of the specialists, and the American Board of Medical Specialties. In this way the study and appraisal of residencies leads to the formulation of lists approved by the Council and acceptable to the respective boards. These lists may be obtained from the Council on request. In most instances, there is indicated for the hospitals on the approved lists the amount of credit (one to three or more years) which is allowed by the appropriate American board toward qualifying for the certification examination.

The specialty boards listed below have been approved by the Council in collaboration with the American Board of Medical Specialties, through the Liaison Committee on Specialty Boards in accordance with the following resolutions of the House of Delegates:

Resolved, That the Council on Medical Education and Hospitals is hereby authorized to express its approval of such special examining boards as conform to the standards of administration formulated by the Council, and be it further

Resolved, That the Board of Trustees of the American Medical Association be urged to use the machinery of the American Medical Association, including the publication of its Directory, in furthering the work of such examining boards as may be accredited by the Council. (See the Council's "Essentials for Approval of Examining Boards in Medical Specialties.")

American Board of Allergy and Immunology
(a Conjoint Board of the American Board of Internal Medicine and the American Board of Pediatrics)

Herbert C. Mausmann, Jr., M.D., Executive Secretary
3930 Chestnut Street, Philadelphia, Pa. 19104

American Board of Anesthesiology

E. S. Siker, M.D., Secretary-Treasurer
100 Constitution Plaza, Hartford, Conn. 06103

American Board of Colon and Rectal Surgery

Norman D. Nigro, M.D., Secretary
615 Griswold, Suite 516, Detroit, Mich. 48226

American Board of Dermatology

Clarence S. Livingood, M.D., Executive Director
Henry Ford Hospital, Detroit, Mich. 48202

American Board of Family Practice

Nicholas J. Pisacano, M.D., Executive Director & Secretary
2228 Young Drive, Lexington, Ky. 40505

American Board of Internal Medicine

John A. Bensen, Jr., M.D., President
3930 Chestnut St., Philadelphia, Pa. 19104

American Board of Neurological Surgery

David G. Klime, M.D., Secretary-Treasurer
750 E. Adams Street, Syracuse, N.Y. 13210

American Board of Nuclear Medicine

(a Conjoint Board of the American Board of Internal Medicine, the American Board of Pathology, and the American Board of Radiology)

S. James Adelstein, M.D., Secretary
475 Park Avenue South, New York, N.Y. 10016

American Board of Obstetrics and Gynecology

James A. Merrill, M.D., Secretary-Treasurer
711 Stanton Young Blvd., Oklahoma City, Okla.

American Board of Ophthalmology

Francis H. Adler, M.D., Secretary-Treasurer
8870 Towanda St., Philadelphia, Pa. 19118

American Board of Orthopaedic Surgery

William A. Larmon, M.D., Executive Secretary
444 N. Michigan Ave., Suite 2970, Chicago, Ill. 60611

American Board of Otolaryngology

Walter Work, M.D., Executive Secretary-Treasurer
220 Collingwood Ave., Suite 130
Ann Arbor, Mich. 48103

American Board of Pathology

A. James French, M.D., Executive Director
Office of the Board, 112 Lincoln Center,
5401 W. Kennedy Blvd., P.O. Box 24690
Tampa, Fla. 33623

American Board of Pediatrics

Robert C. Brownlee, M.D., Executive Secretary
Suite 402, NCNB Plaza, 136 E. Rosemary St.
Chapel Hill, North Carolina 27514

American Board of Physical Medicine and Rehabilitation

Gordon M. Martin, M.D., Secretary-Treasurer
Suite D, 1A Kahler East, Rochester, Minn. 55901

American Board of Plastic Surgery

John B. Lynch, M.D., Secretary-Treasurer
4647 Pershing Ave., St. Louis, Mo. 63108

American Board of Preventive Medicine

Herschel E. Griffin, M.D., Secretary-Treasurer
Graduate School of Public Health, Univ. of Pittsburgh
Pittsburgh, Pa. 15261

American Board of Psychiatry and Neurology

Lester H. Rudy, M.D., Executive Secretary-Treasurer
1603 Orrington Ave., Evanston, Ill. 60201

American Board of Radiology

C. Allen Good, M.D., Secretary
Kahler East, Rochester, Minn. 55901

American Board of Surgery

James W. Humphreys, Jr., M.D., Secretary-Treasurer
1617 John F. Kennedy Blvd., Philadelphia, Pa. 19103

American Board of Thoracic Surgery

Herbert Sloan, M.D., Secretary-Treasurer
14640 East Seven Mile Rd., Detroit, Mich. 48205

American Board of Urology

William L. Valk, M.D., Executive Secretary
4121 W. 83rd Street, Suite 124
Prairie Village, Kan. 66208

FINAL REPORT OF THE WORKING GROUP ON THE TRANSITION BETWEEN
UNDERGRADUATE AND GRADUATE MEDICAL EDUCATION

The first working group established by the Task Force on Graduate Medical Education was charged to review the complex problems graduating students face in their transition from medical school into a graduate program of education and training.

This report has been approved by the Task Force and the Executive Council has authorized its circulation for review and comment. It will be incorporated into the Task Force report for consideration by the Assembly at the AAMC annual meeting in November 1979.

Members of the Working Group on Transition:

- D. Kay Clawson, M.D., Chairman; Dean, University of Kentucky, College of Medicine
- George L. Baker, M.D., Associate Dean for Student Affairs and Curriculum, University of Iowa College of Medicine
- Lewis B. Barnett, Jr., M.D., Chairman, Department of Family Medicine, University of Virginia School of Medicine
- David M. Bell, M.D., Resident in Pediatrics, The Children's Hospital and Medical Center of Boston
- William C. Daeschner, Jr., M.D., Chairman, Department of Pediatrics, University of Texas Medical Branch at Galveston
- Daniel D. Federman, M.D., Dean of Student Affairs, Harvard Medical School
- Cheryl M. Gutmann, M.D., First-Year Resident, Department of Psychiatry Rush-Presbyterian-St. Luke's Medical Center of Chicago
- Martin Helrich, M.D., Chairman, Department of Anesthesiology, University of Maryland
- John Bernard Henry, M.D., Chief of Clinical Pathology, State University Hospital of the Upstate Medical Center
- Marc H. Hollender, M.D., Chairman, Department of Psychiatry, Vanderbilt University School of Medicine
- Harold Jacobson, M.D., Chairman, Radiology, Albert Einstein College of Medicine of Yeshiva University
- Ann S. Peterson, M.D., Associate Dean for Student Affairs, Columbia University College of Physicians and Surgeons
- G. Thomas Shires, M.D., Chairman, Department of Surgery, Cornell University Medical College

Observer/Participant

Paul East, M.D., J.D., M.P.H., Associate Chief for Graduate Medical
Education, Veterans Administration in Washington, D.C.

FINAL REPORT OF THE
WORKING GROUP ON THE TRANSITION
BETWEEN UNDERGRADUATE AND GRADUATE MEDICAL EDUCATION
OF THE TASK FORCE ON GRADUATE MEDICAL EDUCATION
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

November 16, 1978

(Approved by the Executive Council, January 18, 1979, For Discussion and Action by the Assembly at the AAMC Annual Meeting, November 6, 1979)

The need to view medical education as a continuum was well articulated by the Association of American Medical Colleges (AAMC) in 1965. (1) The document adopted in the early 1970s by the Liaison Committee on Medical Education (LCME) officially acknowledged the essentiality of graduate medical education by stating, "The undergraduate period of medical education leading to the M.D. degree is no longer sufficient to prepare a student for independent medical practice without supplementation by a graduate training period which will vary in length depending upon the type of practice the student selects." (2)

Despite the apparent acceptance of the concept of undergraduate and graduate medical education as a continuum, the transition between the undergraduate and graduate phase for many students has become more and more difficult. The decision by the Council on Medical Education of the American Medical Association (AMA) to eliminate free-standing internships, coupled with the decision by several specialty boards to permit entrance into programs in their specialties directly after graduation from medical school, has contributed to the confusion. Inadequate information about graduate programs and a decrease in the resources available to teaching hospitals to make available positions to a growing number of graduating students have compounded the problem.

Smoothing the transition by improving counseling, making the application and selection process less hectic, and ensuring that sufficient first graduate year positions of high quality are available to meet the needs of graduates from U.S. medical schools will require concerted action by medical schools, graduate medical education programs, and institutions and their accrediting bodies. Support for a directed effort to improve the transition must also come from certifying boards and specialty societies. The recommendations set forth below can be implemented if all involved parties place a high priority on improving the quality of medical education and show a concern for the needs of students at this critical juncture in their professional education.

1. Coggeshall, L.T. Planning for Medical Progress through Education, Evanston, Illinois: Association of American Medical Colleges, pp. 38-45, 1965.
2. Liaison Committee on Medical Education. Functions & Structure of a Medical School. Approved by the Assembly of the Association of American Medical Colleges, November, 1972, and the House of Delegates of the American Medical Association, pp. 4-5.

CAREER COUNSELING

Although the separation of undergraduate from graduate medical education is conventional, most students begin their uninterrupted education and professional development with matriculation into medical school. More particularly, their acquisition of clinical knowledge and skills begins when they have their first contact with patients. In some schools this may start at matriculation. As an extension of students' clinical education, graduate medical education is directed primarily toward the refinement of clinical and problem-solving skills, and the enlargement of clinical knowledge. If both students and faculty recognize and accept this concept of the continuum, development of a more effective career counseling relationship between faculty and students and improved articulation of the undergraduate with the graduate phase will be facilitated.

Most medical schools attempt to provide an adviser to entering students. Too often the role of advisers and the services they are expected to offer to students are not clear to either. Academic difficulties, personal crises, and financial problems are often the needs for which students who are troubled seek advice during their early terms in school. Later, as they recognize the myriad of career options available to them, all students, formally and informally, begin to ask for assistance in choosing among alternative careers. Finally, as the time for making decisions about graduate medical education programs draws near, students want and need very specific advice from knowledgeable faculty.

An important part of the career selection process is the elective final year. During the 1960s, when there was a movement toward shortening medical education and encouraging early career decision-making, most U.S. medical schools abandoned their structured, required final year curricula and made most or all of the final year elective. This movement toward greater flexibility is generally viewed as a progressive and satisfactory change; however, the degree of effective utilization of the opportunities provided by an elective final undergraduate year varies widely among students and among institutions.

Students should use the elective final year both to explore their potential interest in and talent for specialties they are considering and to gain experience in areas to which they are unlikely to have significant exposure during their graduate years. Those who approach their final year undecided about a career direction should be counseled to sample areas in which they may have an interest early so that as the time for decision-making approaches, they will have had an opportunity to gain as much insight as possible. Students who are comfortable with a chosen career path should be advised to avoid restricting their elective opportunities to education in the area they have selected and should be assisted in choosing electives which will complement their future career development.

All of these demands on a counseling system by medical students and faculty require that the dean assume the leadership in developing a system which provides mechanisms to identify competent faculty advisers, to educate and train them in their various roles, and to ensure that students have easy access to these individuals. Members of the administration and faculty of

the medical school should formulate and agree upon sound approaches to advising medical students and disseminating information necessary in their counseling at this stage of their development.

Benefits accrue to medical students when an administrative officer or other knowledgeable individuals in the dean's office have broad familiarity and insight into the entire transition process. These persons can provide students with the whole picture of choosing a residency and can screen students and direct them to the proper resources and advisers. Also, persons with broad knowledge can give students a good general approach to the elective year and provide guidance for the faculty advisers.

Advisers who are to deal with student choice of a specialty and of a specific residency should be familiar with both the practice of their own specialty and the characteristics and the quality of the educational programs in other institutions. These advisers should be in touch with national organizations, such as specialty boards or academic societies, to ensure that they are informed of educational trends in the specialty. Awareness of the matching process and deadlines for the National Resident Matching Program (NRMP) is essential to the counselor of a medical student who is deciding on a residency training program. To direct the student toward the most efficient and positive use of elective time, the adviser also should be familiar with the electives available to the medical student.

In their counseling role such advisers should not act as recruiters for their specialty. Rather, they should be prepared to assess students' talent for their field and be expected to transfer to another adviser students who are deemed unlikely candidates for their specialty.

The Liaison Committee on Medical Education (LCME) in its review of schools for accreditation should place a particular emphasis on the advising and counseling provided to students.

INFORMATION ON GRADUATE PROGRAMS

One of the strengths of American medical education is that at the transition between undergraduate and graduate medical education, all students have the opportunity to move from one educational setting to another. One of the weaknesses for many students at the transition is the paucity of information available to them about graduate programs. At one time the AMA regularly published a directory which provided basic data about each program offered. During the 1970s, this directory has been published erratically and has never been timely for student purposes. The NRMP began publishing its own directory in 1975. It distributes the directory to students about October 1 of each year. This, currently, is only a listing of programs and the number and types of positions offered. The AAMC's Organization of Student Representatives has pressed for an expansion of the information in this directory and NRMP has expressed a willingness to respond to this need. The AMA staff is also exploring means for the more regular and timely publication of its directory. Two competing directories would not serve students' needs. AAMC, NRMP, and AMA, working together, should publish annually a directory that lists all programs offering positions to first-year graduates.

The directory should contain as much information about the characteristics of the programs as is feasible. It should be available to students no later than October 1 each year.

A national directory of graduate programs cannot provide all the details that most students want and advisers need. Subjective impressions about the quality of programs can be obtained from alumni and filed for reference by both students and faculty. Faculties are urged to canvas alumni of their school in order to develop such a file.

THE APPLICATION CYCLE AND THE SELECTION PROCESS (See Appendix A)

The expanding number of graduates each year from U.S. medical schools and the diversity of types of first graduate year programs available to students make the development of a workable process of application and selection imperative. The NRMP is the foundation stone upon which an improved process can be developed. Its establishment in 1953 as the National Intern Matching Program (NIMP) was a major step toward easing the pressure on students to make premature decisions. Were the NRMP not in place today, the transition would be chaotic.

In order to make the NRMP services to students and program directors even more satisfactory, the following policies are recommended:

1. All programs in graduate medical education which select residents who are immediate graduates of medical schools accredited by the LCME should be required to utilize the NRMP as a condition of accreditation by the Liaison Committee on Graduate Medical Education (LCGME).

At present the vast majority of graduate medical education institutions and their sponsored programs use the NRMP and responsibly adhere to its policies and procedures; however, some institutions and programs do not participate. These nonparticipants notoriously set deadlines for application and selection that are not in phase with the NRMP cycle; thus, they place undue pressure on students to make premature decisions and tempt program directors who are participating in the NRMP to petition students for early guarantees of accepting their offers. While only a small fraction of students encounter such problems, this unsound educational policy should not be tolerated. The quality of a graduate program is in part dependent upon providing to students a maximum opportunity to make rational and informed decisions in selecting their specialties and programs. Requiring all accredited programs to utilize the NRMP is reasonable and consistent with the purpose of accreditation.

2. A universal application form should be developed. This form should request information about applicants that is universally accepted as essential for making selection decisions. The universal form should not preclude programs from asking for additional information from students in whom they are interested. Directors of residency programs that require additional data such as a biographical sketch, should be asked to indicate in their brochures

the nature of any supplemental information to be sent with the application. The forms should be made available to students at the time they receive the NRMP agreement forms and should provide a return card so that their receipt by program directors can be easily verified to students. The AAMC should assume a leadership role in developing the universal application form.

3. Evaluation letters and transcripts should not be sent by deans' offices to program directors prior to October 1 of a student's final year. Letters of recommendation from faculty also should not be requested by program directors before October 1. The purpose of this policy is to maximize the amount of information available to deans and faculty when they synthesize an assessment of a student's achievements and capabilities. Adherence to this policy by deans, faculty, program directors, and students will inure to the benefit of all.

4. The deadline for both students and programs to make their final decisions and submit their rank order lists to NRMP should be as close to the first of February as possible. At present the deadline falls in the second week in January. Extending this deadline by two to three weeks will significantly expand the time available to students and programs for interviews and for decision-making. The Christmas holiday season can be utilized more effectively for interviews, and selection committees will have more time for deliberation after the holidays. The announcement of the match results shall be in March, as close to the 15th as feasible.

5. There should be a uniform starting date for all graduate medical education programs, and this date should occur no earlier than June 24. An orientation program is recommended for all new residents and should provide (a) a review of the goals and objectives of the institution and of the first-year training program; (b) a review of the expectations for the PGI resident including the educational program, teaching of medical students, and the use of the medical record system; and (c) a clear understanding of the evaluation procedures and the evaluation system employed by the institution and the training program.

STUDENT VISITS AND INTERVIEWS

Visits to graduate education institutions and programs by students during the application cycle are a significant expense. At one medical school, 51 out of 87 students reported expenditures in 1978 of \$300 or more for transportation and maintenance to visit and be interviewed. Five reported expenses in excess of \$1,000, and only 15 had spent less than \$100.

Policies and procedures for visits and interviews vary. Some institutions and programs have a highly structured visit and interview system that requires students to appear only by invitation on specified days, usually only after letters and transcripts have been evaluated. Others accommodate students

on an ad lib basis. It is important that students' time and money be conserved as much as possible. Institutions and programs that adhere to a structured and scheduled procedure should offer a number of dates (at least six to ten) spread over several months. If interviews are conducted only after credentials and letters have been reviewed, they should be scheduled only during the 110-day period between October 1 and January 20. Publication of scheduled visitation dates early in the application cycle will assist students and schools in planning their final year academic programs. All institutions and programs are urged to accommodate students whose schedules do not permit adherence to a rigid interview system without undue cost in time and money.

THE TYPES OF FIRST GRADUATE YEARS

Prior to the 1970s, the first year of graduate medical education was called an internship. Individuals who pursued additional graduate years entered residencies and were called residents during their second and subsequent years of graduate education. Internships were of two types, straight and rotating. Straight internships were offered principally in internal medicine, pediatrics, surgery, and pathology. Rotating internships were institutionally planned and consisted of a variety of rotations often emphasizing one specialty or another. The specialty boards and residency review committees (RRCs) of all specialties except those that offered straight internships did not permit entrance into training programs directly from medical school, and students entering these specialties first completed a straight or rotating internship.

The Millis Commission in 1966 recommended, "The internship, as a separate and distinct portion of medical education, be abandoned, and that the internship and residency years be combined into a single period of graduate medical education called a residency and planned as a unified whole." (3) In the early 1970s two policy decisions occurred in an attempt to implement this recommendation. First, the AMA's Council on Medical Education announced that after 1975 internships (or first graduate years) would no longer be separately approved and that free-standing internships in institutions offering no other graduate medical education would not be permitted. Almost simultaneously, several specialty boards dropped their requirement that an individual complete an internship prior to entering their training programs and permitted entry immediately after graduation. Several of these boards required that either as a part of the first graduate year, or interwoven into later years of the program, residents receive education and training in other disciplines.

To accommodate to these policy changes, the Council on Medical Education devised three designations for the types of programs to be offered in the first graduate year: (4)

3. Millis, J.S. (Chairman). The Graduate Education of Physicians. Report of the Citizens Commission on Graduate Medical Education. Chicago: American Medical Association, 1966.
4. National Resident Matching Program. NRMP Directory. Evanston, Illinois: National Resident Matching Program, 1978, p. 37.

- C CATEGORICAL FIRST YEAR - These are first-year programs planned, sponsored, and conducted by a single, approved residency program as an integral part of that residency. The content of such a first-year will be limited, generally, to the specialty field of the sponsoring residency program.
- * CATEGORICAL* FIRST YEAR - The asterisk designates a first-year program that will be planned, sponsored, and supervised by a single, approved residency as an integral part of that residency. The content need not be limited to the specialty of the sponsoring program, but may include experience in two or more specialty fields as determined by the sponsoring programs.
- FLEX FLEXIBLE FIRST YEAR - The first year will be sponsored by two or more approved residencies and will be jointly planned and supervised by the residencies that sponsor it. Such a first year is designed to give a broad clinical experience for (1) students who feel the need for this type of first year; (2) program directors who feel that such an experience will best serve the purpose of subsequent graduate education in their field; and (3) students who have not yet decided on their specialty but may wish to choose among several fields during their first graduate year. The content of a flexible first year must include four months of internal medicine, but the remainder of the year may be designed in accordance with the purposes of the two or more sponsoring residency programs, and the interests and needs of the student.

Experience has now demonstrated significant problems with these designations and the approval and accreditation policies which apply to the Categorical * and Flexible types. The Categorical (C) type of first graduate year presents little difficulty. RRC's for each specialty are well acquainted with the educational standards set forth in their Special Requirements and in reviewing the educational plan for programs in their specialty are able easily to assess the first graduate year in the context of the total program.

However, when an RRC encounters a Categorical * or Flexible first year sponsored by a program in its discipline but composed of educational experience in specialties other than its own, it is not comfortable to judge the quality of the other specialty offerings. The dilemma is eloquently described by John Romano, Professor and Chairman of Psychiatry, at the University of Rochester. "The assumption that the department of psychiatry would, or could, be in a position to supervise or be responsible for the internship assignment in medicine, pediatrics, neurology, or family medicine in hospital and clinic services at some distance is not only mistaken but patently absurd. When one considers how such an internship could be inspected, examined, or evaluated by review committees, one realizes how impossible is the task. One has only to remember how perfunctory and inadequate is the evaluation of psychiatric residency by the residency review committee." (5)

5. Romano, J. Comment. Am. J. Psychiatry, 135:1206-1209, October 1978.

While it might be assumed that in institutions sponsoring several graduate programs, the Categorical* or Flexible types would consist of rotations through approved and accredited programs, such is not necessarily the case. For example, the required experience in internal medicine for a Categorical* psychiatric program may consist of four months' assignment to the medical service of a psychiatric hospital, and a flexible program cosponsored by anesthesia and obstetrics can consist of rotations through services in hospitals where there are no other residents.

These designations and their attendant sponsorship and accreditation policies have clearly proved to be unsatisfactory. They tend, in fact, to perpetuate the first graduate year as a separate entity rather than to facilitate the development of a unified residency plan as proposed by the Millis Commission.

In order to eliminate the problems introduced by the current designations of first graduate years, it is recommended that only two types of first graduate years be designated and that their sponsorship and accreditation be based on the following principles:

1. Graduate education in any specialty shall only be provided in programs approved by the residency review committee of that specialty and accredited by the Liaison Committee on Graduate Medical Education.
2. Institutions that sponsor programs in specialties requiring that their residents have educational experiences in disciplines other than their primary specialty, should arrange to provide these experiences only in programs approved by the RRC's of the specialties offering the respective experiences.
3. In reviewing and approving their programs each RRC should assess the quality of education provided to transients with the same degree of attention as the review of the quality of education provided residents devoted to a career in that specialty.

Based on these principles, two types of first graduate years should be designated:

CATEGORICAL PROGRAMS - Categorical (C) are programs in a specialty that meet the Special Requirements of the residency review committee for that specialty. Institutions that offer categorical programs requiring educational experiences in other specialties must make the necessary arrangements for residents to gain that experience only in programs approved by the RRC of the specialty offering the respective experiences.

MIXED PROGRAMS - Mixed (M) are programs for students in their first graduate year who desire a mixed experience in several specialties. Institutions that sponsor accredited programs in internal medicine, pediatrics, surgery, and one or more other specialties may offer a Mixed G1 program if there is an identified director with the responsibility for planning the mixed program

and evaluating and counseling the residents.*

Several advantages will result from this change in designation. As mentioned earlier, both the Categorical* and Flexible/Rotating first graduate years were expected to be sponsored by a specialty program or programs and accredited by the RRC for that specialty or specialties. The asterisk informed students that the first graduate year would consist of educational experiences in specialties other than the sponsoring specialty, but no directory currently contains information regarding the content of the program. A simple designation of all specialty programs that accept students directly out of medical school as Categorical, will enable students who have decided to enter a specialty to make their selection without having to make a decision between a Categorical or Categorical asterisk position. This will reduce the present number of 42 combinations being offered in the matching program to 23.

It is also important to recognize that the Special Requirements of specialty boards and RRCs do not usually limit educational experience in other specialties only to the first graduate year. Program directors have considerable leeway in designing their educational plan and may organize their program so that necessary educational experiences in other specialties occur through rotations blended into the entire length of the program. This approach is consistent with the Millis Commission's recommendation that residencies be planned as a unified whole.

Implicit in this designation is the requirement that institutions that sponsor Categorical programs, which select graduating medical students, provide the resources necessary to meet all of the Special Requirements for all of their sponsored programs. In many cases, the needs of programs that require educational experiences in other specialties will be met by the accredited programs in these specialties sponsored by the institution. However, it will be possible for these experiences to be obtained through arrangements with other institutions as long as they are provided in an accredited program. No educational experiences could be obtained in settings that are not under the supervision of the director of an accredited program in graduate medical education.

Since the inception of the three-type designation, the number of Flexible positions available for undecided students or for students who want a mix of clinical education before entering the first year of a residency in their second graduate year, has dropped considerably. The elimination of free-standing, rotating internships in institutions which provided no other graduate medical education has, in part, been responsible for this decline. The competition for resources to mount Categorical* first years has also reduced Flexible offerings in institutions that sponsor multiple programs. The quality of Flexible programs varies markedly, and students are reluctant

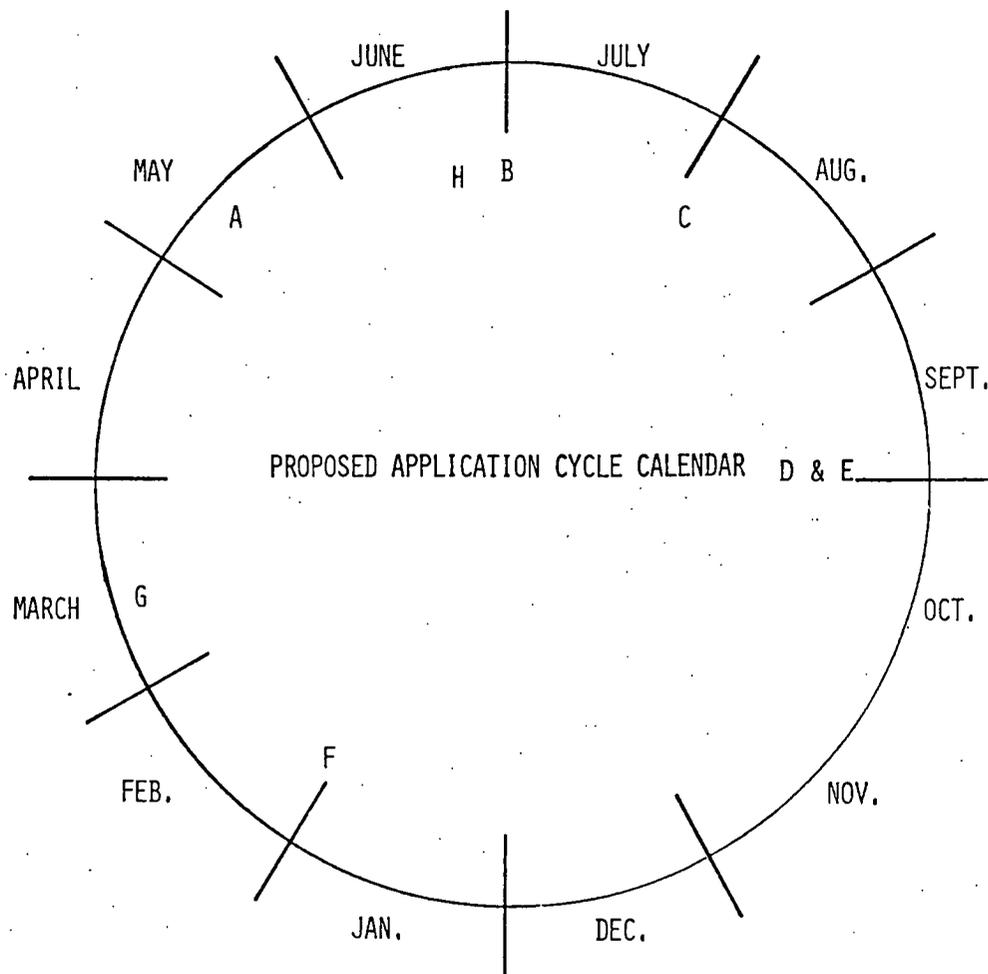
* The Chairman of the Transition Working Group recommended to the Task Force on November 16, 1978, that the designation of types of first graduate years developed and approved by the Liaison Committee on Graduate Medical Education be accepted as a suitable alternative and appended to this report (see Appendix B).

to enter many. In 1978 only eight percent of the graduates in the match sought Flexible positions. Whether that proportion will increase if mixed programs of higher quality become available is open to conjecture, but certainly the needs of undecided students must be accommodated.

The requirement that mixed programs be limited to institutions that sponsor accredited programs in medicine, pediatrics, surgery, and one or more other specialties, will more effectively ensure that the program is of acceptable quality. The requirement that a director be assigned to plan the mixed, first graduate year and to counsel and evaluate the residents will eliminate a common complaint that students have about the lack of an organized plan for current Flexible offerings. The revised General Requirements for Graduate Medical Education, which are now being developed, will place a greater emphasis on requiring institutions to meet fully their responsibilities to their sponsored programs. In implementing these new General Requirements, a mechanism to ensure that mixed programs are being provided effective leadership can be evolved.

APPENDIX A

The application cycle as proposed would follow the calendar set forth in the figure that follows.



- A. May 15-NRMP student agreement forms and uniform application forms available to medical schools for distribution.
Institutional agreement forms sent to institutions.
- B. July 1-Institutions return agreement forms to NRMP.
- C. July 30-Students return agreement forms to NRMP.
- D. Oct. 1-NRMP Directory distributed to students.
- E. Oct. 1-Deans' letters and transcripts available from medical schools.
- F. January (as late as feasible)-Students and institutions submit rank order lists to NRMP.
- G. March (as close to 15th as feasible)-Match results announced.
- H. June 24-Institutional starting time.

APPENDIX B*

4. Types of Programs

Graduate programs of two types may be provided to residents by institutions:

4.1 Categorical Programs: Categorical (C) are programs in a specialty which meet the Special Requirements of the RRC for that specialty. Some specialties require that residents have complementary educational experiences in other disciplines. Whether it is required that such experiences precede or be interwoven into the education and training for the specialty, institutions sponsoring such programs should make the necessary arrangements for residents to gain these complementary experiences in programs approved by the RRC of the specialty providing the experience.

Categorical programs which require educational experience in a variety of clinical disciplines may be conducted in any educational setting which meets the General Requirements and the Special Requirements of the RRC for such specialties.**

4.2 Transitional Programs: Transitional (T) are programs for residents ordinarily in their first graduate year who desire a broad experience in several specialties before entering further training.***

Institutions or consortia of institutions which sponsor an accredited program in internal medicine and at least two other accredited programs from amongst the following: family practice, obstetrics and gynecology, pathology, pediatrics, psychiatry, radiology or surgery, may offer a transitional year if the following conditions are met:

- a) There is a qualified director (or associate director) on site responsible for planning the program, counseling the residents, and coordinating their evaluation;
- b) There is an institutional committee, composed at least of the representatives of the accredited programs providing the components of the transitional year, charged to assist the director in program development and evaluation;

* From "Essentials of Accredited Residencies in Graduate Medical Education," prepared and submitted by the LCGME Committee on Essentials, (August G. Swanson, M.D., Chairman), October 3, 1978.

** This merges what have been termed Categorical and Categorical* designations.

*** These programs are intended to replace those previously designated as Flexible programs.

- c) At least three quarters of the education and training of the transitional year is provided by staff assigned to the accredited programs sponsored by the institution. The balance of the year is spent in educational settings selected by the director and approved by the institutional transitional program committee;
- d) The residents in each of their assignments are associated with senior residents in the participating specialties.

APPENDIX C

WORKING GROUP ON TRANSITION

- CLAWSON, D. KAY,* M.D., Chairman; Dean, University of Kentucky, College of Medicine, 800 Rose Street, Lexington, Kentucky 40506/(606) 233-5119
- BAKER, GEORGE L., M.D.; Associate Dean for Student Affairs and Curriculum, University of Iowa College of Medicine, Iowa City, Iowa 52242/(319) 353-4843
- BARNETT, B. LEWIS, JR., M.D.; Chairman, Department of Family Medicine, University of Virginia School of Medicine, Charlottesville, Virginia 22901/(804) 296-0143
- BELL, DAVID M., M.D.; Resident in Pediatrics, The Children's Hospital and Medical Center, 300 Longwood Avenue, Boston, Massachusetts 02115/(617) 734-6000, Extension 2323
- DAESCHNER, C. WILLIAM, JR., M.D.; Chairman, Department of Pediatrics, University of Texas Medical Branch at Galveston, Galveston, Texas 77550/(713) 765-1011
- FEDERMAN, DANIEL D., M.D.; Dean of Student Affairs, Harvard Medical School, 25 Shattuck Street, Boston, Massachusetts 02115/(617) 732-1000
- GUTMANN, CHERYL M.,* M.D.; First-Year Resident, Department of Psychiatry, Rush-Presbyterian-St. Luke's Medical Center, Chicago; Mailing Address (Residence)--351 Dickens Street, Chicago, Illinois 60614/(312) 248-5112
- HELDRICH, MARTIN, M.D.; Chairman, Department of Anesthesiology, University of Maryland School of Medicine, 655 West Baltimore Street, Baltimore, Maryland 21201/(301) 528-7411
- HENRY, JOHN BERNARD, M.D.; Chief of Clinical Pathology, State University Hospital of the Upstate Medical Center, 766 Irving Avenue, Syracuse, New York 13210/(315) 473-4525
- HOLLENDER, MARC H., M.D.; Chairman, Department of Psychiatry, Vanderbilt University School of Medicine, 21st Avenue South at Garland Avenue, Nashville, Tennessee 37232/(615) 322-2164
- JACOBSON, HAROLD M.D.; Chairman, Radiology, Albert Einstein College of Medicine of Yeshiva University, 1300 Morris Park Avenue, Bronx, New York 10461/(213) 430-2000
- PETERSON, ANN S., M.D.; Associate Dean for Student Affairs, Columbia University College of Physicians and Surgeons, Columbia University, 630 West 168th Street, New York, New York 10032/(212) 694-2500
- SHIRES, G. THOMAS, M.D.; Chairman, Department of Surgery, Cornell University Medical College, 1300 York Avenue, New York, New York 10021/(212) 472-5440

OBSERVER/PARTICIPANT

- EAST, PAUL, M.D., J.D., M.P.H., Associate Chief for Graduate Medical Education, Veterans Administration, 810 Vermont Avenue, N.W., Washington, D.C. 20420/(202) 389-5171

* Also a member of the AAMC Task Force on Graduate Medical Education

PLANNING FOR THE IMPLEMENTATION OF THESE RECOMMENDATIONS

THE APPLICATION CYCLE AND SELECTION PROCESS

Implementation of the recommendations of the Transition Working Group for changes in the application cycle and selection process, will require careful planning. The AAMC, deans for student affairs, program directors, and directors of teaching hospitals must thoroughly discuss the recommendations, understand their implications, and accept the substance of the changes to be made in the selection process for graduate education programs. Before beginning an implementation program, several steps must be accomplished:

1. The universal application form must be developed and then critiqued in order to ensure that it is acceptable. Prior research on residency application forms done by the AAMC staff that is available will make feasible the development and distribution of a universal application form in the near future.
2. The NRMP must be able to move the date for submission of rank order lists as close as possible to the first of February without unduly delaying the announcement of matching results. NRMP is exploring the modification of procedures that would accomplish these changes.
3. Program directors and staff of teaching hospitals must be informed of the rationale for delaying requests for deans' letters and faculty letters of evaluation until October 1. Program directors must also be persuaded of the necessity to modify their interviewing procedures for graduate programs.

Since the population concerned with changes in the transition to graduate education will be difficult to reach through any single channel, multiple approaches will be required. Some possible strategies include the following:

1. Letters and presentations to associations of program directors or to associations of medical school department chairmen.
2. The AAMC Council of Academic Societies 1979 spring meeting, which will focus on graduate medical education, would afford an opportunity for obtaining endorsement of changes in the application cycle and selection process.
3. The AAMC Group on Student Affairs holds regional spring meetings which would provide fora in which to discuss the implementation of changes and their possible ramifications.

Since a large number of people must first be informed and then agree to comply with the proposed modifications, full implementation of the recommendations within one year would be difficult. The introduction of a universal application form and moving the date for submitting rank order lists toward February 1 would set the stage for later implementation of the recommendations that are more difficult to control such as a firm date for deans' letters and changes in policies surrounding the interview process.

ADVISING AND COUNSELING

The Transition Working Group has recommended that the advising and counseling of students who are choosing a specialty and a specific residency be improved. Implementing improvements in advising and counseling systems may be accomplished with a variety of approaches.

1. Individual medical schools must assess their investment of resources and personnel to find a systematic way to ensure that all students have access to the information and assistance that will facilitate sound career decisions. Concomitantly, the Transition Working Group urges the LCME to monitor the advising system in each medical school as it is considered for accreditation.
2. The AAMC, working with the Council of Deans, the Group on Student Affairs, the Group on Medical Education, and the medical school faculties, must develop strategies to assist those who feel their counseling services must be revised. Such a long-term effort will involve study, publications, and workshops for which resources must be acquired.
3. Improved counseling will also require increased and updated directory information about graduate programs and teaching hospitals. Improving the directory will require AAMC cooperation with the NRMP, the AMA, and the LCGME. Increasing the amount of information available to students about graduate programs can most likely be accomplished within two years.

TYPES OF FIRST GRADUATE YEARS

Subsequent to the July 1978 meeting of the AAMC Task Force on Graduate Medical Education, a paper entitled, Types of Graduate Programs: Their Designation and Accreditation, was prepared and circulated to the Task Force and to the AAMC Transition Working Group. The AAMC Executive Committee approved utilizing it as a discussion paper at a meeting of residency review committee chairmen with the LCGME Transition Committee which was held on September 17, 1978, in Chicago. As a result of that meeting the LCGME has recommended changes in the designations and requirements for the first graduate year. These recommendations have been incorporated into Section 4 of the revised General Requirements of the Essentials of Accredited Residencies. The revision has been referred by the Coordinating Council on Medical Education to its sponsoring organizations for review and comment. The Transition Working Group's paper provided the basic concept for the LCGME proposal.

NATIONAL STANDARDS FORMULATION AND ACCREDITATION

The following is a brief history of the development of the accreditation system for graduate medical education. In addition, the Working Group on Accreditation has developed 12 principles upon which to base modifications in the accreditation system which are necessary to make accreditation an effective instrument for improving graduate medical education in the future. These principles will be available for discussion at the meeting.

A BRIEF HISTORY OF NATIONAL STANDARDS FORMULATION AND ACCREDITATION

Among Webster's definitions of the word "accredit" is one that might be said to apply to medical education at both the undergraduate and graduate levels:

To recognize (an educational institution or program) as maintaining standards that qualify the graduates for admission to higher or more specialized institutions or for professional practice (1).

In the United States, accreditation of institutions or programs in higher education is conducted by a variety of voluntary agencies at both the national and regional levels. In medicine the responsibility for the accreditation of medical schools has, since 1942, been vested in the Liaison Committee on Medical Education, jointly sponsored by the American Medical Association and the Association of American Medical Colleges. Authority for this accrediting body is by recognition of the U.S. Commissioner of Education.

Responsibility for accreditation of programs in graduate medical education has only recently come under the aegis of the Liaison Committee on Graduate Medical Education. Representation in this body is drawn from the American Medical Association, the Association of American Medical Colleges, the American Board of Medical Specialists, the Council on Medical Specialty Societies, and the American Hospital Association. The Committee has not sought recognition by the U.S. Commissioner of Education.

(1) Webster's Eighth New Collegiate Dictionary, G & C Merriam Company, Springfield, Massachusetts, 1973.

Accreditation in graduate medical education is a public trust, and its purposes are many:

- *It assures students who are selecting among programs that the programs meet the national standards established for education and training in a particular specialty;*
- *It protects the public by assuring that the residents are provided education and training of high quality in programs that are well supervised by competent teaching staff;*
- *It assures certifying boards that the standards they require are being met by individual programs;*
- *It assures residents in the programs, who are the consumers of the educational process, that they are receiving education and training that is of high quality;*
- *It assures the medical faculty, staff, and program directors, who jointly are responsible for the educational process, that the enterprise in which they are engaged is of high quality; and*
- *It assures funding agencies that the educational programs meet national standards and merit support.*

In order to achieve and retain credibility, accrediting agencies must define and articulate clear standards against which an institution or program can be judged, employ a process which provides methods to determine whether the standards have been met, and be able to demonstrate that decisions to accredit or not to accredit are based solely upon whether the standards have or have not been met.

The structure currently in use was devised between 1930, when 338 hospitals offered 2,028 residency positions, and 1950, when 1,079 hospitals offered 18,669 residency positions. The stress on this system can only be suggested when one considers that in 1976 a total of 1,702 hospitals offered 64,660 residency positions in the United States.

In this report the history of accreditation in graduate medical education is reviewed. Its present status is assessed, and principles for its improvement in the future are discussed.

THE DEVELOPMENT OF A SYSTEM TO APPROVE RESIDENCIES

In the first quarter of this century, graduate medical education varied from courses of a few weeks or months' duration to residencies of several years' duration. Professional organizations of specialists did not support the short-course route to specialist status, and, as certifying boards evolved, residency training of several years duration became the necessary prerequisite to designation as a specialist.

In 1928, the Council on Medical Education and Hospitals of the American Medical Association (AMA) sent forward for approval by the AMA House of Delegates, basic standards for residency programs. These were promulgated under the title of "Essentials of Approved Residencies and Fellowships." It is of interest that a year before the standards were promulgated, the Council published a list of hospitals approved for graduate

medical education. A regularized system of periodic review and approval by a body specifically designated as having the authority to set standards, review, and approve or disapprove hospitals and their training programs was not put in place until much later.

The American College of Surgeons, which from its inception was concerned with the quality of surgical training, in 1937 began the development of a program to set the standards for surgical education, and in 1939 it published a list of hospitals in the United States and Canada Approved for graduate education. At the same time the College published a minimum standard which was titled, "Fundamental Requirements for Graduate Training in Surgery." From 1937 until 1949 the College and the AMA separately evaluated surgical training programs. A major difference was that the College recognized only programs of three or more years duration, while the AMA recognized programs that offered shorter periods of training, as well. In 1949 the AMA, the American College of Surgeons, and the American Board of Surgery joined together to develop the Conference Committee on Graduate Training in Surgery.

Meanwhile, in 1939, the American College of Physicians had begun a similar tripartite effort with the Council on Medical Education and Hospitals and the American Board of Internal Medicine. A conference committee, organized in 1940, began to review hospitals that offered training in internal medicine until World War II interrupted its activities. Plans begun in 1948 to reactivate the conference committee, were completed and agreed to by the three participating organizations in 1949.

The fundamental characteristics and operating policies of both the medicine and surgery conference committees were that:

1. Members of the committee were appointed by each participant.
2. The committees were given the responsibility to recommend educational standards.
3. Recommended educational standards had to be approved by each participating organization.
4. Decisions to approve or disapprove programs were made by the committees with no further review by the participating organizations.
5. Staffing services were provided by the AMA with a member of the staff of the Council on Medical Education and Hospitals serving as the secretary to the committee.
6. On-site surveys were conducted by the AMA staff.

In 1953 the term "conference committee" was replaced by the term "residency review committee" (RRC). This title has persisted.

In 1953 the Council approached the other specialty boards and proposed establishing RRCs to set their educational standards and review their training programs. By 1956 committees had been established in all the specialties except pathology, obstetrics-gynecology, and thoracic surgery. Their policies and modes of operation were similar to those which had evolved for medicine and surgery. Except for the surgical specialties and internal medicine, these RRCs were composed only of representatives appointed by the AMA and the Board. There were no representatives from a specialty society. At present, the sponsorship of RRCs is still variable with some having tripartite sponsorship and some bipartite. In each case, the AMA is a sponsor, and through this mechanism it has had a pervasive influence on graduate medical education. Organizations represented in the RRCs at this time are shown in Table 1.

TABLE 1

ORGANIZATIONAL REPRESENTATION IN 22
RESIDENCY REVIEW COMMITTEES, 1978-79

<u>Residency Review Committees</u>	<u>Organizations Represented</u>
Allergy & Immunology	American Board of Allergy & Immunology <i>(A Conjoint Board of the American Board of Pediatrics and the American Board of Internal Medicine)</i> AMA Council on Medical Education
Anesthesiology	American Board of Anesthesiology AMA Council on Medical Education
Colon & Rectal Surgery	American Board of Colon & Rectal Surgery AMA Council on Medical Education American College of Surgeons
Dermatology	American Board of Dermatology AMA Council on Medical Education
Family Practice	American Board of Family Practice AMA Council on Medical Education American College of Physicians
Neurological Surgery	American Board of Neurological Surgery AMA Council on Medical Education American College of Surgeons
Nuclear Medicine	American Board of Nuclear Medicine <i>(A Conjoint Board of the American Board of Internal Medicine, the American Board of Pathology and the American Board of Radiology)</i> AMA Council on Medical Education
Obstetrics-Gynecology	American Board of Obstetrics & Gynecology AMA Council on Medical Education American College of Obstetricians and Gynecologists
Ophthalmology	American Board of Ophthalmology AMA Council on Medical Education American Academy of Ophthalmology

Orthopaedic Surgery	American Board of Orthopaedic Surgery AMA Council on Medical Education American Academy of Orthopaedic Surgeons
Otolaryngology	American Board of Otolaryngology AMA Council on Medical Education American College of Surgeons
Pathology	American Board of Pathology AMA Council on Medical Education
Pediatrics	American Board of Pediatrics AMA Council on Medical Education American Academy of Pediatrics
Physical Medicine & Rehabilitation	American Board of Physical Medicine & Rehabilitation AMA Council on Medical Education
Plastic Surgery	American Board of Plastic Surgery AMA Council on Medical Education American College of Surgeons
Preventive Medicine	American Board of Preventive Medicine AMA Council on Medical Education
Psychiatry & Neurology	American Board of Psychiatry & Neurology AMA Council on Medical Education
Radiology	American Board of Radiology AMA Council on Medical Education
Surgery	American Board of Surgery AMA Council on Medical Education American College of Surgeons
Thoracic Surgery	American Board of Thoracic Surgery AMA Council on Medical Education American College of Surgeons
Urology	American Board of Urology AMA Council on Medical Education American College of Surgeons

By 1970 the RRC system, staffed by the AMA, was responsible for setting the standards and for reviewing and approving programs in graduate medical education in all specialties except for pathology. The American Board of Pathology continued independently setting standards for and reviewing residencies in pathology until 1972, when it also joined the system.

In the late 1960's as the federal government began to scrutinize graduate medical education, and federal support for graduate medical education was foreseen as a distinct possibility, the AMA requested that the U.S. Office of Education recognize the RRC system as the accrediting agency for graduate medical education programs. The Office of Education denied this request, principally because of the narrow representation on the RRCs and their singular dominance by the AMA. Stimulated by this criticism, the AMA began discussions with other organizations that had a genuine interest in graduate medical education, and by 1972 the American Medical Association (AMA), the Association of American Medical Colleges (AAMC), the American Board of Medical Specialists (ABMS), the Council of Medical Specialty Societies (CMSS), and the American Hospital Association (AHA) had agreed to establish a pentapartite committee to be responsible for the accreditation of graduate medical education. It was agreed that as a first order of business, this accreditation committee, the Liaison Committee on Graduate Medical Education (LCGME), would seek official recognition by the U.S. Office of Education. The five sponsors also agreed to establish another group to be called the Coordinating Council on Medical Education (CCME). The role of this council was to approve major policies not only of the LCGME but also of the Liaison Committee on Medical Education (LCME), which had been functioning since 1942 as a bipartite effort of the AMA and the AAMC for the accreditation of

undergraduate medical education. The CCME was also charged to form a liaison committee to accredit continuing medical education. The Liaison Committee on Continuing Medical Education was established in 1977.

THE LIAISON COMMITTEE ON GRADUATE MEDICAL EDUCATION

In the establishment of the Liaison Committee on Graduate Medical Education and the Coordinating Council on Medical Education, the participating organizations first reached five points of agreement:

- " 1. As soon as possible, there will be established a Liaison Committee on Graduate Medical Education, with representation from each of the five organizations, to serve as the official accrediting body for graduate medical education.
2. Simultaneously, there will be established a Coordinating Council on Medical Education composed of representatives from each of the five organizations to consider policy matters for both undergraduate and graduate medical education for referral to the parent organizations.
3. The existing Liaison Committee on Medical Education and the new Liaison Committee on Graduate Medical Education will have the authority to make decisions on accreditation in their respective areas within the limits of policies established by the parent organizations and with the understanding that Residency Review Committees will continue to function.
4. All policy decisions will continue to be subject to approval by the parent organizations.
5. Policy recommendations may originate from any of the parent organizations or from the two liaison committees, but will be subject to review by the Coordinating Council before final action is taken by the parent organizations."

Subsequently, representatives of the five organizations met and agreed on a proposal for the Liaison Committee on Graduate Medical Education. The purpose and function of the Liaison Committee were specified in a proposal and agreed to and approved by the five sponsors:

"PURPOSE

- A. To consolidate existing multiple accrediting activities in graduate medical education under a single accrediting agency qualified for recognition by the U.S. Commissioner of Education.
- B. To establish a body for supervision and accreditation of graduate medical education comparable to that existing for undergraduate medical education.

FUNCTION

- A. To accredit programs of graduate medical education recommended for approval by residency review committees.
- B. To coordinate the development of improved review and evaluation procedures of residency review committees.
- C. To establish more effective central administrative procedures for the conduct of accreditation in graduate medical education.
- D. To develop and propose to the Coordinating Council on Medical Education policies and methods whereby graduate education programs in the various specialties may be related more closely to each other and to the total educational enterprises in their individual institutions.
- E. To recommend studies directed toward improvement in the standards for organization and conduct of programs in graduate medical education."

The points of agreement and the expressed "Purpose and Function" project that all participants to the agreement who formed the LCGME recognized the need to consolidate the responsibility for accreditation of graduate medical education in one committee; and that committee was charged to improve the review and evaluation procedures and attain sufficient credibility as an accrediting agency so as to be recognized by the U.S. Office of Education. The stipulation in Point 3 that the RRCs should continue to function and the requirement that policies established by the LCGME would have to be approved by the CCME and each of its sponsors indicates that it was not intended that the LCGME be granted exclusive domain over the accreditation of graduate medical education.

The first organizational meeting of the LCGME was held on December 18-19, 1972. In accordance with the articles of the proposal for its establishment, an annual rotation for the chairman was established with each organization appointing the chairman in turn. The staff to the Council on Medical Education of the AMA provided staff support to the committee. In subsequent meetings a financing plan was developed and approved by the sponsors. This plan stipulated that the AMA would defray one-half the cost of all accreditation activities conducted by the LCGME and the RRCs, that programs would be charged for periodic review to generate revenue to support the evaluation process, and that costs not covered by these revenues would be distributed among the five sponsoring organizations. When its Bylaws were approved by the CCME and its sponsors in 1975, the LCGME began officially to accredit programs in graduate medical education.

According to the mode of operation established, RRCs would continue to review programs in their specialty and recommend to the LCGME whether programs should be accredited, not accredited, or placed on probation. The LCGME, after reviewing the documentation of each RRC decision, would then issue a letter advising the program of its status.

When the LCGME began examining the procedures and records of each RRC, it became apparent that, although the Council on Medical Education was represented on each RRC and staff support to each RRC was provided by the AMA, RRC policies and procedures were inconsistent and communication among RRCs was essentially nonexistent. Instances in which programs had been on probation year after year were found frequently, and it was not uncommon to find several programs in the same hospital on probation simultaneously. This inconsistency in policy and procedures and organizational isolation among the RRCs were considered to be important areas on which the LCGME should exert

its first efforts in accomplishing its purpose and function. Of equal or greater concern to the LCGME was the finding that the documentation of the reasons for RCC approval or disapproval of a program was frequently totally lacking, or that the written record often supported a decision opposite to that recommended by an RCC.

A manual of "Structures and Functions" setting forth policies and procedures to be followed by all RCCs was developed. These included policies related to the type of accreditation status that could be designated. Particular emphasis was placed on probationary status which was limited to four years with a review required after a program had been on probation for two years. A policy was established that the accreditation status of programs, including probation, was public information, and the staff was directed to inform deans of medical schools of the accreditation status of programs in hospitals affiliated with the school. The RCCs were asked to state their reasons for making a decision in the record of their meetings and provide this record to the LCGME. These actions and others by the LCGME were not well received initially by the RCCs. Accustomed to operating independently with their own idiosyncratic approaches to review and evaluation, the RCCs viewed the LCGME as an alien group, superimposed upon them. In an effort to improve communications and understanding, initially RCC chairmen were invited to attend the sessions of the LCGME meetings during which their committee actions were to be reviewed, and later, an annual meeting of all RCC chairmen was organized for the purpose of discussing policy development. These meetings with the chairmen revealed that they were also concerned about the quality of information that they had available and were particularly frustrated by the unreliable survey reports that the AMA field staff supplied.

Early in the operation, it was apparent that the LCGME was going to be

extremely dependent on the AMA staff to carry out its purpose and function. Experience demonstrated that the AMA staff was not singularly dedicated to the LCGME and dealt with its needs as tasks superimposed upon the responsibilities to their employer, the AMA. In 1976, discussions to improve staff support were begun within the LCGME, and in 1977, after the AAMC, ABMS, and CMSS issued resolutions calling for staffing of the LCGME independent of the AMA or any other sponsor, the LCGME asked that the sponsoring organizations appoint a commission to investigate the staffing problem and recommend change. This commission has recommended that for the present the AMA continue to provide staff support under conditions specified in a contractual agreement between the Liaison Committee on Graduate Medical Education and the AMA.

THE PAST LINKED TO THE PRESENT AND FUTURE

The development of a system to approve residencies began in an era when graduate medical education for most graduates of United States medical schools consisted of a one-year rotating internship. Hospitals offering residency programs were few, and the number of residents was small.

TABLE 2
HOSPITALS OFFERING RESIDENCY POSITIONS, 1927-1976

<u>Year</u>	<u>Number of Hospitals</u>	<u>Number of Residency Positions</u>
1927	278	1776
1930	338	2028
1935	392	2564
1940	587	5120
1945	736	7666
1950	1079	18669
1955	1201	25841
1960		
1965		
1970		
1976	1702	64660

As can be seen from Table 2, graduate education has grown enormously in both the number of hospitals participating and the number of positions offered. Graduating medical students now expect to be residents for three or more years after graduation, and according to a poll of 7,800 of the 14,500 who graduated in 1978, 94% expect to seek certification by a specialty board. Medical education has become a two-phased process: the first phase prepares students for graduate medical education, and the second phase prepares students for independent practice and certification by a specialty board. Because of these changes, the accreditation of graduate medical education is significantly more complicated and more difficult to do well than it was when only a fraction of United States physicians sought specialty training in a small number of hospitals.

However, the accreditation system, which is now operating, is based upon two principles that evolved between 1930 and 1950:

1. RRCs should be composed exclusively of individuals in the same specialty; and
2. The graduate program is the educational unit to be approved.

Although the standards for training programs in each specialty, as set forth in the "Special Requirements" section of the Essentials of Accredited Residencies, are reviewed and approved by the Council on Medical Education in its capacity as the sponsor of each RRC and by the LCGME, they are conceptualized in isolation from educators in the other specialties. The LCGME has recently required that proposed changes in the "Special Requirements" be accompanied by a statement regarding the impact that these modifications will have on other disciplines in institutional resources. This is a beginning toward achieving the goal of having the various specialties recognize their interdependence.

An analysis of the information requested from programs in the process of reviewing them for accreditation, demonstrates that most RRCs pay little attention to the total educational environment in which programs reside. Only five ask whether there are other graduate programs in the institution, and only one of these asks about the accreditation status of the other programs.* This isolation of the RRCs from meaningful contact with other specialties and their singular focus on program accreditation without regard to the total educational setting, must be considered as a heritage of the early era of graduate medical education evaluation and approval when there were few programs and a small number of residents. For the future, an accreditation system must be developed consistent with Function D as specified in the articles of agreement for LCGME, "To develop and propose to the Coordinating Council on Medical Education, policies and methods whereby graduate education programs in the various specialties may be related more closely to each other and to the total educational enterprises in their individual institutions."

*See pages 76-81.

ANALYSIS OF RRC ACCREDITATION SURVEY FORMS

Evaluating programs for accreditation requires that the accrediting bodies have information concerning the factors that determine or influence the quality of the educational program in the institution. The depth and breadth of information requested by the RRCs in the pre-site visit survey forms which program directors are required to fill out to supply relevant information about the program being evaluated can provide insight into the fund of knowledge RRCs have available when they approve or disapprove a program.

To determine the scope of information now being sought by residency review committees the pre-survey data forms used by 15 RRCs were analyzed for their content. The analysis focused on information provided about the institution, the program, the program's relationship with other residencies in the institution, and the educational process.

Institutional Information

On page 79 it can be seen that most RRCs ask for data concerning the total number of beds in the institution and for the number of beds available on the program's specialty service. Fewer than half of the RRCs (6) request any data concerning other services in the hospital.

All RRCs request some information about the laboratory facilities that are available. However, there are notable omissions. For example, internal medicine does not ask about cardiovascular catheter or pulmonary function laboratories and neurology does not show an interest in the clinical laboratory. Pediatrics asks about the autopsy rate but requests no information about the pathology service.

Only family practice requests information about other ambulatory services beyond those in the specialty being evaluated. Six RRCs ask for data about

the emergency room in the hospital. Family practice is the only RRC that requests descriptions of special units such as the intensive care unit and the cardiac care unit.

Program Information

The table on page 80 details required information from the program being surveyed and other training programs in the hospital. All specialties ask for considerable information on their own programs as regards the number of teaching staff, number of residents, and positions filled. Only seven of the 15 survey forms analyzed ask about undergraduate medical students assigned to the service.

The narrow focus of each RRC in evaluating its own programs is especially demonstrated by the lack of questions concerning other programs in the institution. Seven of the RRCs ask for no information about other programs. Four of the survey forms ask about the number of other graduate medical education programs but these do not request the names of the specialties. Only one survey form inquires about the accreditation status of related programs. Five of the 15 survey forms ask for the name of the program director for related residency programs in the institution. Only one survey form requests information about the teaching staff of other programs, and only one survey form requires the program director to know if there are medical students placed on related services. Five RRCs ask for information about joint activities with at least one other training program in the institution. Four of the 15 specialties surveyed ask for the name of the director of medical education in the institution.

Educational Process

On page 81 important information related to the educational process is tabulated. Seven of the 15 survey forms require the program director to list qualifications for residents to be selected, but none asks for a description of procedures used to select residents. Twelve forms ask the program director to provide a description of educational conferences. The same number requires that an outline or diagram of resident rotations for each level of training be provided. However, only five RRCs require that the content or objectives for each level of training be specified and only eight ask for a description of rotations outside the department.

Evaluation is an important part of the educational process and analysis of the site visit forms suggests that RRCs as a group show little interest in the procedures used to evaluate resident progress or methods of evaluating the program's effectiveness. The table on page 81 reveals that only four site visit forms question the program director about resident evaluation procedures, only one requires information on evaluating faculty, and only two ask for information on internal program evaluation. Seven RRCs request that program directors include a description of resident progression of responsibility.

Only three RRCs ask that the program director list departmental goals for residency training, and only four of the RRCs require a description of the program's contribution to other residents outside the department.

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

INSTITUTIONAL INFORMATION REQUESTED ON PRE-SITE VISIT ACCREDITATION FORMS	Otolaryngology	Allergy & Immunology	Pathology	Dermatology	Anesthesiology	Plastic Surgery	Pediatrics	Psychiatry	Pediatric Surgery	Internal Medicine	Ophthalmology	Neurology	General Surgery	Radiology	Family Practice	Obstetrics & Gynecology
Total Number of Beds in Hospital	X		X	X	X	X		X	X	X		X	X	X	X	X
Average Daily Occupancy				X	X				X	X	X				X	
Number of Beds in Hospital for Each Service																
Otolaryngology	X															
Allergy & Immunology																
Pathology																
Dermatology																
Anesthesiology																
Plastic Surgery						X										
Pediatrics		X	X				X			X				X	X	
Psychiatry								X		X		X			X	
Pediatric Surgery																
Internal Medicine		X	X				X			X					X	
Ophthalmology											X					
Neurology											X	X				
General Surgery			X				X						X		X	
Radiology																
Family Practice															X	
Obstetrics & Gynecology			X												X	X
Laboratory Facilities																
Radiology	X		X	X												
Clinical Laboratory	X				X	X	X	X	X	X	X	X	X	X	X	X
Cardiovascular Catheter Lab																
ECG							X	X								X
EMG								X				X				
EEG								X				X				
Pathology Lab	X			X	X	X			X	X	X	X	X	X		
Autopsy Rate *				X	X	X	X		X	X		X	X	X	X	X
Pulmonary Function Lab		X					X								X	X
Ambulatory Facilities																
Otolaryngology																
Allergy & Immunology		X														
Pathology																
Dermatology				X												
Anesthesiology																
Plastic Surgery						X										
Pediatrics							X									
Psychiatry								X						X	X	
Pediatric Surgery															X	
Internal Medicine																
Ophthalmology										X					X	
Neurology												X				
General Surgery													X		X	
Radiology															X	
Family Practice															X	X
Obstetrics & Gynecology																
Emergency Room																
Number of Visits		X				X	X			X			X		X	
Special Units																
ICU															X	
CCU															X	
Burn Unit																

Accreditation

PROGRAM INFORMATION REQUESTED ON PRE-SITE VISIT ACCREDITATION FORM	Otolaryngology	Allergy & Immunology	Pathology	Dermatology	Anesthesiology	Plastic Surgery	Pediatrics	Psychiatry	Pediatric Surgery	Internal Medicine	Ophthalmology	Clinical Neurology	General Surgery	Radiology	Family Practice	Obstetrics & Gynecology
	Name of Program Director	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Full-time or Part-time	X			X	X		X			X	X					X
Number of Teaching Staff	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Full-time/Part-time	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Number of Resident Positions At Each Level	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Resident Positions Filled At Each Level	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Number of Undergraduate Medical Students Assigned to the Service	X			X		X	X		X	X		X	X			X
Current Accreditation Status	X	X	X	X		X	X	X	X	X	X	X	X		X	X
Date of Last Review (month and year)																
Other Graduate Education Programs in the Institution																
Number of Other GME Programs				X				X							X	X
Accreditation Status		X														
Names of Program Directors		X						X		X		X			X	
Teaching Staff							X									
Description of Joint Activities				X			X					X			X	X
Medical Students Assigned to Service								X								
Name of Director of Medical Education							X		X	X					X	

Accreditation

EDUCATIONAL PROGRAM INFORMATION
REQUESTED ON PRE-SITE VISIT
ACCREDITATION FORMS

	Otolaryngology	Allergy & Immunology	Pathology	Dermatology	Anesthesiology	Plastic Surgery	Pediatrics	Psychiatry	Pediatric Surgery	Internal Medicine	Ophthalmology	Neurology	General Surgery	Radiology	Family Practice	Obstetrics & Gynecology
Qualifications for Residents to be Selected	X			X				X	X		X	X	X			
Description of Selection Procedures																
Description of Educational Conferences		X		X	X	X	X		X	X		X	X	X	X	X
Outline or Diagram of Resident Rotations for Each Level of Training	X	X		X		X	X			X	X	X	X	X	X	X
Description of Content of Rotations for Each Level of Training	X				X			X				X			X	
Rotations Outside Department	X	X			X	X		X				X			X	X
Description of Procedures to Evaluate Residents Skills and Knowledge		X			X		X								X	
Description of Procedures to Evaluate Faculty Teaching Effectiveness															X	
Description of Procedures to Evaluate Effectiveness of Training Program		X													X	
Description of the Progression of Resident Responsibility	X	X		X			X			X	X		X			
Description of Departmental Goals							X				X				X	
Description of the Program's Contribution to					X	X		X				X				

GRADUATE MEDICAL EDUCATION AND SPECIALTY DISTRIBUTION

The Task Force's Working Group on Specialty Distribution was interrupted in its deliberations by the winter snows and has not yet developed a draft report. The first paper is a brief summary of some of the issues related to how and why physicians specialize and subspecialize. The second is an AAMC Working Paper on specialty distribution which was approved by the Executive Council as an interim position.

Members of the Working Group on Specialty Distribution:

Theodore Cooper, M.D., Ph.D.; Chairman; Provost, Cornell University; and Dean, Professor of Pharmacology, and Professor of Surgery, Cornell University Medical College

D. Kay Clawson, M.D., Dean, University of Kentucky, College of Medicine

John M. Dennis, M.D., Dean, University of Maryland School of Medicine

Richard H. Egdahl, M.D., Ph.D., Academic Vice President and Director of the Medical Center of Boston University

Spencer Foreman, M.D., Executive Vice President, Sinai Hospital of Baltimore

Edward W. Hook, M.D., Chairman and Professor, Department of Internal Medicine, University of Virginia School of Medicine

Donald N. Medearis, Jr., M.D., Wilder Professor of Pediatrics, Harvard Medical School, Chief, Children's Service, Massachusetts General Hospital, Boston

Duncan Neuhauser, Ph.D., Associate Professor of Health Services Administration, Department of Health Services, Harvard University, School of Public Health

Warren H. Pearse, M.D., Executive Director, The American College of Obstetricians and Gynecologists

Samuel A. Trufant, M.D., Professor of Neurology, University of Cincinnati Medical Center, College of Medicine

Observer/Participant:

John Mather, M.D., Chief, Medical/Dental Division, Education Service, Department of Medicine and Surgery, Veterans Administration, Washington, D.C.

SPECIALTY DISTRIBUTION

The distribution of physicians by specialty is an issue of growing importance to the medical schools and their teaching hospitals. The public consensus is that there are too many physicians practicing in limited, specialized areas, and too few practicing broad general medicine. *Primary Care*. What it is and who is providing it has been debated by various organizations, government agencies and groups. Medical schools have been required by federal law to have a specified portion of their first year residency positions in three legally designated primary care specialties. Several states have legislated mandatory programs in family practice. There is a growing movement to solve the specialty distribution problem by legislative edict, and the legislation is predominantly targeted at academic medicine.

Whether institutions of undergraduate and graduate medical education are directly responsible for the distribution of manpower across the specialties, or whether they are indirect contributors to the distribution pattern by virtue of their being responsive to the growth of knowledge and the demand for new technology and skills has not been analyzed. Nevertheless, the predominant approach to correcting maldistribution is to constrain the options of academic institutions. These constraints are directed at modifying the selections of candidates to enter medicine, modifying the curriculum provided, modifying access to graduate medical education positions, and modifying the content and curriculum of graduate programs.

At the present time, 65% of U.S. graduates are entering first graduate year positions in programs in internal medicine, family medicine, obstetrics and gynecology and pediatrics. The graduating class of 1978, when queried about their ultimate plans for board certification, indicated that 65% of them planned to be certified in these specialties. It appears that students during their undergraduate years, are opting for the primary care disciplines. However, data from the 1976 Federated Council for Internal Medicine study of graduate medical education indicate that 70% of the senior medical residents in that year planned to go on to subspecialty training. Graduating medical students in 1978 indicated that 51% of those entering internal medicine planned to subspecialize. Twenty-two per cent of students entering pediatrics planned to be certified in the primary care specialties as defined in the 1976 Manpower Act (family practice, general internal medicine, general pediatrics). An additional 7.5% will be certified in ob-gyn.

The Coordinating Council on Medical Education recommended that 50% of U.S. medical graduates should specialize in the four primary care specialties and the Congress mandated that 50% of first graduate year positions in programs affiliated with medical schools must be in the three legally designated primary care specialties by 1980. The Congressional formula required that the number be discounted by the number of residents who left a primary care program after their first graduate year, but there was no discount for subspecialization. When the census in July 1977 demonstrated that even with the discount, 52.8% of positions in programs affiliated with medical schools were already occupied by primary care residents, the Congressional response was dissatisfaction with having placed the quota too low. It is likely that in

the future efforts will be made to require increased positions in the primary care specialties and also to apply discounts for subspecialization.

Academic medicine is faced with a major problem because government has in the past, and probably will in the future, use specialty labels as the measure of the output of our educational programs. A physician labelled as a specialist in family medicine or general internal medicine is presumed to be a public asset. A physician labelled as a surgeon or gastroenterologist is considered to be a product which is not in the public interest. Because physicians emerge from our academic programs with labels as specialists of one kind or another, there is an assumption that academic institutions are directly and totally responsible for specialty distribution. The seemingly logical next step is to correct the perceived distribution imbalance by changing the proportional distribution of labels emerging from the educational system.

It is paradoxical that after 30 years of a most fruitful partnership between government and academic medicine, directed toward improving health through new knowledge and the development of advanced skills and technologies, the partners find themselves to be adversaries. The academic institutions are accused of ignoring the public need and of having been self-serving because practicing physicians now are carrying unwanted labels and are applying the knowledge, skills and technologies which were produced through the partnership. The Congress and public policy makers have been unwilling to look beyond the educational system to determine if specialty distribution can be modified by changes in policies more directly related to how medicine is practiced.

Academic medicine must assess its contribution to students' career decisions and to their ultimate practice styles, and also identify those factors which are beyond the influence and control of the educational system. For example, in the AAMC's Longitudinal Study of 1960, only 46% of those who declared an intent to enter general practice upon graduation in 1960 were in general practice in 1976. Of even greater interest is that of those who designated themselves as general practitioners in 1965, only 79% designated themselves as general practitioners in 1976. The only specialty approaching this post-educational attrition was pediatrics, with 13% of those designating themselves as pediatricians in 1965 not so designating themselves in 1976. Specialties such as internal medicine, obstetrics and radiology showed attritions of 5% or less from 1965 to 1976.

The high attrition in general practice and the moderately high attrition in pediatrics must have been due to factors beyond those controllable by the educational system. By 1965 it can be assumed that 1960 graduates in those specialties were in practice, and changes in their careers were due to knowledge and attitudes gained from practice experiences. If the graduates of 1978 behave similarly, only 35% will ultimately practice in the three legally defined primary care specialties. Of the 60% entering first year graduate positions in these primary care specialties 33% can be expected to subspecialize, and at least another 8% will change careers after going into practice.

Clearly if subspecialization were reduced in internal medicine the number of generalists would be increased. The motivation for subspecialization in internal medicine requires further study. Possible factors are:

1. Easy access to subspecialty training;

2. Intellectual challenge and interest in the technology of the specialty;
3. Desire for recognition as a consultant;
4. Income/work schedule/life-style advantages;
5. Apprehension that in future only "certified subspecialists" will be accorded privileges on hospital services and reimbursement for procedures peculiar to the subspecialty.

During the post-war era many general practitioners left their practices to enter specialties. Detailed studies of why generalists have tended to specialize are not available. However, the factors usually cited are:

1. Lack of prestige and privilege;
2. A work schedule which allows too little privacy and free time;
3. Lower fees per unit professional effort as compared to the fees paid to specialists.

Whether the medical educational system can select students and prepare them to be generalists who will continue as generalists throughout their careers when the economic realities of practice favor specialization and subspecialization is a major, unresolved issue.

AAMC WORKING PAPER
ON SPECIALTY DISTRIBUTION

A number of public and private organizations have recently published their positions and recommended policies on the distribution of physicians among specialties. In view of the involvement of the Association's constituents in graduate medical education, and looking forward to the development of new health manpower legislative authorities, the Association felt it appropriate to develop its own recommendations in this very important area.

AAMC currently has two major task forces working on areas of related interest. The Task Force on the Support of Medical Education, under the chairmanship of Dr. Stuart Bondurant, Dean of the Albany Medical College, is concerned with undergraduate medical education, including the impact of public policy, social change, and methods of financing on such education. Dr. Jack D. Myers, University Professor of Medicine at the University of Pittsburgh, chairs the Task Force on Graduate Medical Education which is examining all aspects of graduate medical education, including its interface with undergraduate medical education, its institutional base and quality control, its accreditation, its role in specialty distribution and its financing. Although the work of both Task Forces will continue throughout this year, and we can expect the development of more comprehensive and detailed recommendations for consideration by the Association's constituents, the Executive Committee has outlined a manpower strategy in this working paper which can be discussed with other interested organizations and appropriate public officials during this period of planning for new manpower legislation.

The Executive Council feels that although arguments can be raised about the specific numbers advocated in this paper, they are substantially correct and reflect its views on the direction and magnitude of changes needed in specialty and subspecialty training. For this reason, and because of the critical nature of this problem, the Executive Council has adopted this working paper as an interim Association position.

There appears to be a consensus in our society that medical education should strongly emphasize the training of the primary care physician who will provide comprehensive and continuing care for the patient. The Association has articulated its support of this objective on numerous occasions in the past, and takes this opportunity to reaffirm its commitment to the education of primary care physicians. It is reasonable to strive toward a goal at which half of the graduates of our

medical schools select a professional career in the delivery of primary care, either as family practitioners, general pediatricians, or general internists. Although the 1977 data from the National Resident Matching Program (NRMP) show that the number of first-year residents in the specialties of family practice, pediatrics and internal medicine exceeds 60 percent, a number of these first-year trainees will eventually practice in some other specialty, or in a subspecialty of their primary field. This reduces the number of physicians that remain in primary care below 50 percent.

Studies have shown that subspecialists in primary care specialties provide a significant amount of continuing, comprehensive care for their patients, but there is no evidence that such care is better or more cost effective than that provided by generalists. It appears that such subspecialties make their most cost effective contribution to our country's medical care system in the practice of their subspecialty. They should not make up a large percentage of primary care physician resources. The possible diminution of skills which can occur if an adequate workload of cases in a subspecialty is not maintained provides additional rationale for this recommendation.

In 1977, there were two generalists for every subspecialist in internal medicine. Evidence now exists that this ratio is changing dramatically because of the substantial number of internal medicine residents who in recent years have continued into subspecialty training. This percentage may be as high as two-thirds of all internal medicine residents. When the increased production of medical school graduates is also considered, it is likely that in less than two decades the number of subspecialty internists will exceed the number of generalists. It is not known if this same trend exists for pediatrics, but the figures for internal medicine clearly signal difficulty in achieving an appropriate supply of primary care physicians.

In the past, decisions about the number and distribution of graduate medical education training positions have been made on an ad hoc, local, decentralized basis. Studies in a number of specialty areas are now providing the data which will make possible the development of a more rational and coordinated approach to achieving national objectives for physician distribution.

The Association recognizes that given the structure and control of graduate medical education positions, it is not

realistic to implement radical changes in distribution in a short period of time. Nevertheless, it is possible to achieve a goal of 50 percent of medical school graduates entering and continuing in a career in the delivery of primary care following their graduate training. This goal should be achieved beginning with the class graduating from medical school in 1981. Primary care as defined here does not include the practice of the subspecialties of medicine and pediatrics. However, it must be recognized that simply modifying access to formal training in the subspecialties may not modify the use of subspecialty procedures by physicians who are designated as generalists.

In the past, a significant number of graduate medical education positions have been filled by foreign medical graduates. Recent legislation is restricting graduate medical education for many such individuals to those who require the additional education and training for practice in their home country. This particular pool of physicians will therefore not affect the physician specialty distribution in the country. However, an unknown number of foreign medical graduates will continue to enter this country as permanent residents under provisions of the immigration legislation, and these individuals will contribute to this country's physician supply. This number should be relatively small in comparison to the graduates of U.S. medical schools, and is not included in this analysis. The Association, however, expects that the principles outlined in this paper would be applied to specialty distribution of these physicians.

Of the 16,000 U.S. medical school graduates in 1981, 8,000 should pursue careers in primary care to meet the Association's 50 percent goal. To achieve this, the following recommendations are made:

1. The number of first-year training positions filled in surgical and other non-primary care specialties should remain at the 1977-78 level. According to data from the NRMP, this group consists of 2,020 surgical residents, and 3,537 residents in the other non-primary care specialties. Subtracting these from the 16,000 graduates (see table) leaves 10,443 positions to be allocated to the primary care specialties of family medicine, pediatrics and internal medicine, from which 8,000 should enter a career in primary care.
2. Data from the Bureau of Health Manpower in the Health Resources Administration of DHEW indicate the approximately 800 students (10 percent) use the first-year

- 4 -

primary care residency as a broad preparation for narrower specialties such as psychiatry, neurology, and dermatology. In addition, more than half of those completing general internal medicine residencies and 20 percent of those completing general pediatric residencies enter subspecialty training. To achieve a 50 percent level of physicians entering primary care careers in family medicine, general internal medicine, and general pediatrics from the 10,443 who enter first-year residencies in these fields, the following changes are necessary:

- The number of first-year residency positions filled by U.S. medical school graduates preparing for narrower specialties should remain at about 800 positions. This is reasonable if the number of residency training positions for careers of U.S. graduates in these specialties remains at the present levels;
- The number of entering positions for subspecialty training in internal medicine and pediatrics for graduates of U.S. medical schools should be reduced by one-third from current 1977-78 levels;
- To meet the continued anticipated needs for medical school clinical faculty, half of the individuals entering subspecialty training should be in programs emphasizing careers in research and academic clinical rather than clinical practice.

The Association further recommends a number of steps to achieve these goals:

- The organizations, institutions and program directors responsible for graduate medical education adopt these principles in the public interest and work for their implementation;
- The Liaison Committee on Graduate Medical Education (LCGME) should establish a registry of all subspecialty positions so that a firm national data base can be maintained;
- The LCGME should adopt an accreditation mechanism to assure the quality of subspecialty training programs;

- 5 -

- o The CCME and the Institute of Medicine should be asked to collect and review data regarding specialty and subspecialty graduate medical education and to make ongoing recommendations on any further changes related to national health manpower policy.

* * * * *

TABLE

Graduates of U.S. Medical Schools, 1981	16,000
Less number of first-year surgical residencies currently filled by U.S. medical graduates	2,020
Less number of first-year residencies in other non-primary care specialties currently filled by U.S. medical graduates	<u>3,537</u>
Number of first-year primary care positions	10,443
Less current migration from primary care to other specialties	800
Less number of positions for sub-specialization in primary care fields	<u>1,643</u>
Number of primary care practitioners (50 percent of line 1)	8,000

PROPOSED REVISION TO CAS RULES AND REGULATIONS

At the CAS Business Meeting on October 23, it was suggested that CAS consider a change in its method of selecting individuals to sit on the CAS Administrative Board. The suggestion was based on the premise that the present election system engenders a loss of interest in CAS on the part of the many outstanding and well qualified individuals who are asked to stand for election and are subsequently not elected. Examples of this phenomenon were cited and it was suggested that the CAS could partially alleviate its perennial turnover problem by adopting a system whereby the nominating committee presents a slate of nominees, one for each Administrative Board vacancy, to the CAS for ratification at the Fall Business Meeting. Both the COD and COTH select board members by this method.

At the January meeting, the CAS Administrative Board considered the proposed revision to the CAS Rules and Regulations which appears at the bottom of the page. For the reasons mentioned above, the Administrative Board agreed that this change would be beneficial to CAS and unanimously approved it.

Section V. Committees

1. The Nominating Committee shall be comprised of seven members. The Chairman of the Administrative Board shall be the Chairman of the Nominating Committee and shall vote in the case of a tie. Six individuals (three basic science and three clinical science) shall be appointed by the CAS Administrative Board from among representatives of the member societies. Not more than one representative may be appointed from a society and not more than two members may be current members of the Administrative Board. ~~The Nominating Committee shall meet to select a slate of officers prior to June 1st of the year of the election. The Nominating Committee shall nominate not more than two individuals for each office.~~ *The Nominating Committee shall report to the Council at its Annual Meeting a slate of nominees for Administrative Board vacancies. Additional nominations for these positions may be made by any representative to the Council present at the meeting.* The Committee will also recommend to the AAMC Nominating Committee candidates for Chairman-Elect of the Association of American Medical Colleges.