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

JANUARY 30, 1975 CAS BRIEFS NO. 28

ENCLOSED ARE SEVERAL ITEMS THAT ARE SENT TO YOU IN ORDER TO FACILITATE REPORTING BY OFFICIAL REPRESENTATIVES OF THE COUNCIL OF ACADEMIC SOCIETIES TO THE SOCIETIES THEY REPRESENT.

AN OVERVIEW OF AAMC ACTIVITIES HAS BEEN PREPARED TO GIVE YOU CONCISE, SUCCINCT NOTES OF AAMC'S MANY PROGRAMS DURING THE PAST YEAR. MORE DETAILED INFORMATION ABOUT AAMC'S ACTIVITIES IS AVAILABLE IN THE AAMC ANNUAL REPORT WHICH WAS DISTRIBUTED TO ALL REGISTRANTS AT THE AAMC ANNUAL MEETING LAST NOVEMBER IN CHICAGO. FOR OFFICIAL CAS REPRESENTATIVES WHO DID NOT ATTEND THE ANNUAL MEETING, A COPY OF THE AAMC ANNUAL REPORT IS ALSO ENCLOSED.

THE REPORT BY THE CAS CHAIRMAN FOR 1973-74, DR. RONALD ESTABROOK, TO THE CAS BUSINESS MEETING OF NOVEMBER 12, 1974, AND THE MINUTES OF THE MEETING ARE ENCLOSED.

IN THE VERY NEAR FUTURE A NEW EDITION OF THE CAS DIRECTORY WHICH IS CURRENTLY UNDERGOING REVISION WILL BE SENT TO YOU. IF YOU WOULD FIND ADDITIONAL INFORMATION HELPFUL IN THE MEANTIME, PLEASE WRITE:

AUGUST G. SWANSON, M.D.
DIRECTOR, DEPARTMENT OF ACADEMIC AFFAIRS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
#1 DUPONT CIRCLE, N.W., SUITE #200
WASHINGTON, D.C. 20036

ENCLS. 3

MINUTES
COUNCIL OF ACADEMIC SOCIETIES
BUSINESS MEETING

November 12, 1974

Conrad Hilton Hotel
Washington, D.C.

I. Call to Order

The meeting was called to order at 2 p.m. Dr. Ronald W. Estabrook, Chairman, presided. Seventy individuals, representing 45 of the 57 member societies, were present. Societies not represented were:

American Association for the Study of Liver Diseases
American College of Obstetrics/Gynecology
American College of Psychiatrists
American Pediatric Society
American Society for Clinical Investigation, Inc.
American Society of Biological Chemists
American Society of Therapeutic Radiologists
Association for Medical School Pharmacology
Association of Professors of Medicine
Association of University Radiologists
Biophysical Society
Society of Surgical Chairmen

II. Approval of Minutes

The minutes of the meeting held March 7, 1974 were approved as circulated.

III. Chairman's Report

A copy of the report given by the Chairman was distributed to the membership.

IV. President's Report - John A.D. Cooper

Since options for Association policy on federal funding of medical schools was on the agenda, this was not taken up as a specific item in the President's Report. Dr. Cooper commented on the Washington scene as characterized by confusion. The change from the Nixon Administration to the Ford Administration has not to date been reflected in the policies with regard to the health area. An openness, however, now exists, and it is hoped that more opportunity will be given for discussion with policy-makers of the federal government. The adversarial position between the Executive and the Congressional branches which started in the Johnson Administration continues in the Ford Administration. Mr. Ford has advocated a National Health Insurance, a stance felt to enhance his position with the nation during the remainder of his term.

Dr. Cooper spoke of the appointment of Paul O'Neill, successor to Fred Malek, as Deputy Director of the Office of Management and Budget. Mr. O'Neill is very knowledgeable about the health area, is a sound thinker, and is experienced by his previous role in OMB. He will be interested much more in program analysis and justification than his predecessor -- a fact interpreted to mean that to get its budgets through OMB, the DHEW will need to provide a much greater substantiation of programs.

Another event that will affect medical education is the enactment of the Congressional Budget and Impoundment Control Act (PL 93-344) which establishes new House and Senate Committees on the Budget and generally revises the Congressional budget review process. The law establishes a Congressional Budget Office (CBO) staffed by budget experts (without regard to political affiliation) to provide a continuing "scorekeeping" analysis of the federal budget, appropriations and authorizations bills, revenues and receipts, and changing revenue conditions. The CBO is to attempt to analyze all public bills (estimating five-year costs, compatibility with budget targets, etc.) and to provide general budget information for Congressional Committees.

In the past, each of the Appropriations Subcommittees has acted more or less independently with no real overview of the entire appropriations process by the House before the total of the appropriations comes out. The budget reform will in essence result in an examination of the health budget under closer scrutiny by the budget control committee comprised of Congressmen and Senators who are not advocates for health. They will have to approve the subcommittee recommendations before they can be enacted finally and appropriated.

V. Report of the Director, Department of Academic Affairs - August G. Swanson

Dr. Hilliard Jason, formerly of Michigan State University College of Human Medicine and most recently serving a two-year appointment as Special Education Consultant to the National Library of Medicine, joined AAMC in September heading a newly created program, the Division of Faculty Development. Dr. Jason is well-known in medical education and is especially well qualified to assume this responsibility.

Dr. Tom Morgan, now at the University of Washington-Seattle, joins the AAMC as Director of the Division of Biomedical Research effective January, 1975, succeeding Dr. Mike Ball. Dr. Morgan has extensive research experience and currently serves on the Council of the Heart and Lung Institute.

As had Drs. Estabrook and Cooper before him, Dr. Swanson expressed regret in losing Dr. Ball whose resignation becomes effective December 31, 1974.

Dr. Swanson reported on three major projects related to direct services to the medical schools and to the CAS:

1. Under the direction of Dr. William Cooper, the Educational Materials Project has made excellent progress toward the development of a clearinghouse system for nonprint multimedia learning materials. Review panels nominated by various officers of the CAS member societies have now evaluated over 2,800 items of audiovisual learning materials. It is anticipated that by next year a limited number of titles with full abstract descriptions will be available through a National Library of Medicine computer system similar to MEDLINE called AVLINE.

2. The Medical College Admission Assessment Program (MCAAP), the AAMC's program to revise the Medical College Admission Test (MCAT), is well under way. Through contract with a national testing agency, AAMC is developing an entirely new set of cognitive exams. This will be targeted on the development of exams to assess reading comprehension, quantitative ability, and achievement of knowledge in biology, chemistry, and physics. Simultaneously the MCAAP is beginning to work on developing systems and methods for exploring noncognitive variables in the assessment of students for selection to medical school.

3. Through support from the Bureau of Health Resources Development within the next year the Division of Educational Measurement and Research will be doing an in-depth study of the 3-year curriculum movement in this country. This study will concentrate on the characteristics and the outcomes of the 3-year curriculum efforts in about 17 U.S. medical schools and will match those against a control group of schools with 4-year curricula.

VI. Action Items

A. New Application

ACTION: The application for membership of the Society for Critical Care Medicine was unanimously approved.

B. Nominations for the Borden Award for Outstanding Biomedical Research

Regulations regarding nominations for the Borden Award appeared in the CAS Agenda on page 12. The CAS Administrative Board recommended that the process of nomination be expanded to provide for each society's submitting one nomination for the Borden Award. In the past solicitations for nominations were sent only to members of the Assembly.

ACTION: The recommendation by the Administrative Board that each Society submit at least one nomination for the Borden Award for Outstanding Biomedical Research was unanimously approved.

C. Report of AAMC Task Force on GAP Committee Report of NBME

CAS held a detailed discussion of the AAMC Task Force Report on the Goals and Priorities Committee recommendations to the National Board of Medical Examiners. The CAS agreed with the concept of a universal qualifying exam, to be required of all students prior to entering graduate medical education, but strongly recommended that the present Parts I, II, and III of the National Boards not be abandoned until such time as a new qualifying exam has been thoroughly tried and its validity determined. The Council also strongly recommended that the Liaison Committee on Medical Education require that in the process of accrediting medical schools, data on student achievement acquired from external evaluations be provided to the accrediting team. This recommendation grew out of a serious concern by the CAS that the basic and clinical sciences content of medical education not be further eroded. The Council also recommended that the results of a qualifying exam be transmitted to the medical schools and to the graduate programs to which students are applying.

D. Dr. Neal L. Gault, Jr., M.D., Chairman of the AAMC Task Force, Dr. Edmund Pellegrino, Chairman of the NBME Advisory Committee on Undergraduate Medical Evaluation, Dr. Robert A. Chase, President of the NBME were present to participate in these deliberations. After an extensive discussion, the CAS took the following action:

ACTION: The Council accepted the "Gault" Report as submitted in the Agenda on pages 23-24 with the following modifications.

1. Delete Paragraph No. 1 and substitute the following:

   The Task Force believes that the 3-part system should not be abandoned until a suitable examination has been developed to take its place and has been assessed for its usefulness in examining medical school graduates in both the basic and clinical science aspects of medical education.

2. Delete Paragraph Nos. 2 and 3 and substitute the following:

   Be it resolved that the AAMC recommend that the Coordinating Council on Medical Education and the Liaison Committee on Medical Education require as a part of the accreditation process that medical schools provide evidence of utilizing external evaluation data in the assessment of the educational achievement of students as they progress through a school's curriculum with continuing emphasis on the basic sciences.

3. Accept the first paragraph of Paragraph No. 4 with only one recommendation (g): that graduates of both domestic and foreign schools should be required to pass the exam as a prerequisite for entrance into accredited programs of graduate medical education in the U.S.

   The other sub-paragraphs listed as recommendations in this item (a-f) should be transmitted to the National Board as information items. The first three of these, a-c, should be transmitted without change. Item (d) is modified to read:

   The results of the exam should be reported to the students and through the students to the graduate programs to which they are applying and to the licensing boards that require certification for graduate students.

   Item (e) is modified to read:

   The exam results may be reported to medical schools if they request them.

   Item (f) is unchanged.

4. Paragraph Nos. 5, 6, and 7 are accepted without change.

5. A final paragraph should be added to direct the National Board of Medical Examiners to administer the examination early enough in the student's terminal year that the results can be transmitted to the program directors without interference in the matching plan.

E. Options for Association Policy on Federal Funding of Medical Schools

Dr. D.C. Tosteson, Chairman of the AAMC, was present to review the options for AAMC policy on federal funding of medical schools and to respond to questions of the Council of Academic Societies. The need for the faculties to assure that the programs of medical education not be dictated by federal legislation was reiterated by Dr. Estabrook and others. The purpose of the discussion was to permit the Council of Academic Societies the greatest possible contribution to the variety of options that would be more fully developed at the subsequent meeting of the Assembly. Although an action was not required, the Council of Academic Societies wished to go on record as having taken the following action.

ACTION: The Council voted unanimously to support the following action taken by the CAS Administrative Board on September 19:

The CAS Administrative Board voted unanimously to recommend that the AAMC be advised of the faculty's concern about the portions of the proposed HPEA bill that constrain and impinge upon the integrity of undergraduate and graduate medical education even to recommend the defeat of the total bill. The CAS Administrative Board further recommends that every Dean and every Board of Trustees seek every opportunity to obtain funding through alternative means such as tuition increases, increased support from state legislatures, or a decrease in faculty size where necessary to preserve the role of the medical schools in developing and implementing educational programs.

F. Election of Nominating Committee

ACTION: The Council of Academic Societies elected the following to constitute the 1975 CAS Nominating Committee.

From the Clinical Sciences:

G.W.N. Eggers, Jr., M.D., University of Missouri
William L. Parry, M.D., University of Oklahoma
Daniel Freedman, M.D., University of Chicago

From the Basic Sciences:

Carmine D. Clemente, Ph.D., UCLA
James B. Preston, M.D., SUNY Upstate Medical Center

G. Resolution from the Society of Academic Anesthesia Chairmen

ACTION: The resolution from the Society of Academic Anesthesia Chairmen regarding the critical shortage of academic anesthesiologists was referred for consideration to the CAS Administrative Board.

H. U.S. Faculty Visiting at the Universidad Autonoma de Guadalajara

The questions posed by this situation were summarized in the Agenda on page 66. Dr. Eastwood suggested that it would be helpful if the AAMC's opinion of the Guadalajara operation could be made available to students. With regard to the major question of involvement of U.S. faculty at Guadalajara, the opinion was expressed by Dr. Relman that this issue was inappropriate for action of the CAS but rather should be a matter for attention of the individual U.S. medical school administrations. Dr. Relman's statement was accepted as the consensus of the CAS.

I. Election of Members to the 1974-75 CAS Administrative Board

ACTION: The Council elected by ballot the following to serve on the CAS Administrative Board effective 1974-75:

Chairman-Elect

Rolla B. Hill, Jr., M.D., SUNY Upstate Medical Center

For Administrative Board, from the Basic Sciences

Robert M. Berne, M.D., University of Virginia
F. Marion Bishop, Ph.D., University of Alabama

For Administrative Board, from the Clinical Sciences

David R. Challoner, M.D., Indiana University
Thomas K. Oliver, Jr., M.D., University of Pittsburgh

J. Installation of Chairman

ACTION: Dr. Jack W. Cole was installed as Chairman of the Council of Academic Societies for 1974-75.

K. Commendations

ACTION: In separate actions by acclamation the Council expressed sincere appreciation and congratulations for their leadership and service to Dr. Ronald W. Estabrook, CAS Chairman for 1973-74, and to Dr. Michael F. Ball, Director of the AAMC Division of Biomedical Research, August 1, 1972-December 31, 1974.

VII. Adjournment

ACTION: The meeting was adjourned at 5:20 p.m.

February 1975

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

ASSOCIATION OF AMERICAN MEDICAL COLLEGES PROGRAMS AND ACTIVITIES* 1974 OVERVIEW

The Association of American Medical Colleges (AAMC), working with its members, engaged in a wide range of activities during 1974. Foremost among these were those in the following areas:

BIOMEDICAL RESEARCH

1. AAMC's impoundment suit was instrumental in procuring release by President Nixon of $165 million FY 1973 funds -- $29 million in health manpower special project funds and $136 million in NIH funds for research, research training, and fellowships.

2. AAMC consulted in drafting regulations on the conduct of biomedical research and took a leadership role of liaison in supporting legislation to establish a national ethics commission.

3. In discussions with key Administration and Congressional representatives, AAMC lent strong support to the system of peer review of proposals for Federal research funding.

4. In testimony before both the House and Senate Appropriations Committee, the Association stressed the importance of the NIH Research and Training Programs and the General Research Support Program, as well as the need for adequate funding for each.

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*This summary has been especially prepared for the Council of Academic Societies. For greater detail, see the AAMC Annual Report, 1974, which was distributed at the AAMC Annual Meeting, November, 1974.

5. With staff of NIH Division of Research Resources, AAMC developed a cost analysis and rate setting manual for animal research facilities. In discussions with NIH, Department of Agriculture, and others, AAMC emphasized that regulations must not adversely affect biomedical research.

6. AAMC continued to support a balanced national program of high quality of biomedical research and opposed establishment of additional categorical disease institutes or institutes dedicated to one or more organ systems at the NIH.

FACULTY

1. AAMC established a Division of Faculty Development to assist faculty through programs and workshops designed to develop effective instructional strategies and improve methods of evaluating student performance.

2. AAMC, through the Faculty Roster, has provided to the medical schools data on faculty composition, mobility, and retention and initiated special manpower studies.

3. Special AAMC studies included the Financing of Medical Education, which examined the manner in which faculty allocate effort, and the annual Medical School Faculty Salary Study.

EDUCATION

1. To obtain data on the degree to which academic medical centers have moved to assume institutional responsibility for graduate medical education, AAMC conducted a questionnaire survey of all centers.

2. Based on the report of its Task Force on Foreign Medical Graduates, AAMC adopted position that all students seeking graduate medical education pass a national qualifying exam.

3. AAMC commissioned a Task Force to study the implications of the Goals and Priorities (GAP) Report of the National Board of Medical Examiners.

4. AAMC, through the Medical College Admissions Assessment Program, began development of separate tests of cognitive assessment to replace the Medical College Admission Test (MCAT).

5. AAMC held a colloquium where experts in career development met to discuss the influence of selection and education on career choice.

6. The AAMC's project with the National Library of Medicine and the American Association of Dental Schools to identify, review, and assess effective nonprint educational materials completed its first year.

7. AAMC completed a feasibility study on developing a health sciences multimedia learning advancement program.

8. AAMC published and distributed 40,000 copies of the Medical School Admission Requirements (25th ed.).

9. AAMC published the third edition of the Curriculum Directory with expanded information on the required and elective programs in the U.S. and Canada.

10. AAMC continued distribution of the AAMC Education News, a newsletter reporting on instructional innovation, assessment, and curriculum, to over 36,000 full-time medical school faculty members.

FEDERAL LIAISON

During 1974 AAMC presented testimony on the following:

1. District of Columbia Medical and Dental Manpower Act of 1970.

2. National Cancer Act of 1971.

3. Health Services Research and Development, Health Statistics, and Medical Libraries Act of 1974.

4. Title I (Indian Health Manpower) of the Indian Health Care Improvement Act.

5. Health planning, resource development, and regulation.

6. Fiscal 1975 budget for the medical program of the Veterans Administration.

7. National Health Service Corps and the Public Health and National Health Service Corps Scholarship Training Program.

8. DHEW appropriations regarding the President's fiscal 1975 budget.

9. National health insurance.

10. Health Facilities Assistance Act of 1974.

11. Health Professions Educational Assistance Act of 1974.

12. Health manpower legislation regarding the distribution of health care by specialty.

HEALTH CARE

1. AAMC sponsored a national invitational Institute on Primary Care and planned subsequent regional workshops.

2. AAMC was active to support, through technical assistance and consultation, institutions involved in development of prototype HMOs.

3. AAMC initiated a program, which will involve six representative institutions, to develop model curricula for physician training based upon medical practice requirements of HMOs.

4. AAMC continued its efforts on the Longitudinal Study of the Class of 1960 and began preparation to conduct a major follow-up of the cohort to derive data on health manpower issues.

5. AAMC conducted a study on the teaching of community medicine in Colombia, Ethiopia, Thailand, and Turkey.

6. AAMC continued its study on the impact of national health service plan on medical education in Canada, the United Kingdom, and Sweden

STUDENTS

1. AAMC expanded its analysis and reporting of data on applicant admission activity.

2. AAMC processed 268,090 applications for admission to 83 medical schools through AMCAS (American Medical College Application Service).

3. AAMC sponsored an Early Decision Plan, in which 51 institutions participated, through which 628 students were admitted without filing an application to any other school.

4. AAMC tested a pilot admissions matching plan in which all schools in California and Michigan participated.

5. AAMC developed Simulated Minority Admissions Exercises which are being used by medical school admissions officers and committees.

6. AAMC filed an amicus curiae brief on behalf of the defendant, the University of Washington, in the case of De Funis v. Odegaard, which was heard by the Supreme Court.

7. AAMC testified to recommend strongly that Federal grants-in-aid and loans to medical students be continued and that the annual limitation on grants-in-aid be increased from $3,500 to $4,500.

8. AAMC supported provisions for loan forgiveness for students who choose to serve in the National Health Service Corps or practice in a health shortage area.

9. AAMC held workshops which over 100 medical school financial aid officers attended.

10. AAMC joined the coalition pressing for modification of the Buckley Amendment dealing with accessibility of student records.

11. AAMC continued COTRANS (the Coordinated Transfer Program for U.S. citizens studying medicine abroad.)

12. AAMC strengthened its liaison with premedical advisors through the development of an information service which makes available to them admissions data about national and individual undergraduate school applicant pools and by providing financial support to the new National Association of Advisors for the Health Professions.

13. AAMC continued the administration of a US/PHS Fellowship Program for medical students in Yugoslavia.

INSTITUTIONAL DEVELOPMENT

1. AAMC continued its Management Advancement Program which consists of a series of seminars which have attracted, in addition to the deans, 63 department chairmen, hospital administrators, vice presidents, chancellors, and others.

2. AAMC sponsored a Delphi forecast of the future of medical education.

3. AAMC established a file on medical school governance.

4. AAMC studied the process and authority for appointment, promotion, award of tenure, and dismissal of faculty.

5. AAMC examined the status of collective bargaining in higher education and its implications for medical school faculties.

6. AAMC has attempted to identify appropriate models for data collection and documentation of personnel procedures to assure institutional compliance with federal regulations for equal opportunity for women and minorities.

TEACHING HOSPITALS

1. In response to regulations regarding the payment of teaching physicians under Medicare, AAMC studies of reimbursement at six medical centers were instrumental in delaying implementation of Section 227 pending a more thorough analysis.

2. With regard to Section 223 of PL 92-603, an AAMC analysis of the SSA's grouping methodology demonstrated that the hospital groups established in the regulations were no better than random groupings.

3. AAMC also responded to proposed regulations seeking to implement other sections of the Social Security Amendments and directly affecting teaching hospitals.

4. AAMC organized a task force to review and analyze the 1973 revisions of the Joint Commission on the Accreditation of Hospitals.

5. AAMC undertook a survey to examine the organizational and functional arrangements of computer services in university-owned teaching hospitals.

6. AAMC conducted the sixth annual Survey of House Staff policy.

COMMUNICATIONS

The AAMC communicates it views, studies, and reports to its constituents and others through a variety of publications, news releases, press conferences, and personal interviews.

1. The major communications vehicle to constituents is the "President's Weekly Activities Report" which is issued 43 times a year and reports on AAMC activities and Federal activities that direcly effect medical education, biomedical research, and health care.

2. The AAMC 's major scholarly publication, which appears monthly, is the Journal of Medical Education.

3. AAMC publishes several other specialized newsletters.

REPORT OF THE CHAIRMAN
COUNCIL OF ACADEMIC SOCIETIES*

By

Ronald W. Estabrook, Ph.D.
Chairman, 1973-74

The faculties of American medical schools have successfully survived another turbulent year. During this year the faculties have shown a remarkable capacity to adapt to subtle, but significant, changes imposed by both external and internal forces which have begun to attenuate their roles in fulfilling their responsibilities for medical education and biomedical research. Further, new constraints have been proposed and many of the vexing problems facing medical education have only recently come into focus, so that detailed study and constructive action can be taken in the near future. The CAS, through its Administrative Board, has attempted to reflect the concerns and interests of the faculties of our medical schools by input into the decision-making process for the establishment of AAMC policy on a broad range of topics.

MANPOWER

Physician

The most obvious impact on faculty activities has occurred as a result of social and legislative pressure which is attempting to correct the

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*Presented November 12, 1974, at the Annual Business Meeting of the Council of Academic Societies, held in conjunction with the AAMC Annual Meeting, Conrad Hilton Hotel, Chicago, Illinois.

ills of the health care delivery system through modifying the educational experience of students while in medical school or in graduate training. Many of us firmly believe that erroneous assumptions have been made by those who assign all of the problems of physician distribution to their formative, education years. Pending legislation for the continuation of federal assistance for health professions education is a prime example of an attempt by an external force to mold a change in the pattern of medical education so that students graduating from medical schools today meet a perceived need in supplying health services to the population. Those in decision-making positions seem deaf to the arguments that the educational process, per se, will not markedly alter the career selection of graduating medical students with regard either to their geographic or specialty choice for the practice of medicine.

The emphasis on the development of primary care educational programs has created conflicts within our institutions and between institutions. Primary care education has been interpreted by some to mean a de-emphasis on education in the basic medical sciences. This I find particularly disturbing, because a physician assuming responsibility for continuing, comprehensive care of patients is a physician most in need of a strong basic science foundation.

Biomedical Research Manpower

The furor over the rapid federal retreat from research manpower training support, which was evident a year ago, has been temporarily quieted by the AAMC's successful suit for the release of impounded

research and research training funds, and the passage of the National Research Act. This immediate short-term answer has served to satisfy the present day needs of our constituency. However, there will be major efforts in the administration and on both sides of the aisles in the Congress to reduce the federal budget. Funding for research manpower training is likely to be considered a controllable variable. Unless we act together to explain the importance of a long-term research manpower training program, the biomedical research capability of this country may be seriously crippled by a rush toward federal budget cutting.

The primary product of our institutions is manpower. Physician manpower and research manpower are the two that most concern me, for the faculties must be responsible for assuring that in all the medical schools there is a strict adherence to quality standards in educating these people. There is little question that the dependency of our institutions on state and federal governments for their support places them in a vulnerable position. The faculties must decide when the demands for program changes, which are coupled with financial support, exceed the bounds of tolerence in their infringement on the traditional rights of faculties to be fully responsible for the education and training of students. Resisting such infringement cannot be left to a few administrators or to your officers and staff in the Association of American Medical Colleges.

Specific manpower problems which have engaged the CAS and the AAMC this year are the role of the foreign medical graduate in American medicine and the recruitment of greater numbers of minority representa-

tives and women in our schools as students and faculty in compliance with affirmative action requirements. These challenges are changing the scope and character of both the undergraduate and graduate medical education in our institutions. As an aside, I would urge that you each re-read both the AAMC Foreign Medical Graduate position statement and the CCME report on the same subject. Licensed foreign medical graduates practicing in our Country are very upset by these documents and have begun to organize to prevent a change in policy. We must emphasize that we are not opposed to the immigration of physicians but rather demand that they meet the same quality standards as our graduates.

Accreditation

The accreditation of both undergraduate and graduate medical education is becoming an ever-more important process. Accreditation assures both students and the public that our institutions are maintaining their excellence and are providing education programs suitable to the needs and expectations of the students they admit. The Liaison Committee on Medical Education and the Liaison Committee on Graduate Medical Education need strong input from the faculties through the CAS if the accreditation system is to accomplish its purpose. The membership of the CAS, and in particular the basic biomedical scientists, must assume a more active role in the accreditation process. I strongly urge that the CAS set this as a goal of highest priority for the future, and we seek the unselfish cooperation of all to offer your services to these important accrediting bodies and that you serve when called upon to carry out this duty.

BIOMEDICAL RESEARCH

The national policy for biomedical research remains unclear; the trend toward directed research through the contract instrument appears to be continuing, and the pressure for the establishment of more and more categorical research programs grows. Included in your Agenda is a policy statement by the Association which urges that this direction of development of national policy be carefully examined and that further growth be allowed only after careful evaluation. In this area, the self-interest of various disciplines or specialties within the CAS may come into conflict. It is my hope that such conflicts can be resolved in a manner which will further the maintenance of a strong and broad biomedical research endeavor in this country.

The ethics of human research will be heavily scrutinized during this coming year. The public demands that clear ethical boundaries be established and enforced. Our concern must be that these boundaries are reasonable and that the system for monitoring the ethical behavior of biomedical investigators and their institutions be both fair and workable. Here again, the CAS has an enormous role to play and an enormous stake in the outcome. For example, whether fetal research continues in our country cannot be just the concern of a few neonatalogists or obstetricians; the ethical guidelines for research on developing humans before and after birth must concern us all.

The importance of scholarly biomedical research in the milieu of the academic environment of our institutions is becoming a critical issue. The rapid development of new medical schools without significant research programs, the enlargement of the classes in existing

medical schools, and the shortening of curricula in some schools, are reducing the opportunity for students to become familiar with research and the intellectual rigor research imposes. This must concern the CAS; the solution is not clear, for the pressure from the public is for the expedient production of M.D.s, not the education of learned physicians.

HEALTH SERVICES

Our institutions are on the one hand being asked to develop innovations in the delivery of health services, while on the other, they are becoming more and more dependent on the income derived from providing health services in the traditional manner. This year I, as a biochemist, learned a great deal about this dilemma. The AAMC has been at the forefront in attempting to resolve the problem of reimbursement for patient services in the educational setting. The academic community and the CAS must become even more deeply involved in the issues of health services and of national health insurance. It may well be that the 94th Congress will be the Congress that passes a National Health Insurance Act. Whether such an Act takes into account the peculiar needs of the academic medical centers is important; only the academic community can convey those needs and can convince policy-makers how important they are.

Your Administrative Board has contributed to the development of policy for the AAMC over a wide range of topics. We on the Board recognize that our constituency is broad and heterogeneous and that problems of primary importance to one group may not be necessarily

of first priority to others. A central theme has been maintained throughout your Board's discussions; that is, to foster the activities which will strengthen medical education, biomedical research, and meet the aggregate concerns of the faculty. All substantive matters are debated among representatives of Hospital Administration, Deans and Faculty. As Bob Petersdorf mentioned last year, sometimes we win, sometimes we lose, but every time our voice is heard. However, your Board and I have been disturbed by the lack of evident interest in many of these issues by our constituency. This lethargy is most disturbing; I urge that each of you as delegates to a scientific society make it your personal responsibility to contact members of the Administrative Board of the CAS and express your opinions on topics of primary concern to your membership and to the academic community.

This last year has been a rewarding, educational experience for me. As Chairman of your Administrative Board I have enjoyed the opportunity of working with the staff of the AAMC, in particular Gus Swanson and Mike Ball. Their unselfish dedication to your interests is a quality to be admired. Change can bring with it benefits that are advantageous for all. Your are all scientists, and you know that very few advances are made by serendipity. Most advances come from long hours of labor and a great deal of hard work. Likewise, solutions to such problems as the impact of national health insurance on medical education, imposition of rules to effect changes in geographic and specialty distribution, establishment of means to better evaluate the basic science and clinical science programs in medical education, and the future support of fundamental biomedical research,

will not come by serendipity. The AAMC stands at the forefront in its leadership role as the spokesman for high-quality medical education and biomedical research; you are the AAMC; I wish you well in seeking the fruitful rewards of your labor.

RWE:kb
12-5-74

COUNCIL OF ACADEMIC SOCIETIES

1974 ROLL CALL

ALLERGY
American Academy of Allergy

Paul Vanarsdel

ANATOMY
American Association of Anatomists

John Finerty

Russell Woodburne

Association of Anatomy Chairmen

Sam Clark

ANESTHESIOLOGY
Association of University Anesthetists

G.W.N Eggers

Douglas Eastwood

Society of Academic Anesthesia Chairmen, Inc.

John Steinhaus

BIOLOGICAL CHEMISTS
American Society of Biological Chemists

CAS 1974 ROLL CALL

CLINICAL RESEARCH

Academic Clinical Laboratory Physicians & Scientists

Ellis Benson

Howard Rawnsley

American Association for the Study of Liver Diseases

American Federation for Clinical Research

David Challoner

American Society for Clinical Investigation, Inc.

Central Society for Clinical Research

Ruy Lourenco

Southern Society for Clinical Investigation

A.J. Bollet

DERMATOLOGY

Association of Professors of Dermatology

I. Graham Smith

Philip Anderson

ENDOCRINOLOGY

Endocrine Society

Robert Blizzard

CAS 1974 ROLL CALL

GASTROENTEROLOGY

American Gastroenterological Association

Thomas? Hendrix

MEDICINE

American College of Physicians

Richard Vilter

Association of American Physicians

Arnold Relman

A. J. Bollet

Association of Professors of Medicine

Association of Teachers of Preventive Medicine

Doug Scutchfield

Society of Teachers of Family Medicine

Marian Bishop

Libby Tanner

MICROBIOLOGY

Association of Medical School Microbiology Chairmen

Quentin Myrvik

Am Coll of Chest Physicians

Arthur Beall, Jr.

Alfred Soffer

not included in count because no longer a member

CAS 1974 ROLL CALL

NEUROLOGY

American Academy of Neurology

Joseph White

American Neurological Association

James Toole

Association of University Professors of Neurology

Phillip Swanson

TR Johns

OBSTETRICS AND GYNECOLOGY

American College of Obstetrics and Gynecology

Association of Professors of Obstetrics and Gynecology

John Donovan

OPHTHALMOLOGY AND OTOLARYNGOLOGY

American Academy of Ophthalmology and Otolaryngology

Gary Thomas

Bruce Spivey

Association of University Professors of Ophthalmology

Richard Schultz

Gus Colenbrender

Society of University Otolaryngologists

Roger Boles

David Brown

James Snow

CAS 1974 ROLL CALL

ORTHOPAEDICS

American Academy of Orthopaedic Surgeons

Frank Wilson

Charles Heck

Association of Orthopaedic Chairmen

D. Kay Clawson

Wm. Kane

PATHOLOGY

American Association of Pathologists and Bacteriologists

Rolla B. Hill — Dr. Hinerman

Association of Pathology Chairmen, Inc.

Jack Layton — Ellis Benson

Fairfield Goodale

PEDIATRICS

American Pediatric Society

Association of Medical School Pediatric Department Chairmen, Inc.

Tim Oliver

Society for Pediatric Research

Lawrence Frenkle

Robert Greenberg

CAS 1974 ROLL CALL

PHARMACOLOGY

Association for Medical School Pharmacology

PHYSIATRY

Association of Academic Physiatrists

Alicia Hastings

PHYSIOLOGY

American Physiological Society

Robert Berne

William Van Der Kloot

Association of Chairmen of Departments of Physiology

James Preston

Ewald Selkurt

Biophysical Society

PSYCHIATRY

American Association of Chairmen of Departments of Psychiatry

David Hawkins

Dan Freedman

American College of Psychiatrists

CAS 1974 ROLL CALL

RADIOLOGY

American College of Radiology

Milton Elkin

Eugene Klatte

American Society of Therapeutic Radiologists

Association of University Radiologists

Society of Chairmen of Academic Radiology Departments

Harold Jacobson

SURGERY

American Association of Neurological Surgeons

Henry G. Schwartz

American Association of Plastic Surgeons

Robert McCormack

Robert Harding

American Association for Thoracic Surgery

Clarence Weldon

American Surgical Association

Gechard Egdahl

CAS 1974 ROLL CALL

SURGERY

Association for Academic Surgery

Francis C. Nance Carter name

Hiram Polk

Plastic Surgery Research Council

Thomas Krizek

Society of Surgical Chairmen

Society of University Surgeons

Eric Fonkalsrud

UROLOGY

American Urological Association

Walter Kerr

Society of University Urologists

William Parry

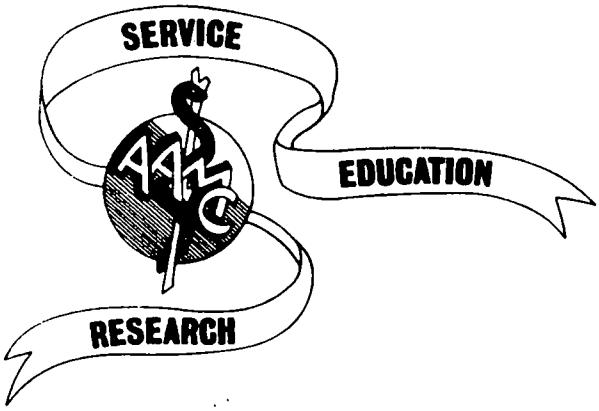
ADDITIONAL SOCIETIES SUBMITTED FOR CONSIDERATION FOR ELECTION TO MEMBERSHIP STATUS WITHIN THE AAMC

Association of Academic Psychiatry

Louis Rittlemeyer

Society of Critical Care Medicine

Additional Individuals Attending the CAS Business Meeting



AGENDA

FOR

COUNCIL OF ACADEMIC SOCIETIES

BUSINESS MEETING

Tuesday, November 12, 1974

2:00 p.m. - 5:00 p.m.

Conrad Hilton Hotel
Waldorf Room
Chicago, Illinois

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

One Dupont Circle

Washington, D. C.

AAMC ANNUAL MEETING — November 11-16, 1974
Conrad Hilton Hotel
Chicago, Illinois

CAS MEETINGS

CAS Business Session — November 12, 1974
2 p.m. - 5 p.m.
Waldorf Room

CAS/COTH Program — November 12, 1974
"Quality Assurance and PSROs"
9 a.m. - 12 noon
Waldorf Room

CAS/COD/COTH Program — November 13, 1974
"Specialty Distribution of Physicians"
2 p.m. - 5 p.m.
International Ballroom

CAS ADMINISTRATIVE BOARD MEETINGS

January 15, 1975
April 3, 1975
June 19, 1975
September 18, 1975

Washington, D.C.

COUNCIL OF ACADEMIC SOCIETIES
BUSINESS MEETING AGENDA

Tuesday, November 12, 1974
2:00 PM - 5:00 PM
Waldorf Room - Conrad Hilton Hotel
Chicago, Illinois

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CAS BUSINESS MEETING AGENDA

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VI. New Business

MINUTES
COUNCIL OF ACADEMIC SOCIETIES
BUSINESS MEETING

March 7, 1974

Mayflower Hotel
Washington, D.C.

I. Call to Order

The meeting was called to order at 9:15 a.m. Dr. Ronald W. Eastabrook, Chairman, presided. Forty-six individuals, representing 38 of the 60 member societies, were present. Societies not represented were:

Academic Clinical Laboratory Physicians & Scientists
American Academy of Neurology
American Academy of Ophthalmology and Otolaryngology
American Association for the Study of Liver Diseases
American Association of Anatomists
American Association of Neuropathologists
American College of Chest Physicians
American College of Obstretrics and Gynecology
American College of Physicians
American College of Psychiatrists
American College of Radiology
American College of Surgeons
American Gastroenterological Association
American Society for Clinical Investigation, Inc.
American Society of Therapeutic Radiologists
Association of American Physicians
Association of Medical School Microbiology Chairmen
Association of Professors of Gynecology and Obstretrics
Association of Professors of Medicine
Association of Teachers of Preventive Medicine
Biophysical Society
Society of Surgical Chairmen

II. Approval of Minutes

The minutes of the meeting held November 4, 1973 were approved as circulated.

III. Chairman's Report

Since the last meeting of the CAS, the White House announced that more than $1 billion in impounded funds for health and education programs would be released. The amount released included funds for NIH research, training, and fellowship grants and funds for one-year special project grants which were the subject of two AAMC suits. The first AAMC suit against the Administration was filed September 20 and sought the release of $28.6 million in health manpower education special project grants. The

second suit, filed September 26, sought the release of $136.3 million in impounded NIH research grants, research training grants, and fellowship funds.

Also the AAMC filed an amicus curiae brief with the U.S. Supreme Court on the case Defunis v. Odegaard on February 4. The brief supported the positions taken and endorsed the arguments presented in the brief of the Association of American Law Schools prepared by former Solicitor-General Erwin Griswold. That brief addresses the question of whether it is constitutionally permissible for an admissions committee of a professional school to utilize non-quantitative selection factors (including race) to accomplish legitimate social policy objectives.

On February 19, AAMC filed an amicus curiae brief in the U.S. Court of Appeals for the District of Columbia Circuit in the case Washington Research Project, Inc. v. Department of Health, Education and Welfare. AAMC is supporting an appeal by the government of a District Court ruling ordering the public disclosure of all HEW research grant applications, site visit reports, and summaries of study group deliberations. AAMC argues that this decision if upheld will seriously undermine the peer review system and ultimately the quality of government-sponsored biomedical and behavioral research.

As an outgrowth of last October's Seattle Research Manpower Conference, on February 12, a small group of individuals representing Washington-based associations, the NIH, the NIMH, NAS, and FASEB, met with Mike Ball to assess whether there was a need to mount a new program of data collection to evaluate patterns of supply of basic medical scientists for the future. It was the consensus of the group that the basic information required to analyze the number of predoctoral students being trained by discipline, the patterns of doctorates being conferred, and the career patterns of these students is currently being gathered by various groups. However, there has been almost no coordination among the data collectors and, as a result of this meeting, efforts will now be directed toward facilitating communication among the various groups.

The CAS Administrative Board has held two meetings since the Fall meeting of the Council. The one on March 6 was followed by a dinner meeting with Lionel Bernstein, Ph.D., Deputy Assistant Secretary for Planning and Evaluation-Health, Department of Health, Education, and Welfare.

The AAMC Fall meetings will be held November 12-16, 1974. CAS societies will be invited to hold their individual meetings on Monday, November 11, the day before the CAS meeting which will consist of one half day devoted to the business meeting, followed by a session addressed to national issues. A joint session of the CAS, COD, and COTH will be scheduled on Wednesday, November 13. The tentative schedule is shown below.

	M 11	T 12	W 13	TH 14	F 15	S 16
A.M.	Societies Hold	CAS Business Meeting	Plenary Session	Plenary Session	Miscellaneous	
P.M.	Individual Invited to Meetings	CAS National Issues Session	CAS-COD-COTH	Assembly	Miscellaneous	

Among other activities Dr. Estabrook described were a 2½ day retreat of the AAMC Executive Committee and key staff to review its activities and to discuss major issues which the AAMC will confront in the coming year; meetings with Congressman Rogers and Congressman Roy regarding the Health Profession Education Act; a meeting with Wilbur Cohen, special counsel to Senator Ribicoff regarding continuity of leadership in the NIH and related matters; and meetings with NIH staff, the AMA Board of Trustees, representatives of FASEB, and the AAMC Biomedical Research and Research Training Committee. Additionally, a number of occasions required conferences with the AAMC Executive Committee.

Finally, Dr. Estabrook said that in an attempt to facilitate communication with CAS constituents particularly to promote active participation of the constituents in charting the course for CAS, he wrote 62 personal letters to selected Societies, from which he received seven responses. He also sent 260 personal invitations to the CAS March meetings. From this effort he estimated around a 10% response, primarily from individuals who had previous commitments to preclude their attending the meetings.

IV. Action Items

A. Change in CAS Rules and Regulations

ACTION: The CAS voted unanimously to approve the proposed change in the CAS Rules and Regulations (see Agenda pp. 8-11) providing for a nine-member Administrative Board, changing the term of office from two to three years, eliminating the position of Secretary, and including the Past-Chairman as a member of the Administrative Board.

B. Distinguished Service Membership

ACTION: The CAS concurred unanimously in the recommendations of the Administrative Board for Distinguished Service Membership (see Agenda p.12).

Of those listed Drs. Tosteson, Clark, Petersdorf, and Knobil wish to have their nominations deferred at this time. Drs. Rhoads, Gregory, Wedgwood, Warren, and Forster wish to have their nominations put forward. Dr. Eastabrook will contact the others on the list with regard to their wishes and proceed accordingly with the recommendations.

C. Recommendations of the FMG Task Force

ACTION: The CAS voted unanimously to adopt the recommendations of the FMG Task Force as set forth in the Agenda on pages 22-24 with the following amendment:

Delete Paragraph 1, in Recommendation 7 and substitute the following paragraph:

7. Special categories - The Task Force recognizes two categories of FMG's, which require special consideration. The first category includes FMGs who are seeking limited education objectives in this country with the full intent of returning to their home country. They may be accepted into special programs without the qualifications contained in the third recommendation of this report, provided these trainees are not permitted to assume any patient care obligations usually required of the members of the housestaff and provided the training thus obtained is not credited toward specialty board qualification in this country.

D. Biomedical Research Manpower Conference

ACTION: The CAS voted unanimously to approve the three recommendations derived from the Biomedical Research Manpower Conference (Seattle/Battelle) held last Fall as principles that should be endorsed by AAMC:

1. That the Congress establish a national commission, possibly under the auspices of the National Academy of Sciences to help in determining the appropriate role for the federal government in the support of biomedical research and research training, with particular attention to the mission of its principal agency, the National Institutes of Health. Such a commission should have broad representation from business, labor, consumers, foundations, the scientific community, and other interested parties.

2. The Association of American Medical Colleges should take a leadership role in the evaluation of needs for manpower development and should call upon the assistance of voluntary health agencies. This program should also involve the biomedical scientific societies participating in the Council of

Academic Societies of the AAMC in order to obtain a broad consensus of needs. The informed support of business, labor, and individual citizens should be utilized to promote a rational, national biomedical research and research training policy. The academic medical community, the professional biomedical scientific associations and the voluntary health agencies should also develop mechanisms to foster public education regarding the implications of biomedical research programs on the public and individual health of the American citizens.

3. A study group should be established to evaluate the biomedical research from the standpoint of optimizing contributions to health care and suggesting guidelines for the allocation of resources to basic and applied research. This group will require input of biomedical scientists and should include among its topics for consideration the factors which contribute to the career choice of students who enter biomedical research.

E. New Application.

ACTION: The application for membership of the Association for Academic Psychiatry was unanimously approved.

F. NIRMP Progress Report

In connection with the NIRMP Progress Report (see agenda pp.29-30), a vigorous discussion ensued concerning the flagrant violations that programs in many disciplines have experienced. There was little optimism about the NIRMP Monitoring Program recently established within the AAMC as a potential deterrent to violations. There seemed to be a general agreement that the LCGME would eventually be the most effective body to enforce violations.

ACTION: The CAS approved the recommendation of the CAS Administrative Board to the Executive Council that it establish a Task Force to evaluate in detail the NIRMP and to produce recommendations to make NIRMP a viable service in this era when the interface between undergraduate and graduate education has become quite complex.

There were two votes against this motion.

V. Discussion Items

Brief progress notes were presented on the following topics:

1. Ethical Aspects of Biomedical Research--Mike Ball.

2. MCAAP Program--Jim Erdmann.

3. National Health Insurance Task Force--Jack Cole.

4. President's FY 1975 Budget.

5. Task Force to study the Report of the National Board's Goals and Priorities Committee (The "GAP" Report)--Ron Estabrook.

6. Institute on Primary Care--Gus Swanson.

VI. Adjournment

The meeting was adjourned at 12:15 p.m.

MHL:ps

MEMBERSHIP APPLICATION
COUNCIL OF ACADEMIC SOCIETIES
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

MAIL TO: AAMC, Suite 200, One Dupont Circle, N.W., Washington, D.C. 20036
Attn: Miss Connie Choate

NAME OF SOCIETY: Society of Critical Care Medicine

MAILING ADDRESS: Children's Memorial Hospital
2300 Children's Plaza
Chicago, Illinois 60614

PURPOSE: The Society is a not for profit organization dedicated to the improvement of care of the critically ill patient.

MEMBERSHIP CRITERIA: As stated in our bylaws

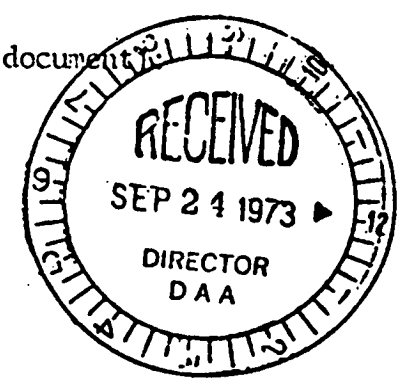
NUMBER OF MEMBERS: approx. 212 (annual meeting has just been held, and at this writing I am not sure of the exact number)
NUMBER OF FACULTY MEMBERS:

DATE ORGANIZED: 7/19/71

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

_____ 1. Constitution & Bylaws

_____ 2. Program & Minutes of Annual Meeting



(CONTINUED - OVER)

QUESTIONNAIRE FOR TAX STATUS

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

   x YES ____ NO

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

   501(c)3

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

   x a. Approved by IRS

   ____ b. Denied by IRS

   ____ c. Pending IRS determination

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

David Allan, M.D.
(Completed by - please sign)

5/24/73
(Date)

B A L L O T

COUNCIL OF ACADEMIC SOCIETIES

1974-75

Administrative Board Positions

Administrative Board

For Chairman-Elect,

VOTE FOR ONE:

HILL, Rolla B., Jr., M.D.

HILL, ROLLA B, JR, b. Baltimore, Md, June 11, 29; m. 51; c. 3. PATHOLOGY, DEVELOPMENTAL BIOLOGY. B.A, Rochester, 50. M.D, 55. Resident & fel. path, Yale, 58-59; pathologist, Bridgeport Hosp, Conn, 59-61; asst. prof. PATH, Colorado, 61-65, assoc. prof, 65-68, acting chmn. dept, 67-68; prof. & v.chmn. dept, Univ. Calif, Davis, 68-69; PROF. & CHMN. DEPT, STATE UNIV. N.Y. UPSTATE MED. CTR, 69- Cert. anat. & clin. path, Am. Bd. Path, 59. Med.C. U.S.A, 56-58, Capt. AAAS; Am. Soc. Exp. Path; Am. Asn. Path. & Bact; Am. Soc. Cell Biol; Int. Acad. Path. Biochemical basis of human disease; mammalian cellular control mechanisms and their abnormalities, lipoprotein metabolism in the liver. Address: Dept. of Pathology, State University of New York Upstate Medical Center, 766 Irving Ave, Syracuse, NY 13210.

KNOBIL, Ernst, Ph.D.

KNOBIL, ERNST, educator, physiologist; b. Berlin, Germany, Sept. 20, 1926; s. Jakob and Regina (Seidmann) K.; came to U.S., 1940, naturalized, 1945; B.S., Cornell U., 1948, Ph.D. (Schering fellow endocrinology 1949-51), 1951; m. Jutane Hotchkiss, July 11, 1959; children—Erich Richard, Mark, Nicholas, Katharine. Asst. zoology Cornell U., 1948-49; Milton Research fellow Harvard, 1951-53, from instr. to asst. prof. physiology Med. Sch., 1953-61; spl. research pituitary gland, endocrinology reprodn. John and Mary R. Markle Found. scholar med. scis., 1956-61; Richard Beatty Mellon prof. physiology, chmn. dept. U. Pitts. Sch. Medicine, 1961—; Bowditch lectr. Am. Physiol. Soc., 1965; cons. USPHS, Ford Found. Mem. adv. council Inst. Lab. Animal Resources, NRC-Nat. Acad. Sci., 1966-69; mem. nat. sci. adv. bd. Growth, Inc., 1969; mem. liaison com. med. edn. A.M.A.-Am. Assn. Med. Colls., 1972—. Served with AUS, 1944-46. Fellow A.A.A.S; mem. Am. Soc. Zoologists, Soc. Exptl. Biology and Medicine, Am. Physiol. Soc. (mem. council 1969-72), Endocrine Soc. (Ciba award 1961; council 1968-71), Soc. Endocrinology (Gt. Britain), Assn. Chairmen Depts. Physiology (pres. 1969), Am. Assn. Med. Colls. (adminstrv. bd. council acad. socs., exec. com.), Nat. Bd. Med. Examiners, Internat. Soc. Endocrinology (exec. com.), Internat. Soc. Neuroendocrinology, Soc. Study Reprodn., Internat. Soc. Research Biology Reprodn. Mem. editorial bd. Am. jour. Physiology, 1959-68, Am. Jour. Endocrinology, 1959—; editorial com. Ann. Rev. Physiology, 1968-72. Home: W Waldheim Rd Pittsburgh PA 15215

For Administrative Board, from the Basic Sciences,

VOTE FOR TWO:

BERNE, Robert Matthew, M.D.

BERNE, ROBERT MATTHEW, physiologist, educator; b. Yonkers, N.Y., Apr. 22, 1918; s. Nelson and Julia (Stahl) B.; A.B., U. N.C., 1939; M.D., Harvard, 1943; m. Beth Goldberg, Aug. 18, 1944; children—Julie, Amy, Gordon, Michael. Intern Mt. Sinai Hosp., N.Y.C., 1943-44, resident, 1946-48; research fellow Western Res. U. Sch. Medicine, Cleve., 1948-49, instr. physiology, 1949-50, sr. instr., 1950-52, asst. prof., 1952-55, asso. prof., 1955-61, prof., 1961-66; prof., chmn. dept. physiology U. Va. Sch. Medicine, Charlottesville, 1966- . Mem. evaluation com. on post doctoral fellowships in life scis. Nat. Acad. Scis., 1963-65; mem. physiology trg. com. NIH, 1964-65; mem. trg. com. Nat. Heart Inst., 1966-70; mem. cardio-pulmonary trg. program VA, 1968-71; mem. physiology test Com. Nat. Bd. Med. Examiners, 1969-70; mem. panel on heart and blood vessel diseases, task force Nat. Heart and Lung Inst., 1972. Trustee Cleve. Area Heart Soc., 1962-65, pres. sci. council, 1964-65; steering com. Circulation Group Physiol. Soc., 1969-71. Served with M.C., AUS, 1944-46. Mem. Am. Physiol. Soc. (mem. council 1970-72; mem. finance com. 1966-70, pres. 1972-73), Am. Soc. for Clin. Investigation, Am. Heart Assn. (com. on med. edn. 1963-66, vice chmn. com. on council basic sci.), A.A.A.S., Cardiac Muscle Club, Assn. Chmn. Depts. Physiology (pres. 1970), Microcirculatory Soc. (mem. council 1971-72, liaison com. 1973), Phi Beta Kappa, Sigma Xi. Author: (with Matthew N. Levy) Cardiovascular Physiology, 1967, 2d edit., 1972. Editor: Circulation Research, 1970. Sect. editor Am. Jour. Physiology, Jour. Applied Physiology, 1964-65; mem. editorial bd. Circulation Research, 1961-67, 68—; Jour. Molecular and Cellular Cardiology, 1969—, Proc. Soc. Exptl. Biology and Medicine, 1962-64. Home: 1851 Wayside Pl Charlottesville VA 22903

BISHOP, F. Marion, Ph.D.

BISHOP, F. Marion, Ph.D.; B.S., U. of Missouri; Ph.D., Wash. U. St. Louis; U. of Missouri, 1963-70; U. of Maryland-Frankfurt, Germany; Visiting Scientist-Health Services & Mental Health Administration-DHEW, 1971-72; Consultant to Missouri Council on Smoking and Health, and R.L.D.S. World Church's Family Ministry Advisory Community; Professor of Family Practice & Community Health and Psychiatry & Behavioral Sciences, U. of Oklahoma, 1972-August, 1974; Professor of Community Health, U. of Alabama, Huntsville, August, 1974-.

GINSBERG, Harold Samuel, M.D.

GINSBERG, HAROLD SAMUEL, virologist, educator; b. Daytona Beach, Fla., May 27, 1917; s. Jacob and Anne (Kalb) G.; A.B., Duke, 1937; M.D., Tulane U., 1941; m. Marion Reibstein, Aug. 4, 1949; children—Benjamin Langer, Peter Robert, Ann Meredith, Jane Elizabeth. Resident Mallory Inst. Pathology, Boston, 1941-42; intern, asst. resident Boston City Hosp., 4th Med. Service, 1942-43; resident physician, asso. Rockefeller Inst., 1946-51; asso. prof. preventive medicine Western Res. U. Sch. Medicine, 1951-60; prof. microbiology, chmn. dept. U. Pa. Sch. Medicine, 1960-73; prof. microbiology, chmn. dept. Coll. Phys. and Surg. Columbia, 1973—. Mem. commn. acute respiratory diseases Armed Forces Epidemiological Bd., 1959-73; cons. NIH, 1959-72, Army Chem. Corps, 1962-64, NASA, 1969—, Am. Cancer Soc., 1969-73; v.p. Internat. Com. on Nomenclature of Viruses, 1966—; mem. space sci. bd., chmn. panel microbiology Nat. Acad. Sci., 1973—. Served to maj., M.C., AUS, 1943-46. Decorated Legion of Merit. Mem. Assn. Am. Physicians, Am. Acad. Microbiolngists (chmn. bd. govs. 1971-72), Am. Society Clin. Investigation (councillor 1958-60), Am. Assn. Immunologists, Am. Soc. Microbiology (chmn. virology div. 1961-62), Soc. Exptl. Biology and Medicine, Harvey Soc., Central Soc. Clin. Research, Am. Soc. Biol. Chemists, Alpha Omega Alpha. Contbr. textbooks. Co- author: Microbiology, 1967. Editorial bds. Jour. Immunology, Jour. Exptl. Medicine, Jour. Virology and Bacteriological Reviews, Jour. Infectious Diseases. Editor Jour. Bacteriology, Intervirology. Home: 450 Riverside Dr New York City NY 10027

RUTTER, William J, Ph.D.

RUTTER, WILLIAM J., educator, scientist; b. Malad City, Ida., Aug. 28, 1928; s. William H. and Cecelia (Dredge) R.; B.A., Harvard, 1949; M.A., U. Utah, 1950; Ph.D., U. Ill., 1952; m. Jacqueline Waddoups, Aug. 31, 1950 (div. Nov. 1969); children – William Henry II, Cynthia Susan; m. 2d, Virginia Alice Bourke, Oct. 3, 1971. USPHS postdoctoral fellow U. Wis., 1952-54, Nobel Inst., 1954-55; from asst. [illegible] U. Ill., 1955-65, prof. biochemistry U. Wash., 1965-69; Hertzstein prof. biochemistry, chmn. dept. biochemistry and biophysics U. Cal. at San Francisco, 1969—; biochem. cons. Abbott Labs., 1958—, USPHS Biochemistry and Nutrition Fellowship Panel, 1963-66; Cons. physiol. chemistry study sect. NIH, 1967-71; mem. basic sci. adv. exec. com. Nat. Cystic Fibrosis Research Found., 1969—, chmn., 1971—; exec. com. div. biology and agr. NRC, 1969-72; mem. developmental biology panel NSF, 1971-73; mem. biomed. adv. com. Los Alamos Sci. Lab.; pres. Pacific Slope Biomed. Conf., 1972-73. Served with USNR, 1945. Guggenheim fellow, 1962-63. Mem. Am. Soc. Biol. Chemists (treas. 1970—, mem. editorial bd. jour. 1970-75), Am. Soc. Cell Biology, Am. Chem. Soc. (Pfizer award enzyme chemistry 1967), Assn. editor Jour. Exptl. Zoology, 1968-72; editor PAABS Revista, 1971—. Home: 80 Everson St San Francisco CA 94131

For Administrative Board, from the Clinical Sciences,

VOTE FOR TWO:

CHALLONER, David Reynolds, M.D.

CHALLONER, DAVID REYNOLDS, b. Appleton, Wis, Jan. 31, 35; m. 58; c. 3. INTERNAL MEDICINE, ENDOCRINOLOGY. B.S, Lawrence Col, 56; U.S. Pub. Health Serv. fel, Cambridge, 58-59; M.D, Harvard Med. Sch, 61. Intern, Columbia-Presby. Hosp, 61-62, asst. resident, 62-63; res. assoc, lab. metab, Nat. Heart Inst, 63-65; chief resident, King County Hosp, Washington (Seattle), 65-66, U.S. Pub. Health Serv. spec. fel. endocrinol, univ, 66-67; asst. prof. med. & biochem, SCH. MED, IND. UNIV, 67-70, ASSOC. PROF. MED. & BIOCHEM. & ASST. CHMN. DEPT. MED, 70- U.S.P.H.S, 63-65, Lt. Comdr. Am. Fedn. Clin. Res; Endocrine Soc; Am. Physiol. Soc; Am. Diabetes Asn; Am. Soc. Clin. Invest. Control mechanisms in intermediary and oxidative metabolism. Address: Dept. of Medicine, Indiana University School of Medicine, 1100 W. Michigan St, Indianapolis, Ind. 46202.

FREEDMAN, Daniel X., M.D.

FREEDMAN, DANIEL X., psychiatrist, educator; b. Lafayette, Ind., Aug. 17, 1921; s. Harry and Sophia (Feinstein) F.; B.A., Harvard, 1947; M.D., Yale, 1951; grad. Western New Eng. Inst. Psychoanalysis, 1966; m. Mary C. Neidigh, Mar. 20, 1945. Intern pediatrics Yale Hosp., 1951-52, resident psychiatry, 1952-55; from instr. to prof. psychiatry Yale, 1955-66; chmn. dept. U. Chgo., 1966—, Louis Block prof. biol. scis., 1969—; career investigator USPHS, 1957-66; dir. psychiatry and biol. sci. trg. program Yale, 1960-66; cons. Nat. Inst. Mental Health, 1960—, U.S. Army Chem. Center, Edgewood, Md., 1965-66. Chmn. panel psychiat. drug efficacy study Nat. Acad. Sci.-NRC, 1966; mem. adv. com. FDA, 1967—; rep. to div. med. scis. NRC, 1971-73, mem. com. on brain scis., 1971-73, mem. com. on problems of drug dependence, 1971—. Dir. Founds. Fund for Research in Psychiatry, 1969-72, Drug Abuse Council, 1972—. Served with AUS, 1942-46. Fellow Am. Psychiat. Assn. (chmn. commn. on drug abuse 1971—), Am. Coll. Neuropsychopharmacology (pres. 1970—); mem. Ill. Psychiat. Soc. (pres. 1971-72), Social Sci. Research Council (dir. 1968-69), Chgo. Psychoanalytic Soc., Western New Eng. Psychoanalytic Inst., Am. Soc. Pharmacology and Exptl. Therapeutics, A.A.A.S., Am. Assn. Chairmen Depts. Psychiatry (pres. 1972-73), Am. Psychopath. Assn., Group Advancement Psychiatry, Psychiat. Research Soc., Am. Psychosomatic Soc. (councillor 1970-73), Soc. Biol. Psychiatry, Sigma Xi, Alpha Omega Alpha. Author: (with N.J. Giarman) Biochemical Pharmacology of Psychotomimetic Drugs, 1965, What Is Drug Abuse?, 1970; (with F.C. Redlich) The Theory and Practice of Psychiatry, 1966; (with D. Offer) Modern Psychiatry and Clinical Research, 1972. Home: 4950 S Chicago Beach Dr Chicago IL 60615

OLIVER, Thomas Keyser, Jr., M.D.

OLIVER, THOMAS KEYSER, JR., physician, educator; b. Hobart Mills, Cal., Dec. 21, 1925; s. Thomas Keyser and Minora E. (McCabe) O.; student U. Cal. at Berkeley, 1943-45; M.D., Harvard, 1949; m. Doris E. Everett, June 18, 1949; children—Katherine, Thomas D. Intern, N.Y. Hosp.-Cornell Med. Center, 1949-50; resident, 1950-51, 53-55; from asst. prof. to asso. prof. Ohio State U., 1955-63; dir. Newborn Nurseries and Premature Center U. Hosp., also head div. neonatal biology dept. pediatrics U. Wash., Seattle, 1963-70, asso. dir. Child Devel. and Mental Retardation Center, 1968-70; prof., chmn. dept. pediatrics U. Pitts., 1970—; med. dir. Children's Hosp. of Pitts., 1970—. Served with M.C., AUS, 1951-53. Diplomate Am. Bd. Pediatrics (examiner 1971—), Nat. Bd. Med. Examiners. Fellow Am. Acad. Pediatrics; mem. Am. Pediatric Soc., Soc. for Pediatrics Research, Am. Assn. U. Profs., Pa., Allegheny County med. socs. Home: 505 S Linden Av Pittsburgh PA 15208 Office: 125 DeSoto St Pittsburgh PA 15213

SNOW, James Byron, Jr., M.D.

SNOW, JAMES BYRON, JR, b. Oklahoma City, Okla, Mar. 12, 32; m. 54; c. 3. OTOLARYNGOLOGY. B.S, Oklahoma, 53; M.D, Harvard, 56. Asst. prof. OTORHINOLARYNGOL., med. ctr, Univ. Okla, 62-64, prof. & head dept, 64-72; PROF. & CHMN. DEPT, SCH. MED, UNIV. PA, 72- Med.C, 60-62, Capt. Am. Acad. Ophthal. & Otolaryngol; Am. Col. Surg; Soc. Univ. Otolaryngol; Am. Laryngol, Rhinol. & Otol. Soc. Pathophysiology of the inner ear. Address: Dept. of Otorhinolaryngology, University of Pennsylvania, Philadelphia, PA 19104.

NOMINATIONS FOR THE BORDEN AWARD FOR OUTSTANDING BIOMEDICAL RESEARCH

The Administrative Board of the CAS is concerned about the number and quality of nominations received in the past for the Borden Award for Outstanding Biomedical Research. The Administrative Board would like to suggest that each society submit at least one nomination for the Borden Award this year. Regulations governing the award are stated in the following President's Memorandum, which was sent out for the 1974 nominations.

* *

Nominations for the Borden Award in the Medical Sciences for 1974 are now open.

This award was established by the Borden Company Foundation, Inc. in 1947 and consists of $1,000 in cash and a gold medal to be granted in recognition of outstanding clinical or laboratory research by a member of the faculty of a medical school which is a member of the Association of American Medical Colleges.

Regulations Governing the Award

1. Nominations may be made by any member of the faculty of a medical school which is a member of the Association of American Medical Colleges.

2. The Award in any year will be made for research which has been published during the preceding five calendar years.

3. No persons may receive more than one Borden Award for the same research although he/she may receive a later Award for a different research project.

4. If two or more persons who have collaborated on a project are selected for an award, the gold medal and check shall be presented to the group, and bronze replicas of the medal presented to each of the collaborators.

5. The Association may refrain from making an Award in any year in which no person reports research of the quality deserving an Award.

6. Only one Award shall be made during any one year.

7. A nominee who fails to receive the Award may be nominated for the Award for the same work in a subsequent year.

8. Materials supporting nomination should include:

   a. Six copies of a statement covering the academic history and scientific accomplishments of the nominee.

   b. Six copies of a reasoned statement of the basis for the nomination.

   c. Six copies of reprints reporting the nominee's important research

9. All materials supporting nominations should be sent to me by May 15, 1974, so I can forward them to the members of the Borden Award Committee. The committee will give consideration to the nominations and make recommendations to the Executive Council of a candidate for this Award.

Memorandum #74-9, March 22, 1974

The Borden Award

Since 1947 the Association, in cooperation with the Borden Company Foundation, has presented an annual award in the medical sciences in recognition of "outstanding research in medicine conducted by a member of the faculty of an affiliated college." This award consists of $1,000 in cash accompanied by an inscribed gold medal. Recipients have been:

1973 – Dr. Thomas C. Merigan, Jr., professor of medicine and chief, Division of Infectious Disease, Stanford University School of Medicine, was selected for his work with the antiviral protein interferon. In 1965 Dr. Merigan and his associates produced evidence that systematic production of interferon would protect humans against viral infections. This work consisted of demonstrating that the systemic interferon produced by infants following their live measles vaccine immunization made them resistant to challenge by an immunologically unrelated virus – the vaccinia used in their smallpox vaccination.

1972 – Dr. George C. Cotzias, professor of medicine, State University of New York at Stony Brook School of Medicine and professor of neurology, Mount Sinai School of Medicine, was cited for his findings which established L-dihydroxyphenylalaline (L-dopa) as a therapeutic drug in the treatment of Parkinsonism. His findings were based on a study in which he used chronically administered high oral doses of L-dopa to produce significant improvement in the conditions of two-thirds of the study subjects.

1971 – Dr. Joseph Willis Beard, professor of surgery and virology, Duke University School of Medicine, was cited for his extensive research into the etiology of cancer, his ingenuity in developing new approaches to the study of virology, and his contributions culminating in the isolation, identification, and characterization of several strains of avian viruses.

1970 – Dr. Robert A. Good, Regents' Professor of Pediatrics and Microbiology, University of Minnesota – Minneapolis Medical School, and recognized physician, scientist, educator, and editor, was cited for the direction of his research and cumulative achievements in the study of developmental and phylogenetic immunology as related to processes in both animals and man.

1969 – Dr. Abraham White, professor and chairman, Department of Biochemistry, Albert Einstein College of Medicine, was the recipient for his outstanding research developments in the field of biochemistry. Dr. White's current research has resulted in the isolation of two hormones from the thymus gland. In clinical application, these two substances have vast potential for prolonging survival of first- and second-skin allografts and for the treatment of malignancies involving lymphoid tissue.

1968 – Dr. Arthur Kornberg, professor and executive head, Department of Biochemistry, Stanford University School of Medicine, was presented this award for the enzymatic synthesis of DNA and the demonstration that infective viral DNA can be synthesized from pure chemical reagents and enzymes. These discoveries opened the way for the synthesis and modification of genetic material and have implications in the prevention and treatment of cancer and genetic disorders.

1967 – Dr. Seymour S. Cohen, Hartzell professor and chairman, Department of Therapeutic Research, University of Pennsylvania School of Medicine, received recognition for his pioneering efforts in biochemical virological investigations. After describing the alteration of macromolecular synthesis caused by virus infection in cells, he isolated and characterized the unique phage acid constituent 5-hydroxymethylcytosine and demonstrated the induction of enzymes by viruses which are required for its synthesis. Also, Dr. Cohen's investigation of the chemical mechanisms by which therapeutic agents exert their biological effects demonstrated the inhibition of thymidylate synthetase by fluorodeoxyuridylate and in a series of studies on streptomycin showed that the lethal effects of this antibiotic were related to abnormal ribosomal RNA synthesis.

1966 – Dr. Oliver H. Lowry, professor and chairman, Department of Pharmacology, Washington University School of Medicine; and **Dr. Janet V. Passonneau,** associate professor, Department of Pharmacology, Washington University School of Medicine, were presented the Borden Award for their teamwork in the study of the nature of the regulation of the rates for key enzyme-catalyzed reactions in the glycolytic sequence.

1965 – Dr. Paul C. Zamecnik, chairman, Department of Medicine, Harvard Medical School, was cited for his research and great triumphs in the field of modern biology. It was Dr. Zamecnik and his associates at Harvard who first achieved the demonstration of protein synthesis in a well defined, cell-free system. In a series of pioneering investigations, they were able to establish much of the chemical framework for the process of protein biosynthesis.

1964 – Dr. Harry Eagle, professor and chairman, Department of Cell Biology, Albert Einstein

College of Medicine, was recognized for contributions to the growth of animal cells in culture which have been extensive and fundamental. His now classic work on the nutritional requirements and metabolic activity of human and animal cells in cultures opened broad new fields of endeavor in cell biology, virology, genetics, and cancer research.

1963—Dr. Klaus H. Hofmann, professor and chairman, Department of Biochemistry, University of Pittsburgh School of Medicine, and editor, *Journal of Biological Chemistry*, was cited for his work in peptide chemistry and reference to the relation between structure and function of the adrenotrophic and other hormones of the pituitary gland; for his research on the structural analysis and synthesis of biotin; for his discovery of a new class of long-chain fatty acids containing the cyclopropane ring; and for his work on steroids, terpenes, and proteolytic enzymes.

1962—Dr. Leon O. Jacobson, professor and chairman, Department of Medicine, University of Chicago Pritzker School of Medicine, was selected for his studies of hematopoiesis; his research on the role of the spleen in protection against radiation; establishment of foundation for the presence of a humoral system in the regulation of erythropoiesis in mammals; and for demonstrations of the importance of the kidney as a source of erythropoietin.

1961—Dr. H. M. Magoun, professor of anatomy, University of California at Los Angeles School of Medicine, was presented this award for his many contributions in the field of neurophysiology and for his discoveries revolutionizing concepts of brain organization and function.

1960—Dr. Robert F. Pitts, professor and chairman, Department of Physiology, Cornell University Medical College, received recognition for his fundamental studies on renal tubular function, for his mastery of known techniques for studying kidney function, and for his development of new methods, which were applicable to mammals, including man.

1959—Dr. Theodore T. Puck, professor and head, Department of Biophysics, University of Colorado School of Medicine, developed a method for cultivation in vitro of colonies from single mammalian cells and extended investigations which were derived from this method.

1958—Dr. Severo Ochoa, professor and chairman, Department of Biochemistry, New York University School of Medicine, received this award for his work on enzymatic synthesis of ribonucleic acid.

1957—Dr. Murray L. Barr, professor and head, Department of Microscopic Anatomy, University of Western Ontario Faculty of Medicine, was presented this award for his work on sexual dimorphism in the structure of the resting mammalian nuclei.

1956—Dr. Harry S. N. Greene, the Anthony N. Brady Professor of Pathology, Yale University School of Medicine, received recognition for his many contributions to the field of oncology, particularly in the transplanting of neoplasms.

1955—Dr. Charles B. Huggins, recipient of the Nobel Prize in Physiology and Medicine 1966; director, the Ben May Laboratory for Cancer Research; and professor of urology, University of Chicago Pritzker School of Medicine, provided outstanding contributions in the field of cancer research, particularly in the area concerning relationships between the endocrine glands and cancer.

1954—Dr. Karl F. Meyer, professor of experimental pathology and director, the George Williams Hopper Foundation, University of California, San Francisco, received this award for his contributions to knowledge of plague, the psittacosis group of viruses and burcellosis.

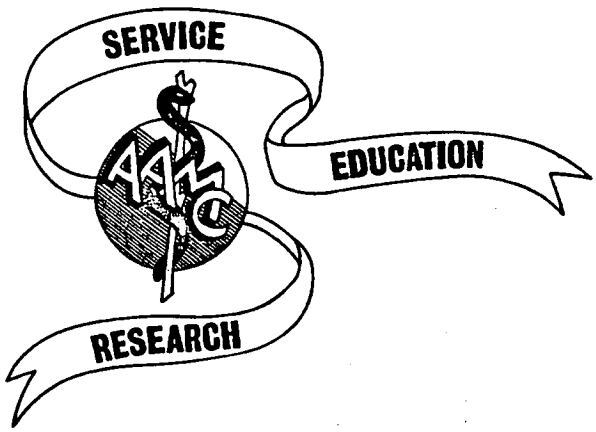
1953—Dr. Jean R. Oliver, distinguished service professor, State University of New York Downstate Medical Center, was presented this award for developing a technique of microscopic dissection of the kidney.

1952—Dr. William S. Tillett, professor of medicine, New York University School of Medicine, received recognition for his research in the mechanism of blood clot liquefaction and for the discovery of the streptococcal enzymes, Streptokinase and Streptodornase.

1951—Dr. Edwin B. Astwood, research professor of medicine, Tufts University School of Medicine, was cited for outstanding research in the field of endocrinology with special reference to hyperthyroidism.

1950—Dr. Gerty T. Cori, professor of biochemistry, Washington University School of Medicine, was recognized for fundamental contributions to the understanding of carbohydrate metabolism.

1949—Dr. Fuller Albright, associate professor of medicine, Harvard Medical School, was selected for his original contributions to the understanding of the metabolism of bone and other tissues, and its relation to renal and endocrine factors.



REPORT OF THE

AAMC TASK FORCE

ON THE

GOALS AND PRIORITIES COMMITTEE

REPORT

OF THE

NATIONAL BOARD OF MEDICAL EXAMINERS

This report is distributed for discussion and comment. The report is not an official policy statement of the AAMC.

Comments Should be Directed to:

John A.D. Cooper, M.D. President
Association of American Medical Colleges
One Dupont Circle, N.W.
Washington, D.C. 20036

October 25, 1974

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

REPORT OF THE AAMC TASK FORCE ON THE GOALS AND PRIORITIES COMMITTEE REPORT OF THE NATIONAL BOARD OF MEDICAL EXAMINERS

The AAMC has long been engaged with furthering the improvement of medical education in the United States. Through direct services to its constituents, interactions with other organizations and agencies concerned with medical education, national and regional meetings and participation in the accreditation of medical schools, the Association has exercised its responsibilities to the schools, teaching hospitals and to the public which is served by its medical education constituency. From time to time, the Association has analyzed and responded to reports bearing on medical education emanating from other organizations and agencies. This Task Force Report on the National Board of Medical Examiners' Goals and Priorities Committee Report is such a response.

Members of the Task Force:

Neal L. Gault, Jr., M.D., Chairman
H. Robert Cathcart
A. Jay Bollet, M.D.
Carmine D. Clemente, Ph.D.
Robert L. Tuttle, M.D.
Ronald P. Kaufman, M.D.
John H. Moxley, III, M.D.
Ms. S. Shackleton (Student)
Mark Cannon (Student)

The Task Force was particularly assisted in its deliberations by the working papers developed from the studies of a committee of the Group on Medical Education chaired by Mitchell Schorow. This committee met with faculty and administrators of schools in all four regions of the country. Many views and comments were also received from academic societies, individuals, schools and from regional groups of the Organization of Student Representatives. The Task Force is profoundly grateful for the assistance which these inputs provided in its deliberations.

THE GOALS AND PRIORITIES COMMITTEE OF THE NATIONAL BOARD OF MEDICAL EXAMINERS

In the Spring of 1971, the National Board of Medical Examiners appointed an eleven person committee called the Goals and Priorities (GAP) Committee, which was charged by the Board to examine American

medical education and make recommendations regarding the role the National Board should play in providing evaluation services during the next decade.

The GAP Report is a thorough treatment of a new role for the National Board of Medical Examiners in providing services for evaluating the developing competence of undergraduate and graduate medical students and the continuing competence of physicians. The NBME has, for nearly sixty years, served as an independent agency for evaluating medical students and newly graduated physicians for certification for licensure. For the past twenty years the NBME has increasingly become involved with research and development in medical student testing, and during the past decade the Board has become engaged in the research and development of testing methodologies for graduate students as well as undergraduate students.

Summary of Major Recommendations of the GAP Report

The GAP Committee Report recommends that the NBME reorder its examination system. It advises that the Board should abandon its traditional 3 part exam for certification of newly graduated physicians who have completed one year of training beyond the M.D. degree. Instead, the Board is advised to develop a single exam to be given at the interface between undergraduate and graduate education. The GAP Committee calls this exam 'Qualifying A', and suggests that it evaluate general medical competence and certify graduating medical students for limited licensure to practice in a supervised setting. The Committee further recommends that the NBME should expand its role in the evaluation of students during their graduate education by providing more research and development and testing services to specialty boards and graduate medical education faculties. Finally, the GAP Committee recommends that full certification for licensure as an independent practitioner be based upon an exam designated as Qualifying B. This exam would be the certifying exam for a specialty. In addition, the GAP Report recommends that the NBME: 1) assist individual medical schools in improving their capabilities for intramural assessment of their students; 2) develop methods for evaluating continuing competence of practicing physicians; and 3) develop evaluation procedures to assess the competence of "new health practitioners."

GENERAL OBSERVATIONS BY THE TASK FORCE

Throughout the GAP Report there is an effort to separate clearly the role of the NBME as a testing agency responsible for certifying that physicians have the necessary qualifications for licensure and the NBME's role in the evaluation of the educational achievement of students. The Task Force believes that this is a very important separation. This report of the Task Force is predicated on the fundamental concept that the faculties of duly accredited medical schools are solely responsible for the evaluation of their students' educa-

tional achievement, their promotion and their being granted the M.D. degree. State licensing boards are solely responsible for establishing criteria for licensure and for the evaluation of a physician's qualifications to practice medicine within their jurisdictions.

The delegation of the responsibility for evaluation, either by faculties or by licensing boards to another agency, must be done only with full and complete knowledge and understanding of the characteristics and limitations of the evaluation instruments which are used. The Task Force further believes that evaluation instruments designed to qualify physicians for certification for licensure (either limited or full) are not appropriate for measuring the educational achievement of individual students as they progress through a school's curriculum.

UNDERGRADUATE EVALUATION AND ABANDONMENT OF PARTS I AND II OF THE NATIONAL BOARD OF MEDICAL EXAMINERS EXAMINATIONS.

The GAP Committee proposes that the National Board cease utilizing its 3 part exam system (Parts I and II in the undergraduate period and Part III at the end of the first graduate year) to certify physicians as qualified for full licensure. This proposal is tempered by the recommendation that the NBME, on request from an educational institution, should provide services for evaluating the educational achievement of individual students and the educational programs themselves. The Task Force supports this recommendation, and proposes that nationally normed exams similar to the present Parts I and II should be made available as a part of the services for evaluation of curricula.

Abandonment of Part I

The abandonment of the certifying function of the Part I exam is viewed by many as yet another inroad into the emphasis upon basic science education in our medical schools. Indeed, this would be true if the NBME, through the Part I exam, were the sole agency responsible for ensuring the scientific integrity of medical education in the United States. However, as emphasized above, the faculties of our duly accredited schools are responsible. This responsibility means that faculties must develop evaluation methods to determine whether their students are achieving their educational objectives in the basic medical sciences; and the LCME, through its accreditation process, must determine whether the educational objectives established by each faculty are adequate and whether the school has evaluation methods which will determine that students have met these objectives. The continued availability of nationally normed exams in the basic sciences will provide an opportunity to evaluate a school's educational programs against a national standard, if the faculty deems such an evaluation necessary or desirable.

The Task Force recommends that the LCME should place greater emphasis, as a factor in the accreditation process, on assessing the effectiveness of medical schools' internal evaluation of their educational programs and of their students' achievement in the basic sciences. The Task Force also recommends that the AAMC, working with the NBME, academic societies, the National Library of Medicine, and other agencies, develop the capability to assist faculties in the development of evaluation instruments and methods which can be flexibly adapted to each school's particular curricular emphasis.

In order for the LCME to place a greater emphasis upon the assessment of the adequacy of each school's evaluation system, the Task Force recommends that accreditation site visit teams include individuals capable of investigating and judging testing methodologies. The Task Force further recommends that individuals capable of assessing the content and quality of basic science course work be included on all site visit teams.

Abandonment of Part II

The comments and recommendations relative to eliminating the certification function of Part I also apply to Part II. Faculties are solely responsible for the evaluation of their students' achievements in their clinical courses and clerkships. Evaluation methodologies must provide for assessment of students' accomplishments in relationship to the educational objectives established by the faculty. Generally, evaluation during the clinical years relies in part upon faculty members' descriptive impressions of a student's attitudes, skills, and accomplishments and in part on an assessment of the knowledge acquired by the student. In recent years testing methodologies to evaluate a student's problem-solving skills have been introduced and are a valuable adjunct to faculty descriptions and knowledge acquisition assessments. The Task Force recommends that the AAMC, in cooperation with the above-mentioned agencies, develop the resources to assist faculties in improving all facets of their student evaluation methods during the clinical years.

The Task Force also recommends that, as in the case of the basic sciences, the LCME place greater emphasis in the accreditation process on the effectiveness of the medical schools' internal evaluation of their students achievements in the clinical sciences.

Nationally normed exams, which permit comparative evaluation of a school's instructional program against a national standard, from time to time will continue to be necessary. The Task Force recommends that the NBME continue to make available the Part II exam, or its improved equivalent, to faculties desiring to assess the adequacy and scope of their curricula through this instrument.

QUALIFYING A

The GAP Committee recommends that the NBME develop an examination to be taken by students at the time of their transition from undergraduate to graduate status. The agencies for whom this exam will be pertinent will be state licensing boards, who are responsible to their jurisdictional constituencies for assuring that individuals providing physician services are competent, and graduate education institutions and programs, who are responsible for the welfare of the patients within their clinical teaching facilities. The examination is not deemed pertinent to undergraduate medical educators for, as emphasized above, the decision to grant the M.D. degree by the faculty of any school must be based upon internal evaluation methods developed by the school. The Task Force concurs with the establishment of such an examination and makes the following comments and recommendations.

The exam would provide for a single standard for the evaluation of all students entering graduate medical education in the United States. Because of the varied curricula in our domestic medical schools and the wide range of quality of foreign students seeking entrance to U.S. graduate programs, it is essential that a single standard be established which will assure that each student who enters a graduate program is ready, as regards both knowledge and clinical skills, to assume patient care responsibility.

The examination should provide a balanced assessment of the student's basic science and clinical knowledge and an assessment of the student's logic and problem-solving abilities. The assessment of basic science knowledge and skills in utilizing fundamental scientific concepts should be sufficiently rigorous so that students passing the exan can be considered to have had a sound education in the basic science disciplines.

If at all possible, the exam should be criterion-based rather than norm-referenced and the results should be reported as either "passed" or "failed".

The results should be reported only to the student, to the graduate institution or program for which the student has been selected, and the licensing agency with jurisdiction over the student and the graduate program. The exam should not be reported to graduate programs as part of the student's application information. The purpose of the exam is to assure readiness for clinical responsibility; it should not be used in the selection of graduate medical students or to predict future success in any clinical discipline.

Students from domestic schools should not be permitted to sit for the exam before the beginning of the last half of their final undergraduate year. The examination schedule should be so arranged that students will have a second opportunity to take the exam and receive the results before the usual date of beginning of the first graduate year. Graduates of foreign schools should be permitted to sit for the exam at any time, but should not be permitted to begin their graduate education until a report that they have "passed" has been received by the above-mentioned agencies.

The Task Force believes that passing the exam should be the responsibility of the student. Students who fail must assume individual responsibility to obtain needed additional education and study. Schools which have granted the M.D. degree to students who fail the exam should have no obligation to provide remedial assistance, although in practice the Task Force believes most students will seek additional education from their own school. This should not be denied if the student is willing to pay the required tuition and fees.

Limited Licensure

The Task Force could not reach unanimous agreement on the GAP Committee recommendation that licensure be limited to providing care in a supervised graduate education setting. Objection by the student members of the Task Force and doubts regarding the willingness of all fifty-five jurisdictions in the United States and its territories to provide such a limited licensure at this stage was the cause of this impasse. It is the Task Force's view that the impetus for implementation of this examination will derive from the Liaison Committee on Graduate Medical Education. The Liaison Committee can insist that only students who have passed the qualifying exam be admitted to accredited graduate programs.

EVALUATION DURING GRADUATE MEDICAL EDUCATION

The GAP Committee recommends that the evaluation of students during their graduate education be vastly improved. The Task Force concurs with this recommendation and makes the following comments and recommendations.

The faculties responsible for graduate clinical education should assume sole responsibility for the evaluation of their students as they progress through their education. Evaluation methodologies should be developed and applied which will assess whether residents are achieving the requisite knowledge and skills expected by the faculty and the specialty boards. The Liaison Committee on Graduate Medical Education should place a strong emphasis on requiring effective in-

ternal student evaluation methods in its accreditation requirements for graduate programs. The specialty boards should require that program directors, when certifying their finishing residents as ready for board examinations, provide evidence of sound internal assessment of each resident's abilities and qualifications.

QUALIFYING B

The GAP Committee recommends that licensure for the unlimited independent practice of medicine be based upon a candidate's passing the Qualifying B examination which would be one of the specialty board examinations. The Task Force recommends that medical licensure should not necessarily be linked to specialty certification. Physicians should be eligible for full medical licensure after the satisfactory completion of the core portion of a graduate medical educational program, this core portion to be delineated individually by each specialty board. Specialty board certification should continue to be a mechanism by which individual physicians may demonstrate outstanding accomplishment in a given field. Such certification may be used by individual physicians as an alternative method of gaining medical licensure, but it should not be required.

RECERTIFICATION AND RELICENSURE

The Task Force concurs with the GAP Committee's recommendation that the National Board of Medical Examiners should be prepared to provide assistance to those agencies which may in the future be responsible for providing periodic examinations for the recertification or relicensure of physicians.

REORGANIZATION OF THE NATIONAL BOARD OF MEDICAL EXAMINERS

The Task Force concurs with the reorganization as proposed by the GAP Committee. The Task Force urges student representation on the National Board of Medical Examiners.

Task Force Report on GAP Committee Report of NBME

SUMMARY OF TASK FORCE RESPONSES TO THE GAP COMMITTEE'S MAJOR RECOMMENDATIONS

1. The NBME should abandon its 3 part system of examination for certification for licensure.

The Task Force concurs.

2. The NBME should continue to make available norm-referenced exams in the disciplines of medicine now covered in Parts I and II of the National Board.

The Task Force concurs and recommends that faculties use these exams to evaluate their curricula and instructional programs only and not to evaluate individual student achievement.

3. The AAMC, NBME and other interested agencies should assist the schools to develop more effective student evaluation methodologies.

The Task Force concurs and recommends that the LCME place a specific emphasis on investigating schools' student evaluation methods in its accreditation surveys.

4. The NBME should develop an exam to be taken by students at their transition from undergraduate to graduate education for the purpose of determining students' readiness to assume responsibility for patient care in a supervised setting.

The Task Force concurs and makes the following recommendations.

a. *The exam should be sufficiently rigorous so that the basic science knowledge and concepts of students are assessed.*

b. *The exam should place an emphasis on evaluating students' ability to solve clinical problems as well as assessing students' level of knowledge in clinical areas.*

c. *The exam should be criterion-referenced rather than norm-referenced.*

d. *The exam should be reported as "passed" or "failed" to the students, to the graduate programs they are entering, and to the licensing boards that require certification for graduate students.*

e. The exam results should not be reported to medical schools.

f. Students failing the exam should be responsible for seeking additional education and study.

g. Graduates of both domestic and foreign schools should be required to pass the exam as a prerequisite for entrance into accredited programs of graduate medical education in the U.S.

5. The Federation of State Medical Boards and their members should establish a category of licensure limited to caring for patients in a supervised graduate medical education setting.

The Task Force doubts that all jurisdictions will establish such a category and believes that the LCGME should require that all students entering accredited graduate medical education pass the exam.

6. The NBME and other agencies should assist graduate faculties to develop sound methods for evaluating the achievements of their residents.

The Task Force concurs and recommends that graduate faculties assume responsibility for periodic evaluations of their residents and that the specialty boards require evidence that the program directors have employed sound evaluation methods to determine that their residents are really to be candidates for board exams.

7. Certification for licensure for independent practice should be based on certification by a specialty board.

The Task Force recommends that specialty certification be only one mechanism by which individual physicians may gain licensure; it should not be the prime or sole mechanism. The Task Force recommends that physicians should be eligible for full licensure after the satisfactory completion of the core portion of a graduate medical educational program.

MINORITY REPORT BY CARMINE CLEMENTE, Ph.D.
MEMBER OF THE TASK FORCE

As the only practicing basic scientist on the Task Force, I do not agree with two of the summary recommendations. I believe the Report does not represent the broad views of the membership of the AAMC, especially those of the basic scientists. In fact, several basic science societies have expressed the view that the elimination of Part I will irreparably reduce the emphasis on basic sciences in the curriculum of the first two years of medical school.

Therefore, I recommend that in the Summary of Task Force Responses, Item 1 read as follows:

1. The NBME should abandon its 3 part system of examination for certification for licensure.

The Task Force believes that the 3 part system should not be abandoned until a suitable examination has been developed to take its place and has been assessed for its usefulness in examining medical school graduates in both the scientific and clinical aspects of medical education.

The issue here is not "licensure", for that function of the National Board has already been supplanted through the use of the FLEX exam. My concern is for the term "abandonment". Once the Task Force concurs with abandonment of the 3 part examination, it will imply a downgrading of the importance of the basic sciences in the education of physicians by eliminating a nationally referenced instrument now available through Part I.

I also recommend a substitute for Item 2 of the Summary. It would read:

2. The NBME should continue to make available norm-referenced exams in the disciplines of medicine now covered in Parts I and II of the National Board.

The Task Force recommends that at least Part I of the National Boards continue to be utilized through the foreseeable future in the current manner, so that faculties at schools of medicine might retain the advantage of evaluating their curricula and instructional programs of the first two years against a national norm. Individual schools could continue to determine, on an ad hominem basis, the manner in which each school wishes to use Part I. Part I and the qualifying exam could then fulfill different functions.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Memorandum #74-37

To: The Assembly

October 21, 1974

From: John A.D. Cooper, M.D., President

Subject: AAMC health manpower policy reconsideration

This memorandum provides background for the reconsideration of current Association policy on federal legislation for health professions education assistance. Adoption of an alternative health manpower policy would represent a major change in Association position. Accordingly, the issue is to be placed before the Assembly during its November 14, 1974, meeting in Chicago.

This memorandum briefly reviews the Association's present health manpower policy and the current legislative situation, and presents a series of possible alternatives for the future guidance of the Association.

Present AAMC policy

Association health manpower policy is based on two reports prepared by the Committee on the Financing of Medical Education. The Executive Council has approved the two reports prepared by the Committee. The first report, in October 1973, Undergraduate Medical Education: Elements, Objectives, Costs, identified the costs of the undergraduate medical education program. The second report, in June 1974, Financing Undergraduate Medical Education, presented recommendations on how undergraduate medical education should be financed.

Specific policy on health manpower legislation is based on the recommendations of the Committee on Health Manpower, which were approved by the Executive Council on November 14, 1973. Among other recommendations, the AAMC policy calls for institutional support through capitation grants at a level slightly higher than the present level, with no preconditions. Capitation bonuses are to be available for increasing undergraduate enrollment, or for programs in primary care, or for programs in underserved areas. At the heart of the Association's present policy is the preservation of capitation grants to provide substantial and continuing support for the federal share of the teaching activities of the medical schools that are essential to undergraduate medical education. Other than routine financial accountability, no preconditions are to be attached.

The Committee considered and rejected "last dollar" financing which would involve federal support, individualized for each school, for that portion of the operating budget not covered by income from other sources. It also considered and rejected the approach advocated by Congressman Roy which would provide only indirect support to medical schools by expanding federal student financial aid programs permitting an increase in tuition to more closely meet the costs of medical education at each institution.

Additionally, the AAMC Task Force on Foreign Medical Graduates recommended in a report adopted by the Executive Council on March 22, 1974, that U.S. medical schools should be the major source of physicians practicing in the United States, that first-year graduate training positions should be reduced

gradually so as to exceed only slightly the number of graduates from U.S. medical schools, and that new health personnel should be trained to meet hospital staff needs created by the reduced training of Foreign Medical Graduates in the face of continuing patient responsibilities.

Current legislative situation

As the health manpower bills have evolved this year, the capitation-grant mechanism has become distorted. Both the House and the Senate have seized on the mechanism as a means of forcing federal initiatives on the schools, and this threatens serious government intrusion into the process of medical education. Capitation conditions of this nature, as of this date, are presented below:

Senate:
Secure national service agreements from at least 25 percent of students, with each such student entitled to a national health service or a shortage area scholarship, provided that the HEW Secretary may agree with a school to increase the requirement to 50 percent and increase the capitation payments by 10 percent.
One-time medical student enrollment increase of 5% or 10 students.
Lowering ceilings on FMGs in affiliated graduate training programs of 40-35-25 percent over three years.
Establish department or program in Family Medicine or comparable primary care. Administer a residency program in Family Medicine of not less than 10-15-20 percent (over three years) of all affiliated graduate training positions or in comparable primary care of not less than 35-40-45 percent (over three years) of all affiliated graduate training positions.

House:
Secure agreements with students to repay capitation payments unless they serve in the National Health Service Corps.
One-time medical student enrollment increase of 5% or 10 students, or offer training as a physician assistant.
Approved plan for remote-site training, to be supported by at least 25% of capitation payment.

The cumulative effect of these conditions for eligibility is to convert capitation from institutional support for basic program maintenance to restrictive support for federal initiatives, distributed on a per capita basis. The changing nature of capitation intent requires a search for alternate mechanisms for providing federal support to the schools for both basic program maintenance, and for responding to national needs identified both in the public and private sectors. The remainder of this memorandum sets forth a series of such alternatives.

Health Manpower Policy Alternatives

This section briefly reviews current public concerns, describes assumptions upon which policy alternatives should be considered and provides a selection of possible policy choices.

Current concerns

Following are brief descriptions -- as seen from the federal perspective -- of major public concerns with medical education and health care personnel.

Basic program: Current Association policy holds that the federal government's share of basic operating expenses should be provided through capitation grants without any preconditions except routine financial accountability. Both Congress and the Administration reject the Association's position. Congress appears willing to continue capitation provided that certain requirements are met by the schools. The Administration wants to drop capitation altogether. Without substantial evidence, both Congress and the Administration believe that without capitation funds no school will be seriously affected, because other funding sources will be found or schools will accomodate by spending less and restricting their programs.

Innovation, quality improvement: These are the traditional special project categories of curriculum development. While special projects show a federal concern for quality, the major emphasis is on numbers of students graduated.

Enrollment increase: There is disagreement within the federal government on the need for additional physicians. Congress generally believes that a further increase in the education and training of new physicians is needed. The Administration does not advocate an increase in the number of medical school graduates beyond those now planned.

Specialty distribution: Both the Administration and Congress believe that there is an imbalance in specialty distribution, and that more primary care physicians are required. There appears to be a willingness to support the efforts of the private sector in bringing about a redistribution of specialists through control of training opportunities over the next two to three years. Control of licensure to prohibit practice in oversupplied specialties has also been discussed.

Geographic distribution: Both the Administration and Congress believe that ways must be found to get physicians into underserved urban and rural areas. There is a widely held view that this can best be accomplished either by requiring medical schools to obtain agreements from students to practice in underserved areas, or by increasing student aid programs which encourage or require service commitments as a condition of receiving the aid. There is little interest in a physician draft to redistribute physicians.

Foreign medical graduates: This concern differs somewhat from the others because the method for dealing with it involves developing exclusionary devices rather than facilitating programs. The implications of certain reactions to this concern appear in both the concern with undergraduate enrollment and the concern with specialty distribution. Congress and the Administration disagree on the issue. The Administration officially supports major reliance on FMGs in meeting domestic American health personnel needs. Congress objects to the rising number of FMGs, and is seeking ways of checking the flow by setting ceilings on the total number of graduate positions and on the percentage of these positions that can be filled by FMGs.

Fiscal and economic situation: This concern, again, is slightly different from the others. Congress and the Administration agree, despite some superficial quarreling, that present federal budgets are excessively large, and that their magnitude requires stringent efforts to hold down future controllable spending. In addition, the overall economic situation is one of persistent inflation at an unacceptably high rate. This leads to rising costs across the whole economy, with particular attention focusing on large cost increases such as those in the health care field generally. Congress and the

Administration agree, again despite some superficial quarreling, that steps must be taken to control rising costs, and that the strongest controls must be leveled at the sharpest cost increases.

Assumptions

Following are a set of assumptions which should be used in considering new Association policies on the federal role in professional health manpower education, in light of current public concerns.

1. Responsiveness toward current public concerns is essential, if the schools are to maintain their position as public institutions worthy of support from any source.

2. There will always be disagreements on the nature of the appropriate mechanisms to respond to federally perceived needs.

3. Public funding of some nature is required to help finance the high cost of quality medical education.

4. Variations among institutions will result in differing abilities to respond to federal requirements.

5. Qualifying requirements can be expected, regardless of the source or mechanism of support, and often these will intrude on traditional institutional prerogatives.

6. Current methods of meeting federal concerns are unstable and can be expected to shift over relatively short periods of time, two to three years for example. Additional concerns are likely to be identified from time to time.

7. Long-term federal assistance for basic program support is being challenged because of shifting public demands for priority use of a relatively limited amount of funds. Short-term developmental aid for specific initiatives is less subject to challenge.

8. Appropriated levels of assistance will almost always be lower than authorized levels of appropriations. (Appropriations are provided through a Congressional process completely independent of the process used in the development of authorized appropriations.)

Policy choices

Following are a set of policy choices for selecting sources of funding for the basic operating programs associated with undergraduate medical education.

Federal support

Funding source	Advantages	Disadvantages
Capitation	If it complies with the original concept of federal support for basic on-going operating budgets, it provides stable support on the basis of the number of students.	It has been distorted to direct changes in educational programs. It is unlikely to be provided without conditions. It fails to

Federal support

Funding source	Advantages	Disadvantages
Capitation (con't.)		differentiate among varying degrees of financial need.
Tuition subsidy to students	If it is sufficiently high, it would allow schools to adjust tuition income to meet basic operating needs.	State schools are not able to adjust tuition without approval by multiple higher authorities. Tuition income does not go directly to many state schools. Tuition subsidy may be used to coerce students to fulfill federally perceived needs. Schools may have to fulfill imposed requirements in order for their students to receive federal financial aid. Tuition subsidy authorization or appropriation, or both, are likely to be inadequate.
Last-dollar	It will prevent failure of schools. It will distribute scarce resources to schools with the greatest need.	Determination of eligibility and of the amount provided will require federal inspection and audit of a school's programs and operations. Eligibility requirements can be used to coerce schools toward federal concepts of form and organization of medical schools.
No federal aid	This would free schools of the constraints associated with federal dollars.	This would force increased reliance on non-federal sources, and thus make a school more vulnerable to coercion from those sources. This is likely to be viewed as an abdication by the schools of their social responsibility, with almost certain adverse results. There is a danger of inadequate support from non-federal sources.

Non-federal support

Funding source	Advantages	Disadvantages
Increased state support:		
state schools	The state has a traditional obligation to maintain the basic program of the school. Negotiations for support provide more opportunities for taking advantage of the local and state interests. Many states currently have revenue surpluses.	The appropriation process in some states would make transition from federal to state sources difficult. State school budgets must be cleared through the university in many cases, and opportunities for advancing the school's interests may be curtailed. State concerns for manpower are similar to federal concerns, and thus direction by the state legislature is a real possibility.
private schools	Provides a portion of basic support, thus augmenting endowment and tuition income.	The appropriation process in some states would make transition from federal to state sources difficult. State-imposed requirements may restrict a school's options: taking increased numbers of state residents, for example. State support may be last-dollar in nature, with all the attendant coercion, and eligibility and reporting requirements.
Tuition increase:		
state schools	Increased payment by students may improve negotiations with university and legislative budget committees for a greater basic operating budget.	Many states are unwilling to increase tuition for residents significantly, or the decision-making authority for tuition rates is well removed from the medical school, or both. Tuition imcome may not be directly available to the schools.
private schools	Tuition adjustment ability is flexible, and tuition can be adjusted to meet needs.	For both state and private schools, increasing tuition to meet basic operating expenses will mean that fewer of lower-income students can attend medical school since it would be difficult to develop the required student financial aid programs.

Non-federal support

Funding source	Advantages	Disadvantages
Medical service income:		
state schools	Increased patient demand for and entitlement to medical services provides a growing source of income. Permits the development of stronger clinical programs.	There is a real potential that an overcommitment to medical service will dominate the other missions of the medical schools. Future constraints and regulations on reimbursement are likely and unpredictable in nature. This income may be viewed by legislatures as an offset, rather than a supplement, to other state support.
private schools	Increased patient demand for and entitlement to medical services provides a growing source of income. Permits the development of stronger clinical programs.	There is a real potential that an overcommitment to medical service will dominate the other missions of the medical schools. Future constraints and regulations on reimbursement are likely and unpredictable in nature.

STATUS OF THE NIRMP

For several years the viability of the National Intern Residency Matching Plan has been of considerable concern to medical students, medical school deans and many directors of programs in teaching hospitals. This concern arose because of an increasing number of violations of the rules of the matching plan by both students and some program directors. Adding to this concern was the inordinate delay in announcements of matching results by the NIRMP in 1972 and 1973.

The increasing number of violations of the matching plan were in large measure related to the decision by several specialty boards that the internship would no longer be required and that students could enter specialty training directly from medical school. Because program directors were anxious to fill their residency positions, overtures were made to students encouraging them to accept positions outside of the matching plan. The NIRMP had also not been able to utilize up-to-date data system management in conducting the matching plan and thus was not able, either to announce results on time, or accomodate to the rapidly changing demands being placed upon it by the altered requirements of the specialty boards.

In the Summer of 1973, the Board of the NIRMP contracted with a systems management group for the development of an effective computer based matching program. This became operational for the 1974 match, and the match was conducted on time; in fact, the matching was completed a full ten days before the announcement date.

The Organization of Student Representatives instituted a NIRMP monitoring program in which every medical school has been asked to establish a committee to investigate alleged violations of NIRMP rules. When medical schools have verified to their satisfaction that a student has been improperly asked to violate the rules of the NIRMP by a program director, the violation is reported to the President of the Association, who informs the program director of the alleged violation. Thus far, the NIRMP monitoring system has been utilized on one occasion, and on that occasion the director of the program alleged to have violated the rules of the NIRMP acknowledged that he was not aware that he was violating the rules.

The Liaison Committee on Graduate Medical Education has appointed a subcommittee to discuss what role the LCGME should play in the maintenance of the NIRMP. At this date, the committee has not yet reported. The CAS Administrative Board has recommended that the LCGME consider requiring adherence to NIRMP as a requirement for accreditation of graduate programs.

COORDINATING COUNCIL ON MEDICAL EDUCATION REPORT

ROLE OF THE FOREIGN MEDICAL GRADUATE

The Physician Distribution Committee of the Coordinating Council on Medical Education prepared the following report on foreign medical graduates. The report was accepted by the Coordinating Council in September, 1974 and has been forwarded to the parent organizations (Association of American Medical Colleges, American Board of Medical Specialties, American Hospital Association, American Medical Association and the Council of Medical Specialty Societies) for approval. When the five parent organizations have approved this report, it will become the operating policy of the Coordinating Council. It is anticipated that the Executive Council will take action on this report in January.

The Role of the Foreign Medical Graduate

A Report of the Coordinating Council on Medical Education*

Since World War II, large numbers of physicians have migrated throughout the world, increasingly from nations which are developing economically to those whose economies are stronger. Particularly during the past decade the rate of increase in foreign medical graduates (FMG's) in the United States has been three times greater than the increase in the total number of physicians in the United States. Foreign medical graduates now approach 21 percent of all physicians in the United States. (Table 1)

One-third of all hospital interns and residents are FMG's. In both 1972 and 1973, almost as many FMG's as USMG's (46.0 and 44.5 percent of the total, respectively,) were added to the licensure registries for physicians in the separate states (Table 2).

In 1973, FMG's made up 50 percent or more of physicians licensed for the first time in 19 states or other jurisdictions and in 4, FMG's comprised 75 percent or more of the new licentiates that year. (Table 3)

These developments have taken place concurrently with the marked expansion in the number of U.S. medical schools and even more marked expansion of U.S. medical student enrollment in those training institutions. In 1973, for the first time, U.S. medical graduates have exceeded 10,000 (10,391). (Table 4) It is anticipated that by 1980 the annual output of U.S. medical schools will approximate 15,000, a goal widely endorsed as providing a better balance between the total number of physicians and the total U.S. population in the

*Approved by the Coordinating Council on Medical Education on September 5, 1974 and forwarded to the five parent organizations for their consideration. Not official policy until approved by those organizations (AAMC, ABMS, AHA, AMA, CMSS).

years ahead. Yet, as the Coordinating Council has cautioned in a previous report on the primary care physician[1] such balance can be achieved only through planned and sustained national effort. Concerted effort must continually be directed to the number of physicians produced by our medical educational system, to their distribution geographically as well as by specialty and to the effect that these considerations have on the amount and quality of medical care available to the U.S. population.*

Some observers have viewed the utilization of large numbers of FMG's in our health care system as a readily available, though temporary, means of relieving excessive burdens, financial as well as other, on the domestic medical educational system. The future flow of FMG's to the U.S. may prove less predictable than it has been in the past. Accordingly, appropriate national concern must also be directed toward domestic and foreign factors that influence international migration of physicians to the U.S. Furthermore, the graduate educational needs of FMG's are of major magnitude and may differ considerably from those of graduates of U.S. medical schools.

This report would not be complete without an expression of gratitude and appreciation to the thousands of FMG's who have been completely assimilated into the U.S. health care system and who have rendered valuable service to the American people. Particular recognition is due those who have become faculty members of U.S. medical schools and have assisted in the education of USMG's.[2] Many good things have occurred, and will continue to occur, as the result of the mix of products of educational systems in foreign countries with the products of our own educational system. This is valuable and should be encouraged under the proper conditions. However, many problems have arisen which need to be

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(1) Physician Manpower and Distribution, The Primary Care Physician, A Report of the Coordinating Council on Medical Education, June 1974.

(2) Dublin, T.D., Foreign Physicians: Their Impact on U.S. Health Care, Science, 185:407-414, August 2, 1974

* Subsequent reports on Physician Manpower and Distribution are in preparation. The present report deals only with the specific problems related to foreign medical graduates.

addressed.

Critical issues affecting the entrance of FMG's into the U.S., their graduate medical training, their distribution and utilization include:

1. Coherent national policies determining the role FMG's can or should play in the U.S. health care system have not been formulated. The lack of national, regional, or state plans is in part due to the widely dispersed and often unrelated authorities that share responsibilities in this area. There is a pressing need for the early reconciliation and coordination of the disparate and conflicting policies and programs of various Federal agencies, national professional and related organizations and the 55 separate state and territorial licensure authorities.

2. Curriculum content and standards of education in different medical schools around the world vary considerably. Thus, FMG's coming to the U.S. comprise a highly heterogeneous group and demonstrate an equally wide range of professional competence. The growing number of FMG's in the United States and their performance on ECFMG, state licensure and specialty certifying examinations have highlighted questions about the equivalency of their educational preparation with that available to U.S. medical school graduates. Questions have also been raised concerning their performance in the delivery of health care.[2] This assessment applies particularly to those FMG's who received their basic medical education in languages other than English or in cultures dissimilar to that of the United States.

3. Whether the FMG enters the U.S. health care system as an exchange visitor, an immigrant, or as a returning U.S. national who has studied

medicine abroad, his point of entry is almost invariably at the graduate level of medical education, the hospital internship or residency. Graduate educational positions in the U.S. have far exceeded the number of U.S. & Canadian graduates enrolled in residencies. (Table 5) Many of the programs to which FMG's gain appointment emphasize service activities with minimal attention to an educational program designed to meet their special educational needs.

4. In order to meet the demand for physician service in some hospitals and in institutions providing long-term, chronic care, particularly state institutions, a large--but inexactly assessed--number of FMG's have been employed under limited or temporary medical licensure arrangements. Some of these FMG's have failed to obtain ECFMG certification or to meet state licensure requirements for unrestricted medical practice. Estimates place the number of such unqualified FMG's as high as 10,000.(3) Many are serving as institutional staff physicians presumably under professional supervision or in a variety of paramedical capacities yet their prospects are severely limited in obtaining the credentials of a physician fully qualified to practice independently.

5. Serious doubts have been raised, particularly in a period of major transition in graduate medical education in the United States, as to the appropriateness of the present ECFMG examination both as a test of the readiness of FMG's to benefit from this graduate educational experience and as an adequate safeguard of the health and welfare of patients. In effect different standards now exist for USMG's and FMG's for admission to graduate medical education.

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(3) Mason, H., Helping the Foreign Medical Graduate Qualify for Medical Practice, Journal of Medical Education 48:684-686, July 1973

In its report, issued in 1967, the National Advisory Commission on Health Manpower urged that "at a minimum, foreign trained physicians who will have responsibility for patient care should pass tests equivalent to those for graduates of U.S. medical schools."(4) More recently the Committee on Goals and Priorities of the National Board of Medical Examiners has recommended that a new system of examination, applicable to both domestic and foreign medical graduates, be instituted to evaluate performance capabilities requisite for providing patient care in a supervised setting.(5) This recommendation predicates the revision of the existing ECFMG examination as well as the provision of improved evaluation instruments to assess better the English language capability and potential ability of FMG's to adjust to the U.S. medical education and health care delivery systems and to the cultural environment within which they will practice.

6. Despite significant growth in the enrollment capacity of U.S. medical schools, large numbers of applicants cannot be accommodated. (Table 6) Increasing numbers of U.S. citizens are attending foreign medical schools. Serious questions have been raised about the quality of medical education in those institutions most willing to accept U.S. students and the appropriateness of that educational experience as a preparation for health care needs in the United States. These U.S. nationals studying medicine abroad present many of the same problems encountered by other FMG's entering the mainstream of American medical practice. Policies regarding U.S. nationals studying medicine abroad are in need of careful review and reappraisal.

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(4) Report of the National Advisory Commission on Health Manpower, Volume I, U.S. Government Printing Office, Washington, D.C. November 1967

(5) Evaluation in the Continuum of Medical Education, Report of the Committee on Goals and Priorities, National Board of Medical Examiners, Philadelphia, June 1973

7. For more than 20 years, the United States, as a component of its programs of foreign aid, has encouraged FMG's to come to the U.S. to obtain a type of graduate medical education not available to them in their home country. Presumably such training would prepare these physicians to practice at a higher level of proficiency upon returning to their home country. As currently operating, the exchange visitor program for physicians is no longer serving its declared purpose and may be counterproductive to the improvement of health services both in the countries represented by the exchange visitor physicians and in the U.S.

8. The Immigration and Naturalization Act Amendments of 1965 (P.L. 89-236) and 1970 (P.L. 91-225) have had major impact on the migration of FMG's to the United States. The termination of the national quota system previously in effect opened avenues of entry to the U.S. for physicians trained in countries where, even in the face of major unmet health needs, the available physician supply exceeds effective economic demand. Secondarily, preferential immigration status has been assigned to medicine and to some related health professions thought to be in short supply in the U.S. Thus, physicians from these developing countries are encouraged to emigrate to the U.S. without regard to the appropriateness of their professional education for medical licensure requirements. Based on current data, physicians migrating to the U.S. each year represent about one-quarter of the annual output of all of the medical schools of the world outside of the U.S., the People's Republic of China, the U.S.S.R. and the socialist countries of Eastern Europe.(6)

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(6) Gish, O., Doctor Migration and World Health Occasional Papers on Social Administration, No.43, Social Administration Research Trust, G. Bell & Sons, London 1971

RECOMMENDATIONS

The issues summarized above demonstrate the extent and complexity of the problems associated with the entrance into the U.S. health care system of large numbers of FMG's. In 1967, a Panel on Foreign Medical Graduates submitted to the National Advisory Commission on Health Manpower detailed recommendations to resolve the problems then identified with FMG's.[4] In the main, these recommendations have not been implemented. Concurrently changes in immigration laws and regulations as well as other forces have increased the flow of FMG's to the U.S. and the problems have become more deep-seated and complex. Simplistic solutions to one phase or another of the problems have already proved inadequate. Moreover, in our pluralistic health care system unilateral action by one organization or agency, even at the Federal level, will fall short of its desired objectives and may, in fact, create additional problems.

To date there has not been concerted and sustained nationwide effort to develop sound and coherent policies affecting the entrance of FMG's into the U.S., their education and training in appropriate institutions and their effective utilization in the U.S. care system. There is an urgent need for unified and continuing national, state and local action programs in which all concerned agencies play an appropriate role in implementing agreed-upon policies.

I. General Recommendations

The Coordinating Council on Medical Education recommends that the following statements be adopted as basic tenets of a proposed Statement of National Policies on the Role of the Foreign Medical Graduate in the U.S. Health Care System:

1. That the U.S. medical educational system (including graduate as well as undergraduate education) provide a sufficient

number of well-trained physicians to meet the health needs of the nation;

2. That the U.S. medical educational system assist other countries, particularly the developing countries of the world, in improving their systems of medical education and their levels of medical practice and public health;

3. That the resolution of problems arising from the current massive international migration of physicians be achieved in a manner consistent with the Universal Declaration of Human Rights adopted by the U.N. General Assembly in 1948, assuring for every individual the right to leave any country, including his own, and to return to his country;

4. That in resolving these migration problems the U.S. should avoid the use of selective discrimination, based on occupation or nationality, against foreign medical graduates seeking either temporary or permanent admission to the U.S.;

5. That the resolution of medical care problems arising from shortages or uneven distribution of physicians in the U.S. should not depend on recruitment of foreign medical graduates from abroad or on the assignment of preferential immigration status to members of selected health professions;

6. That all foreign medical graduates seeking opportunities for graduate medical education must demonstrate that they have met a standard of professional proficiency equivalent to that required of U.S. medical graduates eligible for the same type or level of graduate education so that there may be assurance of their capacity not only to benefit from the educational experience but to provide effective care under supervision.

7. That a physician, FMG or USMG, whether engaged in the independent or institutional practice of medicine, must possess an unrestricted license to practice his profession in the governmental jurisdiction in which his practice is located unless the physician is formally enrolled in a medical educational program approved for such training;

8. That a required component of an accredited graduate medical educational program for FMG's consist of a formal orientation and educational experience incorporating appropriate curriculum content and of sufficient duration to insure the proper orientation of FMG's to the U.S. systems of medical education and health care as well as the acquisition of an adequate understanding of the basic medical sciences, the English language, and U.S. culture;

9. That such acculturative experiences be conducted under the sponsorship of appropriate educational agencies and where feasible and appropriate on an areawide or regional basis;

10. That, in exercising its appropriate responsibility for national policies in graduate medical education, the Coordinating Council on Medical Education formulate national policies with respect to medical educational programs for FMG's; that the Liaison Committee on Graduate Medical Education be assigned responsibility for the accreditation of all graduate medical educational programs in which FMG's are enrolled, including fellowships and other special programs; and that the Educational Commission for Foreign Medical Graduates (ECFMG) be delegated responsibility for the planning of a comprehensive national program designed to improve the professional and related skills of all FMG's coming to the U.S. for graduate medical education.

11. That the funds necessary to establish and maintain for a five-year period the national programs encompassed in the above recommendations be secured through foundations, Federal grants and voluntary contributions of concerned national, state and local organizations.

II. Specific Recommendations

There are significant differences between the problems (and appropriate measures to resolve these problems) presented by physicians born and educated in foreign countries who come to obtain additional education in the United States with the intent of returning to their homeland when they have achieved their educational goal and those who enter with the interest of settling and practicing medicine on a career basis in the United States. The former are temporary visitor physicians usually gaining admission to this country under regulations established by the U.S. Information and Educational Exchange Act of 1948, as amended. Recommendations regarding those visitors are set forth in Section II-A below; recommendations regarding foreign national physicians seeking permanent residence in the U.S. are set forth in Section II-B; and recommendations pertaining to U.S. nationals who have studied medicine abroad are set forth in II-C. Recommendations on an inextricably related set of issues, namely U.S. assistance to international medical education and particularly assistance to medical education in developing countries, the source of all but a small fraction of the FMG's now migrating to the U.S., are encompassed in Section II-D.

A. Recommendations on Temporary Visitor Physicians

Since 1962 over 55,000 foreign medical graduates have been admitted to the United States as exchange visitors in programs authorized

by the Mutual Educational and Cultural Exchange Act of 1961 (The Fulbright-Hayes Act).* The purposes of that Act are: "The improvement and strengthening of the international relations of the United States by promoting better mutual understanding among the peoples of the world through educational and cultural exchanges."

In conformity with the intent of the authorizing legislation, the CCME recommends:

1. That admission of foreign medical graduates to the United States as exchange visitors be limited to the defined purposes and the limited period of time authorized by Department of State regulations governing designated exchange visitor programs; improved safeguards should be established to prevent the employment of exchange visitor programs as alternate pathways for FMG's to immigrate to the United States;

2. That FMG's coming to the U.S. as exchange visitor physicians be assured high quality graduate medical education especially designed to improve their medical knowledge and skills for teaching and practice in their own country;

3. That commencing July 1, 1976 the sponsorship of FMG's coming to the U.S. for graduate medical education as exchange visitor physicians be limited only to accredited U.S. medical schools or other accredited schools of the health professions;

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*As defined by Federal Regulations an exchange visitor is a foreign national who has entered the United States temporarily on a J-1 visa for an educational or cultural experience and as a participant in a program designated by the Secretary of State as an Exchange Visitor Program. An exchange visitor may be paid and may accept a stipend for meaningful contributions or valuable services rendered to the institutional or agency sponsor of the designated program. The State Department has designated AMA approved internships and residencies sponsored by hospitals and related institutions not a part of educational institutions as P-II Exchange Visitor Programs.

4. That such medical schools or schools of the health professions specifically approved by the LCGME to sponsor exchange visitor physicians for graduate medical education should

a. Have the capability to develop programs tailored to meet the needs of each accepted exchange visitor physician;

b. Have developed the necessary attitudes and resources needed to achieve mutual cultural understanding between these exchange visitor physicians and those with whom they will be associated in the institution.

c. Have clearly demonstrated that all interinstitutional arrangements made for the development of especially tailored programs are specifically entered into for the benefit of the exchange visitor;

5. That the U.S. Government through the State Department enter into agreements with the governments of other countries wherein the medical educational system of the U.S. agrees to provide specific types of graduate medical education for individual physicians who have been designated to fill key educational, governmental or other professional posts in that country. Within the framework of governmental agreements, individual educational institutions in this country should make appropriate agreements with recognized educational agencies and institutions in other countries. Candidates selected for such educational experience in the U.S. would be required

before entering into such training to meet standards of professional preparation established by the U.S. educational institutions and accrediting agencies, would be committed to return to their home country on the completion of the agreed upon educational program and would be assured of previously specified academic, governmental or other professional appointments on their return to their home country;

6. That the issuance of an exchange visitor visa be contingent upon each FMG applicant submitting to the U.S. sponsoring educational institution acceptable evidence that he meets its standards of educational attainment, has demonstrated the potential to adapt to the cultural milieu in which he will be studying in the U.S. as well as an effective mastery of the English language and, if his educational experience is to include training at the level of hospital residency, that he has met in a manner acceptable to the LCGME a minimally acceptable standard of professional competence for assuming responsibility for patient care under supervision;

7. That the duration of graduate medical education in the U.S. of all exchange visitor physicians be specified in advance of entering into such training, be limited, in general, to two years or less and be subject to extension only on the request initiated by their governmental and institutional or agency sponsors assuring them of employment on completion of the extended training period;

8. That the Directory of Approved Internships and Residencies identify the graduate medical education programs approved by the LCGME available to FMG's seeking educational opportunities as exchange visitors, and that the ECFMG be prepared to provide information to FMG's concerning the types of

training offered (specialty or other), the number of training positions approved and the number of training positions filled. In addition ECFMG should provide current statistical data on the operational aspects of educational exchange programs, and periodic evaluation of whether these programs are achieving their assigned purposes and whether exchange visitor physicians are fulfilling the commitments made when they accepted a temporary visa to enter the U.S. for graduate medical education;

9. That, as an integral part of this country's international education and cultural exchange activities, Federal funds be authorized and appropriated on an annual basis to support this national coordinated graduate medical education program for exchange visitor physicians;

10. That the Congress be asked to review and reconsider those amendments to the Immigration and Naturalization Act enacted in 1970 (PL 91-225) that permit FMG's and other exchange visitors to convert a temporary visa granted for educational and cultural exchange purposes to permanent immigrant status; and

11. That the granting of H-1 temporary visas* to FMG's be restricted to foreign nationals of "distinguished merit and ability" who have

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*The 1970 amendments to the Immigration and Naturalization Act (P.L.91-225) redefines the H category of temporary visitors as follows: "(H) An alien having a residence in a foreign country which he has no intention of abandoning (1) who is of distinguished merit and ability and who is coming temporarily to the United States to perform services of an exceptional nature requiring such merit and ability; or (2) who is coming temporarily to the United States to perform temporary services or labor, if unemployed persons capable of performing such service or labor cannot be found in this country; or (3) who is coming temporarily to the United States as a trainee, and the alien spouse and minor children of any such alien specified in this paragraph if accompanying him or following to join him."

been invited by universities and other appropriate institutions and agencies to teach and conduct research.

B. Recommendations on Foreign National Physicians Seeking Permanent Residence

Since 1962 more than 43,000 FMG's, graduates of no less than 400 different foreign medical schools and representing over 100 nationalities have been admitted to the United States as immigrants. The problems they face in qualifying for a licence to practice medicine in one or another of the 55 licensing jurisdictions in the U.S. are primarily reflections of the wide variations that exist among countries in standards of medical education and of medical practice in those countries. The possession of a medical degree or even a license to practice medicine obtained in one country does not and should not qualify a physician automatically to practice in another; to disregard these considerations in the administration of our immigration policies will deleteriously affect existing standards of medical education and medical practice in the U.S.

The CCME recommends:

1. That physicians seeking admission to the United States as permanent residents be neither discriminated against in obtaining immigration visas nor assigned special occupational preference for such visas based solely on their possession of a medical degree; physicians (and other health personnel so designated--nurses, pharmacists, physical therapists and dieticians) should not be singled out for blanket (Schedule A) certification by the Labor Department for the issuance of preference of non-preference immigration visas;

2. That in order to qualify for a Third or Sixth Preference immigration visa,* an applicant physician should be required to demonstrate to the Department of Labor that he possesses an unrestricted license to practice medicine in a State or other licensing jurisdiction of the United States or has reasonable prospect of qualifying for such licensure; i.e., he has been accepted for graduate medical education in a program approved by the Liaison Committee on Graduate Medical Education;

3. That, in granting labor certification to an alien physician applying for an immigration visa, the Department of Labor should not base its determination on the premise that there is an insufficient supply of physicians in the United States as a whole; consideration should be given to the wide ranges of physician-population ratios that exist in different geographic areas of the United States and to the specialty distribution of physicians already in the area in which the alien physician proposes to locate;

4. That physician shortage areas in the U.S. designated by the Labor Department for immigration purposes should coincide with physician shortage areas designated by the Department of Health, Education, and Welfare for the assignment of National

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*The 1965 Amendments to the Immigration and Naturalization Act (P.L.89-236) assigned preferential status to immigrants with close kin living in the United States or with professional and technical skills in short supply in this country. Third Preference applies to "qualified immigrants who are members of the professions, or who because of their exceptional ability in the sciences or the arts will substantially benefit prospectively the national economy, cultural interests or welfare of the United States." Sixth Preference applies to "qualified immigrants who are capable of performing specified skilled or unskilled labor, not of a temporary or seasonal nature, for which a shortage of employable and willing persons exist in the United States."

Health Service Corps personnel, for service repayment of Physician Shortage Area Scholarships and of Health Professions Educational Loans or for other purposes; such shortage area determinations should also be subject to review by and concurrence of state or regional health planning authorities including appropriate medical societies;

5. That state legislatures and medical licensure boards adopt eligibility requirements and qualifying procedures for licensure that are uniform for all states and apply equally to U.S. and foreign medical graduates;

6. That eligibility requirements for medical licensure in every State, applicable to both FMG's and USMG's, include two or more years of supervised graduate medical education at the hospital residency level in a program approved for such training by the Liaison Committee on Graduate Medical Education;

7. That eligibility requirements for graduate medical education at the hospital residency level include the provision that all physicians, FMG's as well as USMG's, entering such training meet in a manner to be determined by the LCGME, a minimally acceptable standard of professional competence requisite for assuming responsibility for patient care under supervision;

8. That, in addition, FMG's who have received their undergraduate medical education in a medical school not accredited by the Liaison Committee on Medical Education and who are seeking appointment to an approved residency program be required to demonstrate through appropriate testing procedures acceptable to the LCGME that they meet standards of educational attainment equivalent to those expected of graduates of accredited medical schools, that they have the potential to adapt to the cultural milieu in which they will be pursuing their residency training and that they have achieved an effective mastery of the English language;

9. That the ECFMG in addition to the responsibilities for coordination of educational programs for exchange visitor physicians referred to in Section A above, be assigned responsibility for;

a. the administration of improved screening procedures, preferably as a prerequisite for the issuance of immigration visas to FMG's seeking to immigrate to the U.S. and seeking appointments in approved residency programs, and

b. the planning of a comprehensive national program designed to improve the professional and related skills of all immigrant physicians seeking to engage in the practice of medicine in the United States;

10. That the Directory of Approved Internships and Residencies list the graduate medical education programs approved by the LCGME available to immigrant physicians seeking residency level training, the types of training offered (specialty or other), the number of positions offered and the number of positions filled (including the respective number of FMG's and USMG's

in training in the same program.) ECFMG, in addition to providing current statistical data on the operational aspects of these programs, should evaluate periodically whether these programs are fulfilling their assigned purposes and whether immigrant physicians are being effectively integrated within the U.S. health care system;

11. That on an interim basis special programs of graduate medical education be organized under the sponsorship of accredited medical schools for immigrant physicians who have failed to qualify for approved residencies and who have immigrated to this country prior to January 1, 1976; immigrant physicians applying to such programs must present credentials acceptable to the sponsoring schools; the purposes of these special programs are:

a. To provide a proper orientation to our health care system, our culture and the English language, and

b. To identify and overcome those educational deficits that handicap FMG's in achieving their full potential as physicians in the U.S. health care system; and

12. That exceptions to these policies and procedures for immigrant physicians seeking to practice their profession in the U.S. be permitted only under unusual circumstances, e.g., when a distinguished medical educator or research scholar seeks to take up permanent residence in the U.S.

C. Recommendations on U.S. Nationals Studying Medicine Abroad

Between 4,000 and 6,000 American citizens are believed to be currently enrolled in medical schools located outside of the U.S.,

almost 1,800 of them in a single medical school in Mexico.(7) Such an aggregate estimate of U.S. nationals studying medicine abroad is equivalent to the total enrollment of ten to fifteen average-sized medical schools in this country. Only the 16 Canadian schools, providing educational opportunities for approximately 100 U.S. medical students, are subject to accreditation procedures identical with those required of all U.S. medical schools.

U.S. students contemplating medical education abroad have not had access to reliable information about entrance into U.S. graduate medical education or requirements of the various licensing jurisdictions for full and unrestricted licensure on their return to the United States. The number of U.S. applicants to medical schools will far exceed for some years to come those who can be accepted in U.S. medical schools despite the significant and continuing expansion of enrollments in existing U.S. schools and the establishment of a number of new schools in the past 10 years.

In 1968, two of the major national medical associations most directly concerned with medical education in the U.S. jointly endorsed the position "that all medical schools should now accept as a goal the expansion of their collected enrollments to a level that permits all qualified applicants to be admitted. As a nation we should address the task of realizing this policy goal with a sense of great urgency." This aim has not been achieved and does not appear to be feasible today. In all probability an alternate and sounder approach is now in order, namely, "a broadly based effort...to study the long term future requirement for physicians in the United States,

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(7) Foreign Medical Students in the Americas: 1971-72, U.S. Department of Health, Education, and Welfare, DHEW Publication No. (HRA) 74-27, G.P.O. Washington, D. C., December 1973.

with enrollment levels to be adjusted accordingly."[8]

The CCME recommends:

1. That continuing efforts be made to establish and maintain the United States as self-sufficient in meeting its future health manpower needs;

2. That every American interested in and qualified for entry to the study of medicine be assured equal opportunity to compete for admission to an accredited U.S. medical school; unsuccessful candidates should be encouraged through counseling to enter an alternative career rather than to enroll in a medical school abroad where the quality of medical education may fail to meet U.S. standards and may be inappropriate to U.S. health care needs; those who counsel students in high schools and colleges should be better informed about medical education and practice in giving guidance to students who indicate an interest in medicine;

3. That U.S. medical schools continue and expand their use of the Coordinated Transfer Application System (COTRANS) established by the Association of American Medical Colleges in 1970 to facilitate and accelerate the reintroduction into the mainstream of American medical education larger numbers of qualified U.S. nationals enrolled in foreign medical schools as of July 1, 1975;

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(8) Schofield, J.R., The Stork, Admission to Medical School, Going to a Foreign School and Other Hazards, (Editorial), Journal of Medical Education 48:693-695, July 1973.

4. That pending the achievement of the objective set forth in recommendation C-1 above, funds be made available to assist U.S. medical schools in underwriting the special costs of educational programs for U.S. nationals who are studying in or have graduated from foreign medical schools; and

5. That eligibility requirements for U.S. nationals who have obtained their medical degrees in a medical school not accredited by the Liaison Committee on Medical Education and who seek to enter graduate medical education or to qualify for medical licensure in the U.S. be identical with those required of other graduates of unaccredited medical schools.

D. Recommendations on U.S. Assistance to Medical Education in Developing Countries

The "pull factors" drawing these FMG's to the U.S. have been reasonably well defined. The "push factors" impelling larger and larger numbers of recent medical graduates in developing countries to seek additional training or career opportunities elsewhere than in their homeland are beginning to attract the attention they deserve. Basic responsibility for the resolution of the economic, cultural, professional, and other problems underlying these international migrations must rest within the countries in which these physicians originate. Nonetheless, the United States can, with great benefit to its own interests, materially assist lesser developed countries in finding solutions to their most pressing medical educational problems.

The CCME recommends:

1. That an educational exchange program be established as

an integral component of U.S. foreign policy to assist developing countries in strengthening their own medical and other health professions schools; the objective of this program should be to encourage those countries to establish and maintain educational institutions meeting their own educational standards and which prepare indigenous health manpower specifically to utilize locally available resources in meeting local needs;

2. That the U.S. participate in and support the current efforts of the World Health Organization and associated United Nations agencies to study in detail the worldwide problems resulting from the international migration of physicians and nurses;

3. That cooperative educational programs be developed as a demonstration of the potentials of medical educational exchange for mutual benefit in which medical schools in developing countries share with U.S. medical schools in the training of both American and foreign medical graduates;

4. That the U.S. support both directly and through WHO and other U.N. agencies programs of education in preventive medicine, public health and comprehensive health care in developing countries to meet the mass needs of rural and urban populations now receiving little or no health care;

5. That provisions be made for foreign medical graduates to participate in service programs experimenting with new

ways of meeting community needs in the U.S. so as to provide selected foreign medical graduates an educational experience demonstrating approaches which may assist them in developing similar or related activities in their own country.

III. Implementation of Recommendations

The 44 recommendations offered above parallel and in some instances coincide with the recommendations made in 1967 by the Panel on Foreign Medical Graduates and endorsed by the National Advisory Commission on Health Manpower. Many of the highly pertinent recommendations made at that time have not yet been implemented. In the interim the full effect of the 1965 and 1970 amendments to the Immigration and Naturalization Act has greatly encouraged FMG's to migrate to the United States. This migration has been particularly from less economically advanced countries where standards of medical education and medical practice are not equivalent with our own and cultural backgrounds are quite different from those of the U.S. These amendments have also resulted in a marked increase in the number of foreign national physicians remaining permanently in the U.S. Moreover, in this same period, larger and larger numbers of U.S. nationals have enrolled in medical schools abroad. The majority of these U.S. nationals fail to complete the required course of instruction; even those who obtain a foreign medical degree encounter serious difficulties in qualifying for medical licensure in the U.S.

In setting forth its recommendations, the National Advisory Commission expressed the hope that they be implemented through the voluntary acceptance of appropriate responsibility, by government, universities, the health professions and other organizations and agencies.

Until now there has been no organizational framework on a nationwide scale for such coordinated voluntary action related to key educational components of the issues and problems involving FMG's.

It is the conclusion of the Coordinating Council on Medical Education that the CCME and its associated Liaison Committees are an appropriate mechanism to implement the recommendations on foreign medical graduates set forth in this report. Accordingly, to accelerate such implementation, the CCME recommends:

1. That the report be forwarded to the five parent bodies of of the CCME for review and approval;

2. That CCME assume leadership responsibility for the adoption of sound national policies affecting the graduate medical education of FMG's and their proper role in the U.S. health care system as recommended in the report;

3. That, after approval by the five parent bodies, the report be circulated for comment among appropriate representatives of all concerned national organizations, Federal agencies and other selected individuals; and

4. That there be convened promptly thereafter, in association with other related agencies, an invitational conference of key representatives of national professional associations, other concerned national organizations, and of selected Federal agencies to consider the policy issues and recommendations incorporated in this report and to adopt a coordinated implementation program.

TABLE 1

U.S. Physician (M.D.) Supply 1963-1972

	1963	1972	Increase Number	Increase Percent
Total Physicians	275,140	356,534	81,394	29.6
U.S. Medical Graduates	238,571	282,257	43,686	18.3
Foreign Medical Graduates	36,569	74,277	37,708	103.1
Canadian	5,644	6,268	624	11.1
Other	30,925	68,009	37,084	119.9
Percent FMG's	15.3	20.8		
Physicians/10,000 Population				
Total	14.5	17.1		
U.S.M.G.'s	12.6	13.5		
FMG's	1.9	3.6		
Total U.S. Population (in thousands)	189,242	208,842	19,600	10.4

Source: Distribution of Physicians in the United States, 1963 and 1972, Center for Health Services Research and Development, American Medical Association, Chicago.

TABLE 2

Licentiates Representing Additions
to the Medical Profession in the U.S.
1950 - 1973

	Total	USMG's Number	FMG's Number	FMG's Percent
1950	6,002	5,694	308	5.1
1951	6,273	5,704	450	7.2
1952	6,885	6,316	569	8.3
1953	7,276	6,591	685	9.4
1954	7,917	7,145	772	9.8
1955	7,737	6,830	907	11.7
1956	7,463	6,611	852	11.4
1957	7,455	6,441	1,014	13.6
1958	7,809	6,643	1,166	14.9
1959	8,269	6,643	1,626	19.7
1960	8,030	6,611	1,419	17.7
1961	8,023	6,443	1,580	19.7
1962	8,005	6,648	1,357	17.0
1963	8,283	6,832	1,451	17.5
1964	7,911	6,605	1,306	16.5
1965	9,147	7,619	1,528	16.7
1966	8,851	7,217	1,634	18.5
1967	9,427	7,346	2,081	22.1
1968	9,766	7,581	2,185	22.4
1969	9,978	7,671	2,307	23.1
1970	11,032	8,016	3,016	27.3
1971	12,257	7,943	4,314	35.2
1972	14,476	7,815	6,661	46.0
1973	16,689	9,270	7,419	44.5
TOTAL	214,961	168,235	46,607	21.7
Averages:				
1950-54	6,871	6,290	557	8.1
1955-59	7,747	6,634	1,113	14.4
1960-64	8,050	6,628	1,423	17.7
1965-69	9,434	7,487	1,947	20.6
1970-73	13,614	8,261	5,353	39.3
1950-73	8,957	7,010	1,942	21.7

Source: Medical Licensure 1973, Statistical Review, Journal of the American Medical Association, 229:445-456, July 22, 1974.

TABLE 3

M.D. Licentiates, Additions to
the Medical Profession
1973

States (or Territories) with 50 Percent or more Initial Licenses Granted to FMG's

STATE	USMG's	FMG's	TOTAL	PERCENT FMG's
Virgin Islands	0	2	2	100.0
Maine	26	216	242	89.8
North Dakota	12	65	77	84.4
Delaware	11	33	44	75.0
Puerto Rico	47	117	164	71.3
Michigan	342	844	1,186	71.2
New Hampshire	8	18	26	69.2
New Jersey	86	192	278	69.1
Illinois	345	766	1,111	68.9
Pennsylvania	501	938	1,439	65.2
District of Columbia	91	153	244	62.7
Virginia	145	244	389	62.7
Florida	230	348	578	60.2
Wyoming	2	3	5	60.0
New York	973	1,426	2,399	59.4
Missouri	141	204	345	59.1
Rhode Island	19	23	42	54.7
Vermont	95	104	199	52.3
West Virginia	45	48	93	51.6
TOTAL - Above 19 States	3,119	5,744	8,863	64.8
TOTAL - All States	9,270	7,419	16,689	44.45

Source: Medical Licensure, 1973, Statistical Review, Journal of the American Medical Association, 229:445-456, July 22, 1974.

TABLE 4

STUDENTS AND GRADUATES IN MEDICAL AND BASIC SCIENCE SCHOOLS*

YEAR	NUMBER OF SCHOOLS	1ST YEAR ENROLLMENT	TOTAL ENROLLMENT	GRADUATES
1930-31	76	6,456	21,982	4,735
1940-41	77	5,837	21,379	5,275
1950-51	79	7,177	26,186	6,135
1960-61	86	8,298	30,288	6,994
1970-71	103	11,348	40,487	8,974
1971-72	108	12,361	43,650	9,551
1972-73	112	13,726	47,546	10,391
1973-74	114	14,044***	51,000**	11,862**

*Table developed from information published annually, *Medical Education in the United States*, The Journal of the American Medical Association.

** Estimates

*** AAMC *DATAGRAM*

TABLE 5

AMA Approved Internships and Residencies 1950-51 to 1970-71 and 1972-73

	Total Positions Offered	Total Positions Filled	Positions Filled by U.S. & Can. Graduates	Positions Filled by FMG's	Positions Vacant
Internships					
1950-51	9,370	7,030	6,308	722	2,340
1955-56	11,616	9,603	7,744	1,859	2,013
1960-61	12,547	9,115	7,362	1,753	3,432
1965-66	12,954	9,670	7,309	2,361	3,284
1970-71	15,354	11,552	8,213	3,339	3,802
1972-73	13,650	11,163	7,239	3,924	2,487
Residencies					
1950-51	19,364	14,495	13,145	1,350	4,869
1955-56	26,516	21,425	17,251	4,174	5,091
1960-61	32,786	28,447	20,265	8,182	4,339
1965-66	38,979	31,898	22,765	9,133	7,074
1970-71	46,584	39,463	26,495	12,968	7,121
1972-73	51,658	45,081	30,610	14,471	6,577
Both					
1950-51	28,734	21,525	19,453	2,072	7,209
1955-56	38,132	31,028	24,995	6,033	7,104
1960-61	45,333	37,562	27,627	9,935	7,771
1965-66	51,933	41,568	30,074	11,494	10,358
1970-71	61,938	51,015	34,708	16,307	10,923
1972-73	65,308	56,244	37,849	18,395	9,064

Source: Medical Education in the United States 1972-73, Table 25, JAMA 226:939, Nov. 19, 1973.

TABLE 6

Applicants, Acceptances, New Entrants and First Year Enrollment, U.S. Medical Schools, 1963-1964 to 1972-1973

First-Year Class	Number of Applicants	Number of Applications	Applications per Individual	Accepted Applicants	New Entrants	First-Year Enrollment*	Percent of Total Applicants Accepted
1963-64	17,668	70,063	4.0	9,063	8,565	8,842	51.3
1964-65	19,168	84,571	4.4	9,043	8,587	8,836	47.2
1965-66	18,703	87,111	4.7	9,012	8,554	8,760	48.2
1966-67	18,250	87,627	4.8	9,123	8,775	8,991	50.0
1967-68	18,724	93,332	5.0	9,702	9,314	9,473	51.8
1968-69	21,118	112,195	5.3	10,092	9,740	9,863	47.9
1969-70	24,465	133,822	5.5	10,547	10,269	10,422	43.1
1970-71	24,987	148,797	6.0	11,500	11,169	11,348	46.0
1971-72	29,172	210,943	7.2	12,335	12,088	12,361	42.3
1972-73	36,135	267,306	7.4	13,757	13,352	13,677	38.1

* Includes previously enrolled students.

Source: Dubé, W. F., Applicants for the 1972-73 Medical School Entering Class, Datagram, Journal of Medical Education 48:1161-1163, December 1973.

U.S. FACULTY VISITING AT THE UNIVERSIDAD AUTONOMA DE GUADALAJARA

During the past year, the Medical Faculty of the Universidad Autonoma de Guadalajara instituted a visiting American professor program for the U.S. citizens enrolled in the medical school. Faculty were recruited to cover clinical topics through lectures and patient demonstrations. Areas covered were cardiology, endocrinology, gastroenterology, infectious disease, respiratory disease, neurology, ophthalmology, otolaryngology, psychiatry, orthopaedics, hematology and renal disease. Lectures on forensic and social medicine were also provided.

Sixty-nine faculty members from U.S. medical schools were recruited; each spent approximately ten days in Guadalajara. They were encouraged to bring their families and expenses were paid in lieu of an honorarium. Forty-two faculty came from schools in the Northeast region, four from the South, seven from the Midwest and eleven from the West.

The precise length of the academic term in Guadalajara is not known. Using the average 38 week term for the third year in U.S. medical schools, and assuming a ten day contribution by each visiting faculty member, it can be calculated that U.S. faculty provided approximately three full-time equivalent faculty for the teaching of clinical topics.

This development at Guadalajara raises several serious questions.

1. It may be assumed that this English-speaking faculty is providing a significant portion of the education of the U.S. students, many of whom have difficulty because of their lack of training in Spanish and therefore are not able to benefit maximally from their Mexican professors' lectures and demonstrations. Is it acceptable pedagogically to teach all of the clinical subjects listed above in the lecture-demonstration format with a faculty of three full-time equivalents? Would this be tolerated in U.S. medical schools? What are the implications?

2. How will providing these educational services to a foreign school be viewed when U.S. faculty generally claim to be overburdened by the steadily increasing student bodies in their own institutions?

3. The Universidad Autonoma de Guadalajara has a specific policy of charging high tuition and fees to the U.S. students it can attract in order to provide lower tuition and fees for Mexican citizens. Should U.S. faculty provide services to a school with these policies?

This year another cadre of faculty are being recruited. It appears that about the same number will respond. What should the stance of the CAS and the AAMC be?

INPUT INTO RETREAT AGENDA

During the first week in December, the Chairman and Chairman-Elect of the Councils and the Chairman and Chairman-Elect of the Assembly, will meet with selected AAMC staff to discuss AAMC activities and plan the Association's programs for the coming year. Areas of concern which members of the Council of Academic Societies believe should be called to the attention of the Association officers should be brought up during the discussion of the Retreat Agenda. The Annual Report of the Association, which has been distributed to you, provides information regarding Association activities during the past year.

BIOMEDICAL RESEARCH ETHICS PANEL

The Biomedical Research Act of 1974, which became law in July, contained both authority for research training and mandated the establishment of a National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. In September, Secretary Weinberger announced the composition of the eleven-member Commission. Members of the Commission from within the medical profession include:

Bob Cooke, M.D., Vice Chancellor for Health Sciences, University of Wisconsin Medical School;
Joseph Brady, Ph.D., Behavioral Biology Professor, Johns Hopkins University School of Medicine;
Ken Ryan, Chairman, Department of Obstetrics-Gynecology, Harvard Medical School;
Donald Seldin, M.D., Chairman, Department of Medicine, U. of Texas Southwestern Medical School;
Albert Johnson, a Jesuit Priest at the University of California, San Francisco.

Non-medical members of the Commission include:

Dorothy Height, President of the National Council of Negro Women;
Patricia King, Professor of Law at Georgetown University;
Karen Labacqz, Pacific School of Religion in Berkeley, California;
David Louisell, Professor of Law at the University of California, Berkeley;
Elliot Stellar, University of Pennsylvania Physiological Psychologist;
Robert Turtle, a lawyer from Washington, D.C.

The members of this Commission will elect their own chairman.

FEASIBILITY STUDY OF RESEARCH MANPOWER ALLOCATIONS BY THE INSTITUTE OF MEDICINE

The National Research Service Award Act of 1974, which was enacted on July 12, 1974, specified that the Secretary of the Department of Health, Education and Welfare should request the National Academy of Sciences to conduct a study of the Nation's needs for biomedical and behavioral research personnel. On September 21, 1974, the governing board of the National Research Council authorized a feasibility study to be carried out under the responsibility of the Commission on Human Resources of the National Research Council. It is anticipated that this study will take about 4 months and should be completed early in 1975. The AAMC was requested to nominate individuals both for the steering committee and the various disciplinary panels.

A brief progress report on this study will be presented to the CAS at its business meeting.

COMMISSION ON BIOMEDICAL RESEARCH POLICY

The National Cancer Act of 1974 mandated the establishment of a biomedical research panel composed of the Chairman of the President's Cancer Panel and six additional members appointed by the President. The proposed panel shall review, identify, assess and make recommendations with respect to policy issues concerning the organization and operation of biomedical and behavioral research programs conducted and supported by the National Institutes of Health and the National Institutes of Mental Health over a fifteen month period. The composition of this panel has been the subject of intense discussion over the past several weeks and it is anticipated that a progress report will be made at the business meeting of the CAS.

STATUS OF MEDICAL COLLEGE ADMISSIONS ASSESSMENT PROGRAM

The Medical College Admissions Assessment Program (MCAAP) is now in its second full year of development. The first year of program development was devoted to a series of regional meetings with admissions officers, faculty, members of the Organization of Student Representatives and college premedical advisors for the purpose of defining the scope of a revised admissions assessment program.

The report of the National Task Force for MCAAP was presented at the Annual Meeting in 1973. Subsequently, the Executive Council appointed a committee to review the task force reports. That committee recommended that the Association proceed as rapidly as possible to develop an entirely new battery of cognitive assessment instruments to replace the Medical College Admission Test. These instruments are to be in the areas of Reading Comprehension, Quantitative Ability, Physics, Chemistry and Biology. The committee also recommended that the development of non-cognitive assessment instruments should be carried forward as rapidly as possible and that funding should be sought for these developments.

At the recommendation of the committee, the Executive Council appointed a Committee on Admissions Assessment chaired by Cheves McC. Smythe, M.D. During the Summer of 1974, a request for proposals was prepared by the Association staff; five proposals were received from potential contractors and the decision to award a contract to American Institutes of Research of Palo Alto, California was made following review by the Committee on Admissions Assessment and several outside referees. The development of the cognitive portion of the MCAT is now proceeding rapidly and it is anticipated that new test forms will be available by the Spring of 1976.

Dr. Jack Colwill, a member of the Committee on Admissions Assessment, is preparing recommendations for the development of the non-cognitive portion of MCAAP.

COORDINATING COUNCIL ON MEDICAL EDUCATION REPORT

THE PRIMARY CARE PHYSICIAN

The Physician Distribution Committee of the Coordinating Council on Medical Education prepared the following report on primary care physician distribution. The report was accepted by the Coordinating Council last Spring and forwarded to the five parent organizations for approval. The Executive Council of the Association approved the report at its September meeting, with the deletion of one paragraph and a portion of one sentence. These deletions are indicated in the body of the report. To date, the report has been approved by the Association of American Medical Colleges, the American Board of Medical Specialties and the Council of Medical Specialty Societies.

PHYSICIAN MANPOWER AND DISTRIBUTION

The Primary Care Physician

(A Report of the Committee on Physician Distribution
to the Coordinating Council on Medical Education)

In the late 1950's, concern was expressed that an insufficient number of physicians would be available in the future to meet the health care requirements of the public. The physician-population ratio in 1959 was 149/100,000.* The total number of physicians was 235,000. Osteopathic physicians numbered 14,100. Seven thousand four hundred medical students were graduated from American medical schools.

A Consultant Group appointed by the Surgeon General of the U.S. Public Health Service stated in a report (Bane Report)[1] that maintenance of "the present ratio of physicians to population is a minimum essential to protect the health of the people of the U.S." The report also stated, "To maintain the present ratio of physicians to population will require an increase in the graduates of schools of medicine and osteopathy from the present 7,400 a year to some 11,000 by 1975." At the time concern was also expressed about the increasing number of specialists, the decreasing number of general practitioners, and a decrease in the total number of physicians who served families as primary care physicians.

In 1967, a National Advisory Commission on Health Manpower[2] recommended that "The production of physicians should be increased beyond presently planned levels by a substantial expansion in the capacity of existing medical schools and by continued development of new schools."

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*. The ratio published originally in the Bane Report was 141/100,000. In 1963, a national conference on physician statistics revised the categories of physicians and population to be counted. Using the new agreement, the 1959 physician/population ratio became 149/100,000.

The schools of medicine have responded to the challenge for additional physicians, increasing substantially both in number and in size (Tables I, II). A report entitled "AAMC Program for the Expansion of Medical Education"[3] outlined a goal of 15,000 first-year medical students by the bicentennial year of 1976. This figure is likely to be met in 1975. Similarly, the goals announced in the Bane Report have all been achieved, exceeded or are within reach before the 1975 deadline.

Currently, the net rate of increase of the physician population is about 3% per year, while that of the general population is about 1% per year (Table III). This disproportionate rate of growth would seem to indicate that an appropriate balance will be achieved between the total number of physicians and the population in the years ahead. However, many factors could alter the time at which such a balance is achieved, including the advent of national health insurance, policies for the reimbursement for services, changing demands for health care, and different professional patterns for the delivery of care.

If the present output capacity of American medical schools is maintained and if the influx of foreign medical graduates continues at its present level, the total number of physicians will approach 500,000 by 1980. If the number of foreign medical graduates is reduced substantially in future years, the total number could be considerably smaller. If, for example, no foreign medical graduates were admitted after 1975, the total number of physicians in 1980 might be smaller by 40,000 or more. If continued growth in the output capacity of American medical schools occurs, the number will increase.

The production of numbers of physicians is being addressed with good results, but there is also need for an effective geographic and specialty distribution.

Ideally physicians should be evenly accessible to the population in all geographic settings. This is not the case, for physician distribution, like that of

many segments of the population, has been influenced markedly by economic and social conditions and by urban and rural dynamics (Table IV). The result has been dramatic differences in the concentration of practicing physicians in various population areas (Table V).

Of considerable importance is the problem of having the right physician in the right place at the right time. A psychiatrist is of limited utility when obstetrical services are needed. Excessive numbers of secondary and tertiary care specialists will not meet the need for an adequate number of primary care physicians. Obviously the distribution of physicians by medical specialty is comparable in importance to the total number and their geographical distribution.

One of the most important factors in achieving a proper balance of physician manpower is the availability of primary care physicians to provide access to the health care system. The progressively declining number of primary care physicians in this country has evoked wide-spread concern, which is manifest in the attention given to this subject by private organizations and public agencies, including the federal and state governments.

The present situation has evolved because of the increasing number of specialists other than primary care physicians. Adjustments in the rate of production of specialists desirably would be effected by the creation of appropriate incentives rather than by the imposition of regulations and arbitrary controls. The present need for readjustment, however, is sufficiently urgent that a long-range program of incentives should be developed as promptly as possible.

Specialism has developed spontaneously since World War II as a result of the significant increase in biomedical knowledge, potent drugs, and sophisticated diagnostic and therapeutic techniques. This has occurred largely because of the

extensive support of biomedical research by the federal government and foundations since the late forties. As a result of the response to this national mandate, the faculties of medical schools and the staffs of their associated teaching hospitals became composed almost exclusively of non-primary care specialists and subspecialists. The visibility of the primary care physician dwindled to the point where developing physicians choosing a career found no pattern that displayed in an attractive fashion the professional role of the primary care physician. Until the establishment of the American Board of Family Practice in 1969, there was no specialty board that emphasized certification for primary care and provided professional stature and prestige equivalent to that enjoyed by the other recognized specialties.

A primary care physician (or group of physicians) is one who establishes a relationship with an individual or a family for which he provides continuing surveillance of their health needs, comprehensive care for the acute and chronic disorders which he is qualified to care for, and access to the health care delivery system for those disorders requiring the services of other specialists. The physicians who meet this definition today are general/family physicians, general internists, and general pediatricians. To some degree, other specialists, such as cardiologists, gastroenterologists, obstetricians, and general surgeons, also provide primary care, especially access to the health care system. They are not, however, identified either by education or practice as fulfilling consistently all of the requirements of primary care physicians.

Many studies have been made in an attempt to determine the numbers and proportions of physicians needed in each of the various specialties, but there has been no general agreement on the optimal composition of the physician population. However, most observers of the health care field appear to be in agreement that:

1) there is currently an inadequate number of physicians engaged in the delivery of primary care; 2) there is probably an adequate number, or even an excessive number, of physicians engaged in the delivery of certain types of secondary and tertiary care; 3) the proportions of graduates now engaged in graduate medical education, and the nature of that education, are such that the percentage of physicians engaged in primary care is likely to decrease and the percentage engaged in secondary and tertiary care is likely to increase.

The problems related to the education of various kinds of primary care physicians are somewhat different and are accordingly separated in their consideration below.

GENERAL/FAMILY MEDICINE

In recent years there has been a progressive decline in the number and proportions of American physicians who identify themselves as engaged in general or family practice. In 1931, there were 112,000 physicians who classified themselves as general practitioners on AMA's annual directory questionnaires. In 1960, the number had dropped to 75,000; in 1965, it was 66,000; at the end of 1972, it was less than 55,000. While general practice and family practice are not necessarily the same, the decline in the number of general practitioners is certainly indicative of a decline in the number of primary care physicians.

In years past, most physicians entered general practice directly from medical school or after a one-year rotating internship. While there were some general and family practice residencies in existence in the 1950's and 1960's, they were not very successful in attracting American graduates. There was, of course, no recognition afforded those who completed the residencies, since there was no specialty board in that field. As more and more American graduates

entered some kind of residency, the trend away from general practice was accentuated. By the end of 1971, only 1.6% of all of those engaged in graduate medical education were in general or family practice residencies.

Since the American Board of Family Practice was established in 1969, the concept of family practice has achieved considerable visibility and acceptance. The Board, however, should define more clearly the characteristics and contour of the specialty since it is interpreted in a variety of ways.

A new group of residency programs in family practice was established in 1970. These have grown phenomenally, from 62 approved programs with 131 first-year residents in 1970 to 164 approved programs with 756 first-year residents in 1973,* but their proportion of the total field of graduate medical education is still quite small. It is too early to tell whether the early rapid rate of growth will be sustained.

The Millis Commission pointed out that the average age of general practitioners was above that for other physicians in 1965. The average age of general and family practitioners has been increasing over the past decade. Table VI demonstrates the changing age distribution of GP/FP physicians. With most recent graduates entering other fields, the difference has undoubtedly become greater since that time. Consequently, even though the recent growth of family practice residencies looks promising, the current low percentage of those in residencies, together with the attrition from the higher age population of general practitioners, indicates that the proportion of physicians engaged in general/family practice is certain to decline further over the next few years. Only a major change in the career goals of American graduates and continued expansion of the number of family practice residencies will reverse the trend.

There are many factors which influence the career choices of American

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* 1974 figures to be supplied as soon as they are available.

medical graduates, including such things as the nature of the specialty field, its professional challenge and recognition, the environment for practice, monetary rewards in proportion to time demands and service provided, and the availability of professional associates and supporting services. Although there is good evidence today that these factors have been addressed, further effort is required so that family practice will continue to be a desirable field by growing numbers of medical students.

However, student interest is only one factor which will affect the growth rate of family practice residency programs. A very important determinant will be not only the availability of qualified faculty, currently in short supply, but the excellence of the educational programs themselves. Another will be the rate of development of satisfactory models of family practice and appropriate administrative units for the new programs. Substantial additional financial support will be necessary to enable the development of the necessary personnel, resources, and facilities.

INTERNAL MEDICINE AND PEDIATRICS

Residencies in internal medicine and pediatrics have enjoyed sustained popularity over many years. In 1962, 17.7% of all residents were in internal medicine and 5.9% in pediatrics, compared with 13% and 5% respectively engaged in practice in those fields.[4] In 1966, 17% of all residents were in programs in internal medicine and 7% in pediatrics; the proportions engaged in practice in those fields were still 13% and 5% respectively.[5] In 1972, the percentage in residencies in internal medicine had increased to 23.9 and in pediatrics to 7.7. The proportions in practice had increased to 13.5% and 5.5% respectively.[6]

To some extent the growth in internal medicine and pediatrics may offset the decline in general/family medicine. However, there is evidence to show that substantial numbers of internists and pediatricians extend their training into

subspecialty fields and are consequently being prepared to function principally as secondary and tertiary care physicians rather than as primary care physicians (Tables VII and VIII). Once again, this is not to deny that subspecialists provide some primary care, but simply to point out that their education does not direct them toward primary care.

Prior to 1972, the American Board of Internal Medicine had awarded 23,023 certificates. In addition, 2,697 certificates had been awarded in four subspecialty areas; the number of subspecialty certificates was therefore 11% of the number of general certificates. During 1972, 4,378 certificates were given by the American Board of Internal Medicine. The large number was in part the result of a change in certification policy during the previous year. During the previous period 1,611 certificates were authorized in eight subspecialty areas. This number is equivalent to 37% of the number of general certificates issued in 1972. The increment in subcertification has increased the ratio of subcertificates to general certificates from 11% to 15%. Some of the physicians receiving certificates in subspecialty areas were already practicing and do not represent an increment to the subspecialty manpower pool.

Both the American Board of Internal Medicine and the American Board of Pediatrics in recent years have developed additional categories of subspecialization for which certification is provided and more are planned. At the present time, Internal Medicine provides certification in cardiology, pulmonary disease, gastroenterology, endocrinology and metabolism, nephrology, hematology, infectious diseases, medical oncology, and rheumatology. Pediatrics provides certification in cardiology, hematology-oncology, and nephrology. The Conjoint Board of Allergy and Immunology, recently established, certifies physicians in this specialty.

It is almost certain that with additional opportunities for certification in subspecialty areas a progressively larger percentage of those certified in internal medicine and pediatrics will seek certification by a subspecialty board. If this occurs, there may be proportionately fewer internists and pediatricians whose major interest is to provide primary care. An appropriate balance would be desirable, especially since the need for an increased number of primary care physicians is so evident.

The boards of Internal Medicine and Pediatrics can exert considerable influence upon the attainment of this balance if they re-examine their requirements for admission to their certifying examinations so that the educational programs and careers of internists and pediatricians interested in primary care will have at least the same professional prestige as the subspecialty categories of internal medicine and pediatrics. The Liaison Committee on Graduate Medical Education, its sponsoring organizations, and the appropriate residency review committees can, through the "Essentials" and the review of residency programs, devise methods for emphasizing the desirability and needs of strong and attractive educational experiences for internists and pediatricians interested in primary care.

The preceding discussion indicates that the physician/population ratio is increasing rapidly and very likely will attain an acceptable figure by 1980. The distribution of physicians, however, by specialty and location will not be changed significantly. A progressively larger proportion of physicians certified in Internal Medicine and Pediatrics are entering subspecialty fields. Foreign medical graduates already comprise a significant part of the practicing medical profession and the numbers increase yearly. There is a well documented need for additional primary care physicians which in part could be met by providing greater opportunities, incentives, and security for students

and physicians interested in careers devoted to the teaching and provision of primary care.

This report is directed solely to ways in which the educational endeavors of schools of medicine and graduate educational programs may expand the number of primary care physicians. Many factors in addition to education can, and will, influence the numbers and distribution of primary care physicians. For example, policies and programs for the reimbursement of physicians services have a considerable bearing upon not only the numbers of physicians committing themselves to careers in primary care, but also the numbers who will select careers in other specialties. The developing imminence of national health insurance will almost certainly initiate discussions concerning reimbursement policies.

RECOMMENDATIONS

A. As a national goal, schools of medicine should be encouraged to accept voluntarily a responsibility for providing an appropriate environment that will motivate students to select careers related to the teaching and practice of primary care. An initial national target of having 50% of graduating medical students choose careers as primary care specialists appears reasonable.

Schools of medicine accepting this responsibility may direct their attention to one or both of the following mechanisms in order to increase the output of generalists: (1) the development of instructional programs and services for family medicine, or (2) the reorientation of departments of medicine and pediatrics.

1. Medical schools establishing family medicine administrative units are obligated to provide the necessary resources for the development of family practice curricula

and the operation of family practice clinical services in order that medical students may be exposed to suitable career models in family medicine. Financial support from federal and state governments, as well as support from private foundations and the institutions themselves, should be made available for the support of such activities.

The federal and some state governments as well as private foundations have already recognized that the development of the specialty of family practice could, over the course of the next few years, increase the number of primary care physicians in a significant way. Forty-nine schools of medicine have also recognized the need and have responded by creating departments of family medicine or other suitable administrative units.

Schools of medicine seriously interested in promoting the development of primary care physicians through the specialty of family practice recognize the need to establish administrative units that have the same professional stature as other administrative units in the school. In most instances, this requires the addition of new faculty members with primary care skills, and the training of others. If success is to be achieved, other clinical disciplines in a school must be supportive by contributing teaching time and effort to family medicine. These disciplines should also instill in their own residents appropriate attitudes recognizing the consultant's role in relationship to the primary care specialist who provides continuity of care for the patient. The schools will need financial support for the development of new faculty, curricula, and space. Monies already committed for the support of the schools cannot easily be diverted for this purpose.

2. Medical schools should encourage their Departments of Internal Medicine and Pediatrics to have among their goals the creation of an environment that emphasizes the need for and the development of internists and pediatricians for primary care. The professional and

material resources necessary to achieve such goals must also be provided.

The incorporation into the faculty of academically oriented general internists and pediatricians with the same privileges and stature afforded the subspecialists in these departments would accomplish a great deal in changing the image of medicine and pediatrics presented to undergraduate students.

B. Institutions responsible for graduate education, including university-affiliated hospitals, should be encouraged to establish residencies in family practice, internal medicine and pediatrics, with orientation toward primary care. These programs should have equal professional status with educational programs in the medical and pediatric subspecialties.

Although many of the family practice residencies will be located in hospitals whose essential commitment is the delivery of care to a community, it is essential that a family practice unit exist in a university hospital if the desirable features of a career in family practice are to be appreciated by students and young physicians.

In a few institutions, many of the physical patient, and professional resources are already in existence and require only re-allocation for new objectives and programs. In most, new facilities and professional staff will be necessary to establish successful educational programs.

Special emphasis should be given to the creation and financial support of an appropriate ambulatory care setting for the teaching of family practice, internal medicine and pediatrics with orientation toward primary care. Within the ambulatory care setting, physicians should learn to function with other health professionals in order to increase the overall effectiveness and quality of care.

State governments and their agencies responsible for health and education should be aware of the documented fact that the retention of physicians within their jurisdiction is to a significant degree dependent upon the location, the type, and quality of residency programs within the state. Financial support directed to the development of high quality residencies in family practice, and in internal medicine and pediatrics with orientation toward primary care, would almost inevitably be a sound investment on behalf of the people within a state.

C. Educational institutions should be encouraged to develop better methods for the delivery of primary care, including ways of increasing efficiency and effectiveness of primary care physicians and educating physicians to work with other members of the health care team, so that efficient and complete health care may be provided.

This is particularly important because it is impossible to predict precisely the future patterns of the delivery of health care. While it seems likely and indeed desirable that a pluralistic system of health care delivery will continue to exist, it is possible that there will be a strong movement toward the expansion of group practice and the development of health maintenance organizations. Obviously, the profession and its educational institutions must be prepared to respond to such changes with innovative and imaginative educational programs relevant to demonstrated needs.

However the patterns of care develop in the future, it must be emphasized that there is currently a serious need for more primary care physicians and this need will increase in the years immediately ahead. Major efforts and financial support should therefore be provided for increasing the number of family physicians, and internists and pediatricians committed to the delivery of primary care. Support for this development should be provided in addition to, and not at the expense of,

the support for existing programs.

Rev: 5/15/74 CPD

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2. *Report of the National Advisory Commission on Health Manpower.* Washington, D.C., U.S. Government Printing Office, Vol. I, November, 1967.

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TABLE I

STUDENTS AND GRADUATES IN MEDICAL AND BASIC SCIENCE SCHOOLS*

YEAR	NUMBER OF SCHOOLS	1ST YEAR ENROLLMENT	TOTAL ENROLLMENT	GRADUATES
1930-31	76	6,456	21,982	4,735
1940-41	77	5,837	21,379	5,275
1950-51	79	7,177	26,186	6,135
1960-61	86	8,298	30,288	6,994
1970-71	103	11,348	40,487	8,974
1971-72	108	12,361	43,650	9,551
1972-73	112	13,725	47,546	10,391
1973-74	114	14,044***	51,000**	11,862**

*Table developed from information published annually, *Medical Education in the United States*, The Journal of the American Medical Association.

** Estimates

*** AAMC *DATAGRAM*

TABLE II

AVERAGE SIZE OF MEDICAL SCHOOLS, 1930-1974±

YEAR	NUMBER OF SCHOOLS*	AVERAGE 1ST YEAR ENROLLMENT*	AVERAGE TOTAL ENROLLMENT*	AVERAGE GRADUATES**
1930-31	76	85	289	74
1940-41	77	76	277	79
1950-51	79	91	331	85
1960-61	86	96	352	86
1970-71	103	110	393	101
1971-72	108	114	404	102
1972-73	112	123	425	106
1973-74	114	121	447***	109***

* All medical schools.

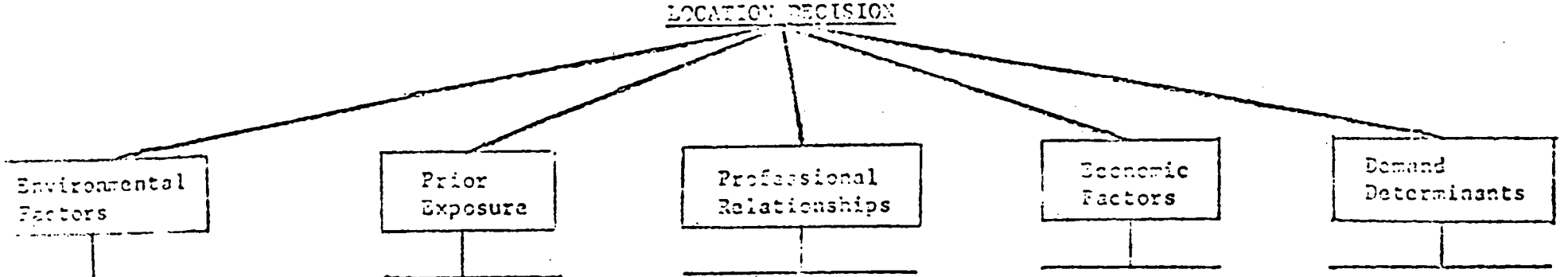
** Excludes schools not graduating students.

*** Estimates.

± Table developed from information published annually, *Medical Education in the United States*, The Journal of the American Medical Association.

TABLE IV

POLICY POTENTIAL OF FACTORS IN LOCATION DECISIONS



Environmental Factors		Prior Exposure		Professional Relationships		Economic Factors		Demand Determinants	
Cultural opportunities	1,2	Place of birth	1	Professional contacts*	4	Income*	4	Population size	1
Quality of educational system	2	Medical school*	4	Stimulation	4	Costs	3,4	Age, sex, race	1
Quality and availability of housing	2	Internship*	4	Opp'ty for continuing education	4	Excess demand*	3,4	Per capita income*	2,3,4
Community security	2	Residency*	4	Opp'ty for utilization of "modern" facilities and techniques	4			Education*	2,4
Pollution	2			Hospitals*	4			Urbanization	2
Intra-regional transport	2			Allied health personnel	4			Population growth	1
Provision of public services	2			Barriers to entry	4			Feedback of physician/population ratio	1,(3)
Information availability	2			Availability of group practice*	4				
Access to shopping	2								
Climate	1								
Recreational facilities	2								

Classification Code:
1. Not subject to policy manipulation
2. Inefficient policy variable
3. Infeasible variable for policy
4. Potential policy variable

Source

McFarland, J.: Toward an Explanation of Geographical Location of Physicians in The United States. In: Contributions to a Comprehensive Health Manpower Strategy, Chic. AMA Center for Health Services, Research Development. Rev. July, 1973 - pp 29-67

* . ..icates variable, in the subset of policy alter... ..s, which seems to be very important

TABLE V

CONCENTRATION OF PRACTICING, NON-FEDERAL PHYSICIANS IN POPULATION AREAS

Metropolitan Area	Resident Population*	Total Non-Fed. Physicians+	Physicians Per 100,000 Pop.
Boston, Mass.	3,388,300	7,624	229
Los Angeles, Calif.	7,062,600	12,632	177
Knoxville, Tenn.	409,500	540	132
Peoria, Ill.	344,800	361	105
Abilene, Tex.	117,200	111	95
Biloxi, Miss.	135,200	108	80
Elkhart, Ind.	132,200	97	74

*As of Dec. 31, 1971.

+As of Dec. 31, 1972.

This table constructed from information published in *Distribution of Physicians in the U.S., 1973, Vol. 2/Metropolitan Areas*. AMA Center for Health Services Research and Development.

Table VI

FP/GP AGE GROUPINGS, 1963 and 1967*

Age Group	1963	1967
Over 50	36,993 (50.28%)	36,883 (53.59%)
Under 50	36,586 (49.72%)	31,947 (46.41%)
Total	73,579 (100%)	68,830 (100%)

*From *Selected Characteristics of the Physician Population, 1963 and 1967.* AMA Department of Survey Research, 1968.

TABLE VII

CHANGE IN SPECIALTY DISTRIBUTION

PRIMARY CARE SPECIALTIES	1965*	1972*	% CHANGE
INTERNAL MEDICINE	38,490	47,994	
PEDIATRICS	15,865	19,610	
GENERAL AND FAMILY PRACTICE	71,366	55,348	
	125,721	122,952	- 2.2
MEDICAL AND PEDIATRIC SUB-SPECIALTIES			
ALLERGY	910	1,638	
CARDIOVASCULAR	1,901	5,883	
GASTROENTEROLOGY	633	1,839	
PEDIATRIC ALLERGY	82	383	
PEDIATRIC CARDIOLOGY	146	514	
PULMONARY DISEASE	1,226	2,065	
	4,898	12,322	+ 151.6
% CHANGE IN RATIO OF MEDICAL AND PEDIATRIC SUB-SPECIALISTS TO TOTAL NUMBER OF INTERNISTS AND PEDIATRICIANS	9.0	18.2	
PRIMARY CARE SPECIALTIES	125,721	122,952	
MEDICAL AND PEDIATRIC SUB-SPECIALTIES	- 4,898	- 12,322	
	120,823	110,630	- 8.4
SURGICAL SPECIALTIES	76,147	91,058	+19.6
OTHER SPECIALTIES	70,809	94,571	+33.6

*Distribution of Physicians in the U.S., 1965, 1972. AMA Center for Health Services Research and Development

TABLE VIII

DISTRIBUTION OF PHYSICIANS IN USA AND POSSESSIONS

Specialty	1965 No.*	%		1972 No.*	%	
General and Family Medicine	71,366	24.45		55,348	15.52	
Internal Medicine	38,690	13.25	43.06	47,994	13.46	34.48
Pediatrics	15,665	5.36		19,610	5.50	
Allergy	910	0.31		1,638	0.46	
Anesthesiology	8,644	3.00		11,853	3.32	
Aviation Medicine	788	0.27		921	0.26	
Cardiovascular Disease	1,901	0.65		5,883	1.65	
Child Psychiatry	817	0.28		2,268	0.64	
Colon & Rectal Surgery	650	0.22		649	0.18	
Dermatology	3,538	1.21		4,227	1.19	
Diagnostic Radiology	38	0.01		2,076	0.58	
Forensic Pathology	51	0.02		194	0.05	
Gastroenterology	633	0.22		1,839	0.52	
General Preventive Medicine	971	0.33		840	0.24	
General Surgery	27,693	9.49		30,989	8.69	
Neurological Surgery	2,045	0.70		2,753	0.77	
Neurology	2,174	0.74		3,494	0.98	
Obstetrics & Gynecology	16,833	5.77		20,202	5.67	
Occupational Medicine	1,745	0.59		2,506	0.70	
Ophthalmology	8,397	2.88		10,443	2.93	
Orthopedic Surgery	7,549	2.59		10,356	2.90	
Otolaryngology	5,325	1.82	56.94	5,662	1.59	65.52
Pathology	8,437	2.89		11,024	3.09	
Pediatric Allergy	82	0.03		383	0.10	
Pediatric Cardiology	146	0.05		514	0.14	
Physical Medicine & Rehab.	1,084	0.37		1,551	0.44	
Plastic Surgery	1,133	0.39		1,786	0.50	
Psychiatry	17,888	6.13		22,570	6.33	
Public Health	2,689	0.92		2,906	0.82	
Pulmonary Disease	1,2[illegible]	0.42		2,065	0.58	
Radiology	9,553	3.27		11,910	3.34	
Therapeutic Radiology	56	0.02		931	0.26	
Thoracic Surgery	1,477	0.51		1,927	0.54	
Urology	5,045	1.73		6,291	1.76	
Other Specialties	--	--		7,010	1.97	
Unspecified	9,750	3.34		8,290	2.33	
Inactive	13,279	4.55		20,110	5.64	
Not Classified	3,566	1.22		12,356	3.47	
Address Unknown	--	--		3,165	0.89	
	291,825	100.00		356,534	100.00	

* Distribution of Physicians in the U.S., 1965, 1972. AMA Center for Health Services Research and Development.

AAMC POLICY STATEMENT ON NEW RESEARCH INSTITUTES AND TARGETED RESEARCH PROGRAMS

The Association of American Medical Colleges reaffirms its strong belief that a key element in the past and future success of our national effort to conquer disease is a strong, diverse, balanced program of high quality biomedical research.

NEW RESEARCH INSTITUTES

The present organizational structure of the National Institutes of Health provides specific attention to various disease categories, organ systems, basic science and the particular needs of various age groups in our population. It is thus a rational arrangement embodying the essential characteristics of diversity and balance. While we recognize that the current structure is not without potential for improvement, we believe it imperative that any modification recognize that an effective national program of support for biomedical research requires an organizational structure with reasonable stability comprised of a limited number of component entities. The fundamental nature of scientific inquiry involves the potential for substantial overlap among projects and programs, thus, the orderly management of scientific programs requires a high degree of coordination. Such coordination would be made more difficult by the proliferation of organizational entities devoted to increasingly narrow concerns. Furthermore, the administrative support required for each new organizational entity imposes new financial burdens and creates additional management complexities for which there is little offsetting benefit. Thus, the Association opposes, as a matter of considered principle, the establishment of additional categorical disease institutes or institutes dedicated to one or more organ systems at the NIH or NIMH. However, the Association recognizes that to accomplish objectives not presently identified it may be necessary to add new responsibilities to existing programs of the various institutes of the NIH/NIMH.

TARGETED RESEARCH

Legislative proposals mandating the establishment of biomedical research programs directed toward specific disease entities should be evaluated in the context of the following considerations.

1. The relative priority of the new programmatic focus in relation to ongoing programs. During a period of constrained budgets, the legislation will increase the emphasis on the identified disease to the detriment of pre-existing programs.

2. An appropriate distinction between research and non-research components of the proposal. The almost insatiable resource demands of service-oriented activities require built-in safeguards if the research activities are to share appropriately in the allocation of resources.

3. The status of the scientific understanding of the disease and the potential for significant progress through a targeted approach. An essential prerequisite for any national program targeted toward the conquest of a specific disease is the

existence of an understanding of the fundamental biological processes underlying the disease in question. In the absence of such knowledge, the search for specific therapeutic treatments must not be over-emphasized to the detriment of investigating the underlying biological phenomena.

4. The suitability of existing legislative authorities for the accomplishment of newly identified objectives. The array of existing authorities provides ample bases and great flexibility for more intensive effort in specifically designated areas.

Finally, the Association believes that the key to our Nation's ability to achieve long-term biomedical research goals is the maintenance of a strong program of fundamental research such as is supported under the aegis of the National Institute of General Medical Sciences. Great care should be taken that our long-term investment in the solution of health problems not be undermined through speculation on short-term and potentially illusory objectives.

For the immediate future, any new legislation dealing with the establishment of new research institutes or targeted research programs should await the comprehensive review of national biomedical research and recommendations of the Biomedical Research Commission, which has been established at the direction of Congress with the passage of the National Cancer Amendments of 1974, PL-93-352.

The four basic programs to which this effort is dedicated includes: the development of procedures for the appraisal of educational materials in non-traditional formats (audio-visual, computer-based instruction and evaluation materials, simulations, etc.); the design and implementation of a clearinghouse system for these materials (AVLINE); the establishment of a needs assessment plan and prioritization for the production of new materials; a review of the problems and potential solutions related to the distribution and retrieval of these materials by students and faculties; and other areas of mutual concern regarding the use of educational technology in health science education.

One of the initial tasks undertaken was that of surveying the medical and dental school faculties in an attempt to ascertain what these individuals have identified as effective educational materials (either self-instructional or lecture support in format), whether they could be made available for panel review and whether they might be available for use by other institutions.

The responses to these queries, added to the survey conducted by the American Association of Dental Schools (AADS) and those previously identified by professional groups and the National Medical Audiovisual Center (NMAC) have identified 22,432 items that could be subjected to review by panelists recommended by academic societies.

Up to the present time, fourteen interdisciplinary panels have been convened to review and appraise educational materials (predominately lecture-support audiovisuals) in neurosciences, cardiovascular system, pathology, periodontics, operative/restorative dentistry, fixed prosthodontics, behavioral sciences, musculoskeletal, reproductive systems, digestive system, orthodontics and pedodontics. The criteria used, the results obtained and a listing of the panelists participating in these reviews is contained in a report entitled "Educational Materials Project Development."

A brief summary indicates that during these fourteen reviews, 2,293 items have been appraised, of which 1,308 have been deemed acceptable for inclusion in the AVLINE data base. A "Highly Recommended" category was achieved by 200 of the accepted items.

The items recommended by the panelists will be included in the National Library of Medicine's data base designated as "AVLINE" which will be tested with users in early 1975. The process of adding to and updating the AVLINE data base is continuous as the Project seeks to identify, evaluate and make available for use those educational materials that have been proven to be effective in medical and dental education.

Educational Technology for Medicine: Roles for the Lister Hill Center, Recommendations for a National Biomedical Communications Network. J. Med. Educ., 46: July, Part 2, 1971.

Educational Technology for Medicine: Academic Institutions and Program Management - Recommendations of a Committee of AAMC to the Medical School Faculties. J. Med. Educ., 48: 203-226, 1973.

MEMBERSHIP CHANGES

The Following Societies Have Withdrawn From The CAS:

Name	Effective Date
American Association of Neuropathologists	November 28, 1973
*Joint Committee on Orthopaedic Research and Education	December 31, 1973
American College of Obstetricians and Gynecologists	June 30, 1974
American College of Surgeons	June 30, 1974

*The Joint Committee on Orthopaedic Research and Education was dissolved.

INSTITUTE OF MEDICINE SOCIAL SECURITY STUDIES

Monday, November 11, 1974
8:00 p.m.
Waldorf Room
Conrad Hilton Hotel

On Monday evening, November 11, Ruth Hanft, Director of the Institute of Medicial Social Security Study, will address a special session of the Meeting. Ms. Hanft, who previously served as Director of the Cost of Medical Education Studies recently completed by the Institute, will present a progress report and discuss the issues involved in the studies which were authorized by the Congress in the Social Security Amendmants of 1973 and are as follows:

1) appropriate and equitable methods of reimbursement for physicians services in hospitals which have teaching programs;

2) the extent to which funds expended under Medicare and Medicaid are supporting the training of medical specialists which are in excess supply;

3) how the funds could be expended to support more rational distribution of physician manpower both geographically and by specialty;

4) the extent to which such funds support or encourage teaching programs which tend to disproportionately attract foreign medical graduates;

5) the existing and appropriate role of such funds which are expended to meet in whole or in part the cost of salaries of interns and residents in teaching programs.

Program on Quality Assurance and PSRO's

Tuesday, November 12, 1974

9 a.m. - 12 noon

"Opportunities in the PSRO Program for Teaching, Research, and Service"

Moderator: Robert J. Weiss, M.D.

9:10	Introductory Remarks - John A. D. Cooper, M.D.
9:20	PSRO Implementation at the National Level - Ruth M. Covell, M.D.
9:40	DHEW Activities in Quality Assurance - Henry E. Simmons, M.D.
10:00	Opportunities for Education in PSRO - Clement R. Brown, M.D.
10:20	Coffee Break
10:30	Opportunities for Evaluation and Research in PSRO - Sam Shapiro and Paul M. Densen, Sc.D.
11:10	Evaluation of National PSRO Program - Michael J. Goran, M.D.
11:30	Summation - Robert J. Weiss, M.D.
11:40	Questions and Answers
12:00	Adjournment

CAS-COD-COTH JOINT MEETING

AAMC ANNUAL MEETING
Wednesday, November 13, 1974
2:00 - 5:15 P.M.

SPECIALTY DISTRIBUTION OF PHYSICIANS

2:00 - 2:30 P.M. *A Congressional Perception of the Problem*

Mr. Stephen E. Lawton
Counsel for the Subcommittee on
Public Health & Environment
of the House Interstate and
Foreign Commerce Committee

2:30 - 3:00 P.M. *Redistribution of Specialty Training Opportunities - Options for the Private Sector*

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

3:00 - 3:30 P.M. *Redistribution of Specialty Training Opportunities - Options for the Government*

Theodore Cooper, M.D.
Deputy Assistant Secretary for Health
Department of Health, Education and
Welfare

3:30 - 3:50 P.M. Intermission

3:50 - 5:15 P.M. Panel Discussion

The panel discussion will take the form of a question and answer session during which the following three individuals will direct questions to the above speakers.

Chairman: Julius R. Krevans, M.D., Dean
University of California, San Francisco
School of Medicine

Robert A. Chase, M.D., Chairman
Department of Anatomy
Stanford University School of Medicine

Charles B. Womer, Director
Yale-New Haven Hospital

Christopher C. Fordham, III, M.D.
U. of North Carolina School of Medicine

SEMINAR ON FOREIGN MEDICAL GRADUATES

Tuesday, November 12, 1974
8:00 p.m.
Williford B & C
Conrad-Hilton Hotel

Moderator: Neal L. Gault, Jr., M.D.
University of Minnesota - Minneapolis

I. The FMG as a Medical Resource

Stanley S. Bergen, Jr., M.D.
College of Medicine and Dentistry of New Jersey

II. FMGs in Specialties

Douglas Eastwood, M.D.
Lister Hill Center

III. The American Medical Student Abroad

Donald W. King, M.D.
Columbia University

IV. The AAMC Task Force Report

Kenneth R. Crispell, M.D.
University of Virginia

Discussion and Panel Session

Robert J. Weiss, M.D.
Harvard Medical School

Betty Lockett
National Institutes of Health

Emanuel Suter, M.D.
Director, Division of International Medical Education
Association of American Medical Colleges