10:20-12 Noon **SESSION V** *Sonora B*

THE ROLE OF EXTERNAL AGENCIES IN SHAPING GME: THE SPECIALTY BOARDS
Charles A. Hunter
Chairman
Dept. of Obstetrics/Gynecology
Indiana University
School of Medicine

THE ROLE OF EXTERNAL AGENCIES IN SHAPING GME: THE LIAISON COMMITTEE ON GRADUATE MEDICAL EDUCATION
August G. Swanson
Director
AAMC Department of Academic Affairs

THE INSTITUTIONAL RESPONSE
James E. Eckenhoff
Dean
Northwestern University
Medical School

Steven C. Beering
Dean
Indiana University
School of Medicine

Sherman M. Mellinkoff
Dean
UCLA
School of Medicine

12 Noon-5:30 p.m. UNSCHEDULED

5:30-7:30 p.m. **SESSION VI** *Sonora B*

THE CANADIAN EXPERIENCE
Arnold Naimark
Dean
University of Manitoba
Medical Faculty

DIRECTIONS FOR THE FUTURE
Frederick C. Robbins
Dean
Case Western Reserve Univ.
School of Medicine

Wednesday, April 20 *Sonora B*

8:30-10:10 a.m. **SESSION VII**

COD BUSINESS MEETING

10:10-10:20 a.m. BREAK *Loggia*

10:20-12 Noon **SESSION VIII**

COD BUSINESS MEETING

12 Noon ADJOURNMENT *Sonora B*

aamc

Association of American Medical Colleges
COUNCIL OF DEANS
SPRING MEETING

PROGRAM

GRADUATE MEDICAL EDUCATION:

"Do we have to do business in the same old way?"

April 17-20, 1977
Scottsdale Hilton Hotel
Scottsdale, Arizona

1977 SPRING MEETING OF THE COUNCIL OF DEANS

April 17-20, 1977

Scottsdale Hilton Hotel
Scottsdale, Arizona

GRADUATE MEDICAL EDUCATION:

"Do we have to do business in the same old way?"

PROGRAM

Sunday, April 17

1:00-6:00 p.m. ARRIVAL & REGISTRATION — *Hotel Lobby*

6:30-8:00 p.m. RECEPTION — *Loggia*

Monday, April 18

8:30-10:20 a.m. **SESSION I** — *Sonora B*

WELCOME & OVERVIEW OF MEETING
John A. Gronvall
Chairman, COD

AN HISTORICAL PERSPECTIVE
Lowell T. Coggeshall

PUBLIC POLICY ISSUES IN GRADUATE MEDICAL EDUCATION
Stephan Lawton
Counsel
House Subcommittee on Health and the Environment

THE NUMBERS—1977
John S. Graettinger
Executive Vice President
NIRMP

A SUMMARY OF THE ISSUES
Chandler A. Stetson
Dean
University of Florida
College of Medicine

10:20-10:30 a.m. BREAK — *Loggia*

10:30-12 Noon **SESSION II** — *Sonora B*

GME: RATIONALE RECONSIDERED
J. Robert Buchanan
President
Michael Reese Hospital and Medical Center

ACADEMIC OBJECTIVES OF GME PROGRAMS
Albert L. Rhoton
Professor of Neurosurgery
University of Florida
College of Medicine

A SCIENCE POLICY PERSPECTIVE
DeWitt Stetten, Jr.
Deputy Director for Science
National Institutes of Health

12 Noon-5:30 p.m. UNSCHEDULED

5:30-7:30 p.m. **SESSION III** — *Sonora B*

WHAT HOUSE OFFICERS DO
Ruth S. Hanft
Visiting Professor
Dept. of Community Medicine
Dartmouth Medical School

A HOSPITAL'S OBJECTIVES IN GME PROGRAMS
Robert M. Heyssel
Executive Vice President and Director
The Johns Hopkins Hospital

FROM OUR PERSPECTIVE—A PANEL OF HOUSE OFFICERS
Christopher C. Baker
Resident in Surgery (R3)
U. of Calif.-San Francisco

James C. Chapin
Chief Resident in Anesthesiology
University of Florida

Ralph M. Stanifer
Resident in Ophthalmology (HO4)
University of Michigan

Basil Genetos
Chief Resident
Department of Internal Medicine
Indiana University

Tuesday, April 19

8:30-10:10 a.m. **SESSION IV** — *Sonora B*

IOM SOCIAL SECURITIES STUDIES REVISITED: IMPLICATIONS OF ALTERNATIVE FINANCIAL SCHEMES
John A. Gronvall
Dean
University of Michigan
Medical School

FUNDING PROSPECTS BEYOND 1977
Walter J. McNerney
President
Blue Cross Association of Chicago

10:10-10:20 a.m. BREAK — *Loggia*

GRADUATE MEDICAL EDUCATION:

Do We Have To Do Business In The Same Old Way?

Proceedings of the Association of American Medical Colleges
Council of Deans Spring Meeting, April 17-20, 1977
Scottsdale, Arizona

IN MEMORIAM

"In gratitude for his service to the Council of Deans and in recognition of his many contributions to the profession of medicine as physician, scholar, teacher and administrator, the Proceedings of the 1977 Spring Meeting are dedicated to:

CHANDLER A. STETSON, M.D.

His warmth and sensitivity profoundly affected both the personal and professional lives of all with whom he worked. The Association of American Medical Colleges will be poorer for the loss of his keen insight, wise judgment and selfless dedication to the Council of Deans, its Administrative Board and the Executive Council."

By action of the Council of Deans
Administrative Board, June 23, 1977

GRADUATE MEDICAL EDUCATION:

"Do We Have To Do Business In The Same Old Way"

**Proceedings of the Association of American Medical Colleges
Council of Deans Spring Meeting, April 17-20, 1977,
Scottsdale, Arizona.**

September, 1977

Association of American Medical Colleges
One Dupont Circle, N.W., Suite 200
Washington, D.C. 20036

PLANNING COMMITTEE

for the

1977 SPRING MEETING OF THE COUNCIL OF DEANS

J. Robert Buchanan, M.D. ..... Chairman (April-August 1976)
Dean, Cornell University
Medical College

Chandler A. Stetson, M.D. ..... Chairman (September 1976 -
Dean, University of Florida April 1977)
College of Medicine

Steven C. Beering, M.D.
Dean, Indiana University
School of Medicine

Frederick C. Robbins, M.D.
Dean, Case Western Reserve Univ.
School of Medicine

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

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AN HISTORICAL PERSPECTIVE

Lowell T. Coggeshall, M.D.*

This is the first time I have accepted an invitation to give a talk since my retirement some 12 years ago. But when the persuasive, lilting voice of Dr. Stetson came over the telephone and explained the importance of the meeting and told me how important it was for me to speak, I thought it was worth a fling. So here I am.

Dr. Stetson said I might wish to talk about some of the pressures that led to the recommendation in the "Coggeshall Report" that the university should involve itself more and more in graduate education. So I will review with you my experience and my feelings in this field and add a few suggestions. I am in an enviable position. If I perform well, nobody is going to hire me. Or if I do a poor job, nobody is going to fire me.

When I reviewed the report, and thought again what the pressures were that created those external influences that led us to believe a university should play a greater role in graduate medical education, I thought "What is graduate medical education?". The more I thought about it, the more I became convinced I really did not know what graduate medical education is, and especially that I did not know what to do about it. So, my thoughts and remarks will be peripheral ventures that indicate greater attention but without very much clearcut idea about what to do.

I am going to speak about an afterview that goes back a considerable period. My medical school training started something over 50 years ago, and the report of the committee I chaired, "Planning for Progress Through Medical Education", is now a little over a decade old. A lot of things have happened in the interim.

The report had one central thrust, largely ignored, towards greater participation and leadership on the part of the university in the important field of graduate education. I see the medical schools increasing in numbers, new and better programs with many demands and expectations, but the overall attitude remains rather passive. As I reread the report, I found it interesting, but I could not find anything very new in it.

If one reviews the field of graduate education, one sees quite clearly that the real leaders of medical education started in the

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*Dr. Coggeshall was President of the AAMC in 1957-58, winner of the Flexner Award in 1963, and author of "Planning for Progress Through Education" in 1965.

1880's to urge greater university concern and involvement. Many, many university scholars felt that the university must play a greater role, even though most of the medical schools those days were not scholarly institutions. Many were only factories that turned out doctors for economic reasons.

In looking over some of the records of the University of Chicago, I found that President Harper said in 1904 that medical education was as important as any other learned profession in a university, and it should be so regarded, that medicine should have people who devoted their entire time to teaching and that the graduates should be given the opportunity for continuing study in fields related to medicine, the same as those in any other discipline had. There were many at Harvard, Yale, Michigan, Hopkins that you will find expressed similar thoughts. And then came the Flexner Report. I had the privilege of knowing Mr. Flexner and shaking his hand. Any of you young fellows who want to come up and shake mine will automatically be inducted into the knighthood of medical deans. I talked to him once about his survey. He said, "There was nothing new in my report. The faults were well known; there were growing pressures to make some necessary changes." Also I asked, "How could you possibly visit the 155 schools personally, when the only means of transportation was by rail and horse and buggy?" He said, "Well, I never worked more than seven hours a day. And, as a matter of fact, even today, if you cannot do anything within seven hours, you are not up to the job." And he added, "I did not visit every school, there were two I could not find."

Even at that time it was a renowned dean at Harvard who was reported to have said that he was all for the Flexner recommendations, but he thought they were a little abrupt because too many of the medical students at Harvard at that time could not read, so one really could not expect them to pass written examinations. I think that story apocryphal, but it typified the status of medical education of those times.

As you know, Flexner's report had three principal recommendations. The first and the one that he is largely remembered by is that many schools, which he identified by name, were indeed shoddy and conducting unethical educational ventures for profit and should be put out of business. They were.

But what Flexner said that was the most important was that education of the medical students should be more and more directed by deans with capacities similar to the deans of other disciplines; medical faculties should have an opportunity to do research, and graduate education should be given more emphasis with greater direction from the universities.

Following Flexner in 1910 there were other educational movements towards graduate education. I would point here to Ward Darley, former director of the AAMC, who consistently urged his former university president colleagues to pay more attention to their medical schools. Incidentally, it was he who really laid the solid foundation for this organization. He and Dr. George Berry were responsible for a series of excellent institutes on the implication of medical education for the universities. The published reports were excellent and they are just as discerning and just as important today as they were when issued. Unfortunately, I am afraid many of those have not been read, at least most of the recommendations have not been heeded. Dr. Darley talked a lot about the holistic approach to medical education. I am not quite sure how he spelled the word, but you and I know what he meant; namely, a consideration of the students' medical educational experience as a whole, not as fragmented portions, which carried on after the receipt of the M.D. degree.

I was admitted to the medical school at Indiana University in 1926. And Dean A. Emerson -- not well remembered for his educational theories -- asked for volunteers from the freshman class to start a new medical venture in education. This group, of which I was a member, would study pathology, anatomy, physiology and chemistry and those other basic science disciplines, along with disease. We'd examine a patient with a preceptor and then go back to the laboratory and lecture room to study the pertinent background. As he said at the time, "this pattern will keep you a student for your lifetime and the university will assist in keeping you abreast of the new developments in knowledge." He asked, "Will you do it with me?", but added, "there may be some penalties." A group of about 15 of us agreed to participate.

When the state licensure board was informed of Dean Emerson's plan, they agreed, but insisted we take all the regularly prescribed courses. We learned that we might not get our degree, at least until we had spent one or two more years to meet these formal requirements. The plan was never instituted, it was ahead of its time.

One of the early major developments was specialization. I need not expand much time on this subject, because you are well informed. I reviewed the record as far as my memory would serve me (since my library is in the National Library of Medicine, I must rely on my sometimes faltering memory) and recalled that the ophthalmologists were the first to identify their need for specialization. The need was real, as you know, because many doctors were becoming convinced that the granting of the M.D. degree was not the end of their educational experience. Many of them returned to physiology, to bacteriology, or anatomy for further study, but most of them went to Vienna or other German clinics for concentrated study in their particular area of interest.

This movement grew particularly in the '30's and more so after World War II. I also recall as an assistant professor of medicine, in 1936, being invited to become a member of the American Board of Internal Medicine without examination. I do not think there was even a charge. You could not help but believe at that time that anything so unimportant would never last, so I never joined up.

I go back to Flexner's recommendations and the ideas of other early leaders. An objective look reveals that all involved a request to the university for assistance. Some were overt, others covert, but nevertheless, the hand was out, and the university ignored it.

As a consequence, licensure was not in the hands of the university, where the student got his education, but it was an external agency that decided whether he was worthy to practice or not. The specialty boards, in their desire to improve the quality of medical service, which was very important and overdue, decided the curriculum for graduate education. They decided the competence of the individual, although the program for the most part was handed back to the university for execution.

Now, as a result, even though the quality was good, the educational experience was fragmented. The internist and the surgeon and the pathologist, or other specialists, you name them, did not consult one another about the necessity of having an overall concern for a balanced program. The genesis of most of the requirements of each specialty program was what it would do for the particular discipline. This is all right, to a degree, but I believe a congealing or coordinating force is needed to bring these groups together. And it has not happened, as far as I can discover, in spite of some efforts in that direction.

The greatest pressures were stimulated by World War II. Prior World War II, medical education was entirely confined to the undergraduate years. But more importantly, the programs were confined to what the individual dean and his university and his faculty wished to do. The external influences, if present, had not yet attained any great significance. In the schools themselves, there was a relative unconcern about community or national needs. The major portion of the medical educational program was very rigid and emphasized only curative medicine. Even the teachers of preventive medicine had little time for their subject.

The rapid development of major therapeutic and technological advances began in the thirties. First, insulin, liver extract, the sulfonamides, then the antibiotics and the immunizing agents were developed. Medicine reached its zenith at that period during and after World War II. Important advances and research discoveries raised great expectations on the part of the public, great demands for service, and the insurance plans came into effect, creating the

ability to pay. There were huge population changes. We were shifting from a rural to an urban society. There were more people in the elderly age groups. There was a growing concern about the needs of the community rather than just the individual, and all these changes were of enormous importance to the medical educator, particularly the dean.

The attitude in this country, as a result of the massive infusion of dollars into the war effort to meet the needs and the sudden technological advancements, was that the research dollars could solve any problem. And indeed they did produce marvelous results. We shifted rapidly from that period in the late '30s until the middle '40s from our dependence on the European countries for basic information. Previously, there was some excellent basic research in this country, but for the most part, up until World War II, we were still reliant upon major institutions abroad. We were highly successful in placing those ideas and discoveries into practical application.

Immediately after the war, the huge funds that had been given to the Office of Scientific Research and Development and the National Research Council and other agencies to spend for the war effort were maintained. The Office of Naval and Scientific Research Development under the Office of Naval Research continued to receive funds and grant them to the universities for research.

Later, Congress created the National Institutes of Health that built huge medical research programs, both in their own disease-oriented laboratories and also through grants in aid to the university scientists. As you are all too well aware, in spite of great material assistance for many areas, many problems were created in others.

At first, in the late '40s, it was decided in Congress that research against specific diseases was the only way that it would provide funds since it was the only way the public would understand giving tax dollars to the university. There was a lot of feeling about keeping separate, the university or support for higher education and the government. There was also a lot of feeling about the church and state. So the first funds had to be for specific research, although there were limited facilities grants for cancer and heart disease.

One of the first grants that I recall -- it was for a cancer research laboratory at the University of Chicago -- included funds for a library and a conference room. When the project was reviewed prior to the final award of funds to the university, the library and the conference room had to be deleted.

Incidentally, one of the earlier developments of great importance that did not materialize, I think, might have changed the face of medical education today, occurred in 1954. The late Senator Robert Taft, Sr., one of the most important, learned men that I have come in

contact with, said at the time, we need more doctors not only at home, but all over the world. But he said, "I have talked to many university representatives and I cannot get the universities to expand their enrollment. They say they cannot afford to". So finally he was ready to introduce a bill which, as I recall, gave each medical school a base sum. This would provide necessary support because he thought that next to our security, the health of our people was a number one priority, and the only way to get action was to provide Federal assistance.

The measure would provide for those schools willing to increase their classes by five percent additional support, amounting to twice the amount for each additional student over their average previous enrollment.

He said, "In my opinion, there's no one in the government that is astute enough and intelligent enough to handle medical education, but I am equally convinced that we need more doctors. We need them now and I don't see anyone stirring themselves in that direction." And he also said, "We need better educated doctors, and I think that this is the university's role, not government's." The generally favorable attitude of Congress at that time toward all matters in health and especially the high regard for Senator Taft, practically insured the passage of any bill he introduced, and it would have received bipartisan support. However, he asked for testimonial support from certain medical educators at the hearings. The first dean his committee staff contacted called back and said, "We won't be able to get any deans to support this bill because, in our opinion, this will induce some of the "weaker schools" to admit more students because they can get more money." So Senator Taft said, "Well, if the deans aren't interested, why should I bother?"

I have often thought things would be different if that bill had passed. He had said, if this is not a good bill, once we start we can amend any weak points, so that universities and the government can work hand in hand to have a more erudite, forceful program, and you can guide it rather than the government.

I think extremely important what happened immediately thereafter. When the Taft approach was rejected, the two next most powerful and learned men affecting medical education, Senator Lister Hill from Alabama and Representative John Fogarty from Rhode Island provided more and more funds, but primarily for research. Research was still the magic word, and it reverberated in the university, and, as you know, research became the thing to do.

Senator Hill once told me, "I can get any reasonable amount of money you want for research. But the research has to be disease oriented. The American people will not understand funds for better educated doctors or improved medical care."

As the first full time special advisor to Secretary Folsom on medical affairs, a position now referred to as assistant secretary, I presented the Administration budget during the Eisenhower administration to Senator Hill's Senate Appropriations Subcommittee for Labor/HEW and to Fogarty's House Appropriations Subcommittee for Labor/HEW. As I recall, the request was for $62 million, which doubled the amount budgeted for the preceding year. Fogarty said, "Listen, you're not really knowledgeable about what's happening in this country. You just have not touched any of the major needs in any realistic manner. This budget should be at least $25 million more." Our health budged was just a part of the huge national budget. That was all I was permitted to plead for.

And, on the following day, I appeared before Senator Hill. "Well," he said, "neither you or Rep. Fogarty are aware of the needs for medical research today." The Senate committee added another approximately $30 million and so my $62 million increased to $117 million in about three months. That gives you some indication of the mood of the time.

One of the most important groups of the time in the whole field of medical research and its implications for education was the heads of the National Institutes of Health. The director was a very intelligent man and a great leader. Basically he was research oriented. I believe that organization he directed saw the university as an instrument for public policy, to carry out the dictates of government, to provide a better health service, better personnel, to provide the necessary services, but primarily, more and better investigators.

I believed then and now that strengthening the universities would have accomplished the same objectives with more solid, lasting results. I think it could have been done, although I am not sure. There were statements that the advisory committees you are all familiar with -- mostly university men -- really controlled all the important decisions. I do not believe that was true at all. I think they followed certain broad guidelines rather closely and responded to the interests of those who managed the sources of the dollars. I could point out in more detail that the government has become the single most powerful force and largely guides our destinies. I believe it will continue to do so even more forcibly in the future.

Let me hasten to add that my experience in government left me with a feeling that I had never been associated with a more dedicated, more intelligent, more hard working group than the government people who were in the general area that I am referring to. I believe, however, that

they are dealing with a program that has become so massive and in many respects so fragmented and uncoordinated, that only with external help will they ever come out of this morass.

I think we are in difficulties in medical education in this country, and I think that, if you look at all the principal elements over the past few decades, they are still operating very much independently. There are pretenses that there is coordination, but I do not see it.

We recognize that many universities and many in this group are making important steps towards bringing the appropriate parts, not all of graduate education, but the appropriate parts of graduate medical education into the university. I believe only the university can fulfill this role in a way that will produce quality results in the decades ahead.

The university's posture as a passive recipient of the many external pressures and its largely negative reaction to them is not surprising. Most university presidents that I know are not comfortable with their medical schools. When they talk to potentially important donor patients, they really go on at some length about the great competence of their medical schools. They boast about their prowess and suggest that they really are part of the university. But they do not really understand them, and sometimes this feeling is characterized as apathy or even hostility at home. Most of the university presidents, particularly those of the scholarly vintage, are accustomed to thinking about their institutions as instruments to provide new knowledge and to dispense it. They do not understand service. As my breakfast companion said this morning, "As far as they are concerned, a medical school is like a curve ball that they have never learned to hit. They just occasionally foul one off, but they have never met the issue squarely." And you cannot really blame them. Why? I believe that it is because we, as their deans, have yet to demonstrate the exact role and responsibility of the university in graduate medical education. I applaud the purpose of this assembly as an overdue step in the right direction.

As Winston Churchill once said, in effect, democracy is not a very effective organization, but it happens to be the best now in existence. I would say the same about the Association of American Medical Colleges and its Council of Deans. It possesses the capacity to provide the stimulation and direction needed for more effectively coordinated programs in graduate medical education.

The conviction that the AAMC had a greater potential than it was realizing led the Executive Council to establish a review committee which was charged with the task of taking a thorough review of the organization. The committee responded with a report in 1965 which

stated, in essence, the organization as constituted was not equipped to provide the most effective leadership the changing times were demanding on such matters as we are discussing today. Subsequent to the report, the organization has been restructured drastically. Capitalizing on the previous excellent progress, President John Cooper has built the Association into the most respected and influential in medical education today. It alone, in my opinion, possesses the resources, integrity and independence to provide the guidance so urgently needed and sought by every element in the health field. The Association of American Medical Colleges can be the most influential force in bringing the parts together. In so doing, we must remind ourselves that the improvement of medical education is our purpose. Successes in side issues must not divert us.

In spite of his great wisdom, Abraham Flexner was in error in his belief that seven hours per day was enough to accomplish any job. Though it may have been adequate in 1910, it will not suffice today.

PUBLIC POLICY ISSUES IN GRADUATE MEDICAL EDUCATION

Stephan E. Lawton, Esq.*

Over the past few years, the number, the diversity and the complexity of public policy issues in graduate medical education certainly have increased manyfold. There has been an increasing interest -- some would say intrusion -- by government, by the Congress, by the Executive Branch, by some of the regulatory agencies in graduate medical education, and I dare say the Federal interest in graduate medical education hardly is going away. Graduate medical education will receive as much Federal attention as it can stand during the next several years, and this is so, in my judgment, for two rather obvious reasons.

First, as you well know, during the 1960's and early 1970's Congressional health manpower concerns were predicated primarily on the need to assure the American public greater access to health care through increasing the supply of health manpower, and thus Congressional concerns, Congressional pressures, Congressional initiatives focused on undergraduate education.

Congressional concerns now are centered on the end product, and thus, the Congressional spotlight has shifted its focus to graduate medical education.

The second reason, equally obvious, is that Congress is expressing its concerns over escalating costs, over increased technology, and in expressing those concerns the Federal government is unable to ignore medical schools. It is unable to ignore medical schools and their teaching hospitals, and thus, it is unable to ignore graduate medical education.

None of you in this room today, I dare say, have to be reminded that the branch of government that has placed the greatest demands on graduate medical education is the Congress. And I think it is fair to say that the Congress' interest in graduate medical education has three predicates.

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*Mr. Lawton is Chief Counsel to the House of Representatives' Subcommittee on Health and the Environment of the Committee on Interstate and Foreign Commerce.

First, primary care -- Congress continues to want to influence through a carrot and a stick approach the production of specialists in family medicine, internal medicine and pediatrics. I think Congress would not mind if some of the other specialties were frozen or even reduced in number of positions.

Second, quality -- Congress has expressed itself as opposed to the use of graduate medical education to provide services to the urban poor by ill trained alien graduates of foreign medical schools.

Finally, cost -- Congress is greatly disturbed by the cost of care in this nation's hospitals, where, of course, graduate medical education is largely based.

If Congress is taking the initiative in attempting to influence graduate medical education, that initiative is threatened first by its agents in the Executive Branch, who are charged with implementing Congressional policy and threatened secondly by an emerging sleeping giant in Washington, the Federal Trade Commission. Long known as one of the least aggressive independent regulatory agencies in Washington, the FTC has awakened with a vengeance and is seeking to prohibit what it views as restraints of trade in the medical profession. Because of the relationship between the economics of our health care delivery system and specialty training, graduate medical education is likely to become significantly affected and certainly hassled by the Federal Trade Commission.

To make matters even more complicated and more frustrating, I am sure, to persons who are involved in graduate medical education, existing or proposed Federal actions do not necessarily reflect a consistent Federal policy toward graduate medical education. I think to say that the left hand does not know what the right hand is doing to to put it somewhat mildly, and indeed somewhat inaccurately. In many instances, the left hand is opposing the right hand's policy. It is stealing the right hand's money, and it is attempting to make it downright illegal for the right hand to conduct its business in a way that the left hand perceives is in the public interest.

Let's look for just a moment at the three goals of the Congress -- primary care, quality and concern with cost. As you well know, Congress wants more primary care and less or at least not more training in non-primary care. It expressed itself quite vigorously in the 1976 health manpower legislation, which requires that as capitation <u>quid pro quos</u> there must be increased commitments by individual medical schools to training in family medicine, in internal medicine and in pediatrics, unless national goals are met.

While it is too soon, I would say parenthetically, to know if these national goals will be met in 1979 and 1980, I think that the Graettinger

numbers, which we will hear about shortly are very encouraging from my cursory review of them. They have not yet been plugged into the Federal formula, but they certainly are encouraging indeed.

Secondly, Congress expressed itself in the health manpower legislation to a greater commitment to primary care through the carrot approach, through increases in authorizations for training in family medicine and for new authorizations of appropriations for training in internal medicine and for training in pediatrics.

There are, however, two huge potential roadblocks to significant increases in the numbers and in the quality of primary care as demanded by the Congress. The first is well known to you. It is a fact of life that the existing reimbursement policy of the Federal government for primary care training is ridiculous. You are well aware that ambulatory care training is hardly cost effective. There is simply no question that existing Medicare and Medicaid reimbursement policies favor residency programs that provide training in conjunction with in-patient services. Those same policies, therefore, constitute significant disincentives to the establishment of primary care residency training programs.

It was primarily for that reason that the Congress, as well as many of the states, enacted legislation to independently fund primary care training and in particular, as you know, family medicine. Well, what has happened? A recent ruling in HEW's Region IV has reversed a ruling that it made three years ago, and has said that prior to the determination of allowable costs under the Medicare program, all revenue coming in for training in primary care either from the states or from the Federal government is going to have to be deducted prior to determining allowable costs.

To make matters worse, some of this has led to demands for repayment. Hospitals involved are being advised that they must, in effect, reimburse Medicare the amounts they have received in grant support.

Obviously, what we have here is a great disincentive to states to keep funding primary care training. And what we also have is the ridiculous approach of the left hand/right hand within HEW, in which the left hand, the Bureau of Health Manpower, is handing out the money to the hospitals and the right hand (the Social Security Administration) is coming back and saying, give it back.

That is not consistent with Congressional intent. Congressman Rogers has corresponded and has had personal meetings with Secretary Califano on this issue. It is a difficult one to resolve, but I am hopeful that this Region IV ruling may lead to a wholesale reexamination of the relationship between Federal reimbursement policy and graduate medical education.

At the very least, it has alerted the Congress to the inconsistency between its goals for graduate medical education and Federal reimbursement policy.

The second potential roadblock to Congress' goals with respect to graduate medical education -- the recent activities of the Federal Trade Commission. The Federal Trade Commission is demonstrating an acute interest in the economic consequences of the activities of professional organizations as well as a general interest in health.

The Federal Trade Commission has taken more actions in the past two years that affect the delivery and the financing of health services than at any time in its 60 year history. Recent Federal Trade Commission actions have included attacks, successful attacks so far, on relative value scales, attacks on advertising prohibitions in the health professions and attacks on fee setting arrangements.

And more importantly from your standpoint, the Federal Trade Commission, as I am sure many of you are already well aware, is conducting a comprehensive investigation of the propriety of specialty boards reducing, or putting a halt to the growth of certain specialties, which according to the Federal Trade Commission staff, is being done now by the urologists, by the psychiatrists and by the neurosurgeons.

The official FTC attitude toward the involvement of professional associations in accreditation is expressed very succinctly in a document that it filed in comment to the Office of Education on whether or not it should approve the LCME petition for another four years as the accrediting body for medical schools.

The petition should be denied, the Federal Trade Commission said, because the American Medical Association relationship with the Liaison Committee on Medical Education is so close that the LCME lacks autonomy and thus cannot insure that its actions will not be against the public interest.

The public interest, in the view of the Federal Trade Commission, demands more, or at least not a holding down of the numbers of, medical schools and of medical students. Of course, it is ironic that in the one area that the FTC has chosen so far -- accrediation of medical schools -- the history is a doubling of the number of students and a huge addition over the last ten years in the number of schools in the American medical system.

Irrelevant, according to the FTC. That matter does not impress them. The appearances of impropriety, the Federal Trade Commission says, is enough to constitute a potential restraint of trade.

Now, with respect to graduate medical education, as I said, the FTC is conducting a comprehensive analysis of graduate medical education. It has sent some 40 subpoenas to specialty boards and societies in an investigation that could very well produce accusations much like their accusations against the LCME. There may very well be accusations that specialty societies, that specialty boards or that the LCGME have collaborated to restrict both the number of physicians authorized to enter specialty training or the number certified to become specialists.

It is certainly too soon to know what will become of the matters that are being investigated, but I think that the LCME experience has several ramifications. As I understand it, the LCGME relationship with the American Medical Association is not unlike that of the LCME and that is a "nasty", according to the Federal Trade Commission.

Unlike the experience with the LCME, there has been a conscious, a deliberate and a public attempt to reduce numbers in certain sectors of the profession. It may well be that the Federal Trade Commission may order a halt to lids that are being placed upon production of certain specialists in graduate medical education. It might well order that the relationship, the United Nations veto-type relationship, between the AMA and the LCGME must be modified, if not abandoned altogether.

Well, I talked to a Federal Trade Commission attorney, who is handling this investigation and gave to him the following argument: "Many health economists say that the basic economic tenet that you, FTC, are trying to advance -- that competition is healthy, that competition will drive down costs -- simply does not apply to the medical profession. Moreover, the Congress has expressed itself quite clearly with respect to these matters, and has said, 'We want more primary care as expressed through the capitation quid pro quo.'"

"Doesn't this mean anything to you people at the Federal Trade Commission?", I asked. The answer was clearly no. "That's your business; that's not my business", he said. "If I find a restraint of trade, if I find a professional organization holding down numbers, then in my judgment that is a violation of the Sherman Act, and I will recommend to the Federal Trade Commission that it prosecute. If Congress wants to exempt graduate medical education from the anti-trust laws like it exempted baseball from the Sherman Act, then that is your business. Go do it. But until that time this is a conspiracy in restraint of trade, as far as I am concerned."

The left hand not only knoweth what the right hand doeth, but it is opposing quite vigorously what the right hand doeth.

Secondly, quality -- the Congress expressed itself quite vigorously with respect to quality vis-a-vis immigration policy. The 1976 health manpower legislation mandates that only persons who demonstrate competency by United States standards may enter graduate medical education in this country. As you are no doubt aware, physicians have been able to enter this country in three ways. They could immigrate like anybody else, or they could get preferences under either a J-visa, in order to enter training, or an H-visa, a work permit if a shortage were found in a profession or for research, training or teaching.

And we might as well admit it, many hospitals have abused the J-visa preference and the H-visa preference and constructed sham medical residency programs in order to get cheap labor from abroad to serve the urban poor. Congress put a stop to that. For J-visas the new immigration amendments require that before an alien physician can come to this country under a J-visa, he must demonstrate a competency in English; he must pass Parts I and II of the National Board of Medical Examiners examination and the only place he can be trained is in a medical school affiliated hospital.

There is a waiver for this requirement that was to be extended on an alien-by-alien basis through the end of 1981, constituting a recognition, I think, by the Congress that this is a very difficult provision that is going to take quite a while in order for some of our major urban hospitals to adjust.

In addition, Congress declared that there is no longer a shortage of physicians in the United States, and thus the H-visa now may not be used in order to enter the country and participate in graduate medical education.

Well, what has happened? Unfortunately, to date we have seen a strange implementation of the immigration amendments. The Department of Health, Education and Welfare was charged with developing an equivalent examination to Parts I and II of the National Board of Medical Examiners examination.

The law was passed in October, the examination is still not ready. The examination will not be ready and will not be given until September 7 and 8 of this year. Almost one year will have passed between the date of enactment and the administration of the examination.

Because of this fact, Congressman Rogers and Senator Javits have agreed to an approach that Secretary Mathews espoused to the Attorney General and the Secretary of State, and that is that there should be a one year blanket waiver with respect to the J-visa. Congress does not have clean hands. It enacted this law, thinking that the examination

was going to be given much sooner than it is. So it agreed to a one year blanket waiver of the J-visa requirements, but predicated waivers in the future on the espoused intention of an individual hospital to phase down its reliance on ill-trained FMGs. Envisioned, for example, was a requirement of a letter of intent from the hospitals or perhaps an established formula based on a declining percentage of alien FMGs that have not passed Parts I and II of the Boards or its equivalent who may come into the hospital. Clearly what is needed is a schedule so that we are not going to have an abrupt cut-off at the end of 1981.

Rogers and Javits received an interesting response from the State Department. It said -- we agree with you entirely. We are very interested in international comity. We are afraid that these amendments might upset some of our brothers in other countries. We are authorizing a waiver through June of next year, which is really a two-year waiver. It said nothing about requiring hospitals to cease their reliance on unqualified aliens holding J-visas ultimately by 1981.

The Justice Department is also in on the act. The Justice Department has interpreted the H-visa requirement, permitting aliens to enter the country to conduct research or do teaching, as authorizing solely research and teaching and prohibiting any involvement in patient care whatsoever. Actually, they just repeated the law in their regulations, except they inserted the term "solely" which makes a big difference.

These actions, as well as the lack of the examination in order that qualified physicians may enter the country under a J-visa may obviate at least for one year many excellent international programs. I think that the malimplementation of the immigration provision -- HEW is at fault, Justice is at fault, State is at fault -- is going to place very great and unnecessary pressures on the Congress to amend it. Proper implementation would have, I think, avoided the problems that graduate medical education is going to face, at least for the coming year.

Finally, costs -- Congress has a commitment to cutting the escalating costs of health care and graduate medical education best be wary.

The Administration, in close consultation with Congressional staff, is currently preparing a proposal which would limit growth in the hospital sector, including teaching hospitals. It would limit growth to 109 percent of 1976 revenues, and it intends to base the limitation on the number of admissions and the cost per admission.

Thus far in the draft proposal, capital expenditures would be limited to a yet to be specified percentage of the estimated current value of existing assets of the hospital sector. Teaching hospitals

will come under the Carter Administration's cost containment proposal, and I would predict that, while it will have very rough sledding, the Carter proposal or something that resembles it will be enacted by the Congress this year.

You are going to participate like everybody else, but there will probably be two problems that will raise their ugly heads and get at cross purposes with your attempts to reduce or at least not escalate costs.

First, the immigration policy is going to cost some of you money. Ill trained, alien FMGs are cheap labor, and it is going to cost a lot more money to have well trained graduates of either United States or foreign medical schools doing such things as staffing emergency rooms, providing care to the poor.

And secondly, I think it is possible that Congress will pass legislation overruling the National Labor Relations Board decision that house staff cannot unionize. And while there is a pass-through in the cost containment proposal for some wage increases due to collective bargaining, that pass-through is only for nonsupervisory personnel. Thus, increased pressures for cost coming from one end, increased pressures to hold down costs coming from the other end -- left hand, right hand.

Obviously, the new demands placed upon graduate medical education are not without their ironies. They are not without their inconsistencies. Congress has asked medical schools if they are to receive funds for undergraduate training to place more emphasis on primary care in graduate programs, which they do not totally control. Federal reimbursement policies are at odds with the federal emphasis on primary care. FTC actions threaten to cut down attempts to cut non-primary care training.

HEW, Justice and State Department implementation of new immigration policy is inconsistent. It is slow, and the graduate medical education process will be disrupted in June because of delays. Graduate medical education will be asked to participate in a cost containment program, while the new immigration policy and perhaps a new collective bargaining policy threaten to drive up costs.

These are big problems; they will be difficult, but they will not be impossible to resolve. Immigration policy will get straightened out within the next few months, and graduate medical education can certainly live without ill trained FMGs. Nobody is going to let the high quality of graduate medical education go down the drain either through unrealistic reimbursement policies or through impossible cost containment programs. If the FTC actions begin to threaten your ability

to plan for more primary care and less unnecessary surgical subspecialties, then in my judgment, you will have a sympathetic ear in Congress.

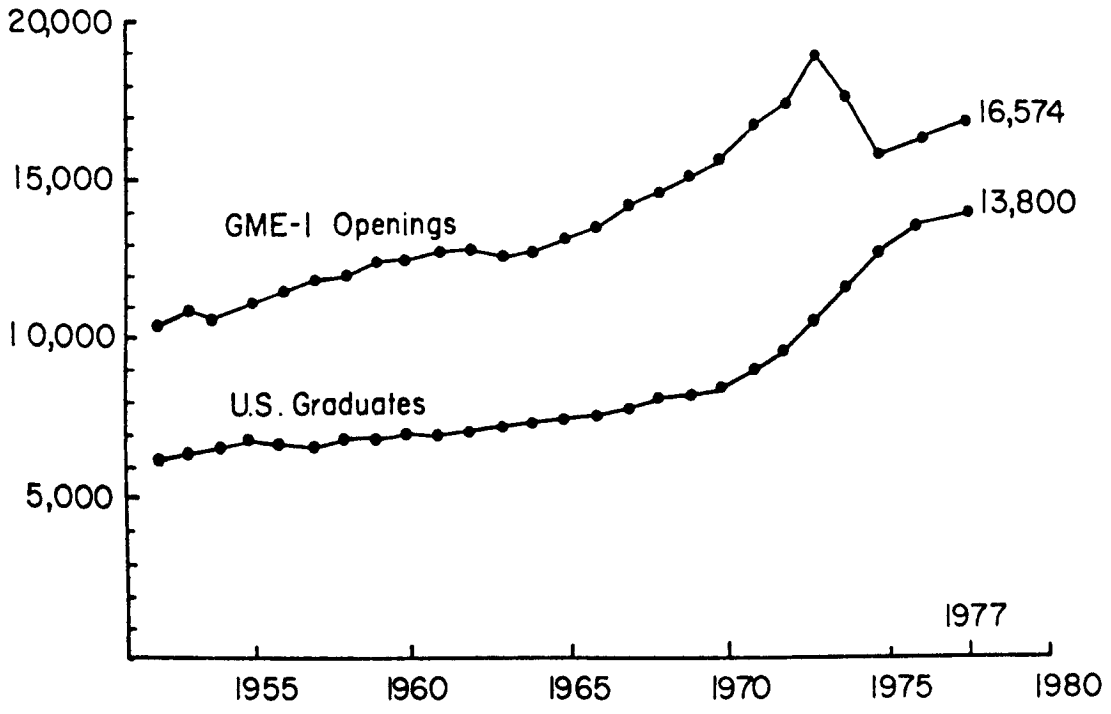
Your theme is "Do we have to business in the same old way?" My answer to that, because of the factors I have mentioned, which I hope you realize are designed by well-intentioned people in the public interest, largely to meet the demands of the public, graduate medical education cannot do business in the same old way.

THE NUMBERS--1977

John S. Graettinger, M.D.*

I would like to try to quantify some of the problems that have been identified. I speak as the one in charge of the black box, the matching program, which is only a process. I shall try diligently to avoid suggesting solutions, which are your business!

Figure 1



The first figure is an update of last year's, which was called, "Jaws"! You will note that the perturbation in the national scene, which

*Dr. Graettinger is Executive Vice President of the National Intern and Residents Matching Program and Dean for Faculty Affairs at Rush University Medical College.

I call AM and PM, that is, ante-Millis, post-Millis in 1975, the doing away of the free standing internship and the integration of the internship with the residency, has adjusted with a narrower but parallel and healthy growth between the number of GME openings at the top and U.S. graduates at the bottom.

The number 13,800 is an estimate of the number of 1977 graduates. As you know, we have had some changes from three to four year curricula and now some changes back from four to three. The correct figure probably should be closer to 14,000.

Figure 2

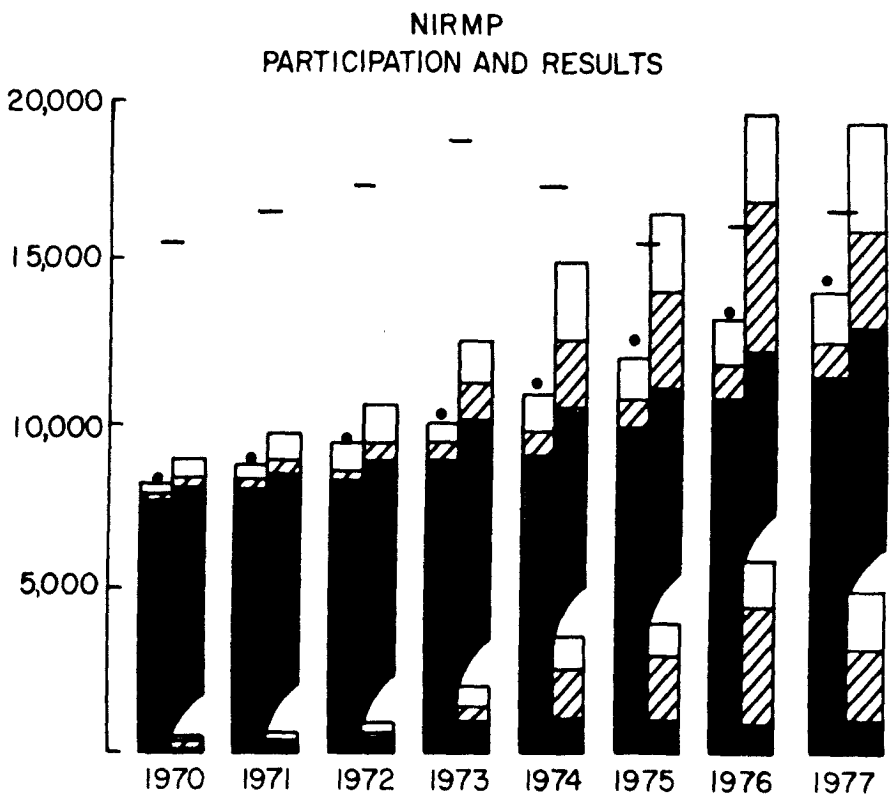


Figure 2 was also shown last year. Over each of the left columns you will see a dot representing the number of graduates. The top of the column represents the number who applied to NIRMP. The clear portion is

the number who withdrew: 11 percent this year, the same as last. These are January-March graduates, couples negotiating separately, people who take positions in non-NIRMP hospitals, including the armed forces and some violations. This year, of those participating, the striped portion of the left column, 94 percent matched, 11,172; six percent were unmatched, 726. Both of those are better than last year, when only 92 percent matched, and eight percent were unmatched.

The right pair of columns in Figure 2 represent the total number of applicants to NIRMP. The total is down about 1,000 this year from the peak of nearly 20,000 in 1976. Who are they? They include osteopaths, Canadians, fifth pathway and independent students; namely, those who did not enter a GME one year right after medical school (the numbers are shown in Table 1, page 36): last year, 331; this year, 458 of that group -- I still call them NAG's -- North American Graduates. The non-U.S. national graduates of non-U.S. medical schools are shown in the insert in the right hand column, FMG's. This year 1,100 fewer applied; their deadline for application was September 1976, two months before P.L. 94-484 was signed. About 1,100 matched, as they have the last four years. The constant number with fewer applying meant a 33 percent match success, up from 24 percent which is due to the drop in the denominator.

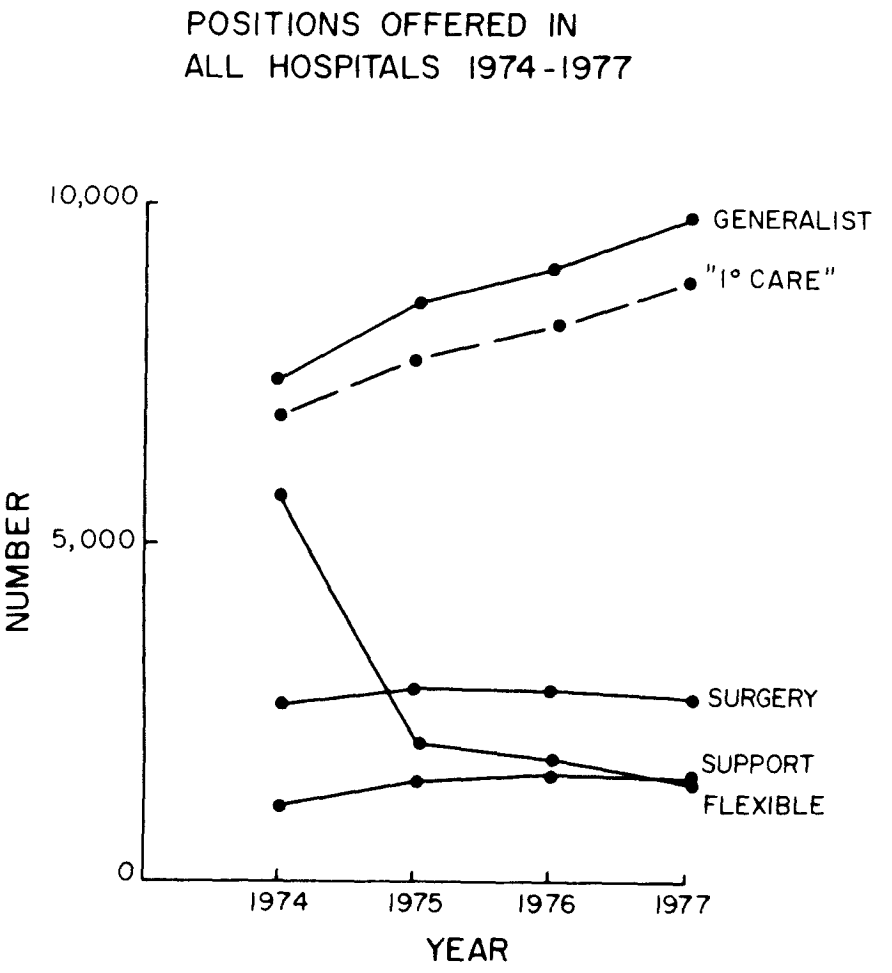
Let's now look at specialties, and I have picked four years from 1974 through 1977, to take us across the implementation of the Millis report. The numbers are in Table 2 (page 37). The gross number of positions offered in all hospitals has gone down by some 800 since 1974. There were 17,403 positions in 1974; this year 16,574, as shown in Figure 3.

In deference to 94-484, "primary care" is defined as the big three of family practice, internal medicine, and pediatrics; "generalist" adds obstetrics. Surgery includes general surgery and the five specialties of neurosurgery, ophthalmology, otolaryngology, orthopedics and urology. The support specialties are those non-bedded specialties of anesthesia, pathology, physical medicine and radiology. Flexible residencies are shown at the bottom. This pattern is the one I will use in all of the following figures.

The figure shows the decrease in 800 overall, an increase of 2,400 in the generalist specialties, 2,100 in primary care. In surgery

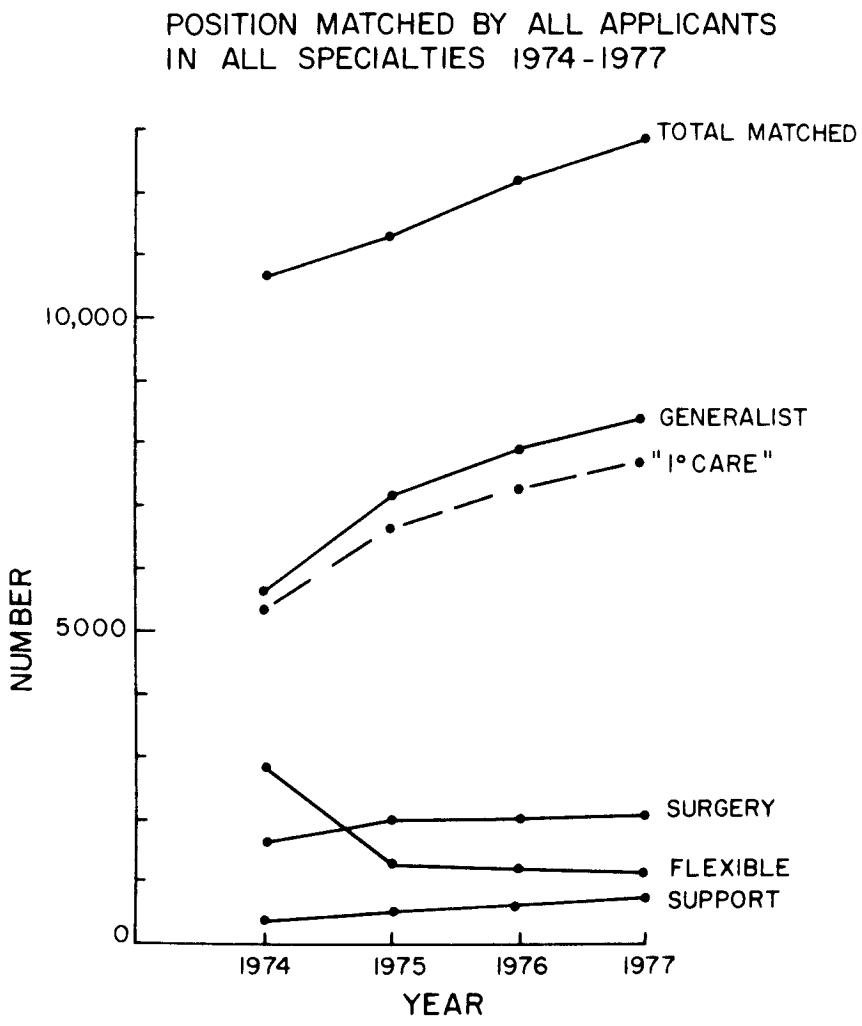
74 more positions have been added since 1974. Support specialty positions are up 390. The transition from rotating to flexible residencies has been accompanied by a decrease of 4,100 positions.

Figure 3



Positions filled by all applicants (Table 3, page 38 and Figure 4) in 1974, there were 10,600 or 61 percent of those positions filled. This year, 12,760 or 77 percent filled, in other words, an increment of 2,100 more house officers matching. This is the total of U.S., NAGS, and FMGs.

Figure 4



In Figure 5 are shown our own students. In 1974, 9,224 United States graduates matched in all specialties; in 1977, 11,172, an increase of 1,948. You will see that essentially all of the increased number have gone into the generalist-primary care specialties.

Figure 5

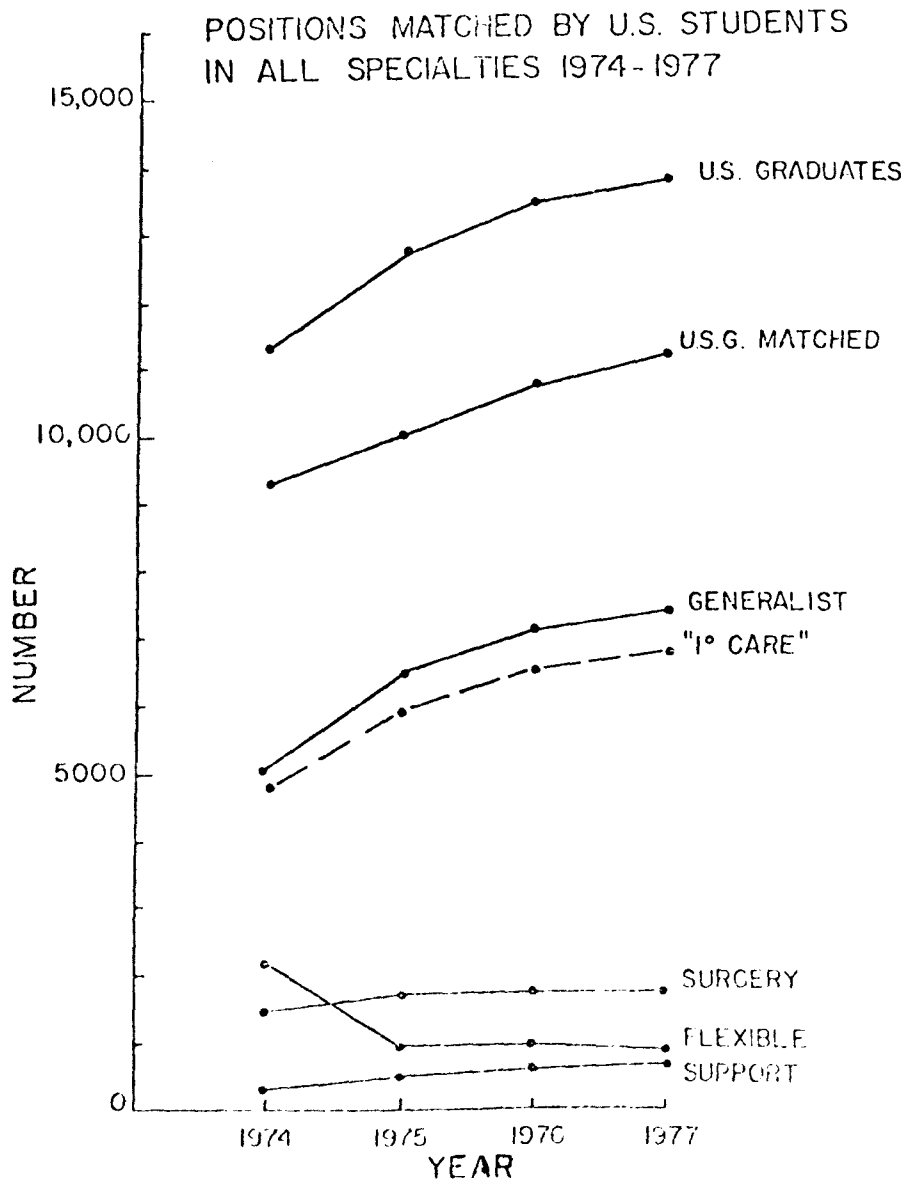


Figure 6

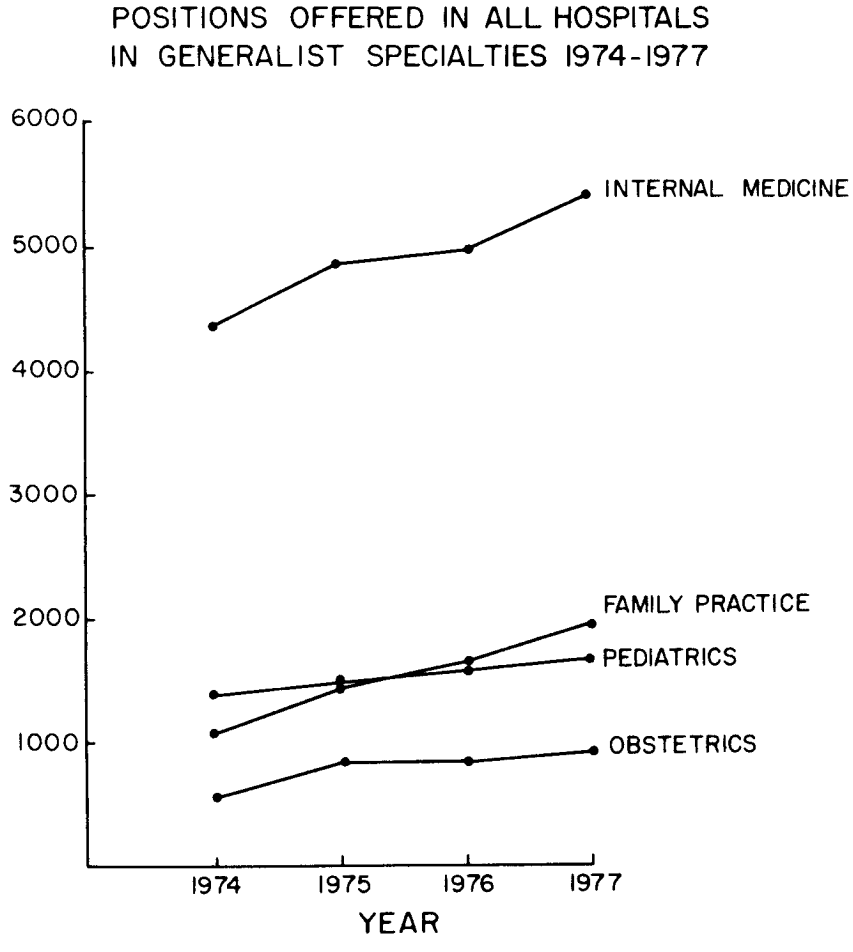
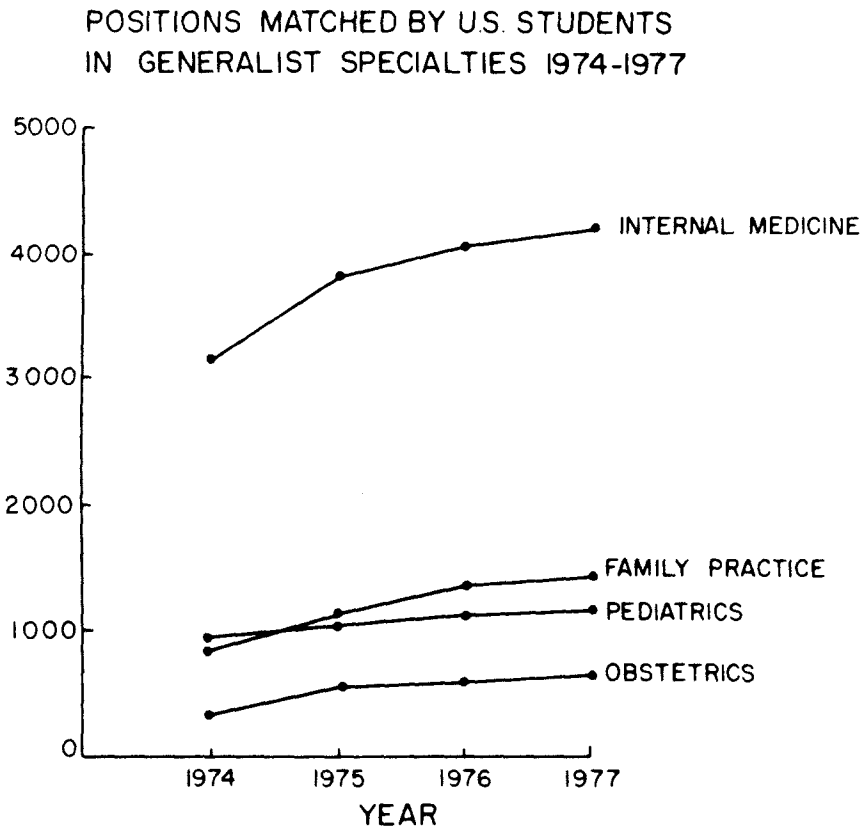


Figure 6 shows a higher power look at positions offered in the generalist specialties. They have increased by 2,404 in the last four years; internal medicine by 1,004, family practice by 858, and 272 for pediatrics and 270 for obstetrics.

How have our students responded to this? (Figure 7) The number of our graduates matching in these specialties in internal medicine has gone up to 4,199, which is 1,077 increase over the last four years, in family practice the increase is 608, in pediatrics, 255 and OB, around 334, for a total of 2,274 more in positions in the generalist specialties. All right. What has happened in the last four years? The increase in the

Figure 7



number of positions in primary care offered by the academic medical centers, the affiliated hospitals, where over 95 percent of GME is going on now, has increased by 2,400 in four years. The number of increase of all other specialties, in other words, the surgical and support specialties and flexible residencies is minus 829.

The increase in number of our graduates matching has been 1,948; the increase of our graduates in the generalist specialties has been 2,274.

The change of our graduates in all other specialties has been minus 326. I submit from these data that the system is responding rather superbly.

A word of caution, however: eight percent of our students were unmatched last year, 952. Eighty percent of them had made a first choice for one of the primary care specialties. This year there were only 726 (six percent) unmatched students, but also over 80 percent of them wanted positions in primary care specialties. Furthermore, we have just published (Journal of Medical Education, May, 1977) a study of all positions in which positions in programs which matched at least one U.S. graduate were separated from those in programs which either remained totally empty or did not match a single U.S. graduate. Over half of the unfilled positions were in the latter kind of program. From the point of view of the beholders, our U.S. students, the number of acceptable empty positions is less than half of what the gross figures show.

With those two caveats, I would say the numbers game is in better shape, clearly heading in the right direction, and the voluntary sector has indeed responded.

I would like to spend the last few minutes showing you data from a study of all 13,500 graduates of 1976. Only 80 percent obtained their GME-I positions through NIRMP. We, therefore, sent to all of you and your deans of student affairs the lists of people who were unmatched and those who withdrew before the match with a request for data. The response rate was almost 100 percent. One school said no, but they had published their list of all the students who graduated and where they went, so we took the liberty of extracting from their published list.

The hospitals of all 13,500 of the '75-'76 class are shown in Figure 8. We see the 80 percent of them got their positions through the NIRMP in the match. Nine percent ended up in NIRMP member hospitals outside the match.

Of the unmatched students, almost all of the 80 percent who wanted primary care specialties, practically all of them are in NIRMP hospitals, and at least 100 in programs that were filled! In other words, the non-system, as it has been called, picked up those unmatched students and got them into the primary care specialties.

Four percent of all students are in non-NIRMP hospitals. Who are they? They are in psychiatric, uni-disciplinary hospitals, who did not join NIRMP, in the Commonwealth of Puerto Rico, whose hospitals do not participate, they are students of one of our schools with a strong ethnic minority group, whose university hospital does not participate, or they are in the hospitals of a strongly religious oriented medical school/hospital system.

Figure 8

LOCATION OF
FIRST POST DOCTORAL YEAR
OF THE 13,500 U.S. GRADUATES 1976

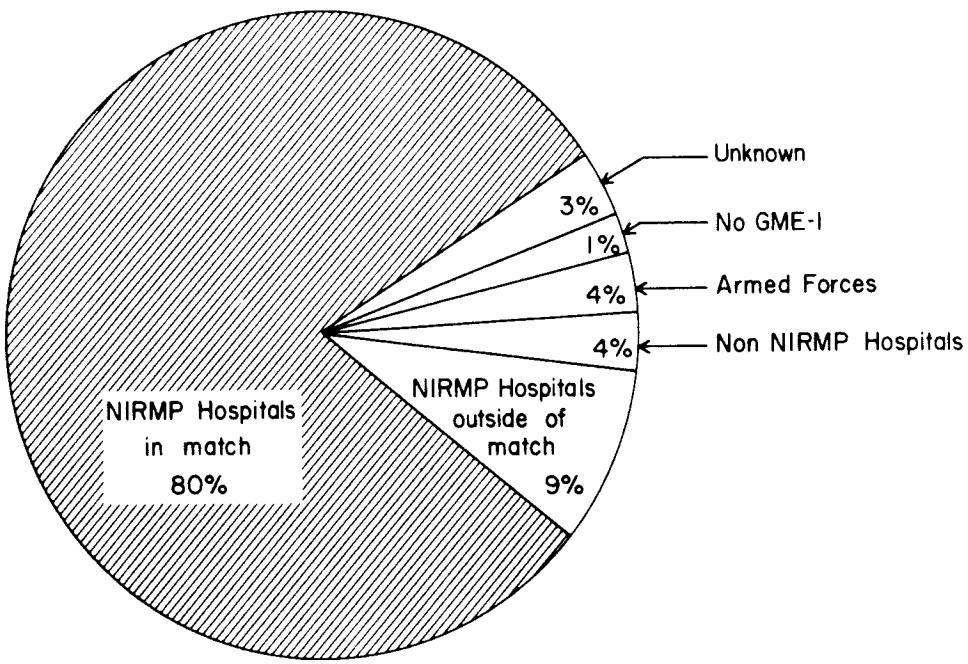
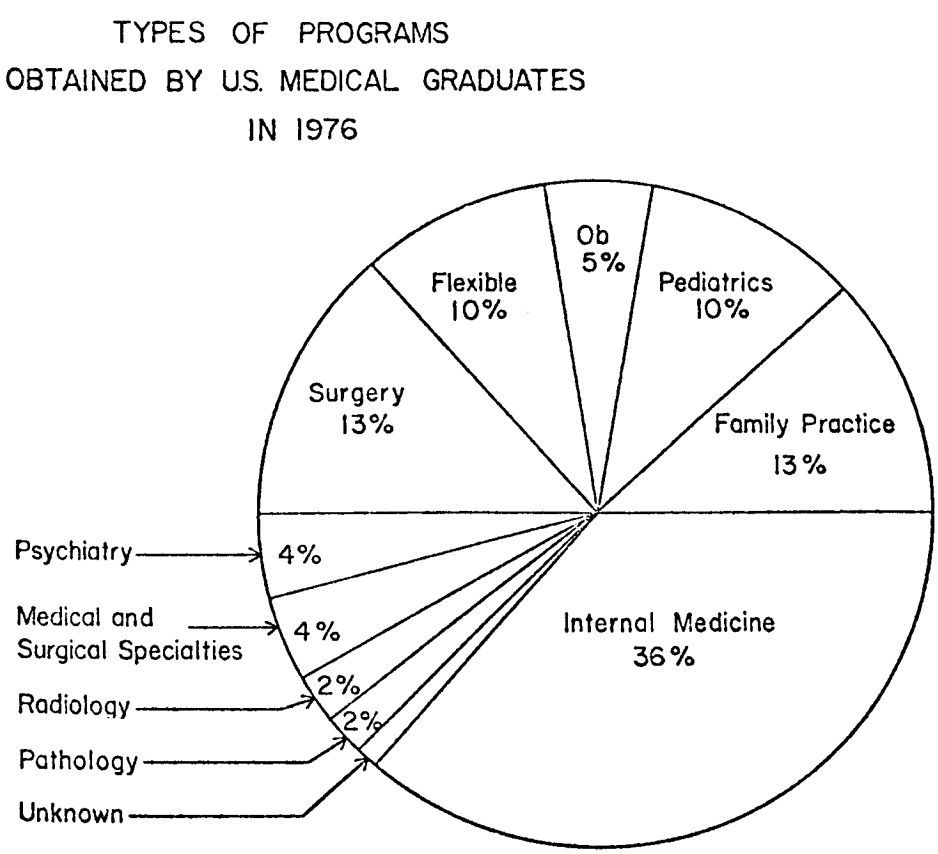


Figure 9



The specialty choices of all 13,500 are shown in Figure 9. In the match, 61 percent were in the three primary care residency types and 66 percent in generalist. For all of them shown in the figure, the percentages are two percent less; namely, of all of our graduates last year, 59 percent are in the primary care specialties, and 64 percent in the generalist specialties.

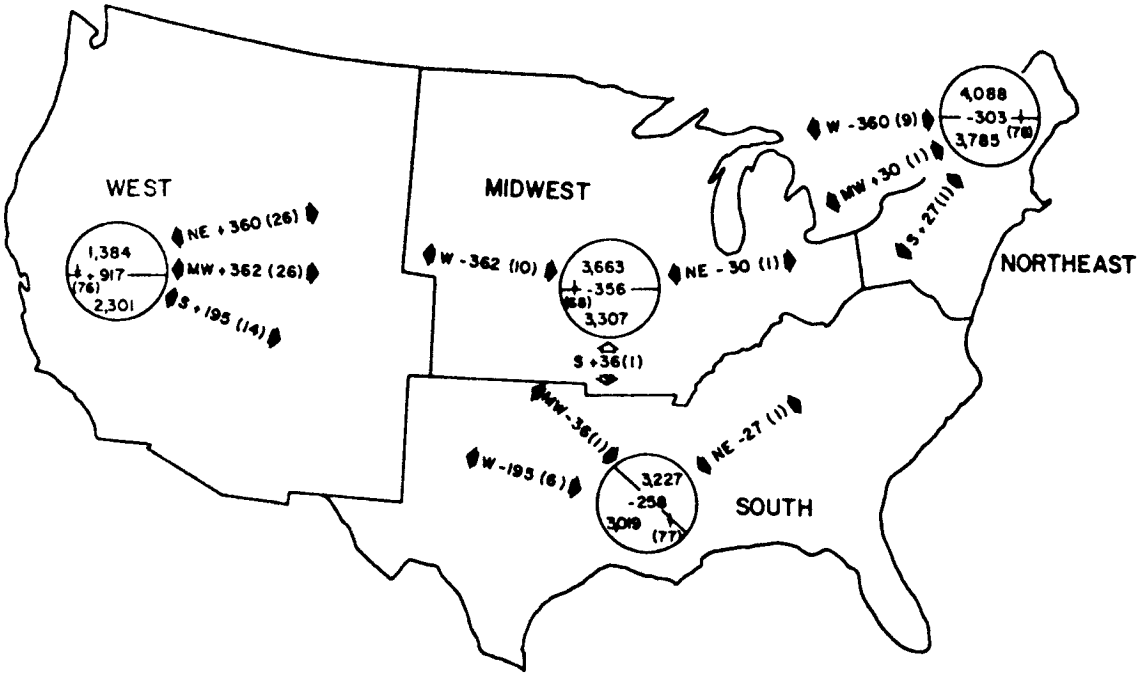
These data, which you supplied, have been coded into the 1976 results and therefore, it will be possible to send a list to each hospital of all students placed in it for the 1976-77 academic year, with a request, which I hope will have your cognizance and backing, that each hospital send back to us an indication of what the graduate is going to do for the '77-'78 academic year. This will allow us to do a tracking study of GME-I to GME-II year of this population.

How do students migrate? Table 4 (page 39) shows that overall, 49 percent of our graduates remained in the state of their medical school and 71 percent in the same AAMC region as their medical school. Only 29 percent moved to another region for the first GME year. As you might expect, the unmatched students migrated a little farther afield to get their spots, as shown in the second pair of columns, and those who withdrew or did not enroll, not unexpectedly, had lined up something closer to home than the matched students.

Finally, let's look at migration with respect to the balance between the graduates from the schools of each region and the number of graduates in GME-I in each region (Figure 10). Within each of the circles in each of the regions on top is shown the number of graduates in 1976. The lower figure in the circle represents the number of U.S. graduates

Figure 10

COMPARISON OF LOCATION
OF GME-I YEAR TO THAT
OF STUDENTS' MEDICAL SCHOOLS



entering graduate medical education in the region, and the figure across the middle is the difference.

For example, the Northeast had 303 less students entering graduate education in the Northeast region than it had graduated students. The West, graduated only 1,384 students, but 2,301 students began the first year of graduate medical education in the West.

The little arrows across the center of each circle points to the percentage retention of its own graduates in a region. For example, the Northeast retained 78 percent of its graduates as part of that 3,785 who started the GME-I year; the West, 76 percent; the Midwest retained only 68 percent and the South 77 percent.

The arrows outside represent the net results of the migrations. For example, the Northeast region lost a net of 360 graduates to the West. In other words, it exported about 450 and imported about 90 from the West, so its net loss was 360 students.

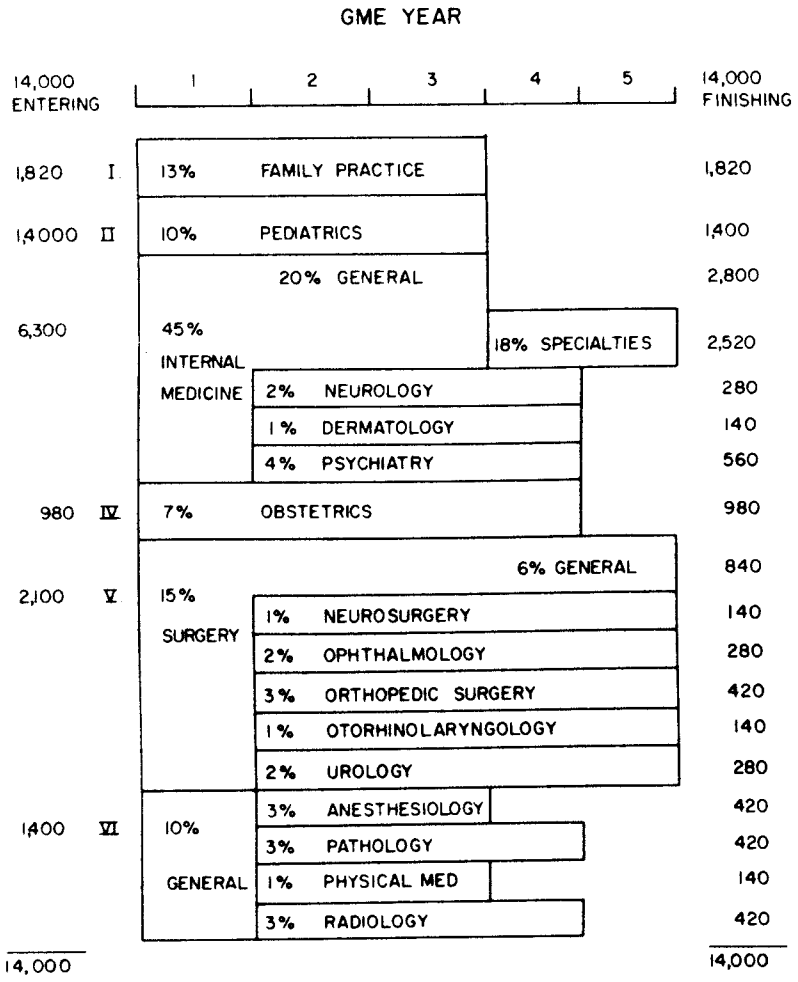
Those 360 students represented nine percent of Northeast graduates, as shown in the upper arrow, but when they got out West, they represented 26 percent of the graduates in the West. The figure shows analyses for the other regions. The South exports to everybody. The West ends up with a number equivalent to 160 percent of its graduates beginning the first year of graduate medical education.

I submit that we cannot simply approach graduate medical education by using national numbers.

In summary, I have suggested that the numbers problem is on the way to solution. We do need a continuing increase in first-rate primary care positions. But the current major problem for NIRMP is not intrinsic to its process but is in education; namely the anarchy of the first and second years. Here are the 41 program types from which our students must select (Figure 11).

Some programs in the specialties are offered in the first year, some in the second. Dr. Farber last year pointed out the problem of the mad hatter syndrome -- the chairmen on the school side of the street who function in committees for admissions, promotions and evaluations and who, when they go across to the other side of the street individually carry out these functions as robber barons in the anarchy which characterizes the graduate medical education programs in the hospitals. This is the serious problem in GME for our students as seen from the vantage point of the NIRMP.

Figure 11



Organization of at least the first two years of GME within each Medical Center, within each school and its hospitals, is urgently needed in order that the transition from undergraduate to graduate medical education can more readily be made. On the basis of the studies we have done plus some speculation, I would like to leave you with the suggestion shown in Figure 11. The 18 types of programs are arranged in the first two years with six types of residencies available in the GME-1 year and the narrower specialties appropriately grouped at the GME-2 level. No flexible residency is shown; instead a general year (VI) is shown for the support specialties which could be a third medicine, pediatrics and surgery or other combinations of the broad specialties and serve as the GME-1 year for the support specialties. The numbers shown are based on a projected class size of 14,000 and the percents on the first choices of our graduates. The distributions after the first year and of those finishing by specialty are, I hope, reasonably educated guesses. The tracking study will help! If all of the program directors within a center, together with management, were to plan the first two years in concert, NIRMP could then match students to the first, the first and second or to all years of GME. Finally, in Figure 12, we have shown the numbers this approach would mean for each Medical Center system.

Figure 12

GME-1 PROGRAMS IN EACH OF 115 ACADEMIC HEALTH CENTER SYSTEMS

		Number	per 100 graduates
I.	FAMILY PRACTICE	16	13
II.	PEDIATRICS	16	13
III.	MEDICINE	59	48
IV.	OBSTETRICS	9	7
V.	SURGERY	22	19
VI.	GENERAL (in II, III, V)	0	0
		122	100

I thank you for your invitation and shall now climb back into my black box.

Table 1

NIRMP MATCHING RESULTS

	1976	1977
Number of Applicants in Match	16,728	15,854
Number Matched	12,215 (73%)	12,760 (80.5%)
U.S. Graduates in Match	11,735	11,898
U.S. Graduates Matched	10,783 (91.9%)	11,172 (93.9%)
Canadian Graduates in Match	44	48
Canadian Graduates Matched	31 (70.5%)	39 (81.3%)
Osteopath Graduates in Match	60	107
Osteopath Graduates Matched	37 (61.7%)	83 (77.6%)
Fifth Pathway Students in Match	252	279
Fifth Pathway Students Matched	227 (90.1%)	257 (92.1%)
FMGs in Match	4,577	3,411
FMGs Matched	1,101 (24.1%)	1,130 (33.1%)
Unclassified in Match	60	111
Unclassifed Matched	36 (60%)	79 (71.2%)

Table 2

POSITIONS OFFERED

Cumulative	1974	1975	1976	1977
Family Practice	1,016	1,362	1,637	1,874
General Practice	67	58	68	55
Internal Medicine	4,347	4,845	4,971	5,351
Pediatrics	1,380	1,450	1,576	1,652
Obstetrics	595	804	808	865
Total Primary Care	(6.810)	(7,715)	(8,252)	(8,932)
Total Primary Care + OB/Gyn	(7,405)	(8,519)	(9,060)	(9,797)
Dermatology	21	16	12	9
Neurology	38	61	82	77
Psychiatry	489	744	897	870
Surgery	2,452	2,497	2,417	2,349
Neurosurgery	8	17	21	27
Ophthalmology	48	63	56	41
Orthopedics	75	139	180	198
Otolaryngology	24	58	50	51
Urology	47	51	48	62
Total Surgery	(2,654)	(2,825)	(2,772)	(2,728)
Anesthesiology	170	393	397	392
Pathology	635	641	601	585
Physical Medicine	37	48	51	66
Diagnostic Radiology	278	360	424	412
Therapeutic Radiology	11	45	59	66
	(1,131)	(1,487)	(1,532)	(1,521)
Flexible	5,665	2,039	1,757	1,572
TOTAL	17,403	15,691	16,112	16,574

Table 3

POSITIONS OFFERED AND FILLED

1977	Offered	%	Matched	%	% Filled	Empty
Family Practice	1,874	11	1,508	12	81	366
General Practice	55	--	13	--	24	42
Internal Medicine	5,351	32	4,670	37	87	681
Pediatrics	1,652	10	1,399	11	85	253
Obstetrics	865	5	710	6	82	155
Total Primary Care	(8,932)	(53)	(7,590)	(60)	(85)	(1,342)
Total Primary Care plus OB/Gyn	(9,797)	(58)	(8,300)	(66)	(85)	(1,497)
Dermatology	9	--	7	--	78	2
Neurology	77	1	57	--	74	20
Psychiatry	870	5	481	4	55	389
Surgery	2,349	14	1,753	14	75	596
Neurosurgery	27	--	18	--	67	9
Ophthalmology	41	--	30	--	73	11
Orthopedics	198	2	155	2	78	43
Otolaryngology	51	--	25	--	49	26
Urology	62	--	34	--	55	28
Total Surgery	(2,728)	(16)	(2,015)	(16)	(74)	(713)
Anesthesiology	392	2	192	1	49	200
Pathology	585	4	301	2	52	284
Physical Medicine	66	--	24	--	21	42
Diagnostic Radiology	412	3	238	2	69	174
Therapeutic Radiology	66	--	14	--	21	52
	(1,521)	(9)	(769)	(5)	(51)	(752)
Flexible	1,572	10	1,131	9	72	441
TOTAL	16,574	100	12,760	100	77	3,814

Table 4

Migration Patterns of

U.S. Graduates* in 1976

Location of GME-1 Year#	Matched		Unmatched		Withdrew		Did not enroll		Total	
	No.	Percent	No.	Percent	No.	Percent	No.	Percent	No.	Percent
Same state	5,164	48	368	41	399	60	108	70	6,039	49
Same Region	2,438	23	230	26	88	13	16	10	2,772	22
Different region	3,109	29	291	33	177	27	30	19	3,607	29
Total	10,711	100	889	100	664	100	154	99	12,418	100

* Excluding USPHS and Armed Forces Hospitals

In relation to location of students' medical schools

A SUMMARY OF THE ISSUES

Chandler A. Stetson, Jr., M.D.*

To a large extent it seemed to the planning committee the key problems and issues around graduate medical education are really intertwined with key problems and issues around our system of health care delivery itself. With respect to geographic distribution of medical manpower, specialty distribution, attitudes of physicians towards social and economic problems in the health care system and like issues, the graduate medical education experience is likely to be one of the prime determinants. Influences coming from society, with increasing frequency in the form of legislation and agency regulation, will be important modulating forces.

The settings in which graduate medical education are carried out have changed rapidly during our professional lifetimes, are changing rapidly at present and seem likely to continue to change in the future. Our challenge, of course, is to try to keep pace with those changes, hopefully to lead rather than to be pushed, so that physicians of the next generation will be optimally prepared to play their proper role in the health care system in which they find themselves.

Now, one of our major proximate problems is that nobody seems to agree as to just what the scenario will be for tomorrow's health care delivery system. Long range and strategic planning for graduate medical education programs is surely needed, but before we can do anything really effective in that regard, we need to have a much clearer definition of goals and objectives than we have right now.

Take the issue of rural health care and how to provide better access and higher quality care for the rural poor of the nation. Some hold that this is only a part of the larger primary care problem and that, if we shift our graduate medical education emphasis, for example, to turn out more primary care and family practitioners, that problem will be well on the way to solution. But one of the major problems among the rural poor, for example, is not at all likely to be solved by or soluble by family practitioners; namely, the problem of the high risk pregnancy and the high infant mortality in this segment of our population. For nutritional and many other reasons, the rural poor pregnant woman is often at relatively high risk for herself and for her fetus, with a propensity to deliver prematurely.

*Dr. Stetson is the Dean and Vice President for Health Affairs at the University of Florida College of Medicine.

Five years ago, two pound babies stood less than a five percent chance of survival in this country, and those who survived had about a 50 percent chance of exhibiting either mental retardation or cerebral palsy or both. Today not five percent, but 50 percent of those two pound babies can be expected to survive (and that percentage is going up every year) with virtually none of the complications that require prolonged or permanent institutionalization. Each year, each such child that survives with normal intelligence represents a saving to society of approximately a quarter million dollars in institutional costs. This represents a return on investment of approximately 100 percent per year. Now, this progress is not being accomplished by training and sending out midwives or physicians' assistants or general or family practitioners. It is entirely dependent on an effective maternal infant care triage system and on the availability of regional perinatal centers where delivery of these high risk mothers can be carried out by accomplished obstetrical teams, with neonatal intensive care unit backup staffed by highly-trained neonatologists.

The high risk mother is the best possible incubator for that high risk baby and needs to be identified and brought into a perinatal center for delivery, rather than being delivered by a less qualified primary care practitioner in a rural setting. It's been estimated that a third of the inhabitants of our retardation institutions in this nation would not be there if they had had proper perinatal care and thus been spared brain damage. The annual national cost of providing this unnecessary institutional care has been estimated at being higher than the total annual cost of our entire national graduate medical education effort.

I cite this example to illustrate that progress in the past five years has very much changed our perception of the nature of this problem and how to solve it. Yesterday's ideas are turning out to be dead wrong, and we need to be very careful and very sure of our ground before we undertake major changes in planning for our future system of graduate medical education. Throwing primary care physicians at that health problem of the rural poor would be as irresponsible as just throwing dollars at it.

In other areas and probably in most other areas we need much more information before making substantive changes. We need clearer problem definition. We need more careful assessment of alternatives and of their cost and of their acceptance by consumers and of their real or fancied effectiveness in actually changing health and disease problems. It is the uncertainty about our data base and about the validity of some of our first approximation analyses that is standing in the way of real progress, we felt.

Now, as the program committee mulled over the issues in preparation for designing this program, some questions and issues were frequently raised. I will tick them off, not in any order of priority, but more or less in the order in which they came up in my notes on these discussions of the planning committee:

Item -- *Is the house officer a junior member of the work force with service to the patient being the name of the game while he gains experience and responsibility?* If so, he or she should be working for the hospital director and paid a salary from funds recovered from patient care. *Or should the house officer be regarded as a student, needing indepth education in his or her chosen field, with education being the name of the game and with patient service being an ineluctable but more or less incidental aspect of his or her experience?* If so, then the student should be stipened and clearly be the responsibility of the educational institution, the department chairman, the program director. I think we all need some sharper focus in this fuzzy area and it will be, I hope, addressed later in this program.

Item -- *How in any case can we protect the educational content of the graduate medical education experience from being overwhelmed by requirements for patient services? What is the proper relationship between hospital director, program director and departmental chairman in the medical school with respect to GME programs?*

Item -- *Should the first year or two of residency be designated education years with specific teaching programs and perhaps with tuition charges, with the later years being more specifically service years?*

Item -- *Should we award the M.D. degree only upon demonstration of competence to practice medicine independently?*

Item -- *What are the facts with respect to primary care manpower needs versus specialty manpower needs, and what are the trends and where are they taking us? What needs to be done, both qualitatively and quantitatively in planning for the future?*

Item -- *What responsibilities do medical schools have for trying to help solve geographic maldistribution problems? What can we do about this. What should we be doing about it?*

Item -- *Who should pay for graduate medical education?* There are subsets of questions relating to reimbursement problems as well as a special problem involved in considering the subsidization of students who are destined to become highly paid professionals.

Item -- *What has happened to institutional responsibility for graduate medical education as a part of the continuum of medical education? What are the intra-institutional problems that have held us back? What are the external forces that have kept institutional responsibility from happening?*

Item -- *What is the future for accreditation of GME programs and for credentialing of the products?*

Item -- *What needs to be done about the "Jaws" issues, the closing trend lines that we've just seen between numbers of entrants and numbers of openings in GME programs?*

Item -- *How effective are our evaluation techniques for evaluating GME programs and their products? What needs to be done about better quality control for these programs?*

Item -- *What about diversification of settings for graduate medical education programs? What is needed? What can be done? Who pays the cost of establishing remote site educational settings?*

A number of other problems were brought up during the year at planning committee meetings, and most of these will be discussed in individual presentations later on in this program.

One troubling question that kept coming up is why do we do graduate medical education at all. The attorney is prepared on graduation to be an independent practitioner of his profession. So is the dentist. There is nothing quite like graduate medical education in our society, except perhaps the post-doctoral fellowship training period for Ph.D. graduates in the sciences.

Collective bargaining, affiliation issues and a number of other topics were deliberately left out of this program for several reasons, mostly lack of time. It was the program committee's hope and expectation that it would be useful to surface these issues and have them explored by the deans at this Spring Meeting in preparation for the Annual Meeting and as a first step toward what will be a major AAMC thrust over the next two to three years.

In the remaining sessions many of these issues will be developed in some detail. I hope that we have laid out the program in such a way that there will be opportunity for the most creative thoughts and the most critical expressions from all of you to be heard. And there are some ifs, ands, and buts in there -- it depends on timing and how well people stick to their time -- as my Irish grandfather used to say, "If ifs and buts were candy and nuts, every day would be Christmas."

GME: RATIONALE RECONSIDERED

J. Robert Buchanan, M.D.*

In approaching the rationale for graduate medical education, we might try to look at it from the point of view of three major and distinct groups participating in the process. First, there are the leaders of our academic health centers, including those who operate our teaching hospitals. Second, there are those engaged in our graduate medical education programs, the trainees themselves. Third, there is the public we serve, our patients, who either pay for their own medical care or for whom services are paid by third-party carriers or governmental agencies. It is this last group and their close associates who most influence public policy-makers and government agency leaders.

As I comment on each of these constituencies and their special view of graduate medical education, keep in mind that I am presenting my view of how they assess graduate medical education. Therefore, there is room for obvious personal bias which I acknowledge from the outset.

In spite of a great deal of rhetoric to the contrary in the last several years, it is probably fair to say that most of the leaders of our academic medical centers still look upon graduate medical education as it has been constituted for the last twenty years - as appropriate and necessary to prepare our graduates for independent practice in contemporary society. Most of us have regarded the four years of basic undergraduate medical education as essential to the acquisition and reasonable mastery of concepts and information and as an introduction to basic clinical skills. On the other hand, there has been a general view that the house staff years are intended to provide the opportunity for mastery of clinical and technical skills to a greater extent than the further acquisition of new concepts and new content areas. That is, undergraduate medical education has been viewed as primarily educational and graduate medical education as largely a period of training. It is debatable, however, that this kind of demarcation is as applicable as it once was. More and more, the graduate years of training have become structured and organized with more features of a genuine educational experience than they once had. In any event, there has been general concurrence that some period of graduate medical education is necessary for the maturation and differentiation of a physician in order for him

*Dr. Buchanan is President of the Michael Reese Hospital and Medical Center, Chicago, Illinois.

to be capable of independent practice. This line of thinking is epitomized by the recommendations of the Committee on Goals and Priorities of the National Board of Medical Examiners. Curiously, while those responsible for our academic medical centers generally acknowledge the importance of graduate medical education programs, they must also acknowledge their lack of direct control over the nature of those programs. Rarely does the university or its teaching hospital determine the content or size of its graduate medical education program. These issues are in large part influenced by extramural agencies, including the residency accrediting mechanism, the specialty boards, the sub-specialty boards, and, in the past, those who funded training grant programs. In fact, many programs in graduate medical education, it seems to me, have been perpetuated regardless of the need for their output or their quality, because of the entrepreneurial skills of the program director or the service requirements of the sponsoring hospital. Moreover, how could any self-respecting university or teaching hospital fail to have a training program in one or more sub-specialties? It would be inconsistent with our usual self-image and our elitist status.

In his discussion of interns in the French medical educational system, Flexner emphasized that individuals entered these highly sought roles by way of stiff competitive examinations. This gate-keeping mechanism regulated the number of individuals who ultimately became teachers and, if you will, consultant specialists in the French health-care system of that day. This might, indeed, be a mechanism for limiting access to training programs in specialties where manpower surpluses already exist or will soon exist. And we see that the neurosurgeons have already gone this route. Such a mechanism would not replace the certifying examinations which specialists and sub-specialists must now fulfill, but it would regulate inflow to the educational programs that precede certification. Our current graduate medical educational programs produce an array of very well-qualified specialists and sub-specialists, the vast majority of whom provide a highly significant amount of primary or general medical care, not directly related to their sub-specialty interest. On this basis, then, it can be argued that the present system is over-training at substantial expense, a significant number of physicians who, though qualified, do not spend most of their time as specialty or sub-specialty consultants, seeing patients referred by other physicians. They do, however, reap financial benefits from their specialty certification and status, even when providing primary care. Obviously, this inflates the costs of health care delivery unnecessarily.

The expense of graduate medical education is one issue on which most academic health center executives would agree. These programs are expensive, and those who pay for patient care are becoming more and more reluctant to see a significant portion of the patient-care dollar diverted to support medical education at any level. This development comes at a most unfortunate time, when there is a widespread effort to cut the basic cost of patient care, and when the support of biomedical research has already been reduced. Hence, those of us in academic medical centers who have espoused graduate medical education programs of the sort we have witnessed in this country for the past two or three decades are now challenged by the public about the nature of our programs and the funding for them. I shall have more to say about this later on.

Trying to look at graduate medical education from the trainees' point of view is interesting, albeit confusing. An apparent schizophrenia is evident. On the one hand, they, house officers, are activist advocates for superb educational opportunities because they are, by their own definition and declaration, graduate students. Indeed, they justify a retinue of laboratory technicians, IV teams, patient escorts and others as necessary to assure them time to realize the full educational potential of our programs, though they commonly use free time to "moonlight" instead of study. On the other hand, they demand that we negotiate with them and reimburse them as valuable employees because of their contribution to our patient care services. These two points of view are not totally inconsistent, but together they provide a basis for whipsawing the leadership of our academic medical centers into complying with a vast number of our trainees' expensive requirements. At the same time, our trainees expect the privilege of making a free choice of specialty and sub-specialty fields, and in virtually every academic medical center. We make this easier by offering the full spectrum of specialty and sub-specialty training programs. Now, the desire of trainees to be viewed both as students and as employees with bargaining unit privileges is inconsistent with today's realities in the academic medical center world. Inflated salaries and expensive job conditions, including rich educational environments and expanding fringe benefit programs, are becoming a burden for hospitals and universities stressed by increasing financial adversity. Interestingly enough, most universities and academic medical centers spend more on the support of their graduate medical education programs than their undergraduate counterpart programs. Moreover, they inappropriately charge many of the graduate medical educational costs to the undergraduate medical education program, because historically this has provided a means

for arguing for more support from governmental agencies for the undergraduate programs, which, until recently, carried a high social premium. It is interesting, too, that although today's house officers were, for the most part, undergraduates in the late 1960's and early 70's, and contributed substantially to the humanistic rhetoric of that time, I am not convinced that such humanistic concerns are the primary motivation for the groundswell of interest in family practice and general internal medicine in rural and semi-rural areas. Rather, I see this choice and the flight to rural areas as more related to lifestyle than to a concern for the redistribution of health services, either as to specialty or geography. There is, I perceive, amongst today's youth, a substantial disaffection with urban and suburban areas.

Now then, how do patients or their agents, the insurance companies, and the governmental agencies, including Medicare and Medicaid, see graduate medical education? For how they see it is, in large part, responsible for how the politicians see it, and how the public policy evolves.

My perception is that the public generally views graduate medical education as producing the wrong kinds of doctors and distributing them inappropriately across the country. Moreover, the public is mistakenly convinced that the medical schools control these phenomena. They see graduate medical education programs as university programs which can, and should be altered to meet social needs. They see these programs as expensive per se, and as generating the kinds of doctors who inflate patient care costs still higher. As I read the newspaper, listen to newscasters, and read the expanding literature on controlling the costs of health care and health education, I'm even beginning to wonder if our public policy-makers now regret having urged the expansion of undergraduate medical education that was sought and which we have met.

It seems to me that the public is saying to us, "We not only want physicians who will be available and who are not so specialized as to be disinterested in all of our problems, but also we want physicians who have deeply felt Samaritan instincts and concerns. We expect you, the country's medical educators, to develop programs during the graduate medical education years which enhance the physician's concern for Samaritan issues". This is said at a time when, in my own view, it is all the more difficult to achieve in our training programs, because of our need to emphasize the expanding technology and science of medicine, to emphasize financial issues, cost containment and legal considerations produced by the malpractice crisis.

In view of the foregoing, one can properly ask, what ought academic medical centers do about the quality and the quantity of their graduate medical educational programs? And how ought the centers' dwindling resources be allocated to these endeavors? If one were given to pessimism, one might take the position that the public, unprepared to support adequately quality medical education and dissatisfied with the abundant specialty and sub-specialty talent we have generated recently, is providing us with a rationale for our total withdrawal from that effort. But surely nobody in this room believes we could justify such a move. It would be irresponsible. Rather, I am convinced that we must do everything possible to develop alternative training programs which will permit the continuation of specialty and sub-specialty training on a scale consistent with the numbers needed, provide increased numbers of generalists for the routine medical care needs of our society, and, importantly, provide a modus operandi for our great academic health centers as they struggle to live within the dollar allocations made available to them. We will have to work together to reduce superfluous specialty and sub-specialty training programs, either as to number of programs, or numbers of trainees or both. Moreover, we must demand approval of our total graduate medical education program, rather than mere segments of it, just as we receive accreditation of our undergraduate medical education activities as a total program. We will have to work harder to fund graduate medical education qua graduate medical education instead of our longstanding practice of loading all educational costs or at least the majority of them, on the undergraduate medical student program.

We can no longer reasonably expect to receive substantially more public support for undergraduate medical education than is currently the case. It will be necessary to emphasize the multiple products or outputs of our medical educational efforts. Moreover, we will have to aggressively seek out and win multiple funding sources for these other educational programs, including graduate medical education, just as we have done in the instance of undergraduate medical education. As I have said, I believe there will also have to be an absolute reduction in the number of advanced graduate education programs. This will further complicate the operation of our hospitals, especially those which see themselves as tertiary care facilities. In these instances, considerable efforts will have to be made to develop physician extenders or surrogates if some of the patient care programs in such institutions are to be continued while the graduate medical education programs in certain specialty and sub-specialty areas are reduced or eliminated.

My final point is that I believe we must reconsider the length and expense of medical education from the time the individual leaves secondary school to the time he is qualified and certified for the independent practice of medicine. As one interested in education, I am not enthusiastic about reducing the time allocated for pre-medical studies. This is such an important time for the development of the student as a person, and an intellect, as an individual interested in ideas and not simply in the target of entering a professional school. But in a world which tells us we can no longer afford that kind of modest luxury, I wonder if we could not, in fact, combine pre-medical and medical undergraduate education into a six calendar year program. In accord with the spirit of this meeting and for the sake of provoking discussion, I would offer the model of two years pre-medical education and four years of undergraduate medical education, including one obligatory year of advanced senior clinical clerkship. To this I would add a two-year program of graduate medical education, designed to produce an individual who is, in essence, an undifferentiated general internist or pediatrician, whichever his or her specialty. I would advocate that the individual also have significant experience in the emergency room as well as selected experiences in office gynecology, the surgical specialties, and pediatrics or internal medicine, whichever is the appropriate alternative for the individual. Upon completion of this program, I would see as a minimum an examination similar to the qualifying B examination proposed in the GAP Report. Further, I would hope that the experience of a rigorous senior advanced clerkship, plus a two-year graduate medical education program, would qualify these individuals for Boards in internal medicine or in pediatrics. Of course, sub-specialty training would have to be available to some individuals each year. I see them entering such programs in limited numbers, determined by the LCGME and the Coordinating Council, after passing the qualifying B examination. Ultimately, upon completion of sub-specialty training, they would sit for certifying examinations offered by sub-specialty Boards much as they are now. These specialists would be expected to function almost exclusively as consultants and teachers, seeing patients referred by general internists and pediatricians. They would not be significantly engaged in the provision of continuing general medical services.

The advantages of this kind of system would accrue to the individual physician, the hospital and society at large. Funding of undergraduate pre-baccalaureate as well as undergraduate medical education is rapidly becoming more difficult. Tuitions are mounting, scholarships are no longer available in sufficient numbers or amount, and the same situation is developing with respect to loan funds. Moreover, the total indebtedness of our students upon graduation from medical school is bound to climb

sharply, while, in my view, society has become increasingly disapproving of continued high incomes for physicians. Reducing the duration and number of educational programs would surely reduce the costs in our major academic health centers and fewer house officers in our academic health centers might well simplify their operation.

Of course, I know there is nothing new about the basic concept of the model I have offered. It is basic to Western European medical education, and has been offered on a more or less experimental basis at various times by a number of United States universities.

In the past, it has been argued that four years of pre-baccalaureate education in the United States was necessary to provide an education comparable to that of the European student, let's say the student in the U.K., entering a six-year program leading to the equivalent of our M.D. degree. If that was once true, I doubt that it is today. Secondary education in the United States, at least that pursued by those who go on to study medicine in this country, is now of a very high order. Just look at the heightened sophistication of today's college and university programs. Only a well-prepared student could possibly deal with them. Thus, I no longer accept the argument that secondary education in the United States is an inadequate base on which to build a six-year educational program which would prepare students for the supervised practice of medicine.

I have also heard it argued that seventeen and eighteen-year-olds are too young and immature to study medicine. Why? We allow them to do virtually everything else in our society. I think these young people will bring a still-fresh enthusiasm to the challenge of studying medicine, instead of the all too blase attitude we commonly find among those who have been virtually saturated by the usual high-powered, overly competitive premedical programs. I might add that these programs often duplicate much of the subject matter of the first two years of the present traditional medical school curriculum. This helps to account for the fairly widespread grudging attitude towards the further study of these subjects in medical school. With a shortened basic program, more realistic and effective alternatives might be offered the disadvantaged socio-economic and educational students, without creating a longer, and therefore more expensive program than the usual present day medical education.

Prior experience in the United States with programs of this kind has been limited. I am advocating serious consideration of a

broad-scale effort with meticulous attention to the integration of the new program at the interface between it and the preceding secondary school education on the one hand, and the post-M.D. degree phase on the other. That is, I am suggesting we approach the preparation of physicians as a continuum, as the Coggeshall Report did, not as a segmented effort, that this continuum begin upon completion of secondary school, and that it end eight years later upon successful fulfillment of qualifying B examination. To do this, we shall have to move away from our current model which is, in effect, a twelve-year model: four years of pre-baccalaureate study, four years of medical education as an undergraduate, and, on the average, an additional four years of graduate medical education. I make this suggestion somewhat reluctantly only because I am convinced that rapidly shifting social priorities will have progressive effects on higher education in general, medical education in particular, and graduate medical education especially. These dynamics are further complicated by the growing preoccupation of the public with containing the costs of health care. Consequently, I believe we would be well-advised to initiate voluntarily carefully considered measures to reduce the costs and preserve the essential qualities of medical education, especially the graduate phase. Unless we do so, I am certain every aspect of medical education will be as regulated and subject to external policy formulation as are our patient care programs and the management of our teaching hospitals.

ACADEMIC OBJECTIVES OF GME PROGRAMS

Albert L. Rhoton, M.D.*

One theme that has been brought out here this morning, that I had not planned to speak to directly, but will because it has been alluded to, is the question of manpower in the neurological specialties. A few years ago in the New England Journal of Medicine, an editorial appeared stating that neurosurgery may die by a neurosurgeon. The theme of the piece was that we're killing ourselves by turning out too many neurosurgeons. Neurosurgeons, true to the commitment that we pursue quality, took this to heart. We looked at the specialty, and, over a number of years now, have asked the question, "are there too many neurosurgeons?". Repeated surveys have been done, most of them conclude that we have just about the right number. But there has been a trend since then to gradually tighten up quality of the applicant and quality of the program, and to slowly reduce the number trained. That is what I want to tell you about today.

Dr. Coggeshall mentioned the trend of moving graduate education to the university. I think that that's been accomplished in neurosurgery as well as any other specialty. Of approximately 100 programs, there are only four, now, outside the university and there will probably never be another one. Since neurosurgeons are a small group, approximately three percent of board certified surgeons, the last thing we would wish to see is manpower planning decision aimed at us which is not part of an overall plan. Unless all of the surgical specialties are considered, a plan could be developed that would literally stifle us in, for example, our ability to do disc surgery in the smaller communities and would limit our ability to continue our creativity. We would like it not to restrict us unduly in terms of the other specialties.

The overall objective of graduate medical education is to train a physician to assume independent care of a patient in a specific discipline. In neurosurgery this utilizes six of a young person's prime years, involves procedures unrivaled in length with a high degree of technical difficulty. The residency is completed in an atmosphere in which surgical risks as measured by potential morbidity and malpractice rates are possibly the greatest of any profession. A highly motivated teacher and trainee are needed but trainee selection is the most important factor in reaching training objectives. By the time a man has spent five years in training, two years in practice, failed the boards a

*Dr. Rhoton is a Professor of Neurosurgery at the University of Florida College of Medicine.

few times, comes back for further training and again sat the exam, he will eventually pass. His admission to the specialty was not determined by the Board but by the program director who accepted him six to ten years previously and in fact, if he had never passed the boards he could still practice. Many now feel that we should admit trainees as we admit students to medical school. The National Board Exam might serve in a similar fashion to the medical college aptitude tests. Students less than top candidates could be directed into less exacting specialties.

At the University of Florida, our residency positions are filled with residents from the upper portion of their medical school classes; over half being members of AOA and most of these were elected members in their junior year. Although many problems are solved by selecting only such high caliber candidates, the Federal Trade Commission has proposed that organized medicine's control of the number of surgeons serves to restrict competition and thus some surgical specialties are faced with anti-trust suits. This year, the annual meeting of neurosurgery program directors will review the possibility of establishing a minimum National Board test score for neurosurgery training applicants. The overall impact of such a decision by one on other specialties must be carefully weighed outside neurosurgery.

Neurosurgery has been successful in the use of testing not only to evaluate but also to improve graduate education. In the 1960's the Board of Neurological Surgery became disturbed by the high failure rate on the certifying exam; it reached 45% of presumably well-trained candidates. Board members asked could it be due to: poor exams, poor examiners, trainees freezing-up during oral examinations, poor training, or selection and retention of inferior trainees for patient care or to man research projects. The Board decided to conduct a written exam during the training program so that the trainee and program director could correct this before the end of training.

It was decided that exam results should not influence the formal board examination. Therefore, a special commission, separate from the Board, aided by the National Board of Medical Examiners, was selected to develop this exam. Results were to be given only to the trainees and their program directors, and not to the Board of Neurological Surgery.

A blue-print six-hour examination designed in 1964 included: neuroanatomy; neuropathology; neurophysiology; neuroradiology; clinical neurology; general surgery; and neurosurgery proper.

The National Board drew from the vast pool of questions used in medical student examinations. Some were accepted by the neurosurgeons; but many were considered too easy or not appropriate. New questions were developed.

All concerned held firmly to the view that the individual's grade should be made available to the Board only after the candidate's certifying oral examination had been completed and graded. Statistical analysis revealed the reliability of the subtests to be excellent. There was a significant difference in the mean scores at different levels of training. The performance of examinees who were tested more than once revealed a progressively higher performance. The highest score was made during the same year as the completion of residency. Two or more years after completion of residency, the mean score dropped. The results ruled out the so-called freeze-up as the cause for the high failure rate on the oral examination. The individual who did well on the written had no difficulty with the oral and the majority who failed the oral did poorly on the written. There was a positive correlation between the National Board scores and scores on the in-training written examination. The in-training examination proved highly valuable to both trainees and program directors, and it decreased the failure rate on the oral examination.

When the in-training exam reliability was proven, it was decided to give Board candidates the option of utilizing the exam to fulfill the basic sciences part of the certifying exam. A few years later it was decided that the written examination must be passed before taking the oral exam, and last year the Board and Residency Review Committee recommended to the LCGME that no trainee be endorsed by the program director as having completed formal training until the exam, now called the primary examination, had been passed. The oral exam must still be passed between two and five years after completion of training.

In an attempt to further objectives and improve the quality of training, the Committee on Graduate Education in neurosurgery, working through the major neurological societies, have made the following recommendations which have been approved by the Board and Residency Review Committee, but not the LCGME:

-- A specialty surgical program requires an atmosphere in which there are other quality training programs. A basic minimum for neurosurgery is that there be approved residency programs in surgery, medicine, pediatrics, and neurology.

quite fortunate in developing a microsurgery education program which brings in seven private practitioners from around the world each month for one week courses. These practitioners attend each of the daily resident conferences and the conferences during the week are planned so as to promote a maximal interaction between medical students, residents, visiting practitioners and our faculty. During each course week our residents have one conference with the visiting physicians aimed at discussing the visitors' training programs with particular attention being given to ideas which might improve their own program. A number of suggestions from these sessions have been incorporated into our program.

Our specialty has come a long way since Harvey Cushing demonstrated to the world that brain tumor surgery was possible. I believe no one would have been more excited than Cushing had he lived to see disc surgery, shunt therapy, tumor chemotherapy, cerebral angiography and computerized scanning. To meet these expanding needs, subspecialties are now developing rapidly in neurosurgery, as they are in the other specialties. We now have pediatric, cerebrovascular, stereotactic, traumatic and spinal neurosurgeons.

Attaining objectives remains an exciting but not overwhelming challenge even amidst the changing climate created by evolving new subspecialties, expanding knowledge, revised emphases of undergraduate medical education, changing needs of society, increasing governmental control, and the increased organizational complexity of American medicine.

A SCIENCE POLICY PERSPECTIVE

DeWitt Stetten, Jr., M.D.*

The title of this talk took me a little by surprise, and if I deviate from this subject a little bit in the next few minutes, I hope I will be forgiven.

I would like to take as a thesis an item out of Mr. Lawton's presentation, in which he pointed out that it was the Federal Trade Commission which was setting or purporting to set certain policies in regard to medical education. This, I must admit, made my hair, such as I have left, stand on end. I do not like medicine referred to as a "trade". I do not like medical schools referred to as "trade schools". And I do not care to hear that the deans of medical schools are, by implication, the deans of trade schools.

I think that what we purport to do at the medical schools of the United States, is to initiate young persons into a profession. I suspect there are as many definitions of the word "profession" in this room, as there are people. I would like to share with you my own personal notion of what a profession is. A professional person is a practitioner, but is also a continuing scholar. It combines the notions of practice and scholarship and these notions are expected of the professional person. It is for this reason a little troublesome to me to learn that graduate medical education is construed by this house as a finite number of years which succeed upon the award of the M.D. degree and then which terminate. I would like to suggest that it might be much more useful to assume that graduate medical education is something which terminates only when the practitioner or scholar dies, retires or attains the age of 72, at which time he can stop being a scholar, as far as I am concerned.

Since I have not attended these meetings regularly for the past seven or eight years, I was reassured to learn that the same arguments are still being discussed, to learn that the same issues are still being proposed, to learn that Dr. Lowell Coggeshall is still setting the pace for our discussions. It was a privilege to hear Dr. Coggeshall again, after so many years.

It seems to me that this nation has made a very large investment in its physicians. There are of the order of 300,000 of these if I recall correctly. And their educations, as has been pointed out, are becoming increasingly costly. These costs are borne by them, their families, their communities, the states in which they reside, and to

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*Dr. Stetten is Deputy Director for Science at the National Institutes of Health in Bethesda, Maryland.

a significant degree, by the federal government. It is an investment which I think we should consider protecting. And it might be worth noting that for many physicians, particularly those who are more remote from these academic medical centers which have been alluded to frequently today, the process of education does, indeed, if not terminate -- slow down, once that last certificate has been earned, once that last examination has been taken and passed.

I would not have believed this while I lived for many years in the sheltered ivory towers of some of our major biomedical institutions. But when I got out into the hustings of central New Jersey, I did learn otherwise.

The process of education as it starts in earliest infancy, is initially the primary responsibility of the teacher. What my grandchild learns depends upon what the teacher teaches. However with the progress of time, through school, college and medical school, the responsibility, I think, quite clearly shifts. The major load is placed, not on the teacher, but on the student. And whether the postgraduate physician learns or does not learn, broadens or does not broaden, depends not so much upon the nature of his faculty, but on his own impulses, his own drives, his own stimuli.

It is for this reason, that I regard medicine's great contribution to the art of pedagogy to be the invention of the residency. As has been pointed out, this was, and to some extent still is, largely a medical device. It is the device of taking the man, after graduation, and totally immersing him into an operating situation where he learns by doing. This goes on substantially for 24-hours a day, for seven days a week, and for a number of years.

This device has been mimicked by certain other professional careers. Thus, there are theological schools, which have internships. And there are or have been in the past, law schools which can provide clerkships for their graduates. But it is in medicine that the residency has been stressed. The residency is good and I think from many of the people with whom I have exchanged views, the residency was the most intense, the most exciting and, in retrospect, the happiest portion of one's education.

If it is all that good, and if we have a problem of providing continuing education, then thought should be given to reviving the residency. There are many attempts in this country to provide opportunities for continuing education to the practitioner, beyond the period of his final formal hospital training. Many of us in this room, I am sure, have made the rounds of the community hospital board rooms, usually after supper to share our scientific wisdom with a generally scanty population of tired physicians. As one does this,

one starts to see the same familiar faces in the audience and one soon appreciates that at least in part the audiences in these hospital board rooms and county medical societies are made up of physicians who do not get along very well with their spouses and use the programmed meeting as a device to leave home. It is, or at least I found it to be, a discouraging exercise in education. And the reason, of course, is that it is entirely passive on the part of the student, at a time of life when education depends primarily on activity on the part of the student.

I have sought ways which seemed to work better. They fall really into two categories, which I should like briefly to describe to you. In a small town in northern New Hampshire where my family and I were summering, I had a daughter who took acutely sick. There was one doctor in town who had prepared himself to be the doctor of this town. His father had been the doctor of the town before him. This man had completed medical school in one of our great institutions and had taken a residency in surgery at the Massachusetts General Hospital, filling out his spare time with a little training in psychiatry, a little training in obstetrics. He had a hospital containing 18 beds in a wooden building. He had one nurse. He had a retired dentist, whom he had trained in the rudiments of anesthesia. He was all of medicine for this community.

Fortunately, he was there and my sick daughter became his patient. I spent every night in the hospital for the next two weeks, my wife spent every day. And I got to know how medicine was practiced in this particular town. It was elegantly practiced. The reason was easy to find. The doctor was a man of enormous energy, and enormous dedication. He worked hard day and night, except on Tuesdays when he would get into his little car, a Ford coupe, and drive over 100 miles to the city of Boston, because he was a member of the tumor clinic at the Massachusetts General Hospital, and this was an important function for him.

It was important in many ways, but perhaps most important, because he carried with him all of the questions, all of the problems which had come to him during the preceding week in his practice. And he came back from Boston Tuesday evening refreshed and informed. He knew MGH well. He had lived there for several years. He knew where to get the information, the guidance, the wisdom that he needed. And this little town in Northern New Hampshire, enjoyed the benefits of a medical practice essentially equivalent to that of Massachusetts General Hospital, something which it really had never bargained for. I mention this anecdote because it shows one way in which a great academic center can, by a process called extension, make its impact felt remote from its main base.

It is, I think, a difficult way of doing it, and one that is not likely to become terribly popular because it does involve an enormous expense; expense in energy, expense in time, and in addition, expense by the town. On Tuesdays, that town had no doctor whatsoever. And that was one of the prices they paid for quality medicine the rest of the week.

A quite different process and one which it seems to me is much more feasible of wide application, is the concept of the refresher residency. I first encountered this idea in the Soviet Union, which I visited in 1958, as part of an official exchange mission. This was at a time when the then current five-year plan included the proposition that every physician in the Soviet Union would spend six months out of every three-year period in an institution. This might be a medical school, it might be a medical or surgical specialty hospital, it might even be a research institution. We were intrigued to learn that during that six-month period, since research and teaching were more highly cherished than medical practice in the Soviet Union, the candidates' stipend went up, only to go down again when they reverted to the practice of medicine.

The plan, as far as I know, was never fully implemented. But it had the elements of other plans, some of which I am sure you are familiar with. The one which I have heard most about was one instituted by Tom Randall when he was surgical director at Memorial Hospital. He attracted former residents to that hospital between five and ten years in practice, to return to the hospital for one month. They were required to abandon their private practices, put on white pants and make like residents. They worked every day, all day, and weekends. The residency experience was adjusted to meet their particular interests, in some area in which Memorial Hospital in New York had competence, such as radiation therapy, pelvic surgery or thoracic surgery.

The program accommodated four such persons a month, or a total of 48 in the course of a year. It paid the doctors $1,000.00 for the experience. This was intended, in part at least, to defray their office expenses which, for that month, would produce no income. I was invited to a luncheon to celebrate the first anniversary of this program and I met the 40-odd young persons who had been through this training program. It was quite clear that the program was, from the candidate's point of view, enormously successful. There was, essentially, unanimous concurrence that upon return to their practices these young men and, I think, a few women, practiced a better quality of medicine than they had prior to that one month's experience. They all seemed to find it exhilarating to drink deep at the Pierian Spring and when I made so bold as to ask the question "Would you do it again in another five years?", I got a unanimous voice in the affirmative.

Such a program, I think, has the germs of national possibility. Such a program might protect that vast investment which we have made in our physicians and assure that they are really practicing current medicine, assure that science and medicine have not passed them by. Medicine and science are progressing at very high rates, and indeed are growing exponentially. Ways must be found to seduce the doctors of the community to come back for refresher residency periods.

It would be costly. Depending on what coefficients you choose to put into the equation, you can calculate what the cost might be. Let us assume that one month out of every five years is deemed an appropriate length of time for service in such a refresher experience. If there are 300,000 doctors in the country, one-fifth or 60,000 would come up for training each year. Being a slave of the Civil Service myself, I suggest that the top salary of the Civil Service would be about right and that comes to $4,000.00 a month. The cost, therefore, of this part of the program, which I am outlining to you, if indeed all 300,000 doctors entered the program, which seems unlikely, would be $250 million, a quarter of a billion dollars. That is either a large number or a small number depending upon your standard of reference. Out of an enterprise of health, which, according to the last figures I saw, was well in excess of $100 billion, this comes to a cost of less than one quarter of one percent, which is, I think, a small sum to invest in order to protect a major share of our investment in that enterprise. There are many things wrong with the suggestion which will at once occur to you. For the doctor who is in partnership or who is a member of a medical group, he may be able to arrange a month away from the office without deleterious effects to his patients. For the solo doctor and, particularly the solo doctors in a community, where he is the only source of medical skill, it may be much more complicated. Maybe it cannot be arranged, or maybe some locum tenens arrangement can be designed whereby the senior residents in an appropriate specialty at the hospital which is going to accommodate the refresher resident, could be dispatched to this community to take charge of the practice while the home doctor is being refreshed. The biggest problem is incentive, and this one I must admit stumps me. There will be some doctors who will do it and who will enjoy it and will want to do it again. As experience has shown, there will be other doctors who have lost the lust for new knowledge.

I suspect that such a program cannot have widespread appeal unless and until relicensure requirements are introduced into medicine, as they have long existed among that other hazardous profession, commercial aviation piloting. When and if such a situation comes to pass it would be interesting, I think, to offer as an alternative to a relicensing examination the opportunity to spend a month in a major teaching hospital as a resident.

I suspect that the prospect of a relicensing examination will be sufficiently terrifying to many physicians that they will leap at the opportunity to renew their residency experience. Furthermore, I would suggest that the month in residency would be of much more use to them, than the three hours or six hours devoted to writing an examination.

I should like to leave you with these notions. I am afraid that I do not agree with Dr. Buchanan, that much is gained in shortening the curriculum. We have been through that before. As he was talking, I was reminded of the fact that my father graduated from P & S in 1904, having entered directly from high school. This was, of course, before the Flexner Report. Surely we can do it without college; we have done it without college before, but I question whether it's a particularly good thing to do.

WHAT HOUSE OFFICERS DO

Ruth S. Hanft*

Before starting with my formal remarks, to show you how confusing the graduate medical education picture is, I would like to tell you a true anecdote from the Social Security Studies.

We used a very sophisticated method to draw the sample of the 96 hospitals in the study, and after the sample had been drawn, we wrote to each of the lucky victims, to advise them that they were part of the study. Unfortunately, very few of them, because of something that the Senate Finance Committee did, had the option to reject participation in the study.

Well, all of the hospitals agreed, except one hospital which wrote back to us and said, "Oh, but we're not a teaching hospital." So we went back to the Green Book, and sure enough, they had any number of approved programs. We called the Administrator, and we said, but you have all these approved programs. Why do you say you're not a teaching hospital? "Oh", he replied, "all of our residents are FMGs!" He remained in the sample.

The program of this meeting is obviously much broader than the issue of what house officers do. The activities of house officers, however, illuminate many issues which were discussed this morning, and will be discussed tomorrow -- the content of graduate medical education, the hospital and medical school roles in graduate medical education and patient care, how graduate medical education should be financed, how care should be provided to low-income people, the appropriate role of house staff in undergraduate medical education, and whether house staff are students, employees, or both.

In the spring of 1975, the Institute of Medicine, as part of a study of payment of teaching physicians, collected log diaries on the activities of house staff in 96 hospitals across the country. Completed time logs were returned for more than 5,000 house staff, which is fairly substantial sample of the total.

One of the purposes of the study was to explore the roles house staff and teaching positions play in patient care activities related to Medicare and Medicaid beneficiaries.

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*Mrs. Hanft is a Visiting Professor in the Department of Community Medicine at the Dartmouth Medical School.

Dr. Gronvall will speak about other aspects of the study tomorrow, and I look forward to his discussion. The findings of the study indicated that a majority of the activities of house staff were related to patient care or joint teaching and patient care, that activities varied by specialty, year of residency, type of hospital, and type of patient, that a large proportion of patient care services were provided by house staff without direct supervision of attending physicians or other house staff, and that house staff supervision varies with the payment status of the patient.

House staff work a little more than 60 hours a week. It's about 60 and a half hours. That does not count moonlighting or on-call, off the premises of the hospital.

Approximately 76 percent of their total time is spent in patient care or joint teaching and patient care. Fifteen percent in learning, and eight to nine percent in other activities such as research, administration or pure teaching.

In the hospital setting alone, 85 percent of their time is spent in patient care, or joint teaching and patient care. Activities vary widely by type of hospital, with the greatest proportion of time spent in patient care activities spent in the local public hospitals, and in something we called the graduate associated hospitals.

The lowest proportion of patient care activities occurs in the private primary hospitals, the ones most closely associated with the private medical schools. In primary hospitals, a large portion of the joint teaching and patient care supports the M.D. programs -- the undergraduate medical education programs of the schools.

Activities also vary widely by specialty. The ratios of patient care and learning in psychiatry, for example, are 65 percent and 23 percent respectively. In family practice, 84 percent and 12 percent respectively. Medicine, 80 and 14 percent, surgery 86 and eight percent.

Obviously, this represents differences in the specialty and in the educational content of the different specialties and should not come as a great surprise to anyone.

The degree of supervision of house staff also varies substantially among types of hospitals and types of patients served. House officer responsibility for three types of patient care services in the in-patient setting were compared -- treatment, surgery and discharge. House officers usually initiated treatment in all of what we call Type Two hospitals. Type Two hospitals are hospitals that serve mainly non-private patients. In contrast, they did so in only ten percent of the cases in Type One, or hospitals that serve mainly private patients.

Similarly, house staff usually initiated treatment for non-private patients in the Type Three hospitals, which we call the mixed hospitals, but seldom for the private patients in those hospitals.

Routine daily management within an approved treatment plan was considered to be a house officer function in all types of hospitals. House officers assisted in surgery, whether the patients were private or non-private. However, a house officer was the primary surgeon in three-quarters of the cases in the Type Two hospitals, and in about one-third of the cases in the Type One hospitals.

House officers usually wrote the discharge summary in all of the sample hospitals. Signing the summary, however, was rarely the house officer's responsibility in Type One hospitals, the privates, but the reverse was the case in the Type Two hospitals, and in the Type Three hospitals, it varied by whether the patient was private or non-private.

The level of supervision of house staff is also different by hospital and type of patient. The attending physician was present, directly supervising house staff, for a greater percentage of time in Type One hospitals, and the mixed settings in Type Three hospitals than in the Type Two non-private hospitals.

The highest percentage of house staff patient care time in all hospitals was spent in independent care, with the expectation of review. Relatively little time was spent in independent activity without expectation of review in any of the facilities.

In Type Two hospitals, however, more supervision was provided by senior house staff than in the other institutions. The supervision by year of training also varies; there is a closer relationship between the attending and the house staff in the higher years of residency, and greater supervision of the house staff in the first several years of residency.

The patterns of supervision are somewhat different in the out-patient department and in the emergency rooms. House staff reported slightly more time in independent activities without supervision in the out-patient departments, but not substantially so, than in the in-patient departments. In the emergency rooms, however, there is a considerable difference. A greater percentage of patient care time, acting independently, is spent in emergency rooms than in any other setting.

They work independently, three-quarters of the time without expectation of review. The IOM study found that a large proportion of the Medicare population, the aged, are regarded by hospitals as private patients, unless they cannot pay their deductibles and

co-insurance. In contrast, although payment may be made in full, Medicaid patients are most often regarded as non-private patients.

Well, what does all this mean? The remarks that follow are my own, and do not reflect the opinions of the Institute of Medicine or anyone else. Some of the remarks are deliberately designed to provoke discussion.

Even though we have increased public financing of medical care, and have made great progress in the reduction of financial barriers to care for the poor, we still have a pervasive system of dual care in our teaching hospitals. The Congress was right in their concern. Since most of the public hospitals with teaching programs are affiliated with medical schools of this country, and the department chairmen, or their designees, supervise the house staff in these public hospitals, it seems to me that the schools must bear a large part of the responsibility for the dual system of care.

I was also very much surprised to find that in a number of state-owned, publicly-financed medical schools, there was still, within the university-owned facility, two types of care provided, primarily based on either the patient's prior association with a physician, or more often, his economic status.

Sometimes this was done with great subtlety and ingenuity. Sometimes it was very blatant. In some cases, the state university or the private university used its own hospitals, the hospitals they owned, for primarily private patients, and the county hospitals for public patients, producing different patient care and economic conditions in the facilities.

Residents serving under the supervision of the same medical school and department chairmen behaved differently in the different settings. I think the medical education community should take a hard look at the continuation of these differences in patient care and graduate education.

This is not to say that anyone has hard data on differences in outcomes -- patient care outcomes. And it may well be that there are none. But there are certainly differences in the input. The perceptions of the administrators in these institutions often do not conform to actuality. We were told in a number of cases, "Oh, no, we do not treat our patients differently, by payment status or any other reason." But once you got in there with a team, and began exploring admissions policies, had the staff time logs, looked at supervision, talked to the admitting clerks and the nurses, an entirely different picture emerged.

Aside from the issue of how teaching physicians should be paid, in circumstances where house staff have primary responsibility for care, there is the important issue of the attitudes that are formed in terms of future behavior of physicians. The psychology of the dual care concept. Are we not reinforcing a two-class system, and teaching young physicians that patients are different, based on economic class?

I also find the emergency room data disturbing. And although I may be expressing a personal bias, I am delighted that my own emergency in 1974, resulted in my being taken to a non-teaching community hospital and having the attention of a Board-certified emergency room physician, general surgeon and thoracic surgeon. I would hate to think of the possible outcome if the attending was an unsupervised first-year resident.

Please look at the supervision of your emergency rooms. One final comment on patient care. The large graduate medical education programs are in the Type Three hospitals, mixed hospitals, where dual care takes place, and in the Type Two non-private hospitals. The smallest programs are in the private hospitals.

Regarding the issues of health care financing, and medical education financing, the IOM study highlights the need for sophisticated study of the costs of graduate medical education and the correlary of its financing. Without data on the actual costs, including indirect costs such as ancillary services, discussions of the financing of this education cannot be conducted on a rational basis.

It is clear from the activities data that house officers spend most of their time in patient care and joint teaching and patient care. Most of the house officer cost is borne by patient care cost. There is a considerable component of teaching in what's being paid for, and learning, that might be borne through other sources of financing, particularly if there are not offsets in patient care costs, from having the residents on the premises.

Patient care payments are basically a regressive method of financing. Premiums and payroll taxes are the most regressive methods of financing medical care. But it's even more regressive, since residencies are unevenly distributed across the states, within migrating physician states, bearing less of the costs than the out-migrating states.

I believe that financing is an escalating public policy issue that cannot be ignored or delayed, particularly in the light of the New York State actions in their rate regulation, the emerging federal cost containment program, and the dialogue on national health insurance.

Finally, I think we are wasting our time in the fight as to whether house officers are employees or students. They clearly spend the majority of their time in patient care activities, and are paid salaries and fringe benefits by the hospitals. Most of them are licensed physicians. They are employees and students and teachers. They serve an apprenticeship, albeit a professional apprenticeship, in the manner of the ancient guilds and modern-day plumbers.

The arguments introduce a red herring. Rather than quarrel about their status, why don't we turn our attention to the more important issues of whether they have adequate supervision in different settings, whether the orientation of the graduate training is consonant with the type of community doctor we want to produce, the content of the training and the length of training, and how can the patient care education and teaching be financed in the future.

A HOSPITAL'S OBJECTIVES IN GRADUATE MEDICAL EDUCATION PROGRAMS

Robert M. Heyssel, M.D.*

I am delighted to be in Scottsdale and have the opportunity to discuss graduate medical education programs at this meeting of the Council of Deans.

When I became Director of The Johns Hopkins Hospital, I did not ask myself why we participated in graduate medical education because perhaps I took the answer to be self-evident. Nor was I concerned that we were "doing business in GME in the same old way." Therefore in preparing this talk, I have spent a large amount of time amongst dusty archives of The Johns Hopkins Hospital trying to determine just how it all started in the first place and to see if I could get some guidance in the matter.

I am pleased to report to you that I can give you the original reasons for the participation of The Johns Hopkins Hospital in graduate medical education programs. I have been able to piece together the thinking and individual objectives of the participants in a meeting that started it all, held early in 1890 in the office of Dr. Henry Hurd, the first director of The Johns Hopkins Hospital.

It is clear that Henry Hurd initiated the meeting. Dr. Hurd called William Welch, then Dean of the not yet operational School of Medicine, and said that he would like to meet with Dr. Welch, Dr. Osler, Dr. Halstead and Dr. Kelly in his office to discuss some problems in hospital operations. The following is taken from almost verbatim records of the conversation that day in January.

Dr. Hurd led off by expressing his displeasure at the fact that on the previous evening when he was the only physician in the hospital, since the others were meeting at the University Club to discuss the formation of the Medical School, ten people had visited the front door of the hospital seeking relief from various ailments. As Dr. Hurd described it only two of the ten were true emergencies. The others suffered from low back-ache, sore throats, and a variety of other non-urgent ailments which could have easily waited to be seen during normal working hours. Of the two who were true emergencies, Dr. Hurd had been able to hold off admitting one of the patients till morning in spite of the fact that Hurd thought the patient had double lobar pneumonia. The other patient had a broken leg and a weak and thready pulse. He said that he was tired,

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*Dr. Heyssel is Director of The Johns Hopkins Hospital in Baltimore, Maryland.

and I presume he said "damn tired" since there was a small "d" with several dashes after it, of being constantly on call when the others were out of the hospital. As an aside, Hurd noted that 40% of the patients he had seen had no insurance coverage and could be considered as bad debts for the hospital. Hurd said that while he knew the others participating in the meeting were full-time and did not individually profit from professional fees, it was equally clear to him that money from professional fees went someplace and that the hospital through the services they provided simply underwrote the university without ever sharing in those revenues. Hurd felt some system needed to be developed to cover front door visits and the house while the full-time staff was away. He finished by saying he had considered proposing they hire established doctors but in view of tight finances and the bad debt problem, he could not see where the money was going to come from to pay experienced practitioners.

Dr. Osler said he fully understood Dr. Hurd's distress. He had for a year and one-half been deeply desirous of spending more time writing a book he had in mind and that as long as he was constantly on call and had to work-up every patient in the hospital, he did not see how he was ever going to get around to finding the time to do that. He felt that perhaps some junior helpers were needed in the hospital.

Dr. Welch then observed that there was another problem facing all of them. A woman with peculiar ideas was prepared to give the University nearly half a million dollars to enable them to start the Medical School, contingent upon their meeting certain conditions such as admitting women on an equal basis. Moreover she was insisting upon a bachelor's degree and a knowledge of two foreign languages as a requirement for entry into the school. Nevertheless, it looked like that if the university was ever going to start the Medical School, it was going to have to take the money on those terms. It now appeared likely to Welch that soon they would be confronted with medical students and the need to teach them. It was clear to Welch, according to the notes, that he felt that there would never be enough money, even with this generous if onerous gift of Mary Jacob Garrett to pay for the required number of full-time faculty to teach the students. They could not depend on voluntary or part-time faculty because most were too busy making money to spend much time in teaching and besides LMD's were not the "role models" students should emulate. In addition to those problems Osler would be writing a book and would not have time to teach and care for patients as well; Hurd was increasingly preoccupied with financial problems in the hospital as well as impending JCAH, OSHA and EEO visits and like any hospital director could not be expected to be much help at anything really. Some solution was required if medical students were to be taught.

With Welch's usual prescience he then went on to suggest that the hospital offer an apprenticeship for young men who wished to become excellent physicians and specialists. Osler seconded the idea and suggested that certainly "interns should be selected for the work they will be able to do, not the reverse, that is for their personal benefit."

Halsted, who had remained silent, cut straight to the heart of the issue when he asked how they would be paid. He noted pay should not come from fees of the surgical staff. He said that the departmental reserve funds were already under severe pressure due to declining grant support. His research into possible materials suitable for protecting the hands during surgery were making large demands on those funds and the only possible source of funds for his important research was professional fees. Halsted noted that earning professional fees to support research was a difficult task since at times the two activities seemed almost mutually incompatible. If he had someone to do the routine things, change dressings, write pre and post op orders, etc., it would be greatly helpful -- allowing him time to work, see more patients and to do more research.

Hurd said, "Why not give them room, board and uniforms in lieu of cash payment." Osler who really understood said "That sounds fine." "We will not pay them at all!" "Their compensation will be through the privilege of spending their time with us!"

And so it remained for almost sixty years. We did not pay them much because they were happy to be with us -- the hospital and professional staff got needed services, the Medical School got its teachers, the country was populated with excellent practitioners, and the base of skilled clinician/teachers/researchers for medical school faculty was established.

The story I have told of how the residency system was established at The Johns Hopkins is in fact not so far from the reality of 1890 even if I have manufactured the conversation. Osler, in fact, did write "we should pick interns for the work they will be able to do" after observing that the interns in a majority of hospitals at the time entered the institutions "for the benefits which can be personally obtained" and remarking further "the reverse principle should guide us in the selection of interns."(1)

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(1) Alan Chesney, "The Johns Hopkins Hospital and the Johns Hopkins University School of Medicine," Vol. 1 (Baltimore: The Johns Hopkins Press, 1943), pp. 161-162.

Hurd was preoccupied with the dispensary load in 1890. The size of the house staff was increased to cope with increased visits and a uniform charge of 10¢ to all who could pay was instituted![2] The objectives in 1890 of meeting service needs, meeting teaching needs, and relieving staff from undue burdens of patient care thereby freeing them for scholarly activity were real and spoken and written about in just those terms. The residency system was the answer -- or the GME system as we call it today.

Lest I be misunderstood, Osler and the others were not indifferent to the need to assure that the resident staff profitted from their experience in the hospital. Clearly they cared greatly. But the point I wish to make is that there were other and compelling considerations which led to the establishment of residency programs -- and the programs were not viewed simply as an educational exercise for the benefit of "superior men who wish to do scientific hospital work" and who were "pleasant and congenial" as Osler described the ideal candidate for the job.

In the last twenty to twenty-five years, something however has happened concerning the contracts or understandings between teaching hospitals, university medical schools and graduate medical students or house staff. There are house staff union and labor management negotiations. There is legislation pending which would place house staff under the jurisdiction of the National Labor Review Board. At the same time some believe house staff should pay tuition. Specialty boards dictate training periods and/or add special research requirements without involvement of the hospitals which generally fund those programs or the Medical Schools and faculty. And the third-party payors, government and Rate Setting Commissions, all question either the level of payment or any payment to house staff. But the interesting thing to me is that I doubt seriously if descendants of any of the participants in the original contract would concede that any of the objectives have really changed.

On the one hand, I think that the teaching hospital today still views itself as having a prime mission of service to patients but also as a unique place of service in that it is also a place for education in practical clinical matters and a setting for research in clinical medicine. I believe the Medical Schools and their faculty are still committed to medical education through a process which recognizes the need for a continuum of graded responsibility in

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[2]Alan Chesney, "The Johns Hopkins Hospital and the Johns Hopkins University School of Medicine", Vol. 1 (Baltimore: The Johns Hopkins Press, 1943) p. 164.

patient care and the positive features inherent in a system of instruction carried on in major part by teachers who are themselves students only recently. The house staff or resident staff or postgraduate trainees still understand that their objective is to learn clinical skills. They agree that in order for that to occur optimally, they must be engaged in clinical practice, and that the course they have set for themselves is demanding of both intellect and energy.

Why then if the fundamental objectives of the three parties in graduate medical education have remained the same, which I believe they have, and why if the system has, in fact, served us pretty well, which I believe it has, do we hear so much talk about reforms in graduate medical education? The answers might be due to changing life styles, changing societal values which no longer include the concept of the student-worker (note what has happened to nursing education), over specialization or science versus art of medicine.

More importantly, probably than any of those, however, is that over the last twenty to twenty-five years a fourth party has entered the scene -- government and other insurers of medical care. That and the more recent issue of maldistribution by specialty and place of physicians services have created in major part the issues with which we must deal. I'd like then to state some principles or facts regarding medical education which should guide us in thinking about these matters.

1. Four years of formal medical education is not adequate preparation for the independent care of patients.

2. A formal period of training and practice beyond medical school is required, structured in such a way that it meets general and special requirements.

3. The settings in which such training is carried out must be excellent in character combining the finest of practice with the spirit of inquiry.

4. Sophisticated hospital care of patients requires a dedicated staff of graduate physicians or residents available at all times, and the quality of care is enhanced by the presence of a supervised resident staff.

5. The care of patients and practice of medicine and acquisition of clinical skills -- in terms of time and devotion required of individuals does not fit easily into the construct of labor negotiations, a 40-hour week, job descriptions and trades rules.

6. To meet all of the above is not an inexpensive task for the institutions, those who seek after the training programs, or third party payors on behalf of patients, and there is a price tag attached which must be borne by someone.

7. The numbers trained by specialty must have some relation to medical need.

My prescription for dealing with the problems we all perceive, can I believe, best be put in the terms of the original reasoning for house officer training programs in hospitals.

First, we need to agree that house officers are in the hospital and clinics to give service. There should be reasonable monetary compensation for that service -- in addition to the indirect compensation the house officers gain in practical experience and knowledge in caring for patients as they prepare for specialty practice.

Second, we need to support -- and fight for -- financing of house officer training via patient payments. They, after all, do give service which is <u>really necessary</u> to patients. To fund that service under the rubric of education is illogical and dangerous.

Third, hospitals should not engage in house officer training unless they make a significant commitment to the education of house staff, including assuring the commitment of an excellent staff willing to devote the time and effort to supervision of house staff and the commitment to adequate facilities and adequate supporting staff. To simply use house staff as cheap labor is as wrong as to view them as pure students.

Fourth, the teaching hospitals and medical schools as a partnership must have a greater, even dominant, voice concerning the general and special requirements of house officer training. The system did not start with multiple specialty societies dictating the depth and content of training with no responsibility for facilities required or financing, and with little documentation of the need for certain requirements. As an example, the requirements imposed by some boards related to increased length of training or

special research experience in order to achieve accreditation for a program are simply not justified. Moreover, we need to, as a group, concern ourselves with overall number of particular kinds of specialists trained.

I find myself, then, in agreement with the participants in the 1890 meeting. The hospitals, house staff, medical schools and patients and the public all have needs which can best be met by a structured period of practical working experience and training after graduation from medical school.

I know this isn't 1890. But fundamentally I believe that on completion of 4 years of formal medical education -- "the student years" -- young men and women enter hospitals to give service -- and in so doing begin the process of learning in practical ways the sometimes terrible but always satisfying responsibility for the care of human beings. You can only do that by working and being truly responsible not by studying about it or observing it. To the extent that every physician in practice should be a "student" of medicine all of his life -- they are students -- but only in that sense.

If that isn't the case then tuition payment rather than stipends should be the rule -- and patients should not pay.

If that isn't the case then I at least can understand and defend both the direct monetary payments to the house staff as well as the indirect payments we make in terms of furthering their growth and knowledge as physicians necessary for their entering independent practice after a period of supervised practice.

Predictions are hazardous. But I believe if we follow the route of "student" classification too narrowly, that experience will be stretched out even further after medical school as observers not doers -- and hospitals will be employing people simply for service in increasing numbers. Further -- what Health takes away, Education won't necessary fund adequately and certainly not without strings attached.

Finally, we cannot have it both ways. Teaching hospitals cannot defend patient costs to support pure students -- even if there are other problems attached such as collective bargaining to the defense and fact that they are primarily employees.

FROM OUR PERSPECTIVE: A PANEL OF HOUSE OFFICERS*

Christopher C. Baker, M.D.
Ralph M. Stanifer, M.D.
James C. Chapin, M.D.
Basil C. Genetos, M.D.

DR. BAKER

I want to begin with one minor comment stimulated by Professor Hanft's view of her emergency room experience. I think that quality of supervision depends on where the emergency room is. Having run the Mission Emergency at San Francisco General, I can attest that I think that supervision there is excellent, and I'll just tell the story of the medical student who was stabbed in the chest two blocks from U.C. The ambulance drivers started to take him up to the U.C. emergency room and he said, "Turn around, take me to the County."

So, I think that it kind of depends on where you are. If you're out in the country, I think you usually have experienced people around, if there is anybody around.

I am currently at the Veterans Hospital, and as a surgery resident, I would just like to question the validity of a statement that was made several times earlier, that house staff do not spend as much time in the hospital as they should. I am sort of skewed at one end of the spectrum, but having been on call from Friday morning to Sunday morning, and leaving tonight to be on call tomorrow, Thursday night, Friday and Saturday, I think that it really depends on what house staff you are talking about. Some of us feel we spend a considerable time in the hospital.

I would like to react a little bit to some of Dr. Rhoton's comments this morning. It sounds like he has an ideal situation in Florida. I think that one of the things he mentioned which is really an excellent concept is that of having basic science in-training as a formal part of the GME experience; also having residents participate in undergraduate medical education in a formal fashion is especially valuable.

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*Dr. Baker is a Resident in Surgery (R3) at University of California - San Francisco School of Medicine.
Dr. Stanifer is a Resident in Ophthalmology (HO4) at University of Michigan Medical School.
Dr. Chapin is Chief Resident in Anesthesiology at University of Florida College of Medicine.
Dr. Genetos is Chief Resident in Internal Medicine at Indiana University School of Medicine.

I question the National Board as a predictor of capabilities. If the neurosurgery residents of UCSF are any example by which to judge, I would recommend that they spend six months in training with Bruce Jenner before they start their residency.

I agree that the general stress that has been stated here today for increased participation of universities in graduate medical education, with university-medical center-based programs is essential. As a surgery resident who is planning on eventually doing some private practice, I would caution against too much centralization that would either phase out or lock out private practitioners and part time clinical professors. These people -- often working in hospitals peripherally related to medical centers -- are really invaluable, at least from the surgery resident's standpoint, both as educators and as alternative role models who help residents make the transition between graduate medical education and fully responsible clinical practice.

A viable alternative to Dr. Stetten's refresher concept would be to send medical students and residents out to spend time with practitioners in the field which would be a stimulating and refreshing experience from both standpoints. This is being done in many areas, but I think it could probably be expanded.

Several comments have been made about lifestyles, and I think that there have been changes in the residents' concept of what their lifestyle should be. And I think it is important to remember the quality of life during graduate medical education. It is easy to look back on it and say how great it was and how happy you were, but I think it is only human to repress and modify unpleasant memories. It is a habit that increases exponentially with time, and with a person's rise in the medical hierarchy.

Being a surgical resident, I think it is only fair that I should say a few words about the age-old topic of scutwork. The surgical intern at U.C. is often known as the simplest tool -- a wedge; I think if we are going to upgrade graduate medical education, we must somehow manage to combat the gross inefficiencies that occur with supportive services, such as radiology, laboratory medicine, escort, et cetera, that occur at least in many VA hospitals and county hospitals across the country and even occasionally within the mecca of university medical centers.

This is not going to be easy, as has been pointed out, given the different governing bodies involved, but I think that if residents are to spend time learning, as they provide patient care, then there must be a reduction in the amount of playing time they have to spend as roving linebackers trying to fill the gaps in health care delivery that are left by other people.

In summary, I would just like to state that I am really relatively happy with my program and where I am. I consider myself both a student and an employee, and I am indebted to my teachers. One future challenge of the general medical education system, I think, will be to train primary care physicians who will be able to have the common sense to know when they need help from specialty back-up sources, and the maturity to call for that help when they need it.

DR. STANIFER

I would like to preface my comments, as I usually do, by saying that my viewpoint is, at times, admittedly somewhat naive and inexperienced. But, I have developed, over the past few years, several biases, which I would like to share with you.

I would like to first comment on why I consider local house staff associations an important aspect of the graduate medical education process. House staff associations have been around for a long time, and until recently, served basically as a social club that planned a Christmas party and a spring dance.

Recently there has been, during the process of politicalization of medicine, a movement among house officers to become more socially and politically aware of the forces affecting their graduate medical education experience, and the problems and inadequacies in delivering patient care in some of the hospitals where they work.

Recently, house staff associations have become much more militant and aggressive in the way they deal with these problems. Historically, the activist-oriented house staff associations developed at urban core public hospitals, such as those in New York, Chicago and Los Angeles.

These are the type of house staff associations who founded the Physicians National House Staff Association (PNHA). I believe that they have done a good job as serving as an alter ego or a voice of conscience, if you will, for their hospital administrations in many instances.

I, personally, do not believe that any one particular structure is applicable to all house staff associations. Some house staff associations, who are forced to deal with an inflexible, bureaucratic, governmental body, such as a county, may need a more formal bargaining type of relationship. Other house staff associations may, because of the lack of issues, remain a social club, and that is fine.

I believe in active house staff associations which provide opportunities for house officers to participate on hospital policy committees, affect in some way the development and utilization of

facilities, and to address in a meaningful way the issues concerning patient care at their hospital.

It is important for professional growth and development for young physicians, as well as for the medical professional in general.

In regard to H.R. 2222, or the Thompson Amendment, I do not believe that the Thompson Amendment, if passed, will hurt the quality of graduate medical education in the United States in any meaningful way. Traditionally, in such labor rulings as that of the Michigan Supreme Court in 1972 allowing the University of Michigan house staff association recognition as a collective bargaining unit under state law, educational matters have been exempt from the bargaining process.

And I would envision, with the proper urging, that Congress would recognize the role of the residency review committees and the LCGME in educationally-related matters. The hospitals who should fear H.R. 2222 are the hospitals with marginal programs, who do exploit young physicians in training to provide service under poor conditions. The Council of Deans does not represent that group of hospitals.

The four most popular arguments expounded by house staff criticizing the National Labor Relations Board decision naming house staff "students" are as follows. First, it may provide the basis for denial of reimbursement of services rendered by house staff to patients covered by third-party payers. Second, it may ultimately jeopardize the general license status of residents, which is now granted in most cases after one postgraduate year. Third, it jeopardizes the professional status of the house staff within teaching hospitals, and their credibility with faculty administrators. Fourth, it denies the public protection they deserve from unannounced disruptions of services, should the house staff association decide for some reason to demonstrate.

I believe that the third-party reimbursement argument is a valid concern. I believe that as a part of cost containment, Congress, state legislatures, and state insurance commissioners will attempt to discount or disallow payments for house staff services, particularly if the hospitals insist on calling their house officers students.

Such discounting of reimbursement was announced by the New York State Health Commissioner shortly after the National Labor Relations Board ruling last spring.

In the area of accreditation, I have the following comments. I am opposed to most of the recommendations of the GAP Report, because I think it is inappropriate and counter-productive to turn over policy jurisdiction in medical education and graduate medical education to the National Board of Medical Examiners as the GAP Report calls for.

I believe that the M.D. degree from an accredited medical school should remain the accepted requirement for entrance into graduate medical education, and that the Liaison Committee on Medical Education should underwrite the credibility of that M.D. degree.

There is certainly validity to the concept of a comprehensive qualifying exam, or the Qual A, which is mentioned in the GAP Report, at the undergraduate/graduate interface. However, I would prefer to see it used as one of the many criteria utilized by medical schools when evaluating their students prior to granting the M.D. degree.

I believe the Federal Trade Commission will continue to harass those bodies interested in insuring the quality of trained physicians, by trying to coerce the system into producing increased numbers without a proven need. I believe all the organizations interested in accreditation, such as the AAMC, the AMA, the specialty boards, specialty societies and teaching hospitals, must hold firm on their commitment to quality, and ride out the storm and resist being pushed into a reactionary position. This in my mind is the only way to maintain the credibility of the LCME and LCGME.

Now, a comment on inter-professional communication.
I am sure that you are aware that the AMA has established a Deans section within their federation structure. I believe that it is in the best interests of graduate medical education in the United States for the AAMC to support participation of academic physicians in the AMA activities.

Your participation in the AMA can only increase communication and understanding between the deans of the medical centers and the community practicing physicians who often help significantly in training young doctors.

The broad first year. Currently, I am participating on an LCGME subcommittee, exploring the need and feasibility of a broad clinical postgraduate first year. Some educators argue that the third and fourth years of medical school can provide enough clinical experience prior to specialty training. Others believe that to provide integrated, efficient patient care based on clinical experience and knowledge, a physician must actually manage patients in an ambulatory hospital setting. As a physician, rather than as a medical student.

I believe prior to specialty training, it would be desirable for each graduate physician to train for one year in a broad-based clinical program. Currently, as Dr. Graettinger pointed out this morning, there are 41 types of first-year programs available for medical students to choose from. Many of these offerings should be eliminated.

A physician well-grounded in the active and cooperative skills of caring for the whole patient and his or her medical, psychological and social needs, is imperative for the humanistic practice of medicine. A broad first year will allow for some young physicians an additional year to more rationally consider his specialty interest and talents.

Coordination within educational program regarding geographic and specialty distribution will result in a more appropriate mix of specialists.

Finally, a broad first year will provide primary care training for physicians who will go on to specialty training in more narrow fields. The LCGME is currently studying the advisability of a broad first year, and I would look to the deans of the medical centers to initiate programs within your medical centers to accommodate first year house officers who need or desire such physicians.

Finally, I would like to recommend that the AAMC establish a house staff advisory committee to review issues affecting AAMC graduate medical education policy and make appropriate recommendations to the Executive Council.

I do not believe a sophisticated representative structure is necessary. I would simply choose a couple of representatives from recognized residents' groups, such as the AMA Resident Physicians Section, tha Academy of Family Practice Resident Physicians Section, the Physicians National House Staff Association, and of course, include the resident representative to the LCGME.

DR. CHAPIN

I would first off this evening like to thank the AAMC for bringing us all here to discuss the many important issues that are related to graduate medical education. I do believe that it is a healthy attitude, indeed, for the AAMC to want to see things from our perspective.

I, personally, have not been politically active in the past in the investigations and discussions related to problems confronting GME, as have some of my colleagues, but I am, nevertheless, a current consumer of graduate medical education, and from that position I have just a few brief points that I would like to comment on this afternoon.

The first of these concerns is the Thompson Amendment. I must say that I am in basic agreement with the AAMC's stand on this matter, and I believe that full implementation of this bill could potentially have disastrous effects on GME as we know it today.

The continuum of medical education from medical school through the internship and residency years is a reality. The M.D. degree, as I see it today, does not label one as a certified practitioner of medicine, but rather, it certifies one as having successfully passed "phase one" in the process of medical education, and will now allow one to go on and get the specialized study one needs to become an expert medical practitioner. To call the fresh medical school graduate a full fledged member of the health care delivery system, that is, a service employee, is not consistent with the demands of modern medicine as I see it.

Another point that I question is what the Physicians National House Staff Association, or PNHA, claims is the "adversary relationship" which they say presently exists between house staffs, faculties and hospitals. This may in fact exist in some of the large, city-based programs, but I think it is far from a clear picture of what exists in most training programs throughout the country today.

The PNHA, despite its claims, does not represent the views of all house staff. The PNHA seems to discount the ability of hospitals and departments within hospitals to work out problems individually or collectively with the house staff. For example, in our Department of Anesthesiology at the University of Florida, we have monthly breakfasts which are attended by all residents in the department, as well as by the department chairman, at which we can discuss and work out common problems. In addition, we have individual appointments with our program director at least twice a year, where again, we can openly discuss various aspects of the training program. I suspect that such opportunities for the working out of mutual problems are not that uncommon in other programs across the country. This "adversary relationship", I believe, has been played up somewhat too much. Most medical educators are truly concerned with the educational well-being of their house staffs. Undoubtedly, however, there are programs where abuses of house staff do occur, with regard to the service versus education function, and perhaps this is where a lot of the noise is coming from.

I would also like to agree with Dr. Coggeshall's statement of the need for coordination of graduate medical education programs -- a job that could best be done by the university. Post-doctoral education should become as much a function of the university as the medical school education is. Specifically, universities should become more and more directly involved in residency training. To me, it does not seem to make a great deal of sense for a university to be concerned with the eight years of education required to make a person ready to become a doctor, only to abandon that educational responsibility in the critical three to five years needed to make a person grow from a potential doctor into a real doctor. Medical education truly is a continuum, and as I see it, it cannot be divided into packets of eight years and three to five years.

Universities must also become involved in graduate medical education, because they have already been charged with the responsibility for the re-examination of medical care systems, and residency training is intimately bound up with the medical care system. A university cannot design and plan health delivery programs in any meaningful way unless it also becomes involved in the who, the what, and the how of education of resident physicians in affiliated hospitals. Specialty certifying boards and other groups cannot be expected to institute the changes in medical care systems or in residency training programs that are necessary to improve the quality and the availability of medical care and to decrease its costs. National specialty boards have as their primary concern preservation of their specialties, not the development of innovative health care schemes. The university is, I believe, in the best position to coordinate these aspects of graduate medical education. I believe a more active role is needed.

DR. GENETOS

I would like to thank the AAMC for inviting me and I would like to briefly mention two areas of specific concern.

First is the Thompson Bill, which we have talked about a little already. But I hope you all realize that there is a very significant number of interns, residents and fellows who do not agree with the PNHA's approval of this bill. More specifically, the house staff at Indiana University, which numbers over 200, has been firmly opposed to unionization. I suspect that there are many centers which feel the same way, but are also less vocal than the PNHA.

Participating in patient care is part of the learning process. It seems impossible to me to separate the two, or to prescribe percentages of time applied to each. We feel we have excellent relationships with our medical school and respective medical departments. Unionization would be detrimental not only to these relationships, but also to an already decaying doctor-patient relationship.

We are writing Congress to inform them that the PNHA does not necessarily reflect a majority, but rather only a very vocal minority.

Second, I would like to respond to Dr. Buchanan's proposals for a shortened medical education process. I feel that such a program would not be in the best interests of physician education. The portion of this proposal of greatest concern was the provision of only two years of graduate medical education, rather than the present average of four years.

I view my current four years of GME as the highlight of my medical career, both in experience gained, medical knowledge accumulated, and

maturity acquired. I consider myself a much better physician now than I would have two years ago.

The front end of the proposal, that is, only two years of medical training, also seems of dubious value. I am one of those who is skeptical of the maturity of the 18 and 19-year-old, especially regarding his future relationships with patients and their families.

Justifying a six-year program, because of the European experience, also needs closer scrutiny. I personally have spent four months of my cardiology fellowship in Amsterdam, Holland, and was very unimpressed with the knowledge, maturity and expertise of their house staff. Since this was a well-respected medical institution, I assume similar conditions could be found elsewhere, and I wonder if it was related to their shortened medical education process.

IOM SOCIAL SECURITIES STUDIES REVISITED: IMPLICATIONS OF ALTERNATIVE FINANCING SCHEMES

John A. Gronvall, M.D.*

My comments will, to some extent, retrace the discussion of our meeting last spring, when we were in the process of working toward an AAMC position on the IOM Report. I will focus primarily on the financing recommendations and then make some comments about the implications I see in those for graduate medical education. I will pose several questions that I hope will be helpful as we continue working on this subject during the year.

My remarks will address the following major areas. First, I will briefly summarize again the background and context of the IOM study, the charge to the IOM and the other recommendations. I will comment on the follow-up to the report and relay to you my (perhaps incomplete) understanding of where the matter stands now. I will discuss the specific recommendations in the report dealing with financing. Finally, I will suggest some of the implications and the issues for the future raised by the financing part of the report.

Background and Context

It became apparent soon after the 1966 passage of the Medicare provisions that there were problems in sorting out Part A and Part B payments in the teaching setting, and in particular, in teaching hospitals. Although the law had attempted to clearly define the difference between hospital services and physician services, the definitions were not easily applied to the academic centers. In 1969, the famous (or infamous) Intermediary Letter 372 attempted to clarify the situation by laying out more explicit requirements and guidelines for determining the physician services which qualified for payment.

In 1972, a new section 227 was enacted into the Medicare Title of the Social Security Act. This section laid out an elaborate series of criteria for classifying hospitals into those that would qualify for fee-reimbursement (essentially private kinds of hospitals), and those that receive reimbursement on a cost basis. That position stimulated an immediate outcry from organizations such as the AAMC and from teaching hospitals, who claimed that the provision was so ambiguous, complex and inequitable that it would inevitably create chaos in the system. And so, in 1973, Congress adopted another amendment which deferred the implementation of section 227. That amendment also called for a study to be conducted by the Institute of Medicine which would develop recommendations to solve the problems. In March of 1976, the IOM Report was issued. Since then, it has been subjected to much analysis, discussion and Congressional testimony.

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*Dr. Gronvall is the Dean of the University of Michigan Medical School.

The charge to the IOM was a four-part charge. First, the IOM was asked to recommend appropriate and equitable methods for paying physicians in the teaching hospital setting. Second, the extent to which Medicare and Medicaid funds were being used to train specialists that were in excess supply was questioned. The third question for examination was how these funds could be used to produce a better geographic and specialty distribution of physicians. Finally, the study was asked to address the extent to which these funds were disproportionately attracting FMGs.

The follow-up actions have dealt, at least in part, with some recommendations of the study. The new Health Manpower legislation expresses Congressional intent to deal with the FMG issue largely as recommended by the IOM, although as Steve Lawton described yesterday, there still are a fair number of stones to be turned before that Congressional intent has actual impact.

The IOM recommendations in regard to the specialty and geographic distribution issues that there be established a new quasi-public body, that would control graduate medical education positions throughout the country, has not been adopted. The new Health Manpower Law, of course, states national and school goals in regard to primary care. The debate on allocating GME positions continues on.

The financing recommendations of the IOM Report have become the major ground on which the continuing review and debate is occurring. They are the subject of our primary interest today.

The report has been submitted to the various bodies for review, and that review process has gone on to date. The Bureau of Health Insurance began its review process by September 1976; the AAMC has established its position, influenced by the discussions we had last spring, and by follow-up discussions in the AAMC. Representatives of the AAMC testified in September before the Subcommittee on Health of the House Ways and Means Committee to present the AAMC response.

Meanwhile, further legislation has been passed to again defer implementation of section 227, until October 1977. In the interim, we have had a change of administration, and the current status of action on the financing recommendations is somewhat in limbo. The Social Security Administration, probably late this spring or this summer, will prepare specific legislative recommendations resulting from its review of the report and the testimony of others. Dick Knapp informs me that his sources believe it likely that implementation will be deferred at least another year. The subject then may well be kept open, for at least another year and a half. So, today's discussion of these financing recommendations is valid both in terms of the importance of the issues, and the timetable that we face.

The Financing Proposals

I now turn, then, to the financing proposals in the report. The study group looked at a number of financing mechanisms for reimbursing both the teaching physician and the house officer in the context of a graduate medical education program. About six existing and potential mechanisms for the financing of such programs were reviewed. It was the conclusion of the report that no single mechanism that was either in effect at any institution now, or that anybody could develop, would adequately cover all of the variety of institutional settings in which such programs existed. So the report recommended three basic approaches to financing: number one, the so-called cost-based approach; number two, a fee-based approach; number three, a unified approach. In addition to these three basic recommendations, the report called on institutions to undertake experimental studies and demonstration projects to determine whether there were other mechanisms that would more appropriately resolve the problems. I will take the three basic recommended approaches in turn, comment on each, and then suggest their impact on graduate medical education.

Cost-Based System. First, in regard to the cost-based system, the report recommended that teaching hospitals be permitted, if they wished, to adopt a cost-based system for reimbursement of their patient care and house officer teaching programs. If this method were adopted, the cost system would "as closely as possible reimburse the full cost of providing the service."

The AAMC review and testimony on this recommended method, basically supported the viability and appropriateness of a cost-based system, but pointed out strongly that the IOM Report, as it stood, was either inadequate or incomplete. It did not lay out any of the details of what would be included in recognizing the full costs of delivering the service. Items such as the full facility costs, the overhead costs, the necessary clerical and other kinds of support costs, are not spoken to in the report. The experience of every institution related to cost-based reimbursement is that, where there are multiple sponsors involved, each requires a cost analysis, and each seeks to delete any questionable items from the cost reimbursement formula. Consequently, while matters are framed in terms of cost plus reimbursement, the issue ends up being cost minus reimbursement. The institution ends up with a core of its programs not fully recognized by any of the reimbursement sponsors. So the AAMC position on that part of the financing recommendation was to raise a big red flag, pointing out that if a cost mechanism was going to be adopted in a teaching institution, it must be with clear understanding that there is a very wide range of cost elements that must enter into the formula. The simple cost of the physician's direct salary and the house officer's direct salary often represent only the tip of the iceberg in actually fielding the total team in an institution providing both care for patients and training for house officers.

The experience that institutions are having with caps being placed by reimbursement agencies, such as percentage limitations going year to year, provide a kind of chilling reality that the cost reimbursement system takes on a set of constraints which are artificial and basically unrelated to the program being supported. Because they can be administered by reimbursement agencies, these tend to gain the upper hand. And once again, the institution ends up with its programs not really being reimbursed.

The Fee-Based System. The fee-based system recommended in the IOM Report was that teaching institutions should have the right to choose reimbursement on a fee system. They would receive fee for services wherever they could appropriately document services rendered to patients.

This was recognized right at the outset by the teaching institutions as a major victory. It had been the apprehension of many people that the substance of the report would be to recommend that teaching institutions should entirely move away from fee for service reimbursement. Along with the fee recommendation, however, the IOM Report recommends that over a period of two years all cost-based reimbursement for teaching activities would be phased out in an institution that selects fee-based reimbursement. Cost-based reimbursement for supervision of house staff would be phased out, so that all that would remain would be reimbursement for the Director of Medical Education, and reimbursement for clearly administrative functions, such as the operation of special care units, cardiac cath labs being used as an example. Beyond that, the report recommended that an individual hospital, while it would be free to move from one payment mechanism to another over time, could not utilize multiple payment mechanisms on a geographic basis within the hospital. It was an all or none decision; the entire institution would have to be on either a cost-based system or on a fee-based system.

There was a major debate within the Association last spring and summer, as to what position to take in regard to the issue of phasing out of cost reimbursement for teaching activities. By the time the debate was over, the Association resolved to support continuing some sort of system that could clearly recognize the teaching function for house staff. I believe that that position is an extraordinarily important one that the AAMC has taken. It is not clear yet, of course, what the outcome of that position will be in terms of national policy, but I think it is a fundamental position.

Many people have counseled the Association that it ought to accept the recommendation as it stood, since it was much better than what many people expected to come out of the report in the first instance. But the opposing view held that we ought to attempt to describe in relation to a teaching program, three functions that we believed could be separately identified, and therefore should be adequately reimbursed. The first of those functions is the direct care of the patient by a responsible physician.

It should be possible to identify the personal, direct care given to a patient which should be reimbursed on a fee basis. And the fee should be comparable to what would be paid wherever the patient was taken care of and by whomever the patient was taken care of.

Second, it seemed clear that teaching physicians in a teaching setting carry an identified responsibility for helping to run the hospital as an organization. This administrative function of running special care units or helping to administer hospital departments should be recognized in some kind of cost reimbursement to the hospital, since the hospital incurs the cost of paying people to administer its operations as an organization.

Third, the teaching of house staff is a function carried on in the teaching setting that can be recognized, identified and separately documented. It should be possible to pay for the time, effort, and role of the faculty physician when that time and effort is spent in teaching house staff. This is the most difficult issue of the report. It raises the question of whether this is, in fact, a double billing system.

The testimony that we presented to the bill pointed out instances and examples where a faculty physician had a responsibility for teaching house officers that was separate from the responsibility of the physician who was caring for a specific patient. It is a common practice in teaching institutions for faculty physicians to make rounds with a group of house officers, working with the house staff in an instructional way, visiting and reviewing the progress of patients whose basic care may be the responsiblity of some other physician. The other physician is being reimbursed for the direct patient care being rendered to the patient, but it should be possible in that setting to identify the faculy physician who is serving in a teaching role with the house staff. This teaching function should be reimbursed.

Our position, then, is that we should work to develop some kind of managerial system that identifies separately, accounts for, and records these three functions so that each can be reimbursed. This would establish, as a policy, that teaching of house staff is a valid, identifiable, recognizable and reimbursable function going on in the teaching institution.

The Unified Method. I will comment on only very briefly the third recommended method of payment in the IOM Report, the unified method. This approach exists in a few highly structured clinic groups in this country, where a physician team approach is utilized. The recommendation of the IOM was that in a few such settings, this kind of financing mechanism might be adopted. All of the services rendered to patients would be reimbursed on a fee basis regardless of whether a house officer

or a faculty staff physician delivered the service, except that first year house officers would be paid on a cost-reimbursement basis to the hospital rather than as part of the physician team. This requires a closed panel of physicians operating under some kind of firm organizational sturcture in probably one institution, or at the most, a couple of institutions.

Implications and Issues

Now I will comment on the implications and issues, particularly in the fee system recommendation of the IOM Report. I will suggest what might be the impact of these issues on graduate medical education in the future.

First, I believe very strongly that the method used to resolve this thorny issue will greatly influence the future of graduate medical education in this country. That probably sounds like a truism, but it seems to me that the programs of graduate medical education in this country have evolved with very little attention to financing. They were low-cost programs that evolved in a complicated institutional setting. The programs have been extraordinarily successful because they accomplished goals and met the needs and desires of essentially all of those involved in the program.

The house staff received additional training that prepared them for medical practice as independent practitioners. The faculty or teaching staff got a benefit by having an additional work force of people to assist in care of patients. In addition, the house officers became the self-replication of the profession, responding to the desire of the faculty to replicate themselves for the next generation of physicians. The hospital benefited by having relatively cheap work force to cover its services and to provide adequate coverage for the necessary functions of the hospital. Medical students responded positively because the house staff, being close to the student level, provided instruction to medical students that was relevant and appropriately related to their level of understanding of what was going on in patient care settings.

At the present time, several of the basic conditions have changed. The system has come apart, or at least has loosened up. The cost factors have escalated to the point where they are highly visible. It now seems likely, unfortunately, that the cost factors will drive some kind of resolution that may be relatively detached from considerations related to the long term evolution and fundamental soundness of graduate medical education programs.

What would be the impact of the IOM recommendations, if adopted? I think that the concept embodied in the fee-based IOM recommendation would, over time, have a deleterious effect on the further evolution of

graduate medical education programs. The concept basically states that the country should pay for the care of patients, but the teaching of the next generation of physicians has to be bootlegged on that system, or carried by the physicians who are delivering the patient service. As a public policy, the education of house staff would not be recognized as an appropriate, reimbursable expense. As a public policy matter, that is destructive to continued attention to the education of house officers. I am tempted to say that as a policy matter it is of more concern that it is as a funding matter. People in various institutions will view that differently. The institutions that are dependent to the extent of $4 or $5 or $6 million on that kind of cost-reimbursement for teaching functions, may consider that the weight of it as a financing matter exceeds the importance as a policy matter.

But I believe that to establish as public policy that house officer teaching is not an appropriately recognizable and reimbursable function would, subtely, but inexorably, influence faculty physicians to begin devoting more and more of their time to the direct delivery of care, documentation of service to the patient and assumption of direct, personal responsibility to the individual patient. House officers would be moved more and more to a kind of tangential or peripheral position in which they become relatively passive observers of the patient care scene. They would not experience the kind of graded assumption of responsibility that is essential for appropriate house officer education programs. Therefore, I believe that we must find some way to pay for and recognize this educational and career development function for house officers in order to establish an appropriate public policy for graduate medical education.

This, then, leads naturally into the important issue of whether we will attempt to continue utilizing essentially a single source for carrying graduate medical education, or whether we are going to turn to multiple payment sources to carry these programs. Traditionally, the great majority of costs related to graduate medical education have come primarily from a single source, from the sick fund of the country. The Association position has been to strongly support this single source approach, believing that the patient care reimbursement stream is an appropriate source to carry the costs of graduate medical education. I think our position has been motivated to a considerable extent by apprehension about what happens whenever a complicated program has to be carried by multiple sponsors. The apprehension is that each sponsor will begin to withdraw pieces of support, and in the way that I mentioned earlier, the program, or some core functions of the program, will end up in jeopardy.

I am about convinced that the time has come when we have to think through more systematically the possibility of moving toward a multiple payment source mechanism for graduate medical education. The obvious fact is that the program does have multiple beneficiaries. The house officers benefit, the faculty benefits, the medical students who are taught by house officers benefit, the hospital benefits. We probably ought to look to the various beneficiaries and begin discussions about the appropriate support for the program in relation to the benefit that each of the beneficiaries receives.

Individual institutions are already, in some cases, well along the road in utilizing multiple sources to carry their programs. The mix of such other sources, state appropriation funds, grant funds and other kinds of funds is quite variable. On the national scene, these other sources make up a relatively small fraction of total funds. But individual institutions have already taken some significant steps.

We need to work toward some kind of basic policy agreement on what the character of graduate education is, what the goals of graduate medical education are, and then, as a follow-up to that, to establish a sound financing mechanism. Unfortunately, we have been backed into the issue because of cost factors and cost considerations, rather than attacking the issue the other way around. This has led, then, to arbitrary decisions, such as the ones recently made in New York. There on arbitrary formula bases, reimbursement of fixed percentage portions of graduate medical education costs might end up becoming non-reimbursable.

If the timetable I suggested for further review of this issue is a correct projection; if we do have another year or year and a half before section 227 or its successor will be implemented, the work of the task force on graduate medical education that is getting underway in the Association, could become a critical force. That task force, focusing and clarifying on the basic goals of graduate medical education, could present a set of programmatic and system-wide goals upon which the public debate about reimbursement could be focused. The enormous amount of data represented by such studies as the IOM study, could then be applied more appropriately to developing a support system that would more adequately and more appropriately continue our graduate medical education programs.

Finally, I would urge strongly that in the interim, every institution attempt, on its own, to develop and to implement some kind of management system that documents and identifies the teaching function of its faculty physicians, even though it may not now be reimbursable because of peculiarities or policies in a particular state or region. If each

institution would diligently undertake that now, I believe out of that would come examples that we could hold up to the public of more adequate means to identify the role of the teaching faculty physician in relation to graduate medical education programs. This would allow us to better defend that function as a teaching function, and to obtain adequate reimbursement for it.

FUNDING PROSPECTS BEYOND 1977

Walter J. McNerney*

There is little question that consumers and providers alike are sensitive to the fact that graduate medical education has had a profound impact on the health system. It certainly determines how a doctor thinks and acts, and the practice of medicine clearly remains the skeleton to which the entire health system is attached.

Policy decisions made by teaching institutions, whether dealing with the total number of house staff, their specialty mix, or their geographical location, impact deeply on the financing and the delivery of care. Less clear is the fact that the organization and delivery of health systems, methods of payment by third parties, and various types of market and regulatory controls, have a reciprocal effect on medical education in general, and on graduate medical education specifically. These factors are assuming increasing importance, and they should be clearly understood.

Because I am exposed generously to the strategies and logistics of financing and of delivery, I will focus primarily on them, and then attempt in general terms to talk about their implications for graduate medical education.

The growing influence of the financing and delivery system on medical education is the result of a number of powerful factors in the contemporary environment. One, of course, is the fact that the costs are increasing extraordinarily rapidly in the health field relative to the rest of the economy. It is sobering to reflect on the fact that HEW projects that in 1981, 10.1 percent of the GNP will be devoted to the health sector. Secondly, major buyers, government and management, are increasingly concerned about these trends. In effect, a general concern is given sharp focus. Government's concern is obvious, as it seeks, short of National Health Insurance, to develop some controls on the system through legislative initiatives such as PSRO, the Health Planning Act, and the current administration's hospital revenue and capital expenditures limitation proposal. Less apparent, perhaps, is the fact that after many years of quiet and inactivity, American management is now poised, and deeply concerned. It is expressing itself through a variety of channels, including individual corporations, the Business Roundtable of the U.S. Chamber of Commerce in Washington, and the Committee for Economic Development.

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*Mr. McNerney is President of the Blue Cross Association of Chicago.

In the latest automotive settlements, a specific provision in the contract directs the carrier to become much more deeply involved with cost containment activities, e.g. utilization review, tying reimbursement to areawide planning decisions, analysis of differential use and length of stay patterns within and among areas, and institution of health education measures. This activity is subject to management audit. Management and labor have formed committees to go around the country looking at and judging the effectiveness of what is being done in the cost containment area.

A third force is consumerism. It took form in the early '50s, addressed to making the unequal more equal, whether stockholders with management, women with men, or consumers wanting to have more control over what they are being sold. These forces are manifested in the broad consumer representation not only on local health planning and hospital boards, but also on Blue Cross boards, which have moved distinctly to the consumer side. This thrust reflects an inherent public distrust of institutions and a tendency to accept far less at face value.

Finally, we see a growing concern in the American population about what pays off. What contributes to health status. What are the outcomes as opposed to the inputs.

Thus, a long standing public frustration with access problems, perceived abuse, and inefficiencies, expressed often through labor and political spokesmen, is now joined by a growing economic, social and what might be called an epidemiological concern. The dimensions are such that the changes they precipitate will inevitably be felt in the world of graduate medical education, as well as throughout the rest of the health field.

Key Issues

What are the key issues? First, what they are not. We are hearing less about the problems of morbidity and mortality. Of the 15 leading causes of death, most have gone down in incidence over the past five years, and only three have increased, i.e. cancer, suicide and murder. The death rate is the lowest in the nation's history, and although there are still some tough comparisons made with other countries, particularly in regard to mortality among young children and mothers, in general, this too has become less of an issue.

The philosophy toward medical care and how it should be rendered is less an issue than five years ago. The convoluted conversations we have all been part of over the years, regarding whether medical care is a right, are heard much less frequently. It is generally agreed that everyone should have reasonably adequate access to care, and that no family should suffer significant deprivation as a result of health expenses.

There is also a growing agreement that the system that evolves has got to be reasonably acceptable to the provider as well as the consumer, as long as both are dedicated to a certain level of effectiveness in that system.

Today's vital issues in the delivery and financing of health care ultimately come down to how to intervene in a weak market to make it more productive and effective. Here the debate rages. On the one hand are those who espouse regulation, whether in the form of certifying beds, admissions, or determining rates. On the other hand are those who say the way to get the system properly rebalanced is to evoke market forces, using for example, co-payments and deductibles giving the individual a direct financial interest in the decisions he makes. This latter group also espouses the use of incentive reimbursement and alternate delivery systems (for the sake of increasing options).

This is an unresolved debate, and we will be hearing a lot more of it in the future. The evidence does suggest that we are gradually becoming successful at shifting care from an expensive inpatient mode to a less costly outpatient mode. For example, Blue Cross plans have paid considerably more outpatient claims than inpatient claims since 1969. The number of new beds built is decelerating markedly. However, in spite of these positive trends, there is still room for humility in terms of how much we know about intervening without destroying the morale or the verve of the system. Undoubtedly, we are going to see a variety of approaches in the forseeable future.

Another central issue is National Health Insurance. This concept embraces all of the above issues, including the relative merits of regulation versus restoring the market, and adds to them the question of goals and priorities. There are a variety of bills before the Congress. A basic question underlying the National Health Insurance debate is who will pay the bill, and whether through taxes (and if so, what taxes) or private means. The questions as to the scope of benefits; how to change the delivery system; how to pace supply and demand; how to wed the public and private sectors in some cohesive partnership are parts of a broad set of operative variables. This debate is ongoing and will continue on an evolutionary path for some time.

The other major issue involves what might be termed new directions. There is a growing recognition here and abroad, particularly abroad, e.g. Canada and England, that health status is a result of many influences outside traditional health services. These influences include: lifestyle, culture and environment.

An awareness is also growing that there are severe limitations to medical care in improving the health of populations. When men like

Cochrane, for example, claim that the National Health Service in Britain has relatively little to do with the health of the population, it is pretty strong medicine.

A growing number of management, labor, intellectual and political observers view medicine as having a diminishing marginal utility, and therefore, alternatives have to be seriously examined. This is not to say that care as it is now rendered is unimportant. It is to say, however, that a growing number are insisting on a broader view of what health is, and an examination of what the relevant factors are that have to be taken into account.

It is not accidental that Blue Cross Plans are working with accounts to implement a package, the purpose of which is to identify employees with health problems such as smoking, hypertension, and alcoholism, and then to pay for group sessions that will presumably turn these problems around through various interventions in the lifestyle of the individual. This is good for the individual, but the fact that the absentee rate of alcoholics is four times the average and for smokers it is twice the average, has not been lost on management.

Which Way is the U.S. Going?

First, what do we see in other countries? The time taken to date to debate national health insurance has given us one great asset. We can look around the world at other developed countries, and learn from what they are doing. What we learn is that in most countries the initial projections on cost were vastly underestimated. Money was devoted largely to an existing system, and the results were inflationary; cutbacks were often necessary, and there was at times not a little unhappiness associated with that on the part of providers and the patients.

In all the developed countries, even with the restraints of government involvement, health care expenditures are rising faster than the GNP. In some cases, they have become a very large part of the overall budget. For example, health care expenditures now account for 28 percent of the Ontario Provincial Budget. Around the world a variety of responses have been fashioned to the problem of escalating health care expenditures. Budget cuts, control of construction, control of doctors' fees, control of the number of doctors and where they can practice are a few such responses. But there has been precious little work done to evaluate the outcomes of many procedures. Responses have been mostly superficial and arbitrary, reactions to symptoms rather than underlying etiology.

Whereas health status around the world, as here, has improved generally, in any system it remains evident that the lowest social classes and those subject to extraordinary stress have the most problems. Consequently,

it becomes increasingly evident that any significant changes in the health status will require changes in social and individual behavior.

What have our experiences been? If one looks at the actuarial projections of Medicare, Medicaid, inflation, the share of GNP covered by health, and the fact that health status is still a function of income and social class, the lesson seems to be that financing care alone is not enough. One must come to grips with the delivery system, and take a broader view of what actually contributes to health outcomes.

Where is the U.S. going to go in regard to the question of national health policy, or national health insurance? My estimate is that it will go the the middle ground on an evolutionary path. That is to say, it will include federalizing Medicaid, expanding Medicare and mandating or certifying benefits for the working population. I say this because of the underlying economic facts: the size of the Federal deficit, what moving monies from the private sector to the Federal sector would do in terms of the size of that deficit, and its impact, in turn, on inflation, and the existence of many unmet competing needs. The Congress tends to look at the issues involved pragmatically, not in a doctrinnaire sense and thus to capitalize on the strengths of an essentially strong private sector.

It is likely that graduate medical education will be an interactive part of a pluralistic system which will have tighter controls on it, but will not be part of a monolithic structure of a Kennedy-type bill which captured such attention three years ago.

In any event, there will be continued efforts accompanying the debate over national health insurance toward building stronger controls. These will be incremental moves, getting at selective problems. And, we may well see greater emphasis on outcomes keyed to health status. The pressure on institutions will be increasingly to identify populations and gauge their own effectiveness in terms of their impact on the health of those populations.

Associated with this, we may see a re-evaluation of research priorities and a harder look at surgical rates, manpower, and other variables keyed to status. Technology may be more carefully examined with greater experimentation required before widespread proliferation is financed. There will be continued efforts to move care to the preventive, primary, ambulatory side through manpower planning and broader community health planning. There will be more, rather than less, aggressive purchaser involvement in cost containment, not necessarily through deductibles and co-payments which has political and substantive limitation, but by the involvement of government, the carrier, management, and other major groups.

There will be greater reference to area goals and guidelines and to structural components, such as consortia and HMO's (seeking greater economies of scale and better management), with the Planning Act serving as a prime catalyst. There will be increasing costs despite all of our efforts, because the greater pressures are on the up-side; an aging population, expanding medical science, increasing private and public health insurance, and growing expectations of a more affluent public. These would tend to offset the gains on the down-side created by such initiatives as more critical, large buyers and various interventions such as incentive reimbursement. Reshaping the lifestyle of the individual and improving the social and physical environments will proceed at a very slow pace. But don't be fooled by it; it may well be a very persistent pace. It will move slowly because of a number of factors. Institutionalization is one. Medical centers particularly, but even the medium-sized hospitals, are deeply concerned with their own ends, as opposed to the needs of the populations they are serving. The health market is uniquely lacking in competitive forces and all weak markets fail continuously to root out weak ideas and replace them with strong ones, to provide options, and therefore to highlight worthy alternatives, unless strengthened or newly directed.

There is an obvious conflict within the scientific community. On one side, Lewis Thomas states that our mission should be to find physical causes of poor health and intercept them through more intensive medical research. He would question, for example, whether there is any real proof that the bad air in New York causes disease, or whether food in fact is a major factor in health, beyond pellagra and some other definitive conditions.

Against this, Thomas McKeown states that the major determinates of health have been, and are, such factors as: environment, population control, food, and water. Both sides of course, share some common ground. But with this division, and with the average medical school and medical faculty allying itself with Thomas as opposed to McKeown, the tendency remains to opt for technology rather than broader social strategies.

There are a variety of other reasons that are going to make the development slower than we all might want. Congress does not have the mechanisms currently to make explicit trade-offs between income, housing, food and health care. It still responds with greater alacrity to categorical interests. We have taught people to be dependent on health services, problems of ennui and alcohol are national, not individual responsibilities. Some suspect an emphasis on new directions is a ploy to thwart national health insurance.

Who is going to be responsible for what down the road? Should medicine expand to embrace these new ideas? How far does health status

extend -- to periodic depression, feeling poorly, or beyond it? These are unresolved issues to which neither we nor Congress have the answers.

We may find ourselves with some new institutions. If the hospitals fail to respond, other institutions will move in. If the physician does not move to expand his role, new categories of professionals will be developed. My purpose is not to project how it will go, so much as to predict that this particular thrust is going to assume greater and greater importance.

There are signs the current Administration is responding. See the examination of a better floor under family income, a plan to prioritize food stamp, school lunch and other programs in terms of their impact on health.

Will medicine continue to get the brunt of criticism for problems rooted in causes beyond its current scope of responsibilities?

Implications for Graduate Medical Education

What are the implications of these general observations to graduate medical education? Between 1960 and 1970, the number of people working in the health field expanded 65 percent, from 2.6 million to 4.3 million. One out of every eight new jobs created since 1960 was created by the health industry. The health establishment overall has grown enormously and many are now concerned about the numbers of workers involved and their effectiveness.

In regard to graduate medical education per se, there are 50,000 graduate medical students and 1,250 teaching hospitals, with the average hospital budget contributing between three and 15 percent toward graduate medical education activities -- a considerable investment. In these hospitals payors are still debating: what is a reasonable division among education, patient care and research, should third parties pay for education at all (Medicaid), is a student an employee or a professional (different conditions for work and pay).

There is also a great deal of ambivalence in the medical centers regarding whether graduate education funds should be channeled through the medical school and labeled purely educational; whether and how to involve community hospitals as more come onstream to deal wtih a growing number of medical school graduates; and whether community hospitals should serve as an educational resource for primary care only or for an extended array of specialties. There is evidence of considerable concern on the part of community hospitals as to whether they will be dominated if they are included, whether they will lose patients, and lose controls over staff appointments.

Finally, a question is emerging as to whether group practices, holistic health centers, and other alternative ambulatory locations should be tied into the graduate medical education process and if so, how.

Looking ahead, you can expect greater controls over graduate medical education. The old days when clinicians donated their time or smuggled education under research are gone. The issue of whether graduate educational expenses should be treated as a pass through for the cost of patient care, or become a direct government subsidy, is clearly on the table.

The controls, I predict, will, as they are in the whole health field, be selective, not neatly packaged in an overall context. The main tool will be financing, not in the classic market sense, but as it is increasingly and selectively geared to expected outcomes. In this framework, you can expect both carriers and government to begin examining the number of house staff, given the fact that there is concern about the overly generous supply today and the fact that the supply is growing. Carriers will probably put limits on budgets this year over previous years, and governments will probably do the same and tie in their subsidies accordingly.

The question of limits carries with it all the drawbacks of insensitivity and arbitrariness; on the other hand, it has the merit of not trying to manage the enterprise.

Specialty mix will continue to be an issue, particularly with the government, but soon with carriers. The problem is temporarily contained, by combining internal medicine, pediatrics, and family medicine under primary care quotas. But quotas will be re-examined in the light of the balance between specialization and new directions. The debate over surgery has gone on too long. The obvious relationship between the number of surgical interventions and number of surgeons is of increasing concern to major buyers. Many are as conversant with the issue as you are.

I predict that the government will continue to work on access through better geographical distribution; a problem that will obviously grow more acute with the new hurdles put in the way of FMG's. This will take the form of subsidies, loan forgiveness, and other devices. The pressure will also grow on medical centers and teaching hospitals to address the type of situation reported in the papers last week where two areas in Chicago had one physician serving six to seven thousand people, right in the shadow of several medical centers that presumably took no cognizance of it.

Procedures are going to be looked at much more energetically by both carriers and government. Admissions, tests, and length of stay will

be studied in an attempt to narrow the gap with the non-teaching institutions. Most who will be doing this will be convinced that more efficient care is better care. The differential costs of a gallbladder operation in a teaching and non-teaching hospital will be narrowed in this process. Justifying differences in the name of teaching or defensive medicine will become increasingly difficult.

The physician assistant education and training programs will be looked at critically by carriers and by government to see that they do not become additive, particularly in the face of increasing physician graduates. The last thing this country needs is to create a new group of skilled professionals in addition to an over-supply of physicians. Some assurances will be needed that physician assistants and physician extenders will increase the productivity of the physician.

Pressures will also grow from government and carriers to have medical centers and teaching hospitals turn outward to the communities they serve, and become involved in promoting health, experimenting with new delivery systems, conducting outcome studies and field trials, studying variations in surgery, and translating these findings into the training programs. The average medical center has been resistent to these concepts. I am not moralizing on the point. I am simply saying that the people who have the money are going to get increasingly energetic about turning medical centers around to look outward towards the actual needs of the population being served.

I also predict pressure for more line officer control of the medical education process. The current responsibilities are too fragmented. This includes the VP in the medical center as well as the CEO of the non-university teaching hospital. The point is that some of the issues that are being debated here today were debated 20 years ago, just as energetically. In many of the institutions there has been no one with the authority and the responsibility to resolve them, and so they go on. As a result, special interests of fiefdoms continue to dominate.

There will be a continued examination of who benefits from graduate medical education; the community, the hospital, the student, the attending physician, and attempts to have each share in the cost. There will be more muddling in the foreseeable future, and not an active resolution of the problem.

I do not think you are going to see Medicaid pulling out, or Blue Cross pulling out, or the government pulling out. There will be a shifting and an evaluation of benefit as it relates to cost without any precipitous moves. It is a situation that is highly susceptible to some rought justice, however. If there were some ad hoc studies done and promulgated evaluating benefit, they could be quite useful. Those of us who are paying the bill would be delighted to contribute our

appropriate share, whether for education or research in this area. If teaching can be demonstrated to be reasonably related to primary care, or to the long term viability of the hospital, I am not sure you will get all of the resistance that you might think.

Teaching hospitals facing all these pressures are apprehensive. If the attending physician has to do all the work in order to get paid, how does the house staff get experience? What happens, specifically, if the house staff are called employees instead of students? What will the elite teaching institutions do if primary and community participation become more sharply focused in terms of support? And while almost everyone is willing to admit that there are too many physicians, they are unsure of the right mixture, unwilling to break down their support of their other friends, or to throw the first stone.

Closing

For at least 25 years, teaching hospitals have not had to face up to cost effectiveness on an everyday basis. Now the issues must be faced. I hope that they will be faced on your initiative and on the basis of your proposals; the financial imperatives will not go away. The fact that controls now exercised or contemplated, are not monolithic in nature, should not be taken as a sign that the '50s or the '60s will return.

In other words, what I am saying to you is go on the initiative and get off the defensive. Financing and delivery factors will assume a greater importance in graduate medical education, spurred by rising costs and better organized consumers. We are headed on an evolutionary path toward financing mechanisms which will demand greater controls affecting house staff, supply, mix, procedures, and efficiency. Payors will also require that teaching hospitals turn outward to serve the population, guided by their needs. The operational environment, if it is approached with a genuine commitment toward cooperative problem solving, innovation and experimentation, will not be totally prescriptive. The planning act will be as close as we come to putting it all together -- goals, organization, manpower, facility, and the other elements which provide the structure for pursuing greater effectiveness as well as efficiency.

Many feel that the teaching setting is, paradoxically, the least amenable to institutional change. Innovations, purportedly, are found in smaller, less complex settings. Perhaps this has been true, at least as far as non-scientific efforts go, but change is now the price of support. And it is only a question of who makes the decisions and exerts the initiative.

THE ROLE OF EXTERNAL AGENCIES IN SHAPING GME: THE SPECIALTY BOARDS

Charles A. Hunter, Jr., M.D.*

Early in the twentieth century the question of adequate training and testing of the qualifications of specialists was raised by a number of leaders in American ophthalmology. In 1914 a joint committee was formed to study ophthalmic education. The report of this committee in 1915 led to the establishment of the American Board of Ophthalmology. This was the first American Board to be formed, with the American Board of Otolaryngology formed in 1924 and the American Board of Obstetrics and Gynecology formed in 1930. Today, there are 22 medical specialty boards. The primary function of each approved specialty board is to determine the competence of candidates in its field who appear voluntarily for evaluation and to certify as Diplomates those who are qualified. To accomplish this certification, the specialty boards determine if candidates have received adequate preparation in accordance with established educational standards, provide comprehensive examinations to determine the competence of such candidates, and certify to the competence of those physicians who have satisfied the requirements.

Evaluation of clinical competence is the primary business of each specialty board. There are many methods used to measure competence: written examinations, oral examinations, direct observation by the program director, and medical audit of the candidate's practice. Each of these methods measure different aspects of learning. For example, written examination tests for cognitive knowledge, oral examinations primarily test for analytical and problem-solving capabilities, direct observations evaluate skills, and medical audit delineates performance and clinical outcome.

No one board uses all of these methods of evaluation at the present time. The majority of the boards (15) utilize the written and oral examination procedures. Only one board uses the medical audit plus the written and oral examination. The use of a case list of all patients hospitalized during the preceding year by the candidate offers to the specialty board evaluation team a very practical, powerful means to evaluate clinical performance and outcome. The use of this case list in the oral examination to further explore how the candidate collects clinical data, analyzes and arrives at a logical conclusion during the course of his practice will be a giant step forward in assessing clinical competence. The "state of the art" of this type of evaluation technique is being further explored.

*Dr. Hunter is Chairman of the Department of Obstetrics/Gynecology at Indiana University School of Medicine.

I should like to think out loud with you to explore new ways of planning graduate medical education. First, each medical specialty needs to clearly delineate what segment of health care it will be responsible for and provide. This has not been done for each of the 22 specialty boards. Areas of overlap and common concern should be noted. To assist the specialty boards in this initial task should be their corresponding specialty societies. If we know what we are training the residents to do to provide a clearly defined portion of health care, then our educational directions will be clear.

Many of the problems concerning the types of physicians and numbers will be easier to ascertain if we know what each physician will do in the provision of health care.

It is probable each specialty will have several prototypes defined. Accordingly, the graduate training program should have "multiple-tracking" educational programs. To maximize the graduate training period, goals and objectives must be established to insure that the resident finishing the graduate program is properly trained. Training must be by design - not by chance.

Today, most residencies are mainly geared to taking care of an unpredictable spectrum of diseases. What process assures each resident of participating in the management of all of the major diseases he will encounter in his chosen specialty? Why do we continue to equate learning with time? Would it not be better to equate learning with performance? In a truly graduate educational program learning should be constant and time the variable.

Admittedly, some of these ideas are hard to achieve. However, until the resident's training is better planned with meeting goals and objectives, then outside agencies and the public will have legitimate concern regarding cost-effectiveness of graduate medical education.

To date, the individual specialty boards have the sole responsibility for establishing the requirements for certification. However, the approval mechanisms for the general essentials, special requirements and guidelines for conducting an approved graduate training program (residency) is a multi-layered, poorly understood process. The individual physician applying for certification by a specialty board must, among other things, have completed an approved residency training program. The individual specialty boards have the sole responsibility for establishing the certification, whereas, the sponsoring organizations of the Residency Review Committee and the Liaison Committee on Graduate Medical Education must approve the training program requirements.

Before someone becomes concerned that the individual specialty boards may exert undue, independent requirements for graduate medical education, I hasten to point out the "multi-layered" approval mechanisms for residency training programs and, secondly, the peer pressures exerted on individual boards by their membership in the American Board of Medical Specialties. This latter effect is powerful and was recently exerted when a specialty board wished to extend the residency training period an additional year. Open discussion of this additional year requirement resulted in delaying this board's decision until additional factors, such as cost-effectiveness, had been determined.

The flow chart for approval of training requirements suggests that with the activation of the LCGME, a new system has been superimposed on the previous system of review and approval. No provision for an appropriate adjustment of the older system has been made. If such is correct, it has created two problems: A time-consuming routing of the proposal through the AMA House of Delegates, and a lack, as yet, of an agreed-upon statement of common goals shared by the LCGME and various residency review committees.

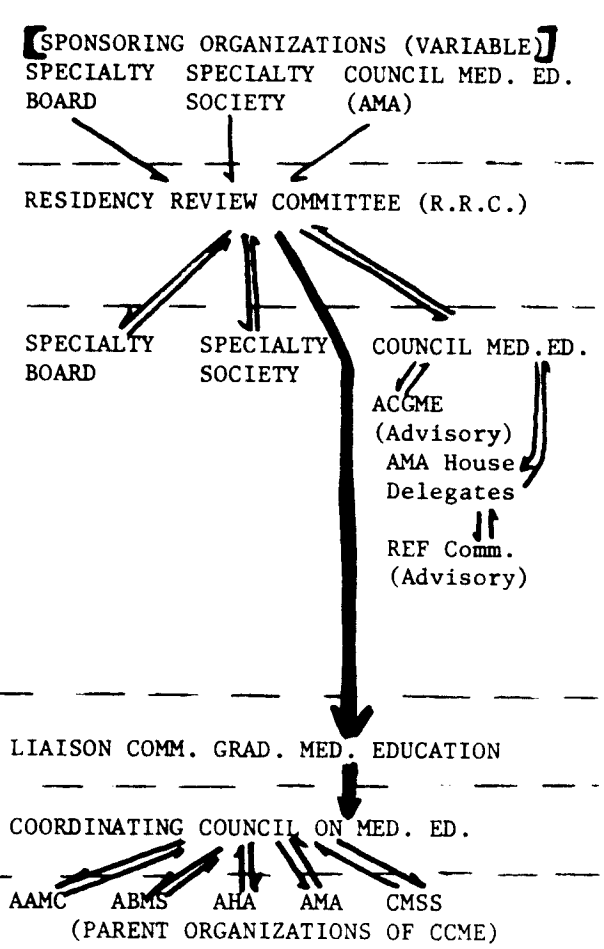
I refer you to the chart on the following page "Development of Essentials and Guidelines for Graduate Medical Education", developed by Glen Leymaster, Executive Director of the ABMS. It lays out the process that we currently muddle in, and without understanding that, it is hard to discuss graduate medical education. At Level I, the sponsoring organizations for residency review committees are somewhat variable, but generally include a specialty board, one specialty society, and the AMA Council on Medical Education.

Although the boards, technically, make their requirements for qualifications to be examined and be evaluated for Diplomate status, they are at the mercy of candidates coming out of approved residency programs. The general essentials are initiated by the LCGME. After two years of work on a draft upgrading the general essentials, there is a document ready for referral to the sponsoring organization for their approval. It's heading for tough waters there, I'm told.

The LCGME proposal goes through CCME to the parent organizations. The CCME action requires a majority vote and final approval is by the 100% rule of the five sponsoring bodies of CCME. If you want to understand medical politics, sit on the CCME for one session and you'll get a real lesson. To have 100% approval by doctors in five different organizations is remarkable.

DEVELOPMENT OF ESSENTIALS AND GUIDELINES FOR GRADUATE MEDICAL EDUCATION

RESIDENCY TRAINING PROGRAMS			STEPS IN CONSIDERATION
ESSENTIALS (GENERAL)	SPECIAL REQUIREMENTS	GUIDELINES	
	Changes may be initiated by any of Sponsors, or R.R.C. Changes often follow changes in certification requirements.* Must be approved by R.R.C. then to sponsors for approval by method of sponsor choice. AMA path at level III unlike other sponsors.		LEVEL I LEVEL II
	AMA requires Council and House approval. Council consults Advisory Comm. on Grad. Med. Ed. (ACGME). House sends to reference comm. for hearings and recommendations.	AMA requires only Council Med. Ed. action (CME seeks advice of ACGME)	LEVEL III
LCGME INITIATES (MAJORITY VOTE)	FINAL APPROVAL (LCGME)	FINAL APPROVAL (LCGME)	LEVEL IV
CCME RECOMMENDS ACTION TO PARENTS (Majority Vote)			LEVEL V
Final Approval Subject to Organization Veto)			LEVEL VI



*BOARDS HAVE SOLE RESPONSIBILITY FOR ESTABLISHING REQUIREMENTS FOR CERTIFICATION
MUST REPORT CHANGES TO ABMS

2/22/77

Changes in the special requirements and guidelines for training programs may be initiated by any sponsor or the RRC. Changes often follow changes in certification requirements. These must be approved by the RRC and then are referred to the sponsors for approval.

AMA approval, depending on the issue, may involve the Council on Medical Education, the Advisory Committee on Graduate Medical Education, a reference committee, and the House of Delegates. On guidelines, the AMA requires only Council on Medical Education approval. This involves the advisory committee but not the reference comittee and the House of Delegates.

The last column of the chart delineates some of these things, the parents of the RRC and its three-layered structure, the AMA process, and the five parents of the Coordinating Council on Medical Education.

The American Board of Medical Specialties, represents the 22 approved medical specialty boards. Its purpose is to improve the quality of health care provided by medical specialists by three main activities. Establishing and maintaining minimal standards of organization and operation of the specialty boards. Second, acting as a spokesman for all approved specialty boards as a group and, third, resolving problems encountered among and between the specialty boards.

The American Board of Medical Specialties has organized and conducted conferences directed toward improved function of individual specialty boards. Examples of these conferences are "Extending The Validation Of Certification" and "The Oral Examination."

Recently, the Secretary of HEW has formed an ad hoc advisory committee called the "Graduate Medical Education Advisory Council" composed of 21 members to:

1) Analyze the distribution of all physicians,

2) Study the types and number of graduate medical educational programs,

3) Study the financing of graduate medical education, and

4) Propose national goals and how to achieve them.

This new Advisory Council, at the federal level, will consist of ten physicians, two osteopaths, two providors, three representatives from the health insurance sector and four from the federal services. Their first meeting is scheduled for April 19th and 20th, 1977.

The federal government and the courts are beginning to look critically at the evaluation methods employed by the specialty boards for certification. Are these evaluations reliable and valid? Do the evaluations really measure what we purport them to do? Can the evaluations reasonably predict the clinical performance of an approved specialist? Are the medical specialty boards' requirements discriminatory? All of these questions will have to be answered. To date, the courts have ruled in favor of the board's evaluation procedures that lead to certification.

There can be no doubt but that the evaluations leading to medical specialty certification has a very direct, strong influence on the graduate medical education of that specialty. I believe that the boards are aware of this fact. The teachers of graduate medical education programs need to pay more attention to the overall continuum of medical education from undergraduate to graduate and on into the continuing medical educational sphere. Too many times in the past we have let change from one hospital to another fragment our educational programs. Learning should proceed continuously and smoothly.

Who should govern graduate medical education? This question is not the critical one. Instead, it should be asked, "how can we design graduate medical education to ensure a more valid learning process to train competent specialists?"

THE ROLE OF EXTERNAL AGENCIES IN SHAPING GRADUATE MEDICAL EDUCATION: THE LIAISON COMMITTEE ON GRADUATE MEDICAL EDUCATION

August G. Swanson, M.D.*

Genesis:

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

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

The representation on the LCGME from each sponsoring organization is:

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

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

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

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

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

*Dr. Swanson is the Director of the Department of Academic Affairs of the Association of American Medical Colleges.

consistent with the increasingly complex demands graduate medical education is making upon institutional and national resources.

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

Simultaneously, the sponsoring organizations established the Coordinating Council on Medical Education (CCME), composed of three representatives from each of the five organizations (Figure 1). The CCME is responsible for broad policy development and for reviewing the activities of the LCGME, the Liaison Committee on Medical Education (LCME), and the Liaison Committee on Continuing Medical Education (LCCME) (Figure 2). Major policy recommendations must be referred to the CCME by the Liaison Committees and the CCME then refers these to the five sponsoring organizations. By agreement, AMA also staffs the CCME, "for the time being".

The System Which Was Operating:

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

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

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

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

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

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

Site visits are conducted either by AMA field staff or by specialist site visitors. The former are predominantly retired-physician employees of the AMA who travel from place to place to verify whether the data submitted are accurate and to submit their appraisal of each program for the record. Few of the field staff have had significant experience as medical educators and, with 23 different specialties to cover, their expertise is severely strained. RRCs are increasingly utilizing specialist site visitors (SSVs) to carry out on-site inspections, particularly of programs that appear to be borderline in meeting standards. SSVs are generally selected from rosters prepared by the boards or specialty societies. It is estimated that 200 SSV site visits will be conducted this year.

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

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

Defects, Deficiencies and Solutions:

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

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

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

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

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

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

Reactions:

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

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

The Future:

The LCGME has revealed the need for having a broadly representative national body with the authority to accredit graduate medical education, and has demonstrated that such a body can improve accreditation without preempting the responsibilities of the specialists who have the knowledge and experience necessary to evaluate the substantive quality of graduate medical education. It must continue and it must become more effective.

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

1. Should the membership of the RRCs be reconstituted?

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

2. Can the review procedure be made more effective?

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

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

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

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

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

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

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

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

Conclusion:

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

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

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

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

Figure 1

COORDINATING COUNCIL ON MEDICAL EDUCATION

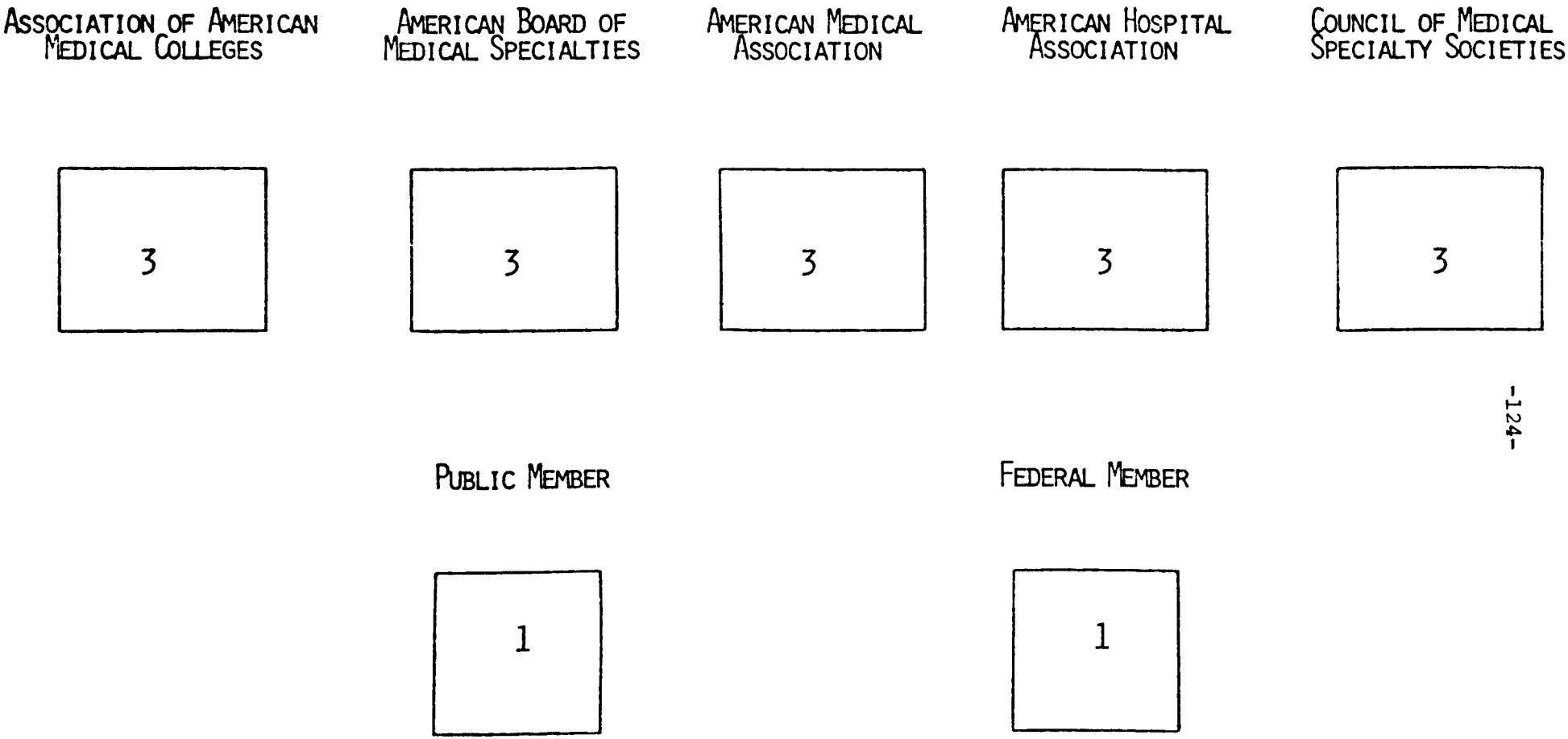


Figure 2

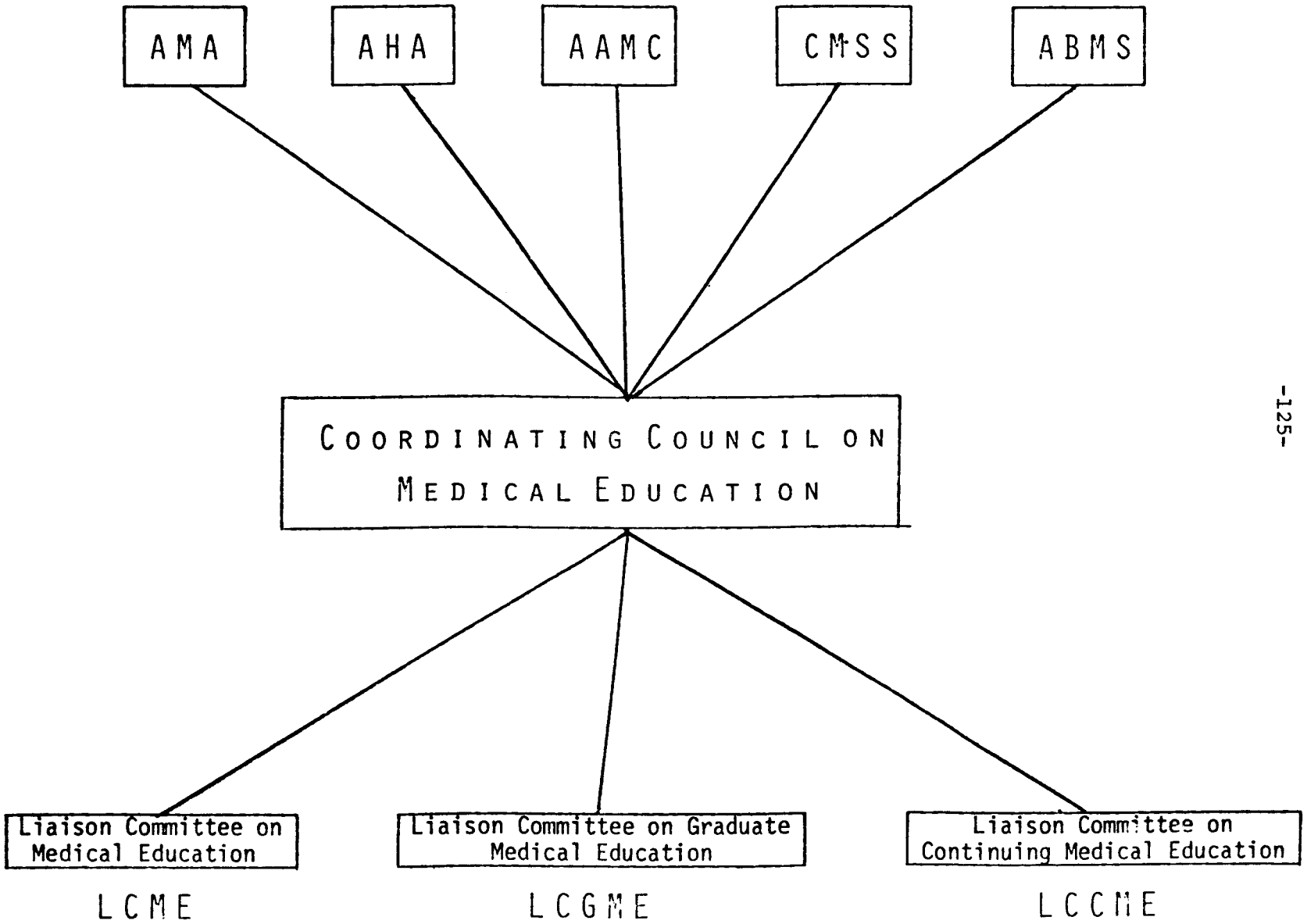


Table 1

AMERICAN BOARD OF MEDICAL SPECIALTIES

American Board of Allergy and Immunology

American Board of Anesthesiology

American Board of Colon and Rectal Surgery

American Board of Dermatology

American Board of Family Practice

American Board of Internal Medicine

American Board of Neurological Surgery

American Board of Nuclear Medicine

American Board of Obstetrics and Gynecology

American Board of Ophthalmology

American Board of Orthopaedic Surgery

American Board of Otolaryngology

American Board of Pathology

American Board of Pediatrics

American Board of Physical Medicine and Rehabilitation

American Board of Plastic Surgery

American Board of Preventive Medicine

American Board of Psychiatry and Neurology

American Board of Radiology

American Board of Surgery

American Board of Thoracic Surgery

American Board of Urology

Table 1 (cont.)

COUNCIL OF MEDICAL SPECIALTY SOCIETIES

American Academy of Dermatology

American Academy of Family Physicians

American Academy of Neurology

American Academy of Ophthalmology and Otolaryngology

American Academy of Orthopaedic Surgeons

American Academy of Pediatrics

American Academy of Physican Medicine and Rehabilitation

American Association of Neurological Surgeons

American College of Obstetricians and Gynecologists

American College of Physicians

American College of Preventive Medicine

American College of Radiology

American College of Surgeons

American Psychiatric Association

American Society of Anesthesiology

American Society of Colon and Rectal Surgeons

American Society of Plastic and Reconstructive Surgeons

American Urological Association

College of American Pathologists

Society of Thoracic Surgeons

Table 2

1977 REPRESENTATIVES TO THE
LIAISON COMMITTEE ON GRADUATE MEDICAL EDUCATION

American Board of Medical Specialties

James A. Clifton, M.D.	Dept. of Internal Medicine, University of Iowa, Iowa City, Iowa 52242
William K. Hamilton, M.D.	Dept. of Anesthesiology, 436S, U. of California Med. Center, San Francisco, CA 94143
Victor C. Vaughan, III, M.D.	St. Christopher's Hospital, 2600 N. Lawrence Street, Philadelphia, Pennsylvania 19133
Frank Moody, M.D.	Dept. of Surgery, University Medical Center Salt Lake City, Utah 84132

American Hospital Association

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

American Medical Association

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

Association of American Medical Colleges

Thomas K. Oliver, Jr., M.D.	University of Pittsburgh, School of Medicine, Pittsburgh, Pennsylvania 15213
Robert M. Heyssel, M.D.	Johns Hopkins Hospital, 601 North Broadway, Baltimore, Maryland 21205

Table 2 (cont.)

James A. Pittman, M.D.	University of Alabama School of Medicine University Station, Birmingham, Alabama 35294
August G. Swanson, M.D.	AAMC, One Dupont Circle, N.W., Suite 200, Washington, D.C. 20036

Council of Medical Specialty Societies

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

Federal Government Representative

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

House Staff Representative

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

Table 3

RESIDENCY REVIEW COMMITTEES

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

Table 3 (cont.)

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

THE INSTITUTIONAL RESPONSE*

James E. Eckenhoff, M.D.
Steven C. Beering, M.D.
Sherman M. Mellinkoff, M.D.

DR. ECKENHOFF

Let me put our medical center into perspective. There are two general hospitals, of about 1,900 beds, 20 miles apart, a children's hospital, a rehabilitation hospital and a VA hospital for a total of about 2,800 beds. There are out-patient clinics and group practices of about 250,000 visits. There were, in 1971, about 500 residents; there are now about 600. We decided to begin an integrated house staff program in 1969, and it became effective in 1970. The first centralized management of all applicants began in July of 1970, and the first centralized registration of all residents was on July 1, 1971.

That centralization seemed to concern itself mostly with fringe benefits and the like; it was amazing how different they were among the hospitals. All of this was managed by an associate dean housed in the medical school with a coordinator and three secretaries on his staff. In spite of our talking about an integrated house staff program, many chairmen ignored one or more hospitals, some hospitals with powerful chiefs of service ignored some chairmen, hospitals and some chairmen promised residencies to individuals without regard for central procedures. We could always count on it; when a chairman went on a junket around the world, I guess like Congress, he would come back having promised residencies to two or three fellows he had met in another country.

In 1973, an ad hoc committee was formed to study our graduate programs because of a markedly uneven quality both in the programs and in the residents. There also was a failure to completely integrate programs throughout the medical center and a lack of information on the content of the educational programs. The committee was chaired by a president of one of the hospitals and consisted of faculty, administrators and community representatives. After a year of deliberation, the foremost conclusion of the report was that we had 18 individual fiefdoms, each operating independently and without regard for each other.

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*Dr. Eckenhoff is the Dean of the Northwestern University School of Medicine.
Dr. Beering is the Dean of the Indiana University School of Medicine.
Dr. Mellinkoff is the Dean of the University of California at Los Angeles School of Medicine.

It pointed out, and this agrees with what Dr. Hunter said, that there were no goals or objectives, no written curriculum and no consistent standards of either admission to the programs or progression through the programs. The effects of this report, after extensive discussion have been considerable. The clinical chairman voted to sit as a committee of the whole to decide upon newly proposed graduate programs. They have done this several times and have done it effectively.

All chairmen now have filed written goals and objectives of their programs, and prepared procedures by which progression through the years of training are evaluated. A grievance procedure for house staff was developed and approved. The integration of programs among the hospitals was strengthened considerably and almost all programs were 100 percent integrated, one notable exception I will mention a little later. Three programs were identified as unacceptable. One chairman resigned and was replaced. A second program was sharply upgraded and a third muddles along. In the second year since the report, all chairmen agreed upon minimal standards for admission to or continuance in the training programs, to be effective July 1, 1977. Actually it was implemented in 1976 and so we have had a full year for implementation. You can imagine which specialties objected to such standards.

A recommendation was made that all house staff programs be moved into the university under the direct control of the chairmen and the dean. This was approved by the hospitals, in the summer of 1976, by the university in September of 1976. We expect the house staff will be registered as graduate students beginning July 1977. All recommendations in regard to programs, number of house staff positions, and budgets are to be made by the chairmen, sitting with three administrators. It is understood throughout the medical center that the educational programs are under the direction of the university, not the hospital. All bargaining is now between house staff, chairmen, and Associate Dean, not between house staff and administrators.

Final budgetary approval is by a committee consisting of all of the chief executive officers and three chairmen sitting together. The decisions are binding on each participating institution. That is about the only thing we do in the medical center that is binding on the participating institutions. The house staff are to have a house staff senate, similar to the student senate and the faculty senate. Within the last six months, the council of chairmen have acted together, considering all requests for increased numbers of positions.

The most recent discussions have led to a good bit of breast beating and blood letting. An ad hoc committee of chairmen and administrators examined graduate programs and recommended how they could be brought into alignment with the requirements of the third year of the health manpower act; namely, 50 percent of all programs in primary medical

care. The recommendations of that committee: 1) continue only quality programs; 2) continue only positions approved by specialty boards; 3) continue only completely integrated programs; 4) continue only programs confined to medical center institutions, unless external training is essential. That came about in part because some programs affiliated with other hospitals unrelated to Northwestern. Finally, delete all positions that habitually not filled with the match. Specifically, we elected to scrub emergency medicine, and move it into the department of medicine; to move flexible programs into the appropriate discipline using them. There were proposed increases in internal medicine and pediatrics and some specialties were reduced by 18 positions total, leading to 64 positions in the three years.

These are quite some concessions to get out of the chairmen sitting as a committee of the whole. That is where we are today.

DR. BEERING

I will describe very quickly for you what we have done at Indiana. We are currently entering our tenth year of a statewide medical education system which embraces continuing medical education, graduate and undergraduate medical education. The Medical Center is characterized -- very much as Dr. Eckenhoff has described his situation -- by an integrated program for graduate medical education which is controlled by the individual chairmen. They are responsible for the recruitment of residents into a single program. They sign the resident's contract and I countersign it in my other role as medical center director on behalf of the university.

The VA, the City-County Hospital, which we manage by contract, the University hospitals and the state psychiatric hospital, all put money into a common account to defray fringe benefits and to pay housestaff salaries which are determined by my office -- for the entire medical center. The various discipline chairmen determine the rotations of residents, not by service requirements, but by educational program needs. We have 2,300 beds and a coordinated house staff of 600.

Another feature of our program is regional graduate medical education on a statewide basis. This program is under the jurisdiction of the Indiana Medical Education Board which is chaired by the medical dean. We, thus, have the opportunity to coordinate residency education in nine cities and in 23 additional hospitals, outside of Indianapolis. Now we have, however, kept these residency programs in an affiliate status on purpose because we have wanted to stimulate recognition on the part of the local community that the individual hospitals are responsible for the administration and accreditation. The Medical School does participate with the local hospitals in a program of joint recruitment of residents. We publish a pamphlet each year, which goes to all junior students in the United States and Canada, describing all GME positions in Indiana.

We also help the individual hospitals get ready for accreditation visits. We help them with curriculum planning and with faculty recruitment. We give appropriate individuals in each hospital faculty appointments, and what is perhaps most crucial and which assures cooperation, we fund them. We fund each hospital on a capitation basis, approximately $2,500 per resident annually and we award $25,000, now for the tenth year, for each full-time, hospital-based program director.

We have, then, a program which it totally integrated on the Medical Center and coordinated on a regional basis by affiliations throughout the state.

Now, let me turn, briefly, to some of the issues that have come up here in the last day and a half, and make several recommendations on the basis of our experience. The geographic dispersal that we have been able to achieve in Indiana and the affiliation, coordination and integration of GME have given us a measure of quality and cost effectiveness which we could not have otherwise attained. Let me cite as one example our hospital stay which in all of our teaching hospitals is identical to that of the community hospitals that are not so involved. Our cost per patient stay in many instances, is actually lower. The Indiana University Hospital is, I believe, the only university hospital without any direct state support. We have a two and a half percent figure of a $60 million budget which is devoted to residency education. The rest comes from the Medical School directly. I think I could justify an increase in the budget of our University hospital if we were to take the approach that industry does in terms of assessing the precentage of gross budget for depreciation of equipment and personnel. This frequently runs in the neighborhood of 30 to 35 percent and that compares very strikingly with the two and a half percent that we have in our University hospital budget for "personnel depreciation," namely, the residency programs.

Now we need to be alert to the fact that only some 22 medical school deans have direct responsibility for their hospitals. Yet there are many external agencies that keep urging us to do something when, in fact, you and I may not have the authority or the line responsibility to even initiate discussions of a meaningful nature. Now in the case of these 22 deans who are also vice presidents for health affairs and directors of medical centers, these kinds of things can be rationally discussed in a reasonable framework. But there are certain actions that deans who do not have those health care responsibilities can bring about.

I would like to suggest first that we need to re-examine the undergraduate curriculum. The permissive attitude we took some years ago in allowing the senior year to be totally elective needs rethinking. There is no question in my mind that we are slipping the clutch, as it were, and being educationally rather ineffective as I view what our students elect. I would recommend that we re-evaluate the senior year, and allow it to be more structured, more selective rather than elective, less permissive and, in fact, have it become the broad first year of graduate medical education.

And that leads me to my second recommendation, I am alarmed at the many specialty boards that are now adding the requirement of another year of residency. This is certainly going to lead to a great deal of external criticism. I would much sooner see us have a senior year in medical school which would lead to the graduation of an undifferentiated physician who is indeed ready to go into primary care as well as specialty residency opportunities.

Finally, I would like to react again to what Mr. McNerney said this morning, I am a little concerned that the reasoning he so eloquently displayed and which is certainly not unique to Blue Cross, will lead to a mandate by the federal government that schools of agriculture will have to start irrigation canals in California, and that schools of law will have to put their faculty on the street to walk the beat in order to do something about crime. I would like to remind us once again that we are in a unique position because we are blamed for the medical drought, as it were, as well as for all sorts of perceived shortcomings in health care delivery over which, in fact, deans have no direct control.

We must get out on the hustings of the political and public sectors and educate our colleagues. With the help of such marvelous individuals as Mr. McNerney and others who have been kind enough to be our guests at this meeting, we can achieve, perhaps, a better breadth of understanding of who is in charge and who can deliver. I am not afraid to be in the marketplace of medical education. I am not afraid to argue the costs and the benefits that we discussed this morning, but I am concerned that we may be asked to produce and to deliver something for which we are not equipped, capitalized or even emotionally attuned.

DR. MELLINKOFF

I would like to say briefly that I very much admire what Northwestern and Indiana, for example, have done and I know many other schools here have done. In a word, UCLA has 17 affiliations. The Rand Corporation is one, so there are 16 with hospitals, ranging from San Bernardino to Ventura, east and west, and from Harbor Hospital at San Pedro on the south, to Bakersfield on the north. It used to go up to Fresno, but Julie Krevans has taken that over; we are grateful to him, it is a big territory! We are doing much the sort of things that you and Jim have been describing. I have nothing really to add except that I do want to get back to one central point, and that is to do all these tremendous things entitled "The Institutional Response" is not easy. Institutions are being asked to respond to an enormous disparate number of pressures or needs or obligations, depending on what you want to call them, and I believe that by and large the schools are trying very hard to respond to those

needs and within their limitations, especially fiscal limitations, I think they are doing a good job. But I would plead with individuals, such as Ruth Hanft, whom I see here and others to help the institutions themselves. I know that Dr. Cooper has stood like Leonidas, holding off the Persians at Thermopylae, and John, I hope the same thing does not happen to you as happened to Leonidas! Perhaps that was an unfortunate allusion. Before an institution can respond it has to have integrity, and integrity means strength. It not only means strength of character and mission and understanding or these goals, but it also means financial integrity.

It also means a certain continuity, security, which we have not had, frankly, for the last 15 years. I am not sure how we are going to achieve continuity, but it reminds me of a story, and I apologize to a few people here who I know have heard this before. I remember my father occasionally would take the family to the old Orpheum Theatre in Los Angeles, long since disappeared, where great vaudeville artists, such as Jack Benny and Fred Allen used to appear, and it was quite a thrill.

I remember one little act that was put on by Willy Howard, which reminds me of the plight of our institutions in the medical world today. In this little act in the first scene, Willy is at his tailor's and he is trying on a suit of clothes that he has already bought and been measured for.

Willy says, "Gee, I think that this right sleeve is a little bit too short," and the tailor says, "no, no, that's just your posture", and he adjusts Willy's shoulders a little bit so that he walks like this. Willy says, "Ah, thanks very much," and he goes home walking like this. His wife sees him and she says, "Willy, what on earth happened to you? Look at the way you are walking there, your left pantleg is too short." And Willy said, "Well the tailor didn't tell me anything about that." So he went back and asked the tailor about his left pantleg. "That is true", the tailor says, "your posture is bad in many ways and if you would just kind of get your hip out like that, you'll be okay." Willy goes through a series of contortions until he looks very much like the hunchback of Notre Dame.

He's hobbling very proudly across the street and he runs into some man who stops him. The man says, "Excuse me, Mr. Howard, could you tell me where you got that beautiful suit of clothes?" Willy says, "I'll tell you, but why do you ask?" The man replies, "Well, your tailor must be a genius if he can make a beautiful set of clothes for you, he can make one for anybody!"

I just hope that we are not too twisted up. This is what I mean by integrity. I think that we have to have enough institutional support to be able to respond to the manifold obligations in graduate medical education and undergraduate medical education. I think the schools now are painfully aware of our obligations and are prepared to move on if we can just get our bodies straightened out.

THE CANADIAN EXPERIENCE

Arnold Naimark, M.D.*

Before beginning my remarks this afternoon, I want to tell you how pleased the Canadian deans have been to have the opportunity to participate in your program and to enjoy the pleasure of your company these past few days.

Canadian medical educators have learned much over the years from their counterparts in the U.S., and we hope that our experiences may in turn be of some interest and value to you. I could not help remembering as I listened to the remarks of the last two days, a cartoon I saw in the French newspaper, Paris-Match. It showed a dachshund wrapped around a telephone pole, looking at his own derriere, and the caption was, "My God, it's me.".

The view is sometimes expressed that Canada, which might have enjoyed English government, French culture and American know-how, has instead succumbed to English know-how, French government and American culture.

Whether or not one agrees with this view, the special political, constitutional and geographic circumstances of Canada and its constituent provinces make it inevitable that we must in the end find our own way, a way which, because of internal disparities, is bound to be pluralistic.

This pluralism applies in large measure to the topic which I have been asked to discuss; namely, the lessons to be learned from government involvement in graduate medical education in Canada. As always, it is tempting when dealing with this issue to concentrate on discrete events in specific provincial jurisdictions, which reflect direct government involvement in graduate medical education. But that would take too long and would be misleading because, for the moment at least, the major and most potent influence of government is indirect. This indirect influence is reflected in the changing relationship between governments on the one hand and the universities and the hospitals they support on the other.

Although the tempo may vary from province to province, there is in general a gathering thrust toward closer governmental control of our universities and our hospitals and therefore increasing constraints on all aspects of medical education. I believe it is far more important to understand the causes of this general trend and its effects on graduate

*Dr. Naimark is the Dean of the University of Manitoba Medical Faculty.

medical education than it is to be concerned about organizational details; however, in view of what I have heard over the past two days, some organizational background is necessary. And so let me begin by outlining the major constitutional feature of the health and education systems in Canada for those who might not be familiar with them.

Federal-Provincial Relations in Canadian Medicine.

Both Canada and the U.S. have a federal structure, but in Canada the division of powers in the fields of health and education is quite different. Each province has complete responsibility for and jurisdiction over health services, health sciences education and regulation of the health professions. The federal government's direct role is limited to the provision of services to certain special population groups and to the support of research.

This arrangement has made the administration of health care and education much more responsive to the needs and political philosophy of the individual provinces. Many national policies had their beginnings in a province in which a particular interaction of social, political and economic factors prompted that province to become a pace-setter in a particular field. Hospital insurance and medical care insurance, for example, were introduced in certain provinces several years before they were accepted as national policy. More recently, individual jurisdictions have extended government insurance coverage to include dental services, prescription drugs and nursing home care.

Although the federal government's influence on health and higher education is indirect, chiefly through sharing the costs of programs which are initiated and administered by the provinces, the specific terms of these cost sharing arrangements (for hospitals, for physicians' services and for universities) have had a steering effect on the way certain programs are conducted; thus provinces have often tended to organize programs in such a way as to obtain maximum federal contributions, even though certain operational difficulties could be predicted. However, a new mode of financing health and higher education has been proposed which is to come into effect this year and which will give the provinces greater flexibility in the use of the federal contribution and which will remove the fiscal impediments to correcting some of the present anomalies.

As far as organized medicine is concerned, it is the provincial medical associations which engage in negotiations with their respective provincial governments, since it is the latter which initiate and administer policies governing health services. The Canadian Medical Association serves as the national voice of organized medicine and has been on balance a progressive force in the evolution of health services and in the study of health problems in Canada.

Graduate Medical Education in Canada.

Now a word or two about medical schools. All medical schools in Canada are constituent parts of universities and all universities are de facto state universities in the American sense. The growth and development of Canadian medical schools in this century has paralleled closely the pattern of schools in this country. They have been called upon to expand their sphere of responsibility so as to incorporate a variety of new programs of education and service and to formalize their role in existing programs, the most important being graduate medical education.

The major organizational elements concerned with graduate medical education in Canada are:

1. the licensing authority in each province which determines the qualifications necessary for registration as a general practitioner or in a traditional specialty.

2. the Royal College of Physicians and Surgeons of Canada which certifies, through examinations or by other means, the qualifications of all specialists and sub-specialists in the various clinical disciplines, except for family medicine.

3. the College of Family Physicians of Canada which certifies the qualifications of family physicians.

In addition, there is in the province of Quebec a supplementary system of examinations and certifications meant to deal with the special circumstances of that province.

In addition to their role as examining bodies, the national Colleges also perform an accreditation function, in that they determine, through site visits by survey teams, which training programs will be recognized as providing suitable preparation for specialty certification. A separate mechanism exists for accreditation of those internships which are not part of a specialty training program.

Responsibility for accrediting Canadian training programs is delegated by the Council of the Royal College of Physicians to a standing committee on accreditation. The committee is composed of 12 to 15 members selected with regard for the specialties represented by the College and for geographical considerations. There are two house officers appointed after consultation with their appropriate associations.

The staff functions of the committee on accreditation are the responsibility of the Division of Training and Evaluation of the College. The Committee is assisted in discharging its responsibilities by special

advisory sub-committees representing all specialties recognized by the College. The sub-committees are appointed by the executive after consultation with the national specialty societies. They advise the Council and the standing committees of the College on all activities relating to their specialty. These specialty sub-committees also have wide representation from interns and residents.

Proposals to establish new programs or to enlarge existing programs must be submitted to the College by the medical schools through the dean's office, not by individual program directors, and must have explicit approval of the school as a corporate entity. Accreditation review of existing specialty training programs by the Royal College of Physicians is conducted at the same time as the site visits by the LCME survey teams, and there is a significant opportunity for interchange of data during such visits.

In the past the administration of graduate medical education at the level of individual medical centers was primarily the responsibility of hospitals. Although medical school faculty were heavily involved in specialist training, the schools themselves had little corporate influence or control over the programs, and in the case of internships in community hospitals the relationships were even more remote. Each specialty training program operated independently, set its own policies regarding admissions standards, in-course evaluation and in many cases the total number of trainees. The result was a haphazard system of programs, varying widely in quantity and quality and removed from the influence of a coordinated approach.

Dissatisfaction with this state of affairs prompted the accrediting bodies to establish the policy that approval of training programs must be contingent upon such programs being conducted under the aegis of medical school, since medical schools were viewed as being best suited to provide adequate control over both quantity and quality of such programs. Thus medical schools in Canada are now directly responsible for all aspects of graduate medical education, with the exception of a small and rapidly diminishing number of free standing internships in certain community hospitals.

In nearly all provinces interns and residents are fully registered as graduate students in the university and are explicitly recognized as part of the medical school's educational responsibility. This responsibility is reflected in the determination of the budgetary appropriations medical schools receive from their parent universities.

In practice there is still some variability from province to province in the details of administration of graduate medical education. This is in part due to the fact that, in general, Canadian medical schools conduct their training programs in hospitals with which they are affiliated, but which they do not own or operate. Since the characteristics of the

affiliation differ from place to place, it is not surprising to find differences in specific operational procedures. Another factor which accounts for some degree of variability is the fact that the salaries of interns and residents are in most instances derived from the budgets allocated to the teaching hospitals by the ministries of health in each province. In some areas the budgeting process is virtually delegated to the medical schools by the hospitals while in other areas it is not.

Despite the variability which presently exists, there is a generally acknowledged movement toward fuller integration of responsibility and authority in the administration of graduate training programs under the governance structures of the medical school. In our own medical school, for example, all policies governing graduate medical education are formulated by a standing committee on GME, and these proposals are placed before the council of the medical school for approval. The major areas in which policies and procedures have been established and promulgated are admissions procedures, allocation of training posts among various programs according to explicit criteria, in-training evaluation of house officers and evaluation of programs.

Day to day administration is the responsibility of an associate dean who presides over a committee of program directors and house officers, with special sub-committees being responsible for such matters as admissions and evaluation. In addition, such a program has its own program committee, again with student representation. The interns and residents association is recognized by the medical school as the official voice of the graduate students. The association has representatives on the school council and on its major policy committees. It is also represented on a variety of other committees, including search committees for department chairmen and deans and promotion committees.

In some provinces, house staff associations have been certified by the labor relations board as bargaining units. In one the provincial medical association assists in the collective bargaining, and in others there is de facto voluntary recognition of such associations as collective bargaining units. In all jurisdictions bargaining is almost totally restricted to "quarters and rations" issues, with academic interests being pursued through the house staff representatives on the various committees of the school councils.

The training of house officers is largely conducted in clinical teaching units. These units are what might be called the clinical laboratory for education at both the undergraduate and postgraduate level. Characteristics of a clinical teaching unit include the following:

1. All teaching staff members serving in the unit must be appointed jointly by the university and the hospital.

2. There must be an identifiable head of each unit at any given time with full authority to enforce regulations governing the operation of the unit.

3. The regulations for the operation of the unit must provide for the proper integration of health care and education including the function of the members of the unit as a team with special concerns for education through graded responsibility.

4. The senior or chief resident is responsible for seeing that the members of the house staff team have an opportunity to assume professional responsibilities appropriate to their level of training. The senior resident is responsible to the head of the unit for administrative matters and to the responsible staff member for matters involving professional service to patients.

5. Patients admitted to the unit must be assigned to a member of the staff of the unit. All patients are insured, and the route by which they arrive in the unit, whether referred by a private physician or by direct presentation at the hospital without a physician referral is of no consequence.

At the national level, the trend for medical schools to be given full responsibility for graduate medical education has been reflected in two ways. First, there has been a growing and increasingly effective degree of collaboration between the Royal College of Physicians and Surgeons and the medical schools in improving standards of training programs and in developing better methods of in-training evaluation. Second, the Association of Canadian Medical Colleges which tended in the past to concentrate almost exclusively on undergraduate medical education now interprets its mandate much more broadly and gives increasing attention to GME. The Association of Canadian Medical Colleges has as one of its key standing committees, a committee on graduate medical education, and the association is represented on all national bodies which have a role in or potential impact on graduate medical education.

Social Forces Affecting Governmental Policies in Health and Higher Education.

Having sketched very briefly the organizational background which is relevant to my topic, let me now say something about the social background as it influences universities and hospitals and therefore medical schools and graduate medical education and let me begin with some recent trends in Canadian higher education.

Universities: During the boom period of the late '50s and early '60s Canadian universities "were everybody's favourite instrument for the advancement not only of knowledge and understanding, but also of the public weal".1/ They were no longer small and selective, but were viewed by nearly all as bestriding the path of social and economic success.

There was a sustained public demand not only for instant expansion of what the universities had traditionally done, but for immedicate extension into many new activities. Universities for their part cooperated willingly in responding to the demands, perhaps not recognizing that they would be transformed in the process.

Governments, as the principal financiers of the expansion, were in the beginning sensitive to the universities' concern that they not lose their autonomy in becoming bigger and more costly. Indeed, it was mainly in order to limit government influence that many provinces funded universities according to formulas based on student enrollment. The system did not funciton perfectly, but it was not until the advent of the mid-'60s, the era of student unrest, that the inclination to preserve university autonomy began to weaken.

Next came the tightening of the high level labor market, particularly in non-professional areas. And faced with the spectacle of unemployment or underemployment of significant numbers of university graduates, the public began to have serious doubts about the economic value of a university education and hence upon the soundness of the public investment in universities. The universities were thus called upon to eliminate expensive overproduction, by the public and by governments.

With no federal presence in the support of higher education and with student tuition fees comprising only a minor and diminishing fraction of university revenue, the provincial government has emerged as the single dominant factor in university financing.2/ At the same time, provincial governments have greatly extended their own responsibilities in such fields as health and social policy, natural resource development, transportation, urban deterioration, rural depopulation, problems of the north, of native peoples and the environment. They have called upon universities for new programs in these specific areas and have thereby added significantly to the costs of higher education.

An increasingly imminent problem for universities in Canada is the projected decline in the university-age population which is expected to begin in the early 1980's and persist to the year 2000. Since so

1/ Evans, J.R., Physicians in a Public Enterprise, Journal of Medical Education. 48: 975-986, 1973

2/ Ibid.

much of the expansionist ethic in universities has in the past been fuelled by enrollment increases, the prospect of a decline has been seized upon by governments as requiring a virtual freeze on growth in some areas and actual retrenchment in others.

Provincial governments have also expressed concern about the single direct relationship between the federal government and the universities, that is, the continuing federal program of direct grants in aid of research. Grants-in-aid, they argue, attract overhead costs, which are charged on the university's budget. Even though 50 percent of such costs are passed on to the federal government through cost sharing agreements, the provinces have taken the position that provincial institutions should not be directing their attention and resources to esoteric areas of little provincial concern, while immediate provincial problems receive too little attention by university researchers.

The factors I have outlined and several others I do not want to take time to mention are impelling provincial government toward closer control of universities and "to regard them as simply the upper level of an integrated educational system thought to exist solely to serve society's needs as interpreted by the government of the day".3/

Health Services: The boom period in the expansion of government supported health services began almost a decade after the rapid expansion of universities. In 1964, a Royal Commission on Health Services reported the results of its comprehensive assessment of health needs and resources in Canada.

The recommendations of the Royal Commission established the blueprint for the development of a national system of comprehensive health care insurance. The federal government ultimately recognized that such a development would generate a great increase in the public demand for health services, which would far outstrip the available resources in medical manpower. A health resources fund was established to provide for the major expansion in clinical and research facilities required in order to increase the numbers of medical graduates and other health service personnel.

New medical schools and teaching hospitals were built. Existing ones were expanded and modernized. And over a billion dollars will ultimately be spent with the conviction that at last the major barriers to accessible comprehensive and continuing health care would be removed and the health of the nation protected to the highest degree possible.

It was soon abundantly clear that removing the financial barriers to health care does not guarantee an adequate system of delivery of health care. Indeed the effect of removing financial barriers is to "highlight

3/ Ibid.

other defects in the system" such as the lack of an organized framework for the delivery of primary care and the lack of cooperative planning of health services.4/

The deficiency in organization of primary care is most readily exemplified by the rapid increase in visits to hospital emergency rooms by patients with non-emergent problems who have been frustrated in their attempts to obtain accessible and continuing care from private physicians. The deficiency in coordination of health services at the regional level is exemplified by wasteful competition between hospitals, duplication of specialized facilities and failure to integrate specialized programs. And this led to the general popularity among health planners of the notion of regionalization of services; that is to say, of the establishment of district health authorities with jurisdiction over the organization of all health services and hospitals in a geographic area.

More recently dissatisfaction with the nature of the health service system has given way to an even more acutely felt dissatisfaction, with the rapid escalation of health care costs. The escalation has its roots in the increasing demand for new and improved services and in the general inflation of the economy.

Health care providers responded promptly to the demand for new services, but like the universities, have been slow to curtail old ones. Faced with costs which have been rising rapidly while at the same time being pressured to introduce new programs, provincial governments have begun to move toward closer control of health service institutions. The autonomy of large urban hospitals has gone the way of the autonomy of universities. In addition to financial control, provincial governments now exert increasing influence on what is done and who does it in our hospitals.

Since no provincial government in Canada, whatever its political stripe, finds it acceptable in political terms to place financial deterrents on patients seeking care, other means of restraining costs are being explored. The first of these is to reduce or at least limit the growth in numbers of active treatment hospital beds, since approximately two thirds of total health care costs relate to the operation of hospitals.

The second is in limiting the number of practicing physicians. The basis for this approach is the contention that the number of practicing physicians is the most important determinant of total health care costs. Physician-generated costs include not only their remuneration in fees for

4/ Sirluck, E., Causes of Tightening Government Control of Universities. STOA 4:3-8, 1974.

b. uneven geographic distribution of medical manpower

c. an imbalance of manpower production between general and specialty practice and among various specialties. Many believe that the present output of specialists of a given type relates more closely to the prestige of the specialty, the momentum of the training program and the laissez-faire attitudes of the past and does not reflect the needs for the products of these training programs.

The response of governments to these manpower problems has been largely indirect. Manpower studies have been undertaken at both the federal and provincial levels, with a view to estimating the future need for physicians. While few have confidence in detailed manpower forecasting, there is not doubt that the mere conduct of these studies and the involvement of medical schools in them has created a climate of accountability and restraint.

As far as the total numbers of physicians is concerned, two things are worth noting. The federal government has introduced restriction on physician immigration and medical schools have frozen their enrollments, with some schools even contemplating enrollment reductions.

With respect to distribution of posts among training programs, some provinces have established guidelines to ensure that training opportunities in primary care will be available for at least 50 percent of medical graduates and have assigned a lower priority to provision of resources for the training of specialists. Responsibility for making the difficult adjustments necessary to correct the imbalance among specialty programs has so far been left to the medical schools themselves. While the adjustments are proceeding at different rates in the various schools, nearly all are taking their responsibilities in this regard quite seriously.

3. Licensure: Provincial governments in Canada have responsibility for regulating the professions. Three issues are currently receiving much discussion among these provincial licensing authorities.

One has to do with the minimum graduate training requirements for the granting of an unrestricted general license to practice medicine or, as we say, to be on the practice register of the provincial college. At present only one preregistration year following the M.D. degree is required in most provinces, but

many argue that a second year should be mandatory. The addition of a prerequisite second year would add to the academic load of medical schools, and in the face of a limit on the total number of trainees might encroach on the number of training posts available for specialty programs.

The second issue is the question of the desirability of replacing the unrestricted general license with limited licensure. This would restrict all physicians to practicing within prescribed limits, which could be altered or extended only after a period of special training and certification of competence.

And the third issue involves relicensure or recertification on a regular periodic basis. The desire to upgrade a limited license or to renew an existing license will inevitably place additional pressures on programs of continuing medical education but may also impinge on graduate medical education training programs. To an increasing extent, graduate training programs are being asked to provide residency type training for practitioners in the field who are not content with or who need more than what traditional continuing medical education courses can provide. As provincial licensing bodies, hospital boards, health service funding authorities and others become increasingly active and demanding in the area of medical standards and medical audit, an increasing number of physicians are being identified whose practice methods are substandard and who require remedial training. A relatively small number of posts in some of our graduate medical education training programs are now set aside for such individuals to do residencies, but pressure to increase the numbers may very well grow in the years ahead.

Summary and Conclusions.

Graduate medical education in Canada has become a central rather than a peripheral concern for medical schools. In taking corporate responsibility for the academic development and control of graduate medical education, medical schools must perforce also take moral and practical responsibility for assisting the public, through provincial governments and in other ways, in grappling with such issues as the overall supply of physicians, their geographic distribution and the balance among the various clinical disciplines.

Medical schools in Canada have undertaken this expanded responsibility at a particularly difficult time. Consideration of the recent trends in government attitudes to higher education and health services reveals a general thrust toward closer control of these sectors and an increasing emphasis on cost containment and accountability.

These trends have cooled the climate for innovation and our schools are now struggling to adapt to the relative freeze. The influence of governments in graduate medical education in Canada has been both direct and indirect. For the time being direct government involvement has not been a major feature of recent developments, but indirect governmental influence can be discerned in many ways.

Despite the change in the climate for graduate medical education, the imperatives for continued academic innovation and improvements are undeniable. With whom does the responsibility for meeting this challenge rest? The complexity of the challenge and the diversity of interests to be served clearly indicate that government, the professions and the medical schools all have a role to play.

In my opinion, the corporate responsibility of medical schools for graduate medical education must be translated into increasingly effective academic control of selection of trainees, supervision of the quality of programs, determination of enrollment quotas which take into reasonable account manpower needs on the one hand and the fostering of centers of excellence on the other and such matters as internal evaluation of both trainees and teachers.

We in Canadian medical schools have, I believe, learned that we must play an active part in the solution of social problems which our programs have to some extent created, for if we do not, the pressures on governments will inevitably force them to exert an increasing level of direct control on graduate medical education with "conformity, rigidity and restraint replacing pluralism, flexibility and incentives..."6/ In the final analysis, as St. Exupery said, "Our responsibility isn't to predict the future, but to enable it."

6/Ibid.

DIRECTIONS FOR THE FUTURE

Frederick C. Robbins, M.D.*

We have heard a great deal in the preceding sessions about the problems we face in graduate medical education. We have heard the point of view of policy setters and medical school faculty members, hospital administrators, house officers themselves and even now from another country. I am supposed to talk about the future.

Before I do this, I would like to recapitulate very briefly what I have learned from this conference in regard to some of the problems. The way they are dealt with will obviously to a considerable extent determine the future. I put these remarks together before this meeting, but, frankly, I have not changed many of my ideas, so I can stick with my prepared text.

I am making the assumption that the goals of graduate education are to extend the student's clinical experience in the broadest sense, to allow for the polishing of skills, the development of independent judgment and the opportunity to specialize in a particular area of medicine. That seems to fit with what we have heard here.

In order to achieve these goals, there must be, as a part of the educational experience, considerable involvement in direct service with graduated responsibility, as well as opportunities for expanding the individual's knowledge and capabilities. When service dominates philosophically and behaviorally, as often happens today, the educational value of the experience is proportionately attenuated. Now, you can turn that around and say that, when education becomes too predominant, the service can suffer. We must not forget that there are two sides to this coin.

Responsibility for educational planning and evaluation in the various residency programs is still fragmented with little direct influence by educational institutions and a lack of corporate responsibility.

Furthermore, residency programs are largely based in hospitals, since they provide the financial support. The way in which graduate education is financed obviously has a great deal to do with determining programs and priorities.

The resident is in an ambiguous position, not quite sure whether he is an employee of the hospital or a student, and this obviously poses many problems.

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*Dr. Robbins is Dean of the Case Western Reserve University School of Medicine.

surgeon or other superspecialist. The precise definition of what one means by practicing medicine independently is obviously a matter that could be argued at some length.

One might choose as the end point the capability of practicing primary care. A degree of specialization could be allowed within this broad category that might include Family Medicine, General Pediatrics, General Medicine, OB-Gyn, Psychiatry. We could even permit greater specialization earlier than we now do and prepare the student in such areas as Radiology, Anesthesiology or Pathology, anticipating that he or she would practice in a controlled environment, starting as a junior physician.

What is the difference between this proposal and what we are now doing, one might ask. This approach would delineate more precisely the difference between the student role and that of a member of the work force. It would remove the present ambiguities of the position of the resident. It would require that those persons who were going to enter highly specialized branches of medicine would pursue this as practicing physicians serving in supervised circumstances with increasing responsibility.

You might say that this is precisely what a senior resident does, and I would not disagree with you. The difference would be that this individual would make no pretense of being a student in the usual sense, and his services would be charged for quite appropriately. He would be making a living as a practicing physician. It would provide some degree of stratification within the practicing community, something that now is almost entirely restricted to the period of residency.

Assuming that the proposition makes any sense at all, let's look at some of the implications, both pro and con. First the pros -- It would 1) eliminate, as I have already said, some of the ambiguities which now surround the residency.

2) By eliminating the amibiguities it should help to solve the present problem of whether or not residents should belong to labor unions. They would be either students or practitioners.

3) It would remove the problem of payment for education from the medical care sector, the issue about which Congress and other third party payers are becoming so concerned. (I have to modify that, for it would not totally eliminate this issue.) But we can come back to that.

4) It would provide a rational end point for graduation from medical school. This would occur when the student had demonstrated the capability of entering the work force and not simply when he had completed a prescribed period of time and possibly passed an essentially meaningless exam.

In a recent article in the New England Journal of Medicine, Eli Ginzberg in his usual pungent way -- he has already been quoted here once -- made the following comment: "In fact the congressional committees concerned with payment for patient services have become impatient about the billion dollars or so of 'their funds', that are expended for graduate education via the reimbursement route. It is strange, to say the least, that medical education has been effectively extended from a four year to an eight year program without ever having directly confronted the issue of financing for the second four year cycle. There may be nothing that the medical schools can do or should do at the present, other than to help prevent having the rug pulled out from under graduate education. But that is a task they dare not neglect."

Residents serve not only as providers and learners, but teachers as well. As we all know, in many situations the resident may be more important as a student teacher in a clinical setting than the faculty. This is not a matter that has been generally recognized or, to my knowledge, have many programs been planned to assist the residents to perform effectively in this role.

These, then, are some of the problems that we are trying to address for the future.

I am going to approach my futuristic assignment by presenting a proposition which might provide some solutions. I am fully aware that what I am going to propose will not appeal to everyone. Nonetheless I hope it will be sufficiently provocative to stimulate discussion and generate other thoughts and suggestions which are perhaps more viable and even more reasonable.

It is easy to devise propositions, but it is much harder to come grips with the real problems involved in implementation. What is the proposition?

My proposition is that we redefine what the M.D. means. Dr. J. Robert Buchanan, in another way, made proposals similar to those I will make. As of now, the M.D. in the United States really means very little, except that the student has spent a certain amount of time in an accredited school, and he is eligible to apply for licensure to practice medicine.

Of course, nobody expects anyone to practice medicine until he has completed anywhere from three to four or more years of training. I would suggest that we redefine the M.D. on the basis of performance criteria. Several end points could be selected, but one possibility might be that the student demonstrate that he or she has the capability to practice medicine independently. This does not mean that the student is prepared to enter the world as a qualified neurosurgeon, cardiovascular

5) It would replace a portion of the service-oriented residencies with educationally-oriented time, for which the medical schools would be responsible, which should reduce some of the present abuses that we all know occur.

6) If we made the end point the capability of practicing primary care, it might well provide some increase in primary care manpower.

7) It should allow for greater freedom from the hospital as a primary base for clinical education, since one would no longer be totally dependent on the resources of the hospital to finance the program, thus allowing greater possibilities of variety in the curriculum.

(An aside -- I would suggest that because our medical schools in following the Flexnerian dictum have become so tightly bound in many instances to highly complex institutions of tertiary care, our education programs have become significantly skewed. This does not mean that the hospitals are bad or that we do not need them, but we do not need them as our sole basis for clinical education.)

8) It would place the responsibility for the educational program throughout the entire medical education period with the same body; namely, the university and its faculty, and to some extent it would reduce the alphabet soup.

Well, so much for some of the pros. Now let's look at some of the cons, and I will admit that this list is longer.

First, an obvious and serious argument against such a program is that it would be a wide departure from what we are now doing. This is always almost a devastating argument, and it would require a major effort to introduce on any scale.

Second, it would almost certainly prolong the educational period. This is a time when people are pushing hard to reduce the period of dependency for a variety of reasons, including financial. However, it would also probably result in a greater effort to shorten the period of college and medical school total time and to further integrate the undergrate university education with medical school. Although the period as a formally registered student would be increased, there is no inherent need to increase the total educational period. And indeed, as I indicated, one might with proper planning be able to reduce it.

Third, it would almost certainly cost the student more. I assume tuition would be charged as long as the student was registered in the university. This is already happening in some places, as we heard; however, these students would be rendering considerable care

in the hospital or whatever service agency they were working in, and the university might well contract with the health service agency for that proportion of the student's time in which he was rendering care. The income so generated would obviously be used to subsidize the student.

Fourth, it might well produce a more complicated relationship between the hospital and the university (although I doubt that it is possible), but one might argue that it could even result in simplification.

Fifth, it is difficult to calculate the financial implications for medical schools and universities. It might prove to be expensive; however, it seems unlikely to me that it would be more expensive than what we are now doing, and it need not be.

Sixth, problems might be created with licensure. In order for graduates to enter the work force directly from school, some accommodation in the present methods of granting licensure would probably have to be made; however, this does seem to me a problem that ought to be soluble.

Seven, an important problem that cannot be ignored is that it would be impossible to introduce such a program in a single institution. It would probably have to be done by a consortium of a number of institutions, probably rather prestigious ones, or it would have to be a national program. Ideally, one would prefer to introduce any new program on a trial basis.

Another obvious need for a consortium or a sizable group, if you are going to put such a program into effect, is that one would prefer not to require students to attend a single institution all the way through this rather prolonged period. To have points at which they could move would be, I think, highly desirable both for the student and the institutions.

Eight, at the present time, the means for satisfactory performance evaluations are not available. On the other hand, were such tests seen as desirable, I am sure that we could devise them. Now, I realize that various residency groups have performance criteria, but I have not been impressed that this is an area in which we are very highly advanced.

Nine, the shift of emphasis from service-oriented residents to educationally-oriented residents would probably increase the responsibilities of the physicians for patient care. It might also increase the interest in utilizing non-physician personnel. This could be regarded either as a disadvantage or a benefit, depending upon your point of view.

Ten, the participation of non-affiliated hospitals in medical education might be made more difficult. On the other hand, the

medical schools could very well become interested in associating with a larger array of hospitals and other health care organizations.

I am sure that each of you can think of many criticisms of this proposition that I have not mentioned. Nonetheless, it seems to me to offer some advantages over what we are now doing and to provide potential solutions for some of the problems that are facing us in the near future, in particular the problem of where the money should come from.

Personally, I have no compunction in supporting education from the health care dollar. In fact, I consider it to be quite appropriate. It is equivalent to the planning in industry for the replacement of capital facilities, which provides for the system to replenish itself. Through education we replenish the manpower needs of the health care system. A principal problem, as was pointed out by Ruth Hanft today, is that the payment scheme as now structured does not spread the load evenly over the population. It is true that the majority of persons have some type of coverage for much of their medical care costs, either by the government or by third parties, so that the inequity is not as great as it might at first seem.

I realize that a program such as I propose would present many problems in implementation, and there are intermediate positions that can and are being taken. In our own institution we have set up a Council on Graduate Medical Education, which includes the directors of all the residency programs in our affiliated hospitals. Actually, we have been very impressed with the program at Northwestern and have looked upon this as a very good model.

Our Council on Graduate Medical Education reports to the faculty. It is anticipated that it will provide for the setting of standards and evaluation of programs. However, since the hospitals are independent institutions and provide the financial support for the programs, it is difficult for this council to exert major influence. I am impressed with what I heard from Jim Eckenhoff that their institution has been able to pull it off in a way that sounds very encouraging.

It has been pointed out many times that the individual hospitals should have committees that are concerned with graduate education, that represent the faculty or staff as a whole and consider each others' programs. Such approaches, and there are many other variations, some of which we have heard about during this conference, are all advances over the present situation. Nonetheless, it seems to me that it will take some rather major changes to deal with the key issues that face us in the future in graduate medical education.

I suspect that a tinkering with the system may well deal with our problems -- adequately. But as I have listened over these two days, and as I have watched the problems as they have developed, I seriously question whether such timid measures are really going to work for us, our students, graduate students and the medical profession.