Miss Littleneyer

Tab D

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

October 29, 1974

MEMORANDUM

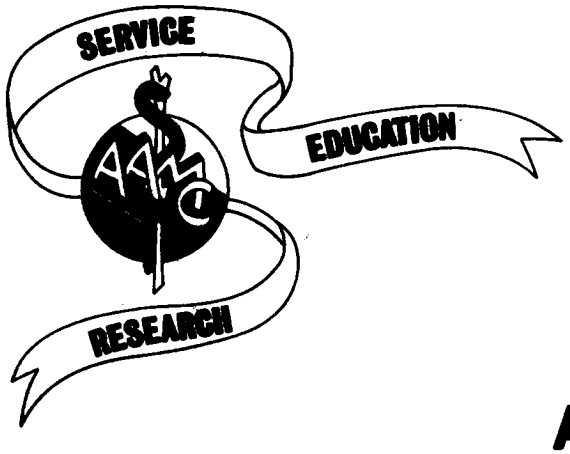
TO: The Council of Deans

FROM: Joseph A. Keyes, Director,
Division of Institutional Studies

SUBJECT: The Council of Deans' Business Meeting Agenda

Enclosed is the agenda for the Council of Deans' Business Meeting to be held from 3:00 p.m. to 5:00 p.m. on Tuesday, November 12, in the Williford C Room at the Conrad Hilton Hotel.

Please note on page 108, in the Information Item section of the agenda, the list of Annual Meeting Activities which deal with matters of interest to the Council. We urge your special consideration to those marked with an asterisk.



AGENDA

FOR

COUNCIL OF DEANS

Tuesday, November 12, 1974

3:00 - 5:00 p.m.

Williford C
Conrad Hilton Hotel
Chicago, Illinois

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

One Dupont Circle, N. W.

Washington, D. C.

COUNCIL OF DEANS BUSINESS MEETING
November 12, 1974
3:00 p.m. - 5:00 p.m.
Williford C, Conrad Hilton Hotel
Chicago, Illinois

A G E N D A

ROLL CALL OF THE COUNCIL OF DEANS -- ASSOCIATION OF AMERICAN MEDICAL COLLEGES

INSTITUTIONAL MEMBERS	REPRESENTATIVES	DESIGNEE	NOT PRESENT
Alabama			
UNIVERSITY OF ALABAMA	JAMES A. PITTMAN		
UNIVERSITY OF SOUTH ALABAMA	ARTHUR J. DONOVAN		
Arizona			
UNIVERSITY OF ARIZONA	NEAL A. VANSELOW		
Arkansas			
UNIVERSITY OF ARKANSAS	THOMAS A. BRUCE		
California			
UNIVERSITY OF CAL., DAVIS	C. JOHN TUPPER		
UNIVERSITY OF CAL., IRVINE	STANLEY VAN DEN NOORT		
UNIVERSITY OF CAL., LOS ANGELES	SHERMAN M. MELLINKOFF		
UNIVERSITY OF CAL., SAN DIEGO	JOHN H. MOXLEY, III		
UNIVERSITY OF CAL., SAN FRANCISCO	JULIUS R. KREVANS		
LOMA LINDA UNIVERSITY	DAVID B. HINSHAW		
UNIVERSITY OF SOUTHERN CALIFORNIA	ALLEN W. MATHIES, JR.		
STANFORD UNIVERSITY	CLAYTON RICH		
Colorado			
UNIVERSITY OF COLORADO	HARRY P. WARD		
Connecticut			
UNIVERSITY OF CONNECTICUT	ROBERT U. MASSEY		
YALE UNIVERSITY	ROBERT W. BERLINER		

ROLL CALL OF THE COUNCIL OF DEANS -- ASSOCIATION OF AMERICAN MEDICAL COLLEGES ASSEMBLY

INSTITUTIONAL MEMBERS	REPRESENTATIVES	DESIGNEE	NOT PRESENT
District of Columbia			
GEORGETOWN UNIVERSITY	JOHN PHILLIP UTZ		
GEORGE WASHINGTON UNIVERSITY	JAMES J. FEFFER		
HOWARD UNIVERSITY	MARION MANN		
Florida			
UNIVERSITY OF FLORIDA	CHANDLER A. STETSON, JR.		
UNIVERSITY OF MIAMI	EMANUEL M. PAPPER		
UNIVERSITY OF SOUTH FLORIDA	DONN L. SMITH		
Georgia			
EMORY UNIVERSITY	ARTHUR P. RICHARDSON		
MEDICAL COLLEGE OF GEORGIA	CURTIS H. CARTER		
Hawaii			
UNIVERSITY OF HAWAII	TERENCE A. ROGERS		
Chicago			
CHICAGO MEDICAL SCHOOL	MARSHALL A. FALK		
UNIVERSITY OF CHICAGO	LEON O. JACOBSON		
UNIVERSITY OF ILLINOIS	WILLIAM J. GROVE		
LOYOLA UNIVERSITY OF CHICAGO	JOSEPH A. WELLS		
NORTHWESTERN UNIVERSITY	JAMES F. ECKENHOFF		
RUSH MEDICAL COLLEGE	WILLIAM F. HEJNA		
SOUTHERN ILLINOIS UNIVERSITY	RICHARD H. MOY		

ROLL CALL OF THE COUNCIL OF DEANS -- ASSOCIATION OF AMERICAN MEDICAL COLLEGES ASSEMBLY

INSTITUTIONAL MEMBERS	REPRESENTATIVES	DESIGNEE	NOT PRESENT
Indiana			
INDIANA UNIVERSITY	STEVEN C. BEERING		
Iowa			
UNIVERSITY OF IOWA	JOHN W. ECKSTEIN		
Kansas			
UNIVERSITY OF KANSAS	E. B. BROWN, JR.		
Kentucky			
UNIVERSITY OF KENTUCKY	D. KAY CLAWSON		
UNIVERSITY OF LOUISVILLE	AUTHUR H. KEENEY		
Louisiana			
LSU - NEW ORLEANS	SILAS E. O'QUINN		
LSU - SHREVEPORT	CLIFFORD G. GRULEE, JR.		
TULANE UNIVERSITY	WILLIAM THURMAN		
Maryland			
JOHNS HOPKINS UNIVERSITY	RUSSELL H. MORGAN		
UNIVERSITY OF MARYLAND	JOHN M. DENNIS		
Massachusetts			
BOSTON UNIVERSITY	JOHN I. SANDSON		
HARVARD MEDICAL SCHOOL	ROBERT H. EBERT		
UNIVERSITY OF MASSACHUSETTS	LAMAR SOUTTER		
TUFTS UNIVERSITY	LAURO CAVAZOS		

OLL CALL OF THE COUNCIL OF DEANS -- ASSOCIATION OF AMERICAN MEDICAL COLLEGES ASSEMBLY

INSTITUTIONAL MEMBERS	REPRESENTATIVES	DESIGNEE	NOT PRESENT
Michigan			
MICHIGAN STATE UNIVERSITY	ANDREW D. HUNT, JR.		
UNIVERSITY OF MICHIGAN	JOHN A. GRONVALL		
WAYNE STATE UNIVERSITY	ROBERT D. COYE		
Minnesota			
MAYO MEDICAL SCHOOL	RAYMOND D. PRUITT		
UNIVERSITY OF MINNESOTA-DULUTH	ROBERT E. CARTER		
UNIVERSITY OF MINNESOTA-MINNEAPOLIS	NEAL L. GAULT, JR.		
Mississippp			
UNIVERSITY OF MISSISSIPPI	NORMAN C. NELSON		
Missouri			
UNIVERSITY OF MISSOURI-COLUMBIA	JOSEPH M. WHITE		
UNIVERSITY OF MISSOURI-KANSAS CITY	RICHARDSON K. NOBACK		
ST. LOUIS UNIVERSITY	GEORGE E. THOMA		
WASHINGTON UNIVERSITY	M. KENTON KING		
Nebraska			
CREIGHTON UNIVERSITY	JOSEPH M. HOLTHAUS		
UNIVERSITY OF NEBRASKA	PERRY RIGBY		
Nevada			
UNIVERSITY OF NEVADA	GEORGE T. SMITH		

ROLL CALL OF THE COUNCIL OF DEANS -- ASSOCIATION OF AMERICAN MEDICAL COLLEGES ASSEMBLY

INSTITUTIONAL MEMBERS	REPRESENTATIVES	DESIGNEE	NOT PRESENT
New Hampshire			
DARTMOUTH MEDICAL SCHOOL	JAMES C. STRICKLER		
New Jersey			
NEW JERSEY MEDICAL SCHOOL	STANLEY S. BERGEN, JR.		
RUTGERS MEDICAL SCHOOL	JAMES W. MACKENZIE		
New Mexico			
UNIVERSITY OF NEW MEXICO	LEONARD M. NAPOLITANO		
New York			
ALBANY MEDICAL COLLEGE	STUART BONDURANT		
ALBERT EINSTEIN COLLEGE OF MEDICINE	EPHRAIM FRIEDMAN		
COLUMBIA UNIVERSITY	DONALD TAPLEY		
CORNELL UNIVERSITY	J. ROBERT BUCHANAN		
MOUNT SINAI	THOMAS C. CHALMERS		
NEW YORK MEDICAL COLLEGE	SAMUEL H. RUBIN		
NEW YORK UNIVERSITY	IVAN L. BENNETT, JR.		
UNIVERSITY OF ROCHESTER	J. LOWELL ORBISON		
SUNY-BUFFALO	F. CARTER PANNILL		
SUNY-DOWNSTATE	LEONARD LASTER		
SUNY-STONY BROOK	MARVIN C. KUSCHNER		
SUNY-UPSTATE	RICHARD P. SCHMIDT		

ROLL CALL OF THE COUNCIL OF DEANS -- ASSOCIATION OF AMERICAN MEDICAL COLLEGES ASSEMBLY

INSTITUTIONAL MEMBERS	REPRESENTATIVES	DESIGNEE	NOT PRESENT
North Carolian			
BOWMAN GRAY SCHOOL OF MEDICINE	RICHARD JANEWAY		
DUKE UNIVERSITY	EWALD W. BUSSE		
UNIVERSITY OF NORTH CAROLINA	CHRISTOPHER C. FORDHAM, III		
North Dakota			
UNIVERSITY OF NORTH DAKOTA	JOHN VENNES		
Ohio			
CASE WESTERN RESERVE	FREDERICK C. ROBBINS		
UNIVERSITY OF CINCINNATI	ROBERT S. DANIELS		
MEDICAL COLLEGE OF OHIO-TOLEDO	JOHN P. KEMPH		
OHIO STATE UNIVERSITY	HENRY G. CRAMBLETT		
Oklahoma			
UNIVERSITY OF OKLAHOMA	THOMAS N. LYNN, JR.		
Oregon			
UNIVERSITY OF OREGON	CHARLES N. HOLMAN		
Pennsylvania			
HAHNEMANN MEDICAL COLLEGE	JOSEPH R. DIPALMA		
JEFFERSON MEDICAL COLLEGE	WILLIAM F. KELLOW		
MEDICAL COLLEGE OF PENNSYLVANIA	ROBERT J. SLATER		
PENNSYLVANIA STATE UNIVERSITY	HARRY PRYSTOWSKY		
UNIVERSITY OF PITTSBURGH	GERHARD WERNER		

OLL CALL OF THE COUNCIL OF DEANS -- ASSOCIATION OF AMERICAN MEDICAL COLLEGES ASSEMBLY

INSTITUTIONAL MEMBERS	REPRESENTATIVES	DESIGNEE	NOT PRESENT
Pennsylvania (cont'd)			
UNIVERSITY OF PENNSYLVANIA	EDWARD J. STEMMLER		
TEMPLE UNIVERSITY	ROGER SEVY		
Rhode Island			
BROWN UNIVERSITY	STANLEY M. ARONSON		
South Carolina			
MEDICAL COLLEGE OF SOUTH CAROLINA	JOHN W. ZEMPH		
South Dakota			
UNIVERSITY OF SOUTH DAKOTA	KARL H. WEGNER		
Tennessee			
MEHARRY MEDICAL COLLEGE	RALPH J. CAZORT		
VANDERBILT UNIVERSITY	ALLEN D. BASS		
UNIVERSITY OF TENNESSEE	T. ALBERT FARMER, JR.		
Texas			
BAYLOR COLLEGE OF MEDICINE	JOSEPH M. MERRILL		
UNIVERSITY OF TEXAS-DALLAS	FREDERICK M. BONTE		
UNIVERSITY OF TEXAS- GALVESTON	EDWARD N. BRANDT, JR.		
UNIVERSITY OF TEXAS- HOUSTON	CHEVES McC. SMYTHE		
UNIVERSITY OF TEXAS-SAN ANTONIO	STANLEY E. CRAWFORD		
TEXAS TECH UNIVERSITY	GEORGE S. TYNER		

ROLL CALL OF THE COUNCIL OF DEANS -- ASSOCIATION OF AMERICAN MEDICAL COLLEGES ASSEMBLY

INSTITUTIONAL MEMBERS	REPRESENTATIVES	DESIGNEE	NOT PRESENT
Utah			
UNIVERSITY OF UTAH	JOHN A. DIXON		
Vermont			
UNIVERSITY OF VERMONT	WILLIAM H. LUGINBUHL		
Virginia			
EASTERN VIRGINIA MEDICAL SCHOOL	ROBERT T. MANNING		
MEDICAL COLLEGE OF VIRGINIA	WARREN H. PEARSE		
UNIVERSITY OF VIRGINIA	WILLIAM R. DRUCKER		
Washington			
UNIVERSITY OF WASHINGTON	ROBERT L. VAN CITTERS		
West Virginia			
WEST VIRGINIA UNIVERSITY	JOHN F. JONES		
Wisconsin			
MEDICAL COLLEGE OF WISCONSIN	GERALD A. KERRIGAN		
UNIVERSITY OF WISCONSIN	LAWRENCE G. CROWLEY		
Lebanon			
AMERICAN UNIVERSITY OF BEIRUT	SAMUEL P. ASPER		
Puerto Rico			
UNIVERSITY OF PUERTO RICO	CARLOS F. GIROD		

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
Minutes
Council of Deans Business Meeting
November 5, 1973
1:30 p.m. - 4:30 p.m.
Ballroom East, Hilton Hotel
Washington, D.C.

I. Call to Order

The Council of Deans Business Meeting was called to order by its Chairman, Sherman Mellinkoff, at 1:30 p.m. The roll was called and a quorum determined to be present.

II. Approval of Minutes

The minutes of the November 3, 1972, and March 7-9, 1972 meetings were approved without change.

III. Chairman's Report

The Chairman reported on the success of the AAMC impoundment suits and the efforts of an Association committee to work with the Health Resources Administration representatives to draft equitable regulations governing reimbursement of physicians in the teaching setting. He commented briefly on the publication of the AAMC study of the cost of medical education and the necessity for the Association to undertake the initiative in this matter.

Dr. Mellinkoff reported on the follow-up to the San Antonio resolution of the COD. The staff will develop a new document which will clearly set out the status of the AAMC policy formulation on issues such as those identified in the "Yellow Book": Medical Education: The Institutions, Characteristics, and Programs, which will include a statement of progress toward identified goals.

He then announced the follow-up action on the recommendations of the ad hoc committee on admissions problems chaired by Carleton Chapman. A study of the feasibility of a medical school admissions matching program had been completed; the medical schools in the states of California and Michigan had agreed to participate in a test matching for the coming year as a further trial of the concept.

He announced the appointment of an Executive Council Committee to recommend an AAMC policy statement on the subject of moonlighting by house officers.

IV. Report of the Chairman of the Regions

Western -- Robert L. Van Citters, M.D.

No regional meetings had been held during the year.

Mid-West Great Plains -- William Grove, M.D.

Four meetings had been held on a variety of issues. One issue of particular interest was the matter of state support for graduate medical education. A survey had been taken of each school to determine the manner and level of state assistance. Neal Gault, M.D. was elected chairman of the regional COD; Ralph Kinsella, M.D., Professor of Medicine at St. Louis University was elected Chairman of the regional plenary session.

Southern Region -- Christopher Fordham, M.D.

The region met. Its discussion focused on area health education centers. Warren Pearse is the newly elected chairman of the region.

Northeast Region -- J. Robert Buchanan, M.D.

No regional meetings had been held although sub groups in the region had met to discuss local issues.

V. Special Criteria for Programs of the Basic Medical Sciences

Thomas Kinney, M.D. provided the background on this document prepared by the LCME which establishes the standards and procedures by which undergraduate medical educational programs which do not culminate in the award of the M.D. degree will be handled for purposes of accreditation. They will be considered for independant accreditation only if in one of the following categories:

1) Existing two-year programs accredited or provisionally accredited,

2) New basic science programs in institutions with a commitment to establish a full M.D. degree program with their own resources or as part of a consortium, and

3) New basic science programs in institutions which are formally affiliated with one or more already established medical schools. In this case, the program will be accredited as a component of the M.D. degree-granting institution or institutions.

ACTION: On motion seconded and passed,the Council of Deans endorsed the "Special Criteria for Programs of the Basic Medical Sciences," and recommended its adoption by the AAMC Assembly.

VI. Proposal for the Modification of Assembly Representation--AAMC Bylaw Amendment

Andrew Hunt, M.D. introduced the proposed Bylaws Amendment designed to increase the representation of the Council of Academic Societies and the Council of Teaching Hospitals in the Assembly. It provided that there be one vote for each constituent member of the respective councils to a total of one half the votes held by the Council of Deans. This would permit the CAS representation for each of its current 51 members and the COTH 57 votes for its 405 members, the OSR would continue to have representation equal to 10 percent of its membership. The amendment would increase the COTH representation on the AAMC Executive Council from three to four,equivalent to that of the CAS. The COD would continue with nine and the OSR with one.

ACTION: On motion seconded and passed, the Council of Deans voted to endorse the proposed bylaws amendment and to recommend its adoption by the AAMC Assembly.

VII. Proposal for the Establishment of an AAMC Membership Category--"Distinguished Service Members"

J. Robert Buchanan, M.D. introduced the proposal and described its provisions:

1) Redesignate Senior Members "Distinguished Service Member."

2) Provide that such members would be elected by the Assembly on recommendation of the Executive Council and one of the constituent Councils.

3) Set the principal criterion for the selection of Distinguished Service Members as active and meritorious participation in AAMC Affairs while a member of one of the AAMC Councils. Additional criteria may be established by the Executive Council or constituent Councils responsible for nominating Distinguished Service Members.

4) Establish that each Distinguished Service Member shall have honorary membership status on the Council which recommended his/her election, i.e. would be invited to

all meetings of the Council and have the privilege of the floor without vote.

5) Provide that the Distinguished Service Members meet as a group once a year at the Annual Meeting and elect a Chairman and/or Chairman-elect.

6) Establish Distinguished Service Members eligibility for Emeritus Membership at age 65; Emeritus Membership would be mandatory at age 70.

7) Provide for an additional position on the AAMC Executive Council to be filled by a Distinguished Service Member elected by the Assembly for a standard three-year term.

ACTION: On motion, seconded and passed, the COD endorsed the establishment of the proposed new membership category and recommended its adoption by the AAMC Assembly.

VIII. Provisional Nomination of Distinguished Service Members

In contemplation of the passage of the proposed establishment of the category of Distinguished Service Members, the Chairman appointed a committee, chaired by Robert L. Van Citters, M.D. and consisting of J. Robert Buchanan, M.D. and Clifford G. Grulee, M.D. to propose candidates for Council nomination for election to such membership. Dr. Van Citters reported the the committee proposed the following individuals:

Carleton B. Chapman, M.D.
Robert J. Glaser, M.D.
John R. Hogness, M.D.
Robert B. Howard, M.D.
Charles C. Sprague, M.D.
William N. Hubbard, Jr., M.D.
Thomas H. Hunter, M.D.
Robert Q. Marston, M.D.
David E. Rogers, M.D.
Robert S. Stone, M.D.

IX. ACTION: On motion, seconded and carried, the COD voted to nominate those listed for election to Distinguished Service Membership.

IX. Election of Institutional Members

The following medical schools,having received full accreditation by the Liaison Committee on Medical Education, and having graduated a class of students, were eligible for full Institutional Membership in the AAMC:

1. Louisiana State University - Shreveport

2. Rush Medical College

3. University of Missouri - Kansas City

The following school of the basic medical sciences has received full accreditation by the Liaison Committee on Medical Education, a class of students has completed its program, and is eligible for full Institutional Membership in the AAMC: University fo Nevada - Reno. These institutions had been recommended for full Institutional Membership by the COD Administrative Board on September 13, and by the Executive Council on September 14, 1973.

ACTION: On motion, seconded and passed, the Council of Deans voted to ratify the action of its Administrative Board and clear the matter for Assembly action.

X. Election of Affiliate Institutional Members

The following medical schools,having received full accreditation by the Liaison Committee on Medical Education, and having graduated a class of students, were eligible for election of Affiliate Institutional Membership in the AAMC:

1. Memorial University of Newfoundland Medical School

2. University of Calgary Faculty of Medicine

These institutions had been recommended for full Affiliate Membership by the COD Administrative Board on September 13, and by the Executive Council on September 14, 1973.

ACTION: On motion, seconded and passed, the Council of Deans voted to ratify the action of its Administrative Board and clear the matter for Assembly action.

XI. Election of Officers

Christopher Fordham, M.D., Chairman of the Council of Deans Nominating Committee, announced that committee's recommendations:

For Chairman-elect of the COD: Ivan Bennett, Jr., M.D., Dean, New York University, School of Medicine

For Member-at-Large of the COD Administrative Board: Andrew Hunt, Jr., M.D., Dean, Michigan State University College of Human Medicine

ACTION: On motion, seconded and passed, the Council elected the nominees to the offices as proposed.

The following recommendations were made to the Assembly nominating committee for offices to be filled by vote of that body:

Chairman-elect of the Assembly: Sherman M. Mellinkoff, M.D., Dean, the UCLA School of Medicine

Council of Deans Representatives to the Executive Council:

John A. Gronvall, M.D., Dean, the University of Michigan Medical School

Clifford G. Grulee, Jr., M.D., Dean, Louisiana State University at Shreveport, Medical School

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

XII. Report on the Management Advancement Program

Ivan Bennett, Jr., M.D., chairman of the MAP Steering Committee, gave a brief review of the progress of the program and the work of his committee.

XIII. Report of the President of the National Fund for Medical Education

John S. Millis, Ph.D. described his perception of the need to obtain more community support for medical education and a program which his agency had been developing to better inform the public of the work and needs of academic medical institutions. He encouraged the deans to provide him with information regarding their financial problems and to work with him in the development of regional and/or state organizations dedicated to this important public information function.

XIV. Report on the Coordinating Council on Medical Education

William G. Anlyan, M.D., Chairman of the CCME reported on the structure of that body, its studies in the areas of financing graduate medical education and physician distribution by specialty. He also discussed the developing relations between the CCME and the present and proposed accrediting bodies. The Liaison Committee on Graduate Medical Education has been formed with representatives from the AMA, AAMC, American Board of Medical Specialties, The

Council of Medical Specialty Societies, and the American Hospital Association. A Liaison Committee on Continuing Medical Education had been proposed and negotiations to establish such a body were in the initial stages. A Liaison Committee on Allied Health Education is projected as a possible additional body, but no steps had been taken to bring it into being to date.

XV. New Business:

1. The Organization of Student Representatives proposed the following changes to its rules and regulations:

a) Section 4, subtitle (a), section 1, add the following sentence at the end of this paragraph: "The Chairperson must be an official member of OSR at the time of his or her election and must have attended the previous OSR annual meeting and the most recent meeting of his or her OSR region. In the event that no OSR member satisfying these criteria seeks the office of Chairperson, these criteria shall be waived.

b) Section 4, subtitle (a), section2, this should be changed to read: "The Vice-Chairperson, whose duties are to preside or otherwise serve in the absence of the Chairperson. If the Vice-Chairperson succeeds the Chairperson before the expiration of this term of office, such service shall not disqualify the Vice-Chairperson from serving a full term as Chairperson." (Wherever appearing in the Rules and Regulations of the OSR, the words "Chairman-elect" shall be replaced by the words "Vice-Chairperson." In the Rules and Regulations this will include changes in Section 4D, line 2; Section 4F, line 5; and Section 5, line 7.)

c) Section 4, subtitle (a), section 3. This section shall be replaced by the following: "The Secretary whose duties it shall be to (i) keep the minutes of each regular meeting; (ii) maintain an accurate record of all actions and recommendations of the organization and (iii) insure the dissemination of minutes of each regular meeting and a record of all actions and recommendations of the organization and of the organization's representatives on the commitees of the AAMC within one month of each meeting."

d) Section 4, subtitle (d), this shall be changed to read: "There shall be an Administrative Board composed of the Chairperson, the Vice-Chairperson, the Representatives-at-Large, the Secretary, and one member chosen from each of four regions, which shall

be congruent with the regions of the Council of Deans. Regional members of the Administrative Board shall be elected at the Annual Meeting by regional caucus."

e) Section 6, subtitle (d) shall be deleted and replaced with the following: "Formal actions may result by two mechanisms: (i) By a majority of those present and voting at meetings at which a quorum is present and (ii) when three of four regional meetings have passed an identical motion by a majority of those present and voting."

f) Section 4, subtitle (e), this section will be eliminated completely.

g) Section 3, Membership, add subtitle (c) "Each school shall choose the term of office of its representative in its own manner."

ACTION: On motion, seconded and adopted, the COD approved the revisions to the OSR Rules and Regulations.

2. The OSR Chairman communicated the OSR desire to have a representative on the COD Administrative Board. He was informed of the Board's action to extend the OSR Chairman a standing invitation to attend its meetings as an observer without vote. No further action was taken on this matter.

XVI. Installation of the New Chairman

Dr. Mellinkoff turned over the gavel to Dr. Emmanuel Papper, who would serve as chairman for the coming year.

Dr. Papper accepted the gavel and expressed his appreciation on behalf of the Council to Dr. Mellinkoff for the leadership he had provided over the previous year.

XVII. Adjournment

The Meeting was adjourned at 4:20 p.m.

IV. 1. Election of Institutional Members

The AAMC Executive Council is required by the Association Bylaws, Chapter VI Section 1, to "set the Education standards and criteria as prerequisites for the election of members of the Association, it shall consider applications for membership and it shall report its findings and recommendations with respect thereto to the Assembly." On June 25, 1971, the Executive Council specified the procedures and criteria for obtaining Institutional Membership appearing on the following pages.

In accordance with those procedures, the Executive Council, having been satisfied that the criteria have been met and on recommendation of the Administrative Board of the Council of Deans, has recommended that the Assembly elect the following institutions to the membership category indicated:

a. Institutional Member

1. The University of Massachusetts Medical School

2. The State University of New York at Stony Brook School of Medicine

3. Texas Tech University School of Medicine

4. The University of Texas Medical School at Houston

b. Provisional Institutional Member

1. Wright State University
School of Medicine
Dayton, Ohio

The Administrative Board and Executive Council actions were each contingent upon ratification by vote of the Council of Deans.

Recommendation: That the Council of Deans ratify the action of its Administrative Board, clearing the matter for Assembly action.

Prerequisites and Election Procedures *

for AAMC Institutional Membership

The following are the procedures and criteria for obtaining Institutional Membership in the Association of American Medical Colleges. The Executive Council hereby specifies the following*:

I. Provisional Institutional Membership

A) Action by the School

A letter from a developing medical school requesting provisional institutional membership in the Association of American Medical Colleges, that letter indicating that the medical school or college has fulfilled the following:

1) has an appropriate sponsor
2) has a definite commitment by that sponsor
3) has appointed a full-time dean
4) has received reasonable assurance of accreditation from the Liaison Committee on Medical Education

B) Action by the Council of Deans

Upon the receipt of said letter and notification from the Liaison Committee on Medical Education of reasonable assurance, the Council of Deans at its next business meeting shall consider the request and shall determine its recommendation to the Executive Council.

C) Action by the Executive Council

The Executive Council at its business meeting following the Council of Deans' meeting shall act on the recommendation from the Council of Deans.

D) Action by the Assembly

The recommendation of the Executive Council shall be presented to the Assembly of the Association and acted on by the Assembly at its next business meeting. Election by the Assembly shall be by majority vote.

II. Institutional Membership

A) Institutional Members shall be those medical schools and colleges of the United States who have graduated a first class of medical students and have been granted full accreditation by the Liaison Committee on Medical Education.

*Adopted by the Executive Council 6/25/71.

B) Action by the Council of Deans

The Council of Deans shall determine its recommendation to the Executive Council regarding the membership status of those medical schools or colleges graduating the first class contingent upon receipt of full accreditation by the Liaison Committee on Medical Education prior to the next business meeting of the Assembly.

C) Action by the Executive Council

The Executive Council at its business meeting following the Council of Deans' meeting shall act on the recommendation from the Council of Deans.

D) Action by the Assembly

The recommendation of the Executive Council shall be presented to the Assembly of the Association and acted on by the Assembly at its next business meeting. Election by the Assembly will be by majority vote.

* Under VI, Section 1 of the Bylaws, the Executive Council shall set educational standards and criteria as prerequisites for the election of members of the Association.

4/15/71

IV. 2. Election of Officers

The Rules and Regulations of the Council of Deans adopted October 31, 1969, provide as follows:

> The Chairman of the Council of Deans shall appoint a Nominating Committee of not less than 5 voting members of the Council who shall be chosen with due regard for regional representation. This Committee will solicit nominations from the voting members for elective positions vacant on the Executive Council and Administrative Board. From these nominations a slate will be drawn, with due regard for regional representation, and will be presented to the voting members of the Council of Deans at least two weeks before the Annual Meeting at which the elections will be held. Additional nominations may be made at the time of the meeting.
>
> Section 4. (f)

Accordingly, Dr. Papper appointed a committee constituted as follows:

John A. Dixon, M.D., Chairman
Dean
University of Utah
College of Medicine

John H. Moxley, III, M.D. (West)
Dean
University of California, San Diego
School of Medicine

John W. Eckstein, M.D. (Midwest-Great Plains)
Dean
The University of Iowa
College of Medicine

Richard Janeway, M.D. (South)
Dean
The Bowman Gray School of Medicine of
Wake Forest University

Donald N. Medearis, Jr., M.D. (Northeast)
Dean
The University of Pittsburgh
School of Medicine

The attached letter constitutes the report of that committee. Additional nominations may be made from the floor.

Recommendation: That the Council of Deans elect a chairman-elect and member-at-large of the Council of Deans Administrative Board from such nominations as are proposed.

THE UNIVERSITY OF UTAH

SALT LAKE CITY 84132

JOHN A. DIXON, M.D.
VICE PRESIDENT FOR HEALTH SCIENCES

July 23, 1974

Emanuel M. Papper, M.D., Dean
University of Miami
School of Medicine
P. O. Box 875
Miami, Florida 33152

Dear Manny:

This letter constitutes my report as Chairman of the Council of Deans Nominating Committee to you as the Chairman of the Council of Deans. The Committee met at 2:00 p.m. on July 8, 1974, by conference telephone call. At that time we had available to us the tallies of the advisory ballots submitted by the Council of Deans.

By the unanimous vote of the Nominating Committee, the following slate of officers is proposed:

Chairman-elect of the Assembly: Leonard W. Cronkhite, Jr., M.D.
Executive Vice President, Children's Hospital Medical Center

Council of Deans Representatives to the Executive Council:
J. Robert Buchanan, Dean, Cornell University College of Medicine (Northeast)

Neal L. Gault, Dean, University of Minnesota Medical School (Mid-West Great Plains)

Note: These offices are filled by election of the Assembly. Consequently, the slate proposed for the Assembly's consideration will be developed by the AAMC Nominating Committee, of which I am a member. Thus, these names will be submitted in the form of a recommendation from our Nominating Committee to that Nominating Committee.

The following offices will be filled by vote of the Council of Deans. The slate proposed by your Nominating Committee is as follows:

Chairman-elect of the Council of Deans: John A. Gronvall, M.D.
Dean, the University of Michigan Medical School (Midwest-Great Plains)

Member-at-Large, Council of Deans Administrative Board:
Andrew Hunt, Jr., M.D., Dean, Michigan State University
College of Human Medicine

These nominations, I believe, accurately reflect the wishes of the members of the Council of Deans. I am confident that we have a slate which will contribute substantially to the work of the Association.

Thank you for the opportunity to serve in this capacity.

Sincerely,

John A. Dixon,M.D.

JAD/cw

cc: Joseph A. Keyes
John H. Moxley III, M.D.
John W. Eckstein, M.D.
Richard Janeway, M.D.
Donald N. Medearis, Jr., M.D.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Memorandum #74-37

To: The Assembly October 21, 1974

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

Subject: AAMC health manpower policy reconsideration

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

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

Present AAMC policy

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

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

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

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

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

Current legislative situation

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

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

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

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

Health Manpower Policy Alternatives

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

Current concerns

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

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

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

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

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

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

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

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

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

Assumptions

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

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

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

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

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

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

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

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

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

Policy choices

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

Federal support

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

Federal support

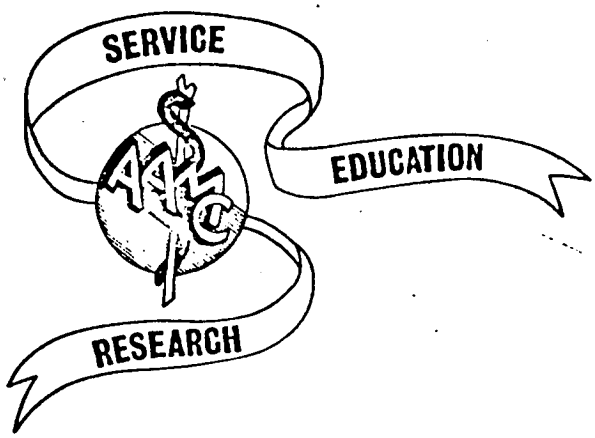
Funding source	Advantages	Disadvantages
Capitation (con't.)		differentiate among varying degrees of financial need.
Tuition subsidy to students	If it is sufficiently high, it would allow schools to adjust tuition income to meet basic operating needs.	State schools are not able to adjust tuition without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

Non-federal support

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

Non-federal support

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



V. 2.

REPORT OF THE

AAMC TASK FORCE

ON THE

GOALS AND PRIORITIES COMMITTEE

REPORT

OF THE

NATIONAL BOARD OF MEDICAL EXAMINERS

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

Comments Should be Directed to:

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

October 25, 1974

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

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

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

Members of the Task Force:

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

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

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

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

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

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

Summary of Major Recommendations of the GAP Report

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

GENERAL OBSERVATIONS BY THE TASK FORCE

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

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

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

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

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

Abandonment of Part I

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

Task Force Report on GAP Committee Report of NBME

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

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

Abandonment of Part II

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

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

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

Task Force Report on GAP Committee Report of NBME

QUALIFYING A

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

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

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

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

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

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

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

Limited Licensure

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

EVALUATION DURING GRADUATE MEDICAL EDUCATION

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

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

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

QUALIFYING B

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

RECERTIFICATION AND RELICENSURE

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

REORGANIZATION OF THE NATIONAL BOARD OF MEDICAL EXAMINERS

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

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

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

The Task Force concurs.

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

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

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

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

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

The Task Force concurs and makes the following recommendations.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

V. 3. COORDINATING COUNCIL ON MEDICAL EDUCATION REPORT

ROLE OF THE FOREIGN MEDICAL GRADUATE

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

The Role of the Foreign Medical Graduate

A Report of the Coordinating Council on Medical Education*

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

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

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

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

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

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

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

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

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

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

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

addressed.

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

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

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

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

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

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

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

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

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

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

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

RECOMMENDATIONS

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

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

I. General Recommendations

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

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

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

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

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

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

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

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

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

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

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

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

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

II. Specific Recommendations

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

A. Recommendations on Temporary Visitor Physicians

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. Recommendations on Foreign National Physicians Seeking Permanent Residence

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

The CCME recommends:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The CCME recommends:

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

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

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

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

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

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

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

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

The CCME recommends:

1. That an educational exchange program be established as

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

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

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

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

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

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

III. Implementation of Recommendations

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

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

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

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

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

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

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

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

TABLE 1

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

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

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

TABLE 2

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

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

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

TABLE 3

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

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

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

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

TABLE 4

STUDENTS AND GRADUATES IN MEDICAL AND BASIC SCIENCE SCHOOLS*

YEAR	NUMBER OF SCHOOLS	1ST YEAR ENROLLMENT	TOTAL ENROLLMENT	GRADUATES
1930-31	76	6,456	21,982	4,735
1940-41	77	5,837	21,379	5,275
1950-51	79	7,177	26,186	6,135
1960-61	86	8,298	30,288	6,994
1970-71	103	11,348	40,487	8,974
1971-72	108	12,361	43,650	9,551
1972-73	112	13,726	47,546	10,391
1973-74	114	14,044***	51,000**	11,852**

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

** Estimates

*** AAMC DATAGRAM

TABLE 5

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

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

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

TABLE 6

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

First-Year Class	Number of Applicants	Number of Applications	Applications per Individual	Accepted Applicants	New Entrants	First-Year Enrollment*	Percent of Total Applicants Accepted
1963-64	17,668	70,063	4.0	9,063	8,565	8,842	51.3
1964-65	19,168	84,571	4.4	9,043	8,587	8,836	47.2
1965-66	18,703	87,111	4.7	9,012	8,554	8,760	48.2
1966-67	18,250	87,627	4.8	9,123	8,775	8,991	50.0
1967-68	18,724	93,332	5.0	9,702	9,314	9,473	51.8
1968-69	21,118	112,195	5.3	10,092	9,740	9,863	47.9
1969-70	24,465	133,822	5.5	10,547	10,269	10,422	43.1
1970-71	24,987	148,797	6.0	11,500	11,169	11,348	46.0
1971-72	29,172	210,943	7.2	12,335	12,088	12,361	42.3
1972-73	36,135	267,305	7.4	13,757	13,352	13,677	38.1

* Includes previously enrolled students.

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

V. 4. Input into Retreat Agenda

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

V. 5. The National Health Service Corps: Current Status and Relationship to Medical Schools

Dr. Paul B. Batalden, Director of the Bureau of Community Health Services has asked for an opportunity to address the Council of Deans for the purpose of describing the current status of the National Health Service Corps, and its projected activities especially as they relate to the medical schools. The attached letter and vitae provide some additional background on this matter.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES ADMINISTRATION
ROCKVILLE, MARYLAND 20852

BUREAU OF COMMUNITY HEALTH SERVICES

OCT 2 1974

October 17, 1974

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

Dear Mr. Keyes:

This letter will confirm Dr. Courie's conversation with you concerning our meeting with the Council of Deans on Tuesday afternoon, November 12, 1974, at the annual meeting of the AAMC in Chicago, Illinois.

Dr. Paul B. Batalden, Director of the Bureau of Community Health Services, will discuss the National Health Service Corps in relationship to the maldistribution of physicians in the United States and the opportunities for the Schools of Medicine, together with the Corps, in addressing the complex issue in light of recent Federal legislation being proposed. A copy of Dr. Batalden's curriculum vitae is enclosed.

We do appreciate the opportunity to bring to the attention of the Council the current status of the Corps and its projected activities.

Thank you for your kind assistance.

Sincerely yours,

Edward D. Martin

Edward D. Martin, M.D.
Associate Bureau Director
Office for National Health
Service Corps

Enclosure

BIOGRAPHICAL SKETCH

Name: Paul Bennett Batalden, M.D.

Position: Director, Bureau of Community Health Services
Health Services Administration
U.S. Department of Health, Education, and Welfare

Birthplace and Date: Minneapolis, Minnesota
December 4, 1941

Education:
Augsburg College, Minneapolis, Minnesota, 1959-1963
B.A. cum laude
University of Minnesota, Minneapolis, Minnesota, 1963-1967, B.S., M.D.
University of Minnesota, Department of Pediatrics, 1967-1968, Internship and Residency
Washington School of Psychiatry, 1970-1971
American Board of Pediatrics, Board Eligible, 1972

Public Health Service Experience:
1969 Clinical Associate, National Cancer Institute, National Institutes of Health
1969-1972 Medical Director, Job Corps, Department of Labor
Special Assistant, Office of the Administrator, Health Services and Mental Health Administration
4/72-7/73 Director, Community Health Service
7/73-present Director, Bureau of Community Health Services

Honors and Association Memberships:
Ambulatory Pediatric Association
American Public Health Association
Society for Adolescent Medicine
James E. Moore Society
Alpha Omega Alpha
Minnesota Heart Association Student Research Award
Ski-u-mah Student Leadership Award
Augsburg Guild of Honor

VI. 1. BIOMEDICAL RESEARCH ETHICS PANEL

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

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

Non-medical members of the Commission include:

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

The members of this Commission will elect their own chairman.

VI. 2. Feasibility Study of Research Manpower Allocations by the Institute of Medicine

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

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

VI. 3. Commission on Biomedical Research Policy

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

VI. 4. Status of Medical College Admissions Assessment Program

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

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

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

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

The members of the Committee on Admissions Assessment are as follows:

Cheves McC. Smythe, M.D., Chairman
Dean
The University of Texas
Medical School at Houston

Willard M. Duff, Ph.D.
Assistant Director of Education
Hartford Hospital

Leslie T. Webster, M.D.
Chairman
Department of Pharmacology
Northwestern University
Medical School

Joseph S. Gonnella, M.D.
Associate Dean
Director of Academic Programs
Jefferson Medical College

Jack Colwill, M.D.
Chairman, C-GSA
Associate Dean, College of Medicine
University of Missouri - Columbia

Walter F. Leavell, M.D.
Associate Dean
State University of New York
Upstate Medical Center
College of Medicine

John McAnally, Ph.D.
Western Regional Chairman
Association of Advisors to the Health Professions
Occidental College
Los Angeles, California

Fred Waldman
Student
Medical College
New York University

VI. 5. Coordinating Council on Medical Education Report: The Primary Care Physician

The Physician Distribution Committee of the Coordinating Council on Medical Education prepared the following report on primary care physician distribution. The report was accepted by the Coordinating Council last Spring and forwarded to the five parent organizations for approval. The Executive Council of the Association approved the report at its September meeting, with the deletion of one paragraph (page 12, Section B, paragraph 2) and a portion of one sentence (page 13, Section C, paragraph 3). These deletions are indicated in the body of the report. To date, the report has been approved by the Association of American Medical Colleges, The American Board of Medical Specialties and the Council of Medical Specialty Societies.

PHYSICIAN MANPOWER AND DISTRIBUTION

The Primary Care Physician

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

GENERAL/FAMILY MEDICINE

In recent years there has been a progressive decline in the number and proportions of American physicians who identify themselves as engaged in general or family practice. In 1931, there were 114,000 physicians who classified themselves as general practitioners on AMA's annual directory questionnaires. In 1960, the number had dropped to 75,000; in 1965, it was 66,000; at the end of 1972, it was less than 55,000. While general practice and family practice are not necessarily the same, the decline in the number of generalist practitioners is certainly indicative of a decline in the number of primary care physicians.

In years past, most physicians entered general practice directly from medical school or after a one-year rotating internship. While there were some general and family practice residencies in existence in the 50's and 60's, they were not very successful in attracting American graduates. There was, of course, no recognition afforded those who completed the residencies, since there was no specialty board in that field. As more and more graduates

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

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

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

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

There are many factors which influence the career choices of American

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

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

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

INTERNAL MEDICINE AND PEDIATRICS

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

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

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

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

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

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

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

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

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

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

RECOMMENDATIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

the support for existing programs.

Rev: 5/15/74 CPD

REFERENCES

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

3. *AAMC Programs for the Expansion of Medical Education.* The Journal of Medical Education 46:105-115, February, 1971.

4. *Medical Education in the United States.* The Journal of the American Medical Association Vol. 186, p. 684, November, 1963.

5. *Medical Education in the United States.* The Journal of the American Medical Association Vol. 202, 8:778, November, 1967.

6. *Medical Education in the United States.* The Journal of the American Medical Association Vol. 226, 8:935, November, 1973.

TABLE I

STUDENTS AND GRADUATES IN MEDICAL AND BASIC SCIENCE SCHOOLS*

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

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

** Estimates

*** AAMC *DATAGRAM*

TABLE II

AVERAGE SIZE OF MEDICAL SCHOOLS, 1930-1974±

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

* All medical schools.

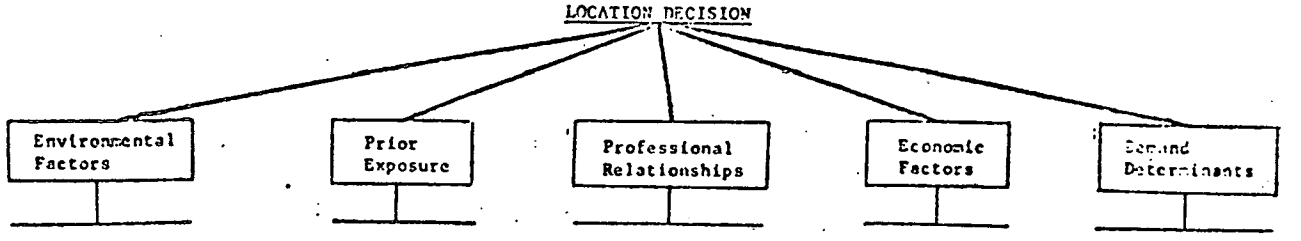
** Excludes schools not graduating students.

*** Estimates.

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

TABLE IV

POLICY POTENTIAL OF FACTORS IN LOCATION DECISIONS



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

Classification Code:

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

Source

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

* Indicates variable, in the subset of policy alternatives, which seems to be very important

TABLE V

CONCENTRATION OF PRACTICING, NON-FEDERAL PHYSICIANS IN POPULATION AREAS

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

*As of Dec. 31, 1971.

+As of Dec. 31, 1972.

This table constructed from information published in *Distribution of Physicians in the U.S., 1972, Vol. 2/Metropolitan Areas*. AMA Center for Health Services Research and Development.

Table VI

FP/GP AGE GROUPINGS, 1963 and 1967*

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

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

TABLE VII

CHANGE IN SPECIALTY DISTRIBUTION

PRIMARY CARE SPECIALTIES	1965*	1972*	% CHANGE
INTERNAL MEDICINE	38,690	47,994	
PEDIATRICS	15,665	19,610	
GENERAL AND FAMILY PRACTICE	71,366	55,348	
	125,721	122,952	- 2.2
MEDICAL AND PEDIATRIC SUB-SPECIALTIES			
ALLERGY	910	1,638	
CARDIOVASCULAR	1,901	5,883	
GASTROENTEROLOGY	633	1,839	
PEDIATRIC ALLERGY	82	383	
PEDIATRIC CARDIOLOGY	146	514	
PULMONARY DISEASE	1,226	2,065	
	4,898	12,322	+ 151.6
% CHANGE IN RATIO OF MEDICAL AND PEDIATRIC SUB-SPECIALISTS TO TOTAL NUMBER OF INTERNISTS AND PEDIATRICIANS	9.0	18.2	
PRIMARY CARE SPECIALTIES	125,721	122,952	
MEDICAL AND PEDIATRIC SUB-SPECIALTIES	- 4,898	- 12,322	
	120,823	110,630	- 8.4
SURGICAL SPECIALTIES	76,147	91,058	+19.6
OTHER SPECIALTIES	70,809	94,571	+33.6

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

TABLE VIII

DISTRIBUTION OF PHYSICIANS IN USA AND POSSESSIONS

Specialty	1965 No.*	%		1972 No.*	%	
General and Family Medicine	71,366	24.45		55,348	15.52	
Internal Medicine	38,690	13.25	43.06	47,994	13.46	34.48
Pediatrics	15,665	5.36		19,610	5.50	
Allergy	910	0.31		1,638	0.46	
Anesthesiology	8,644	3.00		11,853	3.32	
Aviation Medicine	788	0.27		921	0.26	
Cardiovascular Disease	1,901	0.65		5,883	1.65	
Child Psychiatry	817	0.28		2,268	0.64	
Colon & Rectal Surgery	650	0.22		649	0.18	
Dermatology	3,538	1.21		4,227	1.19	
Diagnostic Radiology	38	0.01		2,076	0.58	
Forensic Pathology	51	0.02		194	0.05	
Gastroenterology	633	0.22		1,839	0.52	
General Preventive Medicine	971	0.33		840	0.24	
General Surgery	27,693	9.49		30,989	8.69	
Neurological Surgery	2,045	0.70		2,753	0.77	
Neurology	2,174	0.74		3,494	0.98	
Obstetrics & Gynecology	16,833	5.77		20,202	5.67	
Occupational Medicine	1,745	0.59		2,506	0.70	
Ophthalmology	8,397	2.88		10,443	2.93	
Orthopedic Surgery	7,549	2.59		10,356	2.90	
Otolaryngology	5,325	1.82	56.94	5,662	1.59	65.52
Pathology	8,437	2.89		11,024	3.09	
Pediatric Allergy	82	0.03		383	0.10	
Pediatric Cardiology	146	0.05		514	0.14	
Physical Medicine & Rehab.	1,084	0.37		1,551	0.44	
Plastic Surgery	1,133	0.39		1,786	0.50	
Psychiatry	17,888	6.13		22,570	6.33	
Public Health	2,680	0.92		2,906	0.82	
Pulmonary Disease	1,226	0.42		2,065	0.58	
Radiology	9,553	3.27		11,910	3.34	
Therapeutic Radiology	56	0.02		931	0.26	
Thoracic Surgery	1,477	0.51		1,927	0.54	
Urology	5,045	1.73		6,291	1.76	
Other Specialties	—	--		7,010	1.97	
Unspecified	9,750	3.34		8,290	2.33	
Inactive	13,279	4.55		20,110	5.64	
Not Classified	3,566	1.22		12,356	3.47	
Address Unknown	--	--		3,165	0.89	
	291,825	100.00		356,534	100.00	

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

VI. 6. AAMC POLICY STATEMENT ON NEW RESEARCH INSTITUTES AND TARGETED RESEARCH PROGRAMS

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

NEW RESEARCH INSTITUTES

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

TARGETED RESEARCH

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

VI. 8. STATUS OF THE NIRMP

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

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

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

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

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

VI. 9. COUNCIL OF DEANS ACTIVITIES AT THE ANNUAL MEETING, 1974
Conrad Hilton Hotel, Chicago, Illinois
November 11-14, 1974

		Room
Monday - November 11		
* 8:00 p.m.	Session on IOM Social Security Studies	Waldorf
Tuesday - November 12		
7:30 - 8:45 a.m.	New Dean's Breakfast (by invitation)	Parlor #419
* 9:00 - 12 noon	Program on Quality Assurance and PSRO's	Waldorf
12 noon-1:30 p.m.	COD Administrative Board Luncheon (Board Members)	Dining Room #8
* 3:00 - 5:00 p.m.	COD Business Meeting	Williford C
6:30 - 8:30 p.m.	Group on Public Relations--Deans Reception	Beverly
* 8:00 - 11:00 p.m.	Seminar on Foreign Medical Graduates	Williford B & C
Wednesday - November 13		
7:30 - 8:45 a.m.	Deans of New and Developing Schools Breakfast	Dining Room #1
* 9:00 - 12 noon	Plenary Session	International Ballroom
* 2:00 - 5:00 p.m.	COD/CAS/COTH Program "Specialty Distribution of Physicians"	International Ballroom
6:00 - 7:30 p.m.	AAMC General Reception	Grand Ballroom
Thursday - November 14, 1974		
7:30 - 8:45 a.m.	Midwest-Great Plains Deans Breakfast	Dining Room #4
* 9:00 - 12 noon	Plenary Session	International Ballroom
* 1:00 - 4:00 p.m.	Assembly	Williford
* 4:30 - 6:00 p.m.	Minority Affairs Program	Williford
6:00 - 7:30 p.m.	AAMC General Reception	Grand Ballroom