

ORGANIZATION OF STUDENT REPRESENTATIVES

Administrative Board

A G E N D A

Conference Room
Suite 200
One Dupont Circle, N.W.
Washington, D.C.

March 25, 1981
9:00 am - 5:00 pm

- I. Call to Order
- II. Consideration of Minutes1
- III. Report of the Chairperson
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 - A. Executive Council Agenda
- V. DISCUSSION ITEMS
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 - C. Report on Women in Medicine Activities
- VII. Old Business
- VIII. New Business
- IX. Adjournment

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
 ORGANIZATION OF STUDENT REPRESENTATIVES

Administrative Board Minutes

January 27 and 28, 1981

AAMC Headquarters
 Washington, D.C.

Chairperson

--Lisa Capaldini

Chairperson-Elect

--Grady Hughes

Regional Chairpersons

--Steve Phillips (Northeast)
 Ed Schwager (West)
 Jo Linder (Central)
 Sue Haack (South)

Representatives-at-Large

--Wendy Crum
 Louis van de Beek
 Michael Tom
 Manuel Marquez

Immediate-past-Chairman

--Dan Miller, M.D.

AAMC Staff

--Martha Anderson, Ph.D.
 Janet Bickel
 Robert Boerner
 John A. D. Cooper, M.D.
 Beth Jaeger
 Joseph Keyes
 Richard Knapp, Ph.D.
 Thomas Morgan, M.D.
 August Swanson, M.D.
 Kat Turner

Guest

--Julius Krevans, M.D.

- I. Ms. Capaldini called the meeting to order at 1:00 pm and provided an overview of the activities for the next two and a half days.
- II. OSR Regional Meetings

Each of the regional chairpersons gave a brief overview of present and projected activities related to spring regional meeting plans. Information to the membership is forthcoming from each, and ideas for discussion topics are being solicited (dates of the meetings are to be found in the most recent issue of OSR Report). Ms. Bickel reminded the chairpersons that during the spring meetings nominations for student participant on the Liaison Committee on Medical Education should be solicited and that time should be set aside for discussion of revisions in the NRMP Match.

III. Consortium of Medical Student Groups

Ms. Capaldini reported on events from the December Consortium meeting held in San Francisco in conjunction with AMA-SBS, thanking Ms. Haack (who has been appointed Consortium Communications Coordinator) for writing and distributing the minutes from this meeting as well as an updated membership list. Ms. Haack reported that a copy of a letter inviting the American Medical Women's Association to join was also distributed. One of the topics discussed at this meeting was a questionnaire sent by AMA to Peter Lichty, an officer of AMA-Medical Student Section, requesting input concerning students' opinion of the National Health Service Corp Scholarship Program. Rather than replying to the questionnaire, the Consortium agreed upon the following points:

"That the high percentage of minorities and students from high-priced schools with commitments to the NHSC reflect the fact that it is often used as simply a means of financial aid.

That emphasis should be placed on increasing alternative financial aid programs and thereby decreasing use of NHSC by students as simply a source of financial aid.

That it was rather ironic that only the necessity of continuation of the NHSC was being questioned while the military programs, which involve comparable cost, were not."

Mr. van de Beek criticized the first of these statements as anti-Corps and maintained that, because OSR has an obligation to medical students to support the Corps by whatever means possible, the Administrative Board should not ally itself with this statement even if there is some truth in it. The Board agreed that the context in which such statements are made is an important factor and that the communique to the AMA ought to be examined to see if clarifications are necessary.

The Board also discussed the newly drafted "Document of Understanding" which is being presented to Consortium members for approval. Ms. Capaldini explained that while the Consortium does not consider itself a policy making body, it was felt important to have commonly agreed upon guidelines for participation and voting. Mr. Boerner pointed out that the Board needed to be sensitive to concerns which may be raised by the following sentence of the Document (under "Purposes of the Consortium"): "To serve as a vehicle for expressing the common concerns of all medical and osteopathic students, in the political arena, in academic communities, and in any other appropriate forums." He noted that while the intent of the Consortium is to coordinate communications among medical student groups and to mobilize support for common goals, OSR officers cannot represent the AAMC outside the AAMC just as officers of the other Councils cannot. The Board agreed that there are many fine distinctions to be observed by those student organizations with parent bodies and that it is important to be vigilant about what is put forth under the aegis of the Consortium. Ms. Capaldini stated that she would explain to the Council of Deans Administrative Board the spirit of the Document and potential concerns surrounding it.

ACTION: The OSR Administrative Board approved the Document of Understanding as written.

IV. Residents Conference on Evaluation

Ms. Capaldini provided an overview of the recent AAMC-sponsored conference which was attended by 34 senior residents plus representatives from a number of specialty boards; a large portion of the time was spent in small group settings discussing the resident as evaluator of others, personal evaluation of residents, and program evaluation. She noted that the residents expressed concerns very similar to medical students, i.e., dissatisfaction with current methods of evaluation, lack of feedback about performance, the difficulty of giving and receiving negative comments, lack of familiarity with the accreditation process, and the ever-present but never articulated informal system of evaluation in which everyone except those who are not doing well have a pretty good idea of how they're doing. The Board discussed the importance of having a system of evaluation that enhances rather than detracts from learning to be a better physician and that positively reinforces rather than serving only to highlight problems. They also discussed the difficulties of peer evaluation, i.e., the delicacy of giving negative feedback to those upon whom one depends for moral and physical support, that medical education is not conducive to learning how to talk to one another except in ritualized ways, and that in order to give honest, conscientious evaluations one must feel very secure. The students agreed that it is always very helpful to be told what they are expected to learn during a course or clerkship. They also agreed that these subjects should form the basis of one of their Annual Meeting programs.

V. Nominations to AAMC Committees

The Board reviewed all of the applications received for committee openings and decided upon the appropriateness of having an OSR Administrative Board member serve on the Women in Medicine committee since its primary function is to formulate Annual Meeting plans.

ACTION: The OSR Administrative Board nominated the following students to AAMC Committees:
Stuart Shapira (U of Chicago)-- Journal of Medical Education Editorial Bd
Paul Florentino (St. Louis U)--Flexner Award Committee
Jo Linder (U of Iowa)--Women in Medicine Coordinating Committee

VI. Potential Topics for Discussion at 1981 Annual Meeting

Ms. Capaldini reported that at the AAMC Officers Retreat the main theme for the next Annual Meeting had been chosen: "Tomorrow's Medicine: Art & Science or Commerce & Industry?" Board members suggested the following potential discussion session topics and expressed the desire for feedback from the membership about them and about additional ideas:

Canadian Health Care System--National Health Insurance
HMO's
Effects of Thermonuclear War
Lack of Political Awareness among Physicians
Revisions in NRMP Match
Residents' Role in the Evaluation of Medical Students
Licensing Exams: Flex vs NBME
U.S. Citizens Studying Medicine Abroad

Teaching the Art of Medicine
Implications of GMENAC Report on Career Selection and on Access to Careers
Patient-centered Medical Care (with Society for Health and Human Values?)
Financial Aid
Reagan Administration's Health Manpower Policies and Goals
Allied Health Workers: the Human Aspect of Interaction
Curriculum Reform
Costs of Laboratory Tests

The Board agreed to offer again this year Friday evening (October 30) discussion sessions and to try to locate a place outside the Hilton in which to hold the reception. Mr. van de Beek accepted the responsibility of social coordinator.

VII. Resolutions from 1980 Annual Meeting

The Board reviewed the resolutions as printed in the Annual Meeting minutes and recognized the necessity of postponing the discussion of a number of them until the March meeting when more time and appropriate staff would be available. In response to Resolution A (Teaching of Foreign Languages and Cultural Issues), Ms. Crum agreed to coordinate a listing of extant foreign language course for medical students and other such resources. Asking OSR representatives to bring pertinent materials with them to the spring meetings is one approach to be used here as well as toward a bringing together of information on gerontology courses (Resolution B--Improving Medical Care for the Aged). Pursuant to Resolution C (Cost Containment Education) a workshop, capable of replication at the institutional level, on the costs of laboratory tests could be offered at the 1981 Annual Meeting. This topic as well as Resolution D (Medical School Curriculum Reform) are ones which will be addressed by the General Education of the Physician project if it is funded; students may also want to contact Dr. Hilliard Jason, Director, National Center for Faculty Development in the Health Professions, University of Miami, who is very knowledgeable about faculty development, which is also a subject of this Resolution. Plans to redistribute the Division of Student Program's compendium on contact persons regarding extramural electives were discussed; in the spirit of Resolution E (Senior Electives), OSR members should be informed about the availability of this listing. With regard to Resolution G (Medical Ethics), Mr. Phillips reported that he is a member of his school's committee on undergraduate professional conduct and asked the other members of the Administrative Board to send him copies of their school's policies on cheating and honor codes so that he can begin a composition. Mr. Boerner suggested that Resolution L (Service Contingent Loans) & M (Financing Medical Education) could be shared via the student representative with the GSA Committee on Student Financial Assistance at its meeting on February 6. Activities related to Resolution N (Improved Counseling of High School and Premedical Students) can begin at the Western OSR meeting with a joint meeting between OSR and the Association of Health Professions Advisors; this group will not be meeting in conjunction with the other GSA/OSR regions.

VIII. The meeting was adjourned at 5:00 p.m.

IX. Ms. Capaldini reconvened the meeting at 9:00 a.m. on January 28.

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X. Report from Student Member of External Examinations Review Committee

Mr. van de Beek noted that, although (because of examinations) he had been unable to attend the most recent meeting of this Committee, it was possible to summarize the issues which this group is grappling with. First of all he referred the students to the December 4, 1980 issue of the New England Journal of Medicine which contains a useful discussion of the National Board of Medical Examiners (NBME) vis-a-vis the Federation of State Licensing Boards (FSLB) goal to require all physicians to pass a single examination (FLEX I) to be eligible to enter graduate education and to pass a subsequent examination (FLEX II) for an unrestricted license. He next presented to the Board the guiding principles under which the Committee is conducting its deliberations: 1) faculties are responsible for the pursuit of excellence in their educational programs; 2) diversity among institutions should be maintained; 3) forces moving toward the development of a national curriculum should be resisted; 4) standards for graduating from medical school and standards for licensure should be separate; 5) institutions and faculties should periodically employ external standards for evaluating their educational programs; 6) high quality test items are difficult to prepare and assuring their quality is best achieved through activities of multiple faculties and a pooling of their resources; and 7) all areas of competence except knowledge and some aspects of problem solving will continue to require a direct evaluation by faculty.

Mr. van de Beek described the interdependence between the NBME and U.S. medical school faculty and noted that the NBME has evidenced a shift from proclaiming that its examination be considered only a route to licensure to maintaining the appropriateness of schools' using this examination for internal evaluation purposes. Thus, the NBME's involvement with the preservation of quality of American medical education is very different from the role of the FSLB which is protection of the public from incompetent physicians. A major concern of the AAMC is that if the NBME sequence is no longer a licensure route, the relationship between the NBME and medical faculties will be impaired and the examinations will decrease in viability and quality. Another question before the Committee is whether requiring a comprehensive qualifying examination preempts the authority and responsibility of medical school faculties to decide whether their students are prepared to enter graduate medical education. Mr. van de Beek told the Board that he would attempt to keep them informed about developments regarding these debates.

XI. Price Competition

Drs. Cooper, Krevans and Knapp reviewed with the Board the materials contained in the Executive Council Agenda, including the draft report of the ad hoc Committee on Competition, a summary of a recent meeting with Congressman Gephardt (D-Missouri, who has introduced a bill designed to inject price competition into the service payments of hospitals and physicians) and a methodology to identify total costs in teaching hospitals associated with the presence of educational programs. Dr. Knapp explained that, to those who want to reduce both regulation of and the amount of dollars in our health care system, price competition (that is, changes in the way health insurance and services are selected and purchased as a means to stimulate cost consciousness among providers and consumers) appears to be an attractive approach. Thus, legislation that

would promote competition in the health care industry is expected to receive considerable attention by the new Congress. Forecasting the effects of such legislation is difficult; however, it is clear that advocates of this approach have not adequately considered a number of potential negative consequences. One of these is that competitive pricing could be achieved through cost avoidance such as eliminating charity care. Another major problem for teaching hospitals is that the direct and indirect costs of undergraduate and graduate medical education and biomedical research are subsidized by patient care income; economists have largely ignored the marked interdependence among these three functions of teaching hospitals and how price competition will affect these activities. Dr. Knapp summarized the alternatives facing the hospitals, if competition legislation is passed, as follows: 1) change medical education, 2) attempt to 'price out' educational costs and seek subsidies for these, or 3) do the best they can to continue to serve their multiple roles. He told the students that the Committee had attempted to explore these questions, and the Board agreed that it had done a good job with a very complex and difficult subject.

ACTION: The OSR Administrative Board endorsed the draft report.

XII. Resident Moonlighting

Dr. Knapp explained to the Board that, historically, Medicare has permitted moonlighting residents to be paid on a fee-for-service basis provided that the resident is moonlighting other than in the hospital where the resident is training. Approximately two years ago, Medicare officials found that residents at the Wesley Medical Center in Wichita were moonlighting in the same hospital in which they were residents. When Medicare then disallowed the charges for services provided by these residents, the hospital sued the Secretary of HEW alleging that a policy which paid moonlighting residents in some settings but not others was arbitrary, capricious and discriminatory. The federal district court in Kansas agreed with the hospital and ordered Medicare to change its policy. The AAMC is very concerned that this change in policy may have a number of negative consequences: 1) hospitals with poor training programs could use moonlighting opportunities as a recruiting device; 2) it may stimulate residents' interests in moonlighting; 3) it will be difficult for the government to police with a hospital the "during training/not training" dichotomy. The Health Care Financing Administration has advised AAMC that to minimize the impact of the court-ordered change, the AAMC should develop and distribute to program directors a policy statement on moonlighting.

The Board reviewed the AAMC's present policy on moonlighting, developed in 1974, and discussed how best to inform program directors about this complicated matter. While recognizing that it is each faculty's right to approve or disapprove moonlighting by residents in training at their institutions, the students voiced a number of concerns about the following sentences in the AAMC's present policy: "House officers should not be diverted from their primary responsibilities to their own education and to the patients charged to their care by the training institution by engaging in extramural professional activities. Therefore, as a matter of general principle, the AAMC believes that moonlighting by house officers is inconsistent with the education objectives of house officer training and is therefore a practice to be discouraged." They noted that even though many residents' contracts stipulate that moonlighting is not permitted, the practice is so widespread that the Association's policy is inconsistent with facts.

Moreover, Dr. Miller noted that the Association's present statement is inappropriate because it doesn't take into account that increased debt levels of students may necessitate pursuing such employment opportunities and that such activities may be more desirable than entering a high paying specialty or practice later on. Ms. Linder also pointed out that moonlighting serves the auxiliary functions of helping to ameliorate the physician maldistribution problems affecting rural areas and institutions such as prisons and that for some residents moonlighting opportunities are valuable in upgrading their general medical skills. The Board agreed that program directors need to keep alert to the pros and cons of moonlighting and should do a better job of in-house policing.

ACTION: The OSR Administrative Board endorsed the distribution of appropriate background information about the change in Medicare policy emphasizing an in-house approach to deal with the problem of moonlighting interfering with individual residents' education. If this action is not acceptable, the Board voted not to endorse the AAMC's present policy on moonlighting as written.

XIII. National Health Planning Program

Ms. Turner explained that in 1974 the Association supported the concept of an effective and unified nationwide system of health planning; the act that was passed will expire in September 1982. It is therefore appropriate at this juncture for AAMC to reconsider its stance, especially in view of the growing consensus among health care leaders that the national health planning program is in need of significant alterations. The major issues of concern are set forth in the Executive Council Agenda.

ACTION: The OSR Administrative Board endorsed as an interim measure adopting the statement which expresses the seven areas of major concerns.

XIV. Due Process for House Officers

Mr. Keyes referred the Board to the outline contained in the Executive Council Agenda of a recent court decision that a defendant hospital had breached its contract with a resident by terminating him prior to the expiration of his contract; the court awarded \$100,000 compensatory damages against the hospital and the same against each of two physicians--the department chairman and the program supervisor. AAMC is concerned about the outcome of this case, as well as others underway, and the fact that very few of the Council of Teaching Hospitals have explicit grievance procedures to resolve house officer-initiated concerns or due process procedures for disciplinary actions taken by the institution against a house officer. The question before the AAMC is how best to assist its members to recognize the need for assuring due process for house officers. Mr. Keyes noted that guidelines do not protect an institution unless they are honored and cautioned against confusing breaches of contract with due process, which strictly speaking means fair treatment under a given set of circumstances. Dr. Morgan presented another side of the question which is that problems often arise because of differences in expectations between faculty and student, with the latter not knowing how s/he is being evaluated; thus an educational effort is called for to highlight the importance of communication about expectations between teacher and trainee. The Board discussed these issues at length, noting that minimum service and educational expectations need to be set forth, even though there will always be a large "gray zone" regarding

expectations. The students also noted that it is neither fair nor sound to hold evaluations to the end of a rotation or training period and that informal, verbal feedback throughout is very useful. They agreed that the information to be mailed to the AAMC membership about the need for due process procedures during residency training should emphasize that most problems could be prevented if the resident has a clear knowledge of the evaluation process and is provided frequent feedback about his or her performance. Institutions should be urged to develop specific due process guidelines for their own protection as well as to protect the rights of the residents.

XV. AAMC Response to the Graduate Medical Education National Advisory Committee (GMENAC) Report

Dr. Swanson explained that at the AAMC Officers Retreat it was decided that AAMC should formulate a response to the GMENAC report, expressing doubts about the methodology employed and about the handling of certain issues such as geographic distribution and caution regarding too rapid a reduction in physician capacity. AAMC is particularly concerned about the effect the GMENAC recommendations may have on federal and state support of medical education and on the applicant pool to medical schools. Some of the recommendations, however, are quite supportable, especially those addressing the need to terminate financial support of students studying medicine abroad. In the AAMC's endorsement of this recommendation, the Board noted that a clear distinction needs to be made between students enrolled at foreign schools and U.S. students taking courses or clerkships abroad. The Board also suggested deleting from the AAMC response the following sentence: "Equal support can be given to the recommendation . . . to restrict the opportunity for advanced placement in domestic schools for students desiring to transfer from foreign-chartered schools."

XVI. Policies on U.S. Citizens Studying Medicine Abroad Need Review and Reappraisal

Dr. Swanson summarized AAMC concerns about the growing number of U.S. citizens who are studying abroad with the hopes of returning to the U.S. to practice (a six-fold increase since 1969). In the past such students have re-entered the U.S. as students transferring to U.S. schools with advanced standing or as graduates returning for graduate medical education. A more recent development has been the effort by foreign schools to obtain opportunities in clinical education for their students in the U.S. Such clinical programs are not subject to review for quality or curriculum content by any accrediting body, and the proliferation of such students has led agencies such as the Board of Regents of the State University of New York to consider initiating accreditation activities of their own. While this is not seen as an appropriate route, the re-entry of these poorly trained students may denigrate the quality of medical practice in this country and downgrade medical education if increasingly scarce institutional resources must be devoted to these students. Dr. Swanson noted that many of the foreign-chartered schools are for-profit operations founded to take advantage of unaccepted U.S. medical school applicants; unless opportunities to re-enter the U.S. are severely curtailed, these inferior schools will continue to attract disappointed applicants. The Board expressed concerns about eliminating a return route for those students who are well-qualified to practice medicine in this country, especially given the sometimes misguided decisions made by U.S. medical school admissions committees. Dr. Swanson urged the Board to look at the broader problem of the threat to the integrity of medical education and practice in this country and to separate their concerns about the few qualified students they may have met from the need to curtail our subsidization of these inferior medical schools.

Of the options presented in the Executive Council Agenda, the Board decided that the following three were preferable to the others: 1) Have the ECFMG rule that graduates of foreign medical schools which do not provide the entire educational program leading to the degree within the borders of the nation in which the school is chartered are not eligible for ECFMG certification; 2) Eliminate the Fifth Pathway and require that to enter accredited graduate programs, all graduates of schools not accredited by the LCME must pass the same examination; 3) Convince the licensing jurisdictions to require that all graduates of schools not accredited by the LCME pass a rigorous two-stage examination with the second stage being a practical examination in which the clinical skills of candidates are directly observed and evaluated.

- XVII. The minutes of the September meeting of the OSR Administrative Board were approved without change.
- XVIII. The meeting was adjourned at 3:00 p.m.

1981 ANNUAL MEETING

October 30 - November 5

Washington, D.C.

THEME: Tomorrow's Medicine: Art & Science or Commerce & Industry?

Tentative OSR Schedule

FRIDAY, October 30

6:30 pm

Administrative Board Meeting

7:30 pm

Discussion Sessions

SATURDAY, October 31

8:30 am - 11:00 am

Regional Meetings

11:00 am - 12:30 pm

Discussion Sessions or Program

2:00 pm - 5:00 pm

Business Meeting

5:00 pm - 6:30 pm

Regional Meetings

7:00 pm - 9:00 pm

Reception

SUNDAY, November 1

8:30 am - 10:30 am

Discussion Sessions or Program

10:30 am - 11:30 am

Candidate for OSR Office Session

1:00 pm - 5:00 pm

Business Meeting

5:00 pm - 6:00 pm

Regional Meetings

7:00 pm - 9:00 pm

Discussion Sessions or Program

MONDAY, November 2

12:30 pm - 1:30 pm

Joint Administrative Board Lunch

ANTICIPATING CHANGE IN THE TESTING SEQUENCE FOR CERTIFICATION FOR LICENSURE*

The purpose of this paper is to outline developments and dialogues that are occurring which will affect the national testing and medical licensure systems as we now know them. The hope is that, with greater insight into the agenda of the actors involved, students will be better equipped to contribute to these dialogues.

For many years, medical students around the country have been voicing concerns and articulating a variety of complaints about the role played by the National Board of Medical Examiners (NBME) in medical education. One such contention is that the Part I/Part II division inhibits medical schools from introducing curricular innovations, for instance, integrating clinical experiences with basic sciences. Another is that, because the exams are norm-referenced, students who are adept at multiple-choice testing or who attend schools which attach great importance to Board scores and which schedule a review time have a distinct advantage, especially in applying to residency programs giving significant weight to Board scores in the selection process. It is likely that students will always have concerns about the methods by which they are evaluated and compared. While this summary will not attempt to catalogue and examine these concerns, before describing the changes in the offing, it seems appropriate to acknowledge that our present system is not considered satisfactory by a sizeable proportion of participants. Depending on one's point of view, the changes proposed are regressive, likely to result in improvements in important directions, or not radical enough.

To understand the impetus for changing the system, we need to step back a few paces from the issues directly at hand. Certainly, before 1970 disappointed applicants to medical school sought medical education abroad, but their numbers were not of a troubling magnitude. However, between 1969 and 1980 there was a six-fold increase in numbers of students seeking certification by the examination administered by the Educational Commission for Foreign Medical Graduates (ECFMG) which must be passed by students who complete their education in a foreign school in order to enter graduate training in the U.S. Most U.S. citizens studying abroad are enrolled in only a few schools, and most of these have been established within the past ten years. Aware that many rejected applicants have or can garner the funds to meet high tuition charges, several entrepreneurs--primarily Americans-- have managed to negotiate with various Caribbean island governments for the establishment of proprietary "medical schools." These schools have been highly successful in recruiting their target population despite the facts that clinical facilities are either nonexistent or inadequate and that there are very few experienced faculty. The proliferation of such "educational" programs is cause for concern on many fronts, and it should not be forgotten that the parents of a number of the students enrolling in them wield substantial political power and work to keep the doors open for their sons' and daughters' return to take clerkships and ultimately to practice in the U.S. Although some of these students may be receiving adequate professional preparation, most are not. In 1980, only 39% of the 4,070 U.S. citizens who took the ECFMG passed, and this examination is considered easy by NBME standards.

* Prepared by Janet Bickel as a basis for OSR discussion at 1981 regional meetings

If a state is to issue a license to a student from a foreign school, the state needs to have knowledge of the adequacy of that student's medical education. However, foreign schools are outside the jurisdiction of any American accreditation or evaluation organization. Since it is impossible to monitor the quality of medical education in foreign schools, it seems appropriate that this area of concern must be addressed by each state through its licensing of individuals.

The Federation of State Medical Boards (FSMB) was founded in 1912 to assist states in meeting their responsibilities to assure that physicians practicing within their boundaries have met three requirements: 1) high moral and ethical character, 2) successful completion of a medical curriculum of an approved medical school, and 3) a passing grade on a licensing examination. Not surprisingly, the FSMB is increasingly receiving requests from its member boards for help in evaluating the credentials of applicants for licensure who are graduates of foreign medical schools. In addition to development of some method of accrediting the "off shore" schools, a useful innovation, argues the Federation, would be replacement of the present multiple-route approach to licensure with a policy that is consistent throughout the entire country rather than limited to a particular licensure board's jurisdiction. Actually, the FSMB has been working for some time toward the goal of a uniform national licensure system. In 1968 it introduced the Federation Licensing Examination (FLEX) which is administered by all state licensing bodies. Prior to this time, states offered their own examinations which were not as reliable or up-to-date as FLEX can be (questions for this test are derived from the NBME question pool). Presently, a person wishing to attain a license to practice medicine must pass either the FLEX or NBME sequence. The Federation is proposing that the FLEX I - FLEX II examination sequence become the single route to licensure. The proposed FLEX I would be an examination to qualify medical and osteopathic graduates to practice medicine under supervision in graduate training programs; passing FLEX II would qualify one for unrestricted licensure for the general practice of medicine. One rationale for implementing this system is that graduate training constitutes an unlicensed interval into which licensing organizations have been irresponsible in not more carefully monitoring entrance.

With this background in mind, let us see what the National Board of Medical Examiners has been up to. The NBME was founded in 1915 for the purpose of preparing and administering qualifying examinations of sufficient quality that agencies could use them as criteria for licensure. From the beginning, the Board has heavily relied upon the expertise of medical school faculty in the design and evaluation of test items; this collegial relationship is central to the Board's mission. At present, 48 states accept passage of Parts I, II and III as qualification for licensure and more than three-quarters of all medical school graduates in the U.S. are licensed through this process. The role of the Board has expanded greatly in the past 25 years. As schools found that an increasing number of their students were taking the Boards for the purpose of certification, it became obvious that the test results could also be used to assess the progress of individual students and to evaluate educational programs. In 1980-81, 75% of medical schools require students to take Part I (46% require passage) and 50% require Part II (29% to pass). Fifty-two percent of schools report that they use results of regular administration of the Boards to evaluate their programs. While it has never been the intent of the NBME to direct medical education or curricular content, by virtue of the extensive use of these exams as measures of cognitive knowledge and the extensive involvement of faculty in writing exam questions, the Board in fact has tremendous influence on the content and quality

of medical education. One's perspective determines whether this influence is seen as positive or negative. The conscientious medical student who believes that his teachers are overly concerned about Part I test results and shape teaching and evaluation methods toward that end or who believes that a multiple choice format does not reliably measure his knowledge of a subject will view the Boards as anathema to individual learning styles and progressive teaching methods. The physiology department chairman who believes that students would give insufficient time to the study of this subject were it not for its rigorous testing on Part I and the dean of a new medical school who needs evidence for the LCME accreditation team that his students are receiving a quality education will view the role of the Boards from a quite different perspective.

It can be fairly stated that, as the Boards have evolved, they serve well discipline-oriented educational needs and probably less well as an indicator of minimal clinical competence. While passage of Parts I and II prior to commencement of supervised practice can serve as a double-check on a faculty's judgment that an individual has attained the requisite skills, the NBME has acknowledged that passage of its sequence is no longer as suitable an indicator of readiness to practice as it perhaps once was. With the explosion of medical knowledge and students' completing an average of 3.8 years of graduate training, conferral of the MD marks the mid-point rather than the end of formal medical education. These are the stated reasons why, in 1973, an advisory committee of the NBME projected the need for a new assessment procedure at the interface between undergraduate and graduate medical education to evaluate the capabilities of students to assume new responsibilities for the care of patients. After a lengthy period of study and debate, the NBME conceived an evaluation process that is identified at present as the Comprehensive Qualifying Examination (CQE) Program. Integral to the development of the CQE has been careful dissection of the attributes that are felt to be essential in order for a physician to practice in a supervised setting. The NBME has described five abilities used in defining physician competence: knowledge and understanding, problem solving and clinical judgment, technical skills, interpersonal skills, and work habits and professional attitudes. It has also drawn up a list of ten important physician tasks, e.g., taking a history, use of diagnostic aids, and has combined these tasks and the five abilities into a matrix from which the overall plan for the CQE has been derived. Only twelve of the fifty cells in the matrix are amenable to evaluation by written examination. The other 38 require repeated observations by experienced faculty in many clinical settings. In a sentence, then, the prototype of the CQE which has been developed and is being field tested deals with knowledge about the clinical problems that commonly confront students during the first year of graduate medical education and the capabilities required to carry out their particular patient care responsibilities. While mastery of a considerable amount of basic science material is presumed, the examination is not a rigorous test of basic science knowledge.

Thus we see that, on similar timetables, the FSMB has articulated a need and the NBME is preparing a product; indeed, it is the goal of the FSMB to adopt the CQE to serve as FLEX I and to convince states to require passage of FLEX I as a condition for entry into graduate medical education.

While previously supporting the concept of a qualifying exam at the interface between undergraduate and graduate medical education, the concerns of the AAMC about this proposal are many. Although the Board intends to continue to

produce Part I, II, and III as long as they are requested by a sufficient number of medical schools to make such an effort economically feasible, it seems likely that the CQE will essentially replace Part II. As a consequence, satisfactory completion of the NBME sequence will no longer be the usual route to licensure and if the FSMB has its way, it will not even be a route to licensure. The impact of decreased use and potential loss of this sequence of examinations is open to speculation but many medical educators feel it may be severe. With a change in role on the part of the NBME, medical school faculties may be less willing to expend the time and care they previously have in the design of test items; thus, the quality of both Parts I, II and III and FLEX I-II would decline. Moreover, it is feared that absent a rigorous, widely used national testing of the basic sciences, schools may succumb to pressures to decrease the teaching of the basic sciences. In any case, options for faculty would be decreased rather than increased.

There are other concerns as well. With regard to the LCME, acceptance of the need for an assessment at the interface implies criticism of the accreditation process and the preparation of domestic graduates and of the judgment of faculty about students' qualifications. Moreover, a qualifying exam will not solve the problem of the lack of adequate preparation on the part of foreign graduates since the areas of greatest concern are those which no paper-pencil exam can evaluate. The quality of the CQE is also open to question. At a recent meeting of the AAMC's Council of Academic Societies (CAS), attendees were given a brief opportunity to review a "biopsy" of the proposed exam. CAS representatives criticized many of the items and their lack of emphasis on recent discoveries and treatment modes.

While all parties agree that passage or non-passage of this exam should not be linked to conferral of the M.D., this distinction may be easier to maintain in theory than in practice. Two important, related matters have as yet received little attention; which month of the senior year to administer the exam (and which month for the make-up) and what will be the fate of those graduates who fail.

The fundamental problem with this proposed single route to licensure is the implication that any graduate of any medical school, an accredited U.S. school or a proprietary foreign-chartered school, has demonstrated an equivalent ability to practice medicine. Such a proposition removes all recognition of the role of a competent faculty in medical education. It will ultimately demean the degrees granted by LCME-accredited schools.

It is impossible to predict the outcome of the discussions that are occurring on these subjects and what effects the changes will have. In and of themselves, increased ties between the NBME and the FSMB are not troublesome; but if these jeopardize the traditionally close relationship between NBME and medical school faculty, the quality of whatever tests are administered nationally is likely to decline. While some medical students may decry the uses to which these exams are put, developments in this arena are not likely to represent good news to them any more than they will to faculty members who look to the Boards for confidence that their teaching is effective.

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