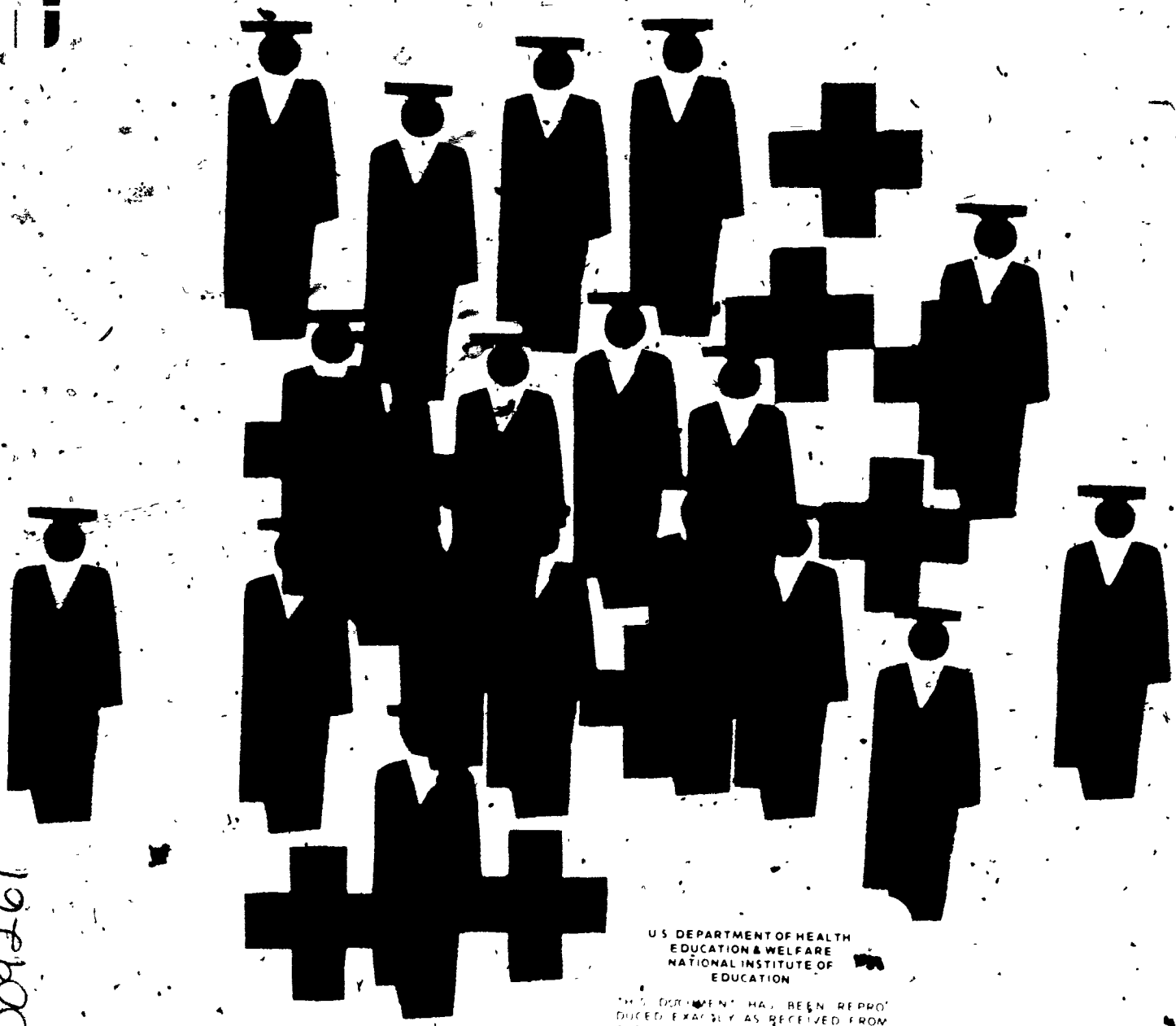
Graduate Medical Education

An Overview of Societal Concern, Social Policy, and Historical Developments - A Background Paper



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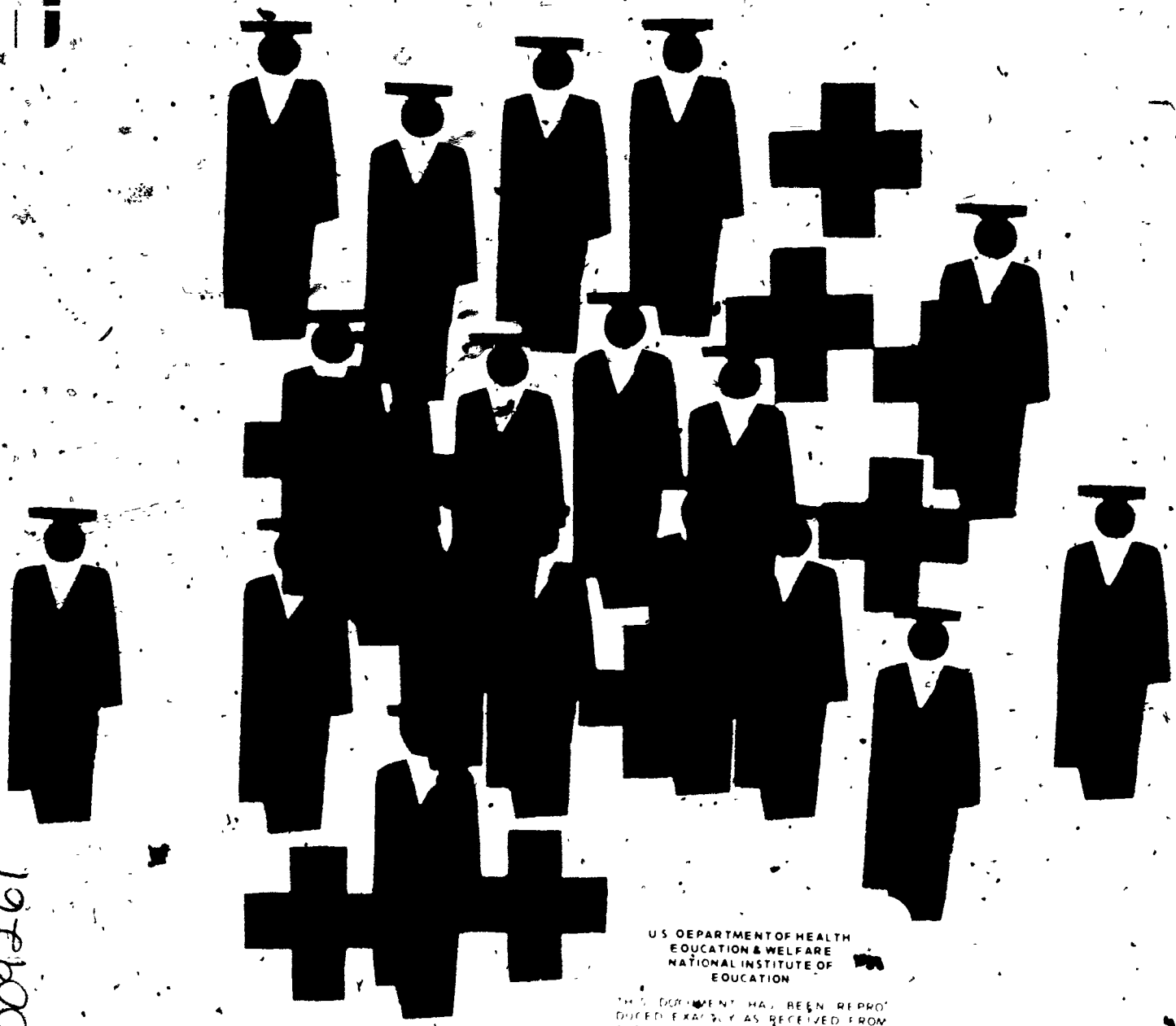

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GRADUATE MEDICAL EDUCATION

AN OVERVIEW OF SOCIETAL CONCERN, SOCIAL POLICY, AND HISTORICAL DEVELOPMENTS

A Background Paper Prepared for the Graduate Medical Education National Advisory Committee

Prepared in the Office of the Administrator, HRA

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AN OVERVIEW OF SOCIETAL CONCERN AND SOCIAL POLICY

On August 1, 1966, John S. Millis signed the preface of the Report of the Citizens Commission on Graduate Medical Education.[1] During the same year, two other reports were completed: the report of the Council on Medical Education's Ad Hoc Committee on Education for Family Practice[2] (the Willard Committee) and the Coggeshall (after Lowell T. Coggeshall) report[3] to the American Association of Medical Colleges. All these reports were concerned with the fragmentation of medical education. In referring to the elements of the structure of medical education, the Millis report stated that "...it seems unlikely that anyone would design from the beginning a system of such diffuseness and complexity."[4] And to those who commissioned these reports, graduate medical education was the primary source of this diffusion and complexity.

By the 1960's, it was becoming clear that simply increasing the aggregate number of physicians would not do. Because of the enormous growth of the specialties after World War II, it was no longer true that the adequacy of physician supply was determined by the size of enrollments in medical schools. The appropriate mix of specialists was now important, and it was graduate medical education which produced that mix.

It is interesting at this point to observe the lag between social policy and the initial stirring of societal concern. In the 60's, social policy on physician supply was oriented toward a societal concern stirred in the 50's by the 1951 Magnuson Commission Report[5] and the 1959 Bane Report.[6] Both of these defined a concern over the numerical adequacy of physician supply. These two reports described a physician population ratio in 1950 which was similar to that in 1940 and lower than the one in 1930. But they also described a wider and intensified demand for health care involving higher technology under new organizational patterns of delivery. Consequently, the response of social policy in the 60's was to increase medical school enrollments via various Federal inducements. And this tendency persisted through the Comprehensive Health Manpower Training Act of 1971 (P.L. 92-157).

As a result of the success of these efforts to overcome the numerical inadequacy of supply perceived in the 50's, it became easier to perceive a refined version of supply inadequacy--maldistribution. Since this included both specialty and geographic maldistribution, and since at this time there was a growing awareness that graduate medical education strongly influences physician distribution, societal concern was then able to focus its attention on graduate medical education as that element of this fragmented system of medical education most in need of attention.

But Millis, Willard, and Coggeshall differed from Magnuson and Bane. The latter two asked for more of the same. The former trio asked for change. Change of the same sort as that which Flexner[7] asked in 1910 from undergraduate medical education was now being asked in 1966 from graduate medical education.

And social policy responded. As of July 1975, the free-standing internship was discontinued, and the first year of graduate education was included in a residency program.[8] In 1972, the Coordinating Council on Medical Education (CCME) and the Liaison Committee on Graduate Medical Education (LCGME) were established by the Association of American Medical Colleges, American Board of Medical Specialties, American Hospital Association, American Medical Association, and the Council of Medical Specialty Societies to oversee accreditation and general policy for graduate medical education. In 1972 the National Health Service Corps was established to provide health care in underserved areas. In 1971 and in 1976 various Federal programs were authorized to foster the development of primary care and family practice. In 1969, Family Practice was recognized as a separate specialty.

The Comprehensive Health Manpower Training Act of 1971 marked the turning point in Federal attention to graduate medical education. Although geographic maldistribution was addressed first in 1965 by P.L. 89-290, which established a program that paid off medical student loans in return for practice in "doctor shortage areas," specialty maldistribution was first introduced as a topic of concern in this 1971 Act. Numerical inadequacy had had its last serious airing, and maldistribution was fast taking over as the issue of highest saliency. When this Act expired in 1974, the tide had so turned that the variety of approaches--some still on numerical inadequacy but most on maldistribution--boiled so hard in the legislative stew that it was the fall of 1975 before a serious start could be made on a piece of legislation to replace the 1971 Act that had expired over a year earlier. And the pot boiled on for a full year more before the Congress finally passed the Health Professions Educational Assistance Act of 1976 (P.L. 94-484) on October 12, 1976.

The final delay between 1975 and 1976 in enactment of health manpower legislation was not, however, due to a confusion of proposals between numerical inadequacy and maldistribution. Geographic and specialty maldistribution are clearly the phenomena to which the 1976 legislation is addressed. In fact, the Act states right in the beginning (sec. 2(a)) that "The Congress further finds and declares that there is no longer an insufficient number of physicians and surgeons in the United States such that there is no further need for affording preference to alien physicians and surgeons in admission to the United States under the Immigration and Nationality Act."

Instead, this latter delay appeared to have a great deal to do with the question of controlling residency positions as a means of alleviating specialty maldistribution. The 94th Congress (convened during 1975 and 1976) considered various bills with proposals for regulating medical residency training programs. In 1975, a proposed House bill would have

required the Secretary of HEW to designate one entity, with first choice going to the LCGME, for the review and accreditation of each medical residency program in the United States, and another entity, with first choice going to the CCME, to establish the number of first-year positions in each accredited medical residency training program.

In the Senate during 1975, S. 898 proposed to establish national and regional councils as did S. 991; S. 992 to designate or establish a medical residency training program accrediting agency and another agency to establish the aggregate number of first-year residencies and assign them to accredited programs. S. 989 proposed to require the Secretary to establish the total number of postgraduate physician training positions and to assign these positions by various specialties and subspecialties to specific regions; S. 991 to require the National Council to do this; and S. 992 to designate an accrediting agency and position assignment. agency with first choice going respectively to the Liaison Committee on Graduate Medical Education and the Coordinating Council on Medical Education. S. 989 and S. 991 proposed to limit the aggregate number of positions to 110% of the previous year's graduates, and S. 989 to limit them to 140% for 1976, 135% for 1977, and 125% for 1978 and thereafter.[9]

At the same time that Congress was considering various proposals to establish bodies to regulate medical residency programs, two similar proposals came forth: one from the Secretary of the National Academy of Sciences. In 1973, Congress had called on the IOM to conduct a study of the payment of physicians in teaching hospitals under Medicare and Medicaid and the effects of Medicare and Medicaid reimbursement on the specialty and geographic distribution of physicians and the training of foreign medical graduates. One of the recommendations in their final report on March 1, 1976, called for the establishment of a permanent, quasi-public, independent, physician manpower commission to monitor physician specialty distribution to determine the appropriate number of residency slots for each specialty. Enforcement of these determinations was to be the responsibility of the LCGME, the CCME, and the American Osteopathic Association Committee on Post-doctoral Training, through their respective accreditation mechanisms. If this did not work within three years, as determined by the Secretary of HEW in consultation with the private sector, then the HEW Secretary could reconstitute the commission as a Federal committee advisory to him, and could permit the withholding of Medicare and Medicaid funds from residency programs in specialties considered in excess supply by the commission.

The Administration's proposals was similar to this, but less regulatory. On November 21, 1975, Secretary Mathews transmitted a letter accompanying draft bill S. 2748 to Vice President Rockefeller, President of the Senate. In it the Secretary described one of the bill's provisions: "...to utilize existing authority (Section 222 of the PHS Act) to establish an advisory council on graduate medical education. The council would be charged with analyzing the distribution among specialties of physicians and medical students and evaluating alternative approaches to insuring an appropriate balance. Recommendations would be provided

to the Secretary within 18 months. The council would also encourage bodies controlling the number, types, and geographic location of graduate training positions to provide leadership in achieving the recommended balance. This council would not have regulatory powers to arbitrarily determine the number and geographic location of graduate training positions in each individual specialty and subspecialty. We strongly feel that such regulatory powers are premature, and there is simply no rational basis to justify one particular distribution over another."[10]

Thus, during the 94th Congress, there were various recommendations or proposals from various sources favoring some form of commission or allocation of responsibility to regulate or advise on an appropriate mix of residency programs and/or training positions in such programs. They were not without opposition.

In their supplemental views transmitted with the reporting out of S. 3239 on May 14, 1976, Senators Beall and Taft stated: "We are in general accord with and recommend that the Senate support the reported bill with the exception of those sections providing for the Federal regulation of the type and location of graduate medical training positions (residencies) in every State and hospital in this nation....This provision of the bill is not only not necessary, and at best premature, but also jeopardizes the ultimate enactment of the legislation. If this bill is not stripped of the regulatory mechanism, we fear this Congress, like its predecessor, will fail to produce a health manpower bill. With the residency provisions contained in Title V, the bill faces a certain veto....We believe as we argued in 1974 that deficiencies in primary care can be addressed and redressed by promoting more primary physicians rather than regulating all residencies....We also believe that the trends and developments in the graduate medical education system are in the right direction and certainly do not indicate a 'failure' of such proportion to warrant direct Federal regulations.... The Senate rejected this provision in 1974; the House has already deleted the residency provisions from its bill; and we urge the Senate to do likewise."[9a] H.R. 5546, reported out on June 7, 1975 containing the regulatory provisions on residency training programs described earlier, also contained opposing views. One view signed by five House members viewed these provisions as "...both an unnecessary and an unwise response to this situation. The present imbalance between primary care specialties and non-primary care specialties reflects the emphasis placed on inpatient clinical settings rather than ambulatory clinical settings for graduate medical training in past years. ...family practice is the fastest growing specialty in medicine. Without enactment of Title VIII, it is expected that over half of the first-year residency programs will be in primary care...within five years...a number of non-primary care specialties...have begun to restrict the number of residency positions in their specialty areas. This process of self-regulation has taken into account many of the concerns of Title VIII and has had the obvious advantage of direction by the most concerned with the quality of training in each specialty. Other specialty groups have undertaken careful assessment of the quality and quantity of their graduate training

positions, the results of which will undoubtedly lead to some self-regulation in the future....we are convinced that many of its provisions will be almost impossible to administer. No consensus now exists regarding which standards should be used to determine the ideal specialty distribution. It is not clear that any standards are reliable and, in any event, the bill does not indicate how the regulating agency is to determine these standards." 11

These same five House members continue with respect to asking the LCGME and CCME to take on the regulatory responsibility: "The provision for first refusal of the Liaison Committee for Graduate Medical Education as the accrediting agency and the Coordinating Council for Medical Education as a designating agency is also problematic. While the Committee understandably looks to the expertise of these groups, the latter in being singled out are placed in an awkward position politically and administratively. Some parent bodies of these groups oppose assumption of the proposed responsibilities for LCGME and CCME and may indeed prevent their participation. Successful discharge of responsibilities, if assumed, are nevertheless subject to the difficulties noted above. The fallback position vesting agency selection in the Department of Health, Education, and Welfare is further complicated by the opposition of HEW to Title VIII.* Not to be regarded lightly in these circumstances are all of the provisions which would place the regulated in the position of regulator. Previous experience suggests these inherent conflicts of interest often are antagonistic to the desired ends." 12

These House members eventually summarize their opposition to the regulatory provisions of H.R. 5546: "it is evident that existing incentives and continued Federal support of these programs, as well as self-regulation by non-primary care specialties, will lead to correction of specialty maldistribution. Quality of care is best assured through evaluation of an individual's progress through levels of the educational process. Title VIII would impose awkward administrative problems on reluctant bodies with little likelihood that meaningful changes would result from their efforts." 13

Representative Broyhill filed a separate view on the regulatory provisions of H.R. 5546: "In effect, this Title will create a new bureaucracy that will have the power to decide not only which hospitals will have residency programs, but also how many residents they will have and in what specialties. This Title is unnecessary because positive incentives to increase the number of primary care physicians have worked. Family practice is the fastest growing specialty....Additionally, several medical specialties have placed or are considering restrictions on a number of residencies in their field....The job of fairly distributing residencies by geography and by specialty through a centralized decision-making process is basically impossible no matter who does it....There are no generally accepted distribution standards, especially for the subspecialties and it is unwise to require the Federal Government to develop them. Government control of residencies also ignores a far more significant method of increasing

*See excerpt above from Mathews letter.

primary care specialists: changing the medical care reimbursement system to pay for more ambulatory care rather than for institutional care... I will offer an amendment on the House floor to strike this Title."[14]

But not only the Congressmen differed in their views on regulating medical residency training programs and positions. In testimony on S. 989 in the summer of 1975, Jack Walsh, speaking on behalf of the National Association of Counties, states: "...The overabundance of physicians in several of the medical and surgical specialties is a well known fact. We urge the Congress to address this problem creatively at the residency training level. We would support legislation which Federally regulates residency assignments."[15] He continues later, "...We do it for airlines, for television stations, for liquor stores, hospitals, and so on. The real solution to health manpower shortage should deal with specialty maldistribution and over time would influence residency training programs in medical schools to meet national needs rather than personal preferences."[16]

Later, at hearings in the fall of 1975, George D. Zuidema, a surgeon from Johns Hopkins University School of Medicine, testified: "The overall regulation of medical and surgical manpower should be vested in the Coordinating Council for Medical Education. The CCME has reasonable representation and should be encouraged to accept this assignment. The existing ties with residency review committees and the Liaison Committee for Graduate Medical Education, LCGME, are already functioning. Alternative methods would involve costly duplication."[17]

Later on the same day of testimony, the Committee heard from representatives of the CCME and its various associations. Dr. Tom E. Nesbitt, immediate past chairman of the CCME's Committee on Physician Distribution, responded to the approaches that envisioned asking the CCME and LCGME to take up various responsibilities with regard to regulating medical residency training programs and positions: "To burden that particular body with a function such as was envisioned in the House legislation relating to the subject would have virtually destroyed the original intent and purpose for which the coordinating council was created. We do not think that the legislation is necessary in view of the trends that are occurring, and it is my personal feeling it would be inappropriate for the coordinating council to undertake that particular task at this point in time. In effect it is unnecessary, and through the voluntary activities of the coordinating council, these objectives which we all have, will be reached if we give it sufficient time."[18]

Dr. John Cooper, President of the AAMC, responded to Senator Kennedy a little while later when he was asked whether it was wise to give authority or power of this sort to the CCME instead of doing it in some other way. Dr. Cooper responded that "We have called for the CCME or a commission made up of CCME nominees to advise the Secretary on the number and distribution of specialty training programs." Or, "...an alternative... committee made up of nominees of the parent organizations of the CCME,

plus public members..." could be substituted if the CCME does not want the authority.[19]

A little later during the same hearings, Dr. David Thompson, M.D., New York Hospital, commented on the American Hospital Association position: "...(it) has been and remains that the matter of control of the types and numbers of specialties in training should remain in the voluntary sector. I think it is also fair to say that the American Hospital Association, along with other representatives of the five parent organizations, do believe that the coordinating council, in developing a report and guidelines with regard to the specialty distribution matter,* that this will have a considerable impact on medicine in the training of individuals."[20]

Dr. C. Rollins Hanlon, M.D., Director of American College of Surgeons, also commented at these hearings on S. 989 with regard to the position of the Council of Medical Specialty Societies: "we emphasized that we did not think that the legislation was necessary...or desirable at this time. Of course, we would not be in favor of its being given to the coordinating council for the reasons which Dr. Nesbitt (sic) has expressed, namely, it is not the function of the coordinating council to address this kind of task on an on-going regulatory basis."[21]

Still later, Dr. William D. Holden, representing the American Board of Medical Specialties and Chairman of the CCME's Committee on Physician Distribution, responded to another question from Senator Kennedy on giving the responsibility to the CCME: "My own attitude towards this is, as I stated before, that ...we can do this ourselves. ...In the event the legislation is passed, I would hope that the CCME does provide at least the policy upon which allocation is going to be made."[22]

It seems clear, therefore, from the above opinions of those representing the members of the CCME that the CCME does not seek and did not seek the power for regulating residency training programs or positions. It does believe, however, that in its own way it will provide the leadership in the private sector that is required to foster an appropriate mix of physician supply in the various specialties. It also appears that if such a regulatory approach is taken, the CCME would wish to play a special role in influencing the policy that guides the activities under such approach.

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*The CCME has prepared two reports on Physician Manpower and Distribution, one on The Primary Care Physician in January 1975 in which they developed their criterion for 50% of specialty physicians in primary care, and one on The Role of Foreign Medical Graduates in June of 1976. They currently have a report on The Specialty and Geographic Distribution of Physicians under review in draft form.

In regards to some of the stipulations associated with the proposals on regulating residency training programs and positions, Dr. Edward F. X. Hughes from Mount Sinai School of Medicine and the National Bureau of Economic Research testified at the hearings on S. 989 in regard to the feasibility of a reasonable report within the 18-month time period called for. He related that "the SOSSUS study took over 4 years; my own work has been underway over 5 years; the health insurance study has been underway for 3 years. Accordingly, it seems unrealistic to set an apparent 18-month deadline on the major study proposed in the bill. While some of the charges given to that study could be performed in 18 months, some could not."[23]

On September 17, 1976, the report on the House and Senate conference over H.R. 5546 stated that: "The Senate amendment provided for the establishment of a National Council on Post-Graduate Physician Training consisting of various officers of the Federal Government and members of the public. Duties of the Council included the making of studies and other activities (and the making of recommendations to the Secretary of HEW) with respect to distribution and goals for the distribution of postgraduate physician training positions among the various medical specialties, the development of working relationships with specialty organizations with respect to number and location of specialists, assessment of the need for financial support for postgraduate physician training, and assessment of the service needs of hospitals and other health institutions for graduate physician trainees, and assessment of the educational component of postgraduate physician training programs, and an assessment of the impact of practice in the United States by graduates of foreign medical schools."[24] This Senate amendment also asked for a report by the Secretary to Congress on the status of specialty and geographic maldistribution, but did not include the notion of regulating the number and type of medical residency training programs and positions. The conference report went on to say "The House bill contained no comparable provision (to the Senate amendment). The conference substitute does not include the Senate provision."[25]

The Manpower bill eventually passed on October 12, 1976, was the bill resulting from this conference. No comparable provision to the Senate amendment or to any of the other alternative approaches to regulating medical residency training programs was included or even alluded to.

In order to understand this result, it is useful to go back approximately six months to the early part of 1976. At that time, a proposed charter for a Graduate Medical Education National Advisory Committee (GMENAC) was sent from the Assistant Secretary for Health to the Secretary of HEW. That charter was an outgrowth of the proposal first made public in the Secretary's letter of November 21, 1975, introducing S. 2748 to the Congress in the form of a draft bill. The Secretary signed off on the charter in May of 1976. It appears, therefore, that the chartering of this committee in great part enabled the manpower legislation to be passed later that year in the fall of 1976.

The issues which stirred this legislative and public debate over the requirements for, and production of, physician specialists are still there. Clearly, Graduate Medical Education is in a state of substantial change in the 1970's, as a result of evolving social and professional perceptions, economic constraints, and alterations in student characteristics and goals. However, there is still concern over whether or not these trends are fully understood or are of sufficient magnitude to correct perceived imbalances. Many doubt whether the current method of financing GME will permit a continuing response to the changing perception of physician specialist requirements. Others recognizing that the annual production of specialists is the sum of thousands of individual programs whose intake and output is largely a function of the decisions of individual program directors and their hospitals, believe that the subject warrants greater study. Efforts need to be undertaken to determine whether the Nation's interests are being appropriately addressed by this production approach. Hence it seems to be a reasonable first step to develop a first approximation of specialty educational goals or targets which can guide program development and evaluation.

Against this backdrop, the Graduate Medical Education National Advisory Committee offers an opportunity for diverse professional and public groups to participate in the examination of the issues in an open forum. The membership of the Committee will include individuals reflecting the interests of the parent bodies of the CCME, as suggested by the IOM and the Macy Foundation reports. It will also include other parties with a stake in the financing and administration of Graduate Medical Education programs, as well as those interested in the consumption of specialty services.

Although the Committee does not have a regulatory function, it does have a mandate to examine the present and future supply and requirements of physicians by specialty and to translate these physician requirements into ranges of types and numbers of needed graduate training opportunities. The Committee is further chartered to propose national goals for the distribution of physicians being trained, and to examine the impact of various public and private policies which influence specialty distribution, particularly reimbursement and financing. Intrinsic to these tasks is the development of a far better understanding of current trends in Graduate Medical Education which can characterize more fully the current operational response of the training system to changing social perceptions and requirements.

GMENAC then represents a critical non-regulatory step in the establishment of goals for the training and differentiation of physician manpower. It is responsive to the intents and judgments expressed by many public and private bodies in recent years and provides an opportunity for the identification and development of issues of concern to the public and the profession. Through its recommendations to the Secretary of HEW, GMENAC will be able to highlight issues in the development of National Health Insurance which relate to graduate education, and to present strategies for consideration in the planning of new health manpower

legislation which will be in its early conceptual stages in 1978 and 1979. Although the Graduate Medical Education National Advisory Committee is but one of many efforts in the continuum of societal responses to public and professional concern, hopefully, like its predecessors, it will have a constructive influence upon the development of physician manpower policy.

THE DEVELOPMENT OF SPECIALTIES IN MEDICINE: A MACRO VIEW OF SOME MAJOR EPOCHS

In many regards, medical specialization can be considered to be as old as the practice of medicine itself. In "The American Health System: Its Genesis and Trajectory," John Freymann refers to Herodotus (484-425BC) reporting on his visit to Egypt as saying, "Every physician is for one disease and not for several, and the whole country is full of physicians; for there are physicians of the eyes, others of the head, others of the teeth, others of the belly, others of the obscure diseases."[26] He goes on to describe the difference in the Middle Ages between the learned physician and the lowly barber-surgeon. Freymann differentiates further the notions of the British dresser, the resident physician, the walker, and the house pupil in United States hospitals during the 19th century. During the 18th century in England, there was specialization of a sort in that those physicians who were members of hospital staffs possessed a mark of distinction that provided them with the opportunity to develop more lucrative practices than those who were not on hospital staffs. During this same time, "English medical education grew up in hospitals that restricted their clientele to a narrow segment of the population with certain acute, episodic diseases."[27]

An almost coincidental seed for the development of medical specialties in the United States was planted when the Johns Hopkins Hospital opened on May 7, 1889. The intention of the medical school associated with the hospital was announced as being to increase knowledge and to prepare students to increase knowledge. When Abraham Flexner came along with his monumental report in 1910, he used the Hopkins model as the basis for his recommendations. He saw it as embodying the best features of the medical schools of France, England, and Germany. This emphasis on knowledge development and the ability to impart such knowledge would support the further development of the specialties which had begun at the end of the 19th century. In fact, the early members of the staff at the Hopkins hospital represented a variety of specialty areas in medicine at that time.

In the 19th century, the specialist societies "...represented the specialty rather than the specialist....By the early 20th century, however, specialism had advanced in some fields to a ...concern over the educational standards and competence of those claiming specialist skills."[28]

As the number of persons claiming to be specialists increased, the profession became concerned over the educational credentials and competence of these claimants. Three vehicles were considered to control this proliferation of specialties: the AMA via educational standards through the Council on Medical Education; the professional boards which were growing out of the specialist societies of the 19th century to set minimum standards for practice and provide a badge of competence rather than to specify educational standards; and some form of state licensure to recognize those who were well trained rather than to legally exclude the inadequate.

The AMA approached the task by attempting to reform the structure of graduate education. In 1920 the AMA Committee on Medical Education and Hospitals organized 15 separate specialist committees to develop suggested curricula in their clinical and pre-clinical specialties.[29] This move directly recognized the differences between educational needs and practicing characteristics of different specialties. These committees "...were therefore in a sense the forerunners of the specialty boards which were to proliferate in the 1930's..."[30] "Gradually nineteen boards in the medical specialties were established during the thirties, coordinated by an Advisory Board for the medical specialties."[31] These specialty boards were the "...outcome of a long intraprofessional movement...also a response to what seemed the inevitable alternative of licensing of specialists by the states...The system developed out of no obvious organizational solution but, ...from compromise among major interest groups."[32] State licensure never did take hold, but died instead with a general disapproval of attempts by the National Board of Medical Examiners to set its own specialty examinations for purposes of the state licensure.[33]

The nature of the development of medical specialties was further affected during the depression of the 30's. Because of difficult economic circumstances, many interns or residents preferred to stay in their hospital positions in order to avoid the financial uncertainty of practice. This tended to strengthen their interest in special knowledge of medicine and thus tended to strengthen the tendency towards the practice of specialty medicine. At the same time high technology was becoming more and more prevalent in the practice of medicine. Thus, as the increasing numbers of physicians remaining in hospitals became associated with the newer technologies, they learned to practice more and more in a setting of specialty medicine with the hospital as the location of such practice.

World War II solidified this growing force toward specialty practice. Specialty medicine became regularized via military health programs. During the War there was a need to set up a system of slots and definitions of physicians in military service according to qualifications and in response to requirements for medical care. And within this system, being designated as a specialist made it easier to obtain military rank. Furthermore, after the War, those who had practiced general medicine became disenchanted with the bureaucratized form of such practice in the service, and tended to move away from any non-specialized form of medicine because of it.[34] All these forces tended to strengthen the role of the specialty boards in organized medicine.

At this same time, the growth of specialty medicine was further enhanced by the combination of growing technological advances, increased demand for service in rural areas (which led to the Hill-Burton Act and the large increase in the number of hospitals in this country), and the growth of the National Institutes of Health (NIH). The complexity of knowledge associated with the new technological advances led to a feeling of practicality and security in specialization. Furthermore, technological advances required practice in the hospital in order to employ them.

As hospitals increased under Hill-Burton, this led to an increased need for hospital staff, especially in the specialty areas since hospitals were organized on a department-by-department basis differentiated usually according to the specialties established in the earlier part of the century. NIH, too, served to further solidify the movement toward specialties in medicine: it fueled the pace of technological advance; it employed a categorical approach to the development of knowledge; and it fostered differing areas of scientific specialization in medicine.

In the 50's, the Magnuson Commission[35] and the Bane Report[36] defined a concern over numerical adequacy of physician supply. They considered the fact that although the physician population ratios in 1950 were the same as those in 1940, the wider and intensified demand for care due to increased technology and differing organizational patterns of delivery made these numbers inadequate to meet the needs of the country. As a result of this concern, social policy in the 60's resulted in increased enrollments in medical schools. But, in combination with the other forces already in place and those to come, and because of the fact that medical education had now expanded to include as an integral portion the medical residency training in the specialties, this led to a further deepening of interest in the practice of specialty medicine.

In the late 50's and early 60's, the AMA Board of Trustees, through their Council on Medical Education, established a Citizen's Commission on Graduate Medical Education and asked Dr. John Millis to be its chairman. The motive behind this Commission was a concern for the character and standards of medical education and thus for the qualifications of the future members of the profession.[37] At the same time, the ad hoc Committee on Education for Family Practice was commissioned by the Council on Medical Education under Dr. Willard,[38] and the AAMC asked Lowell Coggeshall[39] to examine the role of the university in graduate medical education. Over all, the Millis, Willard, and Coggeshall Reports resulted in efforts to develop integrated and graded residency programs, to abolish internships, to increase university control over residencies, and to emphasize teaching for primary medical care. They led to establishment of the American Board of Family Practice by the AMA and the AAGP in 1969 and accreditation of the first new residency programs in family practice in 1970 (by 1978, 293 such programs had been accredited). By April of 1976, over 1900 graduating seniors, almost 20% of all graduates, applied for residencies in family practice. Only a few years ago, 5% or less of the graduates were so inclined.

In particular, the Millis report[40] called for a commission on graduate medical education under the AMA Council on Medical Education. Discussion on this Commission began in the Council in 1967. In January of 1972, the AMA, the AAMC, the AHA, the Council of Medical Specialty Societies, and the American Board of Medical Specialties created two bodies: The Coordinating Council on Medical Education and the Liaison Committee on Graduate Medical Education. The CCME was to generate or consider policy matters for both undergraduate and graduate medical education for referral

to the parent organizations. The LCGME was to serve as the official accrediting body for graduate medical education.

The CCME held its first meeting in January of 1973. At its second meeting, it decided to develop a position on the need for a significant increase in the number of primary care physicians. In its report entitled "Physician Manpower Distribution: The Primary Care Physician," the Committee set a target of [illegible]% of medical students to select careers as primary care specialists.

During the 70's, social policy focused further on graduate medical education as the means for addressing societal concern over the problems of specialty and geographic maldistribution. As noted earlier, legislation during this period provided for a National Health Service Corps to provide service in "doctor shortage areas," loan repayment for physicians who practice in shortage areas, and the development and fostering of primary care and family practice educational programs.

FOOTNOTES

[1] The Graduate Education of Physicians--Report of the Citizens Commission on Graduate Medical Education (Chicago, American Medical Association, 1966).

[2] William Willard, Meeting the Challenge of Family Practice, Report of the Ad Hoc Committee on Education for Family Practice of the Council on Medical Education (Chicago, American Medical Association, 1966).

[3] Lowell T. Coggeshall, Planning for Medical Progress through Education, Association of American Medical Colleges (Evanston, Illinois, 1965).

[4] The Graduate Education of Physicians, P. 96.

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