RESPONSE OF THE AMERICAN COLLEGE OF PHYSICIANS TO THE FINAL REPORT OF THE GRADUATE MEDICAL EDUCATION NATIONAL ADVISORY COMMITTEE (GMENAC)

Background:

The Graduate Medical Education National Advisory Committee (GMENAC) was chartered by the Secretary of Health Education and Welfare on April 20, 1976, for the following purposes:

> ...to analyze the distribution among specialties of physicians and medical students and to evaluate alternative approaches to ensure an appropriate balance. The Committee will also encourage bodies controlling the number, types, and geographic location of graduate training positions to provide leadership in achieving the recommended balance.

The Committee's charge included advising the Secretary on overall strategies on the present and future supply requirements of physicians by specialty and geographic location, the impact of factors influencing specialty distribution, and mechanisms to finance graduate medical education. Its function was also to recommend Federal policies, strategies, and plans to achieve the established goals in concert with the private sector and non-federal agencies.

In fulfillment of its responsibilities the Committee on September 30, 1980, transmitted a comprehensive report to Patricia Harris, Secretary of the Department of Health and Human Resources. The report consisted of seven volumes: a summary, five technical panel reports and an appendix.

The American College of Physicians has been pleased to cooperate with GMENAC and its staff. The College was consulted for nominations to the various Delphi panels, and 16 Fellows of the ACP were selected and participated in the Delphi process. The College was also pleased to be of assistance through the Council of Medical Specialty Societies in the selection of three specialty society representatives who served on GMENAC. It should also be noted that the meetings of GMENAC were open to the public and were attended and monitored by College staff.

Following the June 1980 meeting of the Steering Committee of the Board of Regents of the American College of Physicians, an ad hoc committee, chaired by President-elect Thomas F. Frawley, M.D., F.A.C.P., was appointed to review the GMENAC report and to prepare the College's response. The ad hoc committee immediately began to review background materials and preliminary drafts of GMENAC and its technical panels. The committee reviewed advance copies as well as final copies of both the summary GMENAC report, the five technical panel reports, the appendix volume, as well as the responses to GMENAC of other medical organizations.

A preliminary general ACP response to GMENAC was approved by the Steering Committee of the Board of Regents on January 20, 1981. This more comprehensive response was approved by the Steering Committee on March 10, 1981 and adopted by the Board of Regents on April 9, 1981. This response consists of a general discussion of the positive features of the GMENAC approach, criticism of the GMENAC technique, conclusions and responses to GMENAC recommendations.

The College found that in general the 40 recommendations as presented in the Summary GMENAC report were accurate condensations of the 107 recommendations contained in the technical panel reports and reflected the discussions and intent of the technical panels. However, to respond thoroughly to those issues of most concern to internal medicine, our response is directed to the detailed recommendations of the individual technical panels. We realize that the technical panel reports have not been as widely distributed as the Summary Report to which most organizations responded; therefore, we have provided the verbatim technical panel recommendations with cross references to the Summary Report recommendations.

Refinements and revisions made by GMENAC in the Summary Report are noted and also discussed. This approach facilitates a thorough analysis and discussion of those recommendations which we feel merit further comment and permits highlighting important points which are not emphasized in the Summary.

POSITIVE FEATURES OF THE GMENAC APPROACH

Facts about specialty and subspecialty physician manpower supply and requirements in the United States are needed as a foundation for rational health planning. GMENAC is the first detailed, specialty-by-specialty study of U.S. physician manpower supply and needs which used a consistent methodology and which considered variables influencing supply and demand.

The individual who chaired GMENAC for the last two years is an outstanding physician with experience in the study of physician manpower. The chairman was assisted by a capable staff and by more than 200 consultants. The competence and sincerity of individual members of the committee, the staff and the consultants cannot be doubted.

Extant methodology was inadequate for determining supply and predicting future supply and need. Therefore, GMENAC devised its own innovative methodology, which included several variables not taken into consideration in previous studies. To its credit, GMENAC was the first to acknowledge that its methodology was untried and untested and could be interpreted as possibly incorporating a broad range of error. The preface to the Report of the Modeling, Research, and Data Technical Panel reflects GMENAC's interest in refining further its methods: "The intent of OGME (Office of Graduate Medical Education) is to solicit critique from as wide an audience as possible in order to improve our knowledge of physician manpower analysis. The estimates given in this report should be viewed with caution as they were

derived from a methodology which is still in its infancy." GMENAC deserves considerable praise for is pioneering effort to develop a method for the prediction of manpower supply and need, for its attempt to formulate manpower projections, and for its open invitation for critical review.

CRITICISM OF THE GMENAC APPROACH

The first criticism of GMENAC's endeavor involves its necessary reliance upon subjective and highly variable judgments. GMENAC's projections about the supply of physicians in 1990 are subject to considerable error; its predictions of the number of physicians required in each specialty and subspecialty are at even greater risk of error. The adjusted needs-based approach adopted by GMENAC necessitated that "judgments": educated guesses--in other words--subjective decisions--be made by GMENAC participants about several factors at four points in the process of estimating physician manpower needs in 1990. Great variation in response might well be anticipated among physicians asked to estimate the proportion of persons with various diseases who would require a physician's services; even greater variability and heightened controversy might be expected among physicians asked to predict what proportion of persons, who require a physician's care, need to see a particular specialist or subspecialist. Likewise, a wide range of responses might be given on other key issues bearing on the overall predictions, including the types and amounts of services required, the proportion of services delegated to nonphysician providers, and the productivity of physicians. It is difficult to estimate conditions, needs and practices even for the short term; it is exceedingly difficult to forecast conditions, needs and practices for a decade hence.

However sophisticated its methodology, GMENAC's inquiry into physician manpower supply and requirements in 1990 was necessarily based on subjective judgments and on informed supposition. Therefore, GMENAC's conclusions must be accepted as approximations or gross estimates, which might be useful as general guidelines to manpower planning, rather than as authoritative, precise facts upon which planners could predicate major revisions in the mechanisms that will influence the supply of specialty and subspecialty physicians.

To point out the difficulty of making estimates and to illustrate the high degree of variability which attends such efforts, a few specific examples will need to be cited. First, panelists were instructed to formulate their projections on the basis of what should occur in 1990 rather than on what will or might or could occur at that time. Obviously, estimates of what health care should be in 1990 will differ greatly depending on the perspectives, knowledge bases, attitudes, and biases of the individual forecasters.

The panelists were also told to assume that there would be no barriers, including financial and geographical ones, to health care in the 1990s. Considering the economic and political climate in the nation and the world today, projections which do not take such factors into account seem unrealistic. In fact, although certain decisions require predictions of the influence of variables on the future, it is nearly impossible to identify and quantitate these variables with any accuracy or certainty. Manpower need could be dramatically affected by new medical discoveries, major political events or changes in eco-systems. Therefore, when such predictions are used in planning, they should be regarded as best estimates or trends, certainly not as specific facts mandating specific actions.

The College has serious concerns that many of the recommendations of GMENAC appear unduly narrow and rigid and are insensitive to regional, local or institutional differences which would justify variations or exceptions.

A second criticism of the process by which GMENAC reached its conclusion involves the nonrepresentative composition of some of the Delphi panels. For example, some panels were too heavily weighted with academic specialists as compared to practitioners. The number of persons participating in the expert panels was quite limited, as mentioned above; the small size of the panels, especially those for the medical and pediatric subspecialties, which consisted of one to three panelists apiece, contributed to the possibility of "misrepresentation".

A third criticism addresses the issue that the data developed by the Delphi panels were freely manipulated throughout the process of estimating the supply and requirements of manpower. The results of the Delphi process were reported to the Modeling Panel, which then reviewed and revised the estimates before submitting them to GMENAC. For example, a Delphi panel, utilizing ambulatory care data, concluded that 4,478 infectious disease subspecialists would be required by 1990, but the Modeling Panel, utilizing the same data but drawing different conclusions from it, asserted that only 1,995 infectious disease subspecialists would be needed.

A fourth criticism concerns the validity of data on which the study and its predictions were based. Certain data sources were far from adequate and perhaps of questionable validity. There were many complaints voiced by the panelists about the "softness" of the data. Better data are needed on the incidence and prevalence of conditions and procedures, on norms of care, and on the productivity of all varieties of health care personnel.

Finally, GMENAC may also be criticized in that the utilization of the so-called "modified" Delphi process may have altered the study's outcomes in a number of ways. The free discussion of estimates and factors permitted the emergence of leaders or outspoken proponents of specific views on the panels. This technique may have allowed these individuals to become disproportionately influential in the

decision-making process - which runs counter to the Delphi hypothesis - which is predicated on consensus derivation by objective analysis of data.

CONCLUSION

GMENAC represents a serious, intensive effort on the part of the federal government and representatives of the medical profession and the private sector to plan for meeting the health care needs of the American public in future years. The study has sought to develop a comprehensive data base in the area of health manpower and to forecast physician manpower supply and requirements for the United States in 1990. The GMENAC study required the development of a new methodology, and this methodology has been neither tested nor validated. The study drew on prodigious amounts of data from multiple sources; much of the existing information must yet be refined and new data must be obtained. At most, the specialty and subspecialty manpower projections derived from the data by means of this newly developed methodology should be viewed as approximations or as ranges rather than as hard facts or accurate numbers. Projection of over-production or under-production of physicians, specialists or subspecialists, should be understood as predictions of trends which suggest possible imbalances in supply and demand among the specialties and subspecialties.

It is likely that the predictions contained in GMENAC's report will suggest or alert us to the possibility of such imbalances in physician manpower, and that these suggestions, together with market forces, will be sufficient guides to the correction of manpower imbalances.

Certainly, GMENAC's projections should not be used as the basis for governmental regulatory actions designed to manipulate the total number of physicians entering the various specialty or subspecialty training programs.

The following sections contain the College's comments to each of the GMENAC recommendations most concerning internal medicine. The College has chosen to respond to the detailed recommendations as they appeared in the five technical panel reports. A table, prepared by GMENAC, providing cross references among the technical panel report recommendations and those of the Summary Report appears at the end of this document.

GMENAC TECHNICAL PANEL RECOMMENDATIONS AND
RESPONSES OF THE AMERICAN COLLEGE OF PHYSICIANS

MODELING PANEL (VOL. 2)

RECOMMENDATION 1: No new allopathic or osteopathic medical schools should be established beyond those with first-year students in place in 1980-1981. (Summary #1-A)

ACP RESPONSE: The American College of Physicians concurs with the intent of this recommendation in view of the supply and requirement projections. However, an absolute moratorium on the establishment of new schools would be undesirable in that such action would severely limit or rule out response to needs for new medical schools which might be identified at a later date.

RECOMMENDATION 2: There should be no increase in the entering class size into allopathic and osteopathic medical schools beyond the entering class of 1981. (Summary #1-B)

ACP RESPONSE: The American College of Physicians agrees that any increase in medical school enrollment beyond the current aggregate levels should be discouraged. However, given the limitations of the methodology presently available, ten-year forecasts on which this recommendation is based are hazardous and imprecise. Manpower supply and requirement data should continue to be monitored by means of newly developed and refined methodology and more accurate data bases.

The ACP does not believe that government should institute measures for reducing individual medical school enrollments. On their own, in response to perceived manpower needs or to other regional or local influences, medical schools should voluntarily decrease the size of their entering classes. In some instances, however, increases in class size may be justified.

The College recommends repeal of Federal and State regulations for institutional support which require expansion of enrollments in health professions training programs. (See Responses to Recommendations #4, and #5).

RECOMMENDATION 3: Allopathic and osteopathic medical schools should reduce entering class size in the aggregate by a minimum of ten percent by 1984 relative to the 1978 figure. (Summary #1, with addition: "...or 17 percent relative to the 1980-1981 entering class.")

ACP RESPONSE: The American College of Physicians encourages voluntary efforts to reduce enrollments, but would oppose efforts to apply a blanket percentage reduction equally across-the-board to all medical schools. The College does not believe that the ten-year predictions are sufficiently precise to substantiate this recommendation. The mathematical models used by GMENAC to estimate physician supply and requirements are highly sensitive to change in assumptions, data, and priorities. Furthermore, past efforts to develop long-term manpower

projections, although less sophisticated than GMENAC, have been ineffective and subject to wide variation as a result of changing economic trends, technological advances, demographic changes, and greater public demand for services.

It should be noted also that, if the GMENAC projections of a physician surplus by 1990 are accurate, measures to rule out that surplus will obviate as well any possibility that competition will correct certain perceived problems in the medical marketplace. The argument that competition does not operate successfully in the medical marketplace may be incorrect, because market forces would not be expected to operate in a period of short supply which existed prior to 1970.

The full GMENAC recognized that aggregate entering class size has been growing at approximately 2.5 percent per year since 1978, and therefore added the refinement indicating that a reduction of 17 percent will be needed relative to the 1980-81 entering class. This further assumes that entering class size will be stabilized until 1983-84. If enrollment continues to increase, an even more disrupting decrease in entering class size will be needed to achieve the minimum goal of a ten percent reduction in entering class size relative to 1978 levels.

The size of the medical school class has been the prerogative of the individual institution and its faculty. The decisions of the school and its faculty are subject to multiple influences. If GMENAC's projections are correct, the market forces created by the excess of physicians would be likely to emerge quickly and might well result in diminution of medical school class size. However, the College recognizes that changes in entering class size today may not significantly affect the country's ability to meet its health care needs until ten to fifteen years from now, because of the extensive time required for education and training.

The College also recognizes that medical schools, once having geared-up for larger classes, cannot quickly gear down again. Thus after the effects of a physician surplus begin to be felt, it will take several years before medical schools will be able to reduce enrollments.

> RECOMMENDATION 4: The current health professions law, which authorizes grants to health professions schools for construction of teaching facilities, should be amended to allow the Secretary of the Department of Health and Human Services to grant waivers immediately to allopathic and osteopathic medical schools to allow them to ignore the law's requirement to increase enrollment. This recommendation applies as well to the pertinent Veterans Administration authorities under the Manpower Grants Program. (Summary #1-C)

ACP RESPONSE: The American College of Physicians concurs with this recommendation.

> RECOMMENDATION 5: The current health professions law should be amended to allow the Secretary of the Department of Health and Human Services to waive immediately the requirement that

allopathic and osteopathic medical schools, as a condition of receiving a capitation grant, maintain the first-year enrollment at a level of the preceding school year. This recommendation applies as well as to the pertinent Veterans Administration authorities under the Manpower Grants Program. (Summary #3-D)

ACP RESPONSE: The American College of Physicians concurs with this recommendation. The ACP believes that capitation should be time-phased terminated only if adequately supplanted by other funds. Capitation funds have provided medical schools with the means to finance curricula changes, develop new programs, and equip or staff existing departments to a level of excellence which could not have been otherwise attained. Funds replacing capitation should not be secured by increasing tuition for medical students, since medical school tuition fees are already so high as to exclude many middle-income students.

RECOMMENDATION 6: The number of graduates of foreign medical schools entering the U.S. yearly, estimated to be 4,100 by 1983, should be severely restricted. If this cannot be accomplished the undesirable alternative would be to decrease further the number of entrants to U.S. medical schools. (Summary #2)

ACP RESPONSE: The American College of Physicians agrees that the number of foreign medical graduates should be restricted. However, appropriate mechanisms should be developed to permit medical schools and hospitals to fulfill their responsibility to train postdoctoral candidates from foreign medical schools who wish to return to their native countries to live and practice. Assurances that these foreign nationals will return to their own countries after training should be obtained. Restrictions to entry for training purposes should not be so severe as to appreciably limit entry of qualified candidates who will return to their countries of origin.

The ACP does not accept the proposed alternative, i.e., that the number of entrants to U.S. medical schools be reduced if the number of foreign medical graduates entering the U.S. cannot be limited. It seems wholly inappropriate to penalize American citizens for the uncontrolled influx of foreign medical graduates.

It should be recognized that many graduates of foreign medical schools are fully competent and qualified to practice medicine in the United States. Arbitrary restriction of the entry of qualified foreign medical graduates would mean that such physicians would not be available to fill positions in specialties such as psychiatry and anesthesiology where the manpower supply is short.

RECOMMENDATION 7: Terminate all Federal and State assistance given through loans and scholarships to U.S. medical students initiating study abroad after the 1980-1981 year. (Summary #2-A)

ACP RESPONSE: The American College of Physicians agrees with this recommendation, if the student's foreign study is for the purpose of obtaining a medical degree from a foreign medical school. Termina-

tion of support should not affect students of U.S. medical schools who are engaged in periods of study abroad. It should be noted, however, that such action would discriminate against American citizens studying medicine overseas as compared to American citizens studying in other disciplines at institutions abroad. Loans available to U.S. citizens studying medicine overseas are the same loans (Guaranteed Student Loan Program) available to American students in other disciplines.

RECOMMENDATION 8: Endorse current efforts in the private sector to immediately develop and implement a uniform qualifying examination for administration to U.S. citizens and aliens who graduated from medical schools other than those approved by the LCME for entry into LCGME-approved graduate training programs. (Summary #2-B)

A. Such an examination must assure a standard of quality equivalent to the standard applied to graduates of the LCME-accredited medical schools.

B. Specifically, such U.S. citizens and aliens must be required to successfully complete Parts I and II of the National Board of Medical Examiners examination or a comparable examination.

C. It is specifically recommended that the ECFMG examination not be used as the basis for measurement of the competence of USFMGs or alien physicians.

ACP RESPONSE: The American College of Physicians concurs with this recommendation.

RECOMMENDATION 9: Require that alien physicians who have entered the United States on the basis of being spouses of U.S. citizens successfully complete Parts I and II of the National Board of Medical Examiners examination or a comparable examination prior to entry into residency training. (Summary #2-C)

ACP RESPONSE: The American College of Physicians concurs with this recommendation.

RECOMMENDATION 10: Ability to read, write, and speak English should remain a requirement for entry into graduate medical education programs for all alien physicians. (Summary #2-D)

ACP RESPONSE: The American College of Physicians concurs with this recommendation.

RECOMMENDATION 11: Urge the Federation of State Medical Boards to recommend (and the States to require) that, prior to obtaining unrestricted licensure, all applicants must have successfully completed at least one year of a GME program which has been approved by the LCGME and must have successfully passed an

examination which assures a standard of quality, particularly in the ability to take medical histories, do physical examinations, carry out procedures and develop diagnostic and treatment plans for patients, equivalent to the standard applied to graduates of United States medical schools. (Summary #2-E)

ACP RESPONSE: The American College of Physicians concurs with this recommendation.

RECOMMENDATION 12: Urge the States to restrict severely the number of individuals engaged in the practice of medicine who do not have an unlimited license. This applies to those practicing independently without a full license and to those practicing within an institution without adequate supervision. (Summary #2-F)

ACP RESPONSE: The American College of Physicians concurs with this recommendation.

RECOMMENDATION 13: Eliminate the "Fifth Pathway" for entrance into approved programs of graduate medical education. (Summary #2-G)

ACP RESPONSE: Recognizing that accredited medical schools in the United States and Canada are currently training a sufficient number of physicians to meet expected requirements and that a national surplus of physician manpower supply is projected by 1990, the American College of Physicians supports efforts to discontinue programs which encourage American students to seek medical training abroad for the purpose of obtaining a medical degree. The College advocates a phasing-out of the "Fifth Pathway" program so that U.S. citizens currently studying abroad will continue to have an opportunity to receive the benefit of a one-year supervised training program in a U.S. medical school.

RECOMMENDATION 14: Eliminate the transfer of U.S. citizens enrolled in foreign medical schools into advanced standing in United States medical schools. (Summary #2-H)

ACP RESPONSE: This recommendation seems to involve an infringement on the rights of U.S. medical schools to admit the students of their choice. Admissions criteria should remain the prerogative of the faculty of the individual medical schools.

RECOMMENDATION 15: In view of the projected oversupply of physicians, the need to train non-physician health care providers at current rates should be studied. (Summary #3)

ACP RESPONSE: The American College of Physicians concurs with this recommendation.

RECOMMENDATION 16: In view of the aggregate surplus of physicians projected for 1990, medical school graduates in the 1980s should be strongly encouraged to (1) enter training in

those specialties where a shortage of physicians is expected, and (2) enter training in the generalist fields of family practice, general pediatrics, and general internal medicine. (Summary #5, revised part (2): "or to enter training and practice [underlines added] in general pediatrics, general internal medicine, and family practice.")

RECOMMENDATION 17: To correct shortages or surpluses in a manner which would not be disruptive to the GME system, no specialty or subspecialty should be expected to increase or decrease the number of first-year trainees in residency or fellowship training programs more than 20 percent by 1986, compared to 1979. (Summary #4)

ACP RESPONSE: The American College of Physicians does not believe that the manpower projections made by GMENAC are sufficiently precise to support numerical targets for increasing or decreasing the number of first-year trainees in residencies or fellowships in internal medicine.

GMENAC's projections are acknowledged to be subject to multiple variables and so should be accepted as general estimates only; they point out possible trends. The ACP believes that the identification of these trends, together with the operation of complex market forces, will influence appreciably medical graduates' specialty and subspecialty career choices. Any regulatory action in this direction on the part of the government is highly undesirable.

It should be noted that, prior to the announcement of GMENAC's projections, there has been in recent years an increase in the proportions of trainees entering general internal medicine and primary care and a corresponding decrease in the proportion of trainees opting for careers in the subspecialties of internal medicine.

GEOGRAPHIC DISTRIBUTION PANEL (VOL. 3)

RECOMMENDATION 1: The functional medical service areas, specialty by specialty, are recommended as the geographic unit for assessing availability of physician services. The Graduate Medical Education National Advisory Committee (GMENAC) also recommends that physician market areas by specialty be determined empirically based on patient origin data derived from such information as discharge and claims data, until such time as total enumeration of physicians services is possible, and that the resulting areas be compared to those previously determined by specialty societies. (Summary #14)

RECOMMENDATION 2: GMENAC supports the evaluation of alternative data systems for the monitoring of the geographic distribution of providers. (Summary #18)

RECOMMENDATION 3: GMENAC urges the use of small area population based data on the availability, requirements for and utilization rates of hospital and physician services as a manpower planning tool. (Summary #14)

RECOMMENDATION 4: GMENAC urges that the ranges of variations in the utilization of specific procedures and services among service populations and communities be collected and analyzed (including communities with differing financing and organizational arrangements for the delivery of medical care services). (Summary #16)

RECOMMENDATION 5: Serious attention should be given to making available to physicians their utilization rate experience relative to the norms of other physicians practicing in their immediate area, region, or in the Nation. (Summary #16-A)

RECOMMENDATION 6: Serious attention should be given to the voluntary collection and dissemination for analytical purposes of aggregate statistics relative to utilization rates in various service areas. (Summary #16)

RECOMMENDATION 7: GMENAC encourages the support of efforts within the profession to assess the outcomes of common medical and surgical practices which exhibit high variation across communities as an important step for establishing the long-range requirements for suppliers of medical services in the United States. (Summary #15)

RECOMMENDATION 8: Future health manpower planning groups should compare manpower estimates (whether derived as a "needs" based, "demand" based or "requirements" based model) against empirical estimates selected from areas in the United States which exhibit high and low utilization patterns. (Summary #16-B)

ACP RESPONSE: The American College of Physicians believes that each of these recommendations calls for further investigative research

and should be supported. The College cautions, however, that at this time the investigative techniques recommended have not been proven and need to be rigorously evaluated. The College does not endorse the possible usage of unproven techniques as indicated in recommendations #1 and #7. The ACP supports development of functional medical service areas as the smallest and most appropriate geographical unit for analysis of health manpower requirements.

RECOMMENDATION 9: GMENAC recommends that five basic types of health care services should be available within some minimum time/access standards: adult medical care, child care, obstetrical services, surgical services, and emergency services. In order to monitor the geographic distribution of physicians, GMENAC recommends that a minimum acceptable physician to population ratio for all areas in the U.S. be established. It is recommended that 50 percent of the GMENAC Modeling Panel ratio of physician specialists per 100,000 for 1990 be established as the minimum acceptable ratio for all areas. (Summary #17 and 17-A)

ACP RESPONSE: The American College of Physicians is opposed to this recommendation. The ACP agrees with the American Medical Association, the American College of Surgeons and others that minimum specialty to population ratios should not be adopted as standards. Given the limitations of the currently available data, the need to recognize possibly wide variations in regional and local needs compared to national requirements, the uncertainties of the effects of interventions necessary to achieve the recommended minima and the arbitrary nature of national ratios, we urge that this recommendation not be implemented. Certainly, no effort should be made to proceed with this recommendation until the research required for recommendations 1-8 have been completed and evaluated.

RECOMMENDATION 10: GMENAC recommends maximum travel times of 30 minutes for emergency medical care, 30 minutes for adult medical care, 30 minutes for child medical care, 45 minutes for obstetrical care, and 90 minutes for surgical care services for 95 percent of the population in 1990, recognizing that unusual circumstances may arise which make these travel times impossible to achieve for all areas. (Summary #17-B)

ACP RESPONSE: The American College of Physicians agrees with the intent of this recommendation. The College does not believe that currently available data support the establishment of maximum travel times except as reasonable goals or targets to improve access to health care.

RECOMMENDATION 11: GMENAC recommends that the definition of health manpower shortage area include minimum physician/population ratios and a minimum travel time to service for general surgery, emergency medical services, and obstetrical services. (Summary #17)

ACP RESPONSE: The American College of Physicians does not agree with this recommendation. Currently available data do not support such a recommendation (see responses to #9 and #10 above).

RECOMMENDATION 12: Incomplete information exists on the direction of causation of many of the factors affecting physician location. Additional research is needed to study (1) how background factors such as sociodemographic factors affect specialty and location choices and the interaction between specialty and location choices and (2) what factors affect permanent location choices in underserved/rural areas. (Summary #18)

RECOMMENDATION 13: Since the role of economic factors in location choice is not clear, attempts should be made to improve methodologies to determine this role and to gather data on previously nonquantifiable topics such as income as a motivating force in specialty or location choices. (Summary #18)

ACP RESPONSE: The American College of Physicians concurs with these recommendations as well as the Summary recommendation that alternative data systems for monitoring the geographic distribution of physicians should be developed and evaluated.

RECOMMENDATION 14: Those strategies which GMENAC deemed most promising, such as preceptorships and tax incentives, and those which are most amenable to evaluation efforts, should be evaluated more vigorously. (Summary #23)

RECOMMENDATION 15: There is some evidence that selective admissions policies may improve the geographic distribution of physicians. A nationally mandated alteration in admission policies is not recommended at this time; further study into the location decisions of students with particular ethnic or sociodemographic characteristics is recommended. (Summary #23)

RECOMMENDATION 16: Economic incentives (such as tax credits and deductions) and/or the provision of higher payment levels for services as an inducement for physicians to practice in underserved areas should be explored. (Summary #23)

RECOMMENDATION 17: Demonstration projects should be developed and evaluated to determine the impact of differential rates of reimbursement for technology-intensive versus time-intensive (counseling, patient education) services upon the geographic distribution of physicians and services. (Summary #23)

ACP RESPONSE: The American College of Physicians supports each of these recommendations. The College emphasizes that Recommendation #15 does not recommend a nationally mandated alteration in admission policies at this time. The College would oppose such national mandates. Admissions policies are a basic institutional responsibility and reflect to a great extent institutional identity. Within the limits of accreditation standards and compliance with existing laws, selective admissions policies must remain an institutional prerogative.

RECOMMENDATION 18: It is recommended that practicing physicians and faculty convey to students that the practice of medicine can be delivered in a variety of geographic settings, including both rural and urban shortage areas. As a means of accomplishing this, urban and rural preceptorships for medical students should be continued and expanded in schools with an interest in monitoring such programs. (Summary #19)

ACP RESPONSE: The American College of Physicians concurs with this recommendation.

RECOMMENDATION 19: Given the geographic distributional patterns of family practitioners, graduate medical education programs in family medicine should continue to be supported as a strategy to increase primary care services in certain geographic areas of underservice. (Summary #21)

ACP RESPONSE: The American College of Physicians supports the intent of this recommendation, but adds that many internists practice in underserved areas and that given the projected surplus of physicians, it is likely that many more will choose such practice locations. Recent studies (Schwartz, NEJM, October 30, 1980) indicate that this is already occurring. The recommendation should include support for training programs in primary care internal medicine.

RECOMMENDATION 20: Incentives should be created to broaden residency education experiences to encompass training in underserved areas, provided the appropriate resources are available and standards of education of the relevant accrediting body are met. (Summary #21)

ACP RESPONSE: The American College of Physicians concurs with this recommendation.

RECOMMENDATION 21: Data suggest that nonphysician health care providers favorably affect the distribution of medical services by their tendency to select shortage area locations more frequently than is the case with physicians. It is recommended that nonphysician health care provider training programs should continue to be supported for this reason. (Summary #21)

ACP RESPONSE: Although the American College of Physicians agrees that nonphysician health care provider training programs merit continued support, the College questions the validity of the data used to support this recommendation. The College also questions the implication of this recommendation that nonphysician health care providers deliver the same quality of care as physicians and that they can be used interchangeably with physicians. Serious concerns arise as to the ultimate effects on health if the sole rationale for training nonphysician providers is to affect the distribution of medical services in shortage areas.

RECOMMENDATION 22: Decentralized medical education programs such as WAMI (Washington, Alaska, Montana, and Idaho) and WICHE (Western Interstate Commission for Higher Education) were developed to coordinate medical education and placement programs in a relatively isolated and sparsely populated region. These types of programs have been effective and attention should be given to their replicability. (Summary #22)

ACP RESPONSE: The American College of Physicians concurs with this recommendation.

RECOMMENDATION 23: GMENAC encourages the medical profession, through its training program directors and various specialty societies, in making decisions as to residency training programs, to consider, in addition to the quality of residency programs, the aggregate number of programs, their size, and the geographic distribution of their graduates to meet national and regional needs. (Summary #20)

ACP RESPONSE: The American College of Physicians concurs with this recommendation, but notes that residency training programs must be responsive to community needs which may not coincide with national priorities.

RECOMMENDATION 24: The National Health Service Corps (NHSC) and the NHSC Scholarship Program for increasing the availability of primary care physician services in designated health manpower shortage areas impact favorably on the geographic distribution of physicians; therefore, the NHSC and the NHSC Scholarship Program should continue to be supported. (Summary # 19-4)

ACP RESPONSE: The American College of Physicians concurs with this recommendation. The College strongly endorses the NHSC and the NHSC Scholarship Program so long as the NHSC continues to target assignees to truly underserved populations.

RECOMMENDATION 25: Governmentally sponsored loan and scholarship programs should be catalogued and evaluated to determine their effectiveness in improving the geographic distribution of physicians. (Summary #19-2)

RECOMMENDATION 26: Despite limited evaluation, there is evidence that several AHEC (Area Health Education Center) models are effective in inducing physicians to practice in underserved areas and/or to practice primary care. These types of AHEC's should receive continued support. (Summary #22)

RECOMMENDATION 27: Loan forgiveness programs modeled after those which have been successful should be used as a strategy for attracting physicians into underserved areas. (Summary #19-3)

RECOMMENDATION 28: Comprehensive evaluation of programs to recruit and retain providers in underserved areas (e.g., Rural Health Initiative, Rural Health Clinics, Health Underserved

Rural Area Program) should be performed after a reasonable period of time. Continued funding of these programs should be contingent upon a positive evaluation of their effectiveness. (Summary #23)

RECOMMENDATION 29: Programs that foster or support group practice arrangements in rural areas, coupled with the appropriate communication and transportation networks, should be developed or established on an experimental basis as a means of attracting physicians to rural communities. If these delivery modes prove to be successful in delivering care to underserved areas, start-up funding should be encouraged for new programs. (Summary #23)

ACP RESPONSE: The American College of Physicians concurs with each of these recommendations. The College also suggests that research should be initiated to assess the impact on health status of location of physicians in shortage areas.

RECOMMENDATION 30: Discontinuation of geographic differentials in payment levels of third-party payors when this is in excess of differences in costs of delivering those services as a means of influencing geographic distribution should be the subject of future research. Present reimbursement systems (Federal, State and private) tend to sustain historical differences in fees and incomes among geographic areas and thus provide incentives for physicians to locate in high income communities within metropolitan areas. (Summary #23)

ACP RESPONSE: The College would like to highlight that this recommendation calls for further study regarding discontinuation of geographic differentials in payment levels of third-party payors when in excess of differences in cost of delivering such services. The College supports GMENAC's intent to provide positive incentives to influence physicians to practice in underserved and rural areas, but cautions that this recommendation should not be misconstrued to sanction reduction of payment rates for physicians in high income communities or in areas not considered underserved. CONCLUSIVE EVIDENCE DOES NOT CURRENTLY EXIST WHICH WOULD JUSTIFY TAMPERING WITH THE PRESENT "FREE MARKET" REIMBURSEMENT PRACTICE OF THIRD-PARTY PAYORS OR CHANGING MEDICARE'S AREA-PREVAILING POLICY.

RECOMMENDATION 31: GMENAC recommends that all physicians, both those in primary care and those in nonprimary care specialties, be reimbursed at the same payment level for the same primary care services. (Summary #23)

ACP RESPONSE: The American College of Physicians is opposed to this recommendation. The College appreciates the wisdom of the full GMENAC in omitting this recommendation as written and combining it with the general recommendation (#23) for further research and evaluation. At present, primary care services are defined in terms such as "office call" or "physical examination" rather than in terms of the complexity of the illness of the patient. The service provided in treating a mild respiratory infection is enormously

different from the service provided in caring for patients with chronic, complex multisystem disease. To reimburse "office calls" or "physical examination" equally as "same primary care service" without regard to the complexity of the illness or the expertise of the physician is no more equitable than to reimburse herniorraphy and coronary artery bypass surgery equally because both are "operations"

Therefore, the ACP believes that reimbursement should be based on (a) degree of expertise of clinical judgment, (b) recognition of diverse skills, knowledge, and acumen of practitioners, and (c) costs of delivery of care. In view of the complexity and diversity of medical practice, the pricing of a unit of primary care service on the basis of the service alone, rather than how and by whom it is rendered, may have unpredictable and/or undesirable consequences.

FINANCING PANEL (VOL. 4)

RECOMMENDATION 1: In view of an oversupply of physicians by the year 2000, any increase in medical school enrollment beyond current aggregate levels should be discouraged. (Summary #1-B and #28)

ACP RESPONSE: (See ACP Response to Modeling Panel Recommendation #2, p.6)

RECOMMENDATION 2: Capitation payments to medical schools for the sole purpose of influencing specialty choice or for increasing class size should be discontinued (or phased out should financial conditions of institutions warrant a time-phased approach to termination). (Summary #28)

ACP RESPONSE: The American College of Physicians cannot support this recommendation as written, but supports its intent. Capitation payments have provided medical schools with a means to finance curriculum change, develop new programs, and equip or staff existing departments to a level of excellence not possible from other sources alone. The ACP highlights that the Financing Panel's recommendation provides that a phased-out approach should be available based on financial conditions of institutions. Unfortunately, the Summary Report omitted this important qualification. The ACP believes that capitation support should be discontinued only by a gradual, time-phased approach to avoid substantial disruptions and economic hardships for institutions. Substitute sources of funds other than tuition increases must be made available if medical education opportunities are not to be closed to all but the very rich. (See ACP Response to Modeling Rec. #5, p.7.)

RECOMMENDATION 3: Special purpose grants to support undergraduate and graduate medical education programs should be used to accomplish specific goals in special circumstances and can be an important, effective, and appropriate means of influencing the supply and distribution of physicians. (Summary #29)

ACP RESPONSE: The American College of Physicians concurs with this recommendation provided that the grants are not made too specific or restrictive and that the educational objectives meet the expressed wishes of the medical school's faculty.

RECOMMENDATION 4: Special purpose grants to medical schools and other teaching institutions for primary care training in family medicine, general internal medicine, and general pediatrics should be continued. (Summary #29)

-Project grants for graduate and undergraduate programs in these specialties should be continued in order to continue emphasis upon ambulatory care needs. (Summary #29)

-Family practice programs, at least for the short term, should be given special attention. (Summary #29-A)

-Specialties determined to be in short supply should be considered for special project grants as well. (Summary #29-B)

-Plans for the subsidy of any new specialty programs, if deemed appropriate, should include an analysis of their needs for long-term support. (Not specifically in Summary)

ACP RESPONSE: The American College of Physicians concurs with the intent of this recommendation. The College, however, emphasizes the major role of internal medicine as well as the role of the internist in delivery of primary and continuing care to the U.S. public. The Federated Council for Internal Medicine (FCIM), of which the ACP is a member, issued a statement in May, 1980, "The Internist (Specialist in Internal Medicine)" which contained the following relevant remarks:

1. The internist is a physician who provides for adults both personal, primary care (accessible, accountable, coordinated, continuing, and comprehensive care) and definitive secondary and tertiary care of complex health problems.

2. The internist is knowledgeable in the basic medical sciences, the humanistic aspects of medicine and the intricacies of complex and serious illnesses.

3. The internist's competence encompasses the organ-system specialties of internal medicine (e.g., hematology, gastro-enterology, etc.) and such integrative disciplines as infectious diseases and oncology.

4. Included among internists are broad-based specialists in internal medicine and subspecialists. Both categories provide a large amount of primary health care in the nation.

5. The internist provides first-contact services, usually of a comprehensive nature, and is a major source of consultative services. An internist's practice covers a vast range of complex problems.

6. The internist is an important bridge between the basic medical sciences and clinical medicine, and carries a large responsibility for teaching.

7. The personal, comprehensive, and continuing care provided by the internist meets an important health care need of the nation and is humane, cost-effective, and high in quality.

The American College of Physicians strongly urges that the important role of the internist in providing primary care should not be overlooked. The College is concerned that too much special attention may be given to family practice programs to the detriment of internal medicine and pediatrics which together constitute the largest number of primary care providers. The GMENAC recommendation should be broadened to include financial support of training programs for all specialties delivering primary care particularly internal medicine, pediatrics and family practice.

RECOMMENDATION 5: Grants should be provided for the selective renovation and construction of ambulatory facilities in training institutions as well as for the establishment and support of training centers located in these facilities. (Summary #30)

ACP RESPONSE: The American College of Physicians concurs with this recommendation, but has reservations regarding its interpretation. The College supports efforts to improve the accessibility to ambulatory facilities and would encourage the construction of such facilities by training institutions, HMO's, IPA's and similar type institutions. The College cautions that implementation of this recommendation should not be construed to imply justification for further expansion of regulatory authority by health planning agencies. Currently, most state certificate of need legislation wisely recognizes the continued need to encourage ambulatory care, and consequently exempts ambulatory care facilities from certificate of need requirements. The College believes that further regulation would be counterproductive to achieving the goal of improving access to health care.

RECOMMENDATION 6: Grants should be made available for the support of student preceptorships and residency experiences in ambulatory settings (especially in areas of clear underservice.) (Summary #30)

ACP RESPONSE: The American College of Physicians concurs. It should be emphasized that only preceptorships and residency experiences in ambulatory settings of high educational quality should be considered. The definition of "areas of clear underservice" needs to be clarified. The ACP would question the wisdom of any programs that had the coercive effect of compelling students to go to certain geographic areas against their will to obtain training, and the ACP questions whether optimal medical care could be assured under such circumstances.

The ACP has fully endorsed the following similar recommendation of the Institute of Medicine ("A Manpower Policy for Primary Health Care", May, 1978):

IOM Recommendation 14: "It is desirable that all medical schools direct or have a major affiliation with at least one primary care residency program in which residents have responsibility under faculty supervision for the provision of accountable, accessible, comprehensive, continual, and coordinated care."

The College noted, however, that exposure of medical students, as well as residents in the primary care specialties, to such systems of care is desirable, but not mandatory. This principle applies to the educational preparation of all health professionals regardless of their ultimate career focus. Health professionals can accommodate to this practice setting easily, even without direct experience to it during their training years.

A clinical setting which can provide students exposure to accessible, comprehensive, coordinated, and continuous care of the type appropriate to the intent of the IOM recommendation is not currently available at many medical schools and teaching hospitals.

RECOMMENDATION 7: Financial grants and aid without future service obligation should be continued for first year medical students of exceptional financial need and for those students who are from underrepresented ethnic groups. Such support should be extended to cover the second year of medical school for these students. (Summary #26)

RECOMMENDATION 8: Financial grants and aid with future service obligations and student loans with forgiveness provisions should be continued. (Summary #19)

RECOMMENDATION 9: Consideration needs to be given to the development of an improved government loan program that would permit students to finance their own medical education. (Summary #36)

ACP RESPONSE: The American College of Physicians concurs with each of these recommendations. (See ACP Response to Geographic Distribution Panel Recommendations #24, p. 16)

RECOMMENDATION 10: To the extent that any specialties are determined to be in or will reach undersupply or oversupply, the private sector should develop methods to remedy this situation, working as needed with government at all levels. (Not specifically in Summary: See Summary Recommendations #5, 20 and 31)

RECOMMENDATION 11: The private sector should take steps to ensure the quality of graduate medical education programs. When mechanisms are in place, consideration should be given to full financing and reimbursement only for approved programs. (Summary #31)

ACP RESPONSE: The American College of Physicians concurs with both of these recommendations.

RECOMMENDATION 12: The costs of graduate medical education should include compensation for residents as well as teaching personnel; education support services, such as the costs of library and audiovisual services; the costs of administering the program; and indirect costs such as plant depreciation, cafeteria and laundry services, administrative services, etc., ascribable to the teaching program. (Summary #32)

ACP RESPONSE: The American College of Physicians concurs with this recommendation; however, the College notes that the recommendation is not clear as to how this would be accomplished.

RECOMMENDATION 13: A uniform recognized reporting system should be developed to permit meaningful cost accounting distinctions between graduate medical education and patient care costs. (Summary #32)

ACP RESPONSE: The American College of Physicians cautions that attempts to "cost account" teaching and service activity can lead to many difficulties and should be avoided. The Financing Technical Panel recognized and discussed some of these difficulties (pp. 30-31) and concluded:

Finally, flexibility in advancing a recommendation in this area is needed. In order to assure stability of funding, graduate medical education costs must be fully understood and financing broadly based in order to obtain a reasonable distribution of costs among benefiting individuals and institutions. Alternative approaches to financing and their implications should continue to be fully explored, especially if conditions in future years require changes to be made.

The ACP concurs. The College believes that quality of educational services relates directly to quality of patient care and vice-versa. The ACP subscribes to the philosophy that optimal medical care is most achievable in a setting of quality education and clinical investigation, and the College strongly opposes approaches, as discussed in the Financing Technical Panel report, which would weaken or jeopardize the viability of teaching institutions.

RECOMMENDATION 14: The costs of GME should be borne equitably by all payors as part of the normal rate structure for patient care costs at the teaching hospitals, clinics, and other sites where health services and training are provided, to the extent that such costs are not financed by tuition, grants or other sources of revenue. (Summary #32)

ACP RESPONSE: The American College of Physicians concurs with this recommendation.

RECOMMENDATION 15: Cost considerations should be given explicit and prominent attention in any proposals to change the standards and processes of accreditation in graduate medical education, the length of training, certification requirements, and proposals to initiate new types of training programs and develop new specialties. (Summary #33)

ACP RESPONSE: The American College of Physicians concurs that cost consciousness is appropriate in graduate medical education and the education of health care providers generally. The College would oppose efforts to discourage additional training in a given specialty or to prevent the evolution of new specialties solely on the basis of cost.

RECOMMENDATION 16: With respect to new and existing training programs, the Committee believes that administrators, faculty, and residents must exercise a clear and strong responsibility to continually seek and implement opportunities for cost-savings in health care within an overall context of balancing quality, cost, and access considerations. (Summary #33)

ACP RESPONSE: The American College of Physicians concurs with this recommendation subject to the concerns raised in the response to Recommendation #15.

RECOMMENDATION 17: Adequate financial support must be provided for programs directed towards the development of future medical faculty, administrators, and researchers. (Summary #38)

ACP RESPONSE: The American College of Physicians concurs with this recommendation. The College does not, however, accept the possible reimbursement changes discussed by the Financing Technical Panel (e.g., eliminating inpatient/outpatient differentials in teaching hospitals reimbursement; altering relative fees by specialty, procedure or area; direct billing by residents for patient care services, etc.). GMENAC and the Financing panel are to be commended for their recognition of the complexity of reimbursement issues and their decision that it is premature to issue a more detailed recommendation until the results of a number of studies currently underway are available.

RECOMMENDATION 18: Public and private reimbursement policies should be adjusted and mechanisms identified to provide incentives for physicians to:

-- Emphasize ambulatory care.
-- Practice in geographic areas which are medically underserved. (Summary #34)

ACP RESPONSE: The American College of Physicians concurs with this recommendation.

RECOMMENDATION 19: Public and private sector dialog focusing on health insurance options or reimbursement policies should explicitly consider the implications for physician specialty and geographic distribution of any proposals to alter payment policy and practice. The concept of shared risk among physicians should clearly be given emphasis in such explorations. (Summary #34)

ACP RESPONSE: The American College of Physicians concurs with this recommendation. The concept of shared risk among physicians is experimental and definitely requires further examination.

RECOMMENDATION 20: A number of principles regarding the payment for services in teaching hospitals should be adopted by third-party payors. They include recognition of the need to compensate services to patients rendered by residents and supervising physicians that are necessary for the care of patients. Payment policies should avoid duplicate payment for services rendered; compensate teaching physicians when they have rendered personal identifiable medical services or have personally managed the provision of care to a patient while engaged in supervising and/or instructing residents; and compensate professional services on an equitable basis. (Summary #34)

ACP RESPONSE: The American College of Physicians concurs with this recommendation. The College considers this recommendation constructive and desirable. The ACP has opposed proposed regulations to implement Section 227 of Public Law 92-603, which would have established amended payment provisions for physician services provided to Medicare beneficiaries in teaching hospitals. (October, 1979 ACP Statement on Section 227).

In contrast to the spirit of the GMENAC recommendation the proposed regulations to implement Section 227 were discriminatory to teaching physicians and teaching hospitals and would have impaired the ability of teaching hospitals and medical schools to recruit and retain able, full-time faculty.

The College also wishes to highlight the following portion of the Financing Panel Technical Report which precedes this recommendation and with which we also concur:

> The amount of payment for professional services should be equitably determined by the value of these services to the patients. The reimbursement level to providers of medical care services should not be reduced because of their having provided free care or reduced-fee care for indigent patients.

> RECOMMENDATION 21: A more adequate reimbursement system for physicians' services in ambulatory and outreach settings should be developed to facilitate educational experiences in such settings. (Summary #25)

ACP RESPONSE: The American College of Physicians concurs with this recommendation.

> RECOMMENDATION 22: Special project grants for States on a cost sharing basis should be considered for programs to influence the distribution of physicians within the States. Consideration should particularly be given to the development of incentives for practice in underserved areas, which would be jointly sponsored among governmental levels. (Summary #37)

ACP RESPONSE: The American College of Physicians concurs with this recommendation and finds this to be a positive alternative to recommendations implying efforts to discourage medical schools and teaching institutions from offering training in specialties determined to be in surplus (See Financing Panel recommendations #1, 2, 10 and 15).

> RECOMMENDATION 23: In view of the current state-of-the-art concerning the knowledge base on reimbursement/financing issues, additional research in this area is warranted and should be encouraged. Among the many research questions the following should be pursued:
>
> -- Study of the differential cost, effects on program quality, and the relative effectiveness in meeting physician manpower needs of increased graduate medical education and training in out-of-hospital settings (e.g., physicians' offices, HMOs, Public Health Departments, etc.). This will require additional knowledge regarding the (marginal) costs and revenues and the effect of government subsidy attendant to such programs, as well as the relationship to "essentials" and accreditation of training programs.
>
> -- Determining differential costs of each existing financing strategy in achieving goals in distribution of residency positions by specialty.

-- Investigating the impact of financial incentives on public versus private training institutions.

-- Developing and evaluating demonstration projects for collection and feedback of statistics relative to community wide fees and payment practices on a specialty and condition-specific basis.

-- Examining the relationship of medical students' indebtedness and characteristics to ultimate career choice.

-- Evaluating the implications on health manpower of reimbursing for services provided by non-physicians on an independent free-standing basis.

-- Studying the variations in medical practice provided by different medical specialties for the same or similar disease conditions, in the context of relative costs, long-term outcome studies, and cost benefit. (Summary #36)

ACP RESPONSE: The American College of Physicians concurs with this recommendation.

RECOMMENDATION 24: An ongoing mechanism needs to be developed to carefully monitor and evaluate the impact of existing and new economic incentives and disincentives targeted to medical education and practice. Actions undertaken to alter financing and reimbursement strategies should not be advanced as permanent mechanisms for change until adequate evaluation/demonstration efforts are first performed. (Summary #35)

ACP RESPONSE: The American College of Physicians concurs with this recommendation.

EDUCATIONAL ENVIRONMENT TECHNICAL PANEL (VOL. 5)

RECOMMENDATION 1: The applicant pool must be broadened with regard to students' individual characteristics, i.e., socio-economic status, age, sex, and race. (Summary #2)

ACP RESPONSE: The American College of Physicians concurs with this recommendation. The College advises that this goal should be achieved in light of other GMENAC goals without giving any assurance, implied or otherwise, that there will be an accompanying increase in medical school enrollment beyond current aggregate levels. Medical schools will have to make some hard decisions regarding how they plan to reapportion some of their available positions in each entering class. They must maintain quality in selecting applicants even if the desired objective of a more diversified pool of students is not achieved. One of the glaring weaknesses in the selection system is the lack of well-informed college counselors who can, on the basis of their knowledge and thorough familiarity with medical school admission requirements and academic standards, advise students on how to prepare intellectually and emotionally to enter medical school. Medical schools, on the other hand, have often failed in sharing their information and advice with such counselors. An improved dialogue between both parties would go far toward making the study of medicine a desirable choice for students of different cultural and racial backgrounds.

RECOMMENDATION 2: In an attempt to increase the diversity of individuals entering medicine, GMENAC believes that there must be more flexibility in the requirements for admission to medical school. (Summary #26)

ACP RESPONSE: The American College of Physicians concurs with this recommendation. The ACP agrees that there is a need for expansion of the arts and humanities backgrounds of medical school applicants. The College suggests that the curricula of certain pre-medical college/university programs which are of only three years duration and those which offer a combined university-medical school program totaling six years merit particular attention. These special programs in general will not be able to meet the GMENAC expectation unless there are revisions in the type and scope of present college science courses.

RECOMMENDATION 3: The admission process should be examined in the light of national, regional, and local requirements, and the institutional mission. (Summary #26)

ACP RESPONSE: The ACP concurs that there is a need to consider the admission process, but believes it would be very difficult to apply "regional and local requirements" in the admission process. This might be achieved only at the expense of changing the existing character of the student body of most medical schools, i.e., currently students are drawn from various geographical regions and multiple colleges. This promotes a healthy interchange of cultural and scientific information among students with diverse backgounds and should be retained. The ACP opposes any change that would lead medical schools to develop along parochial lines; this could occur if caution is not exercised in implementing this recommendation.

On the other hand, it would be quite appropriate and generally helpful to prospective students and medical educators to know the particular mission a given institution assumes.

A medical school's admissions policy must remain the responsibility of the faculty. The admission policy must not be mandated by government whether National, State or Local, and must not be politicized.

RECOMMENDATION 4: Education within the medical school should be broad-based and should prepare the student for graduate medical education. GMENAC recommends that there be made available:

A. Project grants to upgrade outpatient services of academic medical institutions to make ambulatory facilities financially viable;

B. Grants to foster educational innovation with respect to education in an ambulatory setting;

C. Suitable faculty reimbursement for ambulatory care;

D. Grants for development of faculty who are competent to teach in the ambulatory setting; and

E. An increased availability of sophisticated career counseling for the student. (Summary #24)

ACP RESPONSE: The American College of Physicians agrees fully with this recommendation. It, more than any other recommendation, reflects most strongly the expressed purposes and goals the ACP has currently for its membership. In the arena of graduate medical education the ACP is recognized widely as a leader and innovator with special expertise.

The ways and means suggested for achieving the mission set forth in this recommendation are desirable, but caution is to be exercised with respect to seeking federal grant support to accomplish the objective. Ambulatory care programs can be established without extensive new financing and should be used in providing experience in ambulatory care. Many such institutions already exist with established training programs and would not require new special purpose grants to become established.

RECOMMENDATION 5: GMENAC recommends that the first year graduate medical education (PGY-1) be a broad-based clinical experience to serve as the foundation for further specialty training. (Summary #24)

RECOMMENDATION 6: Information strategies are needed in this area, as well as more role models and medical educational experiences at both the undergraduate and graduate levels, to make residents aware that medicine can be practiced in other than tertiary care centers. (Summary #24)

ACP RESPONSE: The American College of Physicians agrees with the intent of these recommendations, but believes that GMENAC should not propose specific recommendations for graduate medical school curriculum. This should be left to the LCGME and other organizations experienced in formulating training programs. The American College of Physicians supports the action of the American Medical Association in convening six task forces to examine the critical issues concerning future directions for medical education.

By structuring the years 3 and 4 of undergraduate education to provide a wealth of general medicine experiences and ambulatory care medicine the student will be prepared to derive maximum educational benefits from his or her PGY-1 year. The PGY-1 year should provide sufficient preparation to allow selected tracks for further advanced training either as a general internist or as a subspecialist. The design and implementation of such programs should be left to program training directors.

The College recognizes that there is a need for continued flexibility in medical education. Thus, a requirement that all students must have a broad-based clinical experience during the first year of graduate medical education would reduce elective options in curriculum and appears unduly restrictive.

The ACP represents the largest single body of practicing general internists and subspecialty internists and as such recognizes that training of residents must include all types of medical care patients, via, indigent, ambulatory, emergency, and private patients. Such experiences are not as likely to be fully developed at tertiary care centers and therefore other settings such as municipal, county and community institutions will need to be used as the vehicles for providing these various training opportunities.

> RECOMMENDATION 7: Along the entire educational continuum, medical school applicants, students, students' spouses, administration, and faculty should be continuously provided with information regarding physician manpower needs in the various specialties and different geographic locations (through publications, workshops, or other communication methods). (Summary #27)

ACP RESPONSE: The American College of Physicians concurs with this recommendation.

> RECOMMENDATION 8: Programs which will increase the participation and visibility as academic role models of women and underrepresented minorities should be instituted. (Summary #26)

ACP RESPONSE: The American College of Physicians fully endorses this recommendation. The goal of increased numbers of these individuals, however, must not become so overriding so as to lead to a sacrifice in quality.

> RECOMMENDATION 9: To reduce the financial barriers to medical education which are restrictive to diversity, programs of loans and scholarships should be expanded. (Summary #26)

ACP RESPONSE: The American College of Physicians concurs with this recommendation. The soaring costs of medical education, combined with current high interest rates, necessitate expansion of loan and scholarship programs from both the public and private sectors.

The ACP has supported efforts to extend authority and funding for Health Education Assistance Loans (HEAL), the National Health Service Corps Scholarship Program, exceptional financial need scholarships and other federal scholarship and loan programs. The College also favored extending the repayment period from 10 to 15 years for Health Professions Student Loans (HPSL).

In addition, the ACP sponsors programs which provide scholarship money to promising internists planning to enter either academic or private-practice medicine with emphasis on primary care.

GMENAC RECOMMENDATIONS CONCERNING NONPHYSICIAN HEALTH CARE PROVIDERS

Volume 6, "Nonphysician Health Care Providers Technical Panel" contains twenty-four recommendations relative to this topic. GMENAC has summarized the intent and concept of these recommendations in its own Summary Report into eight recommendations; where appropriate, the ACP has provided comment on each of these Summary recommendations.

As indicated on pages 91-92 of the Summary Report, the Panel confined its discussions to five principles:

1. To limit its study to nonphysician services which substitute for physician's services.

2. To identify reasons for supporting the concept of nonphysician providers.

3. To agree that nonphysician providers should always provide medical services in close alliance with a physician.

4. To determine the extent of utilization of nonphysician providers according to patient choices.

5. To recognize that there is an inverse relationship between requirements for physicians and the requirements for selected types of medical visits by nonphysician providers.

It is also noted that the Panel offers empirical findings relative to the present and projected supply in 1990 of nurse practitioners, physician assistants and nurse midwives. For example, the Panel projects the total active supply of nurse practitioners to reach 29,000 by 1990, 21,000 active physician assistants by 1990, and 2,800 practicing nurse midwives by 1990. The Panel prophesies that the number of nurse practitioners, physician assistants and nurse midwives will more than double by 1990. It suggests that attention to the growth rates of these professions be closely monitored in the future in view of the impending oversupply of physicians.

The Panel has distilled four principles which are used as basic assumptions for its final recommendations. These are as follows:

PRINCIPLE 1. Even in the event that there is an adequate number or surplus of physicians in a particular specialty, the use of nonphysician providers (NPs, PAs or nurse-midwives) may be supported for one or more of the following reasons:

1. When they increase the accessibility of services.

2. When they decrease the costs of expenditures associated with health care delivery.

3. When they are the providers of choice for some consumers.

4. When the utilization of nonphysicians increases the quality of service; i.e., services provided by a team composed of a physician and nonphysician are superior to those which a physician working alone could provide.

PRINCIPLE 2. The services which have been included in the GMENAC model are medical services and, if provided by NPs or PAs, these must be done under the supervision of a physician.

PRINCIPLE 3. Nurse-midwives should practice interdependently in a health care delivery system and with a formal written alliance with an obstetrician, or another physician, or a group of physicians who has/have a formal consultation arrangement with an obstetrician/gynecologist.

PRINCIPLE 4. Patients, physicians, and nonphysician health care providers should jointly determine the extent of nonphysician health care provider involvement in care. The health care system should evolve in ways which enhance the opportunity for patients to assume a larger control of their" health destinies.

ACP RESPONSE: The College strongly supports these Principles and recognizes their validity in proceeding with the analysis of the specific GMENAC recommendations pertaining to nonphysician health care providers. The College reserves comment on Principle 3 relating to the interdependent practice of nurse midwives and would ask that this issue be addressed more appropriately by those practicing in that field. The College does support however, the continuing role of nurse midwives as health care practitioners.

Because many of the 24 recommendations of the Technical Panel Report concern nurse midwives or are specifically directed to nonphysician health care providers, the College has confined its responses in this section to the eight relevant recommendations of the GMENAC Summary Report which address issues concerning adult medical care.

RECOMMENDATION 6: Extensive research on the requirements for NPs, PAs, nurse-midwives and other nonphysician providers should be undertaken as soon as possible. Special attention must be given to the effect of a physician excess on their utilization and to the benefits these providers bring to health care delivery. These studies should consider the full range of complimentary and substitute services.

ACP RESPONSE: The College strongly supports this recommendation, recognizing the projected physician surplus by 1990. The College agrees that studies should be extended into all areas of nonphysician health care providers and their effects on total health manpower planning. Specific emphasis should be placed on the degree of physician supervision required to assure quality of care provided by PAs and NPs. The College also recognizes that the definition of nursing practice and its overlap with medical practice deserves full review and deliberation. This would include specifically types of services given, outcomes and legal responsibility.

RECOMMENDATION 7: Until the studies in Recommendation 6 have been completed, the number of PAs, NPs and NMWs in training for child medical care, adult medical care and obstetrical/ gynecologic care should remain stable at their present numbers...

or adult medical care, GMENAC recommended delegation of not more han 128,000,000 ambulatory visits in 1990 (this is 12% of the adult edical ambulatory care load projected).

CP RESPONSE: The College agrees that there should be no increase in training program output and that the number of annual trainees hould be kept at current enrollment levels. The specific use of he number of ambulatory visits makes even more essential the need or deliberate research into areas such as limits and reasons of onsumer preference for acceptance of nonphysician providers as well s the distinctive features, if any, of the care given by nonphysicians nd the relation to patient outcome.

RECOMMENDATION 8: All incentives for increasing the class size or the number of optometric or podiatric schools should cease until the studies in Recommendation 6 have been completed and evaluated.

CP RESPONSE: The College supports the general premise that there hould be no increase in enrollment for nonphysician providers; ccordingly incentives for increasing the output of such health care roviders should cease. The imperative remains for further studies nd evaluation in these specific specialty areas (optometry and odiatry) as well as other areas such as nuclear medicine, emergency edicine, neurology, preventive medicine and others.

RECOMMENDATION 9: State laws and regulations should not impose requirements for physician supervision of NPs and PAs beyond those needed to assure quality of care.

a. State laws and regulations should be altered as necessary so that a PA or NP working under appropriate physician supervision can independently complete a patient encounter for conditions which are deemed delegable.

b. The states should provide PAs, NPs and NMWs with limited power of prescription, taking necessary precaution to safeguard the quality of care including explicit protocols, formularies, and mechanisms for physician monitoring and supervision.

c. At a minimum, PAs, NPs and NMWs should be given power to dispense drugs in those settings where not to do so would have an adverse effect on the patient's condition.

d. States, particularly those with underserved rural areas, should evaluate whether laws and regulations pertaining to nonphysician practice discourage nonphysician location in these areas.

ACP RESPONSE: The College reaffirms its position that nonphysician providers such as NPs and PAs should not practice independently. It supports amendment of state practice acts to permit expanded roles for NPs and PAs; it recognizes a need to allow such practitioners to function legally so as to use their skills as long as they operate under the supervision of a physician. It is to be emphasized that explicit protocols, guidelines and mechanisms for physician supervision and monitoring must be present and agreed upon in advance. This would extend to item (c) in Recommendation 9 and include the exigencies of emergency situations. The College concurs with the intent of the recommendation and its ramifications.

RECOMMENDATION 10: The requirements of third-party payors for physician supervision should be consistent with the laws and regulations governing nonphysician practice in the state.

ACP RESPONSE: The College concurs with this recommendation which indicates that physical presence of a physician need not be always necessary to meet the requirement for supervision; such requirements should be consistent with state laws and regulations.

RECOMMENDATION 11: Medicare, Medicaid and other insurance programs should recognize and provide reimbursement for the services by NPs, PAs and NMWs in those states where they are legally entitled to provide such services. Services of these providers should be identified as such to third-party payors and reimbursement should be made to the employing institution or physician.

ACP RESPONSE: The College supports the intent of this recommendation but recognizes that other mechanisms exist in addition to fee for service reimbursement. Institutional nonphysician providers may be funded under general reimbursement formulae; those employed by physicians may require a fee for service schedule at a level different from services rendered by a physician. Cost containment arguments as well as the issue espoused in Principle #1 (2) suggests that reimbursement be well defined as well as restricted.

The College emphasizes the need to recognize the most important aspect of medical practice -- the intellectual, decision-making, coordinating function -- as opposed to the purely procedural functions. This recognition supports the conviction that the wisdom and skill derived from the training and experience of the physician are the basis of differentials of payment for services. Payment for procedures should not subsidize or replace the payment for the intellectual, decision-making function. In fact, in many instances the judgment not to perform a procedure is more worthy of payment than a fee for the procedure.

RECOMMENDATION 12: NPs, PAs and NMWs should be eligible for all federal incentive programs directed to improving the geographic accessibility of services, including the National Health Service Corps Scholarship Program.

ACP RESPONSE: The College concurs with this recommendation recognizing that nonphysician health care providers have demonstrated their effectiveness in underserved areas. The application of this recommendation to

the National Health Service Corps Scholarship Program should be limited to issues of geographic accessibility and not be used as an incentive to increase the number of nonphysician providers.

RECOMMENDATION 13: Graduate medical education should be constructed to give residents experience in working with PAs, NPs and NMWs to insure that these physicians will be prepared to utilize nonphysician services.

ACP RESPONSE: The College recognizes that where applicable, residency programs may involve experience with nonphysician providers. It does not support the concept that all residency programs must have experience working with NPs, PAs and NMWs. The College recognizes the need for experience in working with other health care professionals but would not support the specificity of such a requirement.

The American College of Physicians has consistently supported an expanded role for PAs and NPs working under close supervision of a physician as a means of providing more accessible and quality medical care. It supports modifications of state practice acts to make this possible. It does not support independent practice of such nonphysician providers and reaffirms the need for specific protocols and guidelines for monitoring and supervision. In regard to reimbursement, the College supports the recognition of the degree of expertise of the provider and strongly opposes the same fee for similar services regardless of the nature of the provider. Likewise, the College does not believe that PAs or NPs provide the "same" service as a physician. Finally, critical assessment of the nonphysician provider role is highly dependent on factors affecting physician supply during this next decade. The College therefore is highly sensitive to the need of such providers both in their complimentary and substitute roles in relation to physicians.

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