NEW YORK STATE COUNCIL ON GRADUATE MEDICAL EDUCATION

PLENARY SESSION MINUTES

October 21, 2019
10:30 a.m. - 2:15 p.m.

90 Church Street, 4th Floor, Conference Room A/B
New York, New York

Mary Jane Massie, M.D., Chair

MEMBERS PRESENT: Mary Jane Massie, M.D., (Chair), Stephen Boese, Paul Dreizen, M.D., Jody M. Kaban, M.D., Howard Minkoff, M.D., Harris Nagler, M.D., Mark D. Schwartz, M.D., Mark Taubman, M.D.,

MEMBERS ABSENT: Steven B. Abramson, M.D., Rhonda Acholonu, M.D., Joel M. Bartfield, M.D., Gary C. Butts, M.D., Vincent Calamia, M.D., David Milling, M.D., Monika Shah, M.D., Henry F.C. Weil, M.D.,

COUNCIL/DOH STAFF: Thomas F. Burke, Stephen Casscles (DLA), Karolyn Garafalo, Marc Massena, Susan Mitnick,

CONSULTANTS/ OBSERVERS: Anu Ashok (GNYHA), Roseanne Berger M.D., Joseph Burke, Neil Calman M.D., Stacey Farber, Diana Georgie, Diane Hauser, Eugene Heslin, M.D., Fred Jacobs, M.D., J.D., Elizabeth Krajic Kachur, I. Michael Leitman, M.D., Richard McCarrick, M.D., Mary Mitchell (AHEC), Ashley Morrissey, Cassandra Pineda, Michael J. Reichgott, M.D. Jacob Sneva, Jennifer Tassler and Jonathan Teyan (AMSNY), William Wertheim, M.D., Jo Weiderhorn (AMSNY),

I. Introductions

Council members, speakers, and observers were introduced.

II. ACGME Board Chairman - Dr. Gold – Update on ACGME

Mary Jane Massie introduced Dr. Gold. His various titles include, Chancellor of University of Nebraska Medical Center, tenured professor at the College of Medicine and College of Public Health and Chair of the ACGME Board.

Dr. Gold updated the Council on the work of the ACGME. The focus of the last five years was on creating a single integrated accreditation system for all the residency and fellowship programs for osteopathic and allopathic medicine. The process is expected to be completed by June 30, 2020. The board will have seven members and as such will

be one of the largest boards of these types of organization in the county. The purpose of the organization is to guide residency and fellowship education and quality to serve the general public.

There are approximately one hundred and eighty-eight specialist that are accredited at over eight hundred and thirty-five institutions. There are eleven thousand seven hundred residency and fellowship programs across the county. One hundred and forty-seven thousand residents and fellows in the United States are currently enrolled in one of the residency and fellowship programs that are accredited by the ACGME. The number of osteopathic residents that are enrolled in and ACGME accredited program is now at an all-time high.

There is a sub corporation called ACGMEI, which is the international corporation which accredits international residency programs. For example, the Far East, Middle East, Europe, etc. The financial margins created by ACGMEI programs support a lot of the research in the domestic US.

We are working hard in many areas of the clinical learning environment including standards around wellness and work life balance; diversity; equity and inclusion; and training and workforce for rural America. Another focus is on creating a second generation of milestones. We have created one hundred and eighty-eight competency-based milestones and that number continues to grow. Finally, we are looking to reduce burnout and depression and stop suicide by looking to instill joy into residency education. Working on these issues will ultimately translate into quality clinical care.

We have been working hard at CASANAS which will be an outcome based (not process based) accreditation system for the future. It will look at quality of care and clinical outcomes, the learning environment and other things that influence the care and experiences that residents have. The educational experiences that residents have, the practices and the culture they learn in become part of their lifelong practice. A lot of the work we do is in the way of mentorship and it's a way of providing information back to residents, program directors, DIOs, hospitals, and sponsoring institutions that education and train our residents.

One of the biggest challenges facing ACGME just occurred last summer at the Hahnemann Hospital in Philadelphia. It declared bankruptcy with a 60-day window to close and the residents had to be relocated. Hahnemann is not the only example, this also happened at Ohio Valley Medical Center and all residents had to be relocated. There is a trend occurring widely across the US today where private equity venture capital firms are purchasing hospitals, clinics and physician practices, etc. and they are trying to monetize the value of the GME cap positions. These firms are making the case that the GME positions can be sold at a value to local institutions that want to purchase them. We got a staying order and the matter is now pending in court.

Question - Mark Schwartz: I want to ask your perspective on an issue that a set of issues that Senator Grassley recently rephrased. He states the IOM now National Academy of Medicine report on GM financing in 2014 shows a lack of transparency and accountability. I think the organization has done great work over the last decade but some would say there is still a lack of transparency and accountability to the public. What is the view and role of ACGME in addressing questions that we're overpaying for

IME? The public is not getting their money's worth or that medical education is not addressing the maldistribution in the workforce in this country?

Answer - Dr. Gold: ACGME had historically been an inward facing accrediting body. A strategic decision was made and implemented to become for of an outward facing body and in doing so created a subcommittee of the board know at the Policy Committee. This committee serves to provide reliable, trusted data to people who are in policy making decisions on local and more commonly on national level issues. I believe fundamentally that there needs to be transparency in the outcome of the use of federal state taxpayer dollars for the education of resident and fellows – I would call this the Value Proposition. I'm sure it is not lost on anyone that multiple presidential proposed budgets to cut the total of approximately fifteen point five billion dollars a year that is put into GME or to reduce some of the indirect components of it and redistribute those dollars into different areas. There is no question that we are going to be held increasingly accountable for the transparency of the use of these funds, and that we need to find ways to communicate to the American public and people who represent them in Washington and in state capitals. The Board I chair comprises 88 training programs and just under 600 residents and fellows. Dissecting every last IME dollar and how it is allocated and tracked is a very hard thing to do. We can't quantify the cost of residency education both directly and indirectly. I look at it this way, what we gain is future workforce, quality of care, access to innovation and essentially, we are building the future together. I was not aware that Senator Grassley raised this issue with Secretary Azar.

Question - Steven Bowes: I have a question about ACGME and ACGMEI. In NY we have a pathway where someone could be licensed with international training without the ACG accredited training. We are seeing more and more ACGMEI accredited people coming through. What if anything does ACGMEI training tell us as a licensure board and what do you see as the future of it?

Answer - Dr. Gold: ACGMEI was first started out of a request from some programs and the government of Singapore. ACGMEI does not accredit to the United States ACGME standards. It is an organization that helps countries accredit to their local standards of what they believe needs to be in the competencies that they believe are relevant. Therefore it needs to be independently reviewed as any individual. The Liaison Committee of Medical Education (LCME) is an accrediting body of the international accrediting bodies. I think the LCME and the ACGME both continue to provide what I would call consulting services.

III. Council Business

A. Review and Approval of Minutes – May 13, 2019

The minutes of the May 13, 2019 Plenary Session were approved.

B. Executive Director's Report – Thomas Burke
Update on Health Workforce Programs

Thomas Burke provided updates on several DOH workforce development programs. He said that 72 awards were made for the sixth cycle of the DANY Physician Loan Repayment and Physician Practice Support Programs. Their three-year service obligation will start in November 2019. Thus far we have made 637 awards. The next cycle will be released in February and applications will be due in April. This will be the same time frame we will follow on an annual basis. The DANY Psychiatrist Loan Repayment Program has nothing new to report. They have 15 psychiatrist who are currently participating in that program and receiving funding.

Mr. Burke said that Primary Care Service Corps provides loan repayment to non-physician healthcare practitioners in nine professions and they have to agree to practice in a health professional shortage area. Clinicians serve an initial two-year obligation, which can be renewed for an additional three years. There are twenty-nine awardees currently serving in this program. Since this program began in 2012, ninety-one practitioners have received awards. The next funding opportunity for Round Four has been released and DOH is currently accepting applications beginning October 1st. We expect to make thirty-five awards this this cycle. Grantees serve in an active National Health Service Corps site for the duration of their grant.

Mr. Burke said that we made 12 new two-year awards for the Empire Clinical Research Investigator Program (ECRIP). All awards were for five hundred and seventy-four thousand one hundred sixty-six dollars each. All budgets have been received and approved and projects must begin by December 31st. The next cycle will be released in January of 2021 and those projects will begin between July and December of that year.

Mr. Burke noted that there are no new updates for the Health Workforce Retraining Initiative (HWRI) Program. Cycle Four currently has eighty-four awards and that were made in September of 2018.

There are no new updates for DANY Ambulatory Care. There are 8 institutions currently under contract and training is occurring in 25-30 community health practices and/or physician practices. The next RFA released in fall of 2020 and have a start date of July 2021.

Mr. Burke provided updates for the Rural Residency Program at Cayuga Medical Center (they began training residents in July), Arnot Ogden Medical Center and Champlain Valley Physicians Hospital. He also mentioned working with two other programs; one at Bassett and the other at Samaritan in Watertown. When the five programs are fully implemented, we'll have a total of 60 residents training and approximately thirty-five rural sites. This is all because of a grant through the federal government.

There are no new updates for AHEC. The current contract runes until June 31, 2020.

Mr. Burke said the Diversity in Medicine program has no changes. Later, Jo will provide a brief update on the outcomes of this program which runs until June

2020. The AMSNY Scholarship Program provides scholarships to 10 medical students who have completed one of the AMSNY post baccalaureate programs. NYS scholarship students receive up to $42,000 annually in exchange for completing a service obligation (one year for each year they receive scholarship funds) after completing their medical education. In April the legislature provided an additional year of funding at a half a million dollars. These funds will support nine new students.

Mr. Burke said that no new funding was provided by the Legislature to support the Take-A-Look Tour, sponsored by the Iroquois Healthcare Alliance, in collaboration with the American College of Physicians. This program provides residents, medical students and other medical professionals with the opportunity to visit facilities, practitioners and providers in upstate New York. Since the program began in 2012 there has been seven tours to date with approximately 50 participants in total. According to Mr. Burke, the last tour will take place next week and Mark Messina from our office will be participating in the first day of that tour. He will be able to report back on his experiences. This contract ends in December 2019.

For the SUNY and CUNY Diversity Programs, Mr. Burke did not have any new updates. These contracts continue until June of 2023.

Mr. Burke discussed the State "30" J-1 Visa Waiver program, sharing that the 30 waivers recommended by the Department of Health in 2000 and 19 were approved by the US Department of State and forward to the U.S. Citizenship and Immigration Services. Candidates begin serving three-year obligation once the federal government approves a waiver and issues there. They get a H1 B visa. All 30 of those candidates and materials for the 2020 cycle are currently posted on The Department of Health website and the deadline for filing applications for the waiver is December 12th of this year.

Mr. Burke said the Workforce Data Initiative has two contracts for the Center for Workforce Studies at the University of Albany. They conduct projects to support DOH. Some of the highlights are the center's annual resident exit report about to be released by the center. They also recently had a manuscript accepted for publication in Health Affairs based on the resident exit Survey. The article explores the persistence of the gender income gap. The centers created a new web page that provides information to students and clinicians on federal and state service obligated incentive programs for potential applicants. This is a great new resource that provides information on all the of the service obligated programs nationally and in New York. Finally, the center has released a report on trends in RN education in New York. One of the center's contracts will end December. of 2020, and the second is in June of 2023. We do multi-year contracts with the center on these. They also have provided, and we've distributed, this report (see handout). It is a two-page report of an account of the current activities of the center, with respect to our contracts.

Lastly Mr. Burke commented on changes in leadership within the Department of Health. At the last meeting we discussed that Mark Furnish, became the new director for the Center for Health Care Policy and Resource Development. This center is one of three within the Office of Primary Care and Health Systems

Management that is currently led by Deputy Commissioner Dan Shepherd. Earlier this month, Dan announced that he will be retiring at the end of the year. Keith Service, who appeared before the council about two years ago to talk about the work of the OPMC, the Office of Professional Medical Conduct will be the acting deputy commissioner until a new permanent candidate has been identified.

C. Jo Weiderhorn - AMSNY
Updated on Diversity Programs

Jo stated it's important for you to know what it is that we're doing and how successful our programs have been. In addition to the Scholarship program Tom talked about, we have six programs that we support. We have four post baccalaureate programs, a program at CCNY and a program at CUNY. They are all for underrepresented students.

Page six of the report shows outcomes for the year for our traditional post baccalaureate program which started in 1991 at UB. Ninety one percent of the students from this program entered into medical school. The program used to have 25 students annually, but now we only have 20 students in that program. Eighteen of them entered medical school at our three post baccalaureate master's programs. These programs also provide master's degrees. We allow five masters students at each school. All 15 students entered medical school during this past year.

Our report also shows the ethnic and racial breakdown of our students. Eighteen percent of the students in our post grad programs were black males, which is very uplifting to us since there is a dearth of black males in medical school and in medical education. In addition, 27 percent are Hispanic males, 33 percent are black females and 21 percent are Hispanic females. We do have trend data on this if anyone is interested.

We also support a learning center at CUNY College of Medicine, which used to be Sophie Davis. We've been supporting this program now for about 6 years. We support the program at the City College of New York, which used to have 30 students in; it now has 10. Those students are juniors or seniors, and they're paired with NIH or NSF funded researchers to get them interested in and prepared to do scientific research when they graduate.

We have 17 medical schools in New York State and we train about 11000 medical students a year. This is about over 10 percent of the nation's medical students.

This year we were awarded The Inspiring Programs in STEM Award by Insight magazine and we were nominated for this from our program directors of the six programs that we run. We are pleased about that and about the support of our program directors and for Tom's support over the years because we have grown these programs tremendously under his guidance.

D. Nomination Committee – Mark Taubman, M.D.

Mark Taubman states that this committee consists of himself and Doctors Henry Weil and Rhonda Acholonu. Conference calls occurred twice (August 2013 and September 19th) to consider candidates as potential members of the council. It is going to be a complete turnover of the membership. Each candidate submitted their CV and a statement indicating why they were interested in serving on the council and what they hoped to contribute to the body. They reviewed these statements and credentials and recommended that the Department of Health advance another nine candidates along the vetting process. At the last COGME meeting it was mentioned, that eight candidates had already been submitted. This totals 17 candidates in all.

Mr. Taubman shares that this is a diverse group both in terms of gender, ethnicity and race. Individuals are from both upstate and downstate, and major academic medical centers and non-academic medical centers. There are people who represent administration, telemedicine, residency training programs, and community health centers. It is a diverse group of people in terms of interest. Every one of them had experience and a strong interest in graduate medical education. This is one of the missions of this institute.

This appointment process will roll out over time. We don't have a lot of control over when appointments are made. These are Governor appointments and they go through an extensive review process. Some of the candidates have been with the Governor's Office for some time. Approvals will most likely occur in waves. Mr. Taubman asks members whose terms have expired continue to stay on until replacements are made to the council. That would provide some level of tutoring or education to the new members about the process and maintain some continuity. A couple of the candidates are very familiar with the work of the council, have been to council meetings in the past, and understand our work. They have been recommended by former council members.

Mr. Taubman stated that some of the larger academic institutions had several candidates. This was allowed because in each case, these institutions were large enough, more centered in the inner city, represent a huge part of the residency workforce, and the people recommended had very different roles. It was felt that the Department of Health would decide how they wanted to handle that.

The team has one more meeting and it will be considering a couple of more nominations. The gender distribution is about 50/50. There is one candidate that's representing dental.

Question. If a candidate asks what's happening (it is possible that candidates know individual members) could we know where they are in the process?

Answer: I e-mailed all of the six candidates we successfully met and moved through the committee, to let them know that they're under consideration. They know about today's meeting in terms of either attending or viewing it on our webcast. We can only say that their name is still under consideration. We cannot comment on where along the process they are. Hopefully they'll be able to attend these meetings as observers until they're formally appointed.

E. Council Report – Thomas Burke

Mr. Burke states that the Council Report includes the activities of the council over the past several years. It has been drafted and is currently undergoing final clearance before release later this year. It summarizes our presentations and discussions during all council plenary sessions. It includes three policy recommendations that the council has endorsed, and it ties these to the programs and initiatives that I report to you on at every meeting. It highlights our work and our thoughtful delivered deliberations over the past few years. It's also an important piece to share with those interested in medical education and training policy, both in New York and nationally. Finally, it will be a good tool for new members to understand the nature of our work and the challenges that that lie ahead. When this report is approved for distribution, I'll share it with you, and I thank you for your contributions to it.

F. Overview of Council Bylaws – Stephen Casscles, Esq.
Division of Legal Affairs, Department of Health

Steve Casscles stated the following: I've been with the Division of Legal Affairs about fifteen months. My background's mostly municipal law, so I'm familiar with like how boards work. I also worked in the New York State Senate for 32 years working mostly on health and health issues, insurance issues, and health care financing. Most of my background is health care financing and health care regulation.

Per Mr. Casscles, the DOH would like all boards to have a set of bylaws to help assist and benefit the work of the council. Bylaws are kind of like a constitution as far as how this particular organizational will work. They state how are people appointed, who the members are, what the goals are, and what powers you have. The mission statement of what this organization is to do comes from the executive order that created the board. Bylaws tell the goals. It tells what the charges are, what to do, what not to do, and the kinds of things you need to do.

Mr. Casscles explained from the standpoint of the Department of Health, it's really a reference for the councils, so they know how to operate. It makes is very clear what was decided in the past. We want to put something in the bylaws as to what the ethical obligations are of the board.

Mr. Casscles noted another benefit about of bylaws is its guidance for the Chair, for example explaining the following:

- How meetings conducted?
- What kind of committees you can have?
- What the rights and responsibilities of council members?
- How many members do you have? What are the qualifications?
- What are the financial disclosures?
- Are there council officers, chairs, and secretaries? Are they elected or appointed positions?
- What are the terms of office? How are the elections conducted?

- How will council members be reimbursed for the expenses? What kind of expenses?
- How are the agendas setup? Who approves them? How are they sent out?
- Who does the minute meetings?
- How are votes conducted?
- How do you set up new committees? Do you have ad hoc committees?

Mr. Casscles explained that bylaws should reflect the culture of the committee. Also included are charges that were given by the Governor or the Commissioner. I'll create a draft and bring it back to the council for comment. Once we have a final draft, we will give time for comments, and at a scheduled meeting we will conduct a vote to adopt. This process will take place over the course of six months or so.

IV. Proposal to Amend 405 Regulations in Relation to "12-week rule"
Roseanne Berger, M.D. – University at Buffalo
William Wertheim, M.D. – Stony Brook University Hospital

Roseanne stated the following: We want to share with you a proposal to make a revision to the application of the 405 regulations as it pertains to fellowship training in New York State. In terms of background, in the 1980s there was a concern that that there were a number of international medical schools that were growing and accepting large numbers of students, particularly offshore. There was little knowledge of the quality of the graduates of those schools. Although they were having a basic science experience in the Caribbean, their clinical years were predominantly being assigned in New York State and throughout the country, and a large number were being assigned to local clerkships in the New York metropolitan area. That raised a legitimate concern about (1) the quality of the training and (2) the fact that these students were completing for clerkship assignments with our own New York state schools. There was a competition for spots and for dollars that were supporting the training of these offshore schools. A regulation was implemented that would put a restriction on training of international graduates in medical school clerkships.

The proposal that we are making is to waive the 12 Week Rule for a very limited population. That population is graduates of international medical schools who are applying for fellowship programs and are doing so after they have successfully completed an AC accredited program in the United States (which we feel is vetted and giving us an opportunity to judge quality).

Bill stated the following: We have a group of the SUNY DIO's at the four SUNY campuses and this represents the collective efforts of those four people. We are guided by Stacy Farber, who's the provost fellow for from the Office of Academic Affairs. The 12 Week Rule stipulates that international medical school graduates who spend more than 12 weeks of clinical clerkship training outside the home country of their medical school may not enroll in residency or fellowship training in New York State unless that school has been exempted or approved by the NYS Department of Education for the purpose of clinical clerkships. There is an exception made in the DOH regulations for U.S. citizens who were citizens at the time of enrollment in the international school. If they are eligible for licensure in NYS, they are also eligible for GMP training, and that's

found in section 65 28 of the state education law. The list of approved international schools by NYS is a long list (hand out provided), although there are many other schools which might hope to get on this list. Anyone who attends these schools would be exempted from the from the 12 Week Rule restriction.

We remain concerned that a number of fellowship programs in a variety of different specialties remain unfilled both nationally and in New York State. Many of them are in specialties which really need more trained physicians. We feel that perpetuating that short supply impacts the care of patients in New York state. We also feel that we are at something of a disadvantage to be able to recruit and retain specialists. We selected fellowships because we also we recognized that this is a rule that is designed to restrict training to those of a recognized quality of education. These candidates have already demonstrated a level of competence by graduating from an ACGM accredited residency training program. We are particularly concerned about pediatric specialties which are disproportionately affected by short supply, which place our children's hospitals at risk of not being able to fulfill their mission and perhaps not being able to recruit new faculty.

On national trends: international medical graduates comprise almost 40 percent of internal medicine and 20 percent of pediatrics, residents and fellows. Child psychiatry (as is in other psychiatry fellowships) are really affected. It really does affect a wide array of different specialties which are critical to the care of patients in our state. Two hundred nineteen fellowships, specialty positions went unmatched in 2019. That represented 30 unique hospitals, 20 different medical programs at some of our largest as well as our smallest programs. The largest numbers, geriatrics, nephrology, hospice and palliative medicine. Pediatric specialties accounted for 41 one unmatched positions across the board, infectious diseases. This is something that affects, every place in the state that has fellowship training programs.

Bill provided examples of candidates that were affected by this situation then opened the floor to questions.

Question. Has this been vetted through the other DIO's in New York or is it just the four at SUNY?

Answer. We have a group that meets with the Greater New York Hospital Association and we've spoken about it. There haven't been any concerns raised about bringing this to you at that group.

Question: I have concern in terms of the process. If I were an N of 1 as a Dean, I would support it. But I believe that this is something that deserves to be vetted through amnesty, which is the set of the Deans representing all the medical schools in New York, to see if anybody feels that there is a reason why this shouldn't go through.

Answer. We have had a few phone calls with Rosanne and with Greater New York to discuss this. We have spoken of it internally as well. We've all agreed that residencies are not part of this at this point - it would be for fellowships only. Our recommendation was that the fellowship program would have to show that there was underutilization. For example, if the program could not meet the number of individuals they had slots for, for three years or five years, then that then that program could ask for a waiver from the Department of Health. We haven't come to any final resolution on this. One of the things

that we're very cognizant of is that four of our members are the SUNY schools and this is an issue for them. We're trying to work out something that would be amenable to all.

Follow up. It makes sense to me. I was just curious because this sort of hit me as new. And usually we're discussing these types of things regularly. I'm not sure I would qualify it because there's still matches. You're still making decisions on who will come or not. You can have a program that doesn't match for three years because they decided they didn't want to take any of those candidates. But inherently it makes sense to me that if you're going through an ACG, I mean residency here, you should be able to do a fellowship.

Question. I was a previous DIO and actually chaired the committee that knew it and spoke to for several years. My question is, is the goal here to protect the programs or is it to populate certain need areas? Because if the goal is to populate areas that are under populated with physicians, a blanket waiver or releasing this right away, it doesn't make sense. It should be a targeted area based on need, not necessary by program. What you're doing here potentially, is driving people to a program that may be of less quality for whatever reason or less desirability rather than the areas that we have need in terms of physician specialty.

Answer. We did have discussion about that. The consensus was that the broad waiver would ensure getting the best quality residents in fellowship programs and all of the applicants will have been fully vetted. I think there's a fallacy in thinking that a fellow will change their specialty choice, because it's considered an underserved fellowship. By the time someone finishes an internal medicine residency, they've made a pretty strong decision about whether they're going to be an endocrinologist or a cardiologist. It's unlikely that they're going to change that career goal based on a very limited waiver, in my view.

Comment. I would agree with that. I think people make their career decisions out of interest and don't change unless they're obligated to by not matching, for example. But our use of the reference to the underserved programs, was an example of how this hurt. We feel it hurts both programs and the and the patients of New York rather than the sole justification are fundamental issue was that these are people if they've finished ACGME accredited residencies, they've demonstrated that their education has met a reasonable standard of quality.

Comment. The basic reason for doing this is to be fair. People are already vetted. Why shouldn't someone who's gone through a US residency have the same opportunities to do what they want if they happen to be stronger than the American resident and have been in a better program? Maybe the other one will go to the underserved area, but I don't see how you can say this is fair and then direct them to a particular program that you want.

Comment. We had originally discussed in terms of an underserved area, but that's not where we ended up. Where we ended up was an underserved specialty. It would be for a program that hasn't been able to fill its slots. We had a discussion with Roseanne and Bill about what does this mean in terms of, what happens if Columbia can always fill their slots? So that if they always can get what it is that they need. But that doesn't necessarily mean that, people would be going to other programs. And therefore, we

didn't think it should be overall a waiver, but it should be a waiver for those specific programs with vacancies.

Comment. I'll point out that under underfilled does not the same as underserved and if I'm understanding this right, this change in policy would affect those who are not U.S. residents largely. My question is, what is the prediction of the likelihood of such people being able to practice in New York or in the United States after finishing fellowships? And if there are these fees, these are rare or precious commodities and not everybody would be able to stay. It is a question of the purpose – are we talking about a change in policy that would promote filling of residency slot fellowship slots, or are we aiming to increase the workforce in these specialties in the communities?

Comment. Since we are looking at people training and fellowships, these are individuals who already have been able to secure a visa. J-1 allows people to remain here for a period of six years. Each one would have to be transferred to a new institution, but they already have at least demonstrated that they are able to get a visa to train in the US.

Comment by Michael Roche. The only control we have over the quality of education of students coming into the state to be residents is the fact that there are that number of programs that have applied to the committee and have been approved by standards that are now essentially the equivalent of LCME accreditation standards. While I support the concept that's been expressed here, because I think it makes sense that if we vetted a student through the residency program, we ought not to lose the opportunity of having them become fellows. I would urge this group not to open up the possibility of the 12 Week Rule. I'll refer to Mr. Castle's comments about bylaws historically once the bylaws are open. Everything in the bylaws are open for discussion. And I would ask that this committee not accept the idea that this opens the bylaws, opens the possibility of a waiver to extend beyond the narrow focus that this has been presented.

Comment. Did I understand that the proposal was not outright repeal of the rule? It's correct that you would need some accredited training, like a year of accredited training before your main completion of a core residency program.

Comment. It's more extensive than that. Because in order to assess quality, the completion of the core residency program means that the residents have achieved their milestones on an annual basis. They've received a summative evaluation. You have a whole package of assessments to judge that candidate on.

Comment. I understand. Thank you.

Comment. I liked the idea inherently because I believe you've gone through the entire residency program. I also feel in general that if you've been through that, you deserve the same options. I would still ask that this is something to have discussed among the Deans of all the medical schools before we were to vote.

Comment. What we had talked about is that you've either graduated or you will have graduated by the time the fellowship would start. So it wouldn't apply to somebody doing one year of training in a core program and then a fellowship and then going back and completing residency.

Comment. I have no opposition to having the Deans weigh in on this, because I do think it's inherently in the interest of the medical schools and the institutions to get the best candidates. We are the only state in the country that places this restriction on who is eligible for fellowships. We are essentially losing some very talented individuals to our neighbors.

There was a motion from the council and a second to that motion.

Comment – Marie Jane Massie. Greater New York and AMS has already worked with Rosanne and Bill on some draft language that would amend the regulation. If the council is recommending that the Deans then review it, then we would have something for them to look at. If this group wants to review that at the next council meeting, then that might be a good next step and work with whoever is the right designee from the Department of Health on the next step in that process.

Comment. am formally voicing greater New York's support of this amendment to the regulations.

Comment. If we're taking a vote, could I just ask that the record show that I've articulated the department says Education Department has no position at this time.

Comment – Mary Jane Massie. The council endorses the proposal pending approval by the dean's committee. That's the motion. It's been seconded by Mark. Council members, please vote by show of hands, all in favor. We're going to record that six members have voted in favor and one is abstaining.

V. Message from Outgoing Executive Director

Thomas Burke commented on his history with the council that began in 1991 and continues to present day. He noted people he has worked with through the years and notable accomplishments by the council during this time.

Congratulatory comments were made by Neil Calman, Jo Wiederhorn, and Mary Jane Massie.

VI. New Business, New Membership & Future Activities

No new business.

VII. Adjournment

Since there was no further business, the meeting was adjourned.