EXHIBIT B

Comments of Gordon W. Blackwell, Chairman
Blue Ribbon Committee on Medical Doctor Education

March 3, 1983

The task which you set for the Committee on Medical Doctor Education was at once difficult and important. Members of the Committee took our responsibility seriously. We approached our search for the truth as objectively as I believe was possible. We worked hard. It was a good Committee.

Dr. Cathcart Smith, the Committee's Vice-Chairman, and I, with the assistance of the Commission staff, identified Dr. Kenneth E. Penrod as the individual possessing the best combination of knowledge and experience to assist us in our study. We retained him and he was present to assist us from our very first meeting. Dr. Penrod currently directs programs in graduate medical education through community hospitals in the State of Florida. Dr. Penrod has taught physiology in medical schools at Boston University, Duke University, and Indiana University. He served for seven years as Assistant Dean of the Medical School at Duke University, for six years as Vice-President for Medical Affairs at West Virginia University, and for four years as Provost of the Indiana University Medical Center. For four years he was Vice-Chancellor for Medical and Health Sciences of the State University System of Florida before moving to his present position in 1974. His wide experience and insights into the complicated nature of medical education in a statewide setting have been invaluable to the Committee. Also, throughout his medical career, he has served on many medical school accreditation site visits for the Liaison Committee on Medical Education.

Commission staff Dr. John C. Sutusky and Diane K. Jones served the Committee with rare ability, dedication and much hard work.

Since there have already been efforts to discredit the Committee and its recommendations, let me tell you a little about our work. The Committee held seven meetings, usually for a full day. We sought information and ideas from

all those in the State whom we believed could be helpful. We heard everyone who asked to appear before the Committee. In all, 14 people spoke to the Committee, most leaving written materials. Each of us received previous studies and reports, articles, and materials prepared especially for the Committee, all of this making up a file several inches thick. On October 1 at my request I met with the President of the University of South Carolina and the Acting President of the Medical University of South Carolina. My purpose was to tell them together that we would be pleased to receive any materials they might wish us to have, especially their ideas on how the two medical schools might more closely coordinate their programs. Later the Presidents of both institutions spoke before the Committee. My point is that we have tried to cast our net widely to secure as much information and as many diverse ideas bearing on our task as we possibly could. Full minutes with attached materials for each meeting are on file in the CHE office.

The consultant and CHE staff visited the campuses of the two medical schools on three occasions and spent approximately the same amount of time on each campus. The consultant, CHE staff, the Vice-Chairman, and Chairman of the Committee arranged a meeting with staff of the VA Hospital in Columbia and toured the facilities being renovated by the VA for use by the USC Medical School.

I believe the report of the Committee will speak for itself, though the consultant, Dr. Penrod, Dr. Sutusky of the CHE staff, and I are here to answer any questions you may have.

You will note that an Executive Summary of only about four pages is presented at the beginning of the report. Here you will find a concise listing of our main findings and recommendations. Their explanation and substantiation are given in the body of the report.

Addenda to the report include positions held by one or more of the Committee members which may be at variance with recommendations agreed to by the majority. Each such addendum includes the names of Committee members supporting that particular position. Some addenda may not have been received in time to be included as a part of the report today but will be mailed to each of you as they become available.

I shall not take your time to read the Executive Summary. While we believe that each of our findings and recommendations is significant, I should like to single out only three which may be of particular concern to you at this time.

The first deals with the number of physicians which South Carolina should have in 1990. At the beginning of our work we devoted much time to discussing projections based on effective demand for physicians and those based on need for medical care. We came out somewhere between the two, saying that the State does need to increase the number of physicians per 100,000 population. We also concluded that there will be a net increase of about 1100 physicians in the State between 1982 and 1990, assuming (1) continuation of the present volume of undergraduate and graduate medical education in the State, and (2) continuation of the present rate of migration of physicians into the State. Rather than this giving the State a surplus of 879 physicians as one study predicts, we believe the number of physicians by 1990 will be about right to meet the increased demand for medical care that should, and we believe will, develop. To attack the problem of maldistribution of physicians in the State, we recommend that a formal program be established and financed to recruit, place, and retain physicians in needed specialties and underserved localities as has already been done in six other southern states.

The second matter I would mention is our recommendation that no more than approximately 200 South Carolinians should be enrolled each year in the entering class of the medical schools of the State. This conclusion was reached by the committee, almost unanimously, I might add, on the basis of experience throughout the country which shows that the risk of failure increases significantly when many more than fifty percent of the applicant pool is enrolled in medical school. For the year 1982-83 a total of 54.5 percent of the applicant pool of South Carolinians were enrolled in some medical school, 196 in South Carolina and 11 elsewhere. Over the last six years the number of South Carolinians enrolling in medical schools out of the State has ranged from 11 to 33. In keeping with national trends, the size of the South Carolina applicant pool has decreased from 533 in 1977-78 to 387 in 1982-83. In that last year only four other states admitted a higher percentage of applicants: Kansas 60 percent, Rhode Island 59 percent, South Dakota 59 percent, and Wyoming 58 percent. The national average that year was 47 percent as contrasted with South Carolina's 54.5 percent. Furthermore, as measured by the national Medical College Admissions Test (MCAT), the South Carolina applicant pool ranks noticeably below the national average. Unless and until the South Carolina applicant pool can be significantly increased in size and quality, the limitation of about 200 entering South Carolina medical students is necessary and requires reconsideration of the enrollment plans of the two medical schools. The Committee urges that in no way should this limitation inhibit efforts to prepare, recruit, enroll, and graduate more black students. We do not recommend admitting more out-of-state applicants since experience shows that few of these would eventually practice in the State.

Finally, I get to the most difficult part of the Committee's charge which was to consider possible reorganization of medical education in the State.

In this regard 14 of us recommend that the two medical schools be merged, while seven do not agree. We state that the administration of the merged school should be responsible for eliminating needless duplication and assuring the most academically effective and efficient use of physical and personnel resources in all its programs. We suggest that one way this might be accomplished would be to place the first two years of largely basic science instruction at one of the institutions, with the students in the third and fourth years split about equally between two clinical centers, one in Columbia and one in Charleston. In our opinion there is no way in which a merged school with at least 200 entering students could handle the clinical instruction without extensive use of the hospitals in Columbia, as well as the community teaching hospitals throughout the State. Under our proposal even more students would receive clinical instruction in the VA Hospital in Columbia and the fine facilities provided there would serve as headquarters for the Clinical Center. I might add that members of the Consortium of Community Teaching Hospitals favor merger. Rough estimates indicate that a merged school could result in a saving of more than $5 million when fully phased in by 1985-86. Looking ahead 20 years, having one school rather than two competing with each other for national prestige would surely save many times this amount annually.

I hope you will not be too disappointed that we felt it unwise to attempt to recommend a detailed administrative model for a merged school. Reports that we dodged this issue because of pressures brought to bear on individual Committee members are erroneous in my opinion. For one thing we were already past our suggested deadline. For another we would have required considerably more budget for the in-depth studies at each institution which will be needed to come up with the most effective and efficient plan for organization and management. Finally, it is true that there were vested interests represented

on the Committee and understandably so. Should the Commission decide to accept our recommendation of merger, we believe experienced medical school administrators from outside the State should be employed to advise the Commission and the Legislature on this difficult and complicated matter.