I. Approval of Minutes (September 20, 2012)  

II. Health Sciences Division Update:  

A. Vidant Health Update – Dr. David Herman  
B. College of Allied Health Sciences Update – Dr. Stephen Thomas  
C. Health Sciences Update – Dr. Phyllis Horns  
D. Brody School of Medicine Update  
   1. BSOM Update – Dr. Paul Cunningham  
   2. LCME Update – Dr. Paul Cunningham  
   3. Affiliation Agreement Update – Dr. Benson  
   4. ECU Physicians FY2012 Year End Update – Mr. Jowers  

E. Closed Session

III. Health Sciences Informational Updates  

A. Brody School of Medicine  
B. College of Nursing  
C. School of Dental Medicine  
D. Laupus Health Sciences Library
Health Sciences Committee  
ECU Board of Trustees  
September 20, 2012  
1:30 p.m.  
Mendenhall Student Center 

Board Members Present: 

Deborah Davis  
Bobby Owens  
Danny Scott  

Others Present: 

Libby Baxley  
Nick Benson  
Paul Cunningham  
Glen Gilbert  
Phyllis Horns (via phone)  
Ron Mitchelson  
Kenneth Steinweg  
Gary Vanderpool  
Lisa Clough  

Recorder: Christy Daniels  

Call to Order and Approval of Minutes: 

Ms. Davis called the meeting to order at 1:30 p.m. Ms. Davis read the conflict of interest statement required by the State Government Ethics Act. No conflicts were identified. The minutes of July 19, 2012 were approved. 

Dr. Horns shared from the Division: 

The School of Dental Medicine moved into Ross Hall last week. The Ross Hall Dedication and Opening Celebration will be on Friday, October 12, at 2:00 p.m. Board members will receive an invitation (this is during Homecoming weekend). Fifty-two new students began this fall semester. The school’s 104 students represent 50 NC counties. The Ahoskie Community Service Learning Center is open and patients are being seen by dentists and residents. The Elizabeth City Community Service Learning Center is scheduled to open December 2012. The School of Dental Medicine is continuing to hire faculty and staff to meet the growing needs of the school. They currently have 96 faculty, staff, and administrators.
Health Sciences Division programs continue to be very competitive. Over 60% of the graduate applications are in the areas of Health Sciences. Performance of graduates on licensure exams continues to be strong. The College of Nursing’s request for authorization to establish the DNP program will go to the UNC Board of Governors in October.

The Laupus Library is working with Joyner Library as a result of the PPC recommendations to streamline operations. Realignment of technical services between the two libraries has begun and they are working to map out a strategic planning process with the assistance of outside consultants.

Additional college/school informational updates were included in the Health Sciences Committee packets.

**BSOM Update:**

Dr. Kenneth Steinweg, Chair of Family Medicine, gave an overview of the history of the Family Medicine Department and its current services. Patient care includes four clinical sites with over 80,000 patient visits a year. The new Monk Geriatric Center is the largest provider of nursing home care in the county. The BSOM is ranked the #1 medical school in the nation for percentage of medical school graduates who enter Family Medicine programs.

Dr. Baxley gave an update on the LCME accreditation. BSOM administrators met with the LCME Co-Secretariats in August and they were very pleased with their work and the BSOM is positioned to be in good shape. Eighty new students began this fall and they represent 24 different undergraduate schools.

Dr. Cunningham announced that Dr. Eleanor Harris has been appointed the new Department Chair of Radiation Oncology.

Dr. Benson gave an update on the work of the Affiliation Agreement between the BSOM and Vidant Medical. A draft of the agreement will come to the HS Committee at either the November or February meeting and eventually to the full Board for approval. The current agreement expires in 2014.

Mr. Jowers reported on ECU Physicians financial performance as of August 2012 FYTD. There has been a huge growth in charges and collections. Predicted a $0.4 loss, but actual for FYTD was $1.0M profit.

With no further business, the meeting adjourned at 3:00 p.m.
WHEREAS the parties, on December 17, 1975, entered into an Affiliation Agreement which expired in December 1995; and

WHEREAS the parties, on October 14, 1994, agreed to amend the previous agreement and renew it with changes effective January 1, 1995; and

WHEREAS an Affiliation Agreement between the Brody School of Medicine at East Carolina University (BSOM) (the School of Medicine) and Pitt County Memorial Hospital, dba Vidant Medical Center (VMC) (the Hospital) will continue to provide for the utilization of VMC as the primary teaching hospital of the School of Medicine, and will thereby render unnecessary the construction and operation of a separate State-owned teaching hospital with attendant duplication of facilities and services; and

WHEREAS Vidant Medical Center (VMC) and the Brody School of Medicine (BSOM) each recognize that VMC benefits from an affiliation with BSOM through the enrichment of its medical education, research, and other related programs and the care of certain of its patients; and BSOM and VMC each recognize that East Carolina University and its BSOM benefit from an affiliation with VMC by having available for their faculty and medical students opportunities for clinical education, research, patient care, and other related activities afforded by VMC, its medical education programs, and facilities; and

Whereas the majority of the physicians on the VMC medical staff consist of physicians who have faculty appointments from BSOM and a majority of all hospital admissions are made by physicians who are faculty members; and

WHEREAS an Affiliation between the BSOM and VMC will continue to most advantageously utilize their combined facilities, professional staff and other resources to effect their common concern for excellence in community service, patient care, medical education and research for the residents of Pitt County, other counties in eastern North Carolina and the State of North Carolina; and

WHEREAS the principles of a primary Affiliation of the two parties have in the past been jointly developed and approved by representatives of the parties involved; and

WHEREAS expanded facilities which may be necessitated by the Affiliation Agreement will permit continuation of the present Hospital policy of providing for the hospital health care needs of Pitt County residents while expanding the availability of services to the regions to be served by the Hospital; and

WHEREAS it is the objective of both parties that the Affiliation Agreement be so constructed as to comply with the standards and regulations of the reviewing and accrediting agencies involved; and
WHEREAS the parties to this agreement from time to time have entered into leases, contracts and/or agreements outside this Affiliation Agreement which do not violate the spirit of this agreement,

Now, therefore, this agreement is made and entered into this ___14th day of _________, October, 1994, by and between the Board of Trustees of VMC, the Board of Commissioners of Pitt County, the Board of Trustees of East Carolina University, and the Board of Governors of the University of North Carolina, as follows:

I. AREAS OF RESPONSIBILITY
   A. The BSOM shall be operated as a reputable and accredited school of medicine as prescribed by the laws of the State of North Carolina and the requirements of the Liaison Committee on Medical Education (LCME) of the American Association of Medical Colleges and the American Medical Association. The Board of Governors of the University of North Carolina (UNC) shall retain for its facilities all jurisdictional powers incident to separate ownership. The operation of this Agreement as it affects the School of Medicine shall be consistent with the policies of the Board of Trustees of East Carolina University (ECU) pursuant to the Board's authority under the laws of North Carolina and the Code of UNC and policies and regulations adopted by the Board of Governors of UNC pursuant to its authority under the Constitution and laws of the State of North Carolina.
   B. The Hospital Board shall retain for its facilities all jurisdictional powers incident to separate ownership, including the powers to determine general and fiscal policies and to appoint its administrative officers and other personnel, under terms of subsequent paragraphs of this agreement. Teaching and research facilities which are provided by the Hospital Board shall be fully integrated with the program of the School of Medicine. The Hospital Board is not to be understood as intending, and neither is it the intent of this Agreement, to obligate the Hospital to engage in any activities, research or otherwise, beyond those required for accreditation of the Hospital and the School of Medicine, and neither is it the present intent of the Hospital Board to undertake activities, research or otherwise, which are properly the responsibility of the School of Medicine.
   C. The Hospital Board retains final jurisdiction over the administration and the supervision of its facilities and over admission of patients and assignments of beds to them, consistent with the service purpose of the Hospital and the educational program of the School of Medicine. The VMC Board shall seek counsel and advice from the Dean of the School of Medicine when the exercise of such jurisdiction may affects the programs of teaching and research.
   D. Educational programs and research projects, conducted solely by and in the School of Medicine shall remain the responsibility of the School of Medicine.
   E. The School and the Hospital shall collaborate on any education, research or service programs that serve the mission of both institutions if the Dean of the School of Medicine and the President of the Hospital, or their respective delegates, agree to do so. Where applicable, a separate agreement will be formalized for such a program. Both institutions value the products of scientific investigation, including the creation of new knowledge applicable to the healthcare of patients, and will collaborate on such programs as agreed upon. Other programs of education, research and service within VMC shall remain the responsibility of the sponsoring institution. The parties may from time to time jointly engage in, and apply their resources to support, collaborative healthcare delivery arrangements with each other outside this Affiliation Agreement.
which do not violate the spirit of this agreement.

II. RIGHTS AND PRIVILEGES OF PHYSICIANS AND DENTISTS

A. The rights and privileges of all physicians and dentists on the Hospital medical staff shall be maintained consistent with accreditation standards and requirements for the Hospital and the School of Medicine and may not be withdrawn arbitrarily. The Board of Trustees of the Hospital shall maintain the authority to appoint the Hospital medical staff and delineate privileges after consultation with the medical staff.

B. The following terminology shall apply when various physician groups are referred to in this Affiliation Agreement:

1. The Medical Staff: All physicians and dentists who have been admitted to VMC medical staff membership according to the VMC medical staff bylaws.

2. Medical School-Based Faculty: Members of the BSOM faculty who are employed or contracted by the medical school either full or part-time.

3. Community-Based Faculty: Members of the medical staff who are not employed by the medical school, practice in the community and have appointments to the medical school faculty.

4. Non-Faculty Physicians: Members of the medical staff who do not have clinical appointments to the medical school faculty.

III. ADMINISTRATION

A. The Board of Trustees of the Hospital shall administer the Hospital so as to meet accreditation standards for the Hospital and for the School of Medicine’s educational programs.

B. VMC will be governed by a 20-member Board of Trustees. The County will appoint 11 or 55% of the governing body of the Corporation, (at least one of whom shall be a Pitt County physician). The UNC Board of Governors will appoint the remaining 9 seats or 45% of the governing body of the Corporation. Of these 9, one member will be appointed from a slate of four persons nominated by a nominating committee composed only of trustees appointed by the UNC Board of Governors. Neither the County nor UNC Board of Governors shall remove any of their appointed Trustees except for cause.

C. The Executive Committee of the Board of Trustees of the Hospital shall consist of nine members including the Chairman, Vice Chairman, Secretary, and six members elected by the Board of Trustees from the at large membership in a manner such that a total of five members of the Executive Committee are members of the Board appointed by the County Commissioners and a total of four members of the Executive Committee are members of the Board appointed by the Board of Governors of UNC.

D. For appointments by the Board of Governors of UNC (UNC Board), the Chancellor of East Carolina University and the Chief Executive Officer of Vidant Health, or their designees, will develop a slate of candidates for appointments and reappointments to present to the UNC Board as a joint recommendation for appointment to the VMC Board. These recommendations will be based on agreed upon competencies of the candidates as needed for the proper knowledge, expertise and function of the VMC Board. The submission of recommendations to the UNC Board will be in the form of a letter, with the letterhead consisting of the identity of each entity, jointly signed by the Chancellor and the Chief Executive Officer. In the event that
agreement on candidates cannot be reached, separate letters may be sent by the respective parties, with proper notification of the intent to do so. This process does not apply to seat five, as the process for appointment to this seat is established within the Transfer Agreement and may not be modified outside of that agreement.

IV. FINANCIAL RESPONSIBILITY
Expenses incurred for the operation of the facilities of the Hospital shall be paid by the Hospital. Expenses incurred for the operation of the School of Medicine shall be paid by ECU. However, nothing in this paragraph shall prohibit subsequent agreements, subject to the legal powers and limitations of the parties, for the joint employment of personnel and for the pro rata apportionment of salaries thereof or for the pro rata apportionment of other related costs and expenditures. Such agreements will be agreed to by the Dean of the School of Medicine and the President of the Hospital on these or other budgetary matters.

V. PATIENTS
Each patient admitted to a hospital service shall be available for teaching programs unless the attending physician or dentist, the patient, the guardian, or in the event of patient incapacity, the person authorized to consent to care specifies otherwise.

VI. MEDICAL SCHOOL-BASED FACULTY: APPOINTMENT, RECRUITMENT, PRIVILEGES
A. Appointment to the faculty shall be the responsibility of the School of Medicine, subject to the policies and regulations of ECU and of the Board of Governors of UNC.
B. Each search committee for a chair of a clinical department at the School of Medicine shall include unrestricted representation from the VMC President or designee and Community-Based Faculty relevant to the department.

VII. CHIEF OF SERVICE
A. The chairperson of a clinical department in the School of Medicine, or such other person as the Dean of the School of Medicine may designate, and who is confirmed by the President of VMC, shall be appointed by the Hospital Board as the Chief of the corresponding hospital service. The Dean of the School of Medicine and the President of the Hospital will define a process wherein the President will provide input on the annual evaluation of each Chief of Service based on performance criteria defined in a contractual agreement outlining the work of the Chief of Service. Recognition for outstanding performance or failure to fulfill the performance criteria as specified in the contract will be addressed by specific actions in the contract.
B. Each Chief of Service will be responsible for providing a mechanism for representation from all members of the service in developing patient care policies of the service.

VIII. MEDICAL STUDENT AND HOUSE STAFF GRADUATE MEDICAL EDUCATIONAL PROGRAMS
A. Medical student educational programs within the Hospital shall conform to the requirements of the Liaison Committee for Medical Education (LCME). The Chairman of an academic clinical department shall be responsible for medical education programs within that department within the Hospital. Medical student participation in patient care
shall be supervised by members of the Medical School-Based Faculty and Community-Based Faculty as agreed to by the Hospital and the medical school. The medical education programs of BSOM and VMC will assure that the learning environment promotes the development of explicit and appropriate professional attributes in its medical students and residents. BSOM and VMC mutually recognize that the learning environment includes both formal learning activities, and the attitudes, values and informal lessons conveyed by individuals who interact with the medical students and residents. When a medical student is exposed to an infectious, environmental, or other occupational hazard during the course of his/her clinical experience at VMC, initial evaluation and treatment will be shared by BSOM and VMC as set forth in the respective institution’s applicable occupational hazard and exposure plans.

B. VMC and BSOM accept the joint responsibility for developing and administering all residency and other graduate medical education (GME) programs accredited by the Accreditation Council for Graduate Medical Education (ACGME) or other national accrediting agencies, and unaccredited programs as jointly approved by the Dean of the BSOM and the President of VMC. GME programs shall be conducted in accordance with the requirements of the accrediting body and the GME Committee. The Chair of an academic clinical department sponsoring any GME program shall maintain management responsibility for the conduct of these programs unless otherwise directed by the president of VMC and the Dean of BSOM acting jointly.

C. A Graduate Medical Education Committee shall have the responsibility for advising on and monitoring all aspects of residency education. This committee is responsible to the Executive Committee of the Medical Staff of VMC for all medical staff issues related to these trainees. In all other issues, the GME Committee is responsible to the Dean of the BSOM and the President of VMC.

D. The President of VMC and the Dean of the BSOM shall jointly appoint a BSOM faculty member to be the Director of GME in the hospital and the Associate Dean for GME in the school. This person shall be the Designated Institutional Official for the ACGME and chair the GME Committee.

IX. RESEARCH
A. The School of Medicine and Hospital shall encourage the development of research programs to advance medical knowledge, to support the undergraduate and graduate educational programs, and to contribute to the recruiting of an outstanding faculty.
B. All proposed research projects within the Hospital shall conform with federal, state, and other governmental regulations, and be approved by the appropriate Hospital committees.

X. EXPANSION OF TEACHING FACILITIES AND SERVICES
The Hospital and the School of Medicine shall consult with the other regarding proposed expansion and/or renovation plans in order to provide adequate facilities and services for academic and clinical functions.

XI. JOINT POLICY COMMITTEE
In order to administer equitably the provisions of this Affiliation Agreement, there shall be established a Joint Policy Committee, hereinafter referred to as the “Committee”. It shall consist of ten (10) members:
1. The chair of the VMC Board of Trustees
2. The President of VMC
3. One appointed by the chair of the VMC Board of Trustees
4. One appointed by the Pitt County Commissioners
5. The Chief of the VMC Medical Staff
6. The Past Chief of the VMC Medical Staff
7. The Dean of the BSOM
8. The Vice Chancellor for Administration and Finance of ECU
9. and 10. Two appointed by the Chancellor of ECU

The chairperson of the committee shall hold office for one (1) year and be the Past Chief of the VMC Medical Staff.

B. Its duties shall include:
   1. Review of this Agreement, at least annually, to assess its operating effectiveness and to ascertain how, if at all, the Agreement may be improved to the satisfaction and mutual benefit of the parties involved.
   2. Recommendation of amendments to this Agreement.
   3. At the request of the parties, review and make recommendations for solving problems related to the mutual programs of research, teaching, patient care and community services.
   4. Consideration of such other matters which from time to time arise and which are of common concern to both parties.
   5. In the event that the Joint Policy Committee cannot resolve differences, the issue shall be referred for negotiation between the Vice Chancellor for Health Sciences of ECU and the Chief Executive Officer of Vidant Health.

C. Appointments to the Committee shall be for three year terms except those who serve by reason of the position they hold. Any member of the Committee may be reappointed at the discretion of the party making the original appointment. A member may be removed only by the appointing party. In the event of removal, death, or resignation of a member, a successor shall be selected by the appointing party.

D. The Committee shall meet at any time at the request of either the School of Medicine or the Hospital. Such a request shall be submitted in writing to the Chairperson of the Committee. Notice of the time and place of the meeting shall be given at least ten days in advance. Said meeting shall be held within a reasonable time from the date the request is submitted or not more than thirty days.

E. In the event it is impossible for any member to be present at a meeting so called, the appointing party may designate an alternate to attend the meeting.

XII. TERMINATION OR AMENDMENT OF THE AGREEMENT
A. The parties of this Affiliation Agreement acknowledge that the success of the combined program of medical training and patient care can only be achieved through faithful communication and sympathetic cooperation between the Dean of the School of Medicine and its faculty, and the President of the Hospital and its medical staff, and the Board of Trustees of the Hospital, the Board of Commissioners of Pitt County, the Board of Trustees of ECU, and the Board of Governors of UNC.

B. This Agreement shall extend for a period of twenty years from its effective date (the “Initial Term”). It may be terminated prior to the conclusion of the twenty year period only upon mutual consent of the parties. In such an instance, a period of four years shall be
allowed to effect the termination unless a shorter period is established by mutual consent of the parties.

C. It is understood that this Agreement may be amended in writing at any time to include such provisions as are agreed upon by the parties.

D. In the event a Party 1) declares bankruptcy, 2) fails to comply with any Federal or State law that materially impairs its ability to perform its obligations under the Agreement or that materially and adversely affects the operation or regulatory compliance of another party after being notified in writing of a failure to comply, 3) loses any North Carolina, federal, or accreditation agency license or permit that materially impairs its ability to perform its obligations under the Agreement or that materially and adversely affects the operation or regulatory compliance of the other party, or 4) is excluded from participation in Government Programs, then this Agreement may be terminated immediately by written notice of termination given by either of the other Parties. Notwithstanding the foregoing, the party receiving notice of termination shall be allowed 30 days or such other time period as agreed upon by the parties to cure the deficiency.

E. If any party to this Agreement shall be guilty of a material breach of this Agreement other than any of those identified specifically above as a basis for immediate termination, then any of the other parties may cancel the Agreement at its option after written notice of the basis for termination and a reasonable opportunity to cure the breach, which shall be no less than one year.

F. A party shall have the right to terminate this Agreement in the event that the other party merges with a third party and is not the surviving party of such merger or otherwise undergoes a change of control (i.e., a material change in fundamental purposes; a new appointing authority for members of its board of trustees or directors; or a change in majority of the persons on its board of trustees or directors other than in the ordinary course of business pursuant to the bylaws in effect as of the effective date of this Agreement). Each party agrees to provide written notice to the other no later than six (6) calendar months prior to the effective date of any such event if any of these specified events is planned or reasonably foreseeable, and the other party shall, within sixty (60) days of receipt of such notice, notify the other party in writing as to whether or not it elects to exercise its rights under this section. *This paragraph is still under review, including legal analysis, and may be subject to substantial revision.

G. It is further agreed that this Agreement, as it may be amended from time to time, shall be renewed for an additional period of twenty years beyond the Initial Term unless a party provides written notice to the other parties of intent not to renew at least one year prior to expiration of the Initial Term. Future provisions in this document required for accreditation purposes by either party should be addressed by addendum to this agreement or other contractual mechanisms rather than through termination and renegotiation of this agreement.

H. In the event that a party provides such timely notice of intent not to renew, the Agreement shall be extended for two years beyond the Initial Terms to allow for an orderly wind-up of the relationship of the parties. In the event of termination for any reason or non-renewal of this Agreement, the parties agree to cooperate in good faith in the wind-up of the activities that are the subject of this Agreement, including but not
limited to the wind-up of student clinical education or training insofar as feasible. The parties shall conduct the wind-up in a manner minimally disruptive to the parties’ programs and personnel and in compliance with accreditation requirements.

BOARD OF GOVERNORS OF
THE UNIVERSITY OF NORTH CAROLINA
By:_______________________________
Chairman

ATTEST:
________________________________
Secretary

BOARD OF TRUSTEES OF
PITT COUNTY MEMORIAL HOSPITAL
By:_______________________________
Chairman

ATTEST:
________________________________
Secretary

PITT COUNTY BOARD OF
COMMISSIONERS
By:_______________________________
Chairman

ATTEST:
________________________________
Secretary

BOARD OF TRUSTEES OF
EAST CAROLINA UNIVERSITY
By:_______________________________
Chairman

ATTEST:
________________________________
Secretary
ECU BOARD OF TRUSTEES
HEALTH SCIENCES COMMITTEE
November 29, 2012

CLOSED SESSION MOTION

I move that we go into Closed Session:

1. to prevent the disclosure of privileged information under N.C. General Statutes §126-22 to §126-30 (personnel information);

2. to consider the qualifications, competence, performance, character, fitness, or conditions of appointment of one or more prospective and/or current employees and/or to hear or investigate a complaint, charge, or grievance by or against one or more individual employees; and

3. to consult with an attorney to preserve the attorney-client privilege between the attorney and the Committee.
MISSION

East Carolina University School of Medicine was established in 1975 by the North Carolina General Assembly with a three-part charge:

- To educate primary care physicians
- To provide access to careers in medicine for minority and disadvantaged students
- To improve the health care services in eastern North Carolina

ABOUT THE SCHOOL

Named after the Brody Family of Kinston and Greenville, North Carolina, the Brody School of Medicine is a community-based school. In August 2012, 80 North Carolina residents matriculated into the four-year medical curriculum, composed of 40 men and 40 women. Plans to expand the medical student class size to 120 students are being developed. Over 100 learners are taking classes in the accredited Master of Public Health (MPH) program.

At the start of the Fall 2012 semester, 70 students are enrolled in one of six Ph.D. programs: Anatomy and Cell Biology, Biochemistry and Molecular Biology, Microbiology and Immunology, Physiology, Pharmacology and Toxicology, and the Interdisciplinary Doctoral Program in Biological Sciences (IDPBS) Biomedical Concentration. Additionally, 11 students are enrolled in the Master’s program in Biomedical Sciences, a program that enrolled its first students in Fall of 2011.

Over 360 physician faculty and other healthcare providers see patients in 20 different clinics, ranging from the new Family Medicine Center and Monk Geriatric Center to the Emergency Department of Vidant Medical Center, and totaling nearly 600,000 outpatient visits per year. The BSOM is the “health-care safety net” in eastern North Carolina providing more than $150 million per year in uncompensated care.

Patients needing hospitalization are admitted to Vidant Medical Center, the flagship 900-bed hospital for Vidant Health and one of four academic medical centers in North Carolina. The close partnership of the two institutions dates back to 1974, when the founders recognized the vital linkage between a community-based medical school and a robust teaching hospital. Today, the partnership encompasses numerous teaching, clinical, research and service programs bringing the latest advances in patient care to the community.

FAST FACTS

The BSOM is the least expensive public medical school for in-state students, according to a story published in U.S. News & World Report; tuition is just short of $12,000 a year – about $15,000 less than the national average for the academic year 2010-2011.

BSOM is the top medical school in the country for sending graduates into family medicine, according to the American Academy of Family Physicians. Based on a three-year average for the period ending October, 2011, 20.9% of the school’s graduates have entered an accredited family medicine residency program. That ranked ECU first in the country and marked the sixth consecutive year ECU has been ranked in the top 10. In March, 2012, 22% of BSOM’s graduating students matched with family medicine residency programs during the school’s annual Match Day. The 2012 Match resulted in 68.9% of the graduating students entering into primary care residency programs. The BSOM will continue to pursue our mission to serve the citizens of North Carolina with passion and purpose.

The 2012 edition of the Association of American Medical Colleges’ (AAMC) Medical Schools Mission Management Tool demonstrates that BSOM is setting the pace for the nation in several vital ways:

- BSOM ranks in the 100th% for graduating students who choose to practice Family Medicine,
- BSOM ranks in the 98th% for graduates who are African-American,
- When measuring the % of graduates that practice in underserved and rural areas, BSOM ranked in the 97th and the 96th% respectively,
- BSOM ranks in the 94th% for graduates that are practicing within NC and
- BSOM ranks in the 90th% for graduates who practice primary care (Family Medicine, Internal Medicine & Pediatrics).

The statistics, as measured by the AAMC, clearly indicate that BSOM continues to meet the tripartite mission set forth by the NC General Assembly in 1975.

BSOM continues to actively pursue funded research opportunities. In FY 2011/2012, 302 proposals were submitted for a total of $118,312,254. 30% of the proposals were attempts to gain federally funded research. During the same period, 168 proposals were funded at a total monetary award of $21,956,507. Of the 168 awards, 32 are federally funded awards. The value of the federal awards is in excess of $6.4 million; nearly 30% of the total dollars awarded in FY 11/12.

Since 1977, when the BSOM enrolled its first class, more than 1,900 physicians have graduated from the school and 60% of these graduates now practice in the state. A general distribution of the
The class of 2012 matched into residency programs. They graduated at the ECU Commencement in March, 2012, with 100% of the BSOM. The BSOM graduated 73 new physicians at the Spring graduation. All 80 incoming students have earned baccalaureate degrees, and 12 students have taken graduate coursework.

The BSOM graduated 73 new physicians at the Spring 2012 ECU Commencement. In March, 2012, 100% of the class of 2012 matched into residency programs. They will pursue residencies in 17 states; from Hawaii to Maine. Nearly 41% of the graduating class, 29 new physicians, are staying in North Carolina with 10 of those graduates remaining in Greenville to join residency programs co-sponsored by Vidant Medical Center and BSOM.

The Brody Medical Scholarship is North Carolina's most distinguished medical scholarship. Each year, three outstanding applicants to the Brody School of Medicine are invited to become Brody Scholars. This award provides full tuition and fees and most living expenses for four years of medical school, allowing scholars to choose a medical specialty without worry of significant debt after graduation. Since the program began in 1983, Brody scholars have continued to succeed as compassionate healers and community leaders.

THE FACULTY

Fifty physicians from the Brody School of Medicine have been chosen by their peers for inclusion in the 2012-2013 “Best Doctors in America” list. The annual list is compiled by Best Doctors Inc., a Boston-based group that surveys more than 30,000 physicians across the United States who previously has been included in the listing asking whom they would choose to treat themselves or their families. Approximately 3 percent of the physicians who practice in North Carolina make the annual list. The ECU physicians on the list are Dr. William A. Burke, dermatology; Drs. Jon Firnhaber, Susan Keen, Greg W. Knapp, Lars C. Larsen, Tae Joon Lee, Gary I. Levine, Kenneth Steinweg and Ricky Watson, family medicine; Drs. Paul P. Cook and Keith M. Ramsey, infectious diseases; Drs. Andy Brinn, David Goff and Dale A. Newton, pediatrics and internal medicine; Drs. Mary Jane Barchman and Paul Bolin, nephrology; Drs. Raymond Dombroski and Edward R. Newton, obstetrics and gynecology; Drs. David Hannon and Charlie J. Sang Jr., pediatric cardiology; Drs. Glenn Harris, William E. Novotny and Ronald M. Perkin, pediatric critical care. Also listed are Dr. Michael Reichel, pediatric developmental and behavioral problems; Dr. David N. Collier, pediatric obesity; Dr. Daniel P. Moore, rehabilitation and physical medicine, Dr. Eleanor Harris, radiation oncology; Dr. Elaine Cabinum-Foeller, pediatric abuse; Dr. Diana J. Antonacci, John Diamond and Kaye L. physicians indicates that a majority of the graduates reside in the East and the Piedmont.

THE STUDENTS

The Class of 2016 is comprised of 80 students with an average age of 24 (range 21-36). All are North Carolina residents, and they represent 25 counties within the state. All 80 incoming students have earned baccalaureate degrees, and 12 students have also taken graduate level coursework.

THE FACULTY

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THE FACULTY

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ECU Physicians, the faculty practice of the Brody School of Medicine at East Carolina University, proudly recognizes the physicians from our practice featured in 2012–2013 Best Doctors in America.

Wendy S. Biggs, MD; Ashley D. Bieck, MPA; Philip W. Crosley, MBA; Stanley M. Kozakowski, MD

BACKGROUND: This study reports on the number of graduates entering family medicine residencies in 2011 from allopathic, osteopathic, and international medical schools. Allopathic graduate data come from medical school registrars or the American Medical Association Masterfile. The 2012 family medicine residency program director census, with a response rate of 100%, verified residents who entered training July 2011 from all medical schools. Approximately 8.4% allopathic medical school’s graduates of the 17,478 graduates (July 2010 to June 2011) were first-year family medicine residents in 2011, compared with 8.0% in 2010 and 7.5% in 2008. The percent of medical school graduates entering family medicine from each of the allopathic schools was calculated and averaged over 3 years to diminish 1-year fluctuations. Allopathic medical schools’ 3-year average percentage of graduates who entered family medicine residency programs in 2011 ranged from 0.6% to 21.4%. Compared to 2010, osteopathic graduates in Accreditation Council for Graduate Medical Education-accredited family medicine residencies (21.5%) increased 2.8% from 2010, whereas international medical graduates (32.1%) decreased 3.4%. An increasing trend is seen in the number of allopathic graduates entering family medicine residencies. Osteopathic and international graduates’ entry to residency appears inversely related. As medical schools emphasize social accountability to improve the health of communities, higher family medicine graduation rates may occur. Initiatives in medical school admissions may increase the number of medical students more likely to select family medicine careers.

This is the 31st national study conducted by the American Academy of Family Physicians (AAFP) to determine the percentage of graduates from each medical school entering family medicine residency programs. Although the 2011 National Resident Matching Program (NRMP) results demonstrated the highest number of US seniors choosing family medicine since 2002, the results substantiated medical students’ overall preference for subspecialties. Health care costs and outcomes are strongly linked to the availability of primary care physicians. Whereas the majority of internal medicine residents become hospitalists or enter subspecialty training and practice, almost all family physicians are generalists and provide first-access, comprehensive, continuity medical care. Family physicians, therefore, will be relied upon to provide the bulk of primary care, especially for adults, in the future. In addition, for older adults, family physicians distribute themselves more evenly across populations than general internists, addressing the maldistribution of physicians favoring urban/suburban over rural areas and are key access points for medical care in rural areas.

According to the 20th Council on Graduate Medical Education (COGME) report “Advancing Primary Care,”” a substantial shortage of primary care physicians exists in the United States due to insufficient production and suggests that a number of factors, such as compensation, practice environment, and medical school experiences, contribute to the lower entry rate of medical students into primary care. Data here demonstrate differences in family medicine residency entry rate by region and medical school organizational structure. Promotion of family medicine to US medical students is crucial for the future of the US health care system.

From the Division of Medical Education, American Academy of Family Physicians, Lenwood, KS.
Methods

This is the 31st national study conducted by the AAFP that reports retrospectively the percentage of graduates from allopathic and osteopathic medical schools who entered Accreditation Council for Graduate Medical Education (ACGME)-accredited family medicine residency programs. Since June 1972, the AAFP has annually performed a census of all residents in family medicine residency programs. Program directors listed all first-year residents and their medical schools, including the month and year of graduation. The residency program directors also verified the status of second- and third-year residents and the graduates originally reported in previous years. For the last 9 years, this census has been performed through an online survey. After all census forms were returned by program directors in June 2011, the medical school information was coded and keyed. A 100% response rate has always been achieved in this study.

To obtain percentages of graduates entering family medicine residency programs from each medical school, the AAFP contacted medical school registrars or used American Medical Association (AMA) masterfile data that reports graduates from each allopathic medical school based on a July 1, 2010, to June 30, 2011, graduation date. The percentages are reported as 3-year rolling averages. The AAFP also uses data from this reference to determine the type of medical school, public or private. For 15 years, the study has included graduates of colleges of osteopathic medicine and used the same methods outlined above. After the data were returned by the family medicine residency program directors, the registrars of colleges of osteopathic medicine were contacted to verify the graduation month and year of osteopathic physicians who were first-year residents in ACGME-accredited family medicine residency programs. The American Association of Colleges of Osteopathic Medicine provided estimates of the number of graduates from each college of osteopathic medicine.6

Results

Of the 3,435 first-year residents in 2011, 1,470 (42.8%) were identified as having graduated from US Liaison Committee on Medical Education (LCME)-accredited medical schools between July 2010 and June 2011 (Table 1). In addition, there were 125 first-year residents (3.6%) who graduated from US LCME-accredited medical schools outside the reporting period. Therefore, 46.4% (1,595/3,435) of all first-year family medicine residents in October 2011 graduated from US LCME-accredited medical schools, compared with 45.8% (1,520/3,319) in 2010.

Approximately one in five graduates of the University of Oregon Health and Sciences University (23.6%), University of North Dakota (21.8%), and East Carolina University (20.3%) was in a family medicine residency program as a first-year resident in 2011 (see complete list of "Number and Percentage of Medical School Graduates Who Were Family Medicine Residents, by US Medical School, 2011" at www.stfm.org/fammed_match.cfm). The University of Washington graduated the highest number of medical school graduates who chose family medicine residency programs (34), followed by Indiana University (30) and the University of Iowa (27). Of the 17,478 graduates of LCME-accredited medical schools between July 2010 and June 2011, 8.4% were family medicine residents in 2011.

The Mountain and the West North Central regions had the highest percentage of medical school graduates who were first-year family medicine residents in October 2011 (12.6% and 11.9%, respectively) (Table 2). (Also, see "Number and Percentage of Medical School Graduates Who Were Family Medicine Residents in 2011, by Census Region and State of Medical School" at www.stfm.org/fammed_match.cfm.) The New England (5.7%) and Middle Atlantic (5.4%) census regions reported the lowest percentages. Texas (101), California (90), New York (68), Illinois (77), Pennsylvania (77), and Ohio (75) produced the highest number of medical school graduates who entered family medicine residency programs.

A total of 739 graduates of American Osteopathic Association (AOA)-approved colleges of osteopathic medicine were first-year residents in ACGME-accredited family medicine residency programs (21.5%) in October 2011 (Table 1); however, not all of them completed their medical education in the previous year. Of the 4,159 graduates of colleges of osteopathic medicine between July 2010 and June 2011, 680 (19.8%) were in ACGME-accredited family medicine residency programs in October 2011 (see complete list of "Number and Percentage of Graduates

<table>
<thead>
<tr>
<th>Table 1: Number of First-year Family Medicine Residents in July 2011, by Type of Medical School</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number</strong></td>
</tr>
<tr>
<td>US medical school graduate, 7/10-6/11*</td>
</tr>
<tr>
<td>US medical school graduate, outside 7/10-6/11</td>
</tr>
<tr>
<td>Osteopathic school graduate, 7/10-6/11</td>
</tr>
<tr>
<td>Osteopathic school graduate, outside 7/10-6/11</td>
</tr>
<tr>
<td>International medical school graduate</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
</tr>
</tbody>
</table>

* Tables 2-4 relate to 1,470 residents who graduated within the time period.

Source: American Academy of Family Physicians
Table 2: Number and Percentage of LCME-Accredited Medical School Graduates Who Were Family Medicine Residents in 2011 by Census Region of Medical School

<table>
<thead>
<tr>
<th>Census Region</th>
<th>Number of Graduates July 2010 to June 2011</th>
<th>First-year Family Medicine Residents (#)</th>
<th>First-year Family Medicine Residents (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>East North Central</td>
<td>3,331</td>
<td>285</td>
<td>8.6</td>
</tr>
<tr>
<td>East South Central</td>
<td>986</td>
<td>89</td>
<td>9.0</td>
</tr>
<tr>
<td>Middle Atlantic</td>
<td>3,262</td>
<td>177</td>
<td>5.4</td>
</tr>
<tr>
<td>Mountain</td>
<td>522</td>
<td>66</td>
<td>12.6</td>
</tr>
<tr>
<td>New England</td>
<td>1,047</td>
<td>60</td>
<td>5.7</td>
</tr>
<tr>
<td>Pacific</td>
<td>1,423</td>
<td>155</td>
<td>10.9</td>
</tr>
<tr>
<td>South Atlantic</td>
<td>3,100</td>
<td>262</td>
<td>8.5</td>
</tr>
<tr>
<td>West North Central</td>
<td>1,434</td>
<td>171</td>
<td>11.9</td>
</tr>
<tr>
<td>West South Central</td>
<td>2,091</td>
<td>195</td>
<td>9.3</td>
</tr>
<tr>
<td>Puerto Rico</td>
<td>282</td>
<td>10</td>
<td>3.5</td>
</tr>
<tr>
<td>Total</td>
<td>17,478</td>
<td>1,470</td>
<td>8.4</td>
</tr>
</tbody>
</table>

of Colleges of Osteopathic Medicine Who Were Residents in ACGME-Accredited Family Medicine Residencies in 2011, by Osteopathic Medical College at [www.atfm.org/fammed_match.cfm](http://www.atfm.org/fammed_match.cfm). A total of 1,101 first-year family medicine residents (32.1%) in October 2011 were international medical graduates (Table 1), compared with 1,179 (35.5%) in 2010.

Approximately two in five of the US medical school graduates who entered a family medicine residency program in October 2011 stayed in the same state for their residency as their medical school (45.9%) (Table 3). Large proportions of graduates of the medical schools in South Dakota (87.5%), Mississippi (72.7%), Texas (72.6%) and California (72.5%) who entered a family medicine residency remained in the same state.

Medical school funding and structure may influence medical student choice of specialty. Graduates from the 78 publicly funded US allopathic medical schools were more likely to be family medicine residents than were graduates from the 48 privately funded medical schools (9.9% versus 6.0%) (Table 4). Medical schools with family medicine departments produce graduates who are more likely to enter family medicine residency programs than medical schools with other or no administrative structure in family medicine. All medical schools were ranked in descending order based on the average percentage of their graduates who entered family medicine residency programs in the prior 3 years (Table 5) (also see complete list of "Ranked Order of LCME-Accredited Medical Schools Based on the Last 3 Years' Average Percentage of Graduates Who Were Family Medicine Residents in 2011, by Type of Administrative Structure, 2011" at [www.atfm.org/fammed_match.cfm](http://www.atfm.org/fammed_match.cfm). In October 2011, 8.8% of all graduates of medical schools with departments or divisions of family medicine were family medicine residents (Table 6), compared to approximately 2.4% of graduates from the nine medical schools without departments or divisions of family medicine. The medical school with a center of family medicine (Columbia University) increased its graduates entering family medicine by tenfold, from 0.6% in 2010 to 6.7% (one graduate in 2010, nine in 2011).

**Discussion**

Increasing the supply of family physicians is the key to containing health care costs and improving access to health care for future generations of patients. In 2005–2006, the Association of American Medical Colleges (AAMC) and the Council on Graduate Medical Education (COGME) predicted physician shortages. Since then, we have witnessed simultaneous and dramatic increases in class size of existing allopathic and osteopathic medical schools and the creation of new schools. In June 2012, there were 18 new medical schools listed by Liaison Committee on Medical Education (LCME) as applicant (three), candidate (three), preliminary (seven) or provisional (five) status. The number of osteopathic medical schools increased from 19 in 2000 to 29 in 2011, with three more approved in 2012. Including branch campuses and remote teaching sites, osteopathic
### Table 3: Percent of 2010–2011 Medical School Graduates by State or Territory Who Entered a Family Medicine Residency Program in the Same State in 2011

<table>
<thead>
<tr>
<th>State of Medical School</th>
<th>% Entering Family Medicine Residency in the Same State</th>
<th>State of Medical School</th>
<th>% Entering Family Medicine Residency in the Same State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>50.0</td>
<td>Montana*</td>
<td>NA</td>
</tr>
<tr>
<td>Alaska *</td>
<td>NA</td>
<td>Nebraska</td>
<td>52.0</td>
</tr>
<tr>
<td>Arizona</td>
<td>35.8</td>
<td>Nevada</td>
<td>26.3</td>
</tr>
<tr>
<td>Arkansas</td>
<td>57.9</td>
<td>New Hampshire</td>
<td>0.0</td>
</tr>
<tr>
<td>California</td>
<td>72.5</td>
<td>New Jersey</td>
<td>45.5</td>
</tr>
<tr>
<td>Colorado</td>
<td>44.4</td>
<td>New Mexico</td>
<td>33.3</td>
</tr>
<tr>
<td>Connecticut</td>
<td>0.0</td>
<td>New York</td>
<td>43.0</td>
</tr>
<tr>
<td>Delaware</td>
<td>NA</td>
<td>North Carolina</td>
<td>47.9</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>0.0</td>
<td>North Dakota</td>
<td>58.3</td>
</tr>
<tr>
<td>Florida</td>
<td>40.8</td>
<td>Ohio</td>
<td>47.8</td>
</tr>
<tr>
<td>Georgia</td>
<td>34.4</td>
<td>Oklahoma</td>
<td>56.1</td>
</tr>
<tr>
<td>Hawaii</td>
<td>33.3</td>
<td>Oregon</td>
<td>36.0</td>
</tr>
<tr>
<td>Idaho *</td>
<td>NA</td>
<td>Pennsylvania</td>
<td>53.7</td>
</tr>
<tr>
<td>Illinois</td>
<td>43.0</td>
<td>Puerto Rico</td>
<td>10.0</td>
</tr>
<tr>
<td>Indiana</td>
<td>67.7</td>
<td>Rhode Island</td>
<td>44.4</td>
</tr>
<tr>
<td>Iowa</td>
<td>37.3</td>
<td>South Carolina</td>
<td>55.2</td>
</tr>
<tr>
<td>Kansas</td>
<td>34.8</td>
<td>South Dakota</td>
<td>87.5</td>
</tr>
<tr>
<td>Kentucky</td>
<td>35.9</td>
<td>Tennessee</td>
<td>26.4</td>
</tr>
<tr>
<td>Louisiana</td>
<td>55.4</td>
<td>Texas</td>
<td>72.6</td>
</tr>
<tr>
<td>Maine</td>
<td>32.3</td>
<td>Utah</td>
<td>47.1</td>
</tr>
<tr>
<td>Maryland</td>
<td>2.8</td>
<td>Vermont</td>
<td>0.0</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>35.1</td>
<td>Virginia</td>
<td>28.2</td>
</tr>
<tr>
<td>Michigan</td>
<td>54.2</td>
<td>Washington</td>
<td>51.4</td>
</tr>
<tr>
<td>Minnesota</td>
<td>69.0</td>
<td>West Virginia</td>
<td>33.3</td>
</tr>
<tr>
<td>Mississippi</td>
<td>72.7</td>
<td>Wisconsin</td>
<td>40.8</td>
</tr>
<tr>
<td>Missouri</td>
<td>26.2</td>
<td>Wyoming*</td>
<td>NA</td>
</tr>
<tr>
<td>OVERALL</td>
<td></td>
<td></td>
<td>45.9</td>
</tr>
</tbody>
</table>

*Alaska, Idaho, Montana, and Wyoming have no in-state medical school. Students from these states enter the University of Washington under the WWAMI agreement and are listed here as Not Applicable (NA).

Undergraduate medical education occurs in at least 94 locations. Historically, osteopathic schools have graduated a higher percentage of students entering family medicine than allopathic medical schools. One in five residents in ACGME-accredited family medicine residencies graduated from osteopathic medical schools (21.5%). Three new osteopathic schools graduated their first class in 2011. Their graduates entered ACGME-accredited family medicine residencies in rates similar to allopathic graduates and demonstrated the same geographic discrepancy: western schools graduated a higher percentage of students bound for family medicine than the eastern schools (A.T. Still University in Mesa, AZ—19.8%, Lincoln Memorial University Debusk College of Osteopathic Medicine in Tennessee—15.6% and Touro College of Osteopathic Medicine in New York—7.5%). The percentage of allopathic students from the Mountain and West North Central regions entering family medicine was twofold greater than that of the New England and Middle Atlantic regions (12.6% and 11.9% versus 5.7% and 5.4%). One potential explanation is western.
Table 4: Number and Percentage of Medical School Graduates Who Were Family Medicine Residents in 2011, by Type of Medical School

<table>
<thead>
<tr>
<th>Programs*</th>
<th>Number of Graduates July 2010 to June 2011*</th>
<th>Firstyear Family Medicine Residents **</th>
<th>Firstyear Family Medicine Residents %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public (78)</td>
<td>10,938</td>
<td>1,079</td>
<td>9.9</td>
</tr>
<tr>
<td>Private (48)</td>
<td>6,540</td>
<td>391</td>
<td>6.0</td>
</tr>
<tr>
<td>TOTAL (126)</td>
<td>17,478</td>
<td>1,470</td>
<td>8.4</td>
</tr>
</tbody>
</table>

** American Academy of Family Physicians. Annual Survey of Medical Schools.

Table 5: Top 20 Medical Schools Based on the Last 3 Years' Average Percentage of Graduates Who Were Family Medicine Residents in 2011, by Type of Administrative Structure

<table>
<thead>
<tr>
<th>Medical School</th>
<th>%</th>
<th>Administrative Structure</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Carolina University</td>
<td>21.4</td>
<td>Department</td>
</tr>
<tr>
<td>Oregon Health &amp; Sciences University</td>
<td>18.4</td>
<td>Department</td>
</tr>
<tr>
<td>North Dakota, University of</td>
<td>18.1</td>
<td>Department</td>
</tr>
<tr>
<td>Uniformed Services University</td>
<td>17.2</td>
<td>Department</td>
</tr>
<tr>
<td>Marshall University</td>
<td>16.8</td>
<td>Department</td>
</tr>
<tr>
<td>New Mexico, University of</td>
<td>16.2</td>
<td>Department</td>
</tr>
<tr>
<td>Iowa, University of</td>
<td>15.9</td>
<td>Department</td>
</tr>
<tr>
<td>Kansas, University of</td>
<td>15.4</td>
<td>Department</td>
</tr>
<tr>
<td>Washington, University of</td>
<td>15.3</td>
<td>Department</td>
</tr>
<tr>
<td>South Dakota, University of</td>
<td>15.2</td>
<td>Department</td>
</tr>
<tr>
<td>Arkansas, University of</td>
<td>15.1</td>
<td>Department</td>
</tr>
<tr>
<td>California, Davis, University of</td>
<td>14.3</td>
<td>Department</td>
</tr>
<tr>
<td>Utah, University of</td>
<td>14.3</td>
<td>Department</td>
</tr>
<tr>
<td>Nebraska, University of</td>
<td>14.2</td>
<td>Department</td>
</tr>
<tr>
<td>Texas A&amp;M University</td>
<td>14.2</td>
<td>Department</td>
</tr>
<tr>
<td>Missouri, Columbia, University of</td>
<td>13.8</td>
<td>Department</td>
</tr>
<tr>
<td>Massachusetts, University of</td>
<td>13.7</td>
<td>Department</td>
</tr>
<tr>
<td>Minnesota, University of</td>
<td>13.5</td>
<td>Department</td>
</tr>
<tr>
<td>Meharry Medical College</td>
<td>13.1</td>
<td>Department</td>
</tr>
<tr>
<td>Arizona, University of</td>
<td>12.8</td>
<td>Department</td>
</tr>
</tbody>
</table>

Medical schools may admit more students from rural backgrounds, and rural students are more likely to consider family medicine; however, many other factors may also influence this primary care production gap.13

Medical schools are increasingly being called upon to demonstrate "social responsibility," defined as "the obligation of [medical schools] to direct their education, research, and service activities toward addressing the priority health concerns of the community, region, and/or nation they have the mandate to serve."13 Medical schools should demonstrate how their graduates contribute to the quality, equity, relevance, and cost-effectiveness of health services.14 Some form of external measurement is necessary to validate a school's social accountability claims.15 For example, one ranking on "social mission" evaluated medical schools' ability to train physicians to care for the population as a whole, taking
into account the school's graduation rate of physicians who practice primary care, work in underserved areas, and represent the diversity of the population.16 The Medical Education Futures Study selected six medical schools that have demonstrated innovative approaches to teaching, modeling, and promoting their social mission. The synopsis of this research, the "Beyond Flexner Report," identified eight modalities medical schools may use to carry out effective social mission education: school mission, pipeline cultivation, school admissions, curriculum structure and content, location of clinical experience, debt management, mentoring/role-modeling, and postgraduate engagement.17

A medical school's explicit commitment to educate physicians who will pursue careers compatible with community needs appears to affect the career choices of its graduates,18 and establishing specific measurable outcomes related to career choice, both in primary care and subspecialty care, is a part of providing the right mix of providers to the community.

Creating more medical schools and increasing the number of matriculants without addressing family medicine graduate production, however, will not fulfill communities' needs for family physicians. Our data show that in 2011, all medical schools without a department or division of family medicine fell in the lowest quartile of family medicine graduates. In 2012, Mt. Sinai School of Medicine announced it will open a department of family medicine. It is hopeful this new department will help increase Mt. Sinai's family medicine graduating percentage higher than 2011's (2.5%). Our current data demonstrate that public medical schools graduate a higher percentage of future family physicians than private schools. All medical schools that receive public funding should be accountable to their stated mission, especially if it is to meet the health care access needs of their state. Our future surveys will substantiate if these new public medical schools follow through on their commitment to their social mission by graduating more family physicians.

Family medicine residencies have the capacity to accept an increased percentage of US allopathic and osteopathic graduates (at the cost of decreasing international medical graduates' entry into residencies). Medical schools, however, need to admit students who have a greater likelihood of committing to family medicine. Medical school admission policies should favor students more likely to enter primary care, such as the desire to serve the underserved, demonstrate altruism, and commit to social responsibility.12 The LCME states "The institution should establish focused, significant, and sustained programs to recruit and retain suitably diverse students."19 Students of racial/ethnic underrepresented minorities, women, older, or from a rural background are more likely to enter family medicine.20 Pre-baccalaureate programs aiding more students with these characteristics would likely increase a school's family medicine graduates.

As a means to assist in increasing diversity in medical schools, the Association of American Medical Colleges (AAMC) is championing the Holistic Review Project, encouraging the evaluation of medical school applicants in a wider context than using just a single or few factors. The AAMC has developed recommended protocols to help medical schools initiate holistic review practices and provided resources and tools for medical schools to implement these processes.19 The AAMC is also updating the Medical College Admissions Test (MCAT). The MCAT 2015 will add sections on psychological and social foundations of behavior, critical analysis, and reasoning skills.20 Pre-medical students with interests in topics important for community-based medicine and patient communication, such as psychology and sociology, may benefit from these changes. Ultimately, we hope the MCAT changes in addition to holistic review will re-emphasize the need for a broad-based undergraduate education, and also open the way for more underrepresented minority students, which may lead to a larger pool of medical students interested in entering family medicine.22

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Table 6: Number and Percentage of Medical School Graduates Who Were Family Medicine Residents in 2011, by Family Medicine Administrative Structure

<table>
<thead>
<tr>
<th>Administrative Structure</th>
<th>Number of Graduates July 2010 to June 2011*</th>
<th>First-year Family Medicine Residents (#**)</th>
<th>First-year Family Medicine Residents (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department or Division of FM (116)</td>
<td>18,214</td>
<td>1,434</td>
<td>8.8%</td>
</tr>
<tr>
<td>None (9)</td>
<td>1,130</td>
<td>27</td>
<td>2.4%</td>
</tr>
<tr>
<td>Center (1)</td>
<td>134</td>
<td>9</td>
<td>6.7%</td>
</tr>
<tr>
<td>TOTAL (128)</td>
<td>17,478</td>
<td>1,470</td>
<td>8.4%</td>
</tr>
</tbody>
</table>

** American Academy of Family Physicians. Annual Survey of Medical Schools.

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16. The Medical Education Futures Study selected six medical schools that have demonstrated innovative approaches to teaching, modeling, and promoting their social mission.
17. A medical school's explicit commitment to educate physicians who will pursue careers compatible with community needs appears to affect the career choices of its graduates, and establishing specific measurable outcomes related to career choice, both in primary care and subspecialty care, is a part of providing the right mix of providers to the community.
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19. The LCME states "The institution should establish focused, significant, and sustained programs to recruit and retain suitably diverse students." Students of racial/ethnic underrepresented minorities, women, older, or from a rural background are more likely to enter family medicine.
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24. Pre-medical students with interests in topics important for community-based medicine and patient communication, such as psychology and sociology, may benefit from these changes.
25. Ultimately, we hope the MCAT changes in addition to holistic review will re-emphasize the need for a broad-based undergraduate education, and also open the way for more underrepresented minority students, which may lead to a larger pool of medical students interested in entering family medicine.
Reporting graduates entering family medicine residencies is the only reliable measure of future physicians who will provide comprehensive, first-contact medical care. Medical schools often announce the number of graduates matching into pediatrics, internal medicine, and family medicine as their primary care production. Match Day and graduation statistics and percentages overestimate the number of physicians who will practice primary care because they do not accurately account for medical schools' graduates' future medical practice. Sixty percent of pediatric residents and more than 80% of internal medicine residents specialize; whereas, more than 90% of family medicine residents practice primary care.\footnote{Measuring primary care production 2 years after the completion of the initial residency (5 years after graduation for those entering internal medicine, pediatrics, and family medicine residencies) is a more accurate indicator of practicing primary care physicians and does not inflate or mislead the stakeholders of undergraduate medical education: the communities, the state governments, and the patients.}

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Conclusions
The family medicine residency survey conducted annually by the AAFP offers an important look into the composition of the first-year family medicine residents' class and the number of US medical students entering family medicine residencies. The percentage of US allopathic and osteopathic medical school graduates in family medicine residencies increased slightly in 2011; however, the percentage of US seniors choosing primary care careers still remains well below the nation's needs. Some medical schools are embracing their commitment to their social mission,\footnote{Health care policy, graduate medical education financing, and payment reform need to incentivize institutions to change their infrastructure that is currently contributing to the imbalance of specialists to generalists and the rural-urban maldistribution of physicians.\footnote{The AAFP believes that the nation is best served by an appropriately diverse and well-distributed physician workforce that resembles the diversity and distribution of the nation's communities. A sufficient family medicine workforce will be essential to provide effective, efficient, and equitable care for the nation. The percentage of US allopathic and osteopathic medical school graduates in family medicine residencies increased slightly in 2011; however, the percentage of US seniors choosing primary care careers still remains well below the nation's needs. Some medical schools are embracing their commitment to their social mission, and, as the public expects more accountability to their social mission, more medical schools will adopt changes in admission processes and curricula to promote their social mission. Health care policy, graduate medical education financing, and payment reform need to incentivize institutions to change their infrastructure that is currently contributing to the imbalance of specialists to generalists and the rural-urban maldistribution of physicians. The AAFP believes that the nation is best served by an appropriately diverse and well-distributed physician workforce that resembles the diversity and distribution of the nation's communities. A sufficient family medicine workforce will be essential to provide effective, efficient, and equitable care for the nation.\footnote{The AAFP believes that the nation is best served by an appropriately diverse and well-distributed physician workforce that resembles the diversity and distribution of the nation's communities. A sufficient family medicine workforce will be essential to provide effective, efficient, and equitable care for the nation.}} and, as the public expects more accountability to their social mission, more medical schools will adopt changes in admission processes and curricula to promote their social mission. Health care policy, graduate medical education financing, and payment reform need to incentivize institutions to change their infrastructure that is currently contributing to the imbalance of specialists to generalists and the rural-urban maldistribution of physicians.\footnote{The AAFP believes that the nation is best served by an appropriately diverse and well-distributed physician workforce that resembles the diversity and distribution of the nation's communities. A sufficient family medicine workforce will be essential to provide effective, efficient, and equitable care for the nation.\footnote{The AAFP believes that the nation is best served by an appropriately diverse and well-distributed physician workforce that resembles the diversity and distribution of the nation's communities. A sufficient family medicine workforce will be essential to provide effective, efficient, and equitable care for the nation.}}

References
November 4, 2012

Teaching Hospitals, Reliant on Clinical Faculty, Are Said to Be 'Cheapening' Faculty Titles

By Katherine Mangan

San Francisco

As pressure to generate clinical revenue mounts, academic medical centers are handing out faculty appointments to physicians who spend little time teaching or doing research, a development that both cheapens the value of an academic title and shortchanges medical students.

That assertion prompted a lively discussion here at the annual meeting of the Association of American Medical Colleges over the weekend. The meeting, which continues this week, has drawn more than 4,700 medical educators and health-policy experts from 27 countries, as well as a smattering of students.

In a session called "The Faculty of Tomorrow—Can the Definition of Faculty Keep Up With the Times?," panelists discussed how the role of faculty members in academic medical centers had shifted in recent years.

As the centers struggle with state budget cuts and expensive charity-care obligations, they have been pressuring professors to bring in more money from patient care, leaving them less time for teaching and research. Those pressures could increase under federal health-care reform, some medical educators say, because of declining government reimbursements for medical care.

Meanwhile, as medical schools acquire hospitals and physician practices to bolster their bottom lines, they’re handing out faculty titles to physicians who have little to do with the academic side of their mission, speakers said.

That trend has caused some resentment among professors who juggle research, teaching, and service, along with patient care.

But it’s also spawned confusion and frustration for some clinicians when their faculty roles aren’t clearly spelled out, and their chances of advancing through the academic ranks are slim, some medical educators here said.
"Second-Class Citizens"
Without publications or a national reputation, it’s hard to get promoted, said one audience member, Catherine R. Lucey, vice dean for education at the University of California at San Francisco’s School of Medicine.

"Getting that recognition is hard to do if your role is to remain on site and care for patients 40 to 60 hours a week," she said. "We have all these clinicians who are making money for us, and we treat them as second-class citizens. They’re being hired into a role that’s incompatible with success in the traditional promotion system."

Lois M. Nora, president and chief executive officer of the American Board of Medical Specialties, a nonprofit group that oversees physician certification in the United States, described a disconnect between what clinicians who were brought on as faculty members thought their role would be and what they ended up being evaluated on.

"Our faculty title has come to mean so many things that it essentially means nothing," said Dr. Nora, a former interim president and dean at the Commonwealth Medical College, a community-based medical school established in Scranton, Pa., in 2008.

Another panelist, Nicholas H. Benson, vice dean of East Carolina University’s Brody School of Medicine, asked the audience, "As others are brought into this employment model from private practice, is there at least a potential of cheapening or diluting that concept of faculty and what it really means?"

The answer, as far as he’s concerned, is yes. He said that unless there was an explicit expectation that faculty members would spend a certain amount of time teaching and doing research, the new generation of professors won’t be able to fill the shoes of the large numbers of medical faculty who will soon retire, leaving behind heavy teaching loads.
Give respect to teaching and put it back as the central role of faculty supported by research and service. Let clinicians do what they are trained to do—taking care of patients while providing clinical training to those in the health professions. Faculty cannot do it all but their central role ought to be teaching and distinct from the parallel tracks of clinical faculty and research faculty.
Lt. Col. Felicia Rivers shares insight on military return after deployment
To celebrate Veteran’s Day and to further our commitment to prepare students to care for members of the military and their families, Lt. Col. Felicia Rivers, PhD (US Army) presented her research, “US Army Nurses’ Reintegration and Homecoming After Deployment to Iraq and/or Afghanistan,” on Thursday, November 8, 2012. The event was jointly sponsored by the College of Nursing and the ECU Office of Engagement, Innovation and Economic Development. Lt. Col. Rivers also provides consultation to the College of Nursing taskforce to support the national Joining Forces campaign.

$1.098 million grant to expand online education and collaboration
Dr. Pam Reis, assistant professor in the Nurse-Midwifery MSN concentration, received a $1.098 million federal grant for students in nurse-midwifery, medicine and other health-related disciplines at East Carolina University to team up in a virtual clinic to improve women’s health. The three-year grant from the U.S. Department of Health and Human Services’ Health Resources and Services Administration is the largest in the College of Nursing’s history.

$648,148 Advanced Education Nursing Traineeship grant
Dr. Jana Pressler, associate dean for graduate programs and professor, received an Advanced Education Nursing Traineeship grant for $648,148 to enhance the recruitment and retention of Family Nurse Practitioner, Adult-Gerontology Nurse Practitioner and Nurse-Midwifery students. A primary component of the project is to increase the number of primary healthcare providers in rural and underserved populations in North Carolina. The grant is provided by the U.S. Department of Health and Human Services’ Health Resources and Services Administration.

College of Nursing Fall 2012 Enrollment
Total: 1271
508 Prelicensure BSN
165 RN-BSN
533 MSN
35 Post MSN
30 PhD
Ledyard E. Ross Hall
Approximately 600 guests attended the Dedication and Opening Celebration of Ross Hall on October 12. Event speakers included UNC President Tom Ross, Chancellor Steve Ballard, Vice Chancellor Phyllis Horns, and School of Dental Medicine Dean Greg Chadwick. Attendees enjoyed a beautiful fall day, a reception, a tour of the building, and an opportunity to speak with our students. A bronze plaque bearing Dr. Ledyard E. Ross’s likeness was unveiled; the plaque will be mounted in the east entrance to Ross Hall.

Students
Students in the class of 2015 are becoming familiar with Ross Hall clinical facilities with the target of seeing their first patients in January. The school’s first White Coat Ceremony, a rite of passage into the clinical phase of their education, will be held for this class on November 9. Students in the class of 2016 are learning dental morphology and enjoying the many hours they are spending in the technique lab. Interviews are currently underway to fill the 50 available spaces for students entering the class of 2017 next fall. All students enrolled in the School of Dental Medicine are N.C. residents.

Community Service Learning Centers
The School of Dental Medicine’s Community Service Learning Center (CSLC) in Ahoskie is in full operation. The patient schedules are full, and faculty dentists, post-graduate residents, and dental hygienists are seeing a full range of patients. Collaborative efforts with the Roanoke Chowan Community Health Center are also proving a win-win proposition for patients, providers, and the entire community.

The Elizabeth City CSLC will be completed in December and fully operational in January. The school will break ground on its Sylva and Lillington sites in December with openings expected at these CSLCs in July 2013. Other CSLCs will be constructed in Spruce Pine and Davidson County. The remaining four sites will be announced soon. Pre-doctoral students will begin their rotations treating patients in CSLCs in the summer of 2014.

Faculty/Staff Hiring
The SoDM currently employs 88 full-time employees in Ross Hall and at the Ahoskie CSLC. In anticipation of opening the clinical facilities in Ross Hall and additional CSLCs, the school will be hiring approximately 94 employees between now and the end of the fiscal year.
Greetings from Laupus Library

The Country Doctor Museum

Dr. Josephine Newell, founder of the CDM, will be inducted into the Twin County Hall of Fame on November 15th. The Hall of Fame honors men and women, past and present, which have made significant contributions to life in Nash and Edgecombe counties. Previous inductees include Olympian and pro athlete Jim Thorpe and jazz musician Thelonious Monk.

A new exhibit cabinet has been installed on the second floor of the Family Medicine Center. The cabinet was designed and hand crafted by Stuart Kent, MFA, who is an ECU SOAD graduate. This cabinet provides a dedicated space where rotating exhibits from the CDM can be presented in Greenville. The inaugural exhibit for the new display case presents apothecary artifacts from the CDM’s permanent collection in Bailey, NC.

History Alive, this year’s fall CDM community event, was held on Saturday October 26th. Approximately 500 people visited the museum in Bailey for the program. Attendees were treated to free admission to the museum, vendor tables, carriage rides, food and fun. A Benjamin Franklin re-enactor gave lectures on the hour about his contributions to medicine and area museums were on hand to display objects and educate folks of all ages.

Earlier in 2012, the Country Doctor Museum and Laupus History Programs were selected to participate in the NC Museum of History’s Traveling Archivist Program (TAP). A volunteer archivist visited the CDM and met with Laupus staff to determine how archival best practices could benefit both programs. The visit produced a very helpful report that highlighted specific actions which should be taken to improve both programs. Based upon the TAP report, we are contracting with OCLC for cataloging services for foreign language materials in the library’s collection as recommended. The report also recommended we seek a consultant to help identify and prepare artifacts suitable for inclusion in a digitization grant to be sought from the Institute of Museums and Libraries (IMLS). We were unable to identify such a consultant as recommended in the TAP report, but Maury York, Head of Special Collection at Joyner Library met with Anne Anderson, Beth Ketterman and Melissa Nasea to discuss collaborative alternatives. These projects are progressing.
Multimedia & Technology Services

With the conclusion of the contract for MTS to provide AV services to Vidant Medical Center, MTS is now focused exclusively on providing classroom support services for the Division of Health Sciences. MTS is working closely with ITCS and MTS employees Chris Motteler and Tim Smith are settling into their new routines and assignments very effectively.

Health Sciences Author Recognition Program

This 7th annual Health Sciences Author Recognition Program was held on November 13, at the Greenville Hilton. The year’s event recognized 93 faculty and staff from the Division of Health Sciences who have published July 1, 2011 – June 30, 2012. More than 150 authors and their guests joined the DHS deans and Vice Chancellor Horns in recognizing this year’s honorees.

PERSONNEL

Christine Andresen, MLS, has been named to the new position of Instructional Design Librarian. Formerly, Liaison Librarian to Allied Health Sciences, Christine officially began her duties as Instructional Design Librarian employment on November 1, 2012.

Timothy Blanchard joined the staff of Laupus Library as an evening University Library Technician. Tim has extensive experience as a library technician and a degree in astronomy.