

ASSOCIATION OF AMERICAN MEDICAL COLLEGES  
SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

MEETING SCHEDULE  
COUNCIL OF ACADEMIC SOCIETIES  
ADMINISTRATIVE BOARD

March 24, 1976

5:00 p.m.	Business Meeting	<i>Jackson Room Washington Hilton</i>
7:30 p.m.	Cocktails	<i>Independence Room</i>
8:30 p.m.	Dinner	<i>Jackson Room</i>

Guest Speaker: *Mr. Steve Lawton, Counsel  
Subcommittee on Public Health  
and Environment, House*

March 25, 1976

8:30 a.m.	Discussion Session (Coffee and Danish)	<i>Jackson Room</i>
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Guest Speaker: *James A. Pittman, M.D., AAMC  
Representative to LCGME, Dean,  
University of Alabama School of  
Medicine*

1:00 p.m.	Joint CAS/COD/COTH/OSR Administrative Boards Luncheon	<i>Military Room</i>
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Executive Council  
Business Meeting

4:00 p.m.	Adjourn
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AGENDA  
COUNCIL OF ACADEMIC SOCIETIES  
ADMINISTRATIVE BOARD

March 24-25, 1976

I. REPORT OF THE CHAIRMAN

II. ACTION ITEMS

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|---|----|
| *1. Approval of Minutes of CAS Administrative Board Meeting<br>of January 13-14, 1976                   | 1  |
| *2. All Action Items in Executive Council Agenda<br>(previously distributed)                            |    |
| *3. Peer Review System of the National Institutes of Health   | 15 |
| *4. Biology Alliance for Public Affairs   | 16 |
| *5. The Academic Community and the Food and Drug Administration<br>(with Steve Lawton as Guest Speaker) | 18 |

III. DISCUSSION ITEMS

- |   |    |
|---|----|
| *1. Proposed CAS Legislative Workshop   | 21 |
| +2. IOM Social Security Studies: Medicare-Medicaid<br>Reimbursement Policies (previously distributed) |    |
| +3. Graduate Medical Education<br>(with Dr. James Pittman as Guest Speaker)                           | 22 |

IV. INFORMATION ITEMS

- \*1. Information Items in Executive Council Agenda

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\*Business Session -- 5:00 p.m. - 7:30 p.m./March 24  
+Discussion Session -- 8:30 a.m. - 12:30 p.m./March 25

MINUTES  
ADMINISTRATIVE BOARD  
COUNCIL OF ACADEMIC SOCIETIES

January 13-14, 1976

Washington Hilton Hotel  
Washington, D.C.

PRESENT: Board Members

Rolla B. Hill  
Chairman (Presiding)  
Robert M. Berne  
F. Marion Bishop  
A. Jay Bollet  
Carmine D. Clemente  
Jack W. Cole  
Philip R. Dodge  
Donald W. King  
Thomas K. Oliver, Jr.  
Leslie T. Webster\*

Staff

James B. Erdmann\*  
Mary H. Littlemeyer  
Thomas E. Morgan  
Mignon Sample  
August G. Swanson

ABSENT: Daniel X. Freedman  
Robert G. Petersdorf\*\*

The business meeting of the CAS Administrative Board was convened at 5:00 p.m. on January 13.

I. Report of Chairman

Opening the meeting, Dr. Hill welcomed the new members of the CAS Administrative Board: Philip R. Dodge, M.D., Chairman, Department of Pediatrics, Washington University School of Medicine; and Donald W. King, M.D., Chairman, Department of Pathology, Columbia University, College of Physicians and Surgeons. Drs. Dodge and King were elected to one-year terms on the Board. The other newly elected member of the Board, Daniel X. Freedman, M.D., Chairman, Department of Psychiatry, University of Chicago Pritzker School of Medicine, was unable to attend the meeting. Dr. Freedman's term expires in 1978.

Dr. Hill reviewed the format for the quarterly CAS Administrative Board meetings for the benefit of Drs. Dodge and King. In this connection, he noted that two of the actions that came out of the issues section of the CAS Administrative Board in September had not been included in the January Executive Council Agenda. These were, first with regard to Continuing Medical Education, the CAS Administrative Board had agreed in September that:

1. AAMC should work toward developing alternatives to relicensure based solely on continuing medical education credits;

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\*January 14 only  
\*\*Ex Officio

2. AAMC should assess opportunities and problems which moves toward mandated continuing medical education will place before medical schools and faculties; and
3. AAMC should work with the major voluntary agencies in accomplishing (1) and (2); and

secondly, with reference to Biomedical Research Training, the CAS Administrative Board had agreed in September that:

1. The feasibility of the accreditation of research training programs should be explored;
2. Multidisciplinary programs should be supported as a means to training more broadly capable scientists; and
3. The AAMC should work with other organizations such as the NAS, NIH, etc. to achieve long-term solutions to the research manpower problem and its support.

The reason for the omission of these two items was not known.

The Annual AAMC Retreat was held December 10-12, 1975. Each year the newly elected officers of the Association meet with the AAMC Executive Staff to discuss priorities of the AAMC for the coming year.

The current status of health manpower legislation was discussed, and AAMC's position was examined in view of the various concepts pertaining to the legislation now being considered by the Senate Health Subcommittee. It was decided that the Association would continue to meet with members of the Subcommittee in order to make its views and concerns clear to the entire membership of the Health Subcommittee. The future role of the newly formed National Citizens Advisory Committee for the Support of Medical Education was discussed, and a list of possible national issues for their consideration was compiled.

Other items on the retreat agenda which were discussed dealt with the Medical College Admissions Assessment Program; the possibility of the AAMC sponsoring or promoting a critical review of the education of the physician, which would include a thorough investigation and analysis of education at the pre-medical, undergraduate medical, graduate medical, and practicing levels; the status of minority enrollments in medical schools; the roll of the Organization of Student Representatives as a constituent of the AAMC; financing education in the ambulatory care setting; the problems associated with indirect costs of research; and how the AAMC might assist its member institutions in efforts related to the implementation of the National Health Planning and Resources Development Act.

As part of AAMC's centennial celebration one plenary session at the 1976 Annual Meeting will be devoted to the subject of medical education past

and future. The Annual Meeting will be in San Francisco, November 11-15.

Dr. Hill expressed concern that biomedical research was not among the issues included in the agenda. He said the role and mission of the CAS are of continuing concern to him.

## II. Adoption of Minutes

The minutes of the CAS Administrative Board meeting of September 17-18, 1975, were adopted as circulated.

## III. Action Items

### A. Ratification of LCME Accreditation Decisions

In connection with the discussion of this item, the function of the Administrative Board relative to the accreditation decisions was explained. Full information with regard to the accreditation of medical schools is provided to the CAS representatives to the Executive Council.

A list of the representation to the Coordinating Council on Medical Education, the Liaison Committee on Medical Education, and the Liaison Committee on Graduate Medical Education appears as Attachment A.

ACTION: The CAS Administrative Board accepted the accreditation recommendations (as set forth in the Executive Council Agenda on pages 27-28).

### B. LCME Appeals Panel

ACTION: The CAS Administrative Board took no action on this item (as set forth in the Executive Council Agenda on page 29).

### C. 1976 Budget for the Coordinating Council on Medical Education

As shown in Attachment A, five organizations comprise the Coordinating Council on Medical Education. The expenses are borne equally among these five organizations. As noted in the agenda, the 1976 budget was slightly increased over that of 1975.

ACTION: The CAS Administrative Board approved the 1976 budget for the CCME (as recommended in the Executive Council Agenda on page 30).

### D. 1976 Budget for the Liaison Committee on Graduate Medical Education

Dr. Swanson explained some of the background of the rationale outlined in the Executive Council Agenda (p. 31). One of the changes proposed, that average travel reimbursement be limited to no more than \$350 per person for each two-day Residency Review Committee meeting, prompted Dr. Dodge to comment that from a recent assessment of his program, he has real concerns as to the quality of the evaluation. Dr. Swanson said he sees some

progress being made, although by the nature of the process, it will take time to accomplish what needs to be done.

Most of the site visits are made by A.M.A. field staff, consisting of eight people described as a heterogeneous group of retirees. They are not located in A.M.A. headquarters but operate out of their own homes. Increasingly they have been involving a member of the discipline recognized as an educator in the survey. Accreditation is still on a program-by-program basis, includes over 4,700 programs, and is not of the same quality of that of the medical schools. The way the system works now, programs are accredited by members of the Residency Review Committee based on a field site visit or a special site visit. The secretary of the Residency Review Committee writes a letter of recommended action. Subcommittees of the Liaison Committee on Graduate Medical Education review all the letters of recommendation. If any of the information under review is irregular, the recommendation will be turned back to the Residency Review Committee.

Dr. Bollet indicated that in internal medicine the Residency Review Committees are nominated by the American Board of Internal Medicine. According to Dr. Swanson, the appointment of the Residency Review Committees is by the A.M.A. Council on Medical Education based on nominations from both the boards and the principal colleges.

In a further discussion of the quality of the review and subsequent action, Dr. Oliver reported his experiences as a reviewer of a program that he recommended not be approved. The program was approved despite his recommendation. Dr. Swanson indicated that, with the new system, such a situation would have been referred back to the Residency Review Committee.

Dr. James Pittman, who chairs the Liaison Committee on Graduate Medical Education, will be invited to the next Board meeting to discuss this issue. Dr. Bollet suggested that as much substantive background material be circulated ahead of time as possible.

ACTION: The CAS Administrative Board approved the 1976 budget for the LCGME (as recommended in the Executive Council Agenda on page 31).

E. Election of COTH Members

ACTION: The CAS Administrative Board took no action on this item (as set forth in the Executive Council Agenda on page 32).

F. CCME Report--Physician Manpower & Distribution: The Role of the Foreign Medical Graduate

This report had been approved by all the members of the CCME except for the three items listed, to which AAMC had objected. The CCME had asked AAMC to reconsider the items. The following action was taken:

ACTION: With regard to Item A-4, the CAS Administrative Board approved the Alternate Wording (proposed by CCME):

"That commencing one year following the adoption of this report the sponsorship of FMG's coming to the U.S. for graduate medical education as exchange visitor physicians be limited only to accredited U.S. medical schools together with affiliated hospitals or other accredited schools of the health professions."

With regard to Item B-11, the CAS Administrative Board approved the Alternate Wording (proposed by CCME):

"That on an interim basis special programs of graduate medical education be organized for immigrant physicians who have failed to qualify for approved residencies and who have immigrated to this country prior to January 1, 1976. (This time restriction does not apply to physicians entering the U.S. with Seventh Preference visas (refugees).) Immigrant physicians applying to such programs must present credentials acceptable to the sponsoring agencies; the purposes of these special programs are:

- a. to provide a proper orientation to our health care system, our culture and the English language, and
- b. to identify and overcome those education deficits that handicap FMG's in achieving their full potential as physicians in the U.S. health care system; and"

With regard to Item C-6, the CAS Administrative Board supported the Alternate Wording (from AAMC Policy):

"That the special programs currently offered by some medical schools commonly called The Fifth Pathway Program should be phased out. Qualified U.S. citizens who have studied medicine abroad should be provided the same educational opportunities and recognition as their colleagues who enter U.S. medical schools directly. If resources can be made available, qualified students should be selected by the faculty and admitted to advance standing. Their levels of admission should be determined by the policies of the faculty, and they should be provided the regular educational opportunity and challenge deemed necessary for the awarding of the M.D. degree."

In the event that the AAMC above Alternate Wording is unacceptable to the other official bodies, then it would be the recommendation of the CAS Administrative Board that the Item C-6 be deleted (as set forth in the Executive Council Agenda on page 34).

G. Association Membership in the Federation of Associations of Schools of the Health Professions

The Administrative Board reviewed the problems that had occurred in the attempt by FASHP to engage in legislative activities. It was generally felt by the AAMC Executive Committee that the Association should continue to send a staff member to Federation meetings but should not participate in any joint legislative activities. It was generally felt that the Federation should be a colloquium for discussion but should not be involved in the development of legislative policy.

ACTION: The CAS Administrative Board approved the recommendations

1. that the Executive Council communicate to the officers of the Federation a recommendation that the Federation refocus its interests on substantive educational issues and formally agree not to serve as an organization actively developing policy on legislative issues; and
2. that if the Federation decides not to refocus its efforts, the President be authorized to withdraw the Association from membership.

H. Application for Membership

ACTION: The CAS Administrative Board accepted the reports of the formal review of the application for membership in the Council of Academic Societies of the American Association of Gynecologic Laparoscopists that membership be denied on the basis that the primary focus of the organization is technical not academic.

I. Position Paper of National Advisory Council on Geriatric Medical Programs

The CAS Administrative Board considered the position paper in the CAS Agenda (p. 16).

ACTION: Regarding the composition of specific curricula, no matter how commendable a program may be, it is inappropriate for the CAS Administrative Board to recommend its adoption by the medical schools. Rather, the CAS Administrative Board encourages any constituent societies to communicate their recommendations directly to the medical schools.

J. CAS Spring Meeting

Because of the heavy schedule of professional meetings and the fact that a one-day meeting in Philadelphia could not fulfill the desires of the Board to improve the interactions of member societies with federal agencies, it was decided to cancel the March 16 meeting. It



was further decided to explore the development of an alternative meeting in Washington, D.C. specifically directed towards those individuals in the member societies who will have significant and long-term involvement with the societies' legislative and governmental concerns. A one-day workshop format will be scheduled if possible, with participants convening informally the evening before the sessions.

#### IV. Discussion Items

##### A. Report of Joint Task Force on Manpower in Pathology

Increasingly, manpower studies are being undertaken by a variety of professional organizations and specialty societies in both the basic and the clinical sciences. The report of the Task Force on Manpower in Pathology was included in the CAS Administrative Board Agenda as an example of one of these studies. At the present time, the American Board of Internal Medicine, the American College of Physicians, the American Society of Internal Medicine, and the Association of Chairmen of Departments of Medicine are planning a major survey of manpower in Internal Medicine and its 10 subspecialties. The study director has been contacted by AAMC staff, and cooperation is assured. AAMC staff believe that because the Association and its constituents have prime responsibility for the education of physician manpower and biomedical research manpower, AAMC should have a prime objective to assist in the coordination of manpower studies. The advice of the Board and any information regarding other manpower studies now in progress or being contemplated was sought.

Dr. Morgan suggested that any manpower study should focus on supply because of the length of time required to produce a physician. One can look at the supply five years ago, last year, the current supply plus those in training, and project the supply.

According to Dr. Swanson a corollary approach is an attempt to establish a tracking mechanism through the A.M.A. physician records of students on a national basis for several years after their graduation.

The question of whether any AAMC effort should be limited to faculty manpower or whether it should be broad-based to include aggregate manpower production was explored. The consensus was that the AAMC thrust should be on faculty manpower, but that AAMC should be a repository for data and that CAS/AAMC should be identified as interested in knowing of any studies that are being planned or underway.

As a first step it was felt that any AAMC effort should be limited to medicine, cooperating and capitalizing on the joint study now underway. This affords a unique opportunity, utilizing existing AAMC staff, to define the feasibility of any extended study into other clinical sciences.

A number of sources of manpower data were named, among which were:

- The National Science Foundation in Washington--Good data on the basic sciences.
- The major academies and colleges
- The specialty boards
- The A.M.A.--Data hard to get, located in Chicago, etc.
- Federal sources (e.g., NHLI has done study on manpower in pulmonary medicine)
- AAMC--Faculty Roster File (includes over 40,000 full-time U.S. faculty)
- AAMC--Longitudinal Study of Entering Class of 1956 (includes 28 medical schools--extensive data, not only biographical/demographic but also attitudinal and on career choice characteristics)

B. Survey of the Education of the Physician

Participants in the AAMC Retreat discussed at length whether the AAMC should support or promote a critical review of the education of the physician to include a thorough investigation and analysis of education at the premedical, undergraduate medical, graduate medical, and practicing levels.

It was pointed out that the present situation differs from that which existed in medical education in the Flexner era when little information about medical schools and their problems was known. Today, through the accreditation process, a great deal of information about the institutions is available.

Questions were raised about whether such an effort would be appropriate for the AAMC since it could be argued that the Association had a vested interest in the outcome. It was also pointed out that such a study could not be expected to cause a revolutionary change, but might have a positive impact. It was generally agreed that the Association should do something with regard to the options for implementing such a study, as presented in the Retreat agenda.

An expansion of present studies on various aspects of medical education by the Association should be continued, e.g., the education of primary care physicians, the admissions process. These could form an overall view of medical education. The Association could attempt to get funds to carry out such studies. The Association might also press harder for using the accreditation visit as a means for self-study by the institution of its objectives and effectiveness of its educational programs in achieving its goals.

The recommendations of the Josiah Macy, Jr. Foundation committee on medical education to establish a national commission to undertake a

continuing study of medical education were supported. This commission could furnish a means to carry on an ongoing study of medical education from a more disinterested vantage point. There was a general consensus that this would be the best approach to the study of medical education and that a separate independent study should not be launched at this time.

C. MCAAP Non-Cognitive Program

Dr. James B. Erdmann of the Department of Academic Affairs was present to expand upon the general discussion of this topic included in the agenda and to respond to questions from the Board. To the expressed concern of some present, Dr. Erdmann explained that the medical schools will be involved on a voluntary basis in research and development of the program. To the extent that they find it useful, they can employ it. There will be no attempt to administer it in a national testing program.

He asked for the continuing input from the Board members and solicited their ideas.

D. CAS Alert

Dr. Swanson asked members if they had received the first CAS Alert which was distributed on January 2, 1976. Dr. Bishop had had it reproduced and forwarded to the entire membership list of the Society of Teachers of Family Medicine on January 5, 1976. Dr. Oliver had also disseminated it to the Pediatric Chairmen, asking for their reactions. Members were urged to forward any additional information to Dr. Swanson.

V. Adjournment

The formal meeting was adjourned at 12:30 p.m. in time for a joint luncheon with the Administrative Boards of the other two councils. The business meeting of the Executive Council followed.

MHL/mf  
2/11/76

Attachment (1)

## PEER REVIEW SYSTEM OF THE NATIONAL INSTITUTES OF HEALTH

Repeated attacks on the peer review system as employed by the National Institutes of Health have been mounted in the Congress and in certain parts of the Executive Branch, principally the Office of Management and Budget. These criticisms have resulted in the formation of a review committee within NIH headed by Dr. Ruth Kirschstein, Director of the National Institute of General Medical Sciences. Three national hearings have been held to receive support and criticism of the peer review system.

The question is now raised whether in view of national interest in this subject, the AAMC position on this issue should be revised.

### ISSUE: HOW AND BY WHOM SHOULD BIOMEDICAL RESEARCH PROPOSALS BE EVALUATED?

External peer review has been a useful tool to guide the investment of research resources into those areas which hold the greatest promise for significant yield from research. Recently, certain individuals within the Federal Government have questioned whether the external peer review system is a cost-effective management tool. In contrast, the scientific community is convinced that external peer review has been the key element in the success of our national biomedical research program.

### PRESENT STATE OF POLICY DEVELOPMENT:

The AAMC has strongly endorsed the principle of external peer review of research proposals. The AAMC believes that external peer review of individual project grants and contracts, as well as requests for proposals, will ensure that our national biomedical research and development resources are allocated to problems of high relevance. External peer review of individual proposals utilizing scientific merit as the primary criterion will ensure that funds are disbursed within the broad policy guidelines established by the legislature.

## BIOLOGY ALLIANCE FOR PUBLIC AFFAIRS

For more than a year efforts have been made to form an "umbrella" public policy organization to encompass the interests of scientific organizations not now represented effectively in Washington. There has been considerable discussion as to whether the organization should concentrate on professional or technical matters in influencing public policy or whether its scope should be broadened to include specific activities aimed at directly influencing the legislative process. There seemed to be wide agreement that the override of the veto of the Labor-HEW Appropriations Bill provided evidence that the umbrella organizations presently on the Washington scene were handling that type of activity quite successfully. Two areas did emerge as a justification for an umbrella organization. The first was to provide an opportunity for some organizations in the life sciences for which there presently is no such organization to join in common effort to solve problems of mutual interest. The second was to increase even more the effectiveness of the existing organizations in a coalition type activity.

Of particular interest in the matter of governance of the organization to the AAMC and other umbrella organizations (e.g. FASEB) would be the following points:

1. AAMC would be eligible for membership as such and its constituent societies would also be eligible as individual societies.
2. All would have equal status insofar as representation and voting power within the Alliance.
3. An Executive Committee of nine members would be designated, four of which would be the umbrella organizations as permanent members if they wish to join; that is, AAMC, FASEB, AIDS and the American Society of Microbiology. The remaining five would be elected from the individual societies.
4. Emphasis would be placed on developing positions on long-range issues. There would be recognition of and continued dependence on other types of organizations, such as the Coalition for Health Funding.

Biology Alliance  
Page Two

The discussions of the formation of the Biology Alliance have been marked with ambivalence. It is doubtful whether the group's aspirations can be achieved. As to whether another national organization is needed, there is no consensus. However, AAMC has continued to lend its support to the Executive Committee and its provisional Chairman, Dr. Gerald Weissmann. The Council of Academic Societies Administrative Board is now asked to give its recommendations on future relations between the AAMC the the Alliance.

## THE ACADEMIC COMMUNITY AND THE FOOD AND DRUG ADMINISTRATION

In 1974, during hearings on the Food and Drug Administration before the Senate Health Subcommittee, charges were brought by FDA personnel that the agency had approved new drug applications in response to industry pressure. It was alleged also that recommendations of agency personnel had been overturned both by advisory committees and by supervisory personnel after drug company pressure. During the intervening two years, these allocations have been investigated in further hearings before the Health Subcommittee, in a 900 page white paper by FDA Commissioner Alexander Schmidt, and by a select DHEW committee headed by Dr. Thomas Chalmers. The agency subsequently increased its scientific advisory apparatus so that scientific advice may be obtained from the biomedical community sitting on thirteen advisory panels (e.g., obstetrics and gynecology, cardiovascular drugs).

The relationship of these advisory committees to the FDA decision-making process has not always been clear since the agency reserves the right to make decisions regarding clearance of applications for new drugs. Thus in December, Senators Kennedy and Javits introduced two bills (S.2696 and S.2697). A number of groups were asked to comment on these Senate proposals and shortly thereafter additional legislative proposals were introduced in the House.

The proposed Senate legislation would have three major effects on FDA organization: It would split the present FDA into two agencies -- one dealing with drugs and devices and the other with food and cosmetics; it would elevate the various organizational components accordingly; and it would attempt to upgrade the scientific competence of the FDA by establishing means to bring in scientists on a temporary basis and to provide sabbatical experiences for FDA employees at academic institutions and at the NIH. The legislation includes novel provisions relating to the employment of scientists, clinical pharmacists, and physicians in the research development bureau of the proposed Drug and Devices Administration. One-third of each Administration's personnel positions would be reserved for "temporary" appointments for university scientists for periods from 2 to 4 years. Regular employees would be entitled to take university sabbaticals for comparable time periods and would also be permitted to spend one-third of their working time conducting research at the National Institutes of Health or another appropriate facility. There are logistic problems for universities in coping with long absences of their personnel. Likewise, the FDA employees' sabbaticals would face many practical problems.

Academic Community and FDA  
Page Two

The idea of an NIH/FDA interface has reoccurred frequently over the years without significant outcome, and the basic problem appears to be that there is little incentive for scientific exchange as long as the principal activity of FDA scientists remains the review of volumes of drug applications and supporting data. At a recent AAMC workshop to review this problem of FDA scientific competence, representatives of several academic societies supported in general the concept that an increase in scientific competence of FDA is desirable. The AAMC consultants rejected the Senate proposals as unworkable from the standpoint of both the scientific community and the agency. Considerable dissatisfaction was expressed with the present functions of FDA advisory committees by persons familiar with the advisory process at FDA. It was suggested that a number of academic disciplines should be concerned about the relationship of the Food and Drug Administration to the academic community. Several alternative proposals for strengthening scientific input were discussed. One of these suggested that a national center for drug and medical devices be established within FDA which would have a role similar to that of the Communicable Disease Center (CDC) in Atlanta. The combination of scientific competence, regulatory functions, and interstate relations of CDC was held to be particularly relevant to FDA's needs. Another proposal was that the advisory committee role should be strengthened and that "study sections" should be introduced to assist in the review and approval of Investigational New Drug (IND) and New Drug Applications (NDA).

Further areas of concern for academic disciplines were believed to lie in Senate proposals for increasing the scope of regulatory powers to include post-marketing controls on the distribution of certain drugs (so-called Phase D controls). Proposed legislation would limit the distribution of such drugs to certain clinical practitioners or clinical settings. For example, the use of propranolol for hypertension would be restricted to board certified cardiologists. Thus, the drug could not be used by transplantation surgeons who employ it to control hypertension after kidney transplantation. Thus, the Phase D controls might add competency requirements to board certification and medical licensing which were not previously intended by certification and licensing procedures.

Proposals for the creation of a statutory Drug Review Board were felt to be less important to the academic community provided that the advisory apparatus of the Food and Drug Administration could be strengthened. There was unanimity that the Food and Drug



Academic Community and FDA  
Page Three

Administration should not be split into two agencies, however, this was not felt to be a primary concern of either the Council of Academic Societies or the AAMC in general.

The Following Policy is Therefore Proposed:

- 1) The Association of American Medical Colleges supports efforts to increase scientific competence of the Food and Drug Administration. The Association believes that the most significant advance towards this objective will be made by the involvement of a sector of the academic community with the scientific personnel of the agency. The establishment of advisory councils with functions similar to those of study sections of the National Institutes of Health is recommended. Further, the Association supports the establishment of a national center for drug and medical device research.
- 2) The goal of limiting or controlling distribution of dangerous drugs is praiseworthy. However, the Association believes that controlling drug distribution by certification or licensure should be approached with the greatest caution so as not to restrain biomedical research or the clinical practice of medicine.

PROPOSED LEGISLATIVE WORKSHOP  
FOR COUNCIL OF ACADEMIC SOCIETIES

Several member societies of the CAS have expressed interest in learning more about the legislative and executive process in health affairs so as to be able to have greater impact at the national level. A poll of society representatives indicated overwhelming support for a proposed legislative workshop to be conducted this year in the Washington area. A tentative proposal for a workshop has been developed, using as a model a recent workshop held by the American Federation for Clinical Research which very effectively met the objective of educating members of their Executive Council. The proposal for a similar CAS workshop is as follows:

Each society will be requested to nominate a representative who will have primary responsibility for legislative liaison for at least the next two or three years. These designated society representatives will be brought together in the Washington area during the summer Congressional recess. Thirty to sixty participants are expected; these will be divided into three groups. Each group will consider a representative piece of legislation from the standpoint of the authorization process, the appropriation process, and the executive implementation of the enacted legislation.

One group will be led by Congressional staff members drawn from the House and Senate Appropriations Subcommittees. A second group will be led by Congressional staff from the Health Subcommittees. Persons from the Executive Branch who are familiar with the regulatory and management aspects of the legislation will be group leaders of the third group. AAMC staff will accompany each group to stimulate and focus discussion, and to emphasize the input which each society may make as a special interest group at each phase of the legislative process.

Tentative agreement has been obtained from key House and Senate Health Subcommittee and Appropriations staff personnel to participate in this workshop.

## GRADUATE MEDICAL EDUCATION

Several major issues impinge upon the integrity and the future of graduate medical education. These issues have been discussed in a variety of fora and it is anticipated that their discussion will continue and become more pointed. The CAS and the AAMC must be prepared to adopt positions that will assure the adequacy and quality of graduate medical education in the United States.

During the past fifteen years graduate medical education has increasingly become an enterprise largely conducted in hospitals affiliated with academic medical centers as Table 1 demonstrates. Several centers have made plans and begun to implement institutional responsibility for graduate medical education. In the Spring of 1974, 30 centers reported they had made a policy decision to assume institutional responsibility, 32 believed they would, and 31 had not yet considered the issue. A report of this survey is shown in Appendix I. These data indicate that there is a strong movement towards having graduate medical education become a responsibility of academic medicine. As this responsibility for graduate medical education by the academic medical centers increases, it is important that efforts be made to resolve major issues.

### FINANCING

There has been considerable uncertainty over the future financing of graduate medical education. It is estimated that stipends alone now amount to about \$900 million annually. The Coordinating Council on Medical Education is moving toward adopting a position that graduate medical education must be funded by the health care system as a "cost of doing business" in order to ensure the availability of future physicians and the future provision of health services. The IOM Report on Medicare-Medicaid Reimbursement Policies has just been released and will be reviewed by a small ad hoc committee prior to the CAS Board Meeting. A response to that Report will be developed during the Board and Executive Council Meetings. The Association has emphasized the need for improving the reimbursement for patient care in ambulatory settings in order to make both undergraduate and graduate education more feasible in non-inpatient clinical educational environments. The IOM Report does support that view.

### ACCREDITATION

The Liaison Committee on Graduate Medical Education (See Appendix II) has for the past year been reviewing and approving the actions of the Residency Review Committees. This approval of RRC actions has in the main been based upon inconsistencies in the record which have not made clear the reason for the RRC action to

Graduate Medical Education  
Page Two

approve or disapprove a program. During the course of this year efforts have been made to standardize the process and procedures of the 23 RRCs. This has moved rather slowly. There is a reluctance to perturbate the system, which has evolved since the late 1940s.

Composition of RRCs

The advent of the Liaison Committee on Graduate Medical Education has not modified the composition of the RRCs or their manner of appointment. Members are designated by the Boards, the Council on Medical Education of the American Medical Association, and in some instances by the principal college or academy of the specialty.

Essentials

The fundamental documents upon which accreditation judgments are made are the Basic or General Essentials and the special requirements of each specialty.

The General Essentials are now being rewritten by the Liaison Committee on Graduate Medical Education. It is the AAMC position that these should be approved by the Coordinating Council on Medical Education and the five parent organizations. The current By-laws of the LCGME require only approval by the RRCs and their parent organizations (including the AMA House of Delegates), and the LCGME. The special requirements are now developed by the RRCs and then approved by the parent organizations of the RRCs (including the AMA House of Delegates) before being transmitted to the Liaison Committee on Graduate Medical Education for final approval. No action is taken on the special requirements by the parent organizations of the LCGME. The AAMC representatives have been arguing that if the AMA House of Delegates is to have the prerogative of acting on these documents, so should the other parent organizations of the LCGME/CCME.

Accreditation Program and Site Visits

There are approximately 4,800 graduate programs in about 1,500 hospitals in the United States. The review cycle for accreditation is three years. This means approximately 1,600 programs are reviewed annually. Currently, the AMA has 8 field staff doing site visits and has budgeted for 12. This requires that each field staff person visit 130 to 200 programs per year.

Growing dissatisfaction with the quality of site visits is causing RRCs to assign specialist site visitors with increasing frequency. This is both increasing the costs and adding to the burden of the review process.

It would appear that policy changes which would reduce the frequency and improve the quality of program assessment are needed.

#### LCGME FINANCING

The Liaison Committee on Graduate Medical Education budget for 1976 is shown in Appendix III. Approximately one-half of income now derives from \$300 charges to programs for review, one-half comes from the American Medical Association, and the balance is made up by other parent organizations.

#### FELLOWSHIPS

There has never been an organized system to accredit fellowship programs in the subspecialties, except in surgery where the subspecialties are organized under freestanding boards. With the development of procedures by the specialty boards, particularly Medicine and Pediatrics, to recognize special competence there have been requests to develop some means of program review and approval for subspecialty training. This is a knotty problem. If each of the 445 programs in Internal Medicine offer an average of 5 programs in the 10 subspecialty disciplines in medicine, there are an estimated 2,225 subspecialty programs presently in operation. There is at present no accurate count of the number of subspecialty programs or their enrollees. It is anticipated that the study planned by the Board, the College, the Society and the Professors of Medicine will provide more accurate data. If this number of programs proves to be true and were added to the present 4,800 residency programs for review through the present process, the added burden to the system would be intolerable. A mechanism must be developed to assure both the boards and students that fellowship programs in the subspecialty disciplines are of optimal quality. To date, the Board of Internal Medicine has promulgated guidelines for the purpose of letting program directors know what their expectations are, but there is no review mechanism and there is no published list of approved programs.

#### INSTITUTIONAL ACCREDITATION

In its 1971 position paper on graduate medical education, the Association urged that there be institutional accreditation for graduate medical education. This recommendation was not well accepted, particularly by those who firmly believe that only individuals from the same discipline can judge a graduate program. However, given the Byzantine characteristics of the present review and approval system, some movement toward institutional accreditation may become absolutely necessary.

# STUDENTS

With the housestaff seeking recognition as employees for purposes of collective bargaining and the AAMC maintaining that these individuals are students pursuing a course of instruction for purposes of improving their knowledge and skills, the status of the relationship between the faculty, the institutions, and the students is unresolved. A decision has not been handed down by the NLRB and it is impossible to predict how the NLRB will decide.

The narrowing gap between available first-year graduate medical education positions and graduating students is also likely to introduce new stresses into the system in the future. The graph in Appendix IV illustrates the availability of graduate medical education first-year positions and their relationship to the increasing number of graduates from U.S. medical schools.

TABLE 1

## GRADUATE PROGRAMS IN HOSPITALS AFFILIATED WITH MEDICAL SCHOOLS

	<u>NO. OF PROGRAMS</u>		<u>NO. OF POSITIONS FILLED IN 1ST YEAR</u>		<u>NO. OF HOSPITALS</u>	
	<u>Affil</u>	<u>Non-Affil</u>	<u>Affil</u>	<u>Non-Affil</u>	<u>Affil</u>	<u>Non-Affil</u>
1962	3,118	3,055	6,803	3,824	440	1,034
1967	2,975	1,727	9,218	3,363	721	771
1972	3,953	654	15,144	1,629	1,109	453
1973	4,210	630	16,421	1,655	1,100	477

# APPENDIX I

## DATAGRAM

### Academic Medical Centers And Graduate Medical Education

A position statement of the Association of American Medical Colleges (AAMC), adopted by the AAMC Assembly in 1971, recommends that the academic medical centers assume responsibility for graduate medical education in a fashion analogous to their responsibility for undergraduate medical education (1). The Graduate Medical Education Committee of the AAMC published a document discussing the implications of this policy and providing guidelines for institutions planning to assume responsibility for graduate medical education (2). Guidelines were subsequently developed to assist faculties seeking to formulate a plan for institutional assumption of responsibility for the various internship and residency programs in their academic centers (3).

To determine the extent to which the U.S. academic medical centers were moving in this direction, a questionnaire survey was conducted by the AAMC in the spring and summer of 1974. Of the 115 U.S. centers included in the survey, 103 returned questionnaires. Their response is summarized in Table 1 to the key question, "What consensus has been reached to date concerning the assumption of institutional responsibility for graduate medical education at your academic medical center?" As shown in that table, 31 of the centers indicated that they have not considered this possibility, whereas 72 indicated that they have.

In 66 of these 72 institutions the medical center administrative staff has considered this matter. Others involved in the deliberations are: medical center faculty committee (47 centers, 17 of which have included residents and fellows), medical center governing board (29 centers), medical center faculty at large (19 centers), and university governing boards (11 centers).

The six centers that either will not or probably will not pursue this development ranked in order of importance the factors that led

to their decision. Two of the six felt that the most important factor leading to their decision is that the present system is good and does not need changing. Another of the status quo responders said that the "hospitals now fund (graduate medical education) but that the medical school chairmen 'control' the program." Two centers ranked as foremost in consideration (three other centers ranked it as second, third, and fourth in importance) the "fact" that "faculty are not sympathetic to concepts of selection and evaluation of residents on an institutionwide basis." Another problem perceived as important in four centers (one ranked it most important, two ranked it next in importance, and one ranked it fourth) was that the "sources of financing of graduate medical education programs are too many and diffuse to integrate responsibility and authority within the institutional complex of this medical center." Three respondents ranked as second, third, and fifth in importance the belief that it is not possible (for an academic medical center) to establish program goals and learning objectives for residency programs on an institutionwide basis. The reluctance of affiliated hospitals to share their responsibility and authority was seen as a problem by two centers, which gave this item third- and fifth-place rankings.

TABLE I

PLANS OF U.S. ACADEMIC MEDICAL CENTERS  
WITH REGARD TO ASSUMING INSTITUTIONAL  
RESPONSIBILITY FOR GRADUATE MEDICAL  
EDUCATION, 1974  
(N = 103)

Definitely yes	30
Probably yes	32
Probably no	5
Definitely no	1
Currently considering	4
Have not considered	31
Total	103

TABLE 2  
STATUS OF PLANS FOR HAVING ENTIRE MEDICAL CENTER FACULTY ESTABLISH  
PROCEDURES IN SEVEN AREAS AS REPORTED IN 1974 BY ACADEMIC  
MEDICAL CENTERS EITHER DEFINITELY OR PROBABLY  
PROCEEDING WITH CONCEPT (N = 62)

Establish Procedures To:	Status of Plans			Total Respondents
	Completed	In Progress	Not Yet Started	
Determine the general objectives and goals of graduate medical education programs	7	42	11	60
Establish policies for the allocation of resources and facilities of the entire medical center to permit realization of these goals	5	39	15	59
Appoint faculty for graduate medical education programs	16	22	20	58
Select residents	21	16	22	59
Determine the content, process, and length of graduate medical education program	12	28	19	59
Evaluate each resident's progress	16	19	24	59
Designate that residents have successfully completed their graduate medical education program	19	15	25	59

The stages of planning reported by the 62 academic medical centers that say they either are definitely or are probably going to assume institutional responsibility are summarized in Table 2.

Among the 30 academic medical centers that are definitely planning to assume institutional responsibility for graduate medical education, 19 reported that in at least one of the seven stages described in the questionnaire their plans are completed for having their entire medical center faculty establish procedures. Three of the institutions have completed plans in all seven stages. These institutions are identified in Table 3.

An analysis was made of those reporting that they are definitely planning to assume institutional responsibility for graduate medical education as they constitute a percentage of all academic medical centers existing in one of the four geographical regions designated by

the AAMC. The highest activity (33 percent) appeared in the Midwest, with the South (25 percent) and the Northeast (23 percent) following. The fewest centers involved at the time of the survey (18 percent) are in the West.

One-half of the 30 centers that reported definite plans for the assumption of institutional responsibility for graduate medical education are actively seeking to establish new affiliations both with hospitals that have existing graduate programs and hospitals that have not previously had graduate programs. Another seven centers in this response category are actively seeking affiliations but only with hospitals that have existing graduate programs. Four centers indicate that they are actively seeking affiliations but only with hospitals that have not previously had graduate programs. A similar response rate was found for the centers whose plans seem likely to materialize.



Datagram

411

TABLE 3  
ACADEMIC MEDICAL CENTERS WITH PLANS COMPLETED FOR HAVING ENTIRE  
MEDICAL CENTER FACULTY ESTABLISH PROCEDURES IN SEVEN AREAS  
AS REPORTED IN 1974 BY 19 OF 30 ACADEMIC MEDICAL CENTERS  
DEFINITELY PROCEEDING WITH CONCEPT

Academic Medical Centers	Procedures*						
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Baylor	X	X	X	X	X	X	X
Johns Hopkins	X	X	X	X	X	X	X
Mayo	X	X	X	X	X	X	X
CMDNJ—New Jersey Medical		X	X	X	X	X	X
Ohio—Toledo			X	X	X	X	X
Nebraska				X	X	X	X
Northwestern			X	X		X	X
California—San Francisco			X			X	X
Indiana			X	X			X
Minnesota—Minneapolis			X	X	X		
Texas—Houston				X	X		
Connecticut	X			X			
South Alabama				X			X
Georgia						X	X
California—Davis						X	X
SUNY—Downstate	X						
Tulane							X
Washington—Seattle		X					
Vermont	X						

\* (1) Determine the general objectives and goals of its graduate medical education programs. (2) Establish policies for the allocation of resources and facilities of the entire medical center to permit realization of these goals. (3) Appoint faculty for graduate medical education programs. (4) Select residents. (5) Determine the content, process, and length of graduate medical education program. (6) Evaluate each resident's progress. (7) Designate that residents have successfully completed their graduate medical education programs.

#### References

1. Statement on Graduate Medical Education. *Bull. Assoc. Am. Med. Coll.*, VI:3, November 15, 1971.
2. KINNEY, T. D. (Chairman). Implications of Academic Medical Centers Taking Responsibility for Graduate Medical Education. Report of the AAMC Ad Hoc Committee on Graduate Medical Education. *J. Med. Educ.*, 47:77-84, 1972.
3. Guidelines for Academic Medical Centers Planning To Assume Institutional Responsibility for Graduate Medical Education: Report of the Committee on Graduate Medical Education of the Association of American Medical Colleges. *J. Med. Educ.*, 48:777-791, 1973.

ity for Graduate Medical Education: Report of the Committee on Graduate Medical Education of the Association of American Medical Colleges. *J. Med. Educ.*, 48:777-791, 1973.

AUGUST G. SWANSON, M.D.

Director

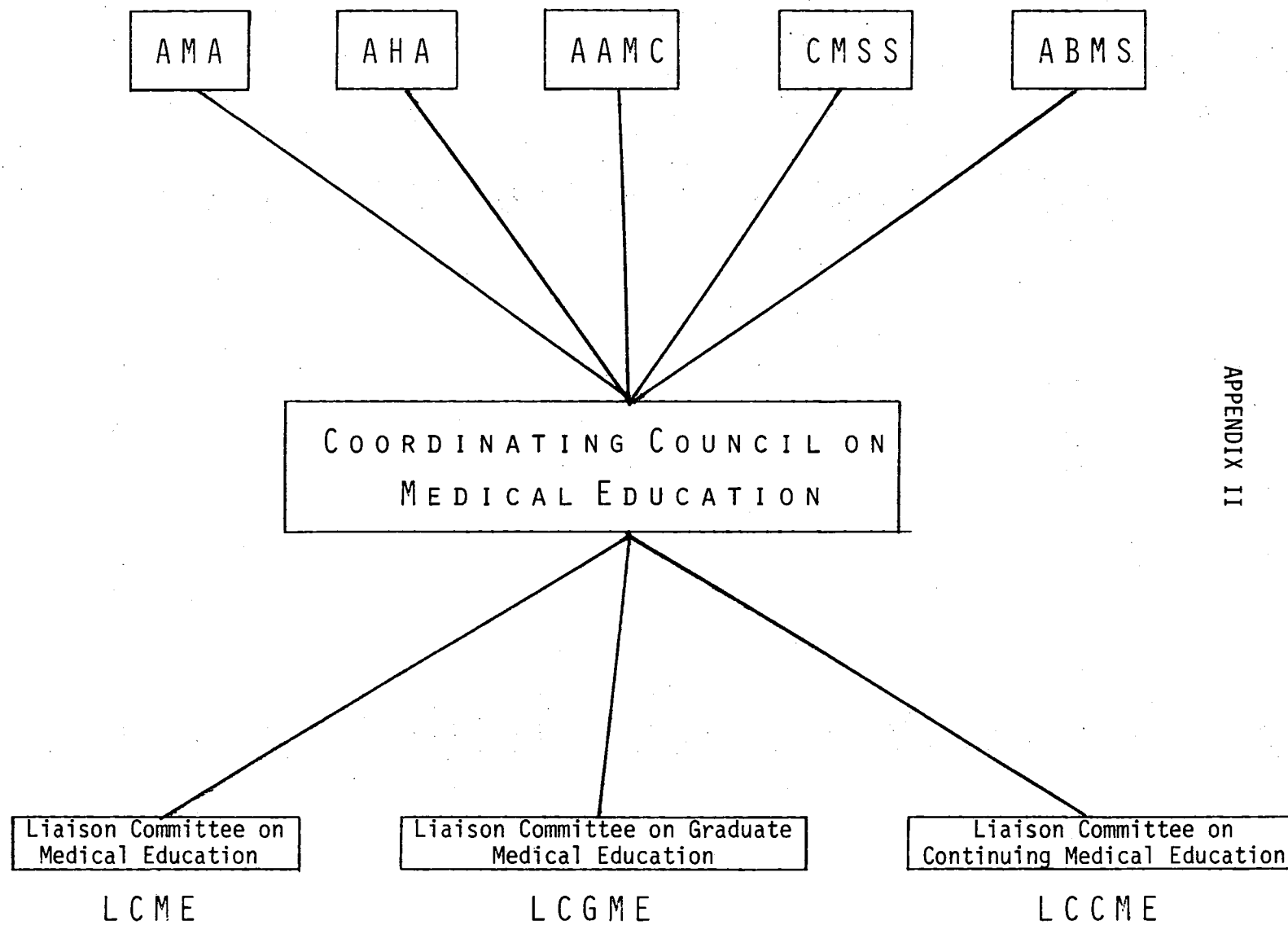
MARY H. LITTLEMEYER

Senior Staff Associate

AAMC Department of

Academic Affairs

Washington, D. C.



APPENDIX II

APPENDIX III

DETAILS OF LCGME BUDGET FOR EVALUATION OF PROGRAMS

CALENDAR YEAR 1976

Expenses

Residency Review Committee Functions

<u>Committee</u>	<u># of Members</u>	<u>Meetings/year</u>	<u>Estimated cost</u>
Anesthesiology	6	2	\$ 9,860
Colon & Rectal Surgery	6	1	1,973
Dermatology	4	1	3,560
Family Practice	9	4	13,225
General Practice	6	1	1,350
Obstetrics-Gynecology	9	3	16,140
Internal Medicine	12	3	13,605
Neurological Surgery	6	2	1,611
Ophthalmology	6	2	2,252
Orthopedic Surgery	9	2	8,343
Otolaryngology	12	2	7,500
Pediatrics	9	2	8,055
Physical Med. & Rehab.	6	2	2,667
Plastic Surgery	9	2	4,313
Preventive Medicine	8	2	4,488
Psychiatry & Neuro.	12	2	9,903
Radiology	8	2	6,223
Thoracic Surgery	9	2	4,369
Urology	9	2	11,117
Pathology	6	2	5,254
Nuclear Medicine	6	2	5,032
Allergy & Immunology	8	2	4,660
Surgery	12	3	15,016
			\$ 160,516
Staff (Secretary & Recorder) travel & lodging			30,190
Field Staff travel & lodging			104,980
Specialist Site Visitors			59,408
Residency Review Committee representatives' travel to LCGME meetings (5 to each of 5, 24 to annual @ \$500)			24,500
Residency Review Committee Functions		Sub Total	\$ <u>379,594</u>

DETAILS OF LCGME BUDGET FOR EVALUATION OF PROGRAMS

CALENDAR YEAR 1976  
(Continued)

Expenses (Contd)

LCGME Functions

Committee Meetings \$ 6,000

Salaries

Committee Secretaries (4 F.T.E.), Administrative  
Assistants (5 F.T.E.), Field Staff (12 F.T.E.),  
Clerk-typists (6 F.T.E.), File clerk (1 F.T.E.) \$ 551,500

Typists (2 F.T.E.) for site visit reports 14,560

Salary Sub Total 566,060

Supplies & Equipment

Office supplies 10,400  
Postage 16,000  
Printing (agenda books, Essentials, guides, etc.) 15,500  
Office equipment rental 10,350  
Telephone 12,000  
Equipment for site visit report typists 2,000

Supplies and equipment Sub Total 66,250

Overhead 320,043

TOTAL EXPENSES \$ 1,337,947

Estimated Costs of Accreditation to Sponsoring Organizations  
and Institutions

Institutions offering residencies 630,000  
(Evaluation fees: 2,100 x \$300)

AMA (4) 678,715

ABME (4) 9,744

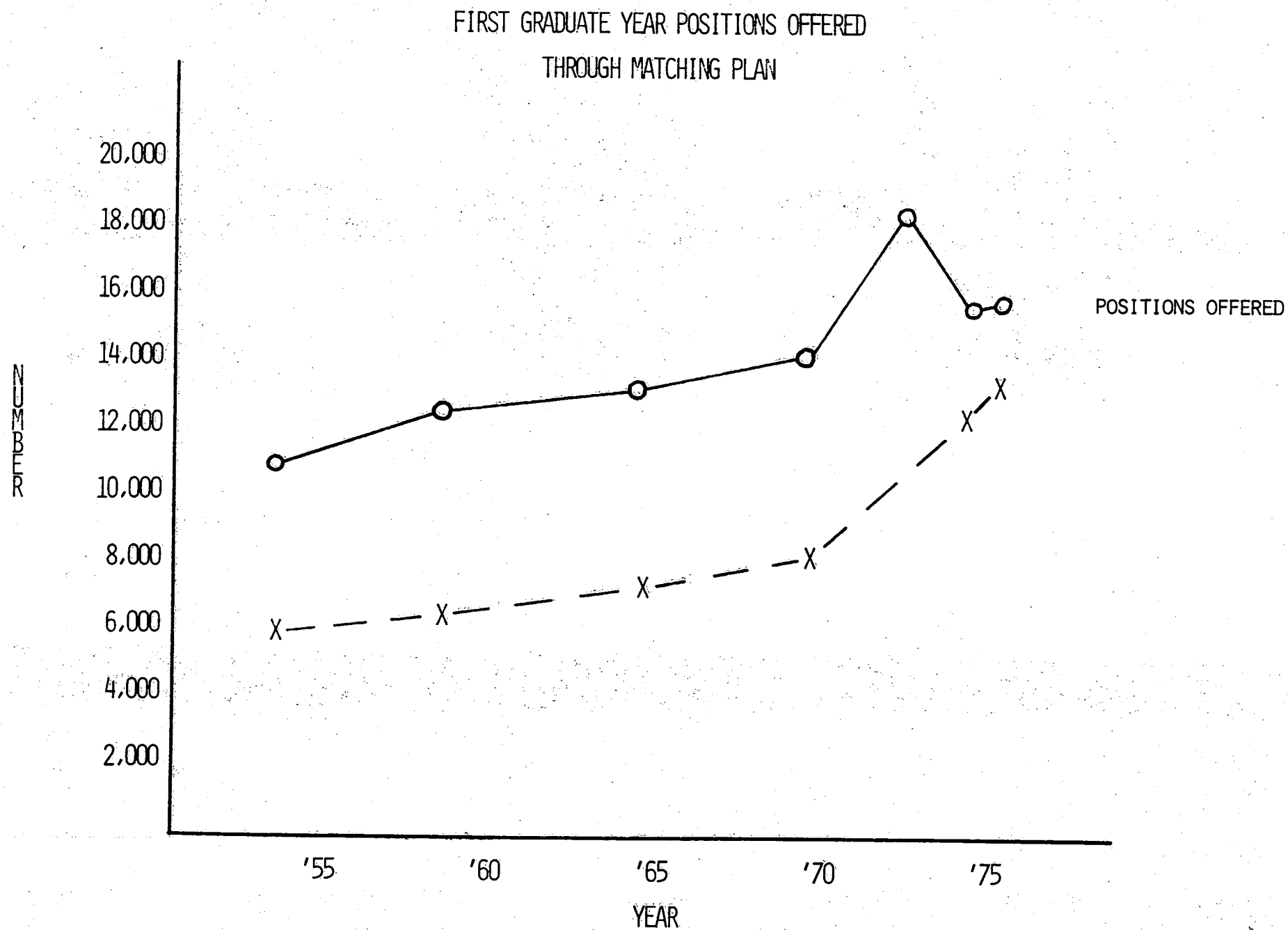
AHA (2) 4,872

AAMC (4) 9,744

CMSS (2) 4,872

TOTAL \$ 1,337,947

Cost per seat \$2,436.00



COUNCIL OF ACADEMIC SOCIETIES  
NUMBER OF MEMBERS OF INDIVIDUAL SOCIETIES

TOTAL NUMBER: (93,595)

ALLERGY	
American Academy of Allergy . . . . .	2,400*
ANATOMY	
American Association of Anatomists . . . . .	2,412*
Association of Anatomy Chairmen . . . . .	140*
ANESTHESIOLOGY	
Association of University Anesthetists . . . . .	200*
Society of Academic Anesthesia Chairmen, Inc. . . . .	90*
BIOLOGICAL CHEMISTS	
American Society of Biological Chemists . . . . .	3,800*
Association of Medical School Departments of Biochemistry . . . . .	95*
CLINICAL LABORATORY	
Academy of Clinical Laboratory Physicians & Scientists . . . . .	223
CLINICAL RESEARCH	
American Association for the Study of Liver Diseases . . . . .	541*
American Federation for Clinical Research . . . . .	6,122
American Society for Clinical Investigation, Inc. . . . .	1,571*
Central Society for Clinical Research . . . . .	800*
Southern Society for Clinical Investigation . . . . .	750*
CRITICAL CARE MEDICINE	
Society of Critical Care Medicine . . . . .	480*
DERMATOLOGY	
Association of Professors of Dermatology . . . . .	
ENDOCRINOLOGY	
Endocrine Society . . . . .	2,900*
FAMILY MEDICINE	
Society of Teachers of Family Medicine . . . . .	1,175*
GASTROENTEROLOGY	
American Gastroenterological Association . . . . .	800
MEDICINE	
American College of Physicians . . . . .	15,000
Association of American Physicians . . . . .	685*
Association of Professors of Medicine . . . . .	120*
MICROBIOLOGY	
Association of Medical School Microbiology Chairmen . . . . .	121*
NEUROLOGY	
American Academy of Neurology . . . . .	3,382
American Neurological Association . . . . .	600*
Association of University Professors of Neurology . . . . .	112*

Continued . . . . .

\*As of 1/76

## NEUROSURGERY

American Association of Neurological Surgeons . . . . . 1,901\*

## OBSTETRICS AND GYNECOLOGY

American College of Obstetricians and Gynecologists . . . . . 9,243\*

Association of Professors of Gynecology and Obstetrics . . . . . 115\*

Society for Gynecologic Investigation . . . . . 253\*

## OPHTHALMOLOGY AND OTOLARYNGOLOGY

American Academy of Ophthalmology and Otolaryngology . . . . . 11,665\*

Association of University Professors of Ophthalmology . . . . . 110\*

Society of University Otolaryngologists . . . . . 250\*

## ORTHOPAEDICS

American Academy of Orthopaedic Surgeons . . . . . 5,738

Association of Orthopaedic Chairmen . . . . . 158\*

## PATHOLOGY

American Association of Pathologists and Bacteriologists . . . . . 1,094

Association of Pathology Chairmen, Inc. . . . . 143\*

## PEDIATRICS

American Pediatric Society . . . . . 600\*

Association of Medical School Pediatric Department Chairmen, Inc. . . . . 118

Society for Pediatric Research . . . . . 400\*

## PHARMACOLOGY

Association for Medical School Pharmacology . . . . . 120\*

## PHYSIATRY

Association of Academic Physiatrists . . . . . 176

## PHYSIOLOGY

American Physiological Society . . . . . 3,985\*

Association of Chairmen of Departments of Physiology . . . . . 127\*

Biophysical Society . . . . . 2,600\*

## PLASTIC SURGERY

American Association of Plastic Surgeons . . . . . 174\*

Educational Foundation of the American Society of Plastic  
& Reconstructive Surgeons . . . . . 1,707\*

Plastic Surgery Research Council . . . . . 79

## PREVENTIVE MEDICINE

Association of Teachers of Preventive Medicine . . . . . 600\*

## PSYCHIATRY

American Association of Chairmen of Departments of Psychiatry . . . . . 114\*

Association for Academic Psychiatry . . . . . 60

## RADIOLOGY

American Society of Therapeutic Radiologists . . . . . 1,020\*

Association of University Radiologists . . . . . 660\*

Society of Chairmen of Academic Radiology Departments . . . . . 131\*

## SURGERY

American Association for Thoracic Surgery . . . . . 400

American Surgical Association . . . . . 300

Association for Academic Surgery . . . . . 800\*

Society of Surgical Chairmen . . . . . 86

Society of University Surgeons . . . . . 734\*

## UROLOGY

American Urological Association . . . . . 3,125

Society of University Urologists . . . . . 290\*

## CAS MEMBER SOCIETIES - MEETING SCHEDULE

January	February	March	April	May
<p>South. Soc. Clin. Inves. New Orleans, LA Jan. 26-29</p> <hr/> <p>Assn. Medical School Depts. of Biochemistry San Antonio, TX Feb. 7-8</p> <hr/> <p>Society of University Surgeons San Diego, CA Feb. 12-14</p> <hr/> <p>Biophysical Society Seattle, WA Feb. 24-27</p> <hr/> <p>Assn. of Medical School Microbiology Chmn. Mobile, AL Feb. 28 - March 1</p> <hr/>		<p>American Academy of Allergy San Juan, PR March 6-10</p> <hr/> <p>Assn. Prof. of Gyn and Ob New Orleans, LA March 9-10</p> <hr/> <p>Soc. for Gyn. Invest. Philadelphia, PA March 24-26</p> <hr/> <p>Assn. Med. School Pharm. Anaheim, CA, April 12</p> <hr/> <p>Amer. Assn. of Anatomists Louisville, KY April 20-23</p> <hr/> <p>American Pediatric Society St. Louis, MO April 26-30</p> <hr/> <p>Assn. Of Univ. Professors of Neurology Toronto, Canada, April 28</p> <hr/> <p>Society for Pediatric Research St. Louis, MO, April 28-30</p> <hr/>	<p>Soc. Teach Fam. Med. New Orleans, LA April 2-4</p> <hr/> <p>Amer. Assn. Neur. Surg. San Francisco, 4-7</p> <hr/> <p>Assn. Chmn. Dept. Physiol. Anaheim, CA April 11</p> <hr/> <p>Assn. of American Physicians Atlantic City, NJ May 1-4</p> <hr/> <p>American Soc. for Clinical Investigation Atlantic City, NJ May 3</p> <hr/> <p>Society of Critical Care Medicine Pittsburgh, PA May 4-6</p> <hr/> <p>Association of Univ. Radiologists Boston, MA May 5-8</p> <hr/> <p>Society of Chmn. of Academic Radiology Depts. Boston, MA May 5-8</p> <hr/> <p>American Association of Plastic Surgeons Atlanta, GA May 9-12</p> <hr/>	<p>Assn. Prof. of Medicine Atlantic City, NJ May 1</p> <hr/> <p>Assn. of Univ. Anesthetists Philadelphia, PA May 1-3</p> <hr/>
June	July	September	October	November
<p>American Soc. of Biological Chemists San Francisco, CA June 6-10</p> <hr/> <p>American Neurological Association San Francisco, CA June 14-16</p> <hr/> <p>Endocrine Society San Francisco, CA June 23-25</p> <hr/>	<p>Amer. Physiolog. Society Philadelphia, PA August 17-19</p> <hr/>	<p>Ed. Found. Amer. Soc. Plast. &amp; Recon. Surg. Boston, MA September 27 - Oct. 2</p> <hr/> <p>Amer. Acad. Ophthal. &amp; Otolaryngology Las Vegas, NV 6-10</p> <hr/> <p>Amer. Soc. Thera. Radiol. Atlanta, GA Oct. 13-17</p> <hr/> <p>Assn. of Teach. of Prev. Med. Miami, FL Mid-October</p> <hr/>		<p>Central Society for Clinical Research Chicago, IL Nov. 4-6</p> <hr/> <p>Assn. of University Prof. of Ophthalmology San Diego, CA Nov. 5-7</p> <hr/> <p>Amer. Assn. Study Liv. Dis., Chi ago, 5-6</p> <hr/> <p>Amer. Assn. Chmn. Dept. Psych, San Francisco, 11</p> <hr/> <p>Assn. Orthopaed. Chmn, San Francisco, 11</p> <hr/> <p>Assn. Pathology Chmn, San Francisco, 11</p> <hr/> <p>Soc. of Univ. Urologists, San Francisco, 13-14</p> <hr/> <p>Assn. Anatomy Chmn., San Francisco, 11</p> <hr/> <p>Soc. of Univ. Otolaryn., San Francisco, 11</p> <hr/> <p>Society of Academic Anesthesia Chmn. Chicago, IL</p> <hr/>
				December



UNITED STATES OF AMERICA  
BEFORE THE NATIONAL LABOR RELATIONS BOARD

CEDARS-SINAI MEDICAL CENTER

Employer

and

Case 31--RC--2983

CEDARS-SINAI HOUSESTAFF ASSOCIATION

Petitioner

DECISION AND ORDER

Upon a petition duly filed under Section 9(c) of the National Labor Relations Act, as amended, a hearing was held on various dates before Hearing Officer James M. Middleton. Following the hearing and pursuant to Section 102.67 of the National Labor Relations Board Rules and Regulations and Statements of Procedure, Series 8, as amended, by direction of the Regional Director for Region 31, this case was transferred to the Board for decision. Thereafter, the Employer and Petitioner filed briefs,<sup>1/</sup> which have been duly considered.

On September 3, 1975, the Board, having determined that this and a number of other cases in the health care industry presented issues of importance in the administration of the National Labor Relations Act, as amended, scheduled oral argument in several of these cases, including this one. Oral arguments were heard on September 8, 1975. Briefs amici curiae were filed by interested parties and have been duly considered.

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<sup>1/</sup> With the Board's consent, Association of American Medical Colleges and the Physicians National Housestaff Association submitted amicus curiae briefs, which have also been carefully considered.

The Board has reviewed the Hearing Officer's rulings made at the hearing and finds that they are free from prejudicial error. They are hereby affirmed.

On the entire record in this case, the Board finds:

1. Cedars-Sinai Medical Center is a private nonprofit California corporation engaged in the operation of a medical center, including acute general hospitals, in the Los Angeles, California, area. The Employer annually receives revenues valued in excess of \$500,000 from such operations, and annually purchases goods valued in excess of \$50,000 from directly outside the State of California. The parties have stipulated, and we find, that the Employer is engaged in commerce. Accordingly, we find that it will effectuate the policies of the Act to assert jurisdiction herein.

2. The Employer contends that the Petitioner is not a labor organization within the meaning of Section 2(5) of the Act. The Petitioner's constitution states its purpose is to unite the Employer's interns and residents for the attainment of their collective goals including, inter alia, contract negotiations pertaining to salaries and working conditions. As we find hereinafter that the interns, residents, and clinical fellows are not "employees" within the meaning of the Act, and the record shows that Petitioner is composed solely and exclusively of interns, residents, and clinical fellows at Cedars-Sinai, we find, for the purposes of this proceeding, that the Petitioner is not a labor organization within the meaning of the Act. .

3. No question affecting commerce exists concerning the representation of employees of the Employer within the meaning of Sections 9(c)(1) and 2(6) and (7) of the Act for the following reasons:

As indicated above, Cedars-Sinai is a nonprofit corporation engaged in the operation of a medical center in the Los Angeles, California, area. The Employer operates two acute general hospitals: the Cedars of Lebanon Hospital Division which is licensed to operate 530 beds; and the Mount Sinai Hospital Division which is licensed to operate 230 beds. The Petitioner seeks to represent a unit of interns, residents, and clinical fellows.<sup>2/</sup> The Employer contends that such a unit is inappropriate because, inter alia, these interns, residents, and clinical fellows are students, not employees. We find merit in the Employer's position, as we find that interns, residents, and clinical fellows, although they possess certain employee characteristics, are primarily students. Accordingly, for the reasons given below, we conclude that the interns, residents, and clinical fellows in the petitioned-for unit are not "employees" within the meaning of Section 2(3) of the Act.

The record shows that the medical education and training of a physician involves a progression from classroom and laboratory education in the basic and clinical sciences, through an internship, and usually then to a period of more advanced training in a specialty or subspecialty of medicine. It is the purpose of internship and residency programs to put into practice the principles of preventive medicine, diagnosis, therapy, and management of patients that the medical school graduate learned in medical school.

An intern is a medical school graduate serving his first period of graduate medical training in a hospital. Most states, including California, require an

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<sup>2/</sup> Petitioner does not seek to represent research fellows.

internship of 1 year to qualify for the examination to practice medicine. A resident is a physician who has completed an internship and serves a period of more advanced training, lasting from 1 to 5 years, in a specialty. A clinical fellow is a physician who has completed an internship and a residency and is taking an educational postgraduate program to qualify for certification in an identifiable subspecialty of medicine. The term "housestaff" is commonly used by medical and hospital personnel, and will be used in this Decision, when referring collectively to interns, residents, and clinical fellows.

Graduate medical education and training programs to qualify for licensing and for certification in a specialty or subspecialty are governed by national medical organizations, such as the American Medical Association, the National Board of Medical Examiners, and the specialty boards, and by state licensing authorities. The standards for internships and residencies are contained in "Essentials of an Approved Internship" and "Essentials of Approved Residencies," hereinafter the "Essentials," prepared by the Council on Medical Education and approved by the American Medical Association. The programs are carried out in hospitals that are accredited by these various bodies and that in many instances have affiliation agreements with approved medical schools. Cedars-Sinai is such a hospital.

Cedars-Sinai offers internships and residencies in medicine, pediatrics, surgery, obstetrics and gynecology, pathology, psychiatry, and radiology. Its programs are fully accredited by the Council on Medical Education of the American Medical Association and by the various specialty boards. Cedars-Sinai has affiliation agreements with the UCLA Medical School. Most of Cedars-Sinai's 41 full-time and 25 part-time staff physicians hold UCLA Medical School appointments and

certain of its approximately 1,000 voluntary attending staff physicians who participate in the teaching program also hold UCLA appointments. The medical staff, but not the housestaff, has admission privileges at Cedars-Sinai.

At the time of the hearing, there were 34 interns, 86 residents, and 24 clinical fellows in the various graduate medical training programs at Cedars-Sinai. The majority of the interns and residents were training in the specialty of medicine. The remaining interns were training primarily in pediatrics or surgery and the remaining residents were spread out over the specialties other than medicine. The vast majority of the clinical fellows were training in subspecialties of medicine.

The placement of graduating medical students at Cedars-Sinai is governed by the National Intern and Resident Matching Program. This program is designed to place graduating medical students with a preferred graduate training institution. Both the students and the hospitals register with the National Matching Program by signing an agreement that they will be bound by the matching results. The procedure is for a graduating medical student to make out a preference list of positions they have applied for (with or without a personal interview) at the participating hospitals approved by the American Medical Association. The hospitals make out a ranking list of their student applicants. The entire basis for matching decisions is the student-ranking list in combination with the hospital list.<sup>3/</sup> Appointments of residents and clinical fellows are made by department directors at Cedars-Sinai. Generally, these positions are filled by interns who were originally placed at Cedars-Sinai through the National Matching Program.

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<sup>3/</sup> If an applicant goes unmatched, he makes individual arrangements among the positions that remain unfilled after the matching.

The activities of interns, residents, and clinical fellows while in graduate programs such as those operated by Cedars-Sinai are prescribed by the accrediting bodies and specialty boards which govern graduate medical education, supra. The training programs consist of patient care activities coordinated with a variety of teaching and educational activities designed to develop the student's clinical judgment and proficiency in clinical skills. The record contains numerous examples of the types of patient care performed by the housestaff in Cedars-Sinai's departments of medicine, pediatrics, and surgery and to a lesser extent in gynecology and the treatment and evaluation center. In general, the patient care activities consist of taking medical histories, performing examinations, preparing medical records and charts, and developing diagnostic and therapeutic plans. The housestaff also participates in service rounds and assists in surgical procedures. These patient care activities, an integral part of a physician's educational training, are coordinated with a variety of teaching and educational activities, such as grand rounds, teaching rounds, laboratory instruction, seminars, and lectures. A housestaff officer also can take elective courses and participate in rotations to other hospitals.

During their training at Cedars-Sinai, members of the housestaff receive an annual stipend which is on a graduated basis ranging from a first-year intern to a fifth-year resident. The amount of the stipend is not determined by the nature of the services rendered or by the number of hours spent in patient care. Nor does the choice of electives or even rotations to other hospitals affect the amount of the stipend. The "Essentials" characterize the stipend as a scholarship for graduate study. The housestaff also receive a variety of fringe benefits, such as medical and dental care, an annual vacation and paid holidays, uniforms, meals

while on duty, and malpractice insurance. They are not eligible for Cedars-Sinai's retirement plan. Discipline is administered by a housestaff committee.

The tenure of interns and residents at Cedars-Sinai is closely related to the length of the program which each individual pursues. The record indicates that 58 of the 120 interns and residents at the time of the hearing were in their first year at Cedars-Sinai, 35 were in their second year, and 22 were in their third year. Thus the average stay of interns and residents at Cedars-Sinai is less than 2 years. As to the clinical fellows, the record indicates that 1974--75 was the first year at Cedars-Sinai for seven of them. Following completion of their programs at Cedars-Sinai, the majority of the housestaff go into private practice and others go into group practices or accept positions with health organizations. Only a few interns, residents, or clinical fellows can expect to, or do, remain to establish an employment relationship with Cedars-Sinai.

From the foregoing and the entire record, we find that interns, residents, and clinical fellows are primarily engaged in graduate educational training at Cedars-Sinai and that their status is therefore that of students rather than of employees. They participate in these programs not for the purpose of earning a living; instead they are there to pursue the graduate medical education that is a requirement for the practice of medicine. An internship is a requirement for the examination for licensing. And residency and fellowship programs are necessary to qualify for certification in specialties and subspecialties. While the housestaff spends a great percentage of their time in direct patient care, this is simply the means by which the learning process is carried out. It is only through this direct involvement with patients that the graduate medical student is able to acquire the necessary diagnostic skills and experience to practice his profession.

The number of hours worked or the quality of the care rendered to the patients does not result in any change in monetary compensation paid to the housestaff members. The stipend remains fixed and it seems clear that the payments are more in the nature of a living allowance than compensation for services rendered. Nor does it appear that those applying for such programs attached any great significance to the amount of the stipend. Rather their choice was based on the quality of the educational program and the opportunity for an extensive training experience. The programs themselves were designed not for the purpose of meeting the hospital's staffing requirements, but rather to allow the student to develop, in a hospital setting, the clinical judgment and the proficiency in clinical skills necessary to the practice of medicine in the area of his choice. The "Essentials," which describe the standards for approved internships and residencies, indicate that the primary function is educational. Moreover, the tenure of a member of the housestaff at Cedars-Sinai is closely related to the length of the student's training program; thus few interns, residents, or clinical fellows can expect to, or do, remain to establish an employment relationship with Cedars-Sinai following the completion of their programs.

In sum, we believe that interns, residents, and clinical fellows are primarily students. We conclude, therefore, that they are not employees within the meaning of Section 2(3) of the Act.<sup>4/</sup> Accordingly, no question affecting commerce exists concerning the representation of "employees" of the Employer within the meaning of Section 9(c) of the Act, and we shall dismiss the petition herein.

<sup>4/</sup> As we have found, for the reasons stated above, that interns, residents, and clinical fellows are not employees within the meaning of the Act, we find no merit in Petitioner's contention that they are employees based on Sec. 2(11) and (12) of the Act, which defines the terms "supervisor" and "professional employee," respectively.



Our dissenting colleague has misconstrued the basis for our decision. We are aware that the Board has included students in bargaining units and, in a few instances, has authorized elections in units composed exclusively of students. However, contrary to our dissenting colleague, we do not find here that students and employees are antithetical entities or mutually exclusive categories under the Act. Instead, we find that the interns, residents, and clinical fellows who filed the petition herein are primarily engaged in graduate educational training at Cedars-Sinai. It is the educational relationship that exists between the housestaff and Cedars-Sinai (a teaching hospital) which leads us to conclude that the housestaff are students rather than employees, i.e., that the housestaff's relationship with Cedars-Sinai is an educational rather than an employment relationship. Thus, far from "exploiting semantic distinctions," our decision rests on the fundamental difference between an educational and an employment relationship.

In addition to misconstruing our decision, our dissenting colleague advances inapposite considerations which have no bearing on whether interns, residents, and clinical fellows are employees within the meaning of the Act. Thus, whether Cedars-Sinai or any other "hospital charges fees in amounts which have sparked national debate," or whether patients ". . . would hardly take comfort in the notion that the individual in whose hands their life itself may repose . . . is primarily a student of the matter," has no bearing on the issue here. Similarly, even assuming that "there is some support for the proposition that the primary interest of the housestaff's representational aims is the improvement of patient care," as our dissenting colleague suggests, that aim is of no significance in resolving the employment status of the individuals before us. Furthermore, our dissenting colleague

is inaccurate in stating that Cedars-Sinai offers " . . . no degree, no grades, no examinations." On the contrary, housestaff are regularly evaluated by staff physicians and Cedars-Sinai is required to certify that the training program has been successfully completed. Teaching hospitals play an integral role in the training of physicians. A graduate of an approved medical school is not ready to practice upon completion of the M.D. requirements. Rather, as more fully described above, he must continue his graduate educational training in a so-called teaching hospital, where the program offered by the hospital and the activities engaged in by the medical students are prescribed by accrediting bodies and specialty boards. In short, it is plain from the record as a whole that the interns, residents, and clinical fellows are engaged in graduate educational training at Cedars-Sinai and that---in view of this educational rather than employment relationship---they are students rather than employees within the meaning of the Act.

## ORDER

It is hereby ordered that the petition filed herein be, and it hereby is, dismissed.

Dated, Washington, D.C. MAR 19 1976

Betty Southard Murphy, Chairman

Howard Jenkins, Jr., Member

John A. Penello, Member

Peter D. Walther, Member

NATIONAL LABOR RELATIONS BOARD

(SEAL)

MEMBER FANNING, dissenting:

At the outset, I wish to emphasize that the issue in these cases is not how to exploit semantic distinctions between the terms "students" and "employees." One does not, necessarily, exclude the other and, indeed, this Board has included "students" in bargaining units in numerous cases and has authorized elections in which the voting group was composed exclusively of "students."<sup>5/</sup> The touchstone has always been whether the "students" were also employees. I equally emphasize that the issues before us are simply stated. Are those doctors commonly denominated "housestaff" entitled to bargain collectively under the auspices of our statute and, if so, do they possess a sufficiently distinct community of interests enabling them to constitute an appropriate unit unto themselves? Nevertheless, because my colleagues choose to proceed on such a basis, I turn initially to consideration of the question whether a finding that housestaff officers are "primarily students" justifies the conclusion they are not, for that reason, "employees" within the intentment of the Act.

I

Section 2(3) of the Act states that the term "employee" is meant to "include any employee . . . unless the Act explicitly states otherwise," and proceeds to explicitly state those excluded from the definition, e.g., agricultural laborers, domestic servants, et al. "Students" are not among those exclusions. Recognition of an underlying Federal policy which seeks to draw a line between labor and

<sup>5/</sup> The Macke Company (II), Case 2--RC--16725 (Not reported in volumes of Board Decisions.) The Macke II students were those originally excluded from the unit found appropriate in The Macke Company, 211 NLRB 90 (1974).

management has further led to the exclusion, on such policy grounds, of two additional classes of "employees," namely, confidential and managerial employees.<sup>6/</sup> That is all. Since the statutory exclusions do not mention and the policy underlying the nonstatutory exclusions does not reach "students," the relationship between "student" and "employee" cannot be said to be mutually exclusive. The fundamental question then is always whether the individual before us, be that individual "primarily a carpenter" or "primarily a student," is, nevertheless, an "employee" under the Act.

The imprecision which necessarily accompanies the attempt to define an "employee," particularly in terms well suited to modern industrial relations, accounts for the deliberate refusal of the drafters of the Wagner Act to define the term in any but a circular fashion. "An employee includes any employee." Historically, that approach gave rise to two conflicting views. The primary consideration, it was contended on one hand, "is whether effectuation of the declared policy and purposes of the Act comprehended securing to the individual the rights guaranteed and protection afforded by the Act."<sup>7/</sup> Such circularity, it was stated on the other, reflected no more than a congressional intent to ascribe an "ordinary meaning" to the term, as that meaning was "developed under the common law."<sup>8/</sup>

<sup>6/</sup> For a more authoritative discussion, see N.L.R.B. v. Bell Aerospace Company, Division of Textron, Inc., 416 U.S. 267 (1974).

<sup>7/</sup> N.L.R.B. v. Hearst Publications, Incorporated, 322 U.S. 111, 131-132 (1944).

<sup>8/</sup> Id. at 120, et seq. See also I Leg. Hist. 309 (1947).

For present purposes, it is unnecessary to consider either the vitality of those early decisions which resolved the matter in favor of the former, more liberal, interpretation or the applicability of those decisions which, in the context of employee/independent contractor disputes, upheld the latter.<sup>9/</sup> If we posit that Section 2(3)'s usage of the term "employee" is no broader than the common law's, housestaff officers are, beyond doubt, employees within the meaning of the Act.

The term "employee" is the outgrowth of the common law concept of the "servant."<sup>10/</sup> At common law, a servant was a "person employed to perform services in the affairs of another and who with respect to the physical conduct in the performance of the services is subject to the other's control or right of control."<sup>11/</sup> Although, under the common law, consideration for the services performed does not appear to have been a sine qua non of establishing the master-servant relationship,<sup>12/</sup> it is generally conceded, today, that such consideration is necessary for classification as an "employee."<sup>13/</sup> So that the conventional meaning of the word implies someone who works or performs a service for another from whom he or she receives compensation.<sup>14/</sup>

<sup>9/</sup> Compare Hearst, supra, with N.L.R.B. v. United Insurance Company, 390 U.S. 254, 256 (1968). See Boire v. Greyhound Corp., 376 U.S. 473, fn. 10 (1964).

<sup>10/</sup> See 30 C.J.S. Employee at 672 (Corpus Juris Secundum). "The shift to the first terminology seems to have accompanied the development of workmen's compensation legislation, which makes clear the substantial identity of the two." Stevens, "The Test of the Employment Relation," 38 Mich. L. Rev. 188, 189 (1939).

<sup>11/</sup> Restatement (Second), Agency, § 200 (1957). See also § 2: "A servant is an agent employed by a master to perform service in his affairs. . . ."

<sup>12/</sup> Id. at § 225, a.

<sup>13/</sup> See, e.g., 30 C.J.S., supra at 673.

<sup>14/</sup> See I Leg. Hist. 309 (1947). See, e.g., Meyer Dairy, Inc., a Subsidiary of Milgram Food Stores, Inc. v. N.L.R.B., 429 F.2d 697, 701 (C.A. 10, 1970). This notion of the "performance of a service for another" merits an aside, for it points out a fundamental confusion on my colleagues' part. Presumably, (continued)

It is significant to note that the common law's development of the master-servant doctrine was principally concerned with establishing a tortious liability in the master for the acts of the servant<sup>15/</sup> and, indeed, the principle of respondent superior plays more than a small part in the current malpractice crisis of which we are all aware. That my colleagues have ignored a significant component of the hospital-housestaff relationship namely the former's vicarious liability for the actions of the latter,<sup>16/</sup> is a convenient introduction to another aspect of these cases which requires greater discussion---the facts.

<sup>14/</sup> the basis for the majority opinion is found somewhere within the confines of The Leland Stanford Junior University, 214 NLRB No. 82 (1974). The Stanford petitioner sought to represent 83 "research assistants" who were graduate students enrolled in Stanford's doctoral physics program. The research they conducted was a fundamental and required part of the course of instruction leading to the degree. The research they conducted was thesis oriented, that is to say, and this is a crucial point, the research assistants did not perform a service for Stanford. With guidance, perhaps, from their mentors, they independently selected their research projects. They performed that research for themselves. In terms of the actual research conducted, Stanford was, essentially, a disinterested party. Stanford did not control the research, did not request the research, and, most significantly, did not receive remuneration from a third party for the particular research. All of which is to say, as Cornell University, amicus curiae in the case, pointed out, the research assistants did not work for the alleged employer and, therefore, were not employees. It is a point of moment. We do not exclude students from coverage because they are students (even less the case where they are "primarily students"). In certain cases, they will be excluded because, as students, they do not work or perform a service for an employer. In other cases, they will be excluded from the unit found appropriate because, as students, their interests may not be aligned with those of other employees. There is, on the other hand, simply no basis either in the Act or in our precedents for concluding that under any circumstances students and employees are antithetical entities.

<sup>15/</sup> See Stevens, supra at 189.

<sup>16/</sup> See Hospital Law Annual, Administrators' Vol. 1(a), 9. Compare Rosane v. Sanger, 112 Colo. 363 (1944), holding a medical staff physician's actions not to have created a liability in the hospital. The fact that liability can be imposed upon the hospital for the actions of its housestaff and will not, under certain circumstances, be imposed for the actions of medical staff is further demonstration that housestaff officers work for the hospital.

## II

All housestaff officers are M.D.'s. All fellows and residents are licensed physicians in every State of the Union. It is, of course, impossible to set forth the full range of services these physicians perform for the hospital and, more importantly, for the patient, but my colleagues' silence as to what these housestaff officers do cannot go unnoted. The records before us demonstrate, for example, that housestaff officers, without immediate supervision of any kind, continually deal in matters literally of the ultimate significance. That they do is a function, no doubt, of their hours. The housestaff work round-the-clock, 7 days a week, 52 weeks a year. No other physicians do. They perform their services, on an individual basis, for periods lasting, at times, well over 100 hours a week, in shifts that often exceed 50 consecutive hours. They singly staff emergency rooms, frequently at times when their supposed "teachers" are not even in the facility. That accounts for the record facts which demonstrate that, without supervision, a housestaff officer can be called upon and, in fact, has been called upon, to open the chest wall of a 3-year-old child; hold the heart of a patient in his hands; remove breast tissues, kidneys, veins; deliver babies; insert tubes in the tracheae of newborns and catheters into abdominal cavities; administer closely controlled and potentially lethal medications; and for a host of similar procedures.

For those services and innumerable others supervised by medical staff but performed by housestaff, the hospital charges fees in amounts which have sparked national debate. In return for those services, the hospital pays that housestaff officer what my colleagues call a "stipend." It exceeds, in some cases of multiple residencies, \$20,000 a year. From that "stipend," the hospital withholds Federal

and state taxes, <sup>17/</sup> contributes to social security, and provides for health insurance. The hospital grants vacations and sick leave, laundry allowances, etc. For the negligent performance of those services the hospital can be sued. For

17/ The "stipend" is taxable income. Although amicus AAMC contends that this point is in doubt, I find no support for that doubt in terms of the type of housestaff officers and training institutions before us. Because of AAMC's position, it merits attention. Under sec. 117 of the Internal Revenue Code, fellowships and scholarships are, under certain conditions, generally excludable from gross income. Such fellowships and scholarships are not excludable if they constitute compensation for services rendered. From the very beginning of sec. 117, added to the Code in 1954, to this very day, the Department of Treasury has taken the position that the typical housestaff officer receives compensation for services rendered. Rev. Rul. 57-386, 1957-2 Cum. Bull. 107; Rev. Rul. 68-520, 1968-2 Cum. Bull. 58; Rev. Rul. 71-36, 1971-2 Cum. Bull. 99; Rev. Rul. 75-490 at 5 (Bull. No. 1975-46). The uniformity of approval of that position is not lightly dismissed. Hembree v. U.S., 464 F.2d 1262 (C.A. 4, 1972); Wertzberger v. U.S., 441 F.2d 1166 (C.A. 8, 1971); Quast v. U.S., 428 F.2d 750 (C.A. 8, 1970); Woddall v. Commissioner, 321 F.2d 721 (C.A. 10, 1963); Tobin v. U.S., 323 F.Supp. 239 (D.C. Tex., 1971); Taylor v. U.S., 22 AFTR2d 5246 (D.C. Ark., 1968); Lingl v. Charles, 21 AFTR2d 410 (D.C. Ohio, 1967); Proskey v. Commissioner, 51 T.C. 918 (1969); Kadivar, T.C. Memo 1973-95; Kaufman, T.C. Memo 1973-21.

There are, of course, cases, the most notable of which is Leathers v. U.S., 471 F.2d 856 (C.A. 8, 1972), which hold, under certain circumstances, the appropriate portion of the "stipend" to be excludable. My analysis of those cases reveals that they do not reflect the typical intern/resident case, to the extent that the individual involved in such cases is either not as actively involved in direct patient care (e.g., Dr. Leathers in Leathers, supra, who devoted the bulk of his time to personal research or study) or the residency involved is undertaken either at the behest of a third-party grantor or in a facility in which the admission of patients is incidental to the purpose of the facility (e.g., the Western State Psychiatric Institute in Wroblewski v. Bingler, 161 F.Supp. 901 (D.C. Penn., 1958). Leathers, supra, did not hold, as AAMC argues that the "stipend" is partially excludable; it merely held that there was substantial evidence justifying the below jury's verdict. Compare the other Eighth Circuit decisions in Quast and Wertzberger, supra. Wroblewski, supra, issued, of course, prior to the lead Supreme Court decision in the area, Bingler v. Johnson, 344 U.S. 741 (1969). In Bingler, the Supreme Court held that the sec. 117 exclusion would be applicable only where the "stipend" was a "relatively disinterested 'no strings' educational grant." I find it difficult to accept my colleagues' apparent conclusion that the hospitals before us stand as disinterested grantors of "stipends" to which no strings are attached. These "stipends" are compensation for services rendered. Make no mistake, as my colleagues do, about that. The recipients are, therefore, employees.



those services the housestaff receives, absent unusual circumstances not before us, no degree, no grades, no examinations. Housestaff officers perform those services on (and in) individuals who would hardly take comfort in the notion that the individual in whose hands their life itself may repose is not primarily interested in performing that service for the hospital and patient but, rather, is primarily a student of the matter. In point of fact, according to a study initiated by the Association of American Medical Colleges itself, approximately 80 percent of a housestaff officer's time is spent "in direct patient care activities."<sup>18/</sup> Certainly, there is a didactic component to the work of any initiate, but simply because an individual is "learning" while performing this service cannot possibly be said to mark that individual as "primarily a student and, therefore, not an employee" for purposes of our statute.

<sup>18/</sup> A. Carroll, "Program Cost Estimating In a Teaching Hospital" at 76. The study was jointly sponsored by the AMA, AAMC, and American Hospital Association (AHA). It is revealing in several respects, not the least of which is its demonstration that parties to Board proceedings have been known to be less than candid. I quote from the study:

The patient care that interns and residents provide is similar to the care that a patient would receive from a practicing physician of his choice. The resident does all of the things that any other physician would do except that where he has not been thoroughly trained, he performs under close supervision. . . .

[T]he hospitalized patient can receive competent medical care regular routinely, or in emergencies as often as he may need it. This would not be possible without either an adequate number of interns and residents or a very large staff of full-time physicians. The present intern and resident system . . . gives hospitals and attending physicians a way to maintain constant stand-by physician services for all hospital patients. And the overall costs of this stand-by care are considerably lower than would otherwise be possible. A patient who has been informed that the intern and resident physicians who care for him work hand in hand with his own private physician and carry out his orders in all important matters will recognize these house staff services as an essential part of the care he receives while in the hospital. [Emphasis supplied.]

Discourse on the exhaustive indicia of "employee status" enjoyed by housestaff officers and ignored by my colleagues should not be undertaken at the expense of what my colleagues actually do say. I turn briefly to a consideration of the limited factors upon which my colleagues purport to rely:

[a] The "Essentials," which describe the standards for approved internships and residencies, indicate that the primary function is educational.

The "Essentials" constitute, in part, a set of guidelines and instructions to hospitals which would seek to become training institutions. Because the hospitals are instructed to view the primary purpose of housestaff programs as educational has no bearing on whether the housestaff ultimately performs a service for compensation<sup>19/</sup> and certainly is not entitled to overcome the classic employment relationship between housestaff officers and these hospitals. In fact, the "Essentials" acknowledge that relationship by their mandate of "Employment Agreements" which "should specify at a minimum . . . the salary . . . vacation periods . . . hours of duty," etc., of housestaff officers. In accordance with that mandate, the AMA, on January 13, 1975, distributed a memorandum to all approved teaching hospitals reporting the adoption of "Guidelines for Housestaff Contracts or Agreements" by the AMA house of delegates. It is an instructive piece of record evidence:

<sup>12/</sup> The study referred to in the preceding footnote devotes substantial discussion to the cost benefits of housestaff programs. The "Essentials" description of such programs as primarily educational may fairly be read as a proper admonition to would-be training institutions not to consider establishment of such programs as a convenience whereby professional medical service may be increased without incurring the greater cost that would otherwise flow from an increase in the medical, as opposed to house, staff. Indeed, the "Essentials," in the same section, remind such institutions that the "primary function" of the training institution will continue to be "providing adequate facilities for the scientific care of the sick and injured."

The agreement should provide fair and equitable conditions of employment for all those performing the duties of interns residents and fellows . . . .

The institution and the individual members of the housestaff must accept and recognize the right of the housestaff to determine the means by which the housestaff may organize its affairs, and both parties should abide by that determination; provided that the inherent right of a member of the housestaff to contract and negotiate freely with the institution, individually or collectively, for terms and conditions of employment and training should not be denied or infringed. No contract should require or proscribe that members of the housestaff shall or shall not be members of an association or union. [Emphasis supplied.]

Other guidelines are variously listed under the following subject headings:

Salary for Housestaff, Hours of Work, Off-Duty Activities, Vacation and Leave, Insurance Benefits, Professional Liability Insurance, Grievance Procedure, and Disciplinary Hearings and Procedure. I do not see how my colleagues can ignore such compelling evidence that the ultimate authority governing housestaff relationships and programs so clearly considers these individuals to be employees.

[b] Nor does it appear that those applying for such programs attached any great significance to the amount of the stipend.

In the cases before us, there is some support for the proposition that the primary interest of the housestaff's representational aims is the improvement of patient care. There is, further, some support for the proposition that the primary value attached to an individual residency or subspecialty is the quality of the institution providing that program, and the opportunity of exposure to a wide range of medical experience. That is, hopefully, not a unique approach in any field of endeavor, particularly professional ones. There is, on the other hand, absolutely no support for a statement which implies that the so-called "stipend" (the AMA calls it "salary," the study initiated in part by AAMC calls it a "wage," the IRS calls it "payment for services rendered") is not a considerable source of concern. Support for the majority proposition requires, merely, the complete

dismissal of the testimony of housestaff representatives before Congress  
 21/  
 and the congressional response to it.

[c] [T]heir choice was based on the quality of the educational program and the opportunity for an extensive training experience. The programs themselves were designed . . . to allow the student to develop, in a hospital setting, the clinical judgment and the proficiency in clinical skills necessary to the practice of medicine in the area of his choice.

I fail to perceive how the fact that an individual desirous of becoming an orthopedic surgeon chooses a residency program based on its quality and the opportunity for extensive training bears relevance to the question whether, having done so, he or she is an "employee" under the Act. It is, for example, fairly common knowledge that physicians engaged in private practice for many years take up residencies both within their certified specialty (to keep abreast of developments) and outside their certified specialty (to expand upon their skills). That the  
 22/  
 housestaff officer's choice is "based on the quality of the educational program and the opportunity for . . . extensive training" is not so much evidence that he or she is "not an employee" as it is evidence of the desire, as the residencies

20/ See, e.g., Hearings on S.794, S.2292, Before the Subcommittee on Labor of the Committee on Labor and Public Welfare, United States Senate, 93d Cong., 1st Sess. at 291--295, 380--382 [hereinafter Hearings]. See also Hearings on H.R.11357, Before the Subcommittee on Labor of the Committee on Labor and Public Welfare, United States Senate, 92d Cong., 2d Sess. at 29--31.

21/ See, e.g., 120 Cong. Rec. S6933 (daily ed., May 2, 1974) (remarks of Senator Cranston).

22/ Considerable attention was devoted in these cases, as the majority opinion reflects, to the procedure by which housestaff officers are employed. The degree of "freedom of choice" accompanying an employment relationship is largely irrelevant once it is established that the individual in question in point of fact performs a service for compensation. Witness, e.g., the "hiring" procedures of professional athletes, National Football League Management Council, et al., 203 NLRB 958 (1973), and individuals supplied by referral agencies, Manpower, Inc., of Shelby County, 164 NLRB 287 (1967).

of fully licensed and certified practitioners demonstrate, of some individuals to perform their functions well.

Finally, in my consideration of what my colleagues have actually stated, as opposed to the notable matters they have ignored, mention must be made of my colleagues' final footnote:

As we have found, for the reasons stated above, that interns, residents, and clinical fellows are not employees within the meaning of the Act, we find no merit in Petitioner's contention that they are employees based on Sec. 2(11) and (12) of the Act . . . .

That simple footnote marks the majority's response to the two most significant considerations presented by these cases---the language of the statute and the intent of Congress.

### III

Section 2(12) of the Act sets forth the definition of a "professional employee" as:

(a) any employee engaged in work . . . (iv) requiring knowledge of an advanced type in a field of science or learning customarily acquired by a prolonged course of specialized intellectual instruction and study in an institution of higher learning or a hospital . . . or

(b) any employee, who (i) has completed the courses of specialized intellectual instruction and study described in clause (iv) of paragraph (a), and (ii) is performing related work under the supervision of a professional person to qualify himself to become a professional employee as defined in paragraph (a). [Emphasis supplied.]

Section 2(12) was, in part, designed to cover housestaff specifically. In the words of the House Conference Report accompanying the Taft-Hartley amendments to the Act, the section was designed to embrace "such persons as legal, engineering,

scientific and medical personnel together with their junior professional assistants,<sup>23/</sup> and, as the language of Section 2(12)(b) so clearly states, included in the definition of professional employee are individuals who have completed courses of specialized instruction and are performing related work under the supervision of Section 2(12)(a) professionals. The definition fits, precisely, housestaff officers. Presumably, the theory underlying my colleagues' position is that Section 2(12) initially defines a professional employee as "an employee, who," and since housestaff are not employees in the first instance the remainder of Section 2(12) is irrelevant. But the "employee" to whom Section 2(12) initially refers is the "employee" of Section 2(3), which does not exclude "students." More importantly, I think it the better course to consider the clear language of Section 2(12) as bearing on the scope of Section 2(3) than to reverse the process and disregard, initially, Section 2(12) and the legislative history behind it; establish, without reference to its language or our precedents, the scope of Section 2(3); and, finally, utilize the conveniently established limits of Section 2(3) to rule out application of Section 2(12). The latter "analysis" would normally merit more attention were there not an example of an even more questionable statement within the majority's final footnote.

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<sup>23/</sup> I Leg. Hist. 540 (1947).

A large segment of the committee hearings on the recent amendments was devoted to the testimony, statements, and accompanying documents of representatives of the housestaff<sup>24/</sup> in support of the amendments. For the most part, the testimony concerned itself with the contention advanced by the Physicians National Housestaff Association, amicus here, that housestaff officers should be excluded from the ambit of Section 2(11) of the Act, which sets forth the definition of "supervisor," because housestaff officers do not exercise supervisory authority "in the interest of the employer." At no time during the course of the hearings was even a mention made that housestaff officers, because "students," might not be entitled to coverage under the Act.<sup>25/</sup> In point of fact, any reasonably diligent reading of the legislative history surrounding the amendments would make it clear that coverage of housestaff, in some context, was an assumption on the part of Congress. That is evident when one considers the congressional response to<sup>26/</sup> the housestaff representatives' contention that amendment of Section 2(11) was necessary:

Various organizations representing health care professionals have urged an amendment to Section 2(11) of the Act so as to exclude such professionals from the definition of "supervisor". The Committee has studied this definition with particular reference to health care professionals, such as . . . interns, residents, fellows . . . and concludes that the proposed amendment is unnecessary because of existing Board decisions. The Committee notes that the Board has carefully avoided applying the definition of a "supervisor" to a health care professional who gives direction to other employees, which direction is incidental to the professionals treatment of patients and thus is not the exercise of supervisory authority in the interest of the employer. [Emphasis supplied.]

<sup>24/</sup> See Hearings, supra at 291--423.

<sup>25/</sup> The AAMC, amicus here, filed a statement subsequent to the testimony and statements of the housestaff representatives. Id. at 636. Support for the proposition that AAMC and the employers in these cases are accomplishing here at the Board what they could not and would not accomplish before Congress is gleaned from the fact that AAMC did not, at that time, even mention the argument so readily accepted by my colleagues.

<sup>26/</sup> S. Rept. 93--766, 93d Cong., 2d Sess. 6(1974). The same language appears in the substantially identical House Report.

Throughout the debates on the floors of both Houses, again, no mention of the "student" status of housestaff officers can be found. Senator Cranston, co-sponsor and floor manager of the Senate bill, indicated, on the other hand, that one of the conditions the bill was designed to redress was the "notoriously underpaid . . . average annual salary for all hospital employees—including doctors . . . . According to [the] president of the Physicians National Housestaff Association, the average house staff officer—intern, resident, or fellow—works 70 to 100 hours per week, and earns about \$10,000 per year. His hourly wage, then ranges from \$1.92 to \$2.74."<sup>27/</sup> The majority's response to the above legislative history bears repeating:

As we have found . . . that interns, residents, and clinical fellows are not employees . . . we find no merit in Petitioner's contention that they are employees based on Sec. 2(11). . . .

Obviously, no petitioner has contended that it represents "employees" because it represents "supervisors." And yet, that, apparently, is how my colleagues dismiss the compelling argument that, in treating the question of amendment to Section 2(11), Congress clearly and explicitly recognized housestaff as employees.

It is clear to me, as the language of Section 2(12) states, the legislative history of Section 2(12) states, the Committee Reports on the hospital amendments state, and Senator Cranston states in explanation to his colleagues, that housestaff officers are covered by this Act.

#### IV

Thus far I have attempted to deal with the substantial errors in judgment I perceive in my colleagues' disposition of these cases. But apart from what I

<sup>27/</sup> 120 Cong. Rec. S6933 (daily ed., May 2, 1974) (emphasis supplied).



consider to be their misstatement of the issue in these cases,

their failure to set forth the complete facts, and what I am convinced is their trifling with the language of our statute and its legislative history, my disagreement with my colleagues, in these cases, equally extends to an understanding of the very purposes of this statute and, more particularly, the additional responsibilities we have recently assumed as a result of the clearly stated congressional conviction that labor relations in the vital health care industry is best governed by this statute. That conviction flows from another, expressed through all the Congresses that have considered our statutory scheme---that this statute is protective and ameliorative. To read the legislative history of the most recent amendments is but to recognize that conviction. Thus, in considering how to minimize the potential for disruption of medical services inherent in an amendment granting significant numbers of employees the right to strike, Congress, realizing that recognition strikes do not cease because outlawed, considered it the wiser course to make available the provisions of this statute for the orderly resolution of such recognition struggles: "The Committee was also impressed with the fact, emphasized by many witnesses, that the exemption of nonprofit hospitals from the Act had resulted in numerous instances of recognition strikes and picketing. Coverage under the Act should completely eliminate the need for any such activity, since the procedures of the Act will be available to resolve organizational and recognition disputes."

And so there is a pathetic irony in what my colleagues do today. The onset of organization of housestaff officers is among us. Fewer cases may come to this Agency, but as many will come to the training hospitals. The one group so singularly involved in the congressional issues, both in terms of its immediate relationship with the delivery of medical services and in terms of its recognition interests,

28/ S. Rept. 93--766, supra at 3.

is, today, by fiat, read out of the Act. This decision is not grounded in the statute, the law, or reason. Accordingly, I must dissent.<sup>29/</sup>

Dated, Washington, D.C.

MAR 19 1976

John H. Fanning, Member

NATIONAL LABOR RELATIONS BOARD

29/ There is a seeming futility in my addressing the subsidiary unit question presented by these cases. But, for the purpose of wholeness and because I suspect that what my colleagues have done today is, in part, shaped by that consideration, I deem it fitting to set forth my views. I would grant a unit of all housestaff officers, to include all fellows. Although the singularity of interests I perceive in these cases runs, generally, only to interns and residents, I nevertheless believe all fellows, by virtue of the fact they are house and not medical staff, and by virtue of that fact alone, must be included. With the exception of amicus AAMC and the employer in St. Christopher's Hospital for Children, 223 NLRB No. 58, issued this day, no employer in the cases decided today contends salaried attending physicians must further be added to the "house staff unit." Nevertheless, one of the unit considerations presented by these cases flows from the expressed congressional admonition to this Board to consider unit questions, in part, from the standpoint of the number of units which might otherwise result from an individual unit determination and, consistent with Board standards in this area, to avoid a proliferation of bargaining units.

A unit of housestaff implies, I suspect, a unit of salaried attending staff. Thus, it is conceivable that in any given institution as many as four professional units may result from that determination, given the Board's determination of the appropriateness of a unit of registered nurses, when sought separately (Mercy Hospitals of Sacramento, Inc., 217 NLRB No. 131 (1975).) The establishment of a unit combining all doctors, thus, has considerable appeal, especially at first glance. However, on my analysis of the records in these cases, it appears to me that in consequence of the vast operational authority vested in medical staff salaried attending physicians in training institutions approximate managerial employees. In addition, their role in relation to housestaff leads me to conclude with a greater degree of assurance that, absent unusual circumstances, they are also supervisory. Finally, as a practical matter, while organizational efforts among attending staff exist, organization of such highly paid individuals can fairly be expected to be minimal. For those and other reasons requiring a more detailed discussion inappropriate here, I resolve the matter on the side of an "all-housestaff" unit. Finally, I note for my colleagues that the Board has already, through its Regional Directors, certified what amount to housestaff units in Kingsbrook Jewish Medical Center, Case 29--RC--02785, and Children's Hospital of the District of Columbia, Case 5--RC--09152. All of which tends to demonstrate, I suppose, that when left to their own devices institutions which truly accept the rights and responsibilities set forth in the Act can come to live with that fact.

Institute of Medicine  
Social Security Studies Final Report

MEDICARE-MEDICAID REIMBURSEMENT POLICIES  
March 1976

Chapter-By-Chapter Summary of Findings

Chapter 1: TEACHING HOSPITALS

Varying amounts of federal and state government dollars flow into hospitals from the Medicare and Medicaid programs. On the average, Medicare and Medicaid funds make up 37 percent of total revenues in the 81 non-federal sample hospitals.

Because of concern over possible conflict under Part B, not all hospitals which could do so claim reimbursement from Medicare for supervision and teaching services of teaching physicians.

Chapter 2: TEACHING PHYSICIANS

Not all physicians in teaching hospitals are teaching physicians; the proportion of teaching physicians is greater the more closely the hospital is associated with a medical school.

Teaching physicians spend about 20 percent of their time in joint activities which result in education and patient care; most of this time is spent with interns, residents, and fellows.

Teaching physician compensation arrangements vary. In the sample hospitals, 44 percent of teaching physicians receive no compensation from a hospital or medical school; 56 percent receive a full or partial salary from a medical school, hospital or both.

Control over professional fees is specified in financial agreements between teaching physicians and institutions. In some cases, the institution controls fee revenues; in others, physicians control them; and in still others, control is shared by the institutions and physicians in elaborate arrangements called practice plans.

Most teaching physicians receive their income from a combination of professional earnings and institutional funds. When the physician controls his own fees, an institution with which he is associated usually does not know his total income, but only the portion, if any, paid from institutional funds.

Physicians employed by public medical schools receive 30 to 40 percent of their income from professional fees. The fee percentage is probably higher in private schools.

Physicians employed by hospitals usually are paid from hospital general revenues and receive no income from fees; five sample hospitals are exceptions in that fees generated by employed physicians flow into hospital general revenues, from which the physician salaries are paid. Thus, they receive income from fees indirectly.

Most institutions and practice plans do not know the payor sources of fee revenues; for the few that record this information, Medicare and Medicaid account for about 30 percent.

Faculty physicians in the 17 sample medical schools generated at least \$60.7 million in fees in fiscal 1974. Over half the fees were used to support the physicians who generated them; the rest supported general institutional expenses such as travel, support staff, and equipment.

Professional fees provide a substantial source of support for most medical schools. In some, support is direct since funds flow through institutional accounts. Even if fees go directly to physicians, indirectly they support institutional programs if those physicians teach and care for patients at little or no cost to the institution.

In about one-third of the sample teaching hospitals, physician fees are controlled by practice plans, which determine how fees are divided between the physicians and the institution. Many plans also specify how the institutional portion is to be used.

Some plans are organized on a medical school basis; others are hospital plans. Plan members are physicians who receive a salary from the institution. The medical school plans provide additional income to the physicians; hospital plans channel fees into research and education funds controlled by the institution or department.

### Chapter 3: ORGANIZATION OF PATIENT CARE

Patients were classified as private or non-private; usually on the basis of two non-medical criteria: patient-physician relationship and ability to pay.

Hospitals always screened for ability to pay hospital charges but did not screen specifically for ability to pay physician charges.

Twenty-three of 81 hospitals in the sample had almost all private patients. The majority of patients in these institutions had a patient physician relationship with their attending physician before admission to an in-patient service. The physician, rather than the patient, determined where the patient would receive hospital care.

Twenty sample hospitals had non-private patients only. The majority of patients in these hospitals went to an institution, rather than to a physician, for medical care. Most patients had no or limited ability to pay for hospital services.

In 38 sample hospitals, there were both private and non-private patients. Patient-physician relationship was the first criterion for patient classification. Ability to pay became the primary determinant for classification if the patient had to be assigned an attending physician during admission.

Sample hospitals were most likely to have both private and non-private patients, regardless of ownership or education association with a medical school. All local government-owned hospitals which had non-private patients only, were an exception. If hospitals with both patient classifications were excluded, privately owned hospitals tended to have private patients only and publicly owned hospitals tended to have non-private patients only.

There were more Medicare patients in hospitals with private patients only and hospitals with both private and non-private patients. There were more Medicaid patients in hospitals with non-private patients only. Medicare beneficiaries able to pay deductibles and coinsurance generally were classified as private in hospitals which had both private and non-private patients.

Beds in geographic settings which could be identified as either private or non-private accounted for a small percentage of total beds in those hospitals with both private and non-private patients.

Hospitals with private patients only had fewer teaching programs than hospitals with non-private patients only or hospitals with private and non-private patients. Hospitals with private and non-private patients tended to have teaching programs in all hospital services.

House officers who saw non-private patients had more responsibility for patient care on inpatient services than house officers who saw private patients.

House officers in hospitals with private patients only and in mixed settings in hospitals which had both private and non-private patients received more direct supervision from attending physicians than did house officers in hospitals or hospital settings with non-private patients only. House officers in all hospitals and hospital settings, however, spent most patient care time either directly supervised or independently with expectation of review.

House officers were generally more responsible for patient care activities and spent more time independently, without supervision, in outpatient areas than they did in inpatient areas.

#### Chapter 4: GRADUATE MEDICAL EDUCATION

Hospital operating funds, composed largely of patient care revenues, are the major source of support for house officer salaries. Those medical schools which share or pay the full cost of these salaries tend to use state appropriation funds for this purpose.

Training programs in hospitals closely associated with medical schools tend to have access to more sources of funds than those less involved.

Because Medicare and Medicaid funds are merged with other patient care revenues to meet ongoing operating costs, it is not possible to separately determine the extent to which they support individual specialties. However, the reimbursement formulas encourage hospitals to expand inpatient specialties and, thus, penalize the specialties which provide care and much of their house officer training in ambulatory care settings.

#### Chapter 5: MEDICARE INTERMEDIARIES AND CARRIERS: THEIR RESPONSIBILITIES IN TEACHING HOSPITALS

All carriers do not maintain comparable information on teaching physicians and teaching hospitals.

There is little exchange of information among intermediaries and carriers.

Carriers do not select teaching physicians, teaching hospitals, or beneficiary claims for IL 372 audit by a uniform method.

Carrier medical record requirements for documentation establishing the attending physician relationship vary significantly. Thirty-nine percent of the carriers require either inadequate documentation or conduct no medical record review.

#### Chapter 6: ANALYSIS OF METHODS OF PAYMENT

From this analysis, three points became clear: the potential for adverse structural effects overshadowed the potential financial effects of changes in the method of payment; no one of these payment methods avoided all adverse impacts and fully satisfied the congressional concerns, thus, modification of them was required; and it was important to assess the potential effects of the modifications just as had been done for the original payment methods.

##### Costs of the Medicare Program

The differential in costs to the Medicare program under the cost and charge methods of payment is best stated as a percentage change relative to the amounts paid on an allowable charge basis in Fiscal Year 1974 to the sample institutions where data were available. Under the cost method, more hospitals would gain than lose professional service revenues and the increased cost to the Medicare program is estimated to be two percent greater than the amount paid under the charge method in Fiscal Year 1974. These computations are based on Medicare paying full costs, not just salaries and fringes, for physician services.

### Modification of the Payment Methods

The recommended payment methods described in Chapter 1, Part I were shaped into final form with modifications, the need for which became apparent in the course of the formal analysis. Only minor modifications were made to the cost method in the ceiling level on the imputed value of volunteer services and the explicit recognition of the ability of a hospital to shift from one payment method to another.

The unified method was explicitly restricted by the steering committee, until its effects are better understood, both in terms of the qualifying criteria and the decision to pay for house officers in their first post-M.D./D.O. year (or second if required for licensure) on a cost reimbursement basis to the hospital. Although the latter decision reduces the administrability of the unified method, the steering committee was hesitant to have house officers in that early stage of training providing billable services. After there is some experience with the unified method, this conditions might be relaxed in certain institutions or across the board under the unified method of payment.

The fee method of payment is modified toward meeting the congressional concerns and improving administrability by the elimination of cost reimbursement for the supervisory and teaching services of physicians on general care nursing units. The establishment of the pre-admission physician relationship as a presumptive test for allowable charge payment is also aimed toward reducing administrative costs. The tightened physician role test will help meet the concerns of Congress.

### Effects of the Payment Method Modifications

These modifications reduce the adverse effects of the payment methods and increase their responsiveness to the congressional concerns. Thus, the recommended payment methods offer improvements in each of these areas. The principal adverse effects of the recommended payment methods are found with the unified and cost methods -- both of which are responsive to the congressional concerns, fit the teaching setting, and decrease administrative costs. Under the unified method, increased costs would shift to the beneficiary because both physicians and house officers would be supported on an allowable charge basis. Under the cost method, program costs for physician services will increase and, because of the elimination of out-of-pocket costs to the beneficiary, utilization might increase, thus, further increasing program costs.

## Chapter 7: IMPROVING PHYSICIAN SPECIALTY DISTRIBUTION IN THE UNITED STATES

A discussion of goals for physician specialty distribution must be placed in the context of all other variables which contribute to the health delivery system. Only limited gains can be achieved by improving one variable without affecting the others. The state-of-the-art of analyzing physician manpower needs for any population is primitive. The weak link between the resources put into the health delivery system and the services

generated by that system as measured by the health status of populations served, forces the manpower planner to rely on indirect measures of improvement which may result from changes in physician distribution. The most useful information on which to base future physician specialty distribution goals is physician productivity data, particularly the amount of time specialists spend delivering non-specialty services. In extreme cases, if a given specialty group uses its unique skills infrequently, a decision to reduce the number of physicians in this specialty can be based on solid evidence.

Caution must be used in applying directly the physician distribution ratios of organized medical care systems to this country. Since organized systems vary among themselves in physician specialty distributions and since each system has a different organization and financing features compared to this country's medical care system, direct application of physician specialty distributions is a dubious approach.

Further research is required to advance the state-of-the-art of developing physician specialty distribution goals. Analytic approaches based on assessing the population's needs for medical services will require accurate data on the use of specific medical services and a clarification of the efficacy of common medical procedures. Even when the health care needs of populations can be more accurately estimated, value judgments will still be required to determine the most appropriate physician specialty distribution to meet these needs.

## Chapter 8: MODELING PHYSICIAN SPECIALTY DISTRIBUTION

There is a wide range of informed opinion among panelists as to the optimal distribution of physicians for any given medical specialty. However, for a few physician categories such as general surgeons and contact physicians, panelists agreed on the desirable direction of change, even though there was a wide spectrum of opinion as to the absolute optimal level of physicians in these categories. The results of these panels shows that the state-of-the-art of estimating a desirable specialty distribution for a given geographic area can point the direction for desirable change, but do not permit determination of precise numbers.

Panelists agreed on the direction of desirable change from the status quo in those specialties for which there is evidence of low productivity. The specialties for which the panelists had the most difficulty in determining optimal physician distributions were those in which the efficacy of therapy was uncertain and those which shared a target patient population with another category of physician.

Even in those specialties for which there was agreement on the desirable direction of change, the opinions of the panelists reflect individual uncertainty. The modeling process was used to demonstrate the difficulty in determining optimal goals for physician specialty mix, not to provide the "right" answer as to the optimal number of any given specialty needed in a state of the country. It is clear that other groups using the same set of data available to these panelists might develop a very different pattern of optimal specialty distributions.



Panelists agreed that additional information on physician productivity in all specialties would increase the level of confidence with which they could make allocation decisions. However, the complex interaction among physician manpower allocation decisions and policy decisions in other elements of the health care system and the tenuous relationship between access to physician services and health status make determination of any specialty distribution a subjective process.

Chapter 9: PHYSICIAN CHOICE OF SPECIALTY AND GEOGRAPHIC LOCATION:  
A SURVEY OF THE LITERATURE

Conceptual, definitional, and methodological problems in the literature on physician choice of specialty and geographic location limit the applicability of the findings for public policy. Much of the research in this area deals with the general practitioner and has limited applicability as the number of such physicians decreased.

Many factors affect a physician's choice of specialty and geographic location in the United States, and financial incentives appear to play only a minor role in these determinations.

There is no fixed time at which a decision to choose a particular specialty is made and specialty choice is frequently changed, particularly if made early in training. The effect of individual characteristics on specialty choice cannot be distinguished from that of institutional variables. In general, however, physician specialty preference appears to be conditioned by background and personality characteristics and reinforced by medical school and graduate medical education experiences, particularly with respect to faculty influence. The paucity of primary care role models in such settings may be partially responsible for a tendency toward specialization among recent graduates.

All specialists are not similarly affected by factors influencing location choice, although there is a direct association between previous geographic contact with a particular area and a physician's choice of practice location. The type of community in which a physician was born or lived before attending medical school, the location of the medical school and graduate training experience contribute to location decisions. Life style factors as well as the existence of professional resources such as medical schools and hospitals are important contributing factors as well. Several studies suggest that a location decision is not made until after graduation from medical school by as much as 75 to 85 percent of all physicians. Although income alone does not explain physician location choice, communities which physicians locate are usually ones in which an adequate income level can easily be generated.

## Chapter 10: PHYSICIAN CHOICE OF SPECIALTY AND GEOGRAPHIC LOCATION: AN ANALYSIS OF THIRD PARTY PAYMENT LEVELS

The current usual and customary reimbursement mechanism is unlikely to ameliorate the geographic distribution problem. Contrary to conventional economic theory, high Medicare prevailing fees are found in high physician density areas. High fees also tend to occur in areas of metropolitan character, with a relatively high concentration of hospital beds, and where one or more medical schools are located. West Coast counties with these characteristics tend to have higher fees than other parts of the country.

After adjustment for cost of living idfferences by county, prevailing fees for identical procedures show as much as a tenfold difference between the highest and lowest.

Medicare mean prevailings tend to be lower than the commerical insurers by about 14 percent. This is consistent with the fact that Medicare prevailings are set at the 75th percentile of the distribution of physician fees, whereas the commercials set their prevailings at approximately the 88th percentile.

Medicaid prevailings were found to average about 72 percent of the Medicare prevailing level. In some areas, the Medicaid prevailing for an individual procedure may be less than 20 percent of the corresponding Medicare prevailing.

Medicare assignment rates have declined from 64 percent in 1969 to just below 50 percent in 1975. Per capita income and the carrier rate of reduction explain much of the variation in assignment rates among regions.

From 1968 to 1972, Medicare fee inflation was greater for procedure oriented specialties such as general surgery and ophthalmology than for specialties such as internal medicine and general practice.

Economic variables did not explain the varying rates of fee inflation from carrier to carrier from 1968 to 1972. Of particular interest was the lack of association between changes in physician density and Medicare fee inflation.

## Chapter 11: FOREIGN MEDICAL GRADUATES

The trend apparent in the 1960s and early 1970s toward increased numbers of FMGs in residency positions now appears to be changing since there are more USMGs seeking training positions. Without further growth in training positions, by the mid-1980s almost all graduate medical education positions could be filled by USMGs. Since most medical licensing jurisdictions in the United States require completion of at least one year of approved post-graduate training, a reduction in the numbers of positions available for FMGs will reduce the number of FMGs who can enter the United States medical care system as fully licensed physicians.

FMGs are not distributed evenly among specialties, institutions, or geographic areas. Attention must be given to the effect that changes in the numbers of FMGs entering the United States will have on institutions and the implications this has for patient care.

Although Medicare and Medicaid support is slightly higher in institutions with higher concentrations of FMGs, the difference is not statistically significant.

House officer activity data do not show great differences in the professional activities of house staff between USMGs and FMGs or in programs of varying concentrations of FMGs.

The data collected from program directors which indicate that United States medical graduates are preferred, and data from house officers which show that FMGs tend to be in the specialty of first choice less often than USMGs, and that FMGs slightly more often cite "availability of training positions in specialty" as a factor for specialty choice indicate that to a certain extent foreign medical graduates tend to occupy residual or less desirable training positions.

Institute of Medicine  
Social Security Studies Final Report

MEDICARE-MEDICAID REIMBURSEMENT POLICIES  
March 1976

Recommendations

RECOMMENDATION 1. A COST-BASED METHOD OF PAYMENT (Page 39)

The elective cost reimbursement payment method currently in effect under Section 15, Public Law 93-233 should be continued. Minor modifications are recommended in the following guidelines:

- ° In hospitals electing cost, fee-based payment should be allowed for special care units, such as burn units or poison centers, that are open to the community.
- ° Payment for physician services should reflect as closely as possible the full costs of providing the services.
- ° Under the cost payment regulations issued under Section 15, Public Law 93-233, inclusion of payment of the imputed value of volunteer services should be continued because:
  - Volunteers provide valuable uncompensated patient care and teaching services to graduate medical education that would otherwise have to be obtained from paid physicians.
  - It will allow the hospital to improve patient care and provide some educational and research benefits to its programs.
  - Loss of volunteer teaching physician services in hospitals with mostly non-private patients could deny access of non-private patients to the services of community physicians, some of whom offer specialties not included in the hospitals' employed physician staff.
- ° Under the same cost regulations, there should be the following modification: The ceiling of \$30,000 (for fiscal years starting July 1, 1973, and subject to revision for subsequent years) on the imputed value of a volunteer teaching physician's services should be changed to the average salary for full-time physicians in the area or the VA compensation for full-time physicians if an area average is unavailable.

Institutions should be allowed to shift from cost to an entirely fee-based payment method by notification of the carrier and intermediary that all of their physicians who meet the proper criteria will begin billing on a fee basis for their services at the beginning of the next cost reporting period. At the close of a six-month period, the carrier would conduct an audit of the care provided; if the audit results were deemed satisfactory, and fee billing allowed, the two year phase out of cost reimbursement for supervisory and teaching services would begin with the next accounting period. (See Recommendation 3).

COMMENTS OR RECOMMENDED POSITION

## RECOMMENDATION 2. A UNIFIED METHOD OF PAYMENT (PAGE 40)

The unified method is appropriate to institutions where there is a physician team approach to patient care and graduate medical education. Present knowledge and understanding of this method of payment suggest that it is responsive to the concerns of Congress and also appropriate to the ideals of graduate medical education. All covered services of licensed physicians (teaching physician and house officer) to Medicare beneficiaries would be paid for on a reasonable charge basis. House officers who have not completed the first year of post-M.D./D.O. training (or the second depending on state licensure requirements) are to be paid on a cost reimbursement basis to the hospital. The proposed conditions for this payment method limit its application to teaching institutions where there is a close relationship between teaching physician and house officer so that the conditions for personal and identifiable service are met by the team regardless of who actually performs the service.

### Characteristics of the Unified Payment Method

- Fee billing for services rendered (a daily or capitation rate for physician services may be more appropriate).
- Whether the teaching physician or the house officer delivers the service should not affect the level of payment for the service provided.
- No cost reimbursement for house officer salaries, except for house officers who have not completed the first year of post-M.D./D.O. training (or the second depending upon state licensure requirements).\*
- All payments would be made on an allowable charge basis and out-of-pocket costs to beneficiaries would increase because of the co-payment provisions in Part B.

### Institutional Conditions for the Unified Payment Method

- There must be a closed panel of teaching physicians in an organized group who receive all of their compensation from the organization, who will enter into a relationship with the house officers.
- Teaching physician practice must be limited to one or two hospitals.
- The closed panel must include skills necessary for a broad spectrum of medical and surgical service within the institution(s). (See Recommendation 3, point 7.)
- To adopt the payment method the institution must have no graduate medical education programs on probation but may have them on provisional approval.

\*Some additional direct payment of a portion of such house officer salaries might also be considered if necessary to adequately support the educational mission and reduce some of the shift of costs to the beneficiaries.

COMMENTS OR RECOMMENDED POSITION

### RECOMMENDATION 3. A FEE-BASED METHOD OF PAYMENT (PAGE 41)

A fee-based method of payment is appropriate, although not necessarily the only appropriate method of payment for teaching physicians, only when they provide personal and identifiable services to program beneficiaries or directly supervise the provision of such services by house officers. Medicare's split financing and the nature of graduate medical education call for special definition of "personal and identifiable." However, the payment method alone cannot assure that personal and identifiable services will be provided and the program's and the beneficiaries' interests must be protected through Professional Standards Review Organizations, carrier audit practices, and other appropriate mechanisms.

With one exception, the role test as described in the proposed Section 227 regulation is deemed appropriate as a test of whether personal and identifiable services are provided. The exception is the requirement for a pre-admission relationship between the physician and patient. This requirement does not recognize the fact that although a patient may not have been referred or admitted by his own physician, he may be indeed receiving personal and identifiable services from an attending physician.

Pre-admission or prior patient-physician relationship, however, is an appropriate "screen" for identifying situations where fee-for-service payment would be automatic. This screen appropriately applies to the physician and his provision of service, not to the institution and its ability to collect or demonstrate past collection of professional service fees as required in the proposed Section 227 patient liability test. Applied this way, the prior relationship screen meets the administrative purpose of the patient liability test which is to identify situations where it reasonably could be assumed that the physician role test was being met.

Guidelines for a fee-based method of payment should include:

- Phasing out cost-reimbursement for supervisory and teaching services in teaching hospitals where fees are paid, over a two-year period at the rate of 50 percent per year. At the close of the two-year period, no cost-reimbursement would be allowed for:
  - Supervision or teaching of house officers, except the director of medical education as noted below;
  - Regular or routine teaching physician service on general care nursing units; and
  - Administrative services of teaching physicians, except where there is a written agreement defining the specific services to be performed; for example, director of medical education, administration of a pulmonary function laboratory, cardiac catheterization laboratory, or the like.
- The Medicare Cost Report forms should be revised so that reimbursable costs for administration, supervision, and teaching of house officers will be reported as an identifiable item. This will permit monitoring of the phase out and assessment of its effects.



RECOMMENDATION 3. A FEE-BASED METHOD OF PAYMENT (PAGE 41 continued)

- Cost reimbursement for house officer salaries, fringe benefits, and related costs would continue.
- The prior or pre-admission relationship which is to be used as an administrative screen should be defined to include any of the following:
  - Patient was seen in attending physician's office prior to admission to the hospital;
  - Referral of the patient to an individual, a department, or the institution by an out-of-area physician;
  - Referral of an inpatient to another physician or department within the hospital; or
  - Emergency patients and out-of-area patients who are assigned to a teaching physician covering the hospital.
- The following physician role test (modified from the proposed Section 227 regulations)\* should be adopted. The teaching physician:
  - reviews the patient's history and the record of examinations and tests, and makes frequent reviews of the patient's progress;
  - confirms or revises the diagnosis and determines the course of treatment to be followed; and
  - personally examines the patient on admission and sees the patient regularly thereafter during the stay; and
  - personally supervises treatment provided by interns, residents, or others to assure it is appropriate, and is present and ready to perform any services performed by a personal physician in a non-teaching setting when a major surgical procedure or a complex or dangerous medical procedure is performed; and
  - is recognized by the patient as his personal physician and is personally responsible for the continuity of the patient's care; and
  - is looked to by the patient to provide or arrange for any needed followup or post-hospital care.
- Within one year, reviews to determine whether personal and identifiable services are being provided to beneficiaries should be conducted in all hospitals in which small proportions of patients meet the criteria for pre-admission patient-physician relationship as described above.
- Institutions should be free to shift from any one of these three recommended payment methods to another, provided the conditions of that option are met. Timing and conditions of the shift must be negotiated with the respective carrier and intermediary. Under the recommended payment methods, all teaching physicians rendering service in a hospital would be covered by a single payment method, with exceptions as noted under Recommendation 1. Mixed and geographic settings for different payment methods within a hospital would not be recognized.

As a result of this recommendation the sample hospitals which currently claim cost reimbursement for supervisory services of teaching physicians would incur a loss to the institutions over two years totalling some 13 to 18 million dollars if they remain on a fee basis.

\*Part A, Intermediary Manual, DHEW, No. A3141.5, July 1973.

COMMENTS OR RECOMMENDED POSITION:

#### RECOMMENDATION 4. DEMONSTRATION AND EXPERIMENTAL PAYMENT METHODS (PAGE 43)

Three payment methods are recommended for demonstration and experiment in the Medicare and Medicaid programs. Each proposal for a demonstration or experimental payment method should include a plan for evaluating the payment method which includes its effects on the program beneficiary, the physician, the institutional provider, and the program itself.

- The unified method of payment (Recommendation 2) with less restrictive conditions and criteria as may be proposed by physician groups or institutions and agreed to by the Social Security Administration on a demonstration and experimental basis.
- The lump sum method is used widely to provide payment for professional patient care services to specific patient groups, for example, crippled children under Title V, Maternal and Child Health. This method of payment involves a negotiated contractual relationship between physicians or institutional providers and the payor. The contract specifies the services that will be provided, the amount that will be paid for them, who will provide them, and may enumerate the patient group as well as describe its characteristics. On an experimental or demonstration basis, the lump sum method of payment offers the features of a negotiated rate for services to a defined patient group, payment in a known amount for physician services, and annual negotiation which can reflect payor satisfaction or dissatisfaction with the services received and physician satisfaction or dissatisfaction with the amount and conditions for payment. The lump sum payment method can provide an intermediate step for the physician group wishing to change from cost to fee-based payment or as a probationary payment method to be required by the payor when conditions for fee-based payment are not fully met. Uncertainties, which may result in possible serious disadvantages, with respect to the lump sum method preclude recommendation for its full adoption. These uncertainties include definition of the patient group, definition of an appropriate physician group, assurance of teaching physician participation in the provision of care, and definition of the appropriate relationship between the physicians and the hospital.

Services of both house officers and teaching physicians could be paid on the basis of costs or charges or both.

- A fee-based method under which licensed residents in family practice, general practice, pediatrics, and general internal medicine who have completed either the first or second year (where a second year is required for licensure) of post-M.D./D.O. training would be certified by the director of the training program as qualified to perform independently certain specified services or procedures in the hospital outpatient department. The resident could be paid for these services just as any fully trained physician would be and he would be the attending physician. There would be no cost reimbursement for salaries of these residents and no consultant fee paid for teaching.

COMMENTS OR RECOMMENDED POSITION:

RECOMMENDATION 5. (PAGE 45)

RECOMMENDATION 5. Section 227 of Public Law 92-603 should not go into effect on July 1, 1976. Until new legislation can be enacted and attendant regulations issued, Section 227 of Public Law 92-603 should be further suspended and authority to continue cost reimbursement for physician services under Section 15, Public Law 93-233 should be extended.

COMMENTS OR RECOMMENDED POSITION:

RECOMMENDATION 6. (PAGE 45)

RECOMMENDATION 6. Administrative priority should be given to more uniform application of the Medicare regulations and guidelines in teaching hospitals across the country. Efforts to improve administration should include:

- A determination of the priority to be assigned administration of teaching physician payment methods in relation to other carrier activities by the Bureau of Health Insurance and the carriers.
- A mechanism to improve communications between carriers so that implementation strategies can be exchanged;
- Selection of teaching hospitals for audit by a sampling methodology that reflects the volume of teaching patients in the institution who are program beneficiaries;
- detailed instructions by the Bureau of Health Insurance on sampling procedures and specifications of acceptable and unacceptable medical record documentation for establishment of an attending physician relationship.

COMMENTS OR RECOMMENDED POSITION:

RECOMMENDATION 7. (PAGE 45)

RECOMMENDATION 7. To move toward more uniform treatment across programs, the recommended payment methods for teaching physicians should be given serious consideration by state Medicaid programs and other third party payors.

COMMENTS OR RECOMMENDED POSITION:

RECOMMENDATION 8. (PAGE 45)

RECOMMENDATION 8. Proposals for future changes in the method of payment should be accompanied by estimates of the dollar differences to result from the change, the effects on the structure for receipt and control of professional service revenues, and the effects on the beneficiary, institutional provider and professional, and the health insurance program.

COMMENTS OR RECOMMENDED POSITION:



RECOMMENDATION (PAGE 63)

The study group recommends that financing mechanisms be changed to provide more equitable support for ambulatory care services so that medical schools and teaching hospitals would find it easier financially to support primary care training programs. Furthermore, Medicare and Medicaid monies might be used as an incentive to support the expansion of training opportunities in the contact physician specialties. The costs of residencies in the contact physician specialties should be excluded from provisions of Section 223\* which place a ceiling on the allowed increase on costs to be covered by Medicare.

\*Section 223 authorizes the Secretary to establish limits on overall direct or indirect costs which will be recognized as reasonable for comparable services in comparable facilities in an area.

COMMENTS OR RECOMMENDED POSITION:

In a hospital reimbursement proposal being drafted by the Senate Finance Committee staff, it is proposed that costs of all interns and residents (as well as other items) be excluded for purposes of determining ceilings to be placed on Medicare routine service costs. The AAMC, after Administrative Board and Executive Council discussion, has supported this approach. The final sentence of this recommendation would comprise the objectives of this exclusion, and should most likely be rejected.

RECOMMENDATION (PAGE 63)

In the absence of a competitive level of support for residents with ambulatory care orientations, until third party payment mechanism have been restructured, the study group recommends that direct support to medical schools and teaching hospitals be continued through special project grants. This support should also be extended to cover the other contact specialties of general internal medicine and general pediatrics where quality programs can be maintained.

COMMENTS OR RECOMMENDED POSITION :

RECOMMENDATION (PAGE 63)

Grants could be given to health maintenance organizations, community hospitals, comprehensive health centers, group practices, and offsite training locations to cover the costs of training medical students and residents.

COMMENTS OR RECOMMENDED POSITION:

RECOMMENDATION (PAGE 64)

Because the VA system trains specialists who later enter the practice of medicine in internal medicine for the general population rather than the VA hospital population, the VA should be encouraged to increase its emphasis on primary care practice in internal medicine and to continue to develop rotations for house staff to community-based hospitals and ambulatory care settings.

COMMENTS OR RECOMMENDED POSITION:

RECOMMENDATION (PAGE 64)

It is the opinion of the steering committee that a national system for monitoring physician manpower should be established. To be effective, the monitoring function must be linked to a mechanism or a body which can effect the desired changes in physician specialty distribution, over time, by having the authority to regulate the number and distribution of residency training positions. The propriety of a wide range of public and private organizational structures to undertake these functions has been considered. The study group recommends that a combined public and private sector effort be undertaken to monitor and control the number of residency positions, by specialty.

COMMENTS OR RECOMMENDED POSITION:

The Association has taken the position that designation of residency positions by specialty should be the responsibility of a national agency. In legislation introduced by the Association the Coordinating Council on Medical Education was to be provided the opportunity to assume this responsibility. In the Association's proposal, the Liaison Committee on Graduate Medical Education would report to the Coordinating Council the accredited programs and the maximum number of residents that could be enrolled commensurate with maintaining the quality of the educational offering. The Coordinating Council would designate the number of positions to be filled based upon its perceptions of national physician manpower needs. The Coordinating Council's recommendations would be made known to the Secretary of HEW. Programs enrolling numbers of trainees greater than recommended by the Coordinating Council would be subject to loss of reimbursement from federal sources.

As an alternative recommendation to the Coordinating Council was that a federal agency be established with membership composed of individuals nominated by parent organizations of the CCME and federal and public members.

See Appendix A - Page 33

RECOMMENDATION (PAGE 66)

The study group recommends that the following interim strategy for post-graduate physician training be implemented on July 1, 1977, and remain in force until the commission and the voluntary accreditation agencies have time to develop and implement a comprehensive physician manpower plan.

- ° With the exception of the category of contact physicians defined as family practice, general internal medicine, and general pediatrics, the number of all other postgraduate specialty training slots available as of July 1977 should be held at the level of residency positions filled as of July 1, 1977.
- ° The number of training slots for contact physicians should be expanded, with care given to ensure that the highest quality educational environment is maintained.
- ° There may be unusual circumstances which warrant an expansion of residency training slots in other than the contact specialties. Examples of these situations would include medical schools in the process of development or pending commitments to individual trainees.

COMMENTS OR RECOMMENDED POSITION:

RECOMMENDATION (PAGE 67)

To encourage this trend, the study group recommends that all third party payors incorporate the following principles:

- ° Benefit structures, including deductibles and coinsurance, should not encourage the use of inpatient care at the expense of ambulatory care. There should be no reduction in current inpatient benefits under Medicare and private plans to achieve this objective.
- ° Fees should be restructured to encourage the delivery of primary care services. Fees earned by contact physicians for the delivery of primary care should be at least equal to the fees earned by specialists for these same services.
- ° In order not to discourage primary care physicians from accepting Medicare and Medicaid beneficiaries, the allowed charges for these programs should be comparable to those of other third party payors. Recognizing the financial pressures faced by state governments, we must nevertheless point out that if fees are very low, as they are in some Medicaid programs, access to health care services may be denied to program beneficiaries.

COMMENTS OR RECOMMENDED POSITION:

RECOMMENDATION (PAGE 67)

A major study should be undertaken to re-examine the basis of physician fees and the fee allowances in public and private health insurance programs.

COMMENTS OR RECOMMENDED POSITION:



RECOMMENDATION (PAGE 70)

The study group recommends that Medicaid practices which pay physicians at lower levels, particularly in underserved areas, be discontinued. This may be difficult to achieve, given the financial pressures faced by many state governments. Furthermore, anecdotal evidence on the disproportionate billing and administrative expense often associated with collective Medicaid fees suggests that a detailed examination of Medicaid administrative practices should be undertaken to document the extent to which these practices affect the availability of physician services in underserved areas.

COMMENTS OR RECOMMENDED POSITION:

RECOMMENDATION (PAGE 85)

In view of the increasing number of United States medical graduates, the decreasing number of positions likely to be available for foreign medical graduates, and the possibility that future foreign medical graduates may not be able to secure the graduate medical education necessary for full-licensure in this country, the steering committee recommends the elimination of existing incentives for physiciansimmigration, including the removal of medicine as a shortage profession under the Department of Labor's Schedule A.\* The recommendation to remove medicine as a Schedule A shortage occupation in no way implies that the steering committee takes a position on whether the United States has adequate physician manpower, but merely reflects the view that graduate medical education positions for foreign medical graduates are not likely to be available in sufficient numbers to justify continued preferential immigration for physicians.

\*Schedule A is issued by the Department of Labor and lists occupations in short supply in the United States.

COMMENTS OR RECOMMENDED POSITION:

(FROM AAMC SPONSORED BILL H.R. 3279)

1 "TITLE XVII—MEDICAL RESIDENCY TRAINING  
2 PROGRAMS

3 "EFFECT OF NONACCREDITATION OR EXCESS POSITIONS IN  
4 MEDICAL RESIDENCY TRAINING PROGRAMS

5 "SEC. 1701. (a) For purposes of this title, the term  
6 'medical residency training program' means a program which  
7 trains graduates of schools of medicine and schools of osteop-  
8 athy in a medical specialty recognized by the liaison com-  
9 mittee for specialty boards established jointly by the Ameri-  
10 can Board of Medical Specialties and the Council on Medical  
11 Education of the American Medical Association (or any suc-  
12 cessor of such committee) and which provides the graduate  
13 education required by the specialty board (recognized by  
14 such liaison committee) for certification in such specialty.  
15 Such term does not include a residency training program in  
16 an osteopathic hospital.

17 "(b) (1) In the case of any entity which is engaged in  
18 business as a health care facility, the compensation of a doc-  
19 tor of medicine or a doctor of osteopathy in a medical res-  
20 idency training program which has not been accredited  
21 under section 1702 for a fiscal year beginning after Decem-  
22 ber 31, 1977, or which has for such year a total number of  
23 positions in excess of the number prescribed for such pro-  
24 gram under section 1703 or a number of first-year positions  
25 in excess of the number prescribed therefor under such sec-

1 tion (which compensation is paid for a health service pro-  
2 vided by such a doctor of medicine or a doctor of osteopathy  
3 in connection with such program), may not be included in  
4 determining Federal payments under title V, XVIII, or  
5 XIX of the Social Security Act. With respect to any entity  
6 which is reimbursed on a per capita basis, in determining  
7 Federal payments under any such title for a year the Sec-  
8 retary shall exclude an amount which in his judgment is a  
9 reasonable equivalent to the amount which would otherwise  
10 be excluded under this paragraph for such year if payment  
11 were made on other than a per capita basis.

12 “(2) If the Secretary determines that an entity is—

13 “(A) operating a medical residency training pro-  
14 gram during a fiscal year beginning after December 31,  
15 1977, which has not been accredited under section  
16 1702, or

17 “(B) operating a medical residency training pro-  
18 gram with a number of all positions or of first-year  
19 positions which for such year exceeds the numbers pre-  
20 scribed for that program under section 1703,

21 the Secretary shall notify the entity of his determination,  
22 shall publish the determination in the Federal Register, and  
23 shall not make any grant to or enter into any contract with  
24 such entity under this Act for the fiscal year beginning after

1 the date the Secretary publishes such determination in the  
2 Federal Register.

3 "MEDICAL RESIDENCY TRAINING PROGRAM ACCREDITING  
4 AGENCY

5 "SEC. 1702. (a) (1) For the purpose of accrediting  
6 the medical residency training programs for which posi-  
7 tions may be occupied or made available under section  
8 1703, the Secretary shall in accordance with subsection (b)  
9 designate or establish a medical residency training pro-  
10 gram accrediting agency (hereinafter in this section re-  
11 ferred to as the 'accrediting agency').

12 "(2) The accrediting agency shall review, in accord-  
13 ance with procedures established and published by the  
14 agency and made available to the public, each medical  
15 residency training program in the United States and shall  
16 either accredit or disapprove such program. Each such  
17 program shall be reviewed at least every three years and  
18 an accreditation of a program shall be in effect for three  
19 years unless the accrediting agency terminates the accredita-  
20 tion before the expiration of three years. As soon after  
21 an accrediting agency is designated or established pursuant  
22 to this section as practicable, it shall review training pro-  
23 grams for purposes of accrediting them or denying accredi-  
24 tation for purposes of this title. For the period prior to  
25 July 1, 1979, the accrediting agency may accredit a pro-

1 gram on the basis of an accreditation granted such program  
2 by an entity generally recognized by the medical profession  
3 for purposes of accrediting such a program.

4 “(3) The accrediting agency shall submit to the agency  
5 designated or established under section 1703 and keep  
6 current for it a list of the medical residency training pro-  
7 grams the accreditations of which are in effect. The first  
8 such list shall be so submitted not later than January 1,  
9 1977.

10 “(b) (1) Not later than September 30, 1975, the  
11 Secretary shall prescribe and publish in the Federal Reg-  
12 ister requirements which must be met by an entity before it  
13 may be designated as the accrediting agency for purposes  
14 of this title. Such requirements shall provide that an entity—

15 “(A) have a governing body which is comprised of  
16 representatives of the medical profession, medical spe-  
17 cialty boards, medical specialty societies, hospitals,  
18 schools of medicine, and the general public; and

19 “(B) meet the criteria established by the Secretary  
20 for recognition of nationally recognized accrediting agen-  
21 cies and associations.

22 “(2) (A) An entity which seeks designation as the ac-  
23 crediting agency shall submit an application to the Secretary  
24 not later than January 1, 1976. If such an application has  
25 been submitted to the Secretary by the liaison committee for

1 graduate medical education of the coordinating council for  
2 medical education before such date, and—

3 “(i) if the Secretary determines that the liaison  
4 committee meets the requirements prescribed under  
5 paragraph (1), he shall approve such application and  
6 designate it as the accrediting agency; or

7 “(ii) if the Secretary finds that the liaison commit-  
8 tee does not meet such requirements, he shall provide it  
9 with such technical and other nonfinancial assistance as  
10 may be appropriate to enable it to meet such require-  
11 ments and, if the Secretary determines that it meets such  
12 requirements, he shall designate it as the accrediting  
13 agency.

14 “(B) If, by July 1, 1976, the Secretary (after providing  
15 such assistance) finds that the liaison committee still does not  
16 meet such requirements, he shall consider other applications  
17 for such designation and shall, if he determines that an entity  
18 filing such an application meets the requirements prescribed  
19 under paragraph (1) and that such entity is otherwise quali-  
20 fied to accredit medical residency training programs, desig-  
21 nate, not later than September 30, 1976, such entity as the  
22 accrediting agency.

23 “(3) (A) A designation of the accrediting agency shall  
24 be in effect for three years unless the Secretary terminates  
25 such designation before the expiration of three years upon a

1 determination by the Secretary (after notice and reasonable  
2 opportunity for a public hearing) that the agency no longer  
3 meets the requirements of paragraph (1) or is not qualified  
4 to accredit medical residency training programs. A designa-  
5 tion may, upon application, be renewed for a period of  
6 three years.

7 “(B) If the Secretary terminates a designation or de-  
8 termines a designated accrediting agency is not qualified to  
9 have its designation renewed, the Secretary shall publish  
10 notice of such termination or determination and solicit ap-  
11 plications from other entities for designation as the accredi-  
12 ting agency.

13 “(4) (A) If—

14 “(i) by September 30, 1976, the Secretary deter-  
15 mines that no entity which has applied for designation  
16 meets the requirements prescribed under paragraph (1)  
17 and is otherwise qualified to accredit medical residency  
18 training programs or if by such date no entity has ap-  
19 plied for designation, or

20 “(ii) upon the expiration of a designation under  
21 this section, the Secretary determines that the designated  
22 agency is not qualified to have its designation renewed  
23 and that there are no other qualified applicants for designa-  
24 tion, or upon the termination of such a designation,



1 the Secretary determines that there are no qualified  
2 applicants for designation,  
3 the Secretary shall, within two months of the determination,  
4 establish an accrediting agency for purposes of this title.

5 “(B) An accrediting agency established by the Secre-  
6 tary under subparagraph (A) shall meet the criteria estab-  
7 lished by the Secretary for recognition of nationally recog-  
8 nized accrediting agencies and associations and be composed  
9 of members who are fairly representative of the medical pro-  
10 fession, medical specialty boards, medical specialty societies,  
11 hospitals, schools of medicine, and the general public. While  
12 away from their homes or regular places of business in the  
13 performance of services for the agency, members of the  
14 agency shall be allowed travel expenses, including per diem  
15 in lieu of subsistence, in the same manner as persons em-  
16 ployed intermittently in the Government service are allowed  
17 expenses under section 5703 (b) of title 5 of the United  
18 States Code. The agency may appoint, without regard to  
19 the provisions of title 5, United States Code, respecting  
20 appointments in the competitive service, and pay, without  
21 regard to the provisions of such title respecting rates of pay,  
22 such personnel as it deems necessary for the agency to carry  
23 out its functions.

24 “(C) The establishment of an accrediting agency under  
25 subparagraph (A) shall be for such period (but not more

1 than three years) as the Secretary prescribes. If an accredi-  
2 ing agency has been established by the Secretary an entity  
3 may apply for designation as such agency upon the termina-  
4 tion of the period for which the accrediting agency was  
5 established. If no entity submits an approvable application  
6 for designation before the date of such termination, the  
7 Secretary shall renew the authority of the established  
8 accrediting agency for a period not to exceed three years.

9 "ESTABLISHMENT OF POSITIONS FOR MEDICAL RESIDENCY

10 TRAINING PROGRAMS

11 "SEC. 1703. (a) (1) For purposes of this title, the Sec-  
12 retary shall, by April 1, 1977, with the approval of the  
13 agency designated or established by him under this section,  
14 (A) establish (and publish in the Federal Register) the  
15 aggregate number of all positions which may be occupied  
16 in the first fiscal year beginning not less than twelve months  
17 after such date in accredited medical residency training pro-  
18 grams and the total number of first-year positions in such  
19 programs which may be made available in such fiscal year;  
20 and (B) establish, and give to each entity which maintains  
21 such a program, written notice of the number of all posi-  
22 tions in its medical residency training program which may be  
23 occupied in such fiscal year and the number of first-year  
24 positions which it may make available in such program in  
25 such fiscal year. The numbers of positions so established

1 for any fiscal year thereafter shall be published in the Fed-  
2 eral Register not later than April 1 of the preceding calendar  
3 year and each entity which maintains an accredited medical  
4 residency training program shall be given written notice by  
5 such date of the numbers of such positions for its program for  
6 such fiscal year.

7 “(2) The Secretary’s and the designated or established  
8 agency’s determinations under clause (A) of paragraph (1)  
9 in any year shall be based on his estimate of the number of  
10 graduates from schools of medicine in the fiscal year which  
11 began in the preceding calendar year, and the number of  
12 positions in medical residency training programs occupied  
13 in such fiscal year. In making their determinations under  
14 paragraph (1) in any year, the Secretary and the desig-  
15 nated or established agency shall—

16 “(A) take into consideration the report made with  
17 respect to the study conducted under section 15(c) of  
18 the Act of December 30, 1973 (Public Law 93-233),  
19 and the annual reports of the Secretary under section  
20 703 of the Health Manpower Act of 1975;

21 “(B) seek to insure that positions in medical  
22 residency training programs are distributed equitably  
23 throughout various geographical areas of the United  
24 States;

1           “(C) afford special consideration to positions in  
2       medical residency training programs maintained in  
3       conjunction with area health education centers under  
4       section 783 of this Act; and

5           “(D) afford particular attention to the need for  
6       medical residency training programs in the primary  
7       health care specialties of general internal medicine,  
8       general pediatrics, family medicine, and obstetrics and  
9       gynecology.

10          “(b) (1) Not later than September 30, 1975, the  
11       Secretary shall prescribe and publish in the Federal Regis-  
12       ter requirements which must be met by an entity before  
13       it may be designated as the agency to establish hereunder  
14       the number of positions which may be occupied or made  
15       available in medical residency training programs accredited  
16       pursuant to section 1702. Such requirements shall provide  
17       that an entity have a governing body which is comprised  
18       of the Secretary (or his delegate) and representatives of  
19       the medical profession, medical specialty boards, medical  
20       specialty societies, hospitals, schools of medicine, and the  
21       general public.

22          “(2) (A) If the coordinating council for medical edu-  
23       cation has submitted an application for designation under  
24       this section to the Secretary before December 31, 1975,  
25       and—

1           “(i) if the Secretary determines that the coordi-  
2           nating council meets the requirements prescribed under  
3           paragraph (1), he shall approve such application and  
4           designate it; or

5           “(ii) if the Secretary finds that the coordinating  
6           council does not meet such requirements, he shall pro-  
7           vide it with such technical and other nonfinancial assist-  
8           ance as may be appropriate to enable it to meet such  
9           requirements, and if the Secretary determines not later  
10          than February 20, 1976, that it meets such require-  
11          ments, he shall designate it.

12          “(B) If, by February 29, 1976, the Secretary has not  
13          designated the coordinating council for medical education  
14          pursuant to subparagraph (A), he shall as soon as practi-  
15          cable establish an agency consisting of the Assistant Secre-  
16          tary of Health and the Administrator of the Health Resources  
17          Administration from the Department of Health, Education,  
18          and Welfare, the Chief Medical Director of the Veterans’  
19          Administration, and the President of the Uniformed Serv-  
20          ices University of the Health Sciences, all ex officio, non-  
21          voting members, and nineteen members appointed by the  
22          Secretary. Of the nineteen appointed members,

23               “(A) ten shall be appointed from lists of nominees  
24               submitted by the American Medical Association, the  
25               American Hospital Association, the Association of Amer-

1       ican Medical Colleges, the American Board of Medical  
2       Specialties, and the Council on Medical Specialty So-  
3       cieties, each such list to contain four or more nominees  
4       and two appointees to be appointed from each such list;

5       “(B) one each shall be appointed from lists of two  
6       or more nominees submitted by the American Osteo-  
7       pathic Association and the American Association of  
8       Colleges of Osteopathic Medicine;

9       “(C) six, none of whom may be providers of health  
10      care, shall be representatives of consumers of health  
11      care; and

12      “(D) one shall be in a full-time medical residency  
13      position.

14      “(3) (A) A designation of the coordinating council  
15      for medical education under paragraph (2) shall be in  
16      effect for three years unless the Secretary terminates such  
17      designation before the expiration of three years upon a deter-  
18      mination by the Secretary (after notice and reasonable op-  
19      portunity for a public hearing) that the agency no longer  
20      meets the requirements of paragraph (1) or is not qualified  
21      to pass upon the number of positions in medical residency  
22      training programs accredited pursuant to section 1702.  
23      Such a designation may, upon application, be renewed for  
24      a period of three years.

1       “(B) If the Secretary terminates such a designation  
2       or determines the designated agency is not qualified to have  
3       its designation renewed, the Secretary shall publish notice of  
4       such termination or determination.

5       “(4) (A) If upon the expiration of a designation un-  
6       der this section, the Secretary determines that the designated  
7       agency is not qualified to have its designation renewed, or  
8       upon the termination of such a designation, the Secretary  
9       shall, within three months of such determination, establish  
10      an agency as provided in paragraph (2) (B) to pass upon  
11      the numbers of positions in medical residency training pro-  
12      grams accredited pursuant to section 1702.

13      “(B) While away from their homes or regular places  
14      of business in the performance of services for the agency,  
15      members of an agency established pursuant to paragraph (2)  
16      (B) shall be allowed travel expenses, including per diem in  
17      lieu of subsistence, in the same manner as persons employed  
18      intermittently in the Government service are allowed ex-  
19      penses under section 5703 (b) of title 5 of the United States  
20      Code. The agency may appoint, without regard to the provi-  
21      sions of title 5, United States Code, respecting appointments  
22      in the competitive service, and pay, without regard to the  
23      provisions of such title respecting rates of pay, such person-  
24      nel as it deems necessary for the agency to carry out its func-  
25      tions.

1       “(C) The establishment of an agency under paragraph  
2       (2) (B) shall be for such period (but not more than three  
3       years) as the Secretary prescribes. If such an agency has  
4       been established by the Secretary the coordinating council  
5       for medical education may apply for designation as such  
6       agency upon the termination of the period for which the  
7       agency was established. If the council does not submit such  
8       an approvable application for designation before the date of  
9       such termination, the Secretary shall renew the authority of  
10      the established agency for a period not to exceed three years.

11      “(5) The Secretary may make grants to the coordinat-  
12      ing council for medical education if designated under this  
13      section for its costs in carrying out its functions under this sec-  
14      tion. Any such grant shall cover the council's costs incurred  
15      in carrying out such functions for a period of not to exceed  
16      one year; and no such grant for any year may exceed  
17      \$300,000.”.