COUNCIL OF DEANS
ADMINISTRATIVE BOARD

Friday, March 16, 1984

8:00 am - 4:00 pm

Francis C. Wood Conference Room
University of Pennsylvania
School of Medicine

AGENDA

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
ADMINISTRATIVE BOARD OF THE COUNCIL OF DEANS

MINUTES

Thursday, September 22, 1983
9:00 am - 1:00 pm
Grant Room
Washington Hilton Hotel
Washington, D.C.

PRESENT

(Board Members)

Arnold L. Brown, M.D.
D. Kay Clawson, M.D.
William B. Deal, M.D.
Fairfield Goodale, M.D.
Richard Janeway, M.D.
William H. Luginbuhl, M.D.
Richard H. Moy, M.D..
M. Roy Schwarz, M.D.
Edward J. Stemmler, M.D.

(Staff)

David Baime
Janet Bickel
Robert Boerner, Ph.D.
John A. D. Cooper, M.D.
Sandra Garrett, Ed.D.
Carolyn Henrich
Paul Jolly, Ph.D.
Thomas J. Kennedy, Jr., M.D.
Joseph A. Keyes, Jr.
James R. Schofield, M.D.
John F. Sherman, Ph.D.
Emanuel Suter, M.D.
Kathleen Turner

(Guests)

Pamelyn Close
Robert Keimowitz, M.D.
Manson Meads, M.D.
Richard S. Wilbur, M.D.

I. Call to Order

The meeting was called to order at 9:00 am.

II. Report of the Chairman

Dr. Janeway reported on several items considered by the Executive Committee at its meeting preceding the Board's:

- While recognizing that there are serious organizational and administrative problems in attempting to involve more fully and formally house officers in the AAMC, the Committee generally felt that since residents are a critical part of the medical education continuum and methods for involving

them in AAMC activities ought to be explored. Several suggestions were discussed including potential relationships with the CAS and the Group on Medical Education. The Executive Committee asked that the CAS Board discuss this matter at its next meeting and explore potential mechanisms for providing a more visable role for house officers without serious alterations to the present AAMC structure.

- Dr. Heyssel, Mr. Rice, Dr. Cooper, Dr. Knapp, and Dr. Sherman recently met with several members of the Board of the Association of Academic Health Centers to discuss the AAHC's desire to establish a joint task force with the AAMC for the purpose of addressing critical issues facing teaching hospitals in the decades ahead. Dr. Janeway reported that the Committee concluded that while the task force may not be the best mechanism, the AAMC should be open to considering ways of cooperating with the AAHC on matters of mutual interest such as this. The AAMC recognizes that vice presidents of academic medical centers, especially those involved directly with the hospitals, have a need to be kept abreast of the changing legislative and regulatory issues often discussed by hospital executives at COTH meetings.

Dr. Cooper stated that a similar need exists for the university presidents as illustrated by discussions at a recent Joint Health Policy Committee.

III. Approval of Minutes

The minutes of the June 30, 1983 meeting of the Administrative Board were approved without correction.

IV. Action Items

A. Blacks and the Health Professions in the 80's: A National Crisis and A Time for Action

The Association of Minority Health Professions Schools recently published a reported entitled, "Blacks and the Health Professions in the 80's: A National Crisis and A Time for Action." Although many of the findings and recommendations of the report were congruent with the Association's 1978 Task Force on Minority Student Opportunities in Medicine, several of the report's findings were either not substantiated by the Association's data or referred to local situations inappropriate for the AAMC to address. Consequently, the staff did not recommend a blanket endorsement of the report, and prepared instead the following:

> The Association of American Medical Colleges commends the Association of Minority Health Professions Schools for its timely report, "Blacks and the Health Professions in the 80's": A National Crisis and A Time for Action." This report

emphasizes many of the findings and recommendations of the AAMC's 1978 Task Force on Minority Student Opportunities in Medicine, and is welcomed as providing additional evidence in support of increasing opportunities for underrepresented minorities in all levels of medical education. The Association takes this occasion to re-affirm its support of this worthy goal.

Pamelyn Close reported that the OSR supported the staff recommendation, but suggested that it would appear somewhat less self-serving if the word "own" in the last sentence of the statement were deleted.

Dr. Janeway stated that in view of our role in the LCME the Association should not endorse a report that addressed issues linked to policies issues, such as the class size of individual medical schools. Board members observed that the nature of the media portrayal of educational opportunities for minority students was becoming increasingly negative.

Dr. Cooper reported that minority applicant pool had not increased over the past years and the percentage of minority students accepted into the health professions had remained relatively constant. In addition, he reported that the Association's Office of Minority Affairs is involved with three projects addressing issues related to the educational needs of minority students: recruitment, financial aid, and retention.

On motion, seconded, and carried, the Board endorsed the staff's recommended statement of commendation to the AMHPS with suggested editorial deletion.

B. COTH Membership Criteria

Dr. Knapp, Director of the Association's Department of Teaching Hospitals reported that the COTH Board had recently undertaken a review of COTH membership criteria. This was stimulated by several factors: (1) a recent analysis conducted by the department's staff had revealed that several members did not meet the current membership criteria because they did not sponsor, or significantly participate in, at least four approved residency programs or they had fewer than 30 FTE residents; (2) many hospitals have begun to establish multi-unit systems consortia or associations. The Board was concerned with the prospect that these groups would apply for COTH membership. If several members sought to be included under an umbrella membership, this would not only result in a reduction in dues revenue, but also would alter the relationships between the AAMC and the teaching hospitals if membership were in the name of a non-hospital entity.

However, because the COTH Board was considering an issue paper dealing with a large number of related matters, it had voted to defer action on changing this criteria for membership to a later time.

Discussion ensued regarding the likelihood of the for-profit hospitals seeking membership in COTH. Mr. Keyes reported that under the AAMC Charter and Bylaws, membership is limited to public institutions not-for-profit IRS 501(C)(3) organizations-- those organized and operated exclusively for charitable purposes. To change our membership criteria to permit for-profit organizations to join may raise serious questions regarding the AAMC's own tax exemption. The issue would be whether the AAMC was, in fact, providing services that served the profit-making objectives of certain of its members.

Mr. Keyes stated that if AAMC membership served only the educational programs of its members and prior approval was obtained from the IRS, one or two for-profit members would probably not affect the Association's tax status.

The Board urged that the staff continue to explore the implications of for-profit hospitals membership in the AAMC.

C. ACCME Protocol for Recognizing State Medical Societies as Accreditors of Intrastate CME Sponsors

Dr. Suter reported that the ACCME had recently met to discuss the Executive Council's dissatisfaction with the proposed protocol, specifically, the Council's recommendation that the ACCME retain the right to ratify or reject a decision by the Committee of Review and Recognition (CRR). Dr. Suter reported that although the ACCME was sympathetic to the Executive Council's objections, a majority felt it was unfeasible to retain the authority for all final decisions at the ACCME. However, the ACCME did move to strengthen its position by requiring that two ACCME members be selected from nominations made by the ACCME member organizations to serve on the CRR. The ACCME members would monitor the activities and decisions of the CRR and report back to the ACCME.

On motion, seconded, and carried, the Board moved to approve the protocol as revised.

D. Issues Related to Appointment to PGY-2

At its June 30, 1983 meeting, the Board endorsed the staff's recommended plan of action for dealing with PGY-2 match issues. The plan included: (1) continued discussion with involved parties regarding the nature and scope of the problem; (2) an analytic summary of the responses to Dr. Cooper's letter to chairmen of the societies; (3) a problem list and mechanisms for addressing the problems including consideration of incentives for compliance and sanctions for noncompliance, and (4) a set of recommendations that could be endorsed by the AAMC, NRMP and the program directors representing the troublesome specialties.

Also provided was a summary of the responses from chairmen of specialty societies to Dr. Cooper's letters: The President of the Association of University Professors of Ophthalmology expressed a

high level of confidence with their own match program; the Association of University Professors of Neurology is now in the process of studying the issue. It has also distributed a detailed questionnaire to all program directors and residents involved in programs to July, 1983, querying their reactions to the match process including the Colenbrander program. The President of Otolaryngologists endorsed the separate ENT match and reported no intention to return to the NRMP; the Chairmen of Psychiatry reported that his association urges its members to work within the NRMP as much as possible, notwithstanding the fact that some are unhappy with the plan; the radiologists believe that their own system is working reasonably well and they have no plans to change; the Association of Orthopaedic Chairmen admits that their approach to the match is in some disarray and plans an indepth discussion of the system at its fall meeting; Chairmen of Pathology are concerned about the "widespread habit of making commitments to prospective applicants prior to the NRMP match" and will discuss the issue at its July meeting; the Chairmen of Pediatrics and Family Medicine regarded the match as a non-problem; Chairmen of Surgery identified lack of communication between the various specialties in medicine and the intense competition for the best students as problems deserving attention at their next meeting; the Chairmen of Thoracic Surgery regard the selection process as "something of a free-for-all" and have asked a member of the society executive council to survey the attitudes of the members and to initiate a discussion at their next meeting; the Professors of OB/GYN have no official statement; and the Chairmen of Medicine did not respond.

Dr. Cooper reported the intention of the NRMP: (1) to continue the traditional PGY-1 match; (2) to re-establish the "S" programs for program directors who want to appoint seniors for their PGY-2 year; (3) to permit students to rank order all programs in a specialty regardless of whether they are categorical or "S" programs; and (4) to make advance resident specialty matches ("R") available for programs that wish to offer positions to residents or other physician candidates, with dates of these matches arranged according to the wishes of the program directors. Dr. Cooper explained that the "S" program matches students for both their PGY-1 and PGY-2 choices for those programs which require that students take their first year after graduation outside of the specialty. The "R" program is designed for residents or returning practicing physicians who want additional training. Dr. Cooper stated his conclusion that these programs covered all matching needs.

Dr. Cooper reported that the NRMP Board did not want to assume responsibility for policing the match; consequently, it had been left to the AAMC to do what we could. He also reported that the release of result books had gone smoothly last year and felt confident that the deans would continue to honor their responsibility for the process. Dr. Cooper stated that Dr. Graettinger would like to extend the role of the deans in distributing result books to include the distribution of the books to nearby teaching hospitals. The Board endorsed the proposal that

the deans be asked to distribute the result books to those hospitals in close proximity.

Additional action steps were discussed. Two recommendations were made: (1) that the NRMP establish an advisory Panel consisting of a representative of each of the specialties offering an approved residency program; (2) that the AAMC Executive Committee invite representatives of Dermatology, Neurology, Neurosurgery, Ophthalmology, and Otolaryngology to meet with them in addition to representatives from the OSR and GSA.

F. Principles for Support of Biomedical Research

Dr. Sherman reported that the paper presented to the Board was the penultimate draft of the Association's statement of principles for the support of biomedical research. Two papers were developed by the staff and presented to the Board for its review at the June meeting. At that time, the Board recommended that the staff synthesize the issues presented into a single strategy paper. A new draft was considered by a review committee in August. Dr. Sherman reported that the only change made since that time was the recommendation that the NIH establish a process by which special interest groups would have the opportunity to present, to some formal body, their case for greater support and visability, and that such presentations with subsequent analysis, be incorporated in the NIH decision making process to assure official cognizant of these views at the highest levels of government.

On motion, seconded, and carried, the Board approved the statement of the principles leaving the staff the latitude to incorporate changes made by the Board.

Dr. Kennedy introduced a second document to be submitted by October 1, 1983 to the Institute of Medicine. This paper set out a proposed AAMC position on the organizational structure of the NIH. He reported that the staff proposed that the document, "Principles for the Support of Biomedical Research" together with supplementary material based on this outline, would form the AAMC position paper to the IOM.

Although the AAMC would recommend that the current structure of the NIH be retained, the position paper introduced several concepts as contributions to the deliberations: that some explicit limitations be placed on the number of operating units with the NIH; that the NIH be required to reconsider its organizational structure every ten years; and that the NIH establish a formal, highly visable forum in which advocates of programs be encouraged to present their views.

Dr. Kennedy reported that the Association strategy was to attempt to shift the arena away from Congressional intervention in the scientific priority setting process and move it back into the executive agency guided by scientific advisors.

On motion, seconded, and carried, the Board endorsed the concepts embodied in the paper and recommended that an additional recommendation be included: that the IOM Committee enlarge the preview of its study to consider the optimal relationship between government and science, particularly, as far as Congressional intervention is concerned.

V. Discussion Items

A. Commercial Support of CME

In a recent communication to Dr. Cooper, Richard S. Wilbur, Secretary of the ACCME, expressed concern that some medical schools may inappropriately co-sponsor CME activities supported by pharmaceutical companies and/or equipment manufacturers. He included in his communication two policy statements regarding the relationship of accredited CME sponsors and commercial companies. On behalf of the ACCME, Dr. Wilbur requested that the AAMC Executive Council Review these statements and consider developing an AAMC policy statement.

It was the concensus of the Board that it was inappropriate for the AAMC to involve itself in the establishment of institutional policy on this matter. If there were violations of accreditation standards it should be handled as a matter between the ACCME and the institution. The Board recommended that a memo be sent to all deans, identifying the issues and attaching the two policy statements for their review and consideration.

B. AAMC Regional Boundary Changes

Mr. Keyes reported that the Association is currently divided into four regions with an unequal number of institutions within each. This has some significance for the nominating process. Although the AAMC bylaws does not require equal representation from each region, the dynamics of the nominating process seems to work in that direction. After this matter had been included in the agenda, we were alerted to the significance of these geographic boundaries in AAMC time series data reports (e.g., housestaff stipend reports, and faculty salary studies).

It was the consensus of the Board that since there was no urgency for making any change and since any issues regarding nominations or elections could be adequately handled in their own right, the boundaries should not be tampered with at this time.

C. Medical Center Officials and the AAMC

Occasionally, the Association receives communication from individuals in the academic health center who would like to be more involved in the AAMC activities. The staff expressed some concern that in many academic medical centers, individuals other than the dean and the hospital administrator are acquiring substantial

authority and responsibility for decisions impacting on medical education. If there is a power shift, the Association should consider how this impacts on its membership and its own position as spokesman for academic medicine. Although the topic will be discussed at the December Officers Retreat, the staff wished to elicit comments from the Board.

A brief discussion ensued in which Board members suggested that these individuals who wished additional information could attend the Association's Annual Meeting and be put on mailing lists, but that nothing should be done to alter the present AAMC structure with new membership categories.

D. Enrollment of Students in Summer Courses

Dr. Luginbuhl suggested that the AAMC consider the issue of member medical schools enrolling students from foreign medical schools in summer courses and to collect data on current practices. The Division of Student Programs made some inquiries and reported that 20 U.S. medical schools offered summer make-up courses. Only one school (Vermont) had a policy that participating students must be enrolled in an accredited U.S., Puerto Rican or Canadian medical school. Of the twelve course directors contacted as to the inquiries received from foreign medical students regarding their summer courses, no one reported more than 5 students had contacted them.

After a brief discussion, the Board determined that there was no need for any AAMC action with respect to foreign medical students in attending summer classes in U.S. medical schools.

E. Evaluation of the Status of the Management of Student Financial Assistance at Selected U.S. Medical Schools

At its June meeting, the Board considered a request for advice regarding the need for a series of workshops to improve the administration of student financial assistance to medical students. The Board members were unconvinced that such workshops were necessary and suggested that they query their financial aid officers at their own institutions and report their findings to the Board.

After a brief discussion, it was the concensus of the group that such workshops were not a profitable activity for the AAMC to conduct.

VI. OSR Report

Pamelyn Close reported that the keynote address for the OSR Annual Meeting session was entitled, "Ethical Considerations for Medical Students: Questions that Nobody Asks." She also announced that the next OSR Report would highlight issues related to computers in medical education, NRMP and social responsibility, and nuclear war. She also reported that with the assistance of Dr. Kennedy, the OSR

has prepared packets of information to help prepare students in their discussions with their legislators.

VII. New Business

A. Recent Action on Medical Education Financing By The Advisory Council on Social Security

Dr. Knapp reported that at its August 24 meeting, the Advisory Council on Social Security adopted a resolution calling for a three-year study of medical education financing as the first step in an "orderly withdrawal of medicare funds from training support." The Advisory Council's rationale was that it is inappropriate for medicare to underwrite medical education costs when its prime purpose is to pay for medical serivces for the elderly.

Dr. Knapp asked the Board to review the staff's recommended action: to work to have the Advisory Council reconsider its resolution; to seek a revised resolution which recommends a study of alternative means of financing medical education and suggest that the findings of the study be used by future Advisory Councils to debate the reasonableness of terminating medicare support for medical education.

The Board endorsed this approach.

VIII. Adjournment

The meeting was adjourned at 1:00 pm.

UNIVERSITY of PENNSYLVANIA

SCHOOL OF MEDICINE

PHILADELPHIA 19104

Edward J. Stemmler, M. D.
Robert G. Dunlop
Professor of Medicine

Office of the Dean
215-898-5181

MEMORANDUM

TO: Drs. Arnold L. Brown
William T. Butler
John E. Chapman
D. Kay Clawson
Robert S. Daniels
Fairfield Goodale
Richard Janeway
Louis J. Kettel
Richard H. Moy
John Naughton
M. Roy Schwarz

FROM: Edward J. Stemmler, M.D.
Chairman of the Council of Deans

DATE: December 14, 1983

SUBJECT: January 18th & 19th Meeting of the Administrative Board

I have asked Joe Keyes to schedule the beginning of the next meeting of the Administrative Board for 4 PM on Wednesday, January 18th, to allow for a two and one-half hour period prior to our cocktail party for discussion of several items concerning the Board. I do hope that all of you can arrange your schedules to be in attendance at that time.

It has become clear that the time allotted for the business of the Administrative Board does not allow for discussion of any items of new business nor for the identification and formulation of ideas which we wish to have explored by AAMC staff in our behalf. Rather, the role of the Administrative Board has been essentially a responsive one. Accordingly, I would like to have the members of the Administrative Board come prepared for a discussion of the role of the Administrative Board and a view of the relationship between the Administrative Board and our constituent group, the Council of Deans. It seems proper to examine this question in some depth so that we might come prepared to promote a more extensive discussion

of this question at the Spring Meeting of the Council of Deans. Many of our colleagues feel disconnected from the central activities of the AAMC and it is certainly our responsibility to do what we can to minimize those feelings.

A second item for discussion is the need for the Administrative Board of the Deans to produce an issue paper, comparable to a White Paper produced by the Council of Teaching Hospitals, which sets forth the main forces on the horizon of medical educational institutions, forces that should command the attention of our AAMC Staff. Joe Keyes has been instructed to write such a paper and I ask that each of you come with a list of the areas or items that you see are of enough concern to be dealt with in this document.

I would like also to discuss the possibility of establishing a program for the Fall Meeting of the Council of Deans, the meeting which has traditionally been merely a business meeting at the national meeting of the AAMC. It is my personal view that the deans could well use one additional programmatic meeting to supplement programs which have, to date, been limited to the Spring Meeting. Please consider this question and come prepared with some ideas.

A final item for the Wednesday afternoon session will be a brief discussion of the Spring Meeting program.

There was a thoughtful and constructive discussion of the GPEP Committee and its perception by the deans at the recent AAMC Officers' Retreat. I believe that there is a deep concern on the part of the AAMC Staff and the leadership of the other councils about the deans disaffection with this important effort. It is my hope that we can have a serious discussion on this subject on the evening of Wednesday, January 18th. It is important that we, as members of the Administrative Board, reason out the mechanisms that might be used to convert the deans' view from that of passive, sullen acquisition into a more active, constructive group. I believe there are some specific actions which we can take toward that end. For the moment, John Cooper and Gus Swanson will attempt to persuade Steve Muller and his committee to avoid the publication of a "final" document and, instead, present a document which may be made available for discussion by the deans. Whether or not this occurs, we continue to have a responsibility to act constructively for the good of medical education.

You will hear from Joe Keyes with the standard agenda which is the business for the Thursday morning session and, for those of you who are members of the Executive Council, for the Thursday afternoon session as well.

I look forward to a constructive meeting.

EJS/mmcd

cc: Joseph Keyes, J.D.

THE UNIVERSITY OF ARIZONA
HEALTH SCIENCES CENTER
TUCSON, ARIZONA 85724

COLLEGE OF MEDICINE
OFFICE OF THE DEAN

(602) 626-7383
January 19, 1984

Edward J. Stemmler, M.D.
Dean, School of Medicine
University of Pennsylvania
Philadelphia, PA 19104

Dear Ed:

Since the meeting for January 18 was cancelled, I thought I would take the occasion to comment on your several questions.

1. The Council of Deans/Administrative Board relationship is an important topic. It would be a good topic for the spring C.O.D. meeting. Issues to be clarified include the time factor. Items often come before the Administrative Board and the Executive Committee of the AAMC which require action at times which disallow participation by the Council of Deans. As a result, after-the-fact information is often delivered. I don't know that anything can be done about that problem.

   A second observation is philosophical. We seem to react more than proact. Somehow, the AAMC would be a more exciting and lively organization requiring interaction between the Council and the Administrative Board if more time were given to the future and planning to deal with upcoming problems before they are upon us. That type of "crystal ball gazing" is a luxury most of us cannot afford and a skill most lack. Yet, we do have some impressions about the future and could spend time preparing positions in anticipation of actions or, more importantly, developing a proactive strategy and trying to cause action.

   A final point. I suggest we develop a mechanism to establish policy on health and education and work with the Council of Deans on strategies for implementation. The Administrative Board then could be charged with appropriate roles in such implementation. As an example, I can easily see some proactive positions that could be developed coming out of the GPEP activities.

2. As regards the "issue paper", a number of items come to mind. Perhaps the most important one is the role for lobbying by the AAMC. Whether this is in Washington or at local levels, or whether it relates to other organizations such as the American Hospital Association, the American Medical Association or the specialty societies, sharing of efforts and coming to more

common positions would seem to be important. We cannot afford politically or financially to develop our own PAC. In my view, we should be able to piggyback on other organizations. This might be a topic to develop with the AAHC as well.

As far as specific items about which we should have concern, it seems to me the entrepreneurial attitudes that are now required in academe must be the highest priority. The subsets of competition, prospective payment, and cost containment follow. The impact on research and education is the subordinate immediate issue at hand.

Another issue is the organizational structure of the AAMC, the relationship of the Council of Deans to the various Groups, and the relationship between the three Councils of the AAMC. In areas there are fairly wide differences in philosophy and potential adversarial relationships created by external forces. Time spent on a long-range plan to assure organization stability and solidity is critical.

3. The idea of a fall meeting for the Council of Deans is superb. One suggested topic is the relationships between colleges of medicine and university hospitals. Another or a subset is the broad issue of affiliations, but I would be more concerned with those hospitals with whom we have specific ownership relationships. The nature of the marketplace realignments being made has caused an almost adversarial relationship in some instances. It has also prompted relationships with for profit proprietary activities which at best are strange to academe. Other topics are the rising cost of education, medical school relationships to university communities, VA and other public sector relationships.

4. I have little to say about GPEP. I remain nonplused. The peculiar involvement of the deans in this process, whether it be at the planning or implementation level, has caused suspicion as well as undue political problems. At the moment, I don't have a good solution, but the aura of "guilt", based on non-validated data and accusations or at least badly codified data, hangs over the process. It is difficult for me to participate in a system which asks to be repaired when it is unclear just how it is broken.

I look forward to these discussions and will participate, weather permitting.

Sincerely,

Louis J. Kettel, M.D.
Dean

LJK:jt
cc: Joe Keyes

PROPOSED SPECIAL GENERAL SESSION
ON INDIRECT COSTS
AT THE
AAMC ANNUAL MEETING

THE ISSUE

The subject of indirect costs as a component of project grant funding in the federal sponsorship of biomedical research remains a seriously divisive influence within grantee institutions and between federal agencies and the institutions. Much of the disagreement in the former instance seemingly results from poor communications between members of faculties and officials of their institutions about various aspects of the subject.

BACKGROUND

The increased competition for research grant monies and the shortfalls in funding direct costs of research in recent years have intensified the perennial intra-institutional tensions over the levels of indirect cost rates and about reimbursement for those costs. That intensification has spread beyond institutional boundaries to array various national organizations on either side of the issue in public pronouncements and in sharply differing representations to the Congress about the allocations of funds for NIH-sponsored research.

Because of the threats to the internal unity of our institutions and to the vitality of the nation's biomedical research enterprise posed by this issue, the Association has sought to identify and promote ways to reduce the problem and the level of antagonism. One such approach was a meeting on July 8, 1983, in which representatives of organizations with positions on either side of the issue met for the first time. A statement agreed to by all participants was subsequently prepared and distributed within those organizations. Several observations of significance emerged in that document, especially:

- The necessity for all to work diligently together for more adequate federal research funding.
- The desirability of a collective effort, including the federal government, to study the problems of indirect costs, especially with respect to reasons for increases in rates and possibilities for controls.
- The importance of initiatives by both faculty and administrators within individual institutions to facilitate better understanding of the subject within both sectors of the institution community and to involve faculty "meaningfully" in the development of policies covering indirect costs.
- The necessity of effecting economies in indirect cost categories.

PROPOSAL

To facilitate these efforts, it is proposed that at the Association's 1984 Annual Meeting, there be scheduled a Special General Session on this topic. The one and one-half hour agenda would feature two or three well-informed speakers covering pertinent aspects of the subject, with sufficient time for discussion with audience participation following the presentations. Suggestions for speakers include:

- Donald Kennedy, Ph.D., President, Stanford University, who feels very strongly about the need for closing ranks on this issue and who has volunteered to speak on such occasions.

- Kenneth T. Brown, Ph.D., Professor of Physiology, USCF, who has written thoughtfully and provocatively on the subject ("Indirect Costs of Federally Supported Research," Science, Vol. 212, April 1981, pp. 411-418.)

- John J. Lordan, Deputy Associate Director, Finance and Accounting Division, Office of Management and Budget, who is the primary federal official responsible for oversight in this subject area.

Each speaker would be asked to place his remarks in a primarily prospective tone so as to emphasize the need for and possibilities of reconciling the current disparate points of view.

QUESTIONS

- Is this concept and format the most effective approach for promoting a "closing of the ranks" at both the institutional and the national levels?

- Should other speakers be substituted? added?

- Should we identify key individuals from the Administrative Boards to initiate and maintain the discussion?

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Office of the Dean and Provost
801 North Rutledge Street

January 23, 1984

Edward J. Stemmler, M.D., Dean
University of Pennsylvania
School of Medicine
36th and Hamilton Walk
Philadelphia, Pennsylvania 19104

Dear Ed:

I very much appreciate your call on Friday, not only as an expression of concern about my views, but also because you were able to provide some very helpful background and advice in regard to the dynamics behind the COTH recommendations.

I have been very pleased that the Association, in recent years, has consistently portrayed to many agencies that it considers the diversity of the institutions represented, not only in their construction, but in their missions to be a strength to the medical education establishment in the United States, and that its role was to assist in meeting the valid needs of all of its medical school members. It was against this background that I found the COTH proposal potentially quite disruptive. The goal of reassessing COTH at this point, and indeed that of the CAS and the COD, can hardly be questioned and much of the material and concerns raised are quite appropriate. Even the parts that I consider controversial are appropriate if it is the intention of the COTH or the Executive Council that these issues be extended for open and public debate. It is my opinion at this point however that to broach some of these issues publicly would be disruptive and counterproductive. Let me suggest what some of these issues are.

I refer to Page 41 of the Blue Book where under the heading "The Environment For COTH" various categories of membership are described which begins the process of identifying the "114 primary teaching hospitals." This is an important issue because on Page 58 it suggests that some members of COTH feel that the AAMC should focus its efforts only on these "primary teaching hospitals." The asterisk on Page 41 indicates the so-called primary indicator of an "inextricable relationship." I consider this definition that the chiefs of the hospital services are also chairmen of the medical school departments to be arbitrary, rigid and to rule out a number of alternative potentially better arrangements, particularly where more than one hospital is involved.

An additional concern is raised on Page 42 where the asterisks show that a definition as to whether the hospital has a "significant commitment to medical education and research" is determined by the ratio of residents to beds. As I suggested to you in our telephone conversation, we have in Springfield an accredited medical school, quite happily maturing and expanding its activities, which is blessed with two 600-bed very prosperous hospitals seven blocks apart with whom we have essentially equal affiliations. The hospital staff chairmen are appointed on the basis of "advise and consent" by the Dean of the medical school. These Chairmen take care of a lot of scut work while supporting our academic full-time chairmen who are completely responsible for the educational programs. In addition, from the very first we have been committed to small, high-quality residency programs, particularly since all of the hospital floors and service functions can operate efficiently without residents if necessary. Since both hospitals support the residency programs, the result is that the ratio in any one of them is less than 0.2 residents per bed. The financial investments that the two hospitals and the community of Springfield have made not only directly, but in terms of the tremendous economic impact in a relatively small community, has resulted in a bond perhaps more inextricable than the simple naming of chairmen. All of these nice attributes notwithstanding I find, according to the COTH tables, that I do not have any "primary teaching hospitals" and those I have are without "significant commitments" to medical education and research. I would be prepared to consider this might simply be clumsy and inadvertent were it not for the phraseology on Page 58 that suggests that at least on behalf of some COTH members this pejorative hierarchy is intentional.

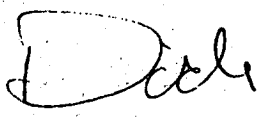
I am not raising this issue because of the potential of hurt feelings, however. We all have concerns about the financing of teaching hospitals and thus the direct and indirect pass-throughs related to residency programs are of great interest, not only to the so-called "primary" teaching hospitals, but also to those large comprehensive hospitals which have more recently joint-ventured with universities to start new academic medical centers. It seems to me almost inevitable that the direct costs and certainly the so-called indirect costs will be challenged by DHHS with the intent to try to ratchet them down in the years to come. The tables prepared in this COTH document, should they become public, would present several ideal cleavage planes with apparent AAMC blessing.

Should the traditional academic health centers persist in trying to position themselves as in some way more uniquely pure or specifically more deserving for federal Medicare funding, it takes no great imagination to picture how some nasty battle lines could be drawn from the perspective of those schools thus left out. One could anticipate that there should be a category of hospitals where the ratio of residents to beds clearly is in excess of any reasonable opportunity for quality teaching. Another category for those hospitals where the residency program exists primarily to meet the service needs of the institution or the ego needs of the chief of the service, rather than a primary commitment to the education of these young men and women. And, finally, it takes no imagination to picture that federal authorities would decide to stop this squabble by using the leverage of their funding to solve both the

problems of the numbers and the geographic distribution of the various medical specialties. From the point of view of the newer schools, many of which were specifically started to help solve geographic problems, this could be a very positive outcome and I suspect some of them might be quite supportive.

I have no doubt that a number of community based institutions will become quite exercised about this draft proposal, and as we discussed on the telephone, the real question is do we want the debate to go on inside or outside the AAMC. Obviously, I hope that we can settle this inside. I see no real good and potentially a great deal of harm to the Association by having this draft go out, even as a discussion piece, and certainly if it is adopted as policy. I very much appreciate your consideration and your attention to these concerns and will be most interested in your further advice and counsel.

Sincerely,



Richard H. Moy, M.D.
Dean and Provost

NEW CHALLENGES FOR THE COUNCIL OF TEACHING HOSPITALS AND THE DEPARTMENT OF TEACHING HOSPITALS

At its June 1983 Administrative Board meeting, the COTH Administrative Board requested that the staff of the Department of Teaching Hosiptals prepare a document outlining the changes taking place and the challanges facing teaching hospitals and the COTH as a constituent part of the AAMC. A document was prepared and revised based on review at the September and November COTH Administrative Board meetings. The document was also reviewed at the AAMC Officers' Retreat in December.

RECOMMENDATION

It is recommended that the document be approved, and sent to all AAMC constitutents with a request for review and comment. It is also recommended that the paper serve as a basis for discussion at the annual COTH Spring Meeting in May 1984.

NEW CHALLENGES FOR THE COUNCIL OF TEACHING HOSPITALS AND THE DEPARTMENT OF TEACHING HOSPITALS

For over three decades, hospitals in the United States have faced a generally supportive environment characterized by increased third party coverage for institutional services, significant expansion and modernization of plant, and a payment system in which expense generated revenue. In the past three to five years, the environment for hospitals has become more constrained, if not hostile, and more competitive. While teaching hospitals flourished under the supportive environment, some observers feel teaching hospitals are especially threatened by a resource constrained, price competitive one. This observation is mirrored by increased anxiety among teaching hospital CEO's about the future prosperity, even survival, of their hospital.

In 1958, teaching hospital chief executives began meeting formally with the Association of American Medical Colleges as a Section on Teaching Hospitals. As a result of the Coggeshall Report entitled, Planning for Medical Progress Through Education, completed in April, 1965, the AAMC underwent a significant reorganization, and the teaching hospitals were involved formally in the governance of the AAMC. Thus, the Council of Teaching Hospitals was organized in 1966 and followed shortly thereafter by the Council of Academic Societies. A major reason for involving teaching hospital chief executives and senior faculty leadership in the AAMC governance was the clear recognition that the organization needed to take a broader mandate including the substantially increasing importance of the academic medical center in providing medical services.

A new and continuing objective of the reorganized AAMC is the initiation and continuous interaction between the leadership of all components of the modern medical center in the development of AAMC policies and programs. All three AAMC

Councils retain their respective identity through their Administrative Boards. Thus, the AAMC, through COTH provides representation and services related to the special needs, concerns and opportunities facing teaching hospitals. COTH has been successful in attracting major teaching hospitals as members, and CEO's in most major teaching hospitals have been supportive of COTH/AAMC activities. However, the rapidly changing environment facing teaching hospitals necessitates a systematic assessment of how the AAMC should function on behalf of its COTH members.

This paper is not intended to be a definitive assessment of past or possible AAMC activities for COTH members. Rather, it is developed to stimulate and focus discussion on the activities and initiatives of the AAMC from a teaching hospital perspective. The paper is organized into three sections: (1) a description of the changing environment facing Council members, including a summary of significant trends and management needs facing teaching hospitals; (2) an assessment of the environment and competition confronting the Council and the hospital activities of the AAMC; and (3) an examination of future directions for COTH and the AAMC.

THE CHANGING ENVIRONMENT FACING COTH MEMBERS

Significant Major Trends Facing Teaching Hospitals

At least ten major environmental trends are presently confronting teaching hospitals.

1. Third party payers, public and private, are limiting their financial risk by imposing revenue limits on providers. Such revenue limits are taking a variety of forms, both regulatory and/or competitive in nature. Given an

"acceptable level" of quality in multiple service settings, payers will use the price of the least expensive setting to pay all other providers.

2. Public and private payers are developing systems which limit hospital payments to the costs incurred by their particular beneficiaries. As a result, and coupled with the trend set forth in item #1, these payers are increasingly unwilling to support, or share in, costs the hospital incurs in caring for charity care and bad debt patients. At the national policy level, there is little or no discussion of new or expanded programs to underwrite the care of these patients.

3. The hospital business is becoming more competitive. While cooperation and community responsibility have been hallmark values and attitudes of the past, the current competitive environment is developing a new set of attitudes and values. Information, management techniques, and organizational structures are beginning to be viewed as corporate assets to be protected rather than shared.

4. The increase in the supply of highly trained physicians is intensifying competition between groups of physicians and hospitals for the provision of capital intensive services.

5. Community hospitals have attracted well-trained subspecialists to their staffs, and have significantly enhanced their clinical capabilities. They can now provide many of the services once thought to be the exclusive province of teaching hospitals.

6. Hospitals will increasingly be required to select specific programs they will offer from an array of options that collectively exceeds the hospital's capital and operating revenues. As a result, teaching hospitals will become more specialized, emphasizing cost competitive care in a

limited number of high cost areas rather than limited volumes of care in a great many high cost areas.

7. Hospitals are increasingly developing formalized structural arrangements blurring hospital boundaries and reducing the distinction between hospitals and associations. Independent hospitals are increasingly looking to some form of "corporate headquarters" for guidance, technical assistance, and large scale identity.

8. Not-for-profit and investor-owned chains will increasingly formalize referral relationships for tertiary care to keep patients and revenues within the system.

9. Investor-owned hospitals will seek management contracts, leases, and ownership of some teaching hospitals to acquire prestige, legitimacy, and full service capabilities.

10. There will continue to be efforts by some in the Administration and some members of Congress to "mainstream" medical services to veterans by providing a voucher system, thereby radically altering the role and function of the Veterans Administration hospital and health care system. In addition, efforts will be made to reduce appropriations to the Veterans Administration, making it more and more difficult for some VA hospitals to maintain their "stature" as teaching hospitals.

Taken together these ten trends suggest the hospital industry is becoming a mature industry rather than a growth industry. In the future, one hospital's growth and economic stability are likely to come at the expense of other hospitals. Market segmentation is gradually occurring, most frequently as a result of corporate strategic planning rather than as a result of cooperative community planning. For a voluntary membership organization, a maturing industry

implies a need to undertake activities which advantage its members compared to other hospitals. It also implies that any activity may advantage one subgroup of members and thereby undermine the unity of the Association itself.

Significant Needs of Teaching Hospitals

Given the dramatic change in the trends facing teaching hospitals, the management agenda of CEO's in teaching hospitals is changing. New management topics are being addressed and the priorities assigned to old topics are being reweighted with at least the following four managerial needs receiving increased attention:

1. The development of systems to manage clinical and financial data in order to identify hospital services, specify costs for each service on a cost accounting basis, and evaluate future program changes;

2. The creation of new operational systems emphasizing revenue management, expense control, variable budgeting, variance analysis, input productivity, and economy of operation;

3. The identification of marketing strategies which include attention to market penetration, market segmentation, and pricing practices designed to meet established revenue objectives; and

4. The clear specification of net income and rate of return goals designed to ensure access to debt capital, and self-funding of new programs and services.

Each of these managerial needs emphasizes the economic elements of the hospital. Each also has major implications for a variety of other issues ranging from the cost of undergraduate and graduate medical education to the cost of providing hospital and physician services to indigent and medically indigent populations.

As a result, new associations and organizations are being created to respond to these economic and other concerns. In light of these new organizations, existing associations face a need to clarify the economic and non-economic benefits of membership.

THE ENVIRONMENT FOR COTH

COTH Membership

In order to examine the environment facing the hospital activities of the AAMC, it is important to understand the composition of the COTH membership. The following review of the membership is one helpful way of assessing the COTH/AAMC role.

	Number of Members	Percent
o Common ownership with the college of medicine	64	15%
o Separate non-profit corporation with inextricable relationships* with the college of medicine	27	7%
o Large public hospital with inextricable relationships* with the college of medicine	23	6%

* The primary indicator of the nature of this relationship is that the chiefs of the hospital services are also chairmen of the respective medical school departments.

o	Specialty hospital	27	7%
o	Federal hospital	74	19%
o	Public hospital with a secondary affiliation with college of medicine	18	4%
o	Affiliated non-profit hospital with significant commitments to medical education and research*	58	14%
o	Affiliated non-profit community teaching hospital**	122	29%

A list of the membership by these categories is included as Appendix A. The mean size of a COTH non-federal hospital is 562 beds, and the regional distribution of members is as follows:

	Percent of Members
Northeast	40%
South	20%
Midwest	27%
West	12%

*Teaching hospitals with a "resident-to-bed" ratio above 0.2 which are not otherwise classified.
**Teaching hospitals with a "resident-to-bed" ratio less than 0.2 which are not otherwise classified.

It is of interest to note that 22% of COTH members are in the states of New York and Pennsylvania. TABLE I on the following page illustrates the fact that a majority of COTH members are in the seven states of New York, Pennsylvania, California, Ohio, Illinois, Massachusetts and Michigan. TABLE II shows that when the geographic distribution of primary teaching hospitals is analyzed, nine states account for a majority of members, and only Michigan drops out of the group. In TABLE II, primary teaching hospitals are defined as having: (1) common ownership with a university; (2) separate nonprofit corporations with inextricable relationships with a college of medicine; or (3) public hospitals with inextricable relationships with a college of medicine. For purposes of this paper, the basic indicator used to define a primary teaching hospital is whether the chiefs of the hospital services are also chairmen of the respective medical school departments. Medical schools without a hospital in any of these three categories are listed in Table III. The geographic distribution of COTH Veterans Administration hospitals is listed in Table IV.

In summary, the COTH membership varies substantially in terms of hospital ownership, hospital-medical school relationship, and geography. As a result, COTH members are not in an equal position to respond to the environmental and managerial issues they face; this underlies both the intensive debate over proper governance relationships of some medical centers and the services various members expect from COTH/AAMC.

New Hospital Organizations Competing for National Attention

The COTH was the first of a growing number of special interest hospital organizations. Since its establishment, a number of associations have developed and many of them compete with COTH for the allegiance of its members.

TABLE I

Distribution of COTH Members by State

State	Number of Members	Percent of Members	Cumulative Percent
New York	56	13.5%	13.5%
Pennsylvania	35	8.4	21.9
California	32	7.7	29.6
Ohio	26	6.3	35.9
Illinois	24	5.8	41.7
Massachusetts	21	5.1	46.7
Michigan	21	5.1	51.8
Texas	18	4.3	56.1
Connecticut	14	3.4	59.5
New Jersey	14	3.4	62.9
Missouri	11	2.6	65.5
Wisconsin	10	2.4	68.0
All Others	133	32.0%	100.0%
TOTAL	415	100.0%	

TABLE II

Distribution of Primary Teaching Hospitals by State

State	Number of Primary Teaching Hospitals	Percent of Members	Cumulative Percentage
New York	14	12.3%	12.3%
California	9	7.9	20.2
Pennsylvania	7	6.1	26.3
Massachusetts	6	5.3	31.6
Texas	6	5.3	36.8
Illinois	5	4.4	41.2
Georgia	4	3.5	44.7
Missouri	4	3.5	48.2
Ohio	4	3.5	51.8
All Other	55	48.2	100.0%
TOTAL	114	100.0%	

TABLE III

Medical School Without a Hospital in the
COTH List of 114 Primary Teaching Hospitals

Primary Teaching Hospital Does Not Belong to COTH

University of Hawaii John A. Burns School of Medicine

University of Louisville School of Medicine

Uniformed Services University of the Health Sciences

Oral Roberts University School of Medicine

Ponce School of Medicine

Schools Using Community Teaching Hospitals as Base Hospital

Southern Illinois University School of Medicine

Chicago Medical School

Michigan State University College of Human Medicine

University of Minnesota - Duluth School of Medicine

University of Nevada School of Medicine

UMDNJ, Rutgers Medical School

East Carolina University School of Medicine

University of North Dakota School of Medicine

Wright State University School of Medicine

Northeast Ohio Universities School of Medicine

University of South Carolina School of Medicine

University of South Dakota School of Medicine

East Tennessee State College of Medicine

Texas A&M College of Medicine

Marshall University School of Medicine

Provisional AAMC Members

Mercer University School of Medicine

Morehouse School of Medicine

TABLE IV

Distribution of COTH Veterans Administration Hospitals (74) by State

- California has nine and New York has seven VA members

- Five states have three VA members: Florida, Illinois, Missouri, Ohio and Texas

- Eleven states have two VA members:

Connecticut	Michigan
Georgia	Pennsylvania
Iowa	Tennessee
Kentucky	Virginia
Louisiana	Wisconsin
Massachusetts	

- Nineteen states, the District of Columbia and Puerto Rico have a single VA member:

Alabama	Minnesota	Oregon
Arizona	Mississippi	Rhode Island
Arkansas	Nebraska	South Carolina
Colorado	New Jersey	Vermont
Indiana	New Mexico	Washington
Maryland	North Carolina	West Virginia
	Oklahoma	

- The Federation of American Hospitals has become an effective and highly visible organization;
- The National Association of Public Hospitals is two years old and gaining strength;
- The Association of Academic Health Centers is exhibiting strong interest in major teaching hospital issues;
- The National Council of Community Hospitals has made its presence felt, and appears to be a viable organization;
- The National Association of Children's Hospitals and Related Institutions has recently moved to Washington, DC;
- The Association of Volunteer Trustees of Not-for-Profit Hospitals has taken on some specific issues, and made an impact;
- Increasingly, hospitals and hospital associations are hiring Washington-based law firms and consulting firms for "representation" purposes. Some (not all) of these law firms have very little substantive or technical knowledge in the areas in which they are engaged to provide "representation" services.

Clearly, the association environment for COTH has changed substantially over the past five to ten years. There is competition for constituents, and for the attention of legislators, legislative staffers, and executive branch political leaders and employees.

In addition, other organizations are developing for a variety of purposes.

- Voluntary Hospitals of America has become a substantial economic force since its inception in 1977;

- Associated Hospital Systems is engaged in a variety of economic and public policy activities;

- The Consortium for the Study of University Hospitals has organized to study governance and other matters peculiar to the operation of hospitals under common ownership with state universities;

- The Council of Independent Teaching Hospitals is a group of hospitals in an organizational stage which hopes to address the problems of hospitals with freestanding residency programs and which do not have a close medical school affiliation;

- The Federation of Jewish Hospitals has hired an individual to explore the possibility of exploiting the collective economic strength of its members;

- The "original" Council of Teaching Hospitals has engaged Howard Newman to explore the development of possible collective activities.

A list of COTH members belonging to some of these new organizations is included as Appendix B.

The development of these new organizations suggests that multi-hospital systems, cooperatives, and organizational entities are to some degree taking on traditional functions of associations. For example, until very recently (the past six months), Voluntary Hospitals of America clearly did not envision a public policy advocacy role. This policy has been reversed, and such an advocacy function is being developed.

COTH Strengths and Areas of Concern

With the exception of the Association of Academic Health Centers, all of the organizations identified in the previous section are "hospital" organizations. They were started by hospitals and their exclusive purpose is to serve their hospital constituents. A unique characteristic of the AAMC is that it brings together in one organization the deans, clinical and basic science faculty, and teaching hospital chief executives. Thus, it is not exclusively a medical school organization nor an organization devoted soley to the needs of academic physicians or teaching hospitals.

The Executive Council, which serves as the AAMC board of trustees, has a plurality of deans, but includes four hospital and four faculty representatives. Committees or task forces of the AAMC, regardless of the focus of their charge, include at least one member from each Council. This policy has been established to improve common understanding of issues, and to aid in the development of more broadly based AAMC policies or programs. Each constituency group may not get optimal outcome from its own point of view, but the unified voice enhances the strength of the AAMC policy position. For example, a position statement on a hospital issue can be given greater strength when it can be supported by the deans and faculty. At the same time, this method of operation appears to have reduced the friction and mistrust between the leadership of the three components of the medical center.

On numerous occasions, COTH members have expressed strong support for both the Council and the AAMC and its staff. This perception of the benefits of membership appears to be based on the following COTH/AAMC characteristics.

1. The hospital activities of COTH/AAMC focus on a limited set of concerns which in the past have not duplicated the efforts of other national organizations:

   a. clinical education issues including faculty relationships;

   b. clinical research issues; and

   c. issues of particular concern to large and/or complex hospitals.

2. In addressing issues and involving institutional representatives, the COTH/AAMC generally takes a corporate level viewpoint of the hospital rather than a departmental or functional one. Administrative Board, AAMC Assembly, and committee appointments are generally CEO appointments. The COTH Spring Meeting is directed at the CEO, and his/her attendance is required if others are to attend the meeting.

3. A teaching hospital CEO's involvement in COTH/AAMC activities involves him/her with other CEO's, deans, and faculty chairmen--all significant reference groups for the CEO.

4. The AAMC communicates its viewpoints directly to hospital CEO's without a state association as an intermediary. The message has frequently been more timely than others, but pending developments at other associations may decrease this advantage.

5. The AAMC staff promptly return telephone calls and correspondence to member CEO's and their staffs. The responsiveness reinforces the CEO perception that the staff pays attention to what concerns him.

In the development of the reorganized AAMC and the operation over the past 15 years, one could expect that a number of questions might be raised. Changes in the environments for both teaching hospitals and associations have stimulated a number of major questions in recent years. The following are some examples.

Why have such a large number of special interest groups developed in the hospital community? "There appears to be a general lack of confidence that a large organization can deal with the special problems of 'my' kind of hospital," is a response that is frequently given in answer to this question. Clear examples are the development of the National Association of Public Hospitals and the Consortium for the Study of University Hospitals.

Does the staff of the AAMC perceive problems trying to represent a wide range of teaching hospital members? The large, private hospitals, which view themselves as the institutions which teach the teachers and support major research programs, on occasion express the view that their unique contributions and problems are not fully articulated. They and their colleagues in the other primary teaching hospitals seem to feel the rest of the COTH constituency dilutes their message. When asked specifically to show how the diverse constituency has diluted or changed the AAMC objectives, the response has not been helpful. At the same time, the affiliated hospitals which are not primary seem to believe the organization is dominated by primary teaching hospitals.

Are there problems with the regional distribution of COTH members? Some constituents express the view that the organization is dominated by representatives from the Northeast corridor. A review of the list of COTH Past Chairmen could make a case for some bias, but a review of Administrative Board membership would not support this view. Since the largest number of

COTH members are in the Northeast, it might be expected that this region has larger representation on the COTH Administrative Board and AAMC committees.

Who should be the COTH representative? A matter of some concern is the request of some members, primarily community teaching hospitals, that their institutional representative be someone other than the CEO of the hospital (e.g., medical director, vice president for medical affairs or a director of medical education). This suggests either: (1) that the role and responsibility of the COTH and its representation of the hospital viewpoint in the AAMC is not well understood; or (2) that in hospitals with limited educational programs, the CEO may not be heavily involved in the education and research issues, and the impact of these two missions has not significantly affected the character of the hospital.

What are the services provided to the COTH Veterans Administration members? In the "hospital community" there is not a full understanding and appreciation of the role of VA hospitals in medical education and as partners in the academic medical center. Over 7,700 residency positions are financed by the VA and a substantial research budget is supported. The AAMC is the only national hospital or medical association which testifies regularly on behalf of the Veterans Administration medical care appropriation. Additionally, the AAMC provides support for the VA in other legislative matters affecting the VA, ranging from chiropractic issues to special pay provisions for physicians. Routine meetings are held with the senior staff of the AAMC and the VA Chief Medical Director's office, and on occasion special consulting teams have been organized to resolve difficulties with some VA hospital-medical school affiliation arrangements.

What other complaints are heard? Many more CEO's wish to participate than can be accommodated. By design, the AAMC does not have standing committees in substantive areas and keeps the number of committees as small as possible. Participation is what generates loyalty and support of the organization. To overcome this difficulty, the Department of Teaching Hospitals staff makes a strong effort to attend the meetings of the regional teaching hospital groups and seeks other ways to make personal contact with the teaching hospital constituents.

A final impression to which the staff sometimes finds it difficult to respond comes across as, "If only your organization would do something, I wouldn't have the problems I now have." Governance problems at the medical center level are a good example of this kind of problem.

FUTURE DIRECTIONS FOR COTH/AAMC

A Framework for Analysis

Associations of autonomous service and business entities, generally focus their activities on one or more of five goals.

Advocacy -- the association works to advantage its members by obtaining favorable or avoiding unfavorable treatment from the environment in which it operates. Advocacy activities may be directed at the political process (legislative and executive) or at the private sector environment.

Economic -- the association works to develop programs and member services designed to improve the efficiency and profitability of its members.

Examples of such programs include group purchasing, standardized operating procedures, and multi-firm benefit and personnel programs.

Information -- the association provides its members with a convenient and reliable network designed to furnish members with significant information on developments in the environment. To the extent that members are willing to share internal information with each other, the association provides a means of facilitating the exchange of "within member developments."

Education --- the association develops educational programs specifically designed to meet the specialized needs of its members.

Research -- the association develops an organized program to monitor the performance of its members, to develop methods or techniques which can be used by all members, and/or to identify early developments likely to affect the environment in which a member operates.

In most associations, each of these goals is present. Differences in associations seem to reflect differences in the emphasis given a particular goal and in the balance of activity across the five goals.

A review of the most recent paper on the "Selected Activities" of the AAMC's Department of Teaching Hospitals, Appendix C*, shows staff activities focus primarily in the areas of advocacy, information, education, and research. Services in the economic area have not been developed. At the AAMC Officers' Retreat in December, 1982, agreement was reached that it would be unwise for the Association to develop service programs unless there is a clearly expressed constituent desire for a service and the Association would be uniquely qualified to provide that service. This decision was approved at the AAMC Executive

*Separate enclosure with this agenda

Council meeting on January 20, 1983. Thus, the absence of these types of economic activities is the result of deliberate AAMC policy.

Within the four areas of existing activity, members commenting on the value of COTH generally cite its advocacy activities. While a large proportion of staff time is devoted to testimony, letters of comment, and personal representation at the Congressional staff level, more time is probably devoted to interaction with HCFA and other executive agency staff, and to participation in advisory board and committees of other hospital associations and groups. Interaction with the staff of other associations or organizations whose interests overlap with those of the COTH/AAMC is particularly time consuming, and very important. Substantial staff time is also devoted to the development and distribution of information including a series of annual studies, the COTH Report, weekly activity report stories, and membership memoranda. In addition, a large proportion of staff time is spent on the telephone conveying information to members, consulting and law firms, and other callers. Thus, while advocacy may be the most valued staff service, information dissemination is also time consuming. The information dissemination function is supportive of the advocacy function (and in some cases is not distinguishable from it) since it serves to establish the credibility and reputation of the AAMC teaching hospital staff members.

Future Directions

The Council of Teaching Hospitals of the AAMC is less than twenty years old, and it grew and developed during the period of hospital expansion and retrospective cost reimbursement. With a changing environment, COTH and the AAMC's services need to be examined to help ensure that traditional activities of the Department of Teaching Hospitals are appropriate and that any new initiatives strengthen both the Council and the AAMC. As the membership and governance

directs their attention to how the Association should function on behalf of its hospital members in the future, past services and emphases are only a prologue. Yet, past activities have demonstrated a commonality of interest. The selection and development of areas of common interest will become increasingly important in a more competitive future. As a result, staff suggests the following recommendations be considered for COTH/AAMC activities in the future.

Advocacy

By its very nature and structure, the AAMC is focused on advocacy. In the past two decades, this advocacy has focused on supporting the expansion and development of member capabilities. In the near future, the advocacy emphasis will shift to protecting the diversity of the membership and preserving special benefits, subsidies, and advantages available to teaching hospitals. With third party payers increasingly setting fixed levels of expenditures for hospital services, the AAMC must work to protect the teaching hospital share.

Advocacy, however, is not limited to the political process of legislation, regulation and oversight. It includes building public awareness, appreciation for, and support of teaching hospitals. The predominately local nature of hospital service markets and the increasing emphasis on local payment arrangements stimulates the need for public advocacy of the generic benefits provided by teaching hospitals. The role, responsibility and contributions of teaching hospitals to the health care system need to be articulated forcefully and constantly. In view of the rapidly changing hospital and medical service evironment, the increasing importance of the role of the COTH and its members in the development of policies and programs of the AAMC should be clearly recognized and understood.

The advocacy position articulated above in fact implies a policy of protecting the diversity of membership and emphasizing the generic contributions and values of all teaching hospitals. A number of COTH members believe, however, that they would be better served if the AAMC perceived its role as advocating the particular needs of only the primary teaching hospitals (i.e., the first three categories shown in Appendix A). At this time, the staff of the Department of Teaching Hospitals does not believe that advocacy on behalf of this limited group of teaching hospitals is the proper policy course to pursue.

- In the era of administered prices, federally sponsored and conducted studies will be used to direct the evolution of the system. It is recommended that COTH/AAMC explicitly work to have their members included on all relevant advisory and research committees.

- It is recommended that COTH/AAMC sponsor an annual seminar for Congressional staff on innovations in teaching hospitals. Medical staff members active in the development of new technologies would describe and discuss the innovation.

- It is recommended that the COTH/AAMC develop a registered service mark or slogan which could be licensed to individual members meeting defined criteria. Examples of the slogan accompanying the service mark are:

  Where Standards of Excellence are Routine

  Where Education and Research Result in Better Patient Care

  World Class Medicine

  Scholarship in Service of Patient Care

Information

Information acquisition costs in all organizations can be dramatically reduced if a reliable and timely link to the environment is established. Critical to the economy of this link is the external sources' ability to sort and prioritize information in the same way the receiver himself would. In a competitive environment, low cost, accurate information is a valuable asset. Because the competitive value of the information is based upon its use, not its possession, competing organizations can generally share in supporting an information network.

In a rapidly changing environment, COTH/AAMC can offer members a valuable service by collecting, analyzing, and distributing information. This goal should continue to receive priority; however, a careful evaluation should be undertaken to assess the types of information presently distributed, the reliance on printed materials and mailed distribution, and the almost exclusive designation of CEO's as the addressee.

- It is recommended that the AAMC develop an electronic communication capability which is regularly used to communicate time sensitive information to its constituents.

- It is recommended that the AAMC supplement its present mailings to hospital CEO's with mailing lists for chief financial officers and directors of planning. Where appropriate, duplicate mailings of memoranda would be directed to one or both of these individuals.

- It is recommended that the AAMC use the data and reports of the American Hospital Association and Healthcare Financial Management Association to develop and publish time series data on teaching hospital utilization, revenue, expense, charity care, staffing, and financial performance.

- It is recommended that the CAS and COTH consider sponsorship of an annual symposium on recent developments in clinical care and technology. The objective of the symposium would be to provide the hospital chief executive officer a broader perspective of new and developing technology, and its implications for medical care in the teaching hospitals.

Economics

Teaching hospitals compete in three markets: in an immediate local market for primary hospital services; in a somewhat broader local market for tertiary hospital services, and in a regional or national market for payer revenues. In each of these markets, many teaching hospitals are competing with each other as well as with community hospitals.

A decision to emphasize economic goals would require the AAMC to expand substantially its present teaching hospital staff. It also would require a willingness to advantage some members at the expense of others. This latter point does not seem to be understood by all who advocate service programs. No recommendations have been developed for this type of activity.

Education

The success in the summer of 1983 of the four regional workshops on the Medicare prospective payment methodology and physician payment regulations demonstrates the ability of the AAMC to mount programs and the favorable response of the constituents if the topics are timely and interesting. These workshops serve as an excellent example of the special role the AAMC can play as a result of its unique tripartite organization. The objective of the workshops was to serve the hospital CEO by educating the medical school dean and faculty about the change in their responsibilities which will accompany the new Medicare payment methodology. The Management Education Programs of

the AAMC have been reorganized and are under intensive review and redevelopment. The needs of all AAMC constituent groups should continue to be examined.

- It is recommended that the COTH/AAMC sponsor "issue development" conferences on such matters as teaching hospital/HMO relationships, the impact of PPO's, development of ambulatory service programs and similar topics.

Research

Traditionally, AAMC research on hospital topics has been a secondary goal undertaken to support either advocacy or information activities. Placing research in a secondary position has worked reasonably well; however new advocacy and information requirements will require enhanced research capabilities (1) in monitoring member performance in the changed environment, (2) in analyzing environmental factors which threaten the survival of teaching hospitals, and (3) in identifying early developments which may be widely present in the environment in 3-10 years. To help ensure that the secondary or derived importance of research is not subject to sporadic attention as time permits, a small but continuous research program should be developed.

- If HCFA cost reports permit, it is recommended AAMC survey COTH members to assess the differences in hospital revenue under cost based reimbursement and prospective payment. Where prospective payment results in reduced revenue, the AAMC should attempt to identify the characteristics of the adversely affected members.

- It is recommended that the AAMC survey its members to determine the Medicare revenue being paid to COTH members under the medical education and

capital pass throughs and under the "indirect adjustment for costs associated with medical education."

- It is recommended that AAMC staff prepare papers on four survival issues facing teaching hospitals: alternative methods for funding residency training, new approaches to financing charity care, developing methods for estimating average and marginal costs per case, and the extent of price differences among payers paying "negotiated" prices.

- It is recommended that AAMC staff prepare a literature review on options and issues in determining capitation payments for Medicare and Medicaid patients.

Reviewing the Recommendations

These are not a set of exclusive recommendations; others could and/or should be added to the list. However, there are two views to be taken. The first is that there are a whole variety of projects, programs and initiatives that could be undertaken. They can be set forth, and the staffing requirements needed to accomplish them can be projected. A second way of viewing the situation is to make the assumption that the staff size will not increase substantially. The question then becomes one of determining which projects, programs or initiatives should receive the highest priority. It is hoped that readers of this paper will take the latter course in thinking about AAMC teaching hospital activities.

Appendix A

Distribution of COTH Hospitals

by

Type of Hospital and School Relationship

64 Hospitals having Common Ownership with the College of Medicine

University of Alabama Hospitals
Birmingham, AL

University of South Alabama Medical Center
Mobile, AL

University Hospital
Tucson, AZ

University Hospital
Little Rock, AR

Loma Linda University Medical Center
Loma Linda, CA

UCLA Hospitals and Clinics
Los Angeles, CA

University of California, Irvine, Medical Center
Orange, CA

University of California, Davis, Medical Center
Sacramento, CA

University Hospital
San Diego, CA

University of California Hospitals and Clinics
San Francisco, CA

Stanford University Hospital
Stanford, CA

University Hospital
Denver, CO

University of Connecticut
Farmington, CT

George Washington University Hospital
Washington, DC

Georgetown University Hospital
Washington, DC

Howard University Hospital
Washington, DC

Crawford W. Long Memorial Hospital
Atlanta, GA

Emory University Hospital
Atlanta, GA

Eugene Talmadge Memorial Hospital
Augusta, GA

Rush-Presbyterian-St. Luke's Medical Center
Chicago, IL

University of Chicago Hospitals and Clinics
Chicago, IL

University of Illinois Hospital
Chicago, IL

Foster G. McGaw Hospital
Maywood, IL

Indiana University Hospitals
Indianapolis, IN

University of Iowa Hospitals and Clinics
Iowa City, IA

University of Kansas Medical Center
Kansas City, KS

University Hospital
Lexington, KY

Louisiana State University Hospital
Shreveport, LA

University of Maryland Hospital
Baltimore, MD

University of Massachusetts Hospital
Worchester, MA

University Hospital
Ann Arbor, MI

University of Minnesota Hospital
Minneapolis, MN

University Hospital
Jackson, MS

University of Missouri Hospital and Clinics
Columbia, MO

St. Louis University Hospitals
St. Louis, MO

University of Nebraska Hospital and Clinics
Omaha, NE

University Medical Center
Newark, NJ

Albany Medical Center Hospital
Albany, NY

State University Hospital
Brooklyn, NY

New York University Hospital
New York, NY

Strong Memorial Hospital
Rochester, NY

University Hospital
Stony Brook, NY

State University Hospital
Syracuse, NY

Duke University Hospital
Durham, NC

University of Cincinnati Hospital
Cincinnati, OH

Ohio State University Hospitals
Columbus, OH

Medical College of Ohio Hospital
Toledo, OH

University Hospital
Portland, OR

Milton S. Hershey Medical Center
Hershey, PA

Hahnemann University Hospital
Philadelphia, PA

Hospital of the Medical College of Pennsylvania
Philadelphia, PA

Hospital of the University of Pennsylvania
Philadelphia, PA

Temple University Hospital
Philadelphia, PA

Thomas Jefferson University Hospital
Philadelphia, PA

Medical University Hospital
Charleston, SC

George W. Hubbard Hospital
Nashville, TN

Vanderbilt University Hospital
Nashville, TN

University of Texas Medical Branch Hospital
Galveston, TX

University of Utah Hospital
Salt Lake City, UT

University of Virginia Hospitals
Charlottesville, VA

Medical College of Virginia Hospitals
Richmond, VA

University of Washington Hospital
Seattle, WA

West Virginia University Hospital
Morgantown, WV

University of Wisconsin Hospital and Clinics
Madison, WI

27 Separate Non-Profit Hospitals with Inextricable Relationships with College of Medicine

Yale-New Haven Hospital
New Haven, CT

Shands Hospital
Gainesville, FL

Northwestern Memorial Hospital
Chicago, IL

The Johns Hopkins Hospital
Baltimore, MD

Beth Israel Hospital
Boston, MA

Brigham and Women's Hospital
Boston, MA

Massachusetts General Hospital
Boston, MA

New England Medical Center
Boston, MA

University Hospital
Boston, MA

Harper Grace Hospitals
Detroit, MI

Rochester Methodist Hospital
Rochester, MN

St. Mary's Hospital
Rochester, MN

Barnes Hospital
St. Louis, MO

Creighton Omaha Health Care Corporation
Omaha, NE

Mary Hitchcock Memorial Hospital
Hanover, NH

Montefiore Hospital
Bronx, NY

The Mount Sinai Hospital
New York, NY

The New York Hospital
New York, NY

Presbyterian Hospital in the City of NY
New York, NY

North Carolina Baptist Hospitals
Winston-Salem, NC

University Hospitals of Cleveland
Cleveland, OH

Presbyterian-University Hospital
Pittsburgh, PA

Rhode Island Hospital
Providence, RI

Hermann Hospital
Houston, TX

Medical Center Hospital of Vermont
Burlington, VT

Medical Center Hospitals
Norfolk, VA

Froedtert Memorial Lutheran Hospital
Milwaukee, WI

23 Public Hospitals with Inextricable Relationships with the College of Medicine

LA County/USC Medical Center
Los Angeles, CA

Harbor-UCLA Medical Center
Torrance, CA

Jackson Memorial Hospital
Miami, FL

Tampa General Hospital
Tampa, FL

Grady Memorial Hospital
Atlanta, GA

Wishard Memorial Hospital
Indianapolis, IN

Charity Hospitals of Louisiana
New Orleans, LA

Truman Medical Center
Kansas City, MO

University of New Mexico Hospital
Albuquerque, NM

Kings County Hospital Center
Brooklyn, NY

Erie County Medical Center
Buffalo, NY

Bellevue Hospital Center
New York, NY

Westchester County Medical Center
Valhalla, NY

The North Carolina Memorial Hospital
Chapel Hill, NC

Oklahoma Memorial Hospital
Oklahoma City, OK

City of Memphis Hospitals
Memphis, TN

Parkland Memorial Hospital
Dallas, TX

Harris County Hospital District
Houston, TX

Lubbock General Hospital
Lubbock, TX

Bexar County Hospital District
San Antonio, TX

Harborview Medical Center
Seattle, WA

Milwaukee County Medical Complex
Milwaukee, WI

University Hospital
Rio Pierdras, PR

27 Specialty Hospitals

Children's Hospital of Los Angeles
Los Angeles, CA

Children's Hospital of San Francisco
San Francisco, CA

Children's Hospital National Medical Center
Washington, DC

Henrietta Egleston Hospital for Children
Atlanta, GA

The Children's Memorial Hospital
Chicago, IL

Schwab Rehabilitation Hospital
Chicago, IL

The Children's Hospital Medical Center
Boston, MA

Massachusetts Eye and Ear Infirmary
Boston, MA

St. Margaret's Hospital for Women
Boston, MA

Children's Hospital of Michigan
Detroit, MI

St. Louis Children's Hospital
St. Louis, MO

Hospital for Joint Diseases
New York, NY

Hospital for Special Surgery
New York, NY

Memorial Hospital for Cancer and Allied Diseases
New York, NY

Children's Hospital Medical Center
Akron, OH

Children's Hospital Medical Center
Cincinnati, OH

Children's Hospital
Columbus, OH

St. Christopher's Hospital for Children
Philadelphia, PA

Children's Hospital of Pittsburgh
Pittsburgh, PA

Eye and Ear Hospital of Pittsburgh
Pittsburgh, PA

Magee-Women's Hospital
Pittsburgh, PA

Western Psychiatric Institute and Clinic
Pittsburgh, PA

Women and Infant's Hospital
Providence, RI

Texas Children's Hospital
Houston, TX

M.D. Anderson Hospital and Tumor Institute
Houston, TX

Children's Orthopedic Hospital and Medical Center
Seattle, WA

Milwaukee Children's Hospital
Milwaukee, WI

77 Federal Hospitals

VA Medical Center

Birmingham, AL
Little Rock, AR
Tucson, AZ
Loma Linda, CA
Long Beach, CA
Los Angeles, CA (Brentwood)
Los Angeles, CA (Wadsworth)
Martinez, CA
Palo Alto, CA
San Diego, CA
San Francisco, CA
Sepulveda, CA
Denver, CO
Newington, CT
West Haven, CT
Washington, DC
Gainesville, FL
Miami, FL
Tampa, FL
Augusta, GA
Decatur, GA
Chicago, IL
Chicago, IL
Hines, IL
Indianapolis, IN
Des Moines, IA
Iowa City, IA
Lexington, KT
Louisville, KT
New Orleans, LA
Shreveport, LA
Baltimore, MD
Boston, MA
West Roxbury, MA
Allen Park, MI
Ann Arbor, MI
Minneapolis, MN
Jackson, MS
Columbia, MO
Kansas City, MO
St. Louis, MO
Omaha, NE
East Orange, NJ
Albuquerque, NM
Albany, NY
Bronx, NY
Brooklyn, NY
Buffalo, NY
New York, NY
Northport, NY
Syracuse, NY

Durham, NC
Cincinnati, OH
Cleveland, OH
Dayton, OH
Oklahoma, OK
Portland, OR
Philadelphia, PA
Pittsburgh, PA
Providence, RI
Charleston, SC
Memphis, TN
Nashville, TN
Dallas, TX
Houston, TX
San Antonio, TX
White River Junction, VT
Hampton, VA
Richmond, VA
Seattle, WA
Clarksburg, WV
Madison, WI
Wood, WI
San Juan, PR

NIH Clinical Center
Bethesda, MD

Wilford Hall USAF Medical Center
San Antonio, TX

Public Health Hospital
Seattle, WA

18 Public Hospitals with a Secondary Affiliation with College of Medicine

Maricopa County General Hospital
Phoenix, AZ

Martin Luther King Jr. General Hospital
Los Angeles, CA

District of Columbia General Hospital
Washington, DC

University Hospital of Jacksonville
Jacksonville, FL

Cook County Hospital
Chicago, IL

Baltimore City Hospital
Baltimore, MD

Worcester City Hospital
Worcester, MA

Hurley Medical Center
Flint, MI

Wayne County General Hospital
Westland, MI

Hennepin County Medical Center
Minneapolis, MN

St. Paul-Ramsey Medical Center
St. Paul, MN

Bronx Municipal Hospital Center
Bronx, NY

Nassau County Medical Center
East Meadow, NJ

City Hospital at Elmhurst
Elmhurst, NY

Harlem Hospital Medical Center
New York, NY

Charlotte Memorial Hospital and Medical Center
Charlotte, NC

Cleveland Metropolitan Hospital
Cleveland, Ohio

Erlanger Medical Center
Chattanooga, TN

58 Affiliated Non-Profit Hospitals with Significant Commitments to Medical Education (resident-to-bed ratio of at least 0.2)

Good Samaritan Hospital
Phoenix, AZ

Kern Medical Center
Bakersfield, CA

Valley Medical Center
Fresno, CA

Mt. Zion Hospital and Medical Center
San Francisco, CA

Presbyterian Hospital of Pacific Medical Center
San Francisco, CA

Hartford Hospital
Hartford, CT

Hospital of St. Raphael
New Haven, CT

Washington Hospital Center
Washington, DC

Illinois Masonic Medical Center
Chicago, IL

Mercy Hospital and Medical Center
Chicago, IL

Michael Reese Hospital and Medical Center
Chicago, IL

Mount Sinai Hospital Medical Center
Chicago, IL

Evanston Hospital Corporation
Evanston, IL

Ochsner Medical Foundation
New Orleans, LA

Franklin Square Hospital
Baltimore, MD

Sinai Hospital of Baltimore
Baltimore, MD

Faulkner Hospital
Boston, MA

New England Deaconess Hospital
Boston, MA

St. Elizabeth's Hospital of Boston
Boston, MA

Detroit Receiving Hospital
Detroit, MI

Henry Ford Hospital
Detroit, MI

Hutzel Hospital
Detroit, MI

Sinai Hospital of Detroit
Detroit, MI

Providence Hospital
Southfield, MI

Jewish Hospital of St. Louis
St. Louis, MO

Monmouth Medical Center
Long Branch, NJ

Middlesex General Hospital
New Brunswick, NJ

Newark Beth Israel Medical Center
Newark, NJ

St. Michael's Medical Center
Newark, NJ

The Bronx Lebanon Hospital Center
Bronx, NY

Misericordia Hospital Medical Center
Bronx, NY

Brookdale Hospital Medical Center
Brooklyn, NY

Brooklyn-Cumberland Medical Center
Brooklyn, NY

Jewish Hospital and Medical Center
Brooklyn, NY

Long Island College Hospital
Brooklyn, NY

Maimonides Medical Center
Brooklyn, NY

Methodist Hospital
Brooklyn, NY

Booth Memorial Medical Center
Flushing, NY

North Shore University Hospital
Manhasset, NY

Nassau Hospital
Mineola, NY

Long Island Jewish/Hillside Medical Center
New Hyde Park, NY

Beth Israel Medical Center
New York, NY

Cabrini Medial Center
New York, NY

Lenox Hill Hospital
New York, NY

St. Vincent's Hospital and Medical Center
New York, NY

Highland Hospital of Rochester
Rochester, NY

St. Vincent's Medical Center of Richmond
Staten Island, NY

Akron City Hospital
Akron, OH

The Cleveland Clinic Hospital
Cleveland, OH

Mt. Sinai Medical Center
Cleveland, OH

Geisinger Medical Center
Danville, PA

Albert Einstein Medical Center
Philadelphia, PA

The Graduate Hospital
Philadelphia, PA

Pennsylvania Hospital
Philadelphia, PA

Presbyterian-U of Penn Medical Center
Philadelphia, PA

Mercy Hospital of Pittsburgh
Pittsburgh, PA

Montefiore Hospital Association
Pittsburgh, PA

Scott and White Memorial Hospital
Temple, TX

121 Affiliated Non-Profit Community Teaching Hospitals (resident-to-bed ratio below 0.2)

Baptist Medical Centers
Birmingham, AL

St. Joseph Hospital and Medical Center
Phoenix, AZ

Tucson Medical Center
Tucson, AZ

Memorial Hospital of Long Beach
Long Beach, CA

Cedars-Sinai Medical Center
Los Angeles, CA

Hospital of the Good Samaritan
Los Angeles, CA

Huntington Medical Center
Pasadena, CA

Riverside General Hospital
Riverside, CA

Mercy Hospital and Medical Center
San Diego, CA

Kaiser Foundation Hospital
San Francisco, CA

Presbyterian-St. Luke's Medical Center
Denver, CO

Bridgeport Hospital
Bridgeport, CT

St. Vincent's Medical Center
Bridgeport, CT

Danbury Hospital
Danbury, CT

Mount Sinai Hospital
Hartford, CT

St. Francis Hospital
Hartford, CT

New Britain General Hospital
New Britain, CT

Stamford Hospital
Stamford, CT

Waterbury Hospital
Waterbury, CT

Wilmington Medical Center
Wilmington, DE

Mt. Sinai Medical Center
Miami Beach, FL

MacNeal Memorial Hospital
Berwyn, IL

St. Joseph Hospital
Chicago, IL

St. Mary of Nazareth Hospital Center
Chicago, IL

Christ Hospital
Oak Lawn, IL

Lutheran General Hospital
Park Ridge, IL

St. Francis Hospital-Medical Center
Peoria, IL

Memorial Medical Center
Springfield, IL

St. John's Hospital
Springfield, IL

Methodist Hospital of Indiana
Indianapolis, IN

St. Vincent Hospital and Health Center
Indianapolis, IN

Iowa Methodist Medical Center
Des Moines, IA

St. Francis Regional Medical Center
Wichita, KS

St. Joseph Hospital Medical Center
Wichita, KS

Wesley Medical Center
Wichita, KS

Jewish Hospital
Louisville, KT

Touro Infirmary
New Orleans, LA

Maine Medical Center
Portland, ME

Maryland General Hospital
Baltimore, MD

Union Memorial Hospital
Baltimore, MD

Carney Hospital
Boston, MA

Mt. Auburn Hospital
Cambridge, MA

Berkshire Medical Center
Pittsfield, MA

Baystate Medical Center
Springfield, MA

St. Vincent Hospital
Worcester, MA

Worcester Memorial Hospital
Worcester, MA

St. Joseph Mercy Hospital
Ann Arbor, MI

Oakwood Hospital Corporation
Dearborn, MI

Mount Carmel Mercy Hospital
Detroit, MI

St. John Hospital
Detroit, MI

Blodgett Memorial Medical Center
Grand Rapids, MI

Butterworth Hospital
Grand Rapids, MI

St. Mary's Hospital
Grand Rapids, MI

Sparrow Hospital
Lansing, MI

St. Joseph Mercy Hospital
Pontiac, MI

St. Luke's Hospital
Kansas City, MO

St. John's Mercy Medical Center
St. Louis, MO

St. Mary's Health Center
St. Louis, MO

Cooper Hospital/University Medical Center
Camden, NJ

Hackensack Medical Center
Hackensack, NJ

St. Barnabas Medical Center
Livingston, NJ

Morristown Memorial Hospital
Morristown, NJ

Jersey Shore Medical Center
Neptune, NJ

St. Joseph's Hospital and Medical Center
Paterson, NJ

Muhlenberg Hospital
Plainfield, NJ

Overlook Hospital
Summit, NJ

Buffalo General Hospital
Buffalo, NY

Millard Fillmore Hospital
Buffalo, NY

Mary Imogene Bassett Hospital
Cooperstown, NY

Catholic Medical Center
Jamaica, NY

United Health Services
Johnson City, NY

The Genesee Hospital
Rochester, NY

Rochester General Hospital
Rochester, NY

St. Mary's Hospital
Rochester, NY

Moses H. Cone Memorial Hospital
Greensboro, NC

Wake County Hospital System
Raleigh, NC

Akron General Medical Center
Akron, OH

St. Thomas Hospital Medical Center
Akron, OH

Aultman Hospital
Canton, OH

Christ Hospital
Cincinnati, OH

Good Samaritan Hospital
Cincinnati, OH

St. Luke's Hospital
Cleveland, OH

Grant Hospital
Columbus, OH

Riverside Methodist Hospital
Columbus, OH

Good Samaritan Hospital and Health Center
Dayton, OH

Miami Valley Hospital
Dayton, OH

Kettering Memorial Hospital
Kettering, OH

The Youngstown Hospital Association
Youngstown, OH

St. Francis Hospital
Tulsa, OK

Emanuel Hospital
Portland, OR

Lehigh Valley Hospital Center
Allentown, PA

The Bryn Mawr Hospital
Bryn Mawr, PA

Crozer-Chester Medical Center
Chester, PA

Mercy Catholic Medical Center
Darby, PA

Hamot Medical Center
Erie, PA

Harrisburg Hospital
Harrisburg, PA

Conemaugh Valley Medical Hospital
Johnstown, PA

Episcopal Hospital
Philadelphia, PA

Frankfort Hospital
Philadelphia, PA

The Lankenaw Hospital
Philadelphia, PA

Alleghany General Hospital
Pittsburgh, PA

St. Francis General Hospital
Pittsburgh, PA

The Western Pennsylvania Hospital
Pittsburgh, PA

York Hospital
York, PA

The Memorial Hospital
Pawtucket, RI

The Miriam Hospital
Providence, RI

Roger Williams General Hospital
Providence, RI

Greenville Hospital Systems
Greenville, SC

Baptist Memorial Hospital
Memphis, TN

Baylor University Medical Center
Dallas, TX

Methodist Hospital of Dallas
Dallas, TX

Presbyterian Hospital of Dallas
Dallas, TX

St. Paul Hospital
Dallas, TX

The Methodist Hospital
Houston, TX

The Fairfax Hospital
Falls Church, VA

Charleston Area Medical Center
Charleston, WV

Ohio Valley Medical Center
Wheeling, WV

Madison General Hospital
Madison, WI

Mount Sinai Medical Center
Milwaukee, WI

St. Joseph's Hospital
Milwaukee, WI

St. Luke's Hospital
Milwaukee, WI

Appendix B

COTH Members Belonging to New Hospital Organizations

Organization	COTH Members
Associated Hospital Systems (founded 1977) (11 members including 5 COTH)	Forbes Health System, Pittsburgh East Suburban Health Center (Corresponding)
	Greenville Hospital System
	Intermountain Health Care, Inc., Salt Lake City LDS Hospital (former member)
	Metropolitan Hospitals, Portland Oregon Emanuel Hospital
	SamCor, Phoenix Good Samaritan Hospital
	Sisters of Mercy Health Corporation, Farmington Hills St. Joseph Mercy Hospital, Ann Arbor
National Association of Public Hospitals (founded 1981) (24 members including 15 COTH)	Harris County Hospital District, Houston
	College Hospital, Newark
	D.C. General, Washington
	Cleveland Metropolitan General
	Grady Memorial, Atlanta
	Los Angeles County/USC Medical Center
	Parkland Memorial Hospital, Dallas
	Truman Medical Center, Kansas City
	University of Maryland Hospital
	Wishard Memorial Hospital, Indianapolis
	New York City Health and Hospitals Corp. Bronx Municipal Kings County City Hospital at Elmhurst Bellevue Hospital Harlem Hospital Medical Center
	Worcester City Hospital
	Cook County Hospital
	Westchester County Medical Center

	Milwaukee County Medical Center
oluntary Hospitals of merica (founded 1977) (54 members including 22 COTH)	Abbott-Northwestern Hospital, Minneapolis (former member)
	Akron General Medical Center
	Baptist Medical Centers, Birmingham
	Baptist Memorial Hospital, Memphis
	Barnes Hospital
	Baylor University Medical Center, Dallas
	Butterworth Hospital, Grand Rapids
	Charleston Area Medical Center
	Christ Hospital, Cincinnati
	Community Hospital of Indiana (corresponding)
	Evanston Hospital Corporation
	Henry Ford Hospital, Detroit
	Lutheran General Hospitals, Park Ridge
	Madison General Hospital
	Medical Center Hospitals, Norfolk
	Memorial Hospital Medical Center, Long Beach
	Miami Valley Hospital, Dayton
	Ochsner Foundation Hospital, New Orleans
	Pennsylvania Hospital, Philadelphia
	Riverside Methodist Hospital, Columbus
	Tucson Medical Center
	Wesley Medical Center, Wichita
	Yale-New Haven Hospital
onsortium of Jewish ospitals 17 members including 15 COTH)	Albert Einstein Medical Center, Philadelphia
	Touro Infirmary, New Orleans

Sinai Hospital of Baltimore

Jewish Hospital of St. Louis

Mt. Sinai Medical Center, Miami Beach

Montefiore Hospital, Pittsburgh

Mt. Sinai Medical Center, Milwaukee

Cedars-Sinai Medical Center, Los Angeles

Beth Israel Hospital, Boston

Mt. Sinai Hospital & Medical Center, Chicago

Miriam Hospital, Providence

Sinai Hospital of Detroit

Michael Reese Hospital & Medical Center, Chicago

Mt. Sinai Medical Center, Cleveland

Jewish Hospital, Louisville

Consortium for the Study of University Hospitals (all COTH members)

University of Alabama Hospital

University of South Alabama Medical Center

University of Arkansas Hospital

UCLA Hospitals and Clinics

University of California Hospitals and Clinics, San Francisco

University of Colorado Hospital

Shands Hospital, Gainesville

University of Illinois Hospital

University of Kentucky Hospital

University of Maryland Hospital

University of Massachusetts Medical

University of Michigan Hospitals

University of Minnesota Hospital and Clinics

University of Nebraska Hospital and Clinics

Responses to the Review of Minutes
of the
MEETING OF THE AAMC EXECUTIVE COMMITTEE
WITH REPRESENTATIVES OF FIVE ACADEMIC (CLINICAL) SOCIETIES
DECEMBER 7, 1983

Individual	Comment
1) Dr. Snow	Accurately reflect the meeting in general.
2) Dr. Stemmler	Minutes are fine.
3) Dr. Cummings	Request that minutes be changed to reflect the fact that he spoke for the Otolaryngologists, not Dr. Snow, and described the inability of the NRMP to meet the needs of the Otolaryngologists and thus, the natural evaluation of his process to choose Colendrander's group. Dr. Cumming recollected that Dr. Snow spoke regarding the lack of effective response of the NRMP to meet their needs.
4) Dr. Dyken	Minutes are fine.
5) Dr. Thompson	Minutes are fine.
6) Dr. Clark	No fault with minutes.
7) Dr. Kalina (Dr. Weinstein)	Minutes are generally accurate, however, proposes revision to own remarks. Original minutes indicate that ophthalmologists were the group which had initiated the alternative to the NRMP system, when in truth, the NRMP system was the alternative to their system since opportunities for matching at the PGY-2 level did not exist at the time the Ophthalmology Matching Program was initiated. Dr. Kalina did not state that "candidates, generally felt comfortable with the system"--no such general survey has been done. What has been done is to ask the candidates whether they preferred the present timing of the ophthalmology match or a later timing.
8) Dr. Freedberg	Change in word usage--"responsive vs. responsiveness" in second paragraph on page two of minutes.
9) Dr. Keimowitz	Wonders if it would be useful to include his feelings that the match process should occur as late as possible, consistent with the other demands on the students and program directors, and that there would be considerable benefit to everyone if all programs operated on a timetable similar to NRMP's. Otherwise, minutes seem accurate.

Individual	Comment
10) Dr. Heyssel	Minutes look fine and accurately reflect the discussion that took place.
11) Mr. Rice	No comments received.
12) Dr. Rbt. Hill	No comments received.

MEETING OF THE AAMC EXECUTIVE COMMITTEE
WITH REPRESENTATIVES OF FIVE ACADEMIC (CLINICAL) SOCIETIES
DECEMBER 7, 1983

Minutes

Dr. Heyssel opened the meeting at approximately 12:45 after most of the participants had arrived and had engaged in informal conversation over lunch. He asked the participants (Listed - Attachment A) to introduce themselves in order around the table, giving their name and affiliation (institution and specialty represented). Dr. Heyssel then expressed his and the Association's appreciation for the willingness of those present to devote the time and energy required to make this dialogue possible. He emphasized that the AAMC's objective in asking for the meeting was to facilitate maximum communication and understanding among groups with varying and sometimes conflicting perspectives on the matter of matching senior medical students into residency positions at the second postgraduate year. Generally stated, the AAMC was seeking an approach which provided:

(1) Students with maximum time and opportunity to make appropriate career choices;

(2) Program directors with maximum opportunity to evaluate and select appropriate candidates for the available positions;

(3) Medical schools with the latitude to provide their students with a sound medical education and to provide program directors with an academic evaluation of candidates grounded in accurate assessments of students in appropriate situations.

Observing that the Neurologists had recently completed an extensive survey of both program directors and resident physicians in that specialty, Dr. Heyssel asked Dr. Thompson and Dr. Dyken to address the concerns of that group first. Dr. Dyken provided a detailed description of the survey and its results. (See Attachment B.) He pointed out, in particular, that the characterization of the findings contained in the AAMC pre-meeting material, while consistent with his own first thoughts, turned out to be not entirely accurate when tested at the program directors' meeting in November. Specifically, the observation that the directors would prefer a late match over an early one and a single match over two matches, while true on a majority/ minority basis, warranted further examination. In actuality, there was a distinct bi-modal distribution of the responses and subsequent discussion disclosed a substantial willingness among the members to accommodate the interests and objectives of each other. This may well result in a decision (at the spring meeting of the program directors) to adopt a bi-phasic match system which would entail a match at both the senior and the PGY-1 years. A condition of such a system would be that program directors reserve at least one position in the second match. Preliminary discussion indicated that the program directors would be generally amenable to such a system. This is based in part on the experience that approximately a third of the positions are now filled by the current match.

Drs. Dyken and Thompson also reported on the results of the 1983 match which had just occurred, and the reasons they adopted the current system. It was their perception that the NRMP was unreceptive to meeting their unique needs and that the experience of others using the services of Dr. Colenbrander had been highly satisfactory. Their own experience with this alternative bore that out since they were impressed with the personal attention and responsiveness of Dr. Colenbrander.

Dr. Freedberg, representing the Dermatologists, was the next discussant. His society had two years of experience with the Colenbrander match and had recently decided to switch to the NRMP. He reported that, contrary to the impression held by the neurologists, the view of his organization was that the NRMP was extremely responsive to the needs of program directors. This view was shared by program directors in pulmonary medicine who had recently conducted an NRMP match for candidates interested in entering that specialty. Extensive discussions are currently under way to accomplish an NRMP-managed match of Dermatology candidates to be conducted during their first post-graduate year. All indications were that this match would go very smoothly.

Dr. Clark and Dr. Pevehouse, representing the Neurological Surgeons, indicated that they had selected the Colenbrander system for its apparent responsiveness to their concerns. Their first match was just recently concluded. It had apparently gone very well. They had not previously used a computer match with a uniform match date and were impressed with the ease of such a system. Their primary motivation was to conduct a match in advance of the NRMP to permit students to select a first year position based upon their neurosurgery program match for convenience of coordination of first and second year positions. (Coordination of the educational experience and minimizing geographic dislocations.) Since the NRMP system did not adequately accommodate this objective, the neurosurgery program directors had adopted the approach of the ophthalmologists. Dr. Pevehouse also described in detail the educational objectives which the neurosurgeons felt had been frustrated by the decision to abandon the internship as a freestanding broad-based experience and the inadequacy of the fourth year of medical school to accomplish the goal of broadening the clinical experience of medical students. In his view, much of the turmoil would be resolved if there were a return to the prior system or if there could be established an adequate level of cooperation between the directors of programs in general surgery to meet the needs of the neurosurgeons.

Dr. Cummings spoke for the Otolaryngologists. He described the inability of the NRMP to meet the needs of the otolaryngologists. He described the inability of the NRMP to meet the needs of the otolaryngologists when they were prepared to join the match. This led to the adoption of the Colenbrander system which had, for them, proven satisfactory thus far, although this is their first year and the match results are not out yet. He expressed interest in the testimony regarding the NRMP's current responsiveness, but suggested that any modification of the otolaryngologist's position did not appear imminent. He did, however, acknowledge the desirability of a more coordinated approach which satisfied the interest of all parties to the transactions.

Dr. Snow reiterated the view that the Otolaryngologists' adoption of the Colenbrander system resulted from the lack of effective response of the NRMP to their needs.

Dr. Kalina, representing the Ophthalmologists, the group which had first initiated a matching program at the PGY-2 level, reiterated the views of others who had subsequently adopted that system: that it was in the students' interest; that it had proven satisfactory to the program directors; and that the candidates, when surveyed, preferred the present timing of the match to a later match. This latter comment drew a response from the Neurologists that any opinion from the candidates, developed during the course of the selection process, should be treated with great caution. The experience of the Neurologist's survey was that opinions given anonymously and outside the match process tended to differ markedly from those collected in the context of the match.

This comment was endorsed by Ms. Close, representing the OSR. While disavowing any ability to represent a unitary "student perspective," she observed that the students would predictably adopt a view which seemed most calculated to advance their own, immediate self-interests. She asked the participants to be cognizant of the burdensome and anxiety-producing nature of the current fourth year interviewing and fragmented specialty selection process. She opined that the system frustrated important educational objectives, was very expensive for the students, and was significantly disruptive of both student equanimity and student satisfaction with the medical education process.

Dr. Keimowitz, speaking on behalf of the Group on Student Affairs, urged the participants to recognize the frustrating nature of the current, fragmented system. He stated that, despite any flaws that the NRMP might have, it did represent a single contact point for student affairs deans for most problems regarding the match. This is of great value to the student affairs deans. A major deficiency of the overlapping or competing match was the student affairs deans' difficulty in managing his/her responsibilities for advising and assisting students through this transition. Lastly, Dr. Keimowitz urged that the match process occur as late as possible, consistent with the other demands on the students and program directors, and that there would be considerable benefit to everyone if all programs operated on a timetable similar to NRMP's.

Dr. Heyssel asked Dr. Short of the AAMC staff to lay out the AAMC position. After a demurrer that her assignment was to describe the NRMP's current technical capabilities -- and to remove some unfortunate misperceptions regarding the NRMP -- not to advocate NRMP utilization as the AAMC position, Dr. Short proceeded to describe the NRMP's current "Advance Student Match" by means of a simple diagram (Attachment C). There followed a discussion of the extent of the current use of this approach. It became apparent that there was almost no use of this comprehensive NRMP match system because an early version had been poorly received in its initial presentation by NRMP in 1982. There was general discussion of the flexibility of this system which could coordinate a match of internship and a separate match for residency in one computer run, and which would also permit students the opportunity to use full (categorical) medicine or surgery programs as "back-up" for their specialty residency choices. It was

acknowledged that this option proved especially useful in such specialties as ophthalmology where the number of applicants far exceeded the number of positions. The Neurosurgeons and Otolaryngologists expressed the desirability of their programs receiving residents from a general surgery background. It was agreed that nothing in the current match systems prevented this, but that any problems lay in coordination between the surgical specialties and the general surgery department to offer a proper career path to candidates.

Dr. Short also emphasized her view and that of the student affairs deans that the early match did not accomplish the objectives set out by the Neurosurgeons and the Ophthalmologists' representatives. She pointed out that the system which matched students to PGY-2 positions in the time frame of mid-November to late December did not reduce the interviewing burden of the students because by that time the interviewing for PGY-1 positions was essentially complete. Thus, the two-to eight-week period between the early match results and the submission of the NRMP preference lists created only an illusory advantage to the students. It is true that knowing the PGY-2 position allows the students to create a PGY-1 preference list with greater certitude at the time of submission. However, it lessened no travel or interviewing burden and created the necessity of participating in two matching processes. The advance student match of the NRMP, while slightly more complex, accommodated at one time all of the objectives related to coordinating positions at the PGY-1 and PGY-2 years. It allowed for a more flexible and somewhat more leisurely interviewing schedule and permitted maximum coordination of the matching system. The NRMP dates also allowed maximal time for students to complete the standard junior year medical school curriculum and to even try several electives in the career fields they were considering before having to make career decisions in early Fall of the senior year. Under the NRMP match timetable Dean's Letters could be sent in early October and include student evaluations from 14-15 months of clinical work.

Several program directors responded somewhat skeptically. Dr. Snow pointed out that the number of supplementary lists -- PGY-1 choices coordinated to the PGY-2 positions -- was limited under current rules. Dr. Short responded that this was not inherent in the match algorithm but was adopted this year purely for administrative convenience. It need not be so limited next year. Program directors also pointed out that the potential for listing up to twenty positions on each supplementary list created a mind boggling number of combinations. Dr. Short suggested that this was conceptually accurate but that the reality was that it did not materially affect the situation students actually faced irrespective of match algorithm or system. Students were already applying to a recommended number of PGY-2 residencies and to all the internships necessary to pair with each of these PGY-2 choices.

The meeting disclosed widespread and shared agreement that the transition from medical school to specialty choice is currently complex, difficult and frustrating for students, fraught with negative impact on the student educational objectives, and deserving of attention from leaders in the medical education establishment. There was uniform enthusiasm for the concept of selecting residents by some computer match system which insured a single date for matching for a specialty rather than the previous open offer

system. There was agreement that this kind of dialogue should prove to be an important first step in addressing such problems. Ultimately, there should be a system with the qualities initially highlighted by Dr. Heyssel and such a system should permit maximum coordination among parties involved.

Dr. Heyssel asked the society representatives if they concurred in the AAMC suggestion that the NRMP ought to establish an advisory panel made up of representatives of each specialty with a residency program whether or not the specialty participated in the NRMP match. There was unanimous agreement with this proposal, it being understood that participation on the panel did not commit the specialty to participation in the NRMP match.

The meeting was adjourned at 3:15 with general expressions of satisfaction that an important dialogue had begun.

association of american medical colleges

JOHN A.D. COOPER, M.D., PH.D.
PRESIDENT

January 23, 1984

(202) 828-0460

Ms. Michelle Roman
U.S. General Accounting Office
810 Vermont Avenue, Stop 801
(Room 810 McPherson Sq. Bldg.)
Washington, D.C. 20420

RE: Proposed Criteria for Resident Supervision in Veterans Administration Hospitals

Dear Ms. Roman:

Thank you for this opportunity to comment on the proposed criteria for adequate supervision of surgical residents in Veterans Administration (VA) hospitals. The draft represents a very reasonable attempt to address a difficult subject area. I have recommended several changes which I believe will enhance the clarity and applicability of the criteria. These suggestions appear in italics on the attached copy of the proposed requirements.

At the outset, please note that I have substituted the term "attending physician" for "supervising physician" throughout the draft. My reasons are two-fold: (1) the latter term is not common parlance in the graduate medical education setting and (2) on a practical level, the proposed criteria address the appropriate participation of the attending physician in the supervision of residents and should consistently emphasize this theme throughout. Additionally, you will note the addition of "senior fellow" where chief residents are cited. Both categories of physicians are considered generally equivalent in level of training and board eligibility.

While most of the modifications I have suggested are self-explanatory, some may need additional detail. For instance, I believe the final sentence in item no.7 under preoperative supervision, which attempts to justify the need for countersignature of progress notes, should be deleted. The statement is gratuitous and undermines the intent of this criterion. The objective can be better met by focusing the requirements for documentation on the "prompt" writing or countersigning of the "admission" (not progress) notes. Where efforts have been made to secure routine countersignature of progress notes, the results have been negligible. Countersigning often would occur after treatment had been administered.

The section devoted to "scheduled" surgery would more appropriately be entitled "elective" surgery. I have reordered and restructured the criteria in this section in a manner that I believe will be more logically consistent and comprehensive. As modified, these requirements would recognize the various combinations and permutations that could occur across the following relevant categories of contingencies:

One Dupont Circ 'ashington, D.C. 20036

Operative Procedure To Be Performed By	Relevant Factors To Be Considered	Supervisory Approach
- any resident for first time	- case or procedure is routine/not complex or risky	- attending scrubbed during procedure
- a first-year resident w/o signif. experience at procedure	- case or procedure is extremely complex or risky	- chief resident or senior fellow in operating room/ attending in hospital
- a first-year resident with signif. experience at procedure or a junior resident	- resident performs only less critical phases of procedures	- attending in hospital
- a chief resident or senior fellow		

I believe this scheme would appropriately recognize that a first-year resident can gain sufficient experience at doing certain procedures and merit junior resident status with respect to their supervision when performing these specific procedures. Additionally, requiring under certain conditions that the attending physician be "in the hospital" rather than "within 15 minutes of the operating room" would do more to ensure that extra-hospital obstructions (e.g., traffic, weather, or vehicular breakdown) do not delay his or her timely arrival at the operating room.

In closing, I wish to reiterate strongly a point made in the comments submitted to you by Dr. Clawson, Executive Vice Chancellor at the University of Kansas College of Health Sciences and Hospital. The successful implementation of the criteria for elective surgery, even as modified above, will require the Veterans Administration to allocate more resources to the surgical services than is currently the case. This would require that each station reassess its work load and make provisions for coverage of the service either through increased allocation of funds for full or part-time physicians or contractual arrangements. The objective cannot be achieved under the current practice at many VA hospitals of managing their surgical specialty patients with consultants who, by virtue of the limited fee paid to them, cannot devote the necessary time to adequately supervise residents.

Thank you again for requesting my review of the proposed criteria. I hope my comments and recommendations prove useful and that you will share future drafts as you continue the process of refinement. Should you have any questions about my suggested revisions, please feel free to contact me at any time.

Sincerely,

John A. D. Cooper

John A. D. Cooper, M.D.

ENCLOSURE - 1

CRITERIA FOR SUPERVISION OF SURGICAL RESIDENTS

This paper sets out criteria for adequate supervision of surgical residents during the preoperative, intraoperative, and postoperative phases of a patient's treatment. Adequate supervision involves two sometimes conflicting goals--training the residents and ensuring the quality of patient care. For example, residents may need to gain confidence and experience in making their own decisions during an operation. However, the patient's interests may not be best served by having a resident perform surgery without an attending physician present.

The criteria in this paper attempt to balance these goals and set minimum levels for adequate supervision of surgical residents. ~~Supervising~~ *Attending* physicians must use their judgment to determine the supervision needed for each case, while maintaining at least these minimum levels.

DEFINITION OF TERMS

For the purpose of this paper, "surgery" is confined to inpatient operations. The preoperative phase starts when the patient is hospitalized and ends when the patient goes to the operating room; the postoperative phase ~~is limited to 24 hours after the operation.~~ *should include the period of hospitalization.*

The term "~~supervising~~ *attending* physicians" refers to attending and consulting surgeons. "Surgical residents" include residents in any of the surgical specialties: general surgery, colon and rectal surgery, neurological surgery, ophthalmology, orthopedic

surgery, otolaryngology, plastic surgery, thoracic surgery, urology, and vascular surgery. "Chief residents" are residents in their last year of a residency program.

Even though the criteria refer to the complexity and risk of operations, these terms are not defined because they may differ depending on the type of operation and the patient's condition. For instance, the complexity and risk of a simple hernia operation will differ for a 20-year-old patient in good health and a 65-year-old patient with a heart condition and diabetes. Attending physicians must determine the complexity and risk of each operation.

OVERALL CRITERIA FOR SUPERVISION

The following criteria apply to the supervision of surgical residents during all phases of the patient's treatment.

1. Residents should be given increased responsibility as they progress through the residency program.
2. The responsibility or independence given to residents should depend on their knowledge, *manual skill,* and experience, as well as the complexity and risk of the operations.
3. To ensure the quality of patient care and proper supervision of residents, ~~one~~ *the same attending* ~~supervisory~~ physician should be responsible for each patient during hospitalization. This physician should monitor the patient's

condition during the preoperative, intraoperative, and postoperative phases.

4. The ~~supervising~~ *attending* physician should always be one qualified in the applicable surgical specialty.

PREOPERATIVE SUPERVISION

During the preoperative phase the patient is prepared for the operation, and the ~~supervising~~ *attending* physician confirms the resident's diagnosis and treatment plan. The minimum standards for adequate preoperative supervision follow.

5. ~~Supervising~~ *Attending* physicians should discuss each case with residents before surgery. This applies regardless of the resident's level *of experience.*

6. ~~Adequate preoperative supervision requires~~ The ~~supervising~~ *attending* physician ~~to~~ *should* see the patient after admission and before surgery, *except in extreme emergencies where immediate intervention is required.*

7. The ~~supervising~~ *attending* physicians should write or countersign ~~progress~~ *admission* notes *promptly* to indicate ~~that they agree~~ *agreement* with the diagnosis and the treatment plan; ~~This does not affect the care given, but it documents the supervising physicians' involvement in the case.~~ *or if in disagreement, to indicate any changes.*

INTRAOPERATIVE SUPERVISION

Operations can be divided into four phases:

a. Making the initial incision.

b. *Exposing the pathology and* Confirming the diagnosis.

c. Performing the ~~surgical~~ *operative* procedure.

d. Closing the wound.

The need for supervision varies according to the phase of the operation. For instance, making the initial incision and closing the wound are generally not as critical as confirming the diagnosis *by the pathological findings at operation* and performing the surgical procedure. ~~Confirming~~ *Unexpected pathological findings may require modification of the operative procedure.* ~~the diagnosis is important to identify any unexpected complications and verify the need for the planned procedure.~~

Obviously, the actual procedure and the technique used determine the ~~surgery's~~ outcome *of the operation.* Therefore, unless noted otherwise, the following criteria address the supervision needed to confirm the diagnosis and perform the procedure.

~~Scheduled surgery~~ *Elective*

8. ~~When a first-year resident operates, a supervising physician should be in the operating room.~~ *When a resident performs any operative procedure for the first time, the attending physician should be in the operating room and scrubbed during the procedure.*

9. ~~When residents other than a first-year and a chief resident operate, the supervising physician should be in the operating room or operating room suite.~~ *When a first-year resident operates and does not have significant experience in doing the procedure, the attending physician should be in the operating room and scrubbed during the procedure.*

10. ~~When a chief resident is operating, the supervising physician should be within 15 minutes of the operating room.~~ *When a first-year resident with significant experience in doing the procedure or a junior resident operates, a chief resident or senior fellow should be in the operating room and the attending physician should be in the hospital.*

11. ~~A chief resident may supervise a more junior resident in the operating room except on complex and risky operations. The supervising physician should within 15 minutes of the operating room.~~ *If the case or procedure is extremely complex or risky, the attending physician should be in the operating room and scrubbed during the procedure.*

12. ~~The supervising physician should be in the operating room the first time a resident of any level performs a procedure.~~ *Unless it is the first time performing the procedure or it is an extremely complex or risky case, a chief resident or senior fellow may operate. The attending physician should be in the hospital.*

13. When any resident is performing the less critical phases--that is, making the initial incision and closing the wound--the ~~supervising~~ *attending* physician should be ~~within 15 minutes of the operating room.~~ *in the hospital.*

14. ~~If the case or the procedure is extremely complex or risky, the supervising physician should be in the operating room during all four phases of surgery, no matter what the level of the resident.~~

Emergency surgery

The following criteria apply for emergency surgery.

15. The resident should contact the ~~supervising~~ *attending* physician and discuss the case before surgery. In life-threatening situations, ~~there might not be enough time to call the supervising physician immediately, but~~ *if there is insufficient time to contact the attending physician preoperatively,* the resident should call the ~~supervising~~ *attending* physician immediately following completion of life-saving procedures.

16. If a chief resident *or senior fellow* is operating, the ~~supervising~~ *attending* physician may decide not to go to the hospital, but he or she should be available by telephone.

If the operation is complex or risky, the attending ~~supervising~~ physician should go to the operating room at once.

17. ~~The supervising physician should be present for operations performed by residents other than the chief resident.~~ For operations performed by other than a chief resident or senior fellow, the attending physician should go to the operating room at once.

18. In urgent situations and with the ~~supervising~~ attending physician's approval, the resident may start the surgery before the ~~supervising~~ attending physician's arrival.

POSTOPERATIVE SUPERVISION

The following criteria address adequate postoperative supervision.

19. ~~Supervising physicians~~ The attending physician should see the patient and discuss the postoperative treatment with residents within 24 hours after surgery, and at least every three days until the patient is discharged.

20. The ~~supervising~~ attending physicians ~~need~~ should ~~not~~ write or countersign/progress notes indicating ~~their~~ at least one postoperative agreement with the postoperative treatment plan.

University of Colorado Health Sciences Center

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January 10, 1984

John A. D. Cooper, M.D., Ph.D.
President
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
One Dupont Circle, N.W., Suite 200
Washington, D.C. 20036

Dear John:

It is my understanding that since I have ceased to be a Dean that it is no longer appropriate for me to continue on the Administrative Board of the Council of Deans. I am henceforth, submitting my resignation from the Council and would take this opportunity to thank you and your staff for making my tenure an enjoyable and pleasant one. I sincerely hope that the Council continues to thrive and am confident that under your leadership and with the support of your staff, that will happen.

My best wishes to you all in this an exceedingly challenging period of time. With warmest best wishes, I am,

Sincerely,

M. Roy Schwarz, M.D.
Vice Chancellor for Academic Affairs

MRS/epn

cc: Dr. Ed Stemmler