ORIGINAL

COUNCIL OF TEACHING HOSPITALS

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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EXECUTIVE COMMITTEE

Washington, D. C.

January 12, 1967

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DuPont Room,
Dupont Plaza Hotel,
1501 New Hampshire Ave., N.W.,
Washington, D. C.
Thursday, January 12, 1967

The Executive Committee met, pursuant to notice, at 8:45 o'clock a.m., Stanley A. Ferguson, Chairman, presiding.

PRESENT:

Lad. F. Grapski

Russell A. Nelson, M.D.

Matthew F. McNulty, Jr.

Joseph MacNinch, M.D.

Charles H. Frenzel

T. Stewart Hamilton, M.D.

Dan J. Macer

Lester E. Richwagen

Richard D. Wittrup

Charles R. Goulet

Ernest N. Boettcher, M.D.

LeRoy S. Rambeck

P R O C E E D I N G S

CHAIRMAN FERGUSON: Shall we get started.

We have a very formal item here, call to order, and then a roll call.

Well, we just called the roll. I believe everyone -- let's see. No, Dick Wittrup was not at our first meeting, and Chuck Gray and Stew Hamilton, that's right; and Ernie Boettcher.

Welcome. You don't feel very strange, do you? We don't consider you to be.

I think that is fine.

Now, there is one other item under that tab.

Just to give you an idea, because Matt explained it to me, the Roman numerals here do not refer to the tabs, but under those items it will say Tab 1 or Tab 4, or something like that. That is when you look at the tab; otherwise, there is nothing in your book.

So, under Tab 1, toward the end, there are two listings: one is the Council of Teaching Hospitals-AHA Liaison Committee. And, as you know, the development of the Council of Teaching Hospitals over the years has been in close liaison and full knowledge of the activities of the people in the AHA. And most all of the people, obviously, are part of that organization. And one of the first things we wanted to do was to be sure that there was a strong liaison, not only at the executive level of the organizations, but also at the membership

and program levels.

We had appointed our group: Lad Grapski, Russell Miller, Ernie Shortliffe, and Mark -- those three, right?

MR. MC NULTY: Right.

CHAIRMAN FERGUSON: And then the AHA has just finished, reported to us; is that correct, Matt, --

MR. MC NULTY: Yes.

CHAIRMAN FERGUSON: -- that Mark Berke is Chairman of their session, Dave Wilson and Howard Taylor at Aultman Hospital of Canton.

MR. MC NULTY: I think, Stan, we would want to note these were appointed earlier, but they had one member appointed to this Committee, who felt there was a conflict of interest.

Am I right, Stew? You felt that to serve on the Liaison Committee and still on the Executive Committee, that this might represent a conflict of interest?

MR. HAMILTON: I asked to be relieved. I couldn't see any moolah in it.

CHAIRMAN FERGUSON: Oh, I see. They were going to have you working both sides.

MR. MC NULTY: Both sides. So, this delayed their appointment.

CHAIRMAN FERGUSON: I don't know what Lad's got.

MR. GRAPSKI: Well, I thought now, Stan, since the Committee has been formed that I will call Berke, and we will

try to get together to let each other know what we are doing, trying to see what our various programs should be and see how we can mesh them and build whatever esprit de corps that we can and allay any fears that may exist on both sides.

CHAIRMAN FERGUSON: You will probably have a meeting with the Committee then?

MR. MC NULTY: Right.

CHAIRMAN FERGUSON: Good.

This next one, then, is our Council's Committee on Government Relations.

Matt or Charlie, any particular comments?

MR. FRENZEL: No, nothing has developed as yet. I have been meeting with Ted Howell on the regional complex thing, so at least two members have been meeting on some of these issues. I am not sure whether we shouldn't wait for some development of a program by the Executive Committee before we begin considering anything.

MR. MC NULTY: Stan, there is one item, and it is on the agenda also, and that is the paper that the AAMC is attempting to develop in terms of a position they would like to express on governmental matters. It is broader than legislation. It involves administrative agencies. And this we have started participating in. Each of you had just received a copy of that paper, and I hope this could be something, Charlie, the Committee might mull over.

MR. FRENZEL: Yes.

CHAIRMAN FERGUSON: All right, let's move on then. Approval of the minutes of the Executive Committee meeting --

DR. NELSON: Stanley, could I ask whether you are going to come back to Government activities later?

MR. MC NULTY: There are one or two items, but if the Chairman is in agreement, this may be a good thought.

DR. NELSON: Well, if I could, I would like to go off the record.

(Whereupon, there was a short discussion off the record.)

DR. NELSON: My suggestion is to get very close to your Social Security friends -- and I am sure they will talk about it -- and find out the progress of the amendings that are going to be put forward, and probably very soon convene a group that would carry real weight with the Congressional and the Department people to propose the third edition to this.

I elected at the last opportunity in HIBAC to remain silent on this point, because the nerves in HIBAC and Social Security on this issue are a bit raw, and I think it better for this to come up from the field, as it were, from the academic field. And if it comes up carefully thought out and with real good academic sponsorship, I think it has a good chance of getting included in their recommendations.

The key to this, of course, is the House Ways and

Means Committee. This is where all this will originate, Congressional-wise. And there was some question about how that would be, how Social Security would be placed in the priority work on that Committee. And you may have noticed any comments after the President's speech, that the first item of business before Wilbur Cohen's Committee -- Wilbur Mills' Committee -- that's Freudian. It probably is right -- is the legislation to raise the debt limit.

I think that this might be almost a perfunctory act this time. And the second is Social Security amendments, which means that it is very likely that they will be into this in 10 days. And you know, well, why didn't we start last week or last month?

The answer to that is it wasn't until Sunday noon that we knew that there might be some Social Security amendments put forward by the Administration. And this is the kind of world you live in on this subject.

So, in summary, I would suggest that you get right at it, staff-wise and get to know what is going on. And, second, get the group that maybe Gardner Child represents. You know, in a way, he is a little bit battered -- if you could get a new professor or something from a well-recognized medical center and not many -- you don't need many to make this case. You don't need all disciplines on this committee. You start with a surgeon anda physician and an OBGYN, maybe -- well, maybe

that would not be so smart. But I would say a small committee, to get together with your drafters -- Bill Reidy would be excellent -- and have your paragraph ready, and have it introduced by just some of the biggest guns you can get out of academic medicine and surgery, and do it by the first of February.

I wish I could play a role. There is nothing I would love better than to make this fight, but I think you can see I can't. I am really kind of in a spot. I don't usually deliberately get into it, but I am boxed in so I have to do it this way.

CHAIRMAN FERGUSON: Russ, you used the term "neautralize." You mean, it can go in either direction? That is what you mean. You want the law to have flexibility because A and B really became so compartmentalized, it was one or the other? Is this what you mean?

DR. NELSON: Well, yes; the convenient categorical way to speak of this neutralization at the moment -- everybody is talking about, let's take all of these steps out of A and out of B and leave it in Part C, and throw all the confusion and neutralization into Part C and let that be an "either-or". I know what to write, I think, for the radiologists and pathologists, and I think others do, too, and that is to have it an A benefit from the standpoint of funds and the beneficiaries, and have the law clearly state that this may be paid as a part

of cost, or a part of original charge -- or a reasonable charge, depending on the arrangements in a hospital. And it may be administered through the A carrier rather than an intermediary, or through the B carrier, depending on the local carrier, hospital, radiologist, decision.

And the settling of financial accounts is between the carrier and the intermediary, you see. And it all goes against A, and all of the beneficiaries would total radiology in-patient, just as they would had there been a Douglas amendment. And only the $40 deductible will apply there.

It will greatly simplify the administration of it and give freedom to the hospital and the radiologist to make a logical choice.

CHAIRMAN FERGUSON: Well, in some radiology, professional fee, for example, could come out of B.

DR. NELSON: No.

CHAIRMAN FERGUSON: No?

DR. NELSON: It could be administered by B.

MR. FRENZEL: It could be paid out of B.

DR. NELSON: Paid out of A.

MR. FRENZEL: I mean, eventually, paid out of B by transferring it --

DR. NELSON: No. They take this from the standpoint of the fund, the Government fund, and the beneficiary, and his dollars and benefits, it would be A, just as if the Douglas

amendment had been passed.

MR. WITTRUP: So that if he elects not to take B, he doesn't have to pay for some hospital services and not others.

DR. NELSON: No. He would have all of it under A.

MR. WITTRUP: Yes.

DR. NELSON: But the point is -- the only thing that we presume that the radiologist is concerned about -- let me put this another way.

It doesn't make any sense to have the radiologist concerned about whether he gets his money from the A trust fund in Washington or the B trust fund in Washington, provided he has the opportunity to set fees, send bills, have leases, and deal with his carrier like a surgeon does.

This doesn't have to be a dollar that says "B" to him, or says "A" to him. This has to be a dollar that is the kind that he wants in the way that he wants it.

MR. GOULET: You do that by putting it in C.

DR. NELSON: Right.

MR. GOULET: That is the way you neutralize it. So it wouldn't be identified, Stan, A or B. It is C.

DR. NELSON: Just forget the funds. Just forget the funds. It would give the benefit to the individual in the pattern of hospital services. It would allow the radiologist and the hospital to decide whether they wanted to go on just as they are, if they are on a combined billing on cost and on

salary or anything else and recover this entirely through the hospital services carrier -- intermediaries. That is where we would deal. If you want to do it the other way, the law would permit reimbursement under those circumstances on the basis of professional fees for the professional component or the whole thing, provided they were reasonable, adjudged reasonable, by the carrier for physicians' benefits.

As far as the radiologist is concerned, if he wants to, and can get an agreement of the kind that this group would think is the worst in the world, he would deal with the physician services carrier, and the carrier would set his fees, and his fees would accrue just exactly the same way as the present law under B says it would.

It gives the option.

MR. WITTRUP: Would it eliminate this problem of dividing his functions between the professional and the administrative departments?

DR. NELSON: It could. It depends on how the law is set up.

MR. WITTRUP: You can see in Part C that radiology would be given either as a hospital service or as a physician service, in part or in whole.

MR. RICHWAGEN: Russ, the Association of Clinical Pathologists has been very busy on this, and as you probably know, it has been promoting the idea of leasing and having all

the payments under Part B. And it has been very aggressive about it, and we have had this fight on our hands for quite a long time. And this fight gets into the college of medicine and into the Executive Committee, the Dean's Executive Committee, and they try to get it into the Board at the hospital, saying that the only way to settle this whole thing and to give us an opportunity to staff the laboratories as we should is to let us have control, although they use some other words, control of the personnel, the hiring and payment and the amount of dollars they get, and so on.

Now, this we don't want.

Now, when we propose this, are we adding fuel to this fire that has been built up by the Association of Clinical Pathologists?

DR. NELSON: Well, once again, I would like this off the record.

(Whereupon, there was a short discussion off the record.)

DR. NELSON: At the present moment, interns and residents can only be considered as hospital or non-physician services. My suggestion would be to explore a segment, another C or F, that would say -- and I am thinking from the top of my head now -- that the services of interns and residents for inpatient care will be considered part of hospital services, but can be reimbursed as physician services -- hospital services,

as regards the beneficiaries, but can be reimbursed on a reasonable charge basis, as is with the case with physician services, and in perhaps the out-patient department they can be reimbursed as physician services, you see, with the payments made either to groups or the schools or the hospitals.

MR. WITTRUP: I think that is going to have to happen because at least in some -- I think we are in a vulnerable situation because at least in some places the Federal Government is really paying for these services twice. It is paying the full cost, a full physician's fee, to the attending --

DR. NELSON: Any time you have a private patient, you do that.

MR. WITTRUP: Well, in some of our situations you don't even have to have a private patient.

DR. NELSON: I think that will get caught up.

MR. WITTRUP: There is no provision under the Act now to catch it up, where you pay a full C to the attendant and then you pay the hospital or the house staff that did the work, so that you really -- I am nervous in our own situation, because that is what is happening. And, really, when you get down to it, there is not much of a way under the law to avoid it unless you want to voluntarily forego some income. And we are patriotic but not that patriotic.

DR. NELSON: I think you are quite right. It is inaccurate. It is incorrect.

MR. RAMBECK: You are assuming that intern services are professional services rather than hospital services.

Russ, I would like to ask about the out-patient chaos you mentioned before.

Who is doing something about this? Who is advising the Department on the out-patient problem?

DR. NELSON: They have had a number of work groups that have come to the Department. I feel quite confident, myself, that there isn't a problem that youhave in your mind that that Social Security staff doesn't know about.

They have had a very abundant experience and a very abundant amount of consultation and information about it. They know all about your troubles.

The difficulty is the law is most specific, and I am sure that there is a feeling that -- I know there is a feeling that there is no correction other than legislation. But I would guess that there are some physicians groups that are beginning to be really concerned about this and would take a position emotionally right now to amend the law to do away with hospital out-patient benefits entirely, saying that there is no need for this.

It is competitive and should be done out in doctors' offices where it would be simpler, administratively -- and it would be.

MR. RAMBECK: Instead of private clinics.

DR. NELSON: Just in doctors' offices. Just strike the words, "hospital out-patient services" from the law, a very simple legislative proposal.

CHAIRMAN FERGUSON: The language now does not cover the words "out-patient service" in the sense we are talking about because hospital out-patient departments are not really covered under the Act. It is by regulation that it is described, this service that we provide.

DR. NELSON: It is out-patient services in the Act.

CHAIRMAN FERGUSON: Yes, but I mean the kind of physician services in our clinics. This is within the general language of the regulations.

MR. RAMBECK: Of course, the situation between diagnostic and therapeutic is sort of ridiculous.

CHAIRMAN FERGUSON: That is the point.

DR. NELSON: Everybody knows this.

CHAIRMAN FERGUSON: Well, Russ, I gather what you are saying to this group is, that as far as teaching hospital groups are concerned, and there may be other groups concerned with this, since we have a particular interest in this because of the fact we have the residency training programs, we have the physician services in the sense of out-patient departments, that we have a very -- we probably, within our hospitals represented here, the kind of representation we have --major part of the problem.

DR. NELSON: Yes. I think you are going to have an abundant opportunity, if you keep on the ball, to react to anything that the Social Security Administration puts forward as a proposed amendment. That's easy. You wait until somebody writes something and puts it in the bill.

What I am really suggesting is --

MR. MC NULTY: That we have our own position.

CHAIRMAN FERGUSON: That is right.

DR. NELSON: -- that you write something yourself, go to them, go to any place that seems appropriate and say, "Put ours in, too." And that is on the intern and resident, because I don't think anyone else is going to do it.

CHAIRMAN FERGUSON: Has the AAMC, our parent, had any involvement in this in any way so far?

MR. MC NULTY: Not to my knowledge.

CHAIRMAN FERGUSON: In other words, from the physician's side or the faculty side, this has been through the American College of Surgeons, et cetera, et cetera, -- right?

DR. NELSON: If I may say so, I don't think time permits any protocol clearing.

CHAIRMAN FERGUSON: Yes; that is right.

DR. NELSON: And I would feel quite confident -- Matt could check this easily and quickly with Dr. Berson, which he would anyway -- that the whole of the AAMC would support the action of freeing up the intern-resident system along with the

type we are talking about. This is just as sure as, you know, more Federal aid for medical schools. You don't have to pause very much to worry about it. And my concern is that the more people you involve and the more questions you ask, the more clearances you get, the less clear your position becomes, and you have missed the train time-wise.

I would move.

MR. RICHWAGEN: Shouldn't there be some assistance to the Chairman and to Matt in an approach to the leaders in the medical school field on this proposition? I mean, this is a damned touchy thing.

DR. NELSON: Yes.

MR. RICHWAGEN: Shouldn't we have some help from a small committee?

CHAIRMAN FERGUSON: That is what he is recommending, that there be --

MR. RICHWAGEN: I thought he recommended that Matt look into it.

CHAIRMAN FERGUSON: Well, as the Executive Officer, but also saying that there should be a committee that would be representative of this group who would start immediately to hammer out some ideas on how we think --

DR. NELSON: I particularly would bring in a small number of outstanding professors of medicine and surgery, and other disciplines, a small number.

MR. MC NULTY: Largely, Russ, if I follow you, for impact upon presentation of what we would like to get changed or what we would like to have introduced.

CHAIRMAN FERGUSON: Understanding, too.

DR. NELSON: Well, I think you would like for them to participate -- you would want them to participate --

MR. MC NULTY: Oh, yes; yes.

DR. NELSON: -- in the creation of the law, the proposal.

MR. WITTRUP: Let's be very specific about what we are talking about.

DR. NELSON: Yes.

MR. WITTRUP: We are talking about the possibility that although house staff would remain Part A benefits as far as the recipient is concerned --

DR. NELSON: Or in-patient.

MR. WITTRUP: -- that house staff services could be financed on the basis of fees.

DR. NELSON: Reasonable cost or reasonable charges by local operations.

MR. WITTRUP: Now, presumably, if you go -- well, would there be provision in that for any -- where does faculty supervision fit into this business? That is what I am trying to say.

MR. GOULET: That is where it fits in. It would

legalize what you are doing.

MR. WITTRUP: Would there be two fees, one for the resident and one for the faculty man, or would there be one to cover both?

MR. FRENZEL: The fee would improve the whole pyramid of the institution.

MR. GOULET: You would have a choice.

DR. NELSON: I don't know how to write the law right now --

MR. WITTRUP: I understand that, but I am trying to understand generally what --

DR. NELSON: Well, I would say, generally, reimburse the parties involved as if -- without such clear designation that it must be an attending surgeon in charge, and as if the patients were all private patients, if that is the local wish, you see.

At the moment, there is a very precise definition that says interns' and residents' services are part of hospital costs and physicians' services are only services rendered by a fully qualified physician who is not an intern or a resident, and rendered in person.

Now, this is so confining that it does not permit you to have an eschelon residency system, andy anyone collect a fee, unless an active staff member will testify that he did this work or was there in person, and this is going to lead to

(4)

all kinds of monkey business.

MR. WITTRUP: Now, you talked about the readiness with which everybody was going to support this.

Is there some possibility that -- let's say, in a situation where the desire is to have the resident function pretty independently, but you still created the opportunity in that situation to have those services mainly reimbursed on a fee basis -- some faculty people would see this as a threat to the residency program?

I have had occasion --

DR. NELSON: If they do, they need not for this system. That is my whole point.

MR. WITTRUP: They might not feel like they would necessarily have the final decision, the faculty people themselves, is what I am -- because presumably a hospital could pay them a modest salary but elect to be reimbursed on some sort of fee which might turn out to be more than a salary. And then, the --

DR. NELSON: That is the radiologist issue, isn't it?

MR. RICHWAGEN: The same thing.

MR. WITTRUP: And then the residents might decide they want to have a piece of that fee. But you say, settle that locally?

DR. NELSON: Absolutely. It will never be any better than the local settlements anyway.

CHAIRMAN FERGUSON: I think what Russ is saying is that the local area has to defend its position. Is the patient "private" or is the patient something other than what has been traditional.

MR. WITTRUP: But wouldn't you agree that there is some degree of -- it tends to kind of get complicated, at least to talk about, and somebody has to be careful that the clinical faculty people don't misunderstand what we are talking about.

DR. NELSON: I would say, bring the clinical faculty people in to write the Act.

MR. MAC NINCH: Russ, isn't that proposal somewhat similar to that that was turned down by the AMA three or four years ago?

DR. HAMILTON: The McKittrick proposal.

MR. MAC NINCH: The discussion of a fee for resident services?

DR. NELSON: I am not sure I -- the one that comes to my mind that the AMA turned down was a statement that -- didn't it include something that the attending staff itself should help support the residency system?

MR. GRAPSKI: That was in San Francisco. The House of Delegates turned it down.

DR. NELSON: I think the answer to your question, Joe, is that organized medicine has consistently been opposed to any system whereby a fee could be charged by any other than

a private practicing doctor in the episode of a resident doing the work, but they have also been consistently opposed to anything that would open up the radiology issue, too, since the passage of the Medicare Act. And this may all come of -- not because there isn't enough medical or polical support for it -- my whole plea remains that by C activity, that some are going to put in pathology and radiology and out-patients, and I suggest that we put in the pot something on the intern-resident, too, and nobody else is going to be putting in the intern-resident.

I feel quite confident of that.

MR. RICHWAGEN: When you get done with this phase of the Medicare Act, I would like to bring up one other aspect of it, Mr. Chairman.

CHAIRMAN FERGUSON: Well, let's try to resolve this one.

I think the sense of this meeting is that we should proceed pronto in getting something on this area that Russ discusses. That is the intern-resident section, and how this service is handled under the Medicare Act.

MR. MC NULTY: It is clear to me, Russ, except with your emphasis of action. I followed what you said that the action should preferably be with the Social Security Administration.

DR. NELSON: Well, I certainly would find out what they are doing and confer with them so that you know, or you

suspect their amendments, or the nature of them, and say that you have this concern and would like to work with them.

MR. MC NULTY: I say that vis-a-vis our going -- let me put it more affirmatively. And if they are going to submit a package and are willing to include any suggestions we have, that would be the route we would want to go, vis-a-vis our trying to get the introduction of an amendment ourselves.

DR. NELSON: I would do that if the other failed. I would rather go in on the Administration proposal. If that fails, then you can go to Wilbur Cohen. And if that fails, you can go to your own contacts in Congress. But it may not be popular every place, and if it is unpopular with the Administration, you have kind of got a problem.

CHAIRMAN FERGUSON: Could I ask you this question, Russ. In a sense you are also -- your movement here is, in the sense of trying to define it, a part of the resident service could well be that of an attending physician. This is another way of saying it.

DR. NELSON: I don't know that I understand that well enough to respond to it. I just would leave it rather broad at this time to withdraw to the national extent the restrictions that now exist in the law on the definitions of resident-intern service, how they may be given and how they may be reimbursed.

CHAIRMAN FERGUSON: Okay.

DR. NELSON: I think you could spend a whole day with the Act and with the regulations, beginning to form some crisp language to get what you want. What you want is a broad piece in the law which allows you to ride up and down with regulations as they are needed. The law is too restrictive now.

CHAIRMAN FERGUSON: What I had in mind, I have always kept in mind that really what the law covered was what I called, something identifiable as an attending physician and then other services, and it is in the other services that we have a piece of a physician known sometimes as an intern and resident, and there is no flexibility. As you say now, it is all one way, and this is obvious if you read everything because, you see, they never even -- the regulations on the intern-resident really define him vis-a-vis an attending physician.

DR. NELSON: Yes. For instance, I can see, let's say, public hospitals -- that we want to keep a residency system under the tight arrangement that we know, with salaries paid to the residents and recovery of that, and that only, through the hospital per diem, so that there is no attendant monkeying in this at all.

That is one of the points that you brought out. I think this ought to be permitted. I can also see some institutions that would like, really, to call the residents members of the physician team of a hospital and get reimbursed

accordingly.

CHAIRMAN FERGUSON: That is what I mean.

MR. RAMBECK: Russ, is there any evidence of a great deal of chaos as far as the Administration is concerned in this area as there is with out-patient and the radiology-pathology issue? This is primarily something that we will be proposing and not something that --

DR. NELSON: No, there is no outcry on this.

MR. RAMBECK: Right; right.

DR. NELSON: I think a lot of the problem here is they are going to come out only after the hospitals and their practices are probed into a bit.

MR. RAMBECK: Yes.

DR. NELSON: But what we are saying is there may be a little hanky-panky going on in some of our institutions. And my own belief is, if there is, it is going to come out.

MR. WITTRUP: Sure, it has to.

DR. NELSON: But nobody is wiring a Congressman about this and nobody is sending letters to the Social Security Department on this, as they are about out-patient departments.

CHAIRMAN FERGUSON: No one understands the intricacies or the subtleties of the system. It's only when the score goes on the board that everybody will suddenly start to realize the ball game was being played.

MR. WITTRUP: Don't say "no one." Some of us have

investigated it pretty thoroughly.

CHAIRMAN FERGUSON: I don't say "we." Russ is talking about Congressmen, you see, and others on the outside.

MR. MC NULTY: I was going to say, with this possible exception. I think certainly Harold Bost, who has been a frequent caller to me, is quite aware of the fact, apparently, Dick, from maybe you or a number of other people calling him, that there is only one interpretation he can give on house staff, and that is the interpretation of the law.

(5) And I think he is aware that there are a number of people who are not calling him who may be using names to charge fees, or they may be charging fees without supporting faculty certification, and so on.

DR. NELSON: A good friend of mine refers to this often as a can of worms.

CHAIRMAN FERGUSON: Some call it a bucket of cobras. That is what I have heard.

DR. BOETTCHER: Mr. Chairman, I am very conscious of this sense of urgency that Russ has tried to convey, and I wonder if it would helpful to Matt if we consider the names of people you might consult from the clinical faculties. My own Chairman of the Department of Surgery, for example, is the Chairman of the American Board of Surgeons, and he is very concerned about this. I am not sure he is the particular person to get in on this, but we have had long discussions

about this. He might tell you who, in the American Board of Surgery would be -- that he would suggest for such a task, unless you have others.

DR. NELSON: There is one Dean, of course, and that is the Dean of Virginia, Bob --

MR. MC NULTY: At Charlottesville.

DR. NELSON: I forget his name.

MR. FRENZEL: Crispell.

MR. MC NULTY: Crispell.

DR. NELSON: Crispell.

MR. MC NULTY: Ken Crispell.

DR. NELSON: He is Chairman of the Committee of the AAMC that is in this area.

Dr. Child has probably given more thought and done more speaking and writing about it than anybody I know. He is the Professor of Surgery at Michigan. You know, he talked at the AAMC, you remember.

DR. BOETTCHER: He also did a survey of the hospitals under the aegis of the American Board of Surgeons.

DR. NELSON: I think Bob Williams, former Chairman of the Department of Medicine at Seattle, and he is head of this Interscience Society, or something, which is an attempt to bring together the specialty groups who are in the academic centers for group actions -- Bob knows this whole story pretty well. He is a "gung ho" fellow when he geta a-hold of some-

thing, as you know, LeRoy.

MR. RAMBECK: Yes, he would be a good man.

DR. NELSON: He would be a good man.

MR. RAMBECK: He has a nice tendency and style about him.

MR. WITTRUP: It is Mississippi, please.

MR. MC NULTY: Yes, it is. That is right.

CHAIRMAN FERGUSON: Well, I am sure we can get together --

DR. NELSON: I shared white pants with Bob Williams so I know him pretty well.

CHAIRMAN FERGUSON: I am sure we can get together a small group that could be very useful, but the first thing for Matt to do is get at his friends down in Baltimore and find out exactly where all this stands.

MR. WITTRUP: Could I ask one more question?

CHAIRMAN FERGUSON: Yes.

MR. WITTRUP: Russ, would the broadening to which you refer, or the hastening of this restrictive approach, would you see that it might also permit the cost system to be used for the total spectrum of physician services? Does that seem to be sensible?

DR. NELSON: Yes. Yes, I could see that.

MR. WITTRUP: I think that would be valuable.

DR. NELSON: I have some concerns that that possibly

is available right now. If you want to press it, I think it might be available right now. I know the prepaid group, for practice plans, is making one hell of a push on this.

CHAIRMAN FERGUSON: You see, the law really permits -- they can get actual cost, isn't that right, for the professional side?

DR. NELSON: Yes. Well, it is pretty complicated because it is cost with prepaid plans and predetermined premiums, which includes something that is an old familiar word to most of us here, "X factor." It seems to be argued that X factor is all right if it is in a premium, but it is not all right if it is in a charge. This is the argument.

CHAIRMAN FERGUSON: I don't know that we need -- does anybody feel that we need an action on this? I think the discussion now has been sufficient, so we will proceed, Matt.

DR. NELSON: I am going to ask once again that you treat this with real respect as far as I am concerned.

MR. MC NULTY: Yes, in terms of its discreteness.

Ken Williamson will be joining us at 10:00 o'clock this morning. I wanted to make one observation concerning Ken.

Mrs. Williamson had a serious accident, a fall, neurological damage, and she is still hospitalized. It seems that they are very concerned that there will be some residual damage. Some of you -- all of you may know more about it than I do. I didn't want anyone not to know about it.

The second point is, Russ, do you think it is appropriate to mention our interest in this area to Ken?

DR. NELSON: I should think so.

MR. MC NULTY: What I am getting at is a close working relationship here.

MR. RICHWAGEN: I think we have to communicate and keep them informed. I don't think that this is anything that AHA is going to go to battle on because of its effect upon possibly five per cent of the hospitals. But certainly, we should let them know what we are doing.

DR. HAMILTON: We might be better off if we didn't.

MR. WITTRUP: We might be, except, remember, that last question I -- if it is possible to move toward, let's say, taking physician services on a cost basis to some kind of institutional setting, you may be right in saying they don't want to get involved in this. But the implications of that possibility extend far beyond --

MR. RICHWAGEN: I think the AHA can make its own decision of whether it wants to get involved.

CHAIRMAN FERGUSON: I think Russ commented that the Social Security Administration is considering this, you see. That will move in in that area. That will come up without anybody bringing that up. They are going to bring that up. Ken knows all about it, and I am sure AHA does.

I want to remind everyone, too, that we have always

invited Ed Crosby to these meetings, and this time since he couldn't be here, why Joe McNinch, his very fine associate, is here, whom we all know so well. So we have already informed everyone, which is appropriate that we do.

Okay; can we move on then?

MR. RICHWAGEN: Mr. Chairman, I asked if I might make a comment on Medicare other than what Dr. Nelson was talking about.

CHAIRMAN FERGUSON: Go ahead. Go ahead.

MR. RICHWAGEN: He mentioned the X factor, which gives me a chance to take off here on another aspect of Medicare, and that is the formula for Medicare. Apparently, it was set up on the basis of community hospitals. And as far as a good many community hospitals are concerned, the formula is very,very satisfactory, especially the very small hospitals which feel that now they are going to get paid and not have any losses.

But to me, as far as the teaching hospitals are concerned, it seems that the formula is very insufficient, and it lacks what Russ Nelson calls the X factor. Teaching hospitals have a good many expenses that far exceed anything that community hospitals may have. Their growth factor is greater; depreciation is not sufficient to allow the construction of new facilities that should be constructed because they are based on historical costs.

We tried to get them on a different basis but could

not; therefore, in a good many instances, and probably most of you around the table would find that the amount of depreciation, the amount of the depreciation the hospital receives, is probably only enough to pay for amortization and interest on the debt they already have -- so where do you get any funds of growth of either facilities or for growth of services? There are always new services that come into being. They say you must have this coronary care unit, you must have this emergency heart and lung bypass, that sort of thing, all of which costs money; and where are you going to get the money, because we are always lagging behind.

And I believe that we ought to be doing something as a teaching hospital council to try to get the Social Security Administration to recognize this X factor.

Now, they recognized it in the nursing home group and have allowed them up to 7-1/2 per cent, total. And the only amount that is allowed as a loading factor under the Medicare formula, as I understand it, is two per cent.

Now, there ought to be a percentage, it seems to me, added on to those hospitals which are primary teaching hospitals. And I am talking about the primary teaching hospitals, which is a limited number, or perhaps hospitals could be graded: primary teaching hospitals, those that have interns and residents, and those that have none.

I would like to throw this out because I feel that

this is awfully important.

For example, our semi-private charges are $8 a day more than the per diem that Social Security pays us, and that must be the same in all the rest of the hospitals. I mean, whose hospital here is getting from Medicare a per diem that equals their semi-private charge?

MR. GOULET: We are.

MR. RICHWAGEN: Well, we will have to look at your bookkeeping, I guess.

MR. RAMBECK: Does that mena, Les, that they are paying you substantially less than it costs you?

MR. RICHWAGEN: No. I think if you went into a cost-accounting, this would be correct, that they are paying us our cost, but they are not paying us this X factor to take care of the losses on the out-patient department, which are heavy. And they are not paying for this extra growth factor that we must have, beyond the community hospital.

And we are loading our day rate now by $6 or $8 a day to take care of these things. Now, if everybody goes on a cost basis, where are the hospitals going to get this extra money to do the things that we have to do? We have to pay for these things before we get reimbursed.

MR. GOULET: I am sympathetic to what you are saying but I -- just for the life of me -- can't see how you could go to the Congress and say that you could separate the sheep from

the goats, and that one gets one percentage and one gets another, because this is a matter of relating this, I think, Les, to cost. And we have asked traditionally for costs, costs in community hospitals, costs in teaching hospitals, and if you demonstrate it as part of cost, I don't think I see how the Congress can respond.

A better way to do it would be to go another route, to medical education resubsidation, teaching hospitals as part of an educational program, but not through the route of purchase and service.

MR. RAMBECK: Les does bring up a very important point, though, next to the out-patient thing that Russ touched on earlier, and that is a substantial subsidation of the out-patient program by a teaching hospital. I am sure it must run nearly 50 per cent in most places.

MR. WITTRUP: As I understand it, though, the Medicare people will reimburse their clients on cost for out-patient, and they will also let you include in that any unpaid, deductible part.

MR. RAMBECK: If they can eliminate the chaos in the administration of it, I think it would be all right.

MR. WITTRUP: So it is hard to say that they are not carrying their share of the freight.

MR. GOULET: Yes, that is the point. There isn't -- if you want to support medical education, do that through

educational legislation, but don't do it through the mechanism of purchase and service because what you are going to eventually have to tell some Congressman is that they are going to pay you five per cent more for that patient who comes to you, and they are going to pay the hospital down the road five per cent less.

Where does this put the patient? The question of quality is going to be finally introduced there.

MR. RICHWAGEN: Well, you already have a differentiation of paying the 7-1/2 bonus to nursing homes.

DR. NELSON: I think I better comment on this.

I sat week end after week end, listening to this in the Social Security Department, and as you know, Les, it is not by any means what we might call the teaching hospitals that feel the bind. Probably the most severe criticism of cost reimbursement under Social Security is coming from the West Coast; in California, specifically.

First, I think one has to remember that the law here -- and I wonder if any of us as citizens would ever construct a law that said it differently -- says that the Social Security Trust Fund shall pay fully for the cost of services rendered their beneficiaries and not have any of those costs carried by other patients, nor, indeed, the fund be used to support the care of people who aren't beneficiaries.

Now, as a Social Security taxpayer, I think that is

right. So that, to get extra payment for a loss in your out-patient department, which has its origin in other patients, is not consistent with the law, and I don't know that I would write the law, myself, any differently in that regard.

MR. RICHWAGEN: Do you think two per cent is enough to take care of --

DR. NELSON: No.

MR. RICHWAGEN: -- the growth factor?

DR. NELSON: Well, the other point that is argued pretty strongly is the obligation in the benefits to pay for the cost of hospital care, not the provision of an expanded hospital system.

Now, you can argue about this. I recognize that. But this is the statement that has been made.

On the other hand, I think the economist would tell you -- tell us -- that if you need a $100,000 addition to your facilities, and if you were 100 per cent reimbursed on the formula that has been set, every patient paid this formula, because there is full reimbursement of interest charged, and since there is real flexibility in the depreciation schedule, theoretically you can finance and refinance and expand your facilities on borrowed capital.

Furthermore, the seven per cent for the proprietary institutions emotionally went down our gullets about as hard as anything I know, because when you look at it, they are paying

more than we are and, you know, we are white and they are not. But the fact of the matter is that a man who puts his money into an endeavor has got a right to get a return on his money, just as a banker has a right if he lends you money. And it is pretty hard to argue against inclusion of an interest return to the man who has lent the money to his own institution.

Well, the case is made, I hope.

Now, in practical terms -- in practical terms, Les, I think the hospital, the voluntary hospital field did not realize that we did not have a good set of principles and a good compendium of facts, and we were reasonably well divided on good capital financing of hospitals.

There are those who will say that hospital should be financed by contributions from the public, and that is why we are tax-free, for instance, and so forth.

And when we got into the discussion about capital financing, we as hospitals, were babes in the woods. We did not have the figures. We did not have a point of view, and we were divided. We got two per cent. Ed Crosby and his gang got two per cent by just a straight political approach to the Department of HEW.

You were there, Stan.

CHAIRMAN FERGUSON: I wasn't there, but I --

DR. NELSON: Well, you know perfectly well what it was. And it was really over the objection of the people who

were looking at reimbursement in these precise principles.

MR. RICHWAGEN: Including Senator Long.

DR. NELSON: Well, Senator Long took off on it very vigorously, and I think the feeling is that certainly 1967 is no year to go sweeten the sweetener.

It might be the year in which to dig in and defend what you have.

MR. MC NULTY: It will be, definitely, I think.

With Senator Long in mind, what is that fellow's name with his staff --

DR. NELSON: Constantine.

MR. MC NULTY: I had lunch with him twice, trying to establish some rapport, and it is very difficult. And Ken tells me I am wasting my time, and I may well be, but I thought I had to go through the exercise. Ken knows him better than I do. But I think Long is going to attack the two per cent: what is the benefit of this? In Louisiana all hospitals can be built by bond issues.

DR. NELSON: You know, it is funny. We are all brought up in the same myth, you know, and for a hospital to borrow money sounds like a failure of the community or perilously close to falling from virtue and grace. And it is like, you know, mortgaging the family car. It is all sorts of very improper things, but it is a pretty darned good way to finance affairs.

And the whole of business and industry in this country would collapse if there wasn't vast borrowing.

MR. WITTRUP: I think that is the key to this. Hospitals have not got accustomed to using borrowed money to expand, and that is what this whole system speaks to.

DR. NELSON: Yes, because we haven't been able to think through, that we might be able to pay it back.

MR. RICHWAGEN: Don't think we haven't borrowed money. We have. Many millions.

DR. NELSON: Well, I don't think proportionately -- if you look at the whole hospital facility of the country, we haven't.

DR. HAMILTON: Except the Baptist chain.

DR. NELSON: They borrow internally.

DR. HAMILTON: They borrow externally. They have done a good job.

(7) CHAIRMAN FERGUSON: I think, too, Les, you have to keep in mind that they reduced the two per cent to one and a half on the proprietaries in exchange for seven per cent on the net equity. Now, the net equity in most of these is pretty low, you see. So I don't know, mathematically, whether they came out much better than if they took per cent on the cost.

But then, again, you must remember that the whole purpose of Title 19, which I think as now recognized was probably more expensive than they thought. You are still supposed

to get under that, you see, reasonable cost. And I think it is going to be very important -- and you remember Allen Winston said this repeatedly, your real problem of getting new money is going to be working at the State level to get your Title 19.

And if, in the State of Vermont, you can get a Title 19 program with reasonable cost on the basis you are getting from Medicare, you are home.

MR. RICHWAGEN: We've got it.

CHAIRMAN FERGUSON: Well, then you had better start opening up new bank accounts.

DR. NELSON: My God, what do you want, Lester?

MR. RICHWAGEN: We have a boot-strap operation. We have to get the money somewhere.

DR. NELSON: Put all your old people in private rooms.

CHAIRMAN FERGUSON: We have about three minutes left before Ken comes --

MR. RICHWAGEN: They won't pay for private-duty nurses.

MR. GOULET: Some of you might be interested to know that the AHA is sponsoring a conference of economists and administrators at the end of this month for the purpose of examining some of the bases for two per cent or five per cent; also, to review the depreciation problem.

MR. RICHWAGEN: Who is calling this meeting?

MR. GOULET: AHA.

MR. FRENZEL: Does anybody know about it?

MR. GOULET: Pardon?

MR. FRENZEL: Nobody knows about it.

MR. GOULET: Yes. The invitees.

CHAIRMAN FERGUSON: The invitees do.

MR. FRENZEL: Is your Liaison Committee of this group going to attend that?

MR. GOULET: We are not invited.

CHAIRMAN FERGUSON: No, the AHA set up a committee on this last fall. I know I was asked to be a part of it, and we started to box with this, and I am sure this is the next step in the development of what Russ has been talking about, how we are going to approach it.

Hi, Ken.

MR. MC NULTY: Ken, have a seat.

DR. NELSON: If I could have the Medicare formula on all my patients, I would be very happy.

CHAIRMAN FERGUSON: Guess what, Ken? We are finishing a little discussion on Medicare.

Ken, why don't you come over here.

MR. WITTRUP: Before we leave it altogether, Stan, I would just like to throw this in the pot.

I assume we are also keeping our eye particularly on how the out-patient services develop under 19.

DR. NELSON: Dick, don't you really have to keep 50 eyes on that?

MR. WITTRUP: I am sure you probably do. I am just thinking --

DR. NELSON: The decisions are really made in the States. The guidelines are out. There are big, thick instructions. In general, the guidelines are following the positions taken for Title 18.

MR. WITTRUP: Yes. I just make that point because I think it affects teaching hospitals --

DR. NELSON: Oh, yes, it does.

MR. WITTRUP: -- in a very disproportionate way from hospitals, in general.

CHAIRMAN FERGUSON: I think this is something that Matt can keep his eye on now and probably it is an item that can well come out in the bulletin of the AAMC, calling specific attention to this, seeing to it that Title 19 is developed.

MR. WITTRUP: Well, the HEW people, at least if our local people tell me right, are pretty demanding when it comes to reviewing and pruning State plans, and in a sense they have the final say on a lot of these things, although the details vary from State to State.

CHAIRMAN FERGUSON: Well, Ken, we are pleased that you could come this morning. I think you know everyone here, don't you?

MR. WILLIAMSON: I think so.

CHAIRMAN FERGUSON: Good.

MR. MC NULTY: Stan, I imposed on Ken's time, and he was thoughtful to come for two reasons: one, to sort of expound for 30 seconds, if it is exposition at all, on what seems to be -- not Ken, but McNulty to expound for 30 seconds, and Ken for much loger -- the approach to the activity of this Council in Washington, and that approach in very general terms, but also very specific as to be of assistance, to supplement, to complement the work of the Washington Service Bureau unless there is some special issue that we would want to emphasize, because it has a teaching hospital or a medical education overtone, w which case I would again go to the Washington Service Bureau for thi r advice, their support, their interest, and whatever else might be involved in the particular issue.

A point in example is what might be called the Minimum Wage Act, the Fair Labor Employment Act, which does involve a decision on interns and residents: are they, or are they not professional talent in terms of the interpretation of the Department of Labor.

Ken and the Washington Service Bureau were handling this most effectively. I considered my role to, on occasions, to be on the phone -- is it going or ain't it -- "or ain't" being the interpretation that we would want them excluded and not considered minimum wage potential. And it was, and

therefore, I saw nothing more for myself to be doing, other than on some occasions such as this occasion, report to you on what had taken place.

With Ken here, he can report that much more effectively than I can.

So the 30 seconds which has now gone to a minute and a half was two-fold: one, this is the activity of this Council and our Washington office with relation to the Washington Service Bureau, as I see it; is there any other perspective that I am missing that I should see which is a close relationship, a support, a complement, a supplement, whatever else Ken would want it to be called.

And, secondly, to bring to you just a message of what took place on the particular amendments of last year.

CHAIRMAN FERGUSON: Ken.

MR. WILLIAMSON: Well, I thought I would talk generally a little while, as Matt said, sort of thinking out loud on what I understand about it. And then some things happened yesterday in a meeting we had on Minimum Wage that have reached the decision stage that I can tell you about, and that I am sure you will be interested in.

I had understood that the effort of this group was in the main educational; that you were concerned about educational developments and opportunitites, and the fact that the hospitals this group represents would be, likely be, the major

centers to develop health personnel. And it is in such institutions that Government would increasingly channel funds, and so on.

So you had a major development interest in the basic problem of the provision of health personnel for the country. And that was what I had understood one of the major interests of your office in Washington to be. And from the one time Matt and I talked about it, prior to his coming down here, I thought this is what Matt was thinking about. And that, I said, made really great sense because I think that there are increasing opportunities to develop, with the assistance of Government -- the Government has a great interest in developing health personnel, but they are not too sure where to turn.

That is clear, and therefore, if there can be concentration in what we now recognize as teaching hospitals, this is all in the right direction, all to the good, and probably would result in substantial increases in theavailability of Government funds to help do this job. And this would be a major mission of an office down here, which to me, as I said, made great sense.

On the other hand, I had understood -- I thought clearly, that the intent was not to establish a lobbying activity.

Now, there is a fine line when you say that you are going to pursue contacts in Washington that are particularly

interested in matters relating to this group as to what is pursuing contacts and what is lobbying. As I look at it, it is akin to reaching the common objective of all hospitals vis-a-vis the Government.

(8)

As I have looked at it in the Catholic Hospital Association and the Protestant -- American Catholic, American Protestant Associations -- it has been in most instances wise not to have independent approaches to the legislative arm of Government. It ends up in great confusion, and it ends up in a lot of differences in approach.

For example, the Catholic group and the Protestant group, there have been basic approaches in the field of education that have been very different, and so on. So to have an umbrella which tries to meld the interests of all groups in the legislative sense lends great strength to the whole field. And this is the way we have operated.

And then, I think, in terms of contacts, as it is increasingly known that you have an office here and Matt is here full time, there are going to be people in Washington who will want to know what your views are on things, and they will want to bring problems to you, hoping that through your group, this particular group, some particular activity can be followed.

I think this is an area where, it seems to me, we have to be very careful, again, that we don't short-change one another, that we don't become divisive in how we approach this,

on our part and on your part both, I think.

And then, I think there are a lot of areas where I don't think there is any problem at all. There are agencies of the Government that will want more information and more contact with the big teaching hospitals of the country, and this they will want to pursue directly with you, and still with the AHA as well, and do it jointly.

Take the Department of Labor situation as a contact area before we get to legislative.

AHA, you know, appoints, or had said when we talked that we wanted a group to sit down in addition to staff and begin to follow these people and project the needs and the problems of the hospital field, to try and guide and influence administrative decisions. So we appointed a group of three people.

One of those, Tom Hale, Dr. Tom Hale, deliberately, we thought, being from a teaching hospital, he would have knowledge of the teaching hospital and the physician problems in relation to it: interns, residents, all that important action he had very much in mind, and nursing, as you all know, he has much in mind, too.

And then, an administrator from a teaching hospital but with different contacts, somewhat, Dave Hitt from Baylor Hospital, which is a different kind of setup really than Tom Hale's. Dave was considered, because he is chairman of a

committee representing -- working in behalf of the State of Texas, all the hospitals on the Minimum Wage and Hours law, with meetings and all the rest of it.

And then, the third person, a fellow, Wood, from Minneapolis-St. Paul, who has been responsible for collective bargaining between organized labor and hospitals. So he knows a lot of finite problems, you know, when you come to wage and and hours laws that a lot of the rest of us don't know, because we have never lived with it.

So those were the three people that we had come.

Now, these people came there under the aegis of the AHA, and exactly how you should or would feel that you should relate your office to that activity is a good thing to talk about.

Now, Matt and I talked, and I said, a little late on my part and not his -- he rightly jogged me and I told him who was meeting and what we were doing, and sent him copies of the stuff that we had written to them, and then we had these meetings and I said to Matt, if we can get any tentative rules out of them on this area, then I would like to call you in and sit down and look at these and see whether you can pick out anything useful, which would have been a good way, I think, to work it.

It wouldn't have, in any way, impeded what AHA's normal practice is and yet would have lent special emphasis. Well, this didn't come about; they moved right ahead, you know,

and they weren't willing to do this. They finally acquiesced, and after lots of pushing on them, they agreed. And day before yesterday we brought the group in, and with staff and lawyers we met with them. And they are coming to -- had come to final decisions on a number of things, not, you know, waiting to give it to us in tentative form so we could check the work or anything, which is a typical Government way of operating. So, there was not the opportunity to do with Matt that which would have been a good safeguard in your behalf, too.

Well, I cite this as an example, because I think -- I assume that in the future in major problem areas like this the AHA will appoint committees, and as they have, try to get representation from major elements in the field. There is no change in that.

And I think that in terms of this contact work and the implications of that, if I am right that you are not a lobbying organization, you should retain contacts in the areas I am thinking of, and this is going to take a lot of working back and forth, with the exchange of information between Matt and ourselves so as to make this work and to make sure we don't get confused -- to make sure that when we talk to a Federal agency, by chance you may not be pushing a different bill of goods than we are, which could happen.

That is the worst thing you could have happen, you know; especially, if we are saying one thing about the teaching

hospitals and you are saying something else.

Now, the other thing in this area of contact is that there is a great inclination for the field -- not being critical, even, but it is just a fact of life -- to get very impatient about what you do in Washington. They just do not understand why, you know, you don't on every issue get everybody on their hind legs and pound on the table; and that if we all did that on every issue, you know, life would be better.

But this is not the way the thing works. And so oftentimes we seem to be sitting on our tails and, you know, letting valuable time go by. And the minimum wage area is where we are getting heaps of mail now. And they answer a lot of letters in Chicago with the labor specialists on what information we have in this field, but there is a stream of letters that come in that are all routed down by Ed and others to me and they all commence, "Where in the hell was the AHA when the law was passed?"

I get these types of letters -- and quite a few of them.

CHAIRMAN FERGUSON: What is your standard reply?

MR. WILLIAMSON: Right where we are now, right here in Washington.

Well, anyway, now that you have this office here, and so on, I am sure that some of your members are going to be pounding on Matt.

MR. MC NULTY: They are.

MR. WILLIAMSON: This damned AHA, sitting on its haunches. And, as usual -- usually, it is the small hospital people saying, you know, we don't know anything about their problems, but increasingly some of them are going to say we don't know and aren't acting in behalf of your problems, too. I am sure of that.

Well now, in legislation it gets a little bit tougher because of this word "contact." I am not sure what you mean by that, except it is my assumption that you do not want to be a lobbying organization.

Now, if the AHA would go about its role in legislative contact, pursuing it just like we have, only more so -- and we are adding additional staff, and so on, in the office, two or three people -- but that is to -- you know, how the AHA procedure is. It gets together with the Council on Government Relations and tries to bring the problems to them in advance as near as it can.

And they think in behalf of all hospitals -- he is the vice chairman, the chairman of vice of the Council on Government Relations, and there are a couple of other people on there -- the chairman is from a big teaching hospital down at Caseley, and there is usually without fail such people on the Council on Government Relations.

So in my mind, the teach hospitals' interests are

being considered pretty well along with everybody else's interests; not the primary interest, but being considered. And sometimes it is the primary interest because they are the source of what, you know, you are talking about, or they are the only source. And then, the AHA, this goes up through the general counsel and the Board, and so on, and becomes policy. And this is what we then are instructed to implement down here.

And then the AHA gets who it thinks is the best person to present the case, to present the testimony, if it seems wise to do so. In many instances, for a lot of good reasons, we do not want to appear in the hearing at all, and it isn't -- sometimes people think we are lazy or do too little work. It is just that it is better not to. So we write statements and get them in the record, and sometimes just letters.

So there are a variety of approaches. But where you get to hearings -- well, this, in each one of these stages, whether you people will be inclined to write letters officially on a piece of legislation or whether you are going to be interested in that the AHA writes on a given piece of legislation, or whether you are going to be inclined to want to appear and have witnesses on a given piece of legislation, or you're content to have the AHA have witnesses and handle the testimony on a given piece of legislation, I think is one area that you need to talk about, and that I am not clear on at all except as I say, that I have understood you are not a lobbying organization.

And if you are not, I guess you would not be performing lobbying functions. The other thing is, as you probably know, that if you decide to move into the area of having representatives do this very often, then you have to qualify as a lobbying organization and register an individual, go through all the, you know, reporting and all the rest of it that you do.

MR. WITTRUP: What sort of working pattern had you developed with the AAMC before this branch of it developed, the particular branch we are talking about?

MR. WILLIAMSON: Very loose.

MR. WITTRUP: Had there been any problem?

MR. WILLIAMSON: No. It had been -- oh, what is his name that is head of --

MR. WITTRUP: Darley? Berson?

MR. WILLIAMSON: Berson -- when it was Darley, and it was out there, Darley would be calling Ed Crosby about things every once in awhile, and Ed would call me and find out what we were doing, and so on.

From the day that Berson came down, then we would either see one another or talk by telephone about areas -- he would call and say, "We hope you are going to say something on this, or at least you will file a statement on an issue," or he would call and say, "What is the point of view of AHA that you are going to express in whatever you do, and vice versa." I

would call him and say that we found that in a certain matter he may want to think of these conditions, so that he would be aware of what we were saying. That is really about the way it worked. It was very informal, very loose.

MR. WITTRUP: Because officially it is still the AAMC you are dealing with.

MR. WILLIAMSON: Yes.

MR. WITTRUP: Of which, as I understand it, this is a part.

MR. MC NULTY: That is right.

MR. WITTRUP: And I think that is useful to keep in mind as this relationship develops.

CHAIRMAN FERGUSON: I would say, too, Ken, I don't think at any time since this group has evolved in the AAMC that there was any feeling that its positions or what it would need to take a position on would be very much different except in most unusual situations which no one has come up with yet, other than what AHA very often would have as basic policy.

And one of the things obviously that Matt will probably do will be to keep aware of, as he has as a hospital administrator before, or as a member of AHA, but now officially we would be able to keep track of policy positions that the AHA takes. And I am sure, as you are pointing out, since the representation on the basic councils and committees that evolve these in AHA, that there is going to be a great crossover. I

don't think any of us ever anticipated but that there would be a great deal of consistency. But I think you are pointing out something most of us are aware of, that one thing is to have representation in Washington. The other is to lobby in Washington, right?

And as far as the AAMC -- how does it act? What is its official position? Do you know, Matt?

MR. MC NULTY: Well, it is not a lobbying activity. In the sense that lobbying means registering, it is not registered to the best of my knowledge.

MR. WILLIAMSON: It does lobby, though. Berson lobbied. He hadn't been caught up with, maybe, but he lobbied, and he was widely recognized on the Hill. People looked at him as though he was there to lobby in your behalf of in behalf of medical schools.

CHAIRMAN FERGUSON: What is the fine difference?

MR. WILLIAMSON: When you appear, they begin to wonder. When you are asking for dough and you seem to become enough involved, then they figure --

MR. WITTRUP: There is a legal definition; isn't there?

MR. WILLIAMSON: Oh, there is a legal definition -- a pretty loose one.

DR. MAC NINCH: But you have to register and report.

MR. WILLIAMSON: Yes. You have to report and register

the organization and the individual.

MR. MC NULTY: That is what I was using as my definition. The AAMC has not registered and has not reported.

MR. WITTRUP: Well, now, this problem must have some counterpart over on the AMA side. I know that they are registered, but what I am saying is, this relationship business must have some precedent that is developed over on the AMA side over the year, which provides some guidelines.

MR. NC NULTY: Well, from my three months here, I would hope that our relationships would be, perhaps, much to the contrary, because -- and I would say this is off the record.

(Whereupon, there was a short discussion off the record.)

MR. WILLIAMSON: The AMA has assumed in all the years I have watched them, that they are authoritative to speak on anything that has to do with physicians, their education or anything to do with it. And they have spoken and have given the impression to Congress officially in terms of the need for more or less physicians and the development of medical schools, and everyghing to do with them. And it say, then, one of the worries, of course,that Congress has had, because in those instances where they were able to feel out deans -- well, take Lister Hill as an example. He would often say to me that the thing that disturbed him most -- he would get a group of deans in his office talking about needs, and they were absolutely

and totally contrary to the AMA. Well, the AMA appeared and gave testimony with a very limited, you know, and to him, a very dissatisfying point of view, and so on, and the Deans were busy trying to overcome this.

MR. WITTRUP: Maybe we can assume that the presence of this office will help to avoid that situation.

MR. WILLIAMSON: As Matt says, living with us is relatively simple; living with them is another proposition. I mean, in terms of -- if you are expecting them not to take action in an area of direct concern to you before they tell you, no such thing is going to happen. They will go ahead and take the action, and you will read about it in the newspaper or hear it from someone. They may call you and tell you that they want you to do this or that. They often do that -- we expect you to take this position.

DR. BOETTCHER: I wonder if we shouldn't become a lobbying organization.

CHAIRMAN FERGUSON: I guess we will be what our parent is. I don't think that we necessarily --

DR. BOETTCHER: No, I mean the parent.

CHAIRMAN FERGUSON: You mean the parent.

DR. BOETTCHER: I think there are a lot of areas where the interest will be solely that of teaching hospitals, where the AHA or the AMA do not feel a strong need or motivation to put a heavy push on.

MR. MC NULTY: Ernie, you make a good point. This is why I was pushing earlier for a specific identification as to what route you wanted me to go in terms of your interest in an intern and resident adjustment under Medicare, just to Social Security or to the extent of getting friends -- and we do have a number of them -- to introduce legislation. I think in the latter case, Ken makes a much better definition than the legal definition, and that is when you start to deal with a Congressman of some type, a Senator or a Representative, or both, if you are going to get legislation introduced, you are getting pretty close to lobbying.

MR. WILLIAMSON: Yes. This is what lobbying is.

MR. MC NULTY: This would be, again -- by way of definition, this would be an activity that the AHA may not want to have a great emphasis on in terms of Medicare, a definition for payment of interns and residents, and so on, but which we would do together. But I think the instructions I had would be to go all the way, go to Social Security. If you can get them to put it in a package, fine; if not, if you can get an administrative concurrence and get it introduced as an amendment, why, proceed in that direction.

And I think that does become, then, lobbying by most definitions.

CHAIRMAN FERGUSON: Well, you are able to invite proposals from time to time, aren't you, Ken?

MR. WILLIAMSON: Sure.

CHAIRMAN FERGUSON: I mean, there is a fine line here; isn't this correct?

MR. WILLIAMSON: Yes.

CHAIRMAN FERGUSON: Because in my working with the AHA, I am sure that the Washington office of the AHA, on the basis of a policy established by the Association -- I think this is what Ken has always been informing these people, all of us in AHA, have a position as you sense that something s coming up. Because you role here in Washington is to see to it that somebody knows you are here so they can say, "What do you think about this?"

Now, this is the opposite of you going to them and saying, "Have you thought about this?" You know that by persistent acquaintanceship there are things that are going to occur. Is this right?

MR. WILLIAMSON: Yes, that is exactly right.

CHAIRMAN FERGUSON: And you know that they will ask you, "What do you think about this?"

MR. WILLIAMSON: That is right. You can plan that they do ask that; in fact.

MR. MC NULTY: Yes. Your charge earlier, though, went beyond that, didn't it, Mr. Chairman?

CHAIRMAN FERGUSON: What was that?

MR. MC NULTY: The charge on the --

CHAIRMAN FERGUSON: We were saying that you have to get together with these people who are knowledgeable in the area of responsibility in Government to be sure that you understand what they are talking about. Like in wage and hour, I am sure Ken knows how they think down there. You have known this over the years. Being informed of what is going on is one thing, right?

MR. WILLIAMSON: That is right.

CHAIRMAN FERGUSON: That is one thing. But then, being prepared, yourself, when they -- you sort of invite them and ask, "What do you think about this? What would you propose?" All right, so you haveindicated an interest, but that is on an informal basis. Then when they come back to you and say, "Well, what do you have to offer?" -- you better be prepared, you see. This is the big thing, isn't it?

MR. WILLIAMSON: That is right.

CHAIRMAN FERGUSON: In responding to Ernie's comments down there, I think this is the real difference.

MR. WILLIAMSON: Speaking just for myself now in terms of medical schools having a lobby, because that is something I can see --

MR. WITTRUP: The AMA would have a hard time accepting that.

MR. WILLIAMSON: Yes, but even they would recognize the fact.

The Members of Congress by and large now, inspired by the Administration's leadership, are not looking to the AMA in terms of questions dealing with medical schools. They aren't thinking about them, and they aren't looking to them, and they are looking for other people to give them the advice. And the AMA knows this, as much as it hurts.

DR. HAMILTON: Doesn't this, coupled with the fact that the AAMC has moved its offices East from Chicago give credence to Ernie Boettcher's point that they probably should be legalizing this thing now, that it is becoming more and more a matter of fact?

MR. WILLIAMSON: I was going to say I could see your legalizing the medical school part, but legalizing the hospital part I would have concerns about because then you are right in the area that I have been talking about of confusion and overlapping.

MR. GRAPSKI: Well, Ithink it is only fair to say that, really, for some time the AAMC has been extremely interested in developing a stronger organization, and they have done this, I think, very definitively through the Coggeshall Report, and they also did it by adding additional staff and, as Stewart mentioned, the moving of people to Washington because this is where all the action is. We worked for eight years in getting the role of the teaching hospital established with the AAMC -- and, incidentally, we did this always with the open invitation

of Ed Crosby or his representative at all of our meetings. There was nothing ever done sub rosa -- and we finally got the AAMC to recognize us officially as a part of their team in support of medical education, medical schools.

And when I think of Matt, when Matt came on board, why, we just assumed that he would be in Washington. This is his proper place. And we have also given special recognition of a liaison committee between this group and the AHA, so that we would be sure that we didn't step on each other's toes. We may from time to time, but I am sure that it would be unintentional rather than premeditative.

MR. WITTRUP: I hope, Stan -- and this is in no way critical of anything that Ken said -- but I hope we don't work too hard on the distinction between lobbying and contact, and this sort of thing, but that we can -- all of us would -- gradually develop a positive orientation to this whole thing, and work to get what good out of it we can. I don't think this is the -- I don't think it is to the interest of teaching hospitals to go somewhere in the Federal Government crossways with Ken's position. That is not going to do either one of us any good.

And it seems to me that we have enough incentives to make this relationship work productively for everybody, that ultimately we have to depend on the good intentions and the good judgment of the people that are working up here to

keep together. And, hopefully for Ken, I would think the presence of Matt up here in an important sense is an added resource. It is somebody else who ought to be well versed in a particular area, and to the extent ought to, you know, help him do his job better. And I would think to a certain extent, you know, the reverse could be true. We don't want to push the AMA-AAMC thing too far because what we are talking about there is a pretty clear jockeying for primacy in particular areas, and I don't think we are involved in that sort of thing, but there may be some things about that situaton over there that makes it inappropriate right now for the AAMC to get lobbying status even though it is lobbying like hell all the time.

So there may be a wider range of consideration, but I hope that this relationship can develop to the mutual interest of all of us, and that we don't work too hard in trying to draw a fine distinction as to exactly who is going to do what.

CHAIRMAN FERGUSON: I don't think we need to be too concerned. I think the purpose of this was just to bring out what the subtle differences are because I want to remind everyone now that, what is it, about 25 per cent of our membership are not necessarily affiliated with medical schools.

MR. MC NULTY: Thirty per cent.

CHAIRMAN FERGUSON: Thirty per cent. So you must keep in mind, however, that our concerned are not entirely, or quite the same as the AAMC's; and I don't think that there is

any question that their relationships with AMA and their concern and their jockeying there is something that is quite a bit different from our concerns here as a teaching hospital form.

I think Ken, again, is right when he points out to us that our concern was to be in that area of education and training of health service personnel, because I think even as AHA was recognized, the majority part of much of this is conducted in a relatively small group of hospitals.

Remember those figures, Stew, that Ed had? What was it, about three or four years ago when we added up the total number of hospitals in the country, as to which ones were really involved in this area of activity? It showed a very definite -- there was a number, and I think we found this out when we invited those who would meet the minimal criteria of this group, and the minimal criteria was three out of five residencey programs.

DR. HAMILTON: And an internship.

CHAIRMAN FERGUSON: And an internship.

DR. HAMILTON: You ended up with, what, four per cent of the hospitals and 30 per cent of the beds?

MR. MC NULTY: Approximately.

CHAIRMAN FERGUSON: Now, I think for Ken's benefit as we define and are able to get better identification of what this hospital group represents, this will be -- obviously, you

will know it, too, because it is probably going to come from your records.

And I note, too, from yourearlier comment that as Matt moves in -- he has only been here for aobut what, half-time, for the last three months, really, -- he will become better aware of the composition of all the committees and councils of AHA, and it is going to continue to be apparent, as it has over the years, that these groups have terrific inter-relationships, and I don't think there needs to be too much concern.

There isn't going to be common thinking. There may not always be total agreement, but a lot of that is going to be ironed out long before it gets to the point where we are asked by Government agencies here in Washington what we think about it. I think your point about the Protestant and the Catholic and other hospital groups working with AHA, what you have indicated is that there you have come to a melding of your thinking as to how you approach it? Is this right?

MR. WILLIAMSON: That is right, yes.

CHAIRMAN FERGUSON: In other words, if they are contacted and they speak on some problem, they are speaking consistent with what you are speaking.

MR. WILLIAMSON: That is right. The thing we do is, for example, frequently we go to them and ask them if they will go with their particular appeal to their group in addition to

what AHA is doing, you see. And this is an effective assist to lobbying, a very effective one. And I think this will occur, hopefully, when we say to Matt, "We are sending this out to the hospitals. All of your members are getting it. If you can follow it through and give them another kick in the britches, this will help."

There is one other thing that is greatly needed down here, and that is a definition of a teaching hospital because the ones we have now are no good. And this is one of the major legislative problems we have.

It came up in the last Session in a very real way in this paramedical? .... paramedical education bill. We wanted them to, you know, broaden the base so that all hospitals which were engaged in programs of teaching and that were approved for a whole lot of .... " " paramedical people, could be included, to broaden the definition beyond affiliated medical school hospitals, which was the original thinking.

Well, then, we got down to -- all right, what is a teaching hospital. And they have information around the field to indicate that a lot of hospitals that we would call teaching hospitals are not teaching hospitals at all. It is nothing but --

MR. WITTRUP: In-service.

MR. WILLIAMSON: -- a pathologist who needs some help so he trains five technicians. And they said, "Do you people

call that a teaching hospital?"

So we were in real trouble.

So that what I finally came down to in an eleventh-hour decision was that any hospital that was approved for internship and residency was a teaching hospital.

But this isn't good enough because we have already got a lot of criticism from the field, that you leave out a lot of people. But anyway, this is on thing that is needed. This will help. This is needed.

There is one thing that the AHA is working on right now with the Committee that came out of the Council, something that is greatly needed wown there, and that is the definition --

MR. RICHWAGEN: You might use our definition of what a teaching hospital is.

MR. RAMBECK: It depends on how you are going to use it.

MR. WILLIAMSON: They looked at that, and I think it was too restrictive. I think maybe we need two kinds of designations.

CHAIRMAN FERGUSON: Well, we will be glad to help.

MR. MC NULTY: What is the committee that is working with this?

MR. WILLIAMSON: It is the Joint Committee that the Board appointed at its last meeting of the Council on Education -- Council on Professional Practice -- I am not sure, maybe

Government Relations. I can't remember.

DR. BOETTCHER: Mr. Chairman, I wasn't suggesting that the AAMC should lobby to create dual channels for the same approach, but I was thinking of some area where the AAMC would be the appropriate channel for the lobbying. I agree wholeheartedly here that Matt has to work closely with Ken on those things that are of joint concern.

MR. RAMBECK: A good example is the animal bill. We weren't very hot and bothered about it in the Council of Government Relations, but this group would be very concerned about it, and could get support from the AAMC.

Matt, I wonder, since all medical schools or nearly all medical schools are an element in a university, what kind of liaison is there between the AAMC staff here and the Council on Education. Because several university presidents are beginning to be quite concerned about the emphasis of the Association of American Medical Colleges in Washington, and concerned about the fact that insufficient attention is given to the principle that education is a State responsibility. And that is beginning to be a sort of a dichotomous point of view here, and I wonder to what extent this liaison is being improved.

(12)

MR. MC NULTY: Well, I can give you my perspective of it, and I don't actually know whether Ken, who has been here longer, has any view on it.

As you know, in addition to being your Director, the

appointment also was as an Associate Director of the AAMC. In that latter category, there is an item on our agenda which says, what have I been doing for the last several months, and I will interject it here so we can get by it.

For two of the last three months, nobody was in the Washington office. They all went to New Delhi to a conference on international medical education.

MR. RICHWAGEN: We will have to stop that.

MR. MC NULTY: Sir?

MR. RICHWAGEN: We will have to stop that.

MR. MC NULTY: I wouldn't stop it. Next time I may be eligible to go.

That was just a plug, Les. I was here as the Washington office. This gave me a perspective with the American Council on Education.

Secondly, they have recently enlarged the committee of which I have either the pleasure or liability of being a member of from the AAMA which is considering the time, reporting, the overhead factors, and so forth, because the Council on Education has become quite interested in it.

These two contacts I emphasize as a method of evaluation. I think the liaison is excellent.

Dr. Wilson, Logan Wilson, who is President of the American Council on Education, is a not infrequent visitor to our office because he has many other offices in that same

building. In my two and a half months, we have had lunch twice. I have been just a bystander, but he and Dr. Berson have had lunch together and discussed a variety of subject matter. I think this is the orientation that Dr. Berson was trying to introduce into the AAMC, more of an emphasis on education; therefore, more of a geographic location in Washington, because that is the center of the educational organization as opposed to a professional relationship which might emphasize its existence in Chicago with the AMA or the AHA or the ADA, and so on.

And, secondly, that medical education was becoming largely supported by Government and so the place to be in attempting to influence favorably any position Government was taking was in Washington.

MR. WILLIAMSON: We have had a lot of difficulty over the years with the education people down here and often had to accomplish things over their dead bodies.

You take the amendment to the Federal Housing Act to provide funds for housing of interns, residents, and so on. They tried every way to stop us from doing that and lobbied against us strongly. And we had to go to a lot of extremes to overcome that because they have got a lot of influence. The excise tax exemption on hospitals is one where staff-wise we have taken it on the chin because they pulled the rug out from under us at a critical stage, sacrificed us to get a partial exemption for themselves some years back. And they only do

that once, and we simply don't trust them.

So they are not an easy group to work with. And their basic feeling is, and this is clear -- they made no bones about it -- a hospital is not an educational institution. And if there is anything they can do to prevent their being recognized as such at all, they are anxious to do it. This is the basic philosophy they have.

Anyway, you might bear that in mind.

The last thing I was going to mention, Stan, for just a moment, if I could --

CHAIRMAN FERGUSON: Go ahead.

MR. WILLIAMSON: -- was that as we see it, our staff down here, the real big job and the tougher job, andthe most needed job is not legislation at all. It is in administration after the legislation is passed. We have got more legislation than anybody can digest now, as you know, and this is becoming clear, and there is going to be more legislation. It is not going to stop. But the big, big job down here now, as we see it, staffing-wise, is to try and help our members get what they potentially can get out of existing legislation. And this can take all the time that Matt and anybody else you will ever afford to bring down here can spend on it, if you really plan to do this, and all the time that we can spend, and then it won't be enough in order to live with the administrative agencies and follow their decisions and be helpful to your

members.

The big hospitals, the single most difficult problem they have now, and where largely they are not doing this because they haven't got the people, is piecing together the pockets. There are now upteen pockets of money in any one field you want to look at, and a big teaching hospital wants to build, you know, and all the various elements and, hell, they have no idea generally of all the pockets there are and how to piece it together. I mean, the constant thing we have is people coming down and they are going to put all their eggs in the Hill-Burton basket, and once they have done it, then they have cut off other baskets -- you know, money available.

And it is how you plan and how you program, which are two different things, and how you present it. So this living with administrative agencies in terms of the field is the bigger job, and it is growing, and growing. And it is the one where we are the most inadequate. We are adding staff people -- Ed Ackert we added recently to the staff, and we call him -- Federal agencies liaison is his responsibility. He was the third top fellow in the General Accounting Office for 24 years and was in control of the staff that did the overseeing of every one of the Federal agencies. He has a whole bunch of lawyers working for him. And so he has tremendous entry into how, you know, the Federal Government works. Ed is strengthening our hand considerably in living with this adminsitrative process. But in terms

of the job that your office can do here, it will become ever clearer to you that that is where you can best serve your members in a big, big way.

CHAIRMAN FERGUSON: In other words, how to understand exactly what gold is in the hills.

MR.WILLIAMSON: Yes. A good example of that, which Matt and I corresponded on for years -- he didn't correspond with me, but he always was thoughtful enough to send me copies. He corresponded with Ed -- is NIH and how NIH reimbursed you people because thet is where the problems arose, you know, under the thing. And we had -- AHA did some things, not enough, and Matt was very impatient in his previous job, rightly enough, because it didn't seem like enough was being done, enough attention was given to it, and all the rest of it.

Well, that is the kind of thing -- there will be examples like that. But in the field of education right now without any new laws at all, there are a fantastic number of potential pockets of educational money available. Some of them we tried to keep very close to, but we only learn about them every once in awhile. Somebody says, "Did you know that in this section of the law, yuu know, that is not our specialty; it is possible to do this? There are all kinds of pockets."

CHAIRMAN FERGUSON: N o one understood they were evern including you.

MR. WILLIAMSON: No, no. And they didn't either, and

they never would have. So this is the big area, you see.

MR. MC NULTY: How much of a staff will you finally have, Ken?

MR. WILLIAMSON: Pardon?

MR. MC NULTY: How much of a staff will you finally have?

MR. WILLIAMSON: Oh, we will have, let's see -- 16, 18 people, something like that.

CHAIRMAN FERGUSON: This will be service to members.

MR. WILLIAMSON: Yes.

CHAIRMAN FERGUSON: Rather than service of membership over into legislation.

(13) MR. WILLIAMSON: Yes. It will be increasing the emphasis on the service to members. And even then this has to be largely mass assist, you know, and that is not good enough. It can't be definitive enough.

MR. MC NULTY: You can't individualize it.

MR. WILLIAMSON: We do some of that. I mean, we get, -- members will get involved, and they will write and come down and day, "Will you establish contact for us to go and see this, and this, and sort of wise us up on what's going on." We do that kind of thing.

Why I mentioned this is if I am any judge of these hospitals, your problem that you are going to have is that every one of these people and all of their brothers and sisters are

going to be coming to you to try and see if you can't help them to get some dough for a project they have gotten out of this pocket, or this pocket.

MR. GOULET: I would like to talk to you, Matt. I have a parking garage idea.

MR. MC NULTY: Yes. Ken has hit the nail on the head. The mail has been coming in 10 letters a day.

MR. WILLIAMSON: I just thought I would tell you some of these major decisions on minimum wage that have now been finalized.

CHAIRMAN FERGUSON: That was your meeting on the 10th, wasn't it?

MR. WILLIAMSON: Yes.

Interns and residents are exempt from both minimum wage and overtime, even though they are unlicensed if they possess a degree in medicine, denistry, osteopathy, pediatry, or optometry.

So this was a great change in their attitude. The hitch there was, were they licensed, and they have gotten over that.

And then they talked about whether they would have to meet the professional standards and at least $115 a week, and they have gotten over that. So that you are home free in terms of interns and residents.

CHAIRMAN FERGUSON: If they are what, now?

MR. WILLIAMSON: Even though unlicensed, even though unlicensed, they don't have to be licensed. They must have an MD degree.

MR. MC NULTY: They must have the MD degree. Now, we stumbled a little on this because there used to be schools that would not grant the MD degree until you completed the internship. Northwestern was one. I believe Duke was one, Charlie.

MR. FRENZEL: We grant the degree --

MR. MC NULTY: But you held them --

MR. FRENZEL: -- and then give the diploma out.

MR. MC NULTY: Right. You didn't give the diploma. Our quick survey determined that it is now safe. There are no schools that withhold the MD degree.

MR. WILLIAMSON: Now, on call time -- this is a big area. It counts as hours worked if the employee must be at the hospital and thus not free to use his time as he pleases. It is not considered hours worked if the employee may remain at home, awaiting a call. Compensable time, however, may be paid at rates as low as the minimum wage.

In other words, you don't have to pay an elevated rate to meet the law. You can dicker with them on a minimum wage.

Now, the one thing they haven't -- the question we put to them that they haven't decided yet is, "Is the residence,

which is their part of the hospital, is that legally his home in terms of overtime, whether he is waiting to be called or not?"

Volunteers need not be compensated if they are true volunteers and are not in employment relationship with the hospital. If a hospital employee wishes to volunteer his services or participate in the hospital's organized volunteer program, his useful activities may well be considered a continuation of his employment, subject to overtime or minimum wage requirement.

We figured after our meeting, suggesting to AHA, that they recommend that hospitals not allow any paid employees to work as a volunteer intheir hospitals any longer because it was quite clear it would be impossible to distinguish between the employee relationship and the volunteer relationship. If they are going to volunteer, they better work in somebody else's hospital. There is quite a lot of this, we found, so this is not a small problem.

Students is another area you are all interested in. Hospital schools may receive payments as stipends or scholarships applicable to hours spent in on-the-job experience.

Student nurses is a big one. And such activities, apparently, are not hours worked if they are required as a part of the curriculum. Work not required under the course of study, a conventional employment status exists.

Now, there are quite a few hospitals, apparently there are still a fair number, that will let a student nurse in her fourth year, or whatever, her third year, is she is physically able, you know, and all that criteria, she can come back and earn some money, and she is an employee when she does that, subject to all the limitations.

I might say on this subject of students, it is clear they are going to be looking carefully, however, at the working relationships, and in relation to -- percentagewise, that to her curriculum. In other words, they are going to be interested to see whether this is beyond a work experience that is essential to education and is work. They are going to be looking at this, too.

It was pretty clear. Students -- now this is high school and other students. College students even may also be employed at 85 per cent of the minimum wage, usually for not more than 20 hours a week if you get certification from the Department of Labor of their status, and you must get that latter requirement.

DR. HAMILTON: Was that 80 per cent or 85?

MR. WILLIAMSON: Eighty-five per cent of the minimum wage, as long as you don't work them more than 20 hours a week.

CHAIRMAN FERGUSON: On an individual basis, or --

MR. WILLIAMSON: Yes, on an individual basis.

A nurse is also eligible for classification as an

exempt professional -- this was the biggest single thing that we got, in addition to the intern-residents -- if: her salary is at a rate of at least $115 a week; she is an RN -- no nurse other than an RN -- she actually performs functions necessary and incident to professional nursing -- and I will talk on that in a minute -- and, fourth, devotes no more than 20 per cent of her time to nonprofessional duties.

Now, we are going to spell this out to the hospitals. It is going to mean you are going to have -- we thought as we went over it and argued it that you could qualify all of your nurses, all of your RN's, but you are going to have to look over their scheduling very, very carefully to make sure that you don't happen to have an RN that just carries bedpans all day, because you are in trouble if you do.

MR. GRAY: If you do, I will hire her.

MR. WILLIAMSON: Or does any such, what we call menial work. You have to make sure that you are careful that the things she does are in the professional, executive and administrative areas. And as we have been through them here, they have duties in all three areas. Even the floor nurse, the general duty nurse, can fit into this.

MR. WITTRUP: That is a big switch on their part, isn't it?

MR. WILLIAMSON: Oh, yes, a tremendous switch. It is going to save you an awful lot of money.

MR. GOULET: Where is it going to save you money?

CHAIRMAN FERGUSON: Yes; where is it going to save you money?

MR. WITTRUP: You are not going to have to pay them time and a half.

MR. WILLIAMSON: You are not going to have to pay them time and a half.

CHAIRMAN FERGUSON: You mean the AMA is going to stand for that?

(14) MR. GOULET: You are going to pay them time and a half within six months whether you like it or not. The AMA is going to force us --

MR. WITTRUP: It will save me a hell of a lot of money for six months, I will tell you that.

MR. MC NULTY: I think what Ken is saying is that you are talking to two different channels. Insofar as the administrative regulations are concerned, you won't have to pay them.

MR. WILLIAMSON: Technicians, technologists, therapists, and dieticians, and so forth, must meet the same general standards applicable to nurses if they are to be exempt from overtime pay as a professional. Possession of a degree or possession of a formal academic course of many years' duration will be required, and the work actually performed will have to be non-routine, intellectural and involve discretion. Also, on the $115 a week test will apply to all of those people.

Food service employees are exempt --

MR. RICHWAGEN: That is what group?

MR. WILLIAMSON: Pardon?

MR. RICHWAGEN: That is what group?

MR. WILLIAMSON: Technicians, technologists, therapists, dieticians, et cetera.

Food service employees are exempt from mandatory overtime pay -- though subject to the minimum wage levels in hospitals open to the general public. It will only be mental hospitals where people are committed that won't benefit from this.

MR. WITTRUP: Say that again. Food service employees are exempt from what?

MR. WILLIAMSON: Food service employees are exempt from mandatory overtime pay.

MR. GRAY: What would happen if you put a sign in front saying your cafeteria is open?

CHAIRMAN FERGUSON: Don't try it. The employee won't come to work for you.

MR. WILLIAMSON: There are a couple of other things I might quickly run over.

As to chaplains, which is a growing area, they reached no conclusions. We are having to submit additional material on chaplains.

DR. BOETTCHER: Whether they are professional or

nonprofessional?

MR. WILLIAMSON: No, whether you have to pay them overtime or pay them a minimum wage.

MR. WITTRUP: How about social workers? Are social workers included in that?

MR. GOULET: They are in the technician group.

MR. WILLIAMSON: Yes, they are in the technician group.

MR. FRENZEL: Are pharmacists in that group?

MR. WILLIAMSON: Yes. Now, there are other people that fit into this that we talked to them about, and that is elderly people who are under Social Security, retired, and don't want to earn more than, you know, the amount that they are allowed to earn in order to draw Social Security. They are going to be quite understanding of this. It was clear. It is difficult to write rules and they are going to apply it in the individual institution on the basis of complaints, if they arise. But if hospitals are doing a social job of giving these people something to do, you know, to occupy them and keep them healthy, and so forth, they don't want to interfere with that if can keep from it, nor do they want to deprive these people of their Social Security check. So that is going to be kind of an individual thing.

The volunteer area, too, is going to be -- although I gave you a general rule, they are going to be watching that very carefully, because they have examples of volunteers that

worry them where they are clearly in paid occupations, and they are being used instead of people hiring them, in their view. So they say, we are going to look at each situation.

Moonlighting, we have a number of questions from hospitals like yours where employees work in the university and then work in your hospital on week ends. That is likely to be all overtime in your hospital, quite likely. They are going to consider that one employer -- the university -- and there didn't seem to be much of a way around that.

MR. WITTRUP: That is determined on the basis of corporate structure, isn't it?

MR. WILLIAMSON: Yes, that is it.

MR. GOULET: What do you mean?

MR. WITTRUP: Well, for instance, Stan's is a separate corporation from Western Reserve, so it wouldn't apply to him. They can moonlight in his place.

MR. GOULET: Oh, no.

Is that what you said, Ken?

MR. GRAPSKI: I thought he said if I had a secretary working in the hospital forty hours a week and then somebody in research wanted to hire her for week ends to type a paper, any hours that she worked was overtime. Is that right?

MR. WILLIAMSON: That is right. What I was talking about is where a university owns the hospital. It is their hospital and they work, you know, as a lab technician, or

teaching, maybe, in lab work. And then they want to come to work for you on the week ends and make some dough. That is likely to be all overtime.

MR. GOULET: But if they were to work for us forty hours and then go across the street in another institution sixteen hours a week, that's --

MR. WILLIAMSON: That is two jobs.

MR. GOULET: Well, that is about what I have.

CHAIRMAN FERGUSON: Thanks, Ken. I found it interesting that we hope we are going to be able to appeal to the professional spirit of the nurse to be considered a professional at the time when, for pay purposes, she wants to be considered nonprofessional. I think this is very interesting, and I wonder if we have argued for a point.

MR. RAMBECK: It sure is.

CHAIRMAN FERGUSON: Pardon?

MR. RAMBECK: It sure is. I think we have a marvelous opportunity here to save an awfully lot of money. Compensatory time is a major factor in many hospitals.

MR. GOULET: I was just looking around the table here, and I --

CHAIRMAN FERGUSON: At Eastern Hospital there is no such thing any more as compensatory time. In other words, you pay people for working, and that concept went out the window about 10 years ago, and they have been pressing as far as I

know, to be treated like other personnel, and that is, they want Saturdays and Sundays off and time and a half for everything over eight hours.

MR. RAMBECK: That is right.

MR. WITTRUP: Let's put it this way: As I understand what he is saying, irrespective of the money, -- we have just been through all this at the University. We are having to convert from a semi-monthly payroll to a bi-weekly payroll, and in order to get down to where you can keep track of this business, you have to have them on a monthly basis snd all that sort of thing, nurses on a monthly payroll.

If they would have been included, then we would have to go through all the steps of getting them back on a bi-weekly payroll and go through all the business of keeping track and being sure somebody doesn't work two hours more here because --

MR. WILLIAMSON: You won't have to keep records here. That's one of the biggest things, the most costly, the record keeping that would have been required.

MR. GOULET: Stan, can I ask Ken one question about this?

What about shift differentials? Does that have to be included in the computation at time and a half, or not?

MR. WILLIAMSON: What do you mean?

MR. GOULET: Let's say you pay a premium for the evening shift.

CHAIRMAN FERGUSON: Yes, $3 for evenings.

MR. WILLIAMSON: Oh, yes, they understand you are going to do that; sure.

MR. GOULET: Does that have to be included in the time and a half compensation?

CHAIRMAN FERGUSON: Yes, I understand so.

MR. WILLIAMSON: Sure. Yes, yes.

CHAIRMAN FERGUSON: All compensation.

MR. WILLIAMSON: All compensation.

CHAIRMAN FERGUSON: Thanks, Ken.

MR.WILLIAMSON: Yes. It's good to see you all.

MR. GRAPSKI: The biggest problem with nurses is that 11-to-7 shift or 3-to-11, where you have an individual in a eight-hour day, they come in at 11:00 and you ask them to work overtime. Is that eight hours in that day or is that really two days?

CHAIRMAN FERGUSON: Well, I must admit this I don't quite understand because I thought that nurses had already declared themselves as being like other people, as other employees. And I can foresee another element. All you need to do is insist that these are professional people, and that almost a worst possibility because professional people go around in long white coats with stethoscopes in their pocket, and they have many rights that we currently have never accorded anybody other than physicians; such as private fees, membership on the

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attending staff -- you name it.

All I am pointing out to you is that you are going to have to come to a basic conclusion here, and you better not do it on the basis of money. That is my hunch.

MR. WITTRUP: Well, we took the private fees away from our doctors, too.

MR. MC NULTY: The Internal Revenue Service is going to do the same, also. There is an item on the agenda on that.

CHAIRMAN FERGUSON: WEll, this was very interesting. I think it gives us pretty good direction in our relationships with AHA.

MR. MC NULTY: Can I, Stan, just follow up with one note that I don't think we need to consider definitively here, but Ken did touch on something that has become more and more apparent to me, and that is in only an infinitesimal time here, relatively, we have crept from a letter now and then to 10 to 15 letters a day, plus telephone calls. And in time we will need to define what it is that we can hope to do through this office, and what are the priorities that we will attempt to provide in terms of service to the membership, because repre-sentation -- both ways, both to the inquiries that I am now getting and the inquiries that are starting to build up from the other side, which is: come to this conference, or go to that conference, or we would like to have the viewpoint of the teaching hospitals on this subject, particularly, as to the

Public Health Service, the Bureau of Health Services. Andas Bill Kissick and Cavanaugh, et al, on Bill Stewart's staff start to consider more and more of the total planning activity that they have been endowed with by legislation for the entire country, it is not inconceivable at this sitting to envision a staff of 30 people.

It is inconceivable to consider our financing of that. So we need to be wrestling this in our minds for some future decision-making, and I will try to bring you the best succinct recommendations that I can.

I am going to proceed with some staff immediately, merely so that I can be in several places at one time, but how far we go -- how far do we go -- I think is something we need to consider down the road.

MR. GRAPSKI: Matt, are you ready to make definitive recommendations on the kind of staff you need, and want, because we talked about this before, not knowing how fast your job would grow.

MR. MC NULTY: Yes.

CHAIRMAN FERGUSON: He will let us know. I think that is the understanding. He will inform us as he decides his staff has to be expanded.

MR. MC NULTY: Yes.

CHAIRMAN FERGUSON: And I say it that way because I guess we agreed that you will run the show. We may not like

the way you run it, and we will tell you.

MR. MC NULTY: I presume you will let me know about it.

DR. BOETTCHER: He is not going to come to us for approval for expanding staff, is that right?

CHAIRMAN FERGUSON: What?

DR. BOETTCHER: He doesn't have to come to us --

CHAIRMAN FERGUSON: No. That was the point we were making to each other again.

MR. MC NULTY: Yes.

CHAIRMAN FERGUSON: Dan?

MR. MACER: I am probably a little naive in some of these things that Ken said, but it seems to me that the charges we are giving to Matt in some of the instances, like the one that came up this morning, can, unless there is clear understanding and good attitude, and I am sure there is sound attitude, have some defensive reaction at some time or point from Ken. This bothered me just a little bit. And I think that we have to be careful to, at all times, be in full support of Matt in the charges that we are giving him because this could be an embarrassing situation.

I don't think I should see how Matt can carry forward in his job without sometimes being engaged in some type of lobbying activity. It may not be lobbying in its purest sense, but it will be in a lobbying area. And I think you,

Charlie, will be concerned with some of this, also, as Chairman of the Committee.

CHAIRMAN FERGUSON: Well, I think we have to move on here to complete our agenda before we break up this afternoon. So can we proceed with some of the more formal items here.

Can we have approval of the minutes of the Executive Committee, Friday, October 21.

MR. RAMBECK: I move.

MR. GRAPSKI: Second.

CHAIRMAN FERGUSON: Unless I hear any other comments, we will consider them approved.

New applications for membership.

MR. GRAPSKI: Move their acceptance.

MR. RAMBECK: Second.

CHAIRMAN FERGUSON: Any comments or questions?

We have seven new members.

All those in favor say, "Aye".

(Whereupon, there was a chorus of "Ayes.")

CHAIRMAN FERGUSON: Now, the next item, Tab 4 -- or item 4. That is merely to bring us up to date on the numbers. Are the numbers all in agreement now? One says 328 and one says 332.

MR. MC NULTY: The numbers are at different times.

CHAIRMAN FERGUSON: I get it.

MR. MC NULTY: The roster -- I am trying to, and getting support from the AHA to work out through their computer activities a deck of cards representing all of our institutions, which will be the start of what I hope would be a profile. They have not been able to give me that deck of cards because they are converting to zip numbers and have a number of other problems. From Jim Hargerring, Cooney, and one other, their computer men, there is cooperation.

The point is, when can we get to our partidular project. And in the absence of this, I went a different route and used a local resource, purchasing time from a computer and did it as of the beginning of the month of December in order to give a roster to the membership. And you are looking t the first roster that has been updated since the time Lad was active in this area, and I am about to send it out. And the reason for the difference between 328 and the totla of 332 is a continuing shift in the membership.

CHAIRMAN FERGUSON: The next two items, five and six --

MR. MC NULTY: Stan, could I ask --

CHAIRMAN FERGUSON: Oh, I am sorry.

MR. MC NULTY: -- could I ask that you look at Tab 6 because this represents hospitals that have not paid, and if I understood --

MR. GOULET: Stan, look at that top one. That is the wealthy hospital that has funds on funds.

CHAIRMAN FERGUSON: Oh, yes.

What is your proposal on this?

MR. MC NULTY: I thought shortly, and I thought your charge in San Francisco was that at whatever timing I picked we should move to indicate that you haven't paid your dues, and at some time in the future if you want to join, fine. But as of this time, why, you are no longer a member, or having not paid the dues, why, you didn't qualify for membership.

DR. NELSON: May I suggest that some of these be handled through a --

MR. MC NULTY: By telephone; yes, yes.

DR. NELSON: Personal approach. For instance, Peter-Bent Brigham should not be -- and there may be others.

MR. MC NULTY: Yes, there are one or two others.

DR. NELSON: Children's Hospital in Boston.

MR. MC NULTY: Yes. I would do this all by telephone not by letter, so that there would be an inter-personal relationship involved.

MR. RICHWAGEN: This one in Burlington is becoming a branch of the Mary Fletcher .

MR. MC NULTY: Is that right? You would send the dues, then, Les; is that right?

CHAIRMAN FERGUSON: Call them up tomorrow before they merge.

DR. NELSON: I think it might be wise just to -- I

haven't read these over -- look at them quickly here.

MR. MC NULTY: My purpose, Russ, is to get any particular slant that you would give to me that I could exercise over the telephone, or any other advice.

The Canadian Hospitals, I believe, will -- six have paid; six have not. I would suspect the six that have paid will not pay next year. They have formed their own organization separate from their own medical schools, and I think they wish to concentrate in that area.

CHAIRMAN FERGUSON: I would think that if Matt contacts the Administrator of each of these by telephone, this should be sufficient.

DR. NELSON: Well, going down the list here, the Children's Hospital Center in Boston probably doesn't really understand what this is all about at this point. I would say Dr. -- what is his name --

MR. MC NULTY: Cronkite.

DR. NELSON: -- Cronkite. If you talk to him or talk to John Knowles.

The Columbia Hospital in Columbia, South Carolina, isn't that, Jim --

MR. FRENZEL: Jim Backus.

MR. MC NULTY: Yes.

DR. NELSON: I am very surprised that that isn't in.

MR. MC NULTY: Yes. We have a dialogue going.

MR. FRENZEL: This is just probably procrastinating.

MR. MC NULTY: No, this involves another subject. They have changed their Director of Medical Education, and there is some discussion going internally. This one I would continue to hold in abeyance.

MR. WITTRUP: When were these -- at what date were these delinquent?

CHAIRMAN FERGUSON: 12-30-66.

MR. WITTRUP: So they have been delinquent 11 days now.

MR. MC NULTY: Oh, no; most of them have been delinquent three to four months.

MR. GOULET: When was the last time they were billed?

MR. MC NULTY: They were billed in November.

MR. WITTRUP: Well, what is the delinquent date for the current dues?

MR. MC NULTY: I think that is what we are establishing now, isn't it? We have had a leniency policy.

MR. WITTRUP: They were due on what date?

MR. MC NULTY: They were due when they were taken into membership. The day they were taken into membership will vary. For most of them it is at least three months.

MR. WITTRUP: Now, some of these have been taken into membership and have never paid dues.

MR. MC NULTY: Right. That is right.

MR. WITTRUP: How did they get in the membership to start with?

MR. MC NULTY: The same process by which we selected the eight hospitals a moment ago. Then, those eight hospitals will be billed.

CHAIRMAN FERGUSON: We do not make it contingent that you pay your money first and then vote you in. We assume that you mean that you want to assume the financial obligation.

MR. WITTRUP: I am a little curious that we don't approve people to membership contingent on payment of dues.

The ones that we just voted in, these seven over here, are they as of now members even though they haven't paid any dues?

MR. MC NULTY: Yes. Well, they will be written a letter saying that they are now eligible for membership,and the membership will be complete upon payment of the dues.

DR. NELSON: We kind of mixed everything together in 1966, Dick. We established membership. We established the way to get to be a member. We established dues, and we had some paying dues before they were members; and vice versa. We can now pick it up. We have a digestible number to work with.

MR. WITTRUP: Now, let's get it straight on these seven. I just got different answers -- I got two different answers on these seven.

CHAIRMAN FERGUSON: You got the right answer from Matt.

Mine was wrong. But that is how informal we have been.

MR. GRAPSKI: Plus one other thing, and that is that during this particular period of time, especially governmental hospitals had great difficulty adjusting their budget to pay, so we were especially lenient until their budgets became viable for payment of dues.

MR. WITTRUP: All right. So then, according to what you said, these people that are on this computer run as being delinquent, we won't have any more like that.

MR. MC NULTY: Well, you may well have one of these eight that decided -- filed an application, was processed, gets the bill for --

DR. NELSON: Or you might not pay your dues next year.

MR. WITTRUP: I know, but I am talking about unpaid dues.

MR. GOULET: What is the fiscal year?

MR. MC NULTY: July 1st to June 30th.

DR. BOETTCHER: These people aren't getting that much during this current fiscal year for membership dues, or for the lack of membership dues. They are no burden to us this year.

MR. MC NULTY: Let's consider the subject as separable, Ernie, the two different groups. The group you are looking at in front of you now, unpaid through December 30th, represent hospitals admitted for membership. They haven't finished

the final qualification, which is paying the dues -- admitted for membership in September or earlier, of this administrative year, '66-'67.

DR. BOETTCHER: They asked to be admitted, indicated a desire to be admitted.

MR. MC NULTY: Well, admission came two different ways. They were either nominated by a dean, you see, and we are going to get some withdrawals on the basis that when I go to the telephone communciation, if we are all in agreement, they are going to say, "Fine, I understand what you are saying, Matt, but theDean nominated me and I don't want to be a member." We have already had some of this. This is why you will see the membership fluctuating up and down. It was 332; it dropped back to 328. Four hospitals said they didn't really want to become members at this time.

DR. NELSON: Matt, I would like to star the following hospitals as those that we ought to be careful, that we just didn't write out of the club on some technicality and that it was done only after some careful consultation.

In addition to the Children's Hospital Center of Boston, and Columbia, King County in Brooklyn; Louisville General, Parkland, Brigham, Philadelphia General, San Diego County, and San Juan City. Those are hospitals I know that have a major commitment to teaching.

MR. WITTRUP: Well then, you better add Children's in

Louisville, also.

MR. GOULET: How about the University of Tennessee Memorial Research Center.

MR. WITTRUP: No.

MR. MC NULTY: No. This is in Knoxville, and here is evidence of a real problem. The Comptroller of the University has refused to authorize payment of the dues.

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DR. NELSON: Well, that makes it pretty clear.

MR. WITTRUP: And the Medical School is not in Knoxville.

DR. NELSON: That is really not what its name indicates.

MR. RAMBECK: Texas Children's, too, might be held up.

MR. GRAPSKI: The other thing I ought to mention, Dick, is that five of these names, for example, were Canadian hospitals that were invited and there was all the dialogue about getting their own group, and so forth. We were interested in getting a large membership fast, and actually I think the payment of the dues came in excellent compared to --

CHAIRMAN FERGUSON: I might just modify it. I don't think we were interested in large or small. It was the fact that we wanted to be sure that no one was omitted if they chose to request membership. That is the one thing we wanted to be very careful of. Everybody who thought they could be a

member had a right to get in. This was our big problem.

MR. WITTRUP: I don't see any point in getting into that same problem with these seven, at this time.

DR. NELSON: No.

CHAIRMAN FERGUSON: You are right; you are right.

DR. NELSON: In the future, membership is purely contingent upon the payment of dues.

CHAIRMAN FERGUSON: We didn't know how to identify all of these hospitals, you see, six months ago.

MR. MC NULTY: And my final point is I am not pushing any decision here. I thought we ought to have a decision and whichever way it went, would be fine.

CHAIRMAN FERGUSON: Okay. Now, we are over to five and six, which were covered last evening.

Seven. A series of reports from Matt. This is what we distributed, right?

MR. MC NULTY: Yes. Seven is just informational. It is either already distributed or in the process of distribution, which may mean yet another 30 to 45 days in process of distribution.

CHAIRMAN FERGUSON: Ernie, this was, I think, in partial response to your -- it was decided at our last meeting that members should get a variety of material, and Matt was empowered to develop whatever he thought was the kind of material the membership should receive as part of their membership

dues. And this is the series of all the things, correct?

MR. MC NULTY: Yes.

CHAIRMAN FERGUSON: Now, remember, prior to this many of these hospitals had never had any of this information.

Have you had any comments on it from any of the members?

MR. MC NULTY: From the bulletin, favorable; from the Journal of Medical Education, favorable. These have already been -- each of you should have received them, and if you haven't, I need to do something. The datagram, favorable, and the employment service book has just gone out -- very favorable. And that's about all so far.

MR. GRAPSKI: We should know that the directory is at $4.00.

MR. MC NULTY: In the process of -- yes.

MR. GRAPSKI: You have to pay $4.00 for it; isn't that right, or do we get it free?

MR. MC NULTY: Right.

MR. GRAPSKI: $4.00.

MR. MC NULTY: It is in the process of revision, and it will go out in March. This is something I don't control. This is why I am saying some of this is down the road.

MR. WITTRUP: Matt, let me ask a question.

Before the development of this thing, I was a personal member of AAMC, just like before I became the Administrator of

a hospital, I was a personal member of the AHA, and I never have been able to decide in AHA whether I am supposed to keep that or not, but are we going to have kind of a posture about that with respect to this organization now?

Am I a nice fellow --

DR. NELSON: No.

CHAIRMAN FERGUSON: Keep going.

DR. NELSON: Has he got another question?

MR. MC NULTY: That's taken care of.

MR. WITTRUP: Well, let's say if I drop my personal membership, am I going to be -- is that going to be frowned upon now that I am --

MR. MC NULTY: No, no.

CHAIRMAN FERGUSON: Let's ask, how many of the group here were personal members.

DR. NELSON: Of what?

MR. WITTRUP: AAMC.

DR. NELSON: I don't know whether I was.

CHAIRMAN FERGUSON: I am like Russ. I don't know. I don't think so.

MR. MC NULTY: Dick, the AAMC has no particular position on it. Many of the Deans are personal members; some are not. And there is no guideline. Whether we would want to establish one or not would be another subject.

MR. WITTRUP: Well, I was thinking of it as more of a

gentleman's understanding, that if I drop mine, that that's not a naughty thing to do.

MR. GRAPSKI: The only thing, Matt, if you remember, there was a period of time in which the AAMC pushed very hard to build up the personal membership.

MR. WITTRUP: I am glad to pay the $10 if it is something that is a nice thing to do, but on the other hand, if it serves no useful purpose except to get me on some mailing list, then --

CHAIRMAN FERGUSON: Well, let's ask Matt to check on what the existing, current policy and point of view of the AAMC is.

MR. WITTRUP: I am sure that that personal membership is a money loser. It costs them more than $10, I am sure, to send out the publications.

CHAIRMAN FERGUSON: It is true of AHA, true of everybody.

Can we move on?

Next item, No. 8, top of page four.

MR. MC NULTY: I have distributed to each of you, and to some others, the Gus Carroll Report. I have a mixed evaluation of it. I think the AAMC is committed to it. The mixed evaluation varies from enthusiasm, that this is an excellent document and will be most useful, to the other extreme, which says that it is too wordy and some other observations of that

type.

The purpose of the agenda item is to inform you of that, (a); (b) to indicate that we want to get into any particular activity with Gus in terms of writing and in terms of presentation and publication.

My advice and recommendation would be not, that he has been engaged in this enterprise for several years, and I don't -- I am pushing hard, and I think I have warn out my welcome. I am pushing so hard to get something done that my own perspective is to just let it go now, and occasionally try to push a little bit more and to transmit to him all of your observations as you may make them.

CHAIRMAN FERGUSON: May I ask a question, particularly of Russ.

Russ, in reading this through, this report that each of us -- I guess all of us got it.

MR. MC NULTY: I sent it to everyone on the Executive Committee.

CHAIRMAN FERGUSON: I was beginning to wonder what implications it had from the standpoint of, how will, say, Government agencies use this if it would become published as a basis for viewing just what we were talking about earlier this morning, and that is, how do you allocate costs.

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LHP

And in view of your sensitive position on HIBAC and other activities like that, I was just wondering, do you see where this wouldbe used in a contrary way? Because it does have implications. This is the only comment I got from my comptroller, who I turned it over to. I said, "What do you see in this?" He said, "Well, I might have some questions about the technicalities of it." And then instinctively you can tell what he was concerned about was that internally it would be excellent, but if it became known externally that this is a basis on which you might do things, then everybody would say, "I tell you what, I'd like that part because it puts all the costs over on the medical school, and therefore it is not patient care." And we are suspicious in Ohio that government agencies would just love to find something like this. They would say, "That's what we have been saying all around. 90 percent of it is a problem of medical education."

MR. WITTRUP: It had one little sentence in there that I commented on in my letter that I thought was unnecessary. He made a pretty flat statement that the incorporation of a teaching program into a hospital, that there was no reason to suppose that it affected the hospital out-of-pocket costs. I guess I would have to admit that there are some times in which I would want to argue that, and there are some times when I would want to argue the reverse. And it didn't seem to me necessary for the purposes of that report, and I thought it ought to come out of there.

CHAIRMAN FERGUSON: Well, this is what I was after, that some of the statements in there -- and I know that in the medicare legislation it said that they should confer with all organizations and groups that had -- what was the language, Russ -- information on cost, reasonable cost, et cetera. And with this document, say somebody said, "Well, we understand there is something new here. Let's use this as a basis," a statement just contrary to that could be made also.

MR. RICHWAGEN: The deans are promoting this, or have been, I think, quite enthusiastically, thinking that here is a chance to try to pin down what the costs are to the medical schools and the teaching hospitals. And it would seem to me as we get into part 2, or whatever parts there are, when they begin to come down to some kind of a way of allocating costs, that the Council of Teaching Hospitals ought to be in there through their advisory committee somehow to make sure that the hospital costs are shown here and not just the medical school costs, because this was started by the AAMC without very much relationship -- I know it came in the section that we had at one time, but actually it was promoted by the AAMC, parent organization.

So there are two ways of looking at it. One is that this might become a Bible, and it might even if we don't get our finger into it. And if there is a possibility that this might become the Bible then we better get active and have

something to do with it.

DR. BOETTCHER: Well, this was my thought, too. I thought this was to develop a methodology rather than a philosophy of where costs should be applied. I think that we should be watching it closely. I don't think we should do the work. We can let Carroll do the work, just push him, but I hope we can get subsequent sections to review.

MR. WITTRUP: It doesn't do in every case what it says it starts out to do. That particular thing struck me. I just thought it was unnecessary and not carefully conceived and could just have implications that the report wasn't intended to have.

DR. NELSON: Stanley.

CHAIRMAN FERGUSON: Yes.

DR. NELSON: For the record, of course, we should recognize that this was started really by Al Smoke.

CHAIRMAN FERGUSON: Yes.

DR. NELSON: And he appealed and appealed and appealed for studies, like this and a position taken by everybody on it and was frustrated year after year because he couldn't make any progress on it. So I think we ought to recognize from the outset that this ball was started down the hill by a hospital, or at least a hospital representative.

Second, just paging through it quickly, it seems to be a man's report of his study. And if that is truly what it

is, it has no standing with the AAMC or hospitals or anybody and as such would have a limited impact, I think, on government and other payers.

On the other hand, if this is to become, even somewhat a position of the AAMC, either by action of committees that review it or individuals who get changes in it, or maybe even just by implication, since Carroll is a staff officer, if not whole at least part time, of the AAMC -- if it gets that coloration, I think we would all recognize that there is such an urgent need for guidelines, and people will have to make these apportionments for payment, that probably are going to get picked up because there is nothing available now. And remember, our cost reimbursemant, the Federal Government and many Blue Cross plans, says essentially this: That the net cost of educational programs in a hospital are includable over the reimbursement costs.

Now, somebody has to define "net," and "cost." And auditors are going to constantly be digging into that.

The final point I would like to make is that this Council and the AAMC could serve its members, it seems to me, extremely well if it began and concluded ultimately a project in which there would come out a set of principles that have had the impact that AHA principles on hospital reimbursement have had on that field.

You will remember that those AHA principles were

really hard to get established. They were kicked around for years. But what really pushed it over was a hard, long working session by the Blue Cross planners and the hospital administrators through representatives in the meetings down in Florida about, what, ten years ago, or something like that.

There is no way to avoid ultimately getting the deans on one side of the table and the hospital administrators on the other side and try to hammer out some basic principles one after the other and painfully. But this is badly needed. And I suppose like many other things, unless it is done by professional bodies that have a mutual interest in it, auditors are going to start to do it.

CHAIRMAN FERGUSON: This is what I was after because I think we are going to have to recognize -- let me ask you this, Russ. You used the term "net cost of education."

Now, let's assume that--

DR. NELSON: I used that because that is just what the language is.

CHAIRMAN FERGUSON: There is no differentiation then under that language what kind of education is involved.

DR. NELSON: Educational programs in the hospital -- I don't have the regulations here but there are a lot of generality statements that follow which become kind of guidelines for the carriers and the auditors to define. But I think though the AHA principles have some regrettable defects,

in the main they are very excellent things, and they have just set the whole pattern.

CHAIRMAN FERGUSON: Well, then--

DR. NELSON: And, Les, you must have had some -- or some of you who have been in the AHA a long time must have had something to do with the development of those principles, and I know it was capped by a 2-week session down in Florida with the Blue Cross executives on one side and the AHA administrator representatives on the other and they went down -- principle No. 1-000 will be. And I am sure that they--

CHAIRMAN FERGUSON: Well, those were principles of reimbursement, and beside that were principles of accounting and allocation of cost. And I think this worked a little bit easier than the second one because that's judgemental, but I think you have given a good twise -- a direction here, and that is that our concern here is how this is going to be used, and then how it can be used, as we see it, from the standpoint of helping to define reasonable cost.

Russ?

MR. RICHWAGEN: I am sorry. Go ahead.

CHAIRMAN FERGUSON: Excuse me. I was going to say, number one, how it is going to be used, the report itself, but then how can it be used in helping to define reimbursement under, say, a reasonable cost formula, which is probably going to permeate more and more into a variety of third party

payers paying on behalf of patient services in our teaching hospitals. Is that right?

DR. NELSON: Yes.

MR. WITTRUP: Well, the whole issue is apportionment between--

CHAIRMAN FERGUSON: Yes, that's what I am saying. Well, should we note then that what we want to keep track of is how the parent organization proposes to use this and see to it that they become--

DR. NELSON: Well, I think you will probably get the answer that they are not going to use it at all. I think that's the answer.

MR. RICHWAGEN: Couldn't we take a position that this is a man's report of a study and should not be used as a guide, but from this perhaps a joint committee of the AAMC and the Council of Teaching Hospitals could sit down and try to hammer out some principles of reimbursement.

CHAIRMAN FERGUSON: How would the language be, then, that we understand now it is being completed and we will be interested in, what? We believe that it will have some--

DR. NELSON: I would like to suggest, knowing what the Executive Council's apt to do and react to -- this is a sensitive area, always has been -- rather than send a general recommendation up there, I believe it would be better to, if you want to appoint a few of this body or others with Matt to

write out a rather specific procedure that would be followed to get out these apportionments. If it is left too general, they are going to say, "No, we don't want to do it. We want to leave it." Remember Doug Bond's beautiful statement to Al Snoke at one of these meetings? Al was wanting clarity, and Doug Bond said, "I want it just a little bit fuzzy and a little bit cloudy."

MR. MC NULTY: Let me mention another overtone.

This study is being monitored, if you will, by a joint committee of the AHA, the AMA and the AAMC. The cover letter that I sent you listed the names of those individuals on that committee. Dr. McKittrick is a member. So therefore, it may well be published as other than a personal study. It may be published as a committee finding. You will get an opportunity to look at each chapter. You can get very basic. It is my observation that this project will fail unless someone keeps pushing it. I don't wish to sound too immodest in this area. I think if I stop pushing it, it won't get done.

Is anyone suggesting it not be pushed?

Al Snoke is hard behind it, and with my helping him a little and his pushing internally we finally freed up Gus Carroll and he stays home now and writes and writes and writes.

DR. NELSON: If I had to do this job and get it done promptly, I would sit down with people who had some experience and say, "Let's list now as many basic principles in this

apportionment as we know about." And I would prepare them with clarity. Then I would ask the AAMC Executive Council to see if they would be willing to appoint an ad hoc committee to work with me to review these principles. This is the substitute for the Florida meeting that I referred to. And try to get some principles on apportionment that there could be an agreement upon. Maybe you wouldn't cover them all. I am sure you couldn't think of them all anyway. But it is the book upon which to begin to develop them as they come up. And I would be willing to, in order to achieve at least some agreement, come out with a relatively few at the start. This is the way we have had to do it in most of our own institutions, anyway. And I bet you there is enough commonness in what has been hammered out that you could get ten or a dozen of these principles.

I am saying this because I would rather go to the deans and the Executive Council with something specific upon which to have a discourse rather than to say, "Look, you so and so's"-- either side -- "You're robbing us." Well, the truth of the matter is that's true, and it is true the other way. But when you have to judge this, you only think about the guy that is going to get after you, and somebody is going to say, "Now, let's leave it alone."

CHAIRMAN FERGUSON: If I understand what you are proposing, Russ, this counsel could well initiate the development of a statement of a series of proposed principles which teaching

hospitals and the related medical schools could use in apportioning or deciding who should assume responsibility for--

DR. NELSON: Apportioning costs. Costs of combined programs is what it really is.

CHAIRMAN FERGUSON: O. K. This would then be somewhat different than this, which I would agree with, because then you are down where I am, because I am trying to figure out which ones do you apportion to whom, because once you do that you may then decide that it will not come, see, through, say a patient care program, even though somebody might attribute it to that, you see. In other words, what was it, Alan Gregg's comment that any patient in a teaching hospital ought to be willing to pay extra for all the education that goes on because he is going to be better off. Well, I'm afraid that philosophy the patient doesn't want to accept wholeheartedly.

DR. NELSON: I will give you a sample principle. Sponsored research carried out in the facilities of the hospital should carry with it the reimbursement to the physician out of the costs engaged by the hospital and that sponsored research if the hospital is not receiving the grant directly.

CHAIRMAN FERGUSON: Right.

DR. NELSON: And that's a principle.

DR. BOETTCHER: Including rent.

DR. NELSON: That's included. You see, now, that is

a principle.

CHAIRMAN FERGUSON: Did you get it?

MR. MC NULTY: Yes. Les is coming through loud and clear, but is there any reaction of the relationship of what Russ is discussing to an ongoing activity within the AAMC; specifically, the Carroll study?

DR. BOETTCHER: This is what I was going to ask, whether we should wait for a completion of this study. And I was going to ask what the deadlines are for this study. Are there set deadlines? Is this going to take ten years or--

MR. MC NULTY: Well, it has taken three so far, or longer, Russ, is it?

MR. GRAPSKI: This is about theeighth or ninth year because this came up real early the first or second meeting.

MR. RICHWAGEN: I think we are safe. We have a representative on the committee. The representative knows how we feel about this. I think, if necessary, it could be held up -- anything of that nature could be done.

MR. MACER: Mr. Chairman, I think this entire study is going to be utilized by government. You have spoken of reimbursement, but it is also going to be used in government planning because for a number of years government has been seeking to define these exact things in their total preparation of the Federal hospital operation. And as I sit here, I know full well that it will be utilized, it will be picked up, and it will play back through the various governmental

channels and utilized.

In answer to the point you have made, I would like to support Russ' point of view, that although it may not necessarily be directly related to this study, we should come to grips with defining these points, and we should do it relatively soon.

CHAIRMAN FERGUSON: Would someone like to propose an action that we can record and proceed with?

MR. GRAPSI: I would propose that we acknowledge receipt of this study and further propose that we develop, we recommend to the Executive Council that a group of deans, hospital administrators and other pertinent people get together to develop a series of statements of principles which can be used by schools and hospitals to interpret what types of information they need, and based on these principles they can develop their own cost allocations in their local areas.

MR. MACER: Second.

DR. BOETTCHER: Is the second part independent of the first?

MR. GRAPSI: Yes.

DR. BOETTCHER: To hopefully get things done sooner?

MR. GRAPSI: Yes. I felt it was important -- since this has come to the agenda, I think we have to acknowledge it. Then I think what we have to do is take a positive approach. I believe we have to take a positive approach here

in what I believe is a better possible solution to the problems that we are having than the Carroll study, and I think this is probably the best way of saying it. I would support all of the discussion here.

MR. RAMBECK: How about an expression of emergency on our part.

MR. GRAPSI: For the development of the principles?

MR. RAMBECK: To get on with this thing. It seems to me that it has been dragging so long now.

DR. NELSON: I am just wondering about the wisdom of making a recommendation to the Executive Council at this time. Suppose they rejected or suppose they didn't act on it but just said, "Well, we will think about this." This then ties your hands. And I can understand at this point why with all the things that are going on in the AAMC they wouldn't particularly want to stir up this nest again. We have had the trouble with the study, I think, among other reasons, because people were nervous about stirring up this nest. Couldn't you accomplish more by just going ahead with your own authority here, set up a group to meet some place a day or two, the object of which is on the basis that this study or anything else you can get to try to hammer out some trial principles so that you know more specifically where you stand. Then ask through the medium of this specific set of proposals that it be considered by a joint group. You are freer, it seems to me, if you do this. They

might just sit on it because it is too general at this point.

CHAIRMAN FERGUSON: Yes, this is what I--

DR. NELSON: Don't you feel free to act yourself without--

CHAIRMAN FERGUSON: Yes, sir. This was the comment I was going to make as Chairman, that I thought that what we ought to do -- my own feeling is I would like to see this Council proceed in a sense of identifying principles of program responsibility and attendant costs as between the hospital activities and the medical schools, because this is really what we are after, aren't we?

DR. NELSON: Matt, could I ask you whether you think there is any reason why this Council and you as the Chairman could, any reason why you couldn't go right ahead with a small group of selected hospital administrators or accountants, or anybody who has expertise, call a meeting, prepare some material, just go right ahead without further official approval of the AAMC?

MR. MC NULTY: I wouldn't see any reason why we couldn't.

DR. NELSON: Then that's what I would suggest we do. Don't keep asking questions all the time. You might get answers.

MR. GRAPSKI: Russ -- excuse me -- I was under the impression that you had felt that when you and Matt go to the

Executive Committee here shortly, that you wanted something relatively definitive from us.

DR. NELSON: No.

MR. GRAPSKI: Well, then if not, Mr. Chairman, I withdraw my motion. Can I do that?

CHAIRMAN FERGUSON: Yes, sir.

MR. MACER: Second is withdrawn.

CHAIRMAN FERGUSON: Now, who will rephrase the proposal or motion?

MR. MC NULTY: Well, is it sufficient for the minutes to reflect that it was the consensus that we needed to be moving promptly in convening, if you would, a group that would identify the areas of shared costs and the need for establishing principles with relation to them?

DR. NELSON: Nobody is disagreeing.

CHAIRMAN FERGUSON: O. K. The minutes will so note.

MR. MC NULTY: I am just trying to be helpful.

CHAIRMAN FERGUSON: That is all right. I think we have got a consensus now.

MR. MC NULTY: Just a footnote to what Russ said.

Russ, I would sort of predict that if this went to the Executive Council, they might have to take a position in support of the Gus Carroll study and say, "Well, no, let's hold off until this Carroll study is finished."

DR. NELSON: The Carroll study, I haven't read it.

It gives me that great platform of ignorance, but if you feel it is deficient and it looks like--

DR. HAMILTON: It is very general.

DR. NELSON: If it is very general, why push it? Why don't you just let it ride.

CHAIRMAN FERGUSON: Go its normal way.

DR. BOETTCHER: I am not so sure the Carroll study doesn't have some merit. I think it would be good if we had some guiding principles that we have worked out ourselves, and then we would be in a better position to the ultimate of the Carroll study.

CHAIRMAN FERGUSON: Well, I had the feeling in reading the Gus Carroll report that it really said that once the school and the hospital come to agreement on what it is, how they want to apportion responsibility for programs, then you can use this device to determine the costs of the programs. I think what we are talking about now is what are the principles that you should follow as you sit down vis-a-vis a hospital and its related medical school -- what are the things about which you should come to some decision on. And used as an example cost of research space used, you see.

MR. WITTRUP: Let's not deceive ourselves. The Carroll material contains by implication some principles. And in the absence of any other activity, that being the only place where that exists, they are going to be used. It

doesn't make any difference what we say that report is. I think we could make motions every time we meet. If that gets published, that is going to be the guiding document. So I am not sure I still quite understand what the strategy is.

Now, I am sure that if we can get on this business of developing some principles we can have that done before the Carroll study is completed, because it is going to be another couple of years. And if that is the strategy, I am for it.

DR. MC NINCH: Wouldn't publication of this report depend on the approval of the three sponsoring bodies really --

MR. GRAPSKI: I think so.

DR. NELSON: I think so.

DR. MC NINCH: --which is a long way in the future, possibly.

CHAIRMAN FERGUSON: O. K. I think we have gotten the word.

DR. MC NINCH: But I think we should continue to push it. I may be wrong.

MR. GRAPSKI: You should continue to push this, you say?

DR. MC NINCH: The Carroll study.

MR. FRENZEL: Push the study, he means.

MR. GRAPSKI: The Carroll study?

DR. BOETTCHER: Yes.

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MR. GRAPSKI: You think we ought to push it?

DR. BOETTCHER: Yes, if we can get our guiding principles ready soon enough.

MR. WITTRUP: Just push hard enough to make sure it doesn't come out before the principles do.

DR. BOETTCHER: Right. I agree with that.

CHAIRMAN FERGUSON: O. K. Shall we move on to the next item, No. 9, Matt?

MR. MC NULTY: General clinical research centers. Dr. Merrill, Joe Merrill, who is the director of that particular division, and several of his colleagues and I have been in communication and have had one or two meetings. Joe is concerned not so much on the reclaimed procedure under the old 85.15 and which he is not handling. That is being handled directly in Dr. Shannon's office, and the status of that is the same as it always has been. It is an amorphous mass and it hasn't come into crystallization and nobody is doing much about it except waiting to see if the General Accounting Office is ever going to do anything about it.

More pertinent, though, are the escalating costs and 1140 general clinical research beds that are now in existence, and the ability of the general clinical research centers branch to finance those beds at full costs. And they have been doing so, as you all know. As they now anticipate the costs and anticipate their appropriation they can do it through

September 30 of this year. Unless their funds are increased significantly, they will be facing the early summer and mid-summer discussions with institutions as to how they will reimburse them come the new grant year, which is October 1. And they don't know where they stand on their appropriations. The word they get and the word I get is that the amount of money they requested was cut in the NIH. It was cut somewhat at the Public Health Service. I don't know what treatment it received at the departmental level, and there has been no word yet from the Bureau of the Budget as to what they did with it. These are about five places it has to go through before it even gets into a Congressional request.

MR. WITTRUP: Are you telling us we are facing the possibility within twelve months here of picking up part of the costs of these things?

MR. MC NULTY: Yes, I am. Yes, I am, Dick.

MR. WITTRUP: Well, revisions that are designed to pay less than the cost of them?

MR. MC NULTY: No, to reduce the number of beds.

MR. WITTRUP: Oh, reduce the number of beds.

MR. GRAPSKI: It is one way.

MR. FRENZEL: Either way.

MR. RAMBECK: They have been considering eliminating the alternative of fixed and variable costs, too, Matt, and insisting on either a cost center system or a fee for service,

or a cost related to charges system.

MR. WITTRUP: Well, you know, people can quibble about what's the best way to arrive at cost. You know, you can argue about that forever, but I thought you were saying that they were going to be paying something less than cost.

MR. MC NULTY: They are considering ways of approaching the hospitals because they anticipate -- they are trying to preplan, for which I commend them. Secondly, several of you have met with them. Les' folks have met with them, and each time they have reported back to me, which I appreciated. They are preparing four or five alternatives. One alternative is a reduction -- payment at less than cost. Another alternative is reduce the number of beds, a nd we'll pay you full cost to the extent that we have available so much money.

DR. BOETTCHER: Are they considering the possibility of charging third party payers where appropriate or the patient where appropriate?

MR. MC NULTY: Yes, they are.

DR. BOETTCHER: But having the grant money used for that part which is not recoverable from third party payers?

MR. WITTRUP: Well, I think we ought to--

DR. NELSON: Happy days, fellows.

MR. WITTRUP: I hope that we remind the Federal Government that it ought not to get committed to more than -- if they don't want to pay, you know, for this many beds, they

21 better quit approving applications.

CHAIRMAN FERGUSON: They will.

MR. MC NULTY: They have. They are taking no more beds.

DR. BOETTCHER: What about applications now pending? We have got one that just went in.

MR. MC NULTY: It is my understanding that they intend to hold them in abeyance, that they have no more money to fund them.

DR. BOETTCHER: I see.

MR. WITTRUP: But the ones they have got going they better stay with. And we better be prepared to raise an awful lot of hell -- like LBJ says, guns and butter. Now, we are talking about butter here and -- they got us into this.

MR. RAMBECK: I would like to make a couple of comments here. I think we are going to see a rather strong emphasis on review at the turn-around point, either the 5-year point or the 7-year point, and some possible recommendations on scaling back the scope of the program, even though it has been at a higher level irrespective of the possibility of an across-the-board cut in the allocations.

CHAIRMAN FERGUSON: Sure, this would seem to me the most appropriate one that they will follow, because they could well follow every other section, and that is, decide the merit of the research that is being conducted. And I remember when

they came around to us the first time and a very prominent professor of medicine in this country said, "Why don't you make it X beds instead of what you have got"? He implied that this was better off because it would be better research because it would be twice as large. And my only comment was, "But then, sir, it will cost somebody twice as much." And he thought that was better because, "It would be more efficient." So I can see -- it is always coming ba ck to haunt the researchers that their appetites are much greater than the consumers' ability. I think that's what we are going to see, and I have got a hunch that what they are really going to do is bring the experts in to take a look at the quality of research being conducted, and this is going to be full of anguish.

MR. RAMBECK: Next month we have our meeting in Palo Alto and there will be six site visits by the committee to six centers in the Bay area where there will be evaluation of the research conducted, utilization of the resources and the whole business. And even though they are in the middle of a grant period, it is quite possible that there will be recommendations for some kind of administrative action to curb any poor utilization of beds, misutilization of beds or over-use of any part of the facilities by a single individual or a small group. Where it is truly not a multicategorical facility but primarily serving one man and his program, it is going to be looked at with a very, very severe eye.

23 MR. WITTRIP: Well, I think that is appropriate. I am a taxpayer, too, and I'm for that. All I am saying is once they decide it is all right, then, by golly, let's get paid.

CHAIRMAN FERGUSON: You'll get paid.

MR. MC NULTY: You want full costs.

DR. BOETTCHER: Do you think any of those six are going to be approved and funded?

MR. RAMBECK: I am not at liberty to comment on that.

CHAIRMAN FERGUSON: All right, could we move on to the next one?

10. This is just to report that there has been a committee appointed by the AAMC to study the report on training for family practice and graduate education of physicians. I guess this is the Millis report and what was the other group that came out?

MR. MC NULTY: Willard report.

CHAIRMAN FERGUSON: Willard report. This is the intention of the AAMC to take, make a decision on how they--

MR. WITTRUP: Are we represented at all?

CHAIRMAN FERGUSON: Well, it has been proposed that I be a member of that committee. It is chaired by Pellegrino. I don't know what I will be able to contribute, but this is the way people thought it ought to go, so I will do my best. The members of the committee will be Pellegrino, Chairman;

Dr. Barry Hill, North Carolina; Dr. Dennis, Oklahoma; Leon Jacobson, Chicago and California, Davis.

MR. WITTRUP: May I make an observation about this family practice thing?

It strikes me as a -- well, I don't know of any situation in which we have succeeded in creating a role by first beginning with an educational program. The way education has gone in this country, as I observe it is that the role gets created by necessity or by somebody's desire, and people start functioning in it, following which it is determined to be a good idea to develop an educational program to help them do it better.

And it seems to me that on this basis of family practice, until we can actually find some people doing it, that it is a little bit foolish to talk about creating educational programs because there is not going to be anything for them to do when they get on it.

CHAIRMAN FERGUSON: Write your letter to Pellegrino.

MR. RICHWAGEN: I agree with you, Dick, but don't you think the general internist is engaged in family practice? I look at this as a modification of the residency program in internal medicine that will put less emphasis on endocrinology and hematology and some of these other exotic subspecialties that internal medicine is getting into and keep it general internal medicine but strengthen it in the area of gynecology

and pediatrics and psychiatry.

MR. WITTRUP: This is not what it says in these reports.

MR. RICHWAGEN: I know it isn't, but this is what the teaching centers have got to develop here. There is family practice going on.

MR. WITTRUP: Not the way it is described in those reports.

MR. RICHWAGEN: No.

CHAIRMAN FERGUSON: Well, that is what this committee is going to grapple with, and I am sure we will be involved as a Council of the AAMC when the reports start to come out in preliminary form.

MR. FRENZEL: What is the Willard report?

MR. MC NULTY: The Willard report was a report conducted for and with the AMA. It has just been issued about a month ago.

What is the title of it?

MR. RICHWAGEN: Is that the ad hoc committee on education?

MR. MC NULTY: Yes.

CHAIRMAN FERGUSON: Then there was the other one. What was it, American public Health Association--

MR. MC NULTY: This was a community health study, the other one was, but the Willard study dealt entirely with

the family practice concept, if it is a concept, as Dick has challenged, I think, very pertinently.

CHAIRMAN FERGUSON: And the Academy of General Practice believes that the proposals of the Millis Commission now validate the position that they have consistently taken.

DR. BOETTCHER: They look on it as a modification of the--

CHAIRMAN FERGUSON: No, they say that all that has -- they have confirmed the role that you were talking about and this confirms now that educationally -- it will confirm what they have been consistently saying they are.

MR. WITTRUP: What they would like to be.

CHAIRMAN FERGUSON: No, that isn't what they say. Read their report.

MR. WITTRUP: I read their report.

CHAIRMAN FERGUSON: Well, let's move on. We have gotten No. 11, correct? That has been covered.

No. 12 has been covered and I guess we now move on to 13.

What time is lunch?

MR. MC NULTY: Lunch is at 12:30.

CHAIRMAN FERGUSON: All right.

MR. WITTRUP: Are we going to eat here?

MR. MC NULTY: We are going to eat here, right.

DR. NELSON: In this room?

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MR. MC NULTY: Yes, in this room.

13 is a report only. The exploration of a Council of Academic Societies is proceeding. I can report, if anyone is interested, the specific groups that are involved: Medicine, Pediatrics, Surgery, Radiology, Preventive Medicine, odolaryngology, OBGYN, Psychiatry, Anatomy, Physiology, Pharmacology, Pathology, Dermatology, and so on -- the American Association of Physicians, American Society for Climical Investigation, American Surgical Association, and the Federated Societies.

Now, I say it is being pursued. There are sort of conversations and discussions. I wouldn't want to conclude that there is any great enthusiasm yet, but that's only the way I see it. And others of you may be closer to it than I am, but there is a very deliberate attempt, and I think it is a constructive attempt, to move in this direction.

Russ, what were you going to say?

DR. NELSON: It is quite unfair, but I can't resist it. It's there is so damn many societies. I presume they have already cast their bylaws and have the forms set up to nominate the officers, and I presume they have got a school tie and a pin for the lapel of the coats and are taking on all the forms of the American professional association -- another one. So you see my comments are nothing but facetious but I am getting a little tired of all these societies.

MR. WITTRUP: Are you going to join the Four S group?

DR. NELSON: What's that?

MR. WITTRUP: That's the Society for the Suppression of Superfluous Societies.

DR. NELSON: I have been a member emotionally for a long, long time.

No, those are very fine people and as a matter of fact, it is a mechanism that -- if it can avoid the pitfalls of the normal society, it would be a very good group to work with.

CHAIRMAN FERGUSON: To have as a part of the AAMC.

DR. NELSON: Well, I don't know how, but this is a way to get at the physicians on faculties. We haven't had that really. We have struggled through the AMA and the College of Physicians and so forth and you don't really getat our own faculty members on a national basis. There is no way to do it. This might make a difference.

MR. MC NULTY: And this is, as Russ has so succinctly described it, Mr. Chairman, the intent -- this was the purpose of trying to form a Council of Academic Societies, to get faculty participation in the AAMC.

CHAIRMAN FERGUSON: Now, the next two items have to do with our annual meeting. The time and place has been changed?

MR. MC NULTY: That is correct. This took aboutthree

weeks of work. It was originally scheduled for Detroit, but it has been changed to New York and the New York Hilton Hotel from October 27 to October 30, which, if I recall, is a week -- one way or the other, a week earlier or a week later than it was scheduled originally.

DR. NELSON: What were those dates again?

MR. MC NULTY: Friday, October 27, through Monday, October 30.

CHAIRMAN FERGUSON: Business Council will meet on Tuesday.

DR. NELSON: All I can say is if we are meeting in New York, bring money.

MR. MC NULTY: We have traditionally met the day before, which would be Thursday, the 26th.

MR. RAMSECK: You mean this Executive Committee here.

MR. MC NULTY: This Executive Committee; yes, sir.

CHAIRMAN FERGUSON: We have to be prepared to be in New York on Thursday.

MR. MC NULTY: Right. So for the calendars, Thursday, October 26th, and then whoever is elected to the Executive Council of the AAMC, they usually stay an extra day and meet the day following the close of the meeting. That is the purpose of the paren that is in your remarks.

CHAIRMAN FERGUSON: Members of this group then should be expected to be there from sometime on Thursday

through Monday.

The Executive Council met on--

MR. MC NULTY: We met last time on Monday afternoon.

CHAIRMAN FERGUSON: Can we plan on that?

MR. MC NULTY: I would hope so, yes. Let me make an observation in passing. If there is formed a Council of Academic Societies and if those societies request the same recommendation on the Executive Council that they are now requesting, I would look for this Council to request a like representation. So by the time October comes along there may be more than one representative from this committee.

CHAIRMAN FERGUSON: O. K. We have received the dismal information.

MR. RAMBECK: Your advice is for us to plan to be there from Thursday through Monday?

MR. MC NULTY: Correct.

CHAIRMAN FERGUSON: Bring turkey. You can stay through Thanksgiving.

Now, this next item, I guess, is one thing that Matt would like us to consider, and maybe we can do it during lunch because we have got 15 more minutes before 12:30.

What was the reaction to the meeting last year, the one we had in San Francisco, for all of you who attended?

DR. BOETTCHER: I thought it was good.

MR. WITTRUP: We are all trying to remember what it

was.

DR. BOETTCHER: These group sessions, though, became problematical because there were always two or more that you wanted to be at at the same time. These workshop sessions, wasn't that part of COTH?

MR. MC NULTY: Yes, there were six of them.

MR. RAMBECK: There were too many of them.

CHAIRMAN FERGUSON: There were what?

MR. RAMBECK: To many sessions.

DR. BOETTCHER: How can you have fewer without getting them too big?

MR. RAMBECK: The time before, was it in Philadelphia, the year before that?

MR. MC NULTY: In Philadelphia we had five.

MR. RAMBECK: They were too big.

MR. MC NULTY: And they took on the proportions you are indicating.

DR. NELSON: Some of them this time were pretty big. There were 40 or more in one room.

MR. GRAPSKI: Except that was because of the large attendance we had. So maybe instead of fewer we will have more.

CHAIRMAN FERGUSON: We are going to have more in New York.

MR. MACER: I felt this year it was a definite improvement over the previous year's program, and its close relationship

32 to the total program of AAMC was definitely valuable.

MR. GRAPSKI: The integration of our meeting and the deans' meeting was very good.

MR. WITTRIP: I think we ought to have a meeting without having anything about Medicare on it.

CHAIRMAN FERGUSON: O. K.

DR. BOETTCHER: That would be refreshing.

CHAIRMAN FERGUSON: You mean you are going to try to obliterate from your mind the fact that the government is now in your life?

MR. WITTRUP: No, I am not concerned about that. I am just tired of going to meetings where they go on and on about Medicare.

MR. RAMBECK: I think we ought to keep in mind, too, that we have a lot of members that are relatively new to the AAMC and the programs of this Council and see if we can't emphasize some points that they would be interested in particularly.

MR. MC NULTY: This is what I am fishing for here, Roy. What are some of the points that we would think of.

CHAIRMAN FERGUSON: Well, I checked with a couple of my colleagues from Cleveland who were there who were not with affiliated hospitals and the reaction I got was that they found it very interesting to be in this kind of a grouping. Apparently they knew some of the people but they were in a different

environment in regard to their problems. And I noted that there were directors of medical education who had come from these hospitals. And so I think that there is going to be a different -- I think that one of the problems will be, Matt, how do we get at this group to be sure that we can reflect some of their interests. But in these one or two instances when they talk to me, I got the clear impression that what was being discussed there with the people they talked to in informal sessions was very helpful to them. They received points of you that they wouldn't get in their normal way of moving around. I think this is why we all go to these meetings, to get different slants. So I don't think we should be too concerned about what they want to be talking about.

Did any of the rest of you hear from folks in hospitals that were not directly affiliated --

MR. FRENZEL: The same sort of reaction.

MR. RAMBECK: Same reaction.

MR. MACER: Same thing.

CHAIRMAN FERGUSON: Then I don't think they were trying to be polite, were they?

MR. FRENZEL: No. Very enthusiastic.

CHAIRMAN FERGUSON: These fellows that I talked to can usually tell you right off the bat if they don't like something.

DR. BOETTCHER: I had the same reaction.

CHAIRMAN FERGUSON: Your personal reaction to the meeting?

DR. BOETTCHER: Was exactly as you described it.

CHAIRMAN FERGUSON: You had a chance to talk about things that were not on the list.

DR. BOETTCHER: They weren't talking about laundries, or, you know, nursing shortages. They were talking about education.

MR. WITTRUP: I would think that this subject, though, of the disappearing service patient is one that probably ought to stay on the program for a number of additional years.

DR. BOETTCHER: How can you talk about that without talking about Medicare?

MR. WITTRUP: Well, I know that it relates indirectly or sort of directly, but when I say let's not talk about Medicare, I am thinking about part A and part B and all the internal technicalities. But the business of the disappearing service patient I think is good for a few more years on our programs.

DR. BOETTCHER: Another one is delivery of health care mechanisms, delivery mechanisms.

MR. GRAPSKI: Well, what seems to be very pertinent both under that heart, stroke and cancer thing and, you know, the Cavanaugh activity is the planning, the whole activity of planning at the state level and the involvement of the medical school and teaching hospitals, wouldn't you say, Charlie?

MR. FRENZEL: Yes.

MR. GRAPSKI: This is really going to hit us.

CHAIRMAN FERGUSON: So far everything we have talked about I am sure is going to be the concern of the parent body. I noticed the minute we start talking here we are out of the laundry very quickly and we are right up to what the -- this is what we found last year, didn't we, Russ? We found that our thinking and their thinking almost clocked, although we weren't organized.

DR. NELSON: Right.

CHAIRMAN FERGUSON: They came in and gave us their proposals as to what their theme was and we were able to fit in under their umbrella very, very well.

DR. NELSON: They have a committee that plans the annual program and I was part of it, so I knew what was going on, but it was largely happenstance planning.

MR. MC NULTY: They have not started yet this year but I was anxious that we get going.

MR. WITTRUP: Is heart, cancer, stroke still good? Will much be happening between now and then?

MR. MC NULTY: A number of the grants will have been awarded.

CHAIRMAN FERGUSON: You might be interested that last year when we met on this the topics of interest were the impact of Medicare on the programs of the teaching hospital;

paramedical education; what impact will Medicare have on the numbers of beds required; occupancy; funds for same; education, and so forth; how do we get moneys to resolve the problems of capital financing; what are medical schools doing in compre-hensive care, extended care units; is the teaching hospital part of the main stream or does it have a different role to play.

We are not going to change by radical number of steps but we are going to evolve in other areas.

I will give you something to think about for your program. I think all of us are trying to do two things today. I have before me a very, very early draft of a certain section of the Manpower Commission report, and that report is due June 30. And the President is apt to, we understand, deal with this report in whatever way he handles it during July, August and September. So it might bea public document in advance of this meeting. I can't say that it will nor can I really give a very firm projection of what this is going to cover at this point.

CHAIRMAN FERGUSON: It is a good point.

DR. NELSON: I would say that the present spirit of the Commission is to be pretty aggressive and say some things that I think we all saysort of quietly and don't ever get out in at least national articulation. I will just read a para-graph which will raise some hackles probably.

"People who have the biggest say about how..." (reading).

And you can see what this is apt to do. And it goes on and gets a little closer to the administrative functions, saying that the trouble is that hospital management generally suffer from the edifice complex, each building it larger, and larger and larger.

Now, we have all said this but it hasn't been said publicly. And I am not saying it will be, either, because I have lived with it and so has Joe.

DR. BOETTCHER: If you use those same words at the White House Conference.

DR. NELSON: Yes, but there is apt to be, could possibly be a pretty strong focus on costs in hospitals, the adequacy of personnel and tremendous inadequacy in the system.

CHAIRMAN FERGUSON: System of using?

DR. NELSON: Just the whole system of health services. There's talk in many circles now that no matter what we say about family practice some new character has got to come on the scene, that our present machinery just won't do it.

So this is something for you to start thinking about as being a part of your program.

CHAIRMAN FERGUSON: That also reminds me that the public Health Service has just announced their reorganization.

They do have a bureau on manpower. I think what Russ is saying is that by the time our program comes around this is going to be on the table just like Medicare was a year ago, and we better start sensing it.

MR. WITTRUP: If that Millis report catches on, that is a very profound document.

CHAIRMAN FERGUSON: This one on family practice will rest.

MR. MC NULTY: And it may well catch on at the June AHA meeting.

CHAIRMAN FERGUSON: If the AAMC is considering a committee to consider what it wants to say about it, undoubtedly this will be on the program. They are going to have to have the reaction to it at this meeting in October, right?

MR. MC NULTY: Yes.

CHAIRMAN FERGUSON: I mean the report came out during the summer and it was really not officially disseminated. I don't think they are going to be able to hide from having something to say about it.

MR. WITTRUP: Even among people who ought to know, unless I totally misinterpret their report, there are not very many people who have really caught on to what they are really saying in there.

CHAIRMAN FERGUSON: That is typical of most reports.

MR. WITTRUP: It hit this very softly for some reason

or other.

DR. NELSON: What are they saying? How do you interpret it?

MR. WITTRUP: As I interpret it, they are saying, in the first place, we can look forward to the day when the specialty boards are going to be abolished. As I interpret it they are saying that the chief of surgery ultimately won't have any more to say about the house staff program than he does about the medical school curriculum. And of course, the internship goes, and so forth -- a complete reorientation of the structure of the in residency training.

DR. NELSON: I had hoped you would pick out the one that I would, which was that the institutions of higher learning would be responsible for it.

CHAIRMAN FERGUSON: For what, agency training?

MR. GOULET: Yes, sure.

CHAIRMAN FERGUSON: This is one that is going to cause the most annoying.

MR. GOULET: Yes, but the guys in medical schools are picking that up and they are not fully recognizing this other business, you see. And a lot of them feel like they are going to have their cake and eat it, too, but that is not what the report says.

CHAIRMAN FERGUSON: I know, having heard Jack Millis, we have talked about this -- where is the corporate responsibility for graduate medical education, which is not in the

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same sense that there is corporate responsibility for undergraduate medical education. Let's face it. All of us know what they are talking about. And in our situation we have pulled in at various times, and they are getting closer each time because they are beginning to recognize that education, no matter what you are going to do with it, it can never be left with a single group.

MR. WITTRUP: That's the core of the problem discussed last night, I think.

DR. NELSON: Exactly.

CHAIRMAN FERGUSON: Well, you remember the Brown report of the AHA really -- remember, Russ? Hit at that, that there was corporate, there was corporate responsibility today, it wasn't just a loose collection of individuals who wanted to "use the facilities of the institution." And that there was that landmark decision in the State of Illinois that said hospital trustees are responsible in a little different degree than providing facilities and then standing with their arms folded.

DR. NELSON: Interesting times are coming, my friend.

CHAIRMAN FERGUSON: Yes, sir. All you have to do is watch your malpractice suits.

Is there anything further to express here to Matt? It is 12:30 and I guess we -- let's not inhibit the help if

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they want to do something.

(Whereupon, at 12:30 p.m. the Council recessed until 1:30 p.m.)

WARD & PAUL
917 G St., N. W., Washington 1, D. C.

AFTERNOON SESSION

(1:30 p.m.)

CHAIRMAN FERGUSON: Before you all get away, could I ask this question: There has been some indication that perhaps our time for closing has been a little bit tighter than it might have been. Would you be willing at the next meeting to come the evening before and then let the closing hour, say, be 4:00 o'clock? Does this get you home? In other words, let's just check the timetables. Would this get you back on a Friday night or a Thursday night -- in other words, do your plane schedules permit this? We didn't know.

MR. RAMBECK: They do for me. We leave at 6:00 o'clock.

CHAIRMAN FERGUSON: In other words, this time we were pushing for a 2:00 o'clock adjournment. What if we made it a 4:00 o'clock adjournment? Would this work all right with everyone?

MR. GRAPSKI: Fine.

MR. FRENZEL: Fine.

CHAIRMAN FERGUSON: Just about as well?

MR. RAMBECK: 12:00 o'clock lunch?

MR. WITTRUP: Well, not quite at 12:00, but as near to 12:00.

CHAIRMAN FERGUSON: Does it cause any severe inconvenience? I think we ought to try to make these as convenient

as possible, too.

Let's keep that in mind, then, but you are all willing to come in the night before as we did this time?

MR. MACER: I would like to.

DR. MAC NINCH: Yes.

DR. BOETTCHER: Yes.

CHAIRMAN FERGUSON: Because I suggested that we might hear some of these program developments, and I think maybe the first night's meeting could be well adapted to this -- you know, listening to some kind of a description of some activity as these things occur, a report from the committee, or something like that. Last night, I think, went very well.

O. K. What do we have left?

MR. MC NULTY: I think we are up to 16.

CHAIRMAN FERGUSON: Yes, Administrative Committee (The Officers); Executive Council (Tab 9) and Regional Meetings.

MR. MC NULTY: Tab 9 lists the members of the Executive Council. I thought some of you might be interested in that.

CHAIRMAN FERGUSON: Our representative is Russ Nelson.

DR. NELSON: Pardon?

CHAIRMAN FERGUSON: I was just saying you are our representative from this Council on the Executive Council.

DR. NELSON: Thank you.

CHAIRMAN FERGUSON: What about this regional meeting idea that we discussed? Matt?

MR. MC NULTY: We discussed in San Francisco one, the fact that the AAMC was going to divide into regional meetings, into regional areas of the country, which they have done. And under Tab 10 you will note the regions that have been set up, again using a different base. If you add the hospitals under Tab 10 you get 313 -- using a different base. When we made out the map we tried to distribute the hospitals throughout the United States showing what region they fell within. The AAMC in turn is conducting meetings--

DR. NELSON: Excuse me, Matt. Does that about follow the medical school proportions? The Northeast has 34 of the medical schools. I remember that.

MR. MC NULTY: Yes, it does, Russ.

DR. NELSON: And 135 of our members. That's 34 of what, 90--

MR. MC NULTY: Of 135. That's about a third of them.

DR. BOETTCHER: Do you have the schools for each of the regions? I am very curious about the Great Plains. I feel under-represented.

MR. MC NULTY: I don't have them right in focus, Ernie. I could add it quite easily, though. I guess I could

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count them off pretty quickly.

MR. WITTRUP: Who is pressing for this? I just can't imagine anybody wanting another meeting to go to.

MR. RAMBECK: I think it's much too soon to talk about this. We have these regional meetings now in every section of the country.

CHAIRMAN FERGUSON: No, this is just a report, that the AAMC is going to set up regions for its basic purposes, is that correct?

MR. MC NULTY: Right. They have set them up, and these are the regions as represented by this map.

DR. NELSON: Gentlemen, remember that there is the Northeast section known as the poison ivy league of hospitals and there is something in the Midwest and there is something in the far West, which have been informal groupings for essentially the same kind of hospital, and one of the thoughts at one time was that this might be the vehicle by which they could have these meetings. Some are left out now, you see. When the Northeast meets, it's really only about a dozen out of that 135.

MR. MC NULTY: Yes. If I would react as I presume you would want me to, I think Russ' point is well taken, that at some time we should have regional meetings. I think perhaps what some of the others of you are saying is that it's too early. Here I would rather this decision be yours than any advice from me because I would have a prejudiced viewpoint.

I do not have a secretary so I have some organizational complications. Miss Dittmair is from Western Girls or one of these services and has been very helpful.

DR. NELSON: What happened to that other girl?

MR. MC NULTY: She defected to the Republicans. She married a Republican and a very staunch one, and when they were elected en masse, why, she--

DR. NELSON: Is she with a Republican committee?

MR. MC NULTY: She is a staffer for the Republican representative from Illinois. Some of you may remember that that's the part of the country she is from.

MR. GOULET: Which one?

MR. MC NULTY: Findley, a newly elected one.

MR. RAMBECK: I think we might take it upon ourselves to inviite Matt to our regional meetings, at least one of them, so he can be familiar with them, what they do, how they function.

MR. MC NULTY: The Northeast group did.

MR. RAMBECK: And we will do this, too.

MR. WITTRUP: We have one in Appalachia, one lad defected after he helped organize it.

CHAIRMAN FERGUSON: Could you tell us, Matt, will AAMC this year have regional meetings?

DR. NELSON: There is one called already for the Northeast.

MR. MC NULTY: They will, and they are on a very informal basis.

CHAIRMAN FERGUSON: Will members of the COTH--

MR. MC NULTY: No.

CHAIRMAN FERGUSON: No, this will only be for deans.

DR. NELSON: Were you invited to the Northeast one by Booker?

MR. MC NULTY: No, I was not.

DR. NELSON: I will see that you get to go for me, then.

MR. MC NULTY: All right. Fine. I didn't attempt to project my interest.

DR. NELSON: Let's not forget that, Matt.

MR. MC NULTY: Yes.

CHAIRMAN FERGUSON: I think it would be well for you to attend a couple of these so you could get some idea as to how useful they might be.

MR. GOULET: Didn't they invite you?

MR. MC NULTY: No, no. These are meetings of deans.

MR. GOULET: How did you get in on that?

MR. MC NULTY: They invite members of the Executive Council, and Russ is on the Executive Council.

MR. GOULET: Oh, I see.

DR. NELSON: You represent me, will you, because I can't go.

MR. MC NULTY: Fine, good. It would be eaier, Russ, if you dropped a note and indicated that you weren't coming but you had requested me to come.

DR. NELSON: Yes. My only concern is that you and I will forget this.

MR. MC NULTY: My own reaction would be that it would be very difficult to initiate a series of meetings this spring, but on the other hand the difficulty could always be overcome. I would like to spend more time seeing us getting organized in a central office but you all represent the field and you may have a more sensitive finger on the pulse than I do.

MR. RICHWAGEN: Couldn't we do one thing. There are a number of medical centers that are not included in these groupings. Perhaps the chairman might suggest to the different areas that they might invite those who are not now included who are in their area, because I think these meetings are very important. I get minutes, for example, from the Midwest university complex. I guess you belong to that, don't you, Stan?

CHAIRMAN FERGUSON: UATC?

MR. RICHWAGEN: No, it's Iowa, along in this area.

DR. BOETTCHER: UFEC.

DR. WITTRUP: You are talking about Missouri and Kansas and that area?

MR. RICHWAGEN: No, I am talking about Iowa and that area.

CHAIRMAN FERGUSON: That's a bit west because the UATC and the other group keep minutes.

MR. RICHWAGEN: I get the minutes of the meetings because of a friend, and it's pretty good stuff.

CHAIRMAN FERGUSON: Yes, they have pretty good bull sessions.

MR. WITTRUP: I think that serves a much different purpose than these groups of 28 and 30 and 68 and 59 and so forth. We have got a little group, too, you know. We have 9, and if that went to 15 we might as well forget it. Maybe we ought to forget it. I don't know.

MR. MC NULTY: In time I would like to see us have -- if I should express an opinion or would express an opinion, in time I would like to see us have them, Dick.

What you are receiving is merely a travel expense form.

DR. BOETTCHER: Matt, on a personal note, would it be too much trouble for you to get me a list of the hospitals and schoolsin the region I am in, the Great Plains?

MR. MC NULTY: No, not at all.

DR. BOETTCHER: I could pick them out of the membership list, but if it's easier for you--

MR. MC NULTY: If they can ever get the computers

9 going, they ought to be able to toss this out fairly easily, but we can do it by hand. It may be a week or two.

DR. BOETTCHER: Mr. Chairman, I would like to ask -- I think there is at least one of us from each region -- is there any thought about whether a communication from me to the members in a region following this meeting to try to let them know what's going on, what the dynamics of the new organization are, to get their interest up?

MR. MC NULTY: If I could respond, it would be two-fold. I think, one, Ernie, I would hope that a summary of each of the Executive Committee meetings would come from the central office. Now, beyond that, whether Executive Committee members wish to have sort of a circular of their own, which, in my experience, is somewhat of an ACHA arrangement to try to keep his affiliates informed, I don't know. I am responding affirmatively to the first in the sense that I would like to see the central office send out a report so that it is uniformly done and so that it reaches every member -- what I would call a digest of the Executive Committee meeting.

DR. NELSON: Stan?

CHAIRMAN FERGUSON: Yes.

DR. NELSON: And I have no desire, Matt, to complicate your life any more than it is, but I would like to express the thought that there is something to be gained both in enthusiasm and in direction for the whole Council and its

10 Executive Committee to have some meetings of the members in small groups and very informal. And if there are no restrictions placed, Matt, on your activities and you can travel and put out a little money to rent a hall, just little things like that, just invite here and there and some of these regions the administrator members to come, circulate a very simple agenda which might be: Would like your view on; your concerns with, or discussion of, and then put down medicare and a few other things that you know people are concerned about and have a one-day meeting -- no action, just a chance for the people to meet and talk, I bet you will get a pretty enthusiastic response and attendance. I bet you will get your members feeling that things are moving, even though you may, and we may think that this is really not moving. And more than that, probably in the long run you will get a feedback from them about things that will become program points that we are not even thinking about. We are kind of a different group here really. We don't have -- despite the degree we think we are, we are really not the grass roots. Although I don't know that you have to cover all districts and all regions, and I don't know that you need to do more than one or two, but I would really give a crack at it. You don't have to pay their expenses. Just invite them. Or if you have some concern about it, circulate them and see how many would come if you set a meeting up in Atlanta.

I have this concern, that we are going to sit here and organize and reorganize and structure and structure and we are remote from them. We don't know what they are thinking about, and they are wondering what the hell are we doing, you know. And I think a couple of regional meetings, or three, if you can put your effort into it, even if you don't have a secretary, might be worthwhile. I really do.

DR. BOETTCHER: Matt, in my area, for example, I would offer to do the whole setup.

DR. NELSON: Yes, I would, too.

DR. BOETTCHER: Make all the arrangements, send all the invitations, the preliminary inquiry and what have you.

MR. MC NULTY: Mr. Chairman, am I sensing this is an opinion? That way it would work very well. I mean we could get going in a hurry.

CHAIRMAN FERGUSON: I think this would be consistent with what we talked about last fall in San Francisco. We said that since the AAMC was going to start regional meetings, we might consider joining with them on this. Now what we are saying is let's not join with them on this, but do it once or twice merely as a trial. That's Russ' point.

MR. GOULET: I think, Stan, it would be desirable to try to see if we could schedule the regional meetings of the administrators at the same time that the deans are meeting.

CHAIRMAN FERGUSON: But the point I think to be made

here is that they are going to start this as a parent organization approach and we can now try our own hand and see--

DR. NELSON: Once again, I don't think we have to follow them.

CHAIRMAN FERGUSON: That's right.

MR. FRENZEL: I agree. We have had experience with this joint meeting bit. It doesn't work too well.

DR. NELSON: For instance, Matt, the one you attended in Baltimore, which is the old poison ivy league. The arrangements to be made for that are incredibly simple. We tend to go a little bit ivy leaguish in our social functions now and then, but this isn't important for what I am talking about now. If Ernie is willing to take the hosting responsibility in the sense of making the arrangements -- wow, that's great. And I'll bet you you can find somebody in every district that's got enough steam to do his own.

CHAIRMAN FERGUSON: A good idea.

DR. BOETTCHER: All we ask is that you make your own plane reservations and show up.

MR. GRAPSKI: We have our geographical representation just on this committee that could assist Ernie.

CHAIRMAN FERGUSON: Why don't you try it.

MR. MC NULTY: One other point interpreting what Russ mentioned. One thing that would make it considerably simpler would be to combine several of these regions which are fairly large geographically but small in terms of total number.

DR. NELSON: Just have meetings.

MR. MC NULTY: Yes. All right.

DR. NELSON: I don't think you need to follow any particular pattern.

MR. GOULET: I imagine I could take on the Midwest group there. In fact, we might do this, Matt, a day before the ACHA Congress or something.

CHAIRMAN FERGUSON: Don't build it up too big, now. Try this on for size. I understood that is what Russ was saying. Try it on for size and report to the membership you are going to try it on for size.

MR. WITTRUP: Don't feel like you have got to get everybody every time.

CHAIRMAN FERGUSON: That's right.

DR. NELSON: That's right. And don't think you have to take actions or keep minutes or take the role or have any particular agenda. Let the people determine their own agenda, but knowing that nobody will really think about it put some feelers out.

MR. MC NULTY: Four or five subjects.

DR. NELSON: Have your own agenda if you don't get any results.

CHAIRMAN FERGUSON: Very good.

DR. NELSON: I will tell you, when you do this you are going to need more than one secretary pretty fast because

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you are going to have a whole lot of questions that somebody is going to want to have somebody look into -- where is my $500 going?

MR. MC NULTY: Mr. Chairman, I apologize for bringing up the subject of the secretary.

CHAIRMAN FERGUSON: We need a meeting time for the next meeting.

MR. MC NULTY: Look at the insert. There is an extra page that was given to you in your material which shows the meetings of the Executive Committee and the Administrative Committee. The Administrative Committee of the AAMC is evolving la rgely as the officers.

DR. NELSON: Are we involved in that in any way?

MR. MC NULTY: No, in no way. I have gone to one meeting for a portion of it and I left for another reason. I don't believe I was -- I felt no slight. I had to leave, and I don't think there was any closed meeting concept on it. I don't know how they are going to keep going.

DR. NELSON: Are you going to the next Executive Council meeting?

MR. MC NULTY: Yes, I will go.

DR. NELSON: O. K.

MR. WITTRUP: Well, somebody did a pretty good job of scheduling that. Whoever did that, why don't we let him schedule the next one?

DR. NELSON: Matt.

CHAIRMAN FERGUSON: Matt and I said that looks like a good time.

MR. WITTRIP: You did real well. I suggest we follow that same autocratic procedure next time around.

MR. RAMBECK: The 18th and 19th of May. Wrap it around that Executive Council meeting.

MR. GRAPSKI: They have suggestions here of May 12 or April 7 and 8. Item 17, is that the right one?

MR. FRENZEL: Yes.

MR. RAMBECK: That would be May 11 and 12, Thursday and Friday.

MR. GRAPSKI: I like May 11 and 12 better than I do April.

MR. RAMBECK: April is very bad.

MR. MC NULTY: At the end of the table I am getting a favorable reaction to May 11 and 12, or in that neighborhood.

MR. MACER: Sounds good.

CHAIRMAN FERGUSON: O. K. That's good.

MR. MACER: With the proviso that if things move faster, the Chair is free to call meetings before that.

CHAIRMAN FERGUSON: O. K.

MR. MC NULTY: Right.

CHAIRMAN FERGUSON: It probably means we will have one more-- this will probably be the meeting that will try to

be helpful on the program, right?

MR. MC NULTY: Right.

CHAIRMAN FERGUSON: And then there will be one more meeting before we have the meeting in New York.

MR. MC NULTY: Right, before the annual meeting in October.

CHAIRMAN FERGUSON: O. K.

MR. MC NULTY: Right.

MR. RAMBECK: When you say before the meeting, you mean just preceding?

CHAIRMAN FERGUSON: No. Sometime during the summer.

MR. MC NULTY: Sometime in May and then perhaps -- September is the way we met last time, as I recall. We met last time in June and September.

DR. NELSON: I think so.

CHAIRMAN FERGUSON: Financial report.

MR. WITTRUP: We are solvent, aren't we?

MR. MC NULTY: We're solvent.

DR. NELSON: We better be.

MR. MC NULTY: We are going to have a few dollars left over.

No. 19 is only to report that the AAMC is trying the same endeavors in the area of the Allied Health professions as they are in the Council of Academic Societies, and that is trying to see if they can interest these so-called allied health

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professions in an umbrella-type of organization or relationship.

The National Conference on Regional Medical -- shall I proceed, Mr. Chairman?

CHAIRMAN FERGUSON: Keep going.

MR. MC NULTY: National Conference on Regional Medical Programs is only to report that Bob Marsten, Stan Olson and others were most cooperative. We got about 60 names in the hopper. I don't know how many will eventually come. That's starting this Sunday.

CHAIRMAN FERGUSON: Who is invited to that of the Council of Teaching Hospitals -- this entire membership?

MR. MC NULTY: This entire Executive Committee in total. They accepted quite readily. I submitted, as I said, 60 other names, just going down at random, those that seemed to be most interested in the subject, and gave it to them and then withdrew because I didn't want to be part of the selection of which ones -- I believe they selected about 40 of the names to come. So I don't know how many will come, though. There are some conflicts.

MR. FRENZEL: The conference, Matt, will be between 500 and 600 on last count so it will be a big one.

MR. GOULET: Is that right, Charlie?

MR. MC NULTY: They have tried to cover the country. The AHA did the same thing. One could have sent the full

membership roster.

No. 22, the activity of COTH headquarters. I have already made the point, I hope, that is going to be somewhat complicating that while it is desirable to wear two hats in the AAMC organization, wearing the second hat requires a certain amount of responsibility which I have found so far is a little divisive of concentration on COTH activities.

DR. NELSON: What are you doing besides--

CHAIRMAN FERGUSON: He is not going to New Delhi. That is what he meant.

MR. MC NULTY: Well, the one thing, Russ, was handling all of the miscellaneous calls and visitors and committee meetings that came to the Washington office when everyone else was away. So actually for about two weeks all I did was go to meetings, answered mail and saw visitors who came to the office.

CHAIRMAN FERGUSON: He was Mr. AAMC.

MR. MC NULTY: Might poor representation but--

CHAIRMAN FERGUSON: No, you weren't.

MR. MC NULTY: It was an interesting learning experience. I gained a little insight as to what goes on.

DR. NELSON: More fun than working, too.

CHAIRMAN FERGUSON: He was the resident. He took over the boss' duty.

MR. MC NULTY: With not nearly as much competency as most residents have.

CHAIRMAN FERGUSON: Next year he goes to New Delhi.

MR. MC NULTY: Well, I was leading up to that.

Sixty-third Annual Congress on Medical Education is only to indicate the program, and I am going to distribute the program to our membership because I think it would be desirable if--

DR. NELSON: I guess most of this committee will be there, won't they?

MR. MC NULTY: I would hope so.

DR. NELSON: It might be a chance to caucus if you need to, Stan.

CHAIRMAN FERGUSON: Yes.

DR. NELSON: All you have to do is give free lunch.

CHAIRMAN FERGUSON: That's right. You can get a lot of people. All you have to do is mention a little bit of liquor.

DR. NELSON: I think we will all be there. It's a kind of time that if you need a meeting you could call it.

MR. MC NULTY: We could set up a little informal one, if nothing else.

CHAIRMAN FERGUSON: If you need it.

MR. MC NULTY: Yes.

CHAIRMAN FERGUSON: I wouldn't do it unless you needed it.

MR. MC NULTY: All right.

No. 15 is the paper sent to you on the proposals for support of medical education by the Federal Government as designed by a committee of the AAMC.

I don't know, Stan, whether Charlie has had a chance to look at it yet. It really doesn't include teaching hospitals very much. I think we have made a point, a significant point that we should be included and that the purpose of our getting the distribution, and so forth, was an agreement by the Administrative Committee that we ought to be contributing something to it.

DR. NELSON: Has it been approved -- excuse me, Charlie. Has it been approved by the AAMC?

MR. MC NULTY: No. It is going through another draft.

MR. FRENZEL: What is the timing on it, Matt?

MR. MC NULTY: They hope to present it to the institutional membership meeting in Chicago in February. I will give you the precise date of that institutional--

DR. NELSON: What are the areas of controversy or debate or question, if any, Matt, as it is in the document now?

MR. MC NULTY: As I have looked at the document, and I had one participation with the committee, I really don't see any, only in the negative. It doesn't cover teaching hospitals whatsoever.

DR. NELSON: No, I wasn't thinking about us. I was thinking just generally.

MR. MC NULTY: I have no specific reaction.

MR. MACER: Who is chairman of that committee?

MR. MC NULTY: Ken Crispell.

DR. BOETTCHER: I wonder if it's too late to get the teaching hospital records on this.

MR. MC NULTY: I don't think so, Ernie. No, it is not too late.

DR. BOETTCHER: The institutional membership meeting is on the 11th. That's about all the time we will be convening in Chicago, too, but I think that some of these proposals, such as the one on page 4, Item 2, legislative authority be requested for the allocation of a maximum 15 percent for their research work in each of these two categories -- in other words, 15 percent can be shifted to education for a research ward of vice versa, and I think that that can work three ways, for patient care, teaching or research. And this could help us a lot in our appropriation of reasonable cost between hospital and medical schools. And I think that would be well worth working into this draft.

DR. NELSON: Well, Crispell is a very liberal person.

DR. BOETTCHER: He is.

DR. NELSON: He is a very understanding person. I think if it was brought to his attention he would probably do it.

DR. BOETTCHER: Yes.

CHAIRMAN FERGUSON: They probably were reflecting the types of legislation that have been passed.

MR. FRENZEL: It starts out with patient service and then it drops.

DR. BOETTCHER: That's right. I think they mean well but they haven't got the ability to do it.

DR. NELSON: When do you need to get that in, Matt? Or Charlie?

MR. FRENZEL: Suppose Matt and I work on it, get together by phone or otherwise and see if we can come up with something.

MR. MC NULTY: I think we need to do it with some dispatch.

MR. FRENZEL: Yes.

MR. RAMBECK: On page 10, Matt, the first paragraph: "The full effort will involve the entire system of higher education including the teaching hospitals."

Now, that seems to be a little bit out of keeping with what we get from the preamble here -- "is meant to include those teaching hospitals that are not a part of the medical centers."

CHAIRMAN FERGUSON: That's what it says, not a part of the medical center complex.

MR. FRENZEL: It emphasizes the delivery of health services in the latter part of the report and obviously there

is going to be more participation by the teaching hospitals than in any other form of research.

MR. RAMBECK: I would offer just to say "including those teaching hospitals which are not part," in order to make it clear.

CHAIRMAN FERGUSON: You will note, also, on the top of page 3, "support of the integrity of the medical centers' inseparable functions are: Research, education and patient service." You have got it broad there, as you say.

MR. FRENZEL: Broad in the beginning but then it drops it.

CHAIRMAN FERGUSON: It drops it, and in some way, somewhere maybe you can reemphasize it again, reemphasize it.

DR. BOETTCHER: On the section of the improvement of the delivery of personal health services, I don't think it gives enough recognition to our teaching hospitals and their role. I haven't got a specific thing to mention there, but I think if a hospital administrator rewrites it, he could inject some of this.

MR. RAMBECK: May I make one observation on the last page. I think that's too much emphasis and wrongly placed emphasis on accounting, cost accounting and fiscal expectation of the government. It just doesn't strike me as a good place to put this strong statement.

DR. BOETTCHER: If they would only let the

administrators do their accounting for them, they could do more research, but they don't trust us with their research funds.

MR. MC NULTY: I would add a couple of chapters and verses on that, but I won't. The same liability exists within the AAMC, I would say, but I will proceed on to another subject.

MR. RAMBECK: One last point, Matt.

I really wonder if they meant to say what they said in the first paragraph, where it says, "recognize and accept the responsibility they have" -- medical colleges -- "to serve the health needs of the people by increasing the supply of physicians and personnel." Is this the sole or the main responsibility as perceived by the AAMC, to increase the supply of physicians and other health personnel?

MR. FRENZEL: Not sole, but they don't say it says sole responsibility.

MR. MC NULTY: I think they consider that a responsibility and perhaps the most important responsibility.

MR. GOULET: That was the issue that was raised in the Coggeshell report, Roy, and it was modified, as you recall, slightly, but I think what is said here is correct as to interpretation.

MR. MC NULTY: Coggeshell certainly didn't equivocate about it. He said this was totalresponsibility, perhaps to the exclusion of other places.

MR. GOULET: This is what I said.

MR. RAMBECK: My feeling is that this was too

limiting a statement, really. It talks only about numbers rather than quality and, you know, concern about utilization of manpower and so on.

CHAIRMAN FERGUSON: Well, I would presume this is implied, a supply of adequately qualified physicians.

MR. FRENZEL: More foreign medical graduates, you mean?

MR. RAMBECK: I think it is too limiting for an august body like the AAMC.

CHAIRMAN FERGUSON: There is no quality statement in here, which very often affects -- last night from that discussion we had of Dr. -- what was his name, Margulies?

MR. MC NULTY: Margulies.

CHAIRMAN FERGUSON: --he was implying that maybe if we are not careful, we are going to have figures which indicate we are overtraining doctors.

DR. BOETTCHER: The AMA has such figures. I think they are getting concerned about the educational extension of graduates.

CHAIRMAN FERGUSON: That wasn't what I meant. His figures were that in the State of New Jersey 30 percent of the physicians are over-trained.

DR. BOETTCHER: The AMA has figures to indicate that by 1985 the population will increase about 20 percent and the physicians will increase by about 70 percent. So do

we blow a whistle here?

DR. NELSON: I hope I make it. I hope I make it. Don't you, Joe?

DR. MC NINCH: I made it.

(Laughter.)

CHAIRMAN FERGUSON: O. K. Go on to the next one. Item 15. Here's 1985 for you, tab 13. You can get all of the numbers.

DR. BOETTCHER: How did we get back to agenda No. 15 just to needle Matt a little. His numbering system broke down. He went from 23 to 14.

MR. MC NULTY: That wouldn't surprise me in the least. I haven't picked it up, I must say.

Yes, I see. We just mixed one X there, didn't we. That's the X factor that was dropped out earlier.

That's informational only. It's an unpublished report. The AAMC is debating whether to publish it or not. I think it would make interesting information, but that's the responsibility of the Operations Division.

CHAIRMAN FERGUSON: Boy, look at those full-time faculty.

MR. MC NULTY: There are a lot of overtones involved here so--

CHAIRMAN FERGUSON: They are going to double the full-time faculty and only go up 50 percent on the students.

Well, that ought to make interesting conversation.

MR. RAMBECK: Look at the ratio there, 1.9 to 1.09. How far does it go down? To .001 eventually.

DR. BOETTCHER: That's a pretty costly operation.

MR. RAMBECK: Where do these figures come from, this projection?

MR. MC NULTY: From a sampling process done by the Operations Division of the AAMC.

I would ask for your cooperation in that it not get into any publication channels.

CHAIRMAN FERGUSON: What do you mean? I am going to call up the editor of the local paper tomorrow.

MR. RAMBECK: I think the AMA could really be rough on something like this.

MR. MC NULTY: I believe to some degree they have participated, the Council on Medical Education has participated in the collection of the figures.

CHAIRMAN FERGUSON: Sure. Let's face facts, fellows, that may be truth.

MR. MC NULTY: I put it in because I thought it was interesting information. I am a purveyor of information, not a supporter of position or anything.

The next item, the address by the Surgeon General, perhaps represents a certain interest on my part. It is there for information only. If you do thumb through it you will notice several emphases on the organization and delivery of

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health services as they would be sponsored by the Public Health Service which I think is good. There is not too much emphasis on the participation of all of the existing activities.

DR. BOETTCHER: If I could comment on it. It's the last item I read last night. And the thought I had was that the Surgeon General did a fantastic job of walking lightly between egg shells in describing the height of complexity in the approach to the health care field in attempting to integrate it. My only hope is that this is the height and from now on we start simplyfying administrative procedure. It reflects a hopelessly complex interlacing of agencies.

MR. MC NULTY: The appointment of the Nominating Committee, Mr. Chairman, has traditionally been the three immediate past chairmen with the most immediate past chairman being the chairman of the nominating committee.

CHAIRMAN FERGUSON: That would be whom?

DR. NELSON: I accept.

MR. MC NULTY: That's Russ Nelson and Harold Hixson --

MR. GOULET: And McNulty.

MR. MC NULTY: No, McNulty got out of it last year. And Phil Bonnett is the third member: Nelson, McNulty, Hixson and Bonnett, and I think I should be excluded.

CHAIRMAN FERGUSON: All right. But who would be the fourth person?

MR. MC NULTY: Three, a 3-man committee.

CHAIRMAN FERGUSON: Oh, just have a 3-man committee.

MR. MC NULTY: It has been a 3-man committee.

CHAIRMAN FERGUSON: I see. Well, we are all set, then.

DR. NELSON: I threw Smoke into it last year just for good measure, didn't I?

MR. MC NULTY: To be helpful because I was sort of bowing out of it. Russ, that was your -- which I appreciated, but we can have four.

DR. NELSON: Well, as long as I can control the committee, I don't care who is on it.

MR. MC NULTY: You don't care.

CHAIRMAN FERGUSON: Anybody want seven to be sure that Nelson doesn't run off with the show?

Well, we come to Item--

DR. NELSON: Matt, you keep that in mind about the meetings and so forth, will you?

MR. MC NULTY: Right, the Nominating Committee.

DR. NELSON: Yes. Send me a little notice on it.

CHAIRMAN FERGUSON: We have a few minutes. Any observations? New business?

DR. BOETTCHER: Did we set the next meeting date?

CHAIRMAN FERGUSON: Yes.

MR. MC NULTY: So far May 11 and 12 are the dates--

CHAIRMAN FERGUSON: Would you send out a confirming note -- would you please?

MR. MC NULTY: Surely.

CHAIRMAN FERGUSON: I don't know about the rest of you but I always like to get another letter. It's much more better than putting it in the book. Send it, Al.

MR. MC NULTY: I wrote down more betterer.

MR. GOULET: May 11 and 12?

MR. MC NULTY: Yes.

MR. GOULET: In Washington?

CHAIRMAN FERGUSON: Yes. We come in on the night of the 11th.

MR. MC NULTY: 11th, and stay until 4:00 p.m.

CHAIRMAN FERGUSON: 4:00 p.m., put that in the note, too, would you?

MR. MC NULTY: All right.

CHAIRMAN FERGUSON: And then I suppose depending, Matt, if we see that the agenda is shorter as we get close to the meeting, we can inform people so they can plan an earlier departure if necessary.

MR. MC NULTY: Yes, we can get together in Chicago, if there is any particular interest. I think Stan was saying here "Let's not have aluncheon just to have one, but if there is any subject matter, have one."

DR. BOETTCHER: I would be interested in a follow-

up on this request for governmental support, this tab 12.

MR. MC NULTY: The institutional meetings have generally been open meetings, that is, we don't participate in them but there is seating around the periphery and this undoubtedly will be debated there, Ernie, just as another method of getting further clued in.

DR. BOETTCHER: That would be enough to satisfy my appetite, really.

CHAIRMAN FERGUSON: Yes, the meetings of the institutional membership are open meetings.

MR. MC NULTY: So far they have been in my experience.

CHAIRMAN FERGUSON: I mean anyone can walk in, isn't that correct?

MR. MC NULTY: Right.

CHAIRMAN FERGUSON: The only meetings that are closed are of the Executive Council.

MR. MC NULTY: Right. That's right.

CHAIRMAN FERGUSON: Is there anything further that anybody would like to present or bring up for discussion?

If not, we are adjourned.

(Whereupon, at 2:10 the Council adjourned.)