

COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
1346 Connecticut Avenue, N.W.
Washington, D.C. 20036
202/223-5364

AGENDA

EXECUTIVE COMMITTEE MEETING (#68-4)
Thursday and Friday, September 5 & 6, 1968
Mayflower Hotel
1127 Connecticut Avenue, N.W.
Washington, D.C. 20036
202/347-3000

Thursday, September 5, 1968:

6:30 p.m.	Reception	New York Suite (2nd floor)
7:00 p.m.	1. Dinner Meeting 2. Presentation:	New York Suite
	William H. Stewart, M.D. ^a Richard M. Magraw, M.D. ^b	
10:00 p.m.	Recess	

Friday, September 6, 1968:

9:00 a.m.	Reconvene - Roll Call	Pennsylvania Suite (2nd floor)
	3. Approval of Minutes, Executive Committee Meeting #68-3, May 9 & 10, 1968	<u>Tab 1</u>
	4. Report on Action Items from Executive Committee Meeting #68-3	<u>Tab 2 - 2b</u>
	5. Report on COTH Financial Status	<u>Tab 3</u>
	6. Formal Recording Action for New Member Elected by Mail Ballot: Nassau Hospital, Mineola, New York	<u>Tab 4</u>
	7. New Applications for Membership	<u>Tab 5</u>
	A. Nominated by a Dean: University Hospital, State University of New York at Stony Brook	
	B. Self-nomination on the Basis of Approved Educational Programs:	
	1) Harrisburg Polyclinic Hospital, Harrisburg, Pennsylvania	
	2) Children's Hospital & Adult Medical Center of San Francisco, California	
	8. Withdrawals from Membership	<u>Tab 6</u>

a - Surgeon General, Public Health Service, Department HEW

b - Deputy Assistant Secretary for Health Manpower, Department HEW

9. Report of Membership Statistics (including foregoing applicants) Tab 7
10. Report of Committees:
- A. Ad Hoc Committee on COTH Program Development:
- 1) Minutes of July 29, 1968, Meeting Tab 8a
- 2) American Hospital Association Projected Dues Increase Structure Tab 8b
- 3) Proposed Revised Rules & Regulations Tab 8c
- B. Committee on Modernization & Construction - Funds for Teaching Hospitals:
- 1) Minutes, June 28, 1968, Meeting Tab 9a
- 2) Recommended Position Statement Tab 9b
- 3) COTH-AAMC Statement before National Advisory Commission on Health Facilities Tab 9c
- C. Committee on Financial Principles for Teaching Hospitals:
- 1) Minutes of June 6, 1968, Meeting Tab 10a
- 2) Recommended Position Statement Tab 10b
- 3) Two Systems of Reimbursement for Hospitals (91 Hospitals have Clinical Research Centers) Tab 10c
- D. Regional Meetings:
- 1) Minutes (note schedule of 68-69 meetings) Tab 11a
- 2) AAMC Ad Hoc Committee Tab 11b
- E. Committee on Nominations:
- 1) List of Current Membership Tab 12a
- 2) List of Positions to be Filled Tab 12b
- 3) List of Previous Office-Holders (COTH) Tab 12c
11. COTH Participation in House Staff IRS Problem
- A. Report of Cooperation with NARI
- B. Action Possibility Concerning Section 117, IRS Code Tab 13
12. Status Report on Contracts:
- A. Feasibility Study for Teaching Hospital Information Center:
- 1) Curriculum Vitae, Richard Knapp, Ph.D. Tab 14a
- 2) Quarterly Report Tab 14b
- B. Study of the Effects of Recent Social Legislation on Teaching Hospitals
13. Commission Studies:
- A. Information:
- 1) Millis Commission Report - AHA Evaluation Tab 15a
- 2) National Advisory Commission on Health Manpower - AHA Evaluation Tab 15b
- 3) Statement by Carnegie Commission on Higher Education, July 1968 - Any Action? Tab 15c
- B. Information - Other Commission Studies
- 1) National Conference on Medical Costs
- 2) National Conference on Private Health Insurance
- 3) National Conference on the Group Practice of Medicine
- 4) National Conference on Cost of Health Facilities
- 5) National Advisory Commission on Health Facilities

AGENDA

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| 14. Medicare Reimbursement for Medical Faculty Rendering Services | <u>Tab 16</u> |
| 15. Teaching Hospitals - Financial Support for the Medically Indigent | <u>Tab 17</u> |
| 16. Current Status of Program for Annual Meeting | <u>Tab 18</u> |
| 17. Annual COTH Awards | |
| A. List of Recipients Last Year | <u>Tab 19a</u> |
| B. Suggested Recipients this Year | <u>Tab 19b</u> |
| 18. Change of Name: Association of Hospital Directors of Medical Education to Association for Hospital Education | |
| 19. Search for AAMC Space, Consolidation of Washington & Evanston Locations; and Report of Current Additional Space in Dupont Circle Building | <u>Tab 20</u> |
| 20. DHEW Advisory Committee on Grants Administration Policy: Concern Relating to Multiple Payments for Residency Support | <u>Tab 21</u> |
| 21. Meeting with and Request from Bureau of Health Insurance, Social Security Administration, HEW | <u>Tab 22</u> |
| 22. Informational Items: | |
| A. August 5th Memorandum to COTH Committee on Modernization & Construction Funds | <u>Tab 23</u> |
| B. Council of Academic Societies Workshop | <u>Tab 24</u> |
| C. Workshop on Medical School Curriculum | <u>Tab 25</u> |
| D. Meetings with Various University Teaching Hospital Groups | |
| E. Second General Conference of Pan American Federation of Associations of Medical Schools | <u>Tab 26</u> |
| F. LeRoy E. Bates, M.D. - Change of Address | <u>Tab 27</u> |
| G. Prototype Pages of 1968-69 COTH Directory | <u>Tab 28</u> |
| H. House & Senate Report on DHEW Appropriations | <u>FOLDER</u> |
| I. House & Senate Report on Health Manpower Act of 1968 | <u>FOLDER</u> |
| J. House & Senate Report on Health Services Amendments of 1968 | <u>FOLDER</u> |
| K. P.L. 90-490, Health Manpower Act of 1968 | <u>FOLDER</u> |
| 23. Future Meeting Dates | <u>Tab 29</u> |
| 24. Other Old Business | |
| 25. New Business | |

4:00 p.m. Adjournment

Coffee and rolls will be served on Friday morning in the Pennsylvania Suite

Lunch will be served at 12:30 p.m. on Friday in the New York Suite

COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
1346 Connecticut Avenue, N.W.
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202/223-5364

MINUTES

EXECUTIVE COMMITTEE MEETING (#68-3)
Hotel Dupont Plaza
1500 New Hampshire Avenue, N.W.
Washington, D.C. 20006
Thursday & Friday, May 9 & 10, 1968

Present:

Lad F. Grapski, Chairman
LeRoy S. Rambeck, Chairman-Elect
Stanley A. Ferguson, Immediate Past Chairman
Leonard W. Cronkhite, Jr., M.D., Member
Charles R. Goulet, Member
LeRoy E. Bates, M.D., Member **
Charles H. Frenzel, Member
T. Stewart Hamilton, M.D., Member (COTH Member, AAMC Executive Council)
Dan J. Macer, Member
Lester E. Richwagen, Member
Richard D. Wittrup, Member
Harold H. Hixson, Member, Ex Officio Member (COTH Member, AAMC Executive Council)
Joseph H. McNinch, M.D., AHA Representative
Robert Q. Marston, M.D. *
Michael H. Anderson, Director, Public Relations, AAMC **
Thomas J. Campbell, Assistant Director, Division of Operational Studies, AAMC **
William G. Reidy, Editor, The Bulletin, AAMC **
Matthew F. McNulty, Jr., Director, COTH
Grace W. Beirne, Staff Assistant, COTH
Fletcher H. Bingham, Ph.D., Assistant Director, COTH
Elizabeth A. Burgoyne, Secretary to Director, COTH

Absent:

Ernest N. Boettcher, M.D., Member
Russell A. Nelson, M.D., Ex Officio Member (COTH Member, AAMC Executive Council)

I. Call to Order:

The meeting was called to order at 8:15 p.m. by Chairman Grapski. Attendance was taken as noted above.

* Attended Thursday evening only

** Attended Friday only

II. Presentation:

Robert Q. Marston, M.D., Administrator, Health Services and Mental Health Administration and Director, Division of Regional Medical Programs, NIH, presented comments on the reorganization of HEW and the possible contributions of teaching hospitals to HEW's activities. His presentation was followed by a question and discussion session.

III. Recess:

Following Doctor Marston's presentation, Mr. Grapski thanked him on the Committee's behalf. After having moved the Friday morning meeting to 9:00 a.m., the meeting was adjourned at 9:45 p.m.

IV. Reconvene -- Roll Call of the Committee:

The meeting reconvened at 9:15 a.m., and roll call was taken as previously noted.

V. Approval of Minutes -- Executive Committee Meeting #68-2, January 11-12, 1968:

ACTION #1

ON MOTION, SECONDED AND CARRIED, THE EXECUTIVE COMMITTEE APPROVED THE MINUTES OF THE JANUARY 11 & 12, 1968, MEETING AS PRESENTED

VI. Report on Action Items from Executive Committee Meeting of January 11-12, 1968:

A. Action #3:

Mr. McNulty reported that he had discussed the question of admitting osteopathic hospitals with Robert C. Berson, M.D., Executive Director, AAMC, and that Dr. Berson has arranged to meet with Mr. Lawrence Mills of the American Osteopathic Association to discuss the matter. Mr. McNulty indicated that the question is still pending since the AAMC has not yet taken a definite stand and any positive action would necessitate revision of the Rules and Regulations.

B. Action #4:

Mr. McNulty reported that concern over the Federal "fund freeze" has been expressed at the Federal level, most effectively through the AAMC testimony

to the House Appropriations Subcommittee for Departments Labor-HEW. He noted that the AAMC Committee on Federal Health Programs continues to emphasize this concern.

C. Action #5:

Dr. Bingham reported that Mr. Karol has formed a committee to study the implementation of the guidelines established in the "Guide for Hospitals", on which COTH is very well represented. This Committee met once, and a subcommittee was formed to develop an implementation report. Depreciation, interest, bad debts, and gain or loss on sale of equipment have not been discussed. However, it was recommended that the guidelines be retroactive to June 30, 1967. Mr. Goulet noted that with the current budget situation there are no more Federal funds available, and that the guidelines are not being implemented and not being followed by any governmental agency. He added that the reorganization of HEW has impeded the Committee's activities.

D. Action #6:

Mr. McNulty reported that liaison with the AHA continues good as represented by the active participation of Robert C. Linde on the Committee on Financial Principles for Teaching Hospitals and the meeting of AHA-COTH Presidential Officers, as well as other communication channels.

Mr. Rambeck reported that the meeting of Edwin L. Crosby, M.D.; David B. Wilson, M.D.; Lad F. Grapski; Matthew F. McNulty, Jr.; and himself went very well, with Dr. Crosby being interested in the relationship as having much potential with hard work from both sides. Mr. Grapski noted that it was the most successful meeting in three years; and since the Presidential Officers seemed interested in continuing to meet, the COTH-AHA Liaison Committee would become temporarily inactive.

E. Action #7:

Mr. McNulty briefly called attention to the item, noting that the Nominating Committee will meet during the Annual Meeting to present its recommendations to the AAMC Executive Council.

F. Action #8:

Mr. McNulty called the Committee's attention to the signed contract with the Department HEW for the feasibility study of a teaching hospital information center. He indicated that Thomas McCarthy, Ph.D., would be Project Officer and that COTH has narrowed its recruitment efforts for Project Director down to three people. He commented that the PHS had made the initial contact with regard to the study. Mr. Rambeck noted that the contract was quite significant in light of Dr. Paul Sanazaro's new position. With regard to the proposed HEW-COTH study of the effects of Titles 18 and 19 and other social legislation on teaching hospital patient population, Mr. McNulty reported that the contract is still being negotiated since HEW has appended several other tasks to the original concept. The prognosis, however, is good and several capable people have been interviewed to man the study. Much of the decision rests with Dr. Shannon, Director of NIH, who wants to use the study results to determine if NIH should continue traineeships and fellowships. Many members strongly emphasized the need to avoid making value judgments on behalf of HEW and to avoid any possible conflict of interest between pure research and any government objective. Mr. Grapski requested that these minutes reflect Mr. Richwagens' comment that the contract efforts represented a great deal of work on the part of the COTH staff and others.

ACTION #2

CHAIRMAN GRAPSKI EXPRESSED AGAIN THE COMMITTEE'S UNANIMOUS ENDORSEMENT OF THE CONTRACT NEGOTIATIONS BETWEEN COTH AND HEW AND ITS CONGRATULATIONS TO THE STAFF ON ITS EFFORTS.

G. Action #10:

Mr. McNulty reported that staff presented the proposed AAMC reorganization chart in lieu of a draft of proposed revisions of the Rules and Regulations because any change would depend upon the fate of the reorganization plans.

Mr. Hixson reported that at the AAMC Executive Council Meeting of March 28-29, the main concern was the participation of the CAS and the solving of any hurt feelings among the CAS members. He and Mr. McNulty noted that the question of who will have power is causing some concern. They both reviewed the proposed structure as outlined in the chart, which is attached as a permanent part of these minutes.

Discussion then arose concerning the discrepancy between CAS and COTH representation on the proposed new Executive Council. Present plans provide for the Chairman of CAS plus three and the Chairman of COTH plus two sitting on the Council. General discussion was to the effect that some statement of concern be made to the Executive Council about increasing the COTH representation to four persons for reasons of full representation and attendance. After careful consideration concerning proper wording, the following motion was made and acted upon:

ACTION #3

MR. RICHWAGEN MOVED THAT THE EXECUTIVE COMMITTEE GO ON RECORD IN SUPPORT OF AAMC REORGANIZATION AS OUTLINED IN THE CHART REVISED AS OF MARCH 29, 1968; AND THAT THE COTH MEMBERS ON THE PRESENT EXECUTIVE COUNCIL REQUEST CONSIDERATION OF AN INCREASE FROM 3 TO 4 COTH REPRESENTATIVES ON THE PROPOSED COUNCIL; AND THAT SUCH REPRESENTATION BE MADE BY COTH MEMBERS AT THE MAY 21 EXECUTIVE COUNCIL MEETING AND PRESSED WITHIN THE LIMITS OF THEIR JUDGMENT AS THE PROCESS DEVELOPS THAT EVENING. THE MOTION WAS SECONDED BY MR. MACER AND CARRIED UNANIMOUSLY.

Dr. Hamilton inquired why AHA was not included in the Federation for Health Education section of the chart. Mr. McNulty said that the invitation list was evolved outside the AAMC, but that AUPHA had been asked and had agreed by a vote of the membership to participate, yet was also not on the list. He requested Dr. McNinch to pursue the question within AHA.

H. Action #11:

Mr. McNulty, in carrying out his charge to summarize current and anticipated program activity and attached budget needs, presented a chart of COTH present and hoped for activity with an explanation of what exists and what would exist. That chart is presented as a permanent part of the minutes in lieu of Mr. McNulty's verbal explanation since it will present a more lucid description of that summary. He noted that currently COTH is working at 30-40 percent of possible program activity.

Some of his main points were:

1. the need of formal legal advice -- \$10,000
2. international teaching hospital activity, an area in which the staff could be creative, perhaps getting AID funds for program support
3. consultation demands -- need for an individual to respond to the increasing demands of "won't you come?"
4. possibility of an executive development fellowship program to evolve a talent pool in the field, perhaps using the ACE program as a model
5. a two-person Division of Membership Services; Division of Education, Research and Development; with subdivisions for handling meetings and resources information center with data accumulation capabilities all desirable activities within COTH's identity.

Mr. Ferguson stressed the need for great thoughtfulness in obtaining soft money and how to build in objectivity, especially since dependency on such funds will increase as COTH grows. Several members noted that the development of general information on which decisions are made is not necessarily a conflict of interest as long as membership services are kept distinct from research activities.

Mr. Rambeck urged the need for timing in that the Council has developed alot of momentum that should not stop, but that the momentum not conflict with AHA. There was subsequent general discussion of the problems associated with soft-money financing in the sense noted above.

Dr. Bates questioned that stress on such overall national activities might lead to overlooking the improvement of the end product. General agreement, however, was that improvement of the delivery of health care was an implicit goal in all COTH activities. Mr. Rambeck noted the importance of being certain that the Executive Committee and staff are not getting too far ahead of the membership's interests and desires. Mr. Wittrup said he did not know what more could be done to keep members informed. It was agreed that the mass of information is appreciated, but that there are several segments in a hospital that never see it.

Mr. McNulty observed that in fulfilling the charge, he did not want to be seen as pushing for an increase. He noted that financial increase could come from enlarged membership, such as more municipal or Veterans Administration hospitals.

Mr. Macer noted that he was not speaking for the Veterans Administration, but as a point of clarification pointed out the delegation of authority to the VA Hospital Director to determine membership in the Association. He pointed out, however, that when General Accounting notes an item as large as \$30-35 thousand being paid to a national association such as the AHA or AAMC (COTH) that it naturally caused questions that the Administrator of Veterans Affairs must seek to answer. He is sure that it is in this light that questions of the Administrator and discussion have taken place.

ACTION #4

ON MOTION (WITTRUP), SECONDED (BATES) AND CARRIED, THE EXECUTIVE COMMITTEE APPROVED THE CREATION OF A COMMITTEE TO REVIEW COTH PROGRAMS, CURRENT AND PROJECTED, AND ACCOMPANYING BUDGET IN ORDER TO EVOLVE A RECOMMENDATION FOR ACTION. CHAIRMAN GRAPSKI APPOINTED DR. CRONKHITE CHAIRMAN OF THIS COMMITTEE.

VII. Status Report on Membership:

Mr. McNulty called the Committee's attention to the information evidence in the

agenda, noting particularly the fact that 73 percent of total filled internships in the United States are in COTH member hospitals.

VIII. New Members Elected by Mail Ballot:

Scott and White Memorial Hospital, Temple, Texas; Nussa Municipal Hospital, San Juan, Puerto Rico; Grasslands Hospital, Valhalla, New York; Wilford Hall USAF Base Hospital, Lackland AFB, San Antonio, Texas; Veterans Administration Hospital, Providence, Rhode Island; University of Arizona Hospital, Tucson, Arizona, are those hospitals which have been elected to membership by mail ballot since the January Executive Committee Meeting.

ACTION #5

CHAIRMAN GRAPSKI REQUESTED THAT THE MINUTES REFLECT THAT THE MAIL BALLOT RESULT WAS REPORTED TO AND APPROVED BY THE EXECUTIVE COMMITTEE.

IX. New Application for Membership:

Mr. McNulty voiced the staff recommendation for approval of the Schwab Rehabilitation Hospital.

ACTION #6

MR. WITTRUP MOVED FOR APPROVAL OF THE APPLICATION FOR MEMBERSHIP OF THE SCHWAB REHABILITATION HOSPITAL, CHICAGO, ILLINOIS. MR. RAMBECK SECONDED THE MOTION, WHICH WAS APPROVED UNANIMOUSLY.

X. Other Membership Possibilities:

Mr. McNulty called attention to the lists of potentially eligible hospitals under present rules and regulations and under relaxed rules and regulations. Discussion was concentrated on those hospitals meeting present standards of membership eligibility. Mr. Grapski said that action was necessary since prior Committee action had authorized no follow-up to those who had declined a previous invitation to membership. It was brought up by several members that, pending any action on increasing dues, it would be precipitous to issue an invitation now and then raise the dues. Dr. Hamilton noted that many on the list would benefit from membership.

MOTION #7

MR. FERGUSON MOVED THAT THE COTH STAFF ISSUE MEMBERSHIP INVITATIONS TO THOSE HOSPITALS ON THE LIST HAVING THREE (3) OF THE FIVE (5) REQUIRED RESIDENCIES AND INTERNSHIP PROGRAMS AFTER THE 1968 AAMC ANNUAL MEETING. THE MOTION WAS SECONDED AND CARRIED UNANIMOUSLY.

XI. Inquiry into Possibility for Membership -- Postgraduate Medical Institute:

Mr. McNulty said this item was more pertinent to the revision of the rules and regulations since it exists as another type or category of membership.

XII. Luncheon:

At 12:30 p.m. a break was taken for an informal luncheon, after which the Executive Committee went into Executive Session.

XIII. Summary of Discussion of Executive Session:

It was noted that the Executive Committee was: (1) most pleased with the excellent performance of the duties and responsibilities of the Executive Director of the COTH, namely, Matthew F. McNulty, Jr. -- as well as his staff; (2) would encourage Matthew F. McNulty, Jr., to continue with the AAMC in his present capacity to permit the COTH to continue to grow rapidly and intelligently under his leadership, as well as to implement new programs of the COTH (to be financed by the membership); and (3) requested the Chairman, Mr. Grapski, to inform Drs. Berson and Parks of this statement.

(Submitted and Signed)
Lad F. Grapski, Chairman

XIV. Progress Report on Contracts:

Chairman Grapski noted that this subject had been covered in prior discussion.

XV. Report of Committees:

A. Committee on Modernization and Construction Funds for Teaching Hospitals:

Mr. Frenzel reported that this committee's two major concerns currently are the White Paper on modernization needs and the informal contact with members of the National Advisory Commission on Health Facilities. He also noted

that a follow-up questionnaire on expansion needs had been prepared and is being pre-tested by Committee members at their institutions. Mr. McNulty added that since the January meeting, Dr. Appel has been more effectively contacted and that Dr. Kissick has recently visited the COTH offices to discuss several areas of mutual interest. He said the White Paper has been reviewed by several people and he hoped for Committee approval.

Mr. McNulty also noted the Modernization Committee's concern that the AHA definition of a teaching hospital would create difficulties. In response to Mr. Goulet's question as to what had been done about the word change suggested at the last Executive Committee meeting, Mr. McNulty said that at the meeting of the COTH-AHA Presidential Officers, the feeling of Drs. Wilson and Crosby was that it would be better to wait and see some "for instances" of problems. Although specific changes in wording were not brought up, the AHA officers said it is a statement of policy.

In general discussion, Mr. Goulet noted that many hospitals in Chicago do not agree with the study of the Chicago Metropolitan Hospital Council cited in the White Paper. Mr. Ferguson suggested expansion of the title of the Paper to "...Expectations for Service and Excellence..." Dr. Hamilton further suggested that "patient care" be included in the title. The subjects of borrowing to pay for cost of servicing debts and the AHA's urging of the loan route versus the grant route were discussed briefly.

B. Committee on Financial Principles for Teaching Hospitals:

Mr. Goulet called the Committee's attention to the minutes of the meeting of January 25, 1968, particularly the discussion of overhead for training grants and actions on page 4 and the draft statement of financial principles prepared by the Subcommittee. He suggested that any comments on or suggestions for the draft be sent to himself or Mr. McNulty prior to the June 6 meeting of the Committee on Financial Principles and defer Executive

Committee action until the draft has been approved by the Committee on Financial Principles.

Mr. McNulty recommended Dr. Sweeney's (Francis J. Sweeney, Jr., M.D., Hospital Director, Jefferson Medical College Hospital, Philadelphia, Pennsylvania) addition as mutually beneficial since the Committee is comprised of the medical centers in the AAMC-HEW study and Jefferson Medical College is the only study participant whose hospital is not represented on the Committee on Financial Principles.

ACTION #8

MR. GRAPSKI AUTHORIZED THE INVITATION OF FRANCIS J. SWEENEY, JR., M.D., OF THE JEFFERSON MEDICAL COLLEGE HOSPITAL TO JOIN THE COTH COMMITTEE ON FINANCIAL PRINCIPLES FOR TEACHING HOSPITALS.

ACTION #9

MR. GRAPSKI AUTHORIZED REVISION OF THE MINUTES OF THE FINANCIAL PRINCIPLES COMMITTEE MEETING OF 1/25/68 TO INCLUDE ARTHUR J. KLIPPEN, M.D., IN THE LIST OF THOSE PRESENT.

Mr. Goulet called the Committee's attention to a letter from Nathaniel H. Karol to Thomas J. Campbell clearing up the purposes of the 7-medical center cost allocation study. Mr. Campbell reported that 5 of the 7 should have data in by the end of May. Collection of data at Michigan and NYU involves the size problem. A report is scheduled for the study sponsors by October, after having gone through the Steering Committee. In response to questioning, Mr. Campbell noted that the report will present 7 different techniques for cost allocation and not one system upon which HEW would evolve a system for pro-rating costs. Mr. Campbell observed that a clear statement of purpose can be found in paragraph 2 of the Karol letter and that if there is a better way to show the Federal government the medical center costs, the government would be willing to change. In summary, Mr. Goulet said that the study can best be defined as an attempt

to change cost accounting approach from one of dealing with specific grants and objects to one of programmatic cost finding.

Mr. McNulty called attention to the HEW Release on Regional Conferences on Health Care Costs as an informational item. These conferences are invitational and Mr. McNulty urged all who could to attend since they could be forums for productive discussions. Members backed up the need for sincere participation by COTH members.

C. AAMC-COTH Committee on Federal Health Programs, and Federal Health Legislation:

Mr. McNulty commented that earlier discussion had covered this topic, but reiterated the excellent rapport that now exists which will be helpful in the long run when funds become more readily available. Miss Beirne noted that the Kennedy legislation will probably go nowhere at the moment. Mr. McNulty commented parenthetically that the NAS Board on Medicine could develop into a National Academy of Medicine and that he has informally suggested a National Academy of Health Services Administration as a policy forum of sorts. Senator Kennedy's recommendation is compatible with this concept.

D. COTH-AHA Presidential Officers Meeting:

This subject was covered in earlier discussion.

XVI. AHA Statement on Financial Requirements of Health Care Institutions and Services:

Dr. McNinch reported having heard minimal objections to the statement which eliminates depreciation. He noted that one advantage over Medicare is that it speaks in terms of current prices as opposed to historical depreciation.

Mr. Goulet and Mr. Wittrup said the AHA statement is consistent with the COTH position in terms of the concept that every program should generate its portion of operating and capital needs.

XVII. Correspondence from Committee of Interns and Residents of the New York Municipal Hospitals of the City of New York:

Dr. Hamilton reported that a committee had been formed at the AAMC Executive Council meeting of March 28 and 29 consisting of John Deitrick, M.D., Eben Alexander, M.D. and T. Stewart Hamilton, M.D., and had met on Friday, May 3, in New York City. The discussion at that meeting was to the effect that house staff are M.D.'s and while education is offered, service must take priority; that Medicare, third-party payment plans, etc. are leading to the increased demands of interns; that house staff should probably be considered hospital employees during preliminary discussion; that the tremendous gap between senior residents' pay and junior faculty members' pay should be avoided and salaries scaled down; that there should be a study in depth of the current system of graduate medical; and that while it is difficult to separate education from service, it seems that most of the house staff considers it is doing a service. Mr. McNulty commented that action is necessary, but with the number of diverse viewpoints any recommendation might be challenged.

XVIII. Annual Meeting -- 1968:

Mr. McNulty stressed the fact that this year's COTH program content would be Friday and Saturday afternoons as opposed to Saturday and Sunday and called for suggestions from members. Among the suggestions were institutionalizing medical practice; the degree of social, community responsibility the university and the hospital can be expected to engage in; the changing of "merger" to "consolidate" in the suggested program since it's a more appropriate description of the process; how to take a hospital's ability and translate it into the community for care of the poor with practicable options; what should health-care leaders be doing about cost and hospital effectiveness; and the potentially detrimental

fragmentation of educational programs. Chairman Grapski urged all members to write to Mr. McNulty with their suggestions for topics and speakers and reminded them that they need to be in Houston by noon on Thursday, October 31, 1968.

XIX. Position Statement by Association of Hospital Directors of Medical Education:

Mr. McNulty noted that this group still seems to be in a kind of limbo concerning how to develop an identity. General discussion was to the effect that their interest in the AAMC is appreciated but that their most effective participation would be having their hospitals join COTH.

XX. Resignation of Lee Powers, M.D., and Successor:

Informational copy. Dr. Powers has resigned and the search for his successor has been narrowed down to two very competent candidates.

XXI. Commemorative Resolution -- A.J. "Gus" Carroll:

ACTION #10 CHAIRMAN GRAPSKI APPROVED THE RESOLUTION AS PRESENTED AND INSTRUCTED THE SECRETARY OF COTH TO ENDORSE THE RESOLUTION AND FORWARD IT TO MRS. CARROLL.

XXII. COTH Regional Meetings:

Mr. McNulty called attention to the agendas exhibited and noted the enthusiasm of attendees at the four regional meetings. In pointing out the action at the Southern Regional Meeting, requesting a study of house staff role and stipends, he commented that this falls in the domain of the AAMC Ad Hoc Committee on which Dr. Hamilton sits.

XXIII. COTH Permanent Membership Certificate:

Mr. McNulty said two possible certificates had been circulated to Executive Committee members and the one exhibited represented the majority approval. This certificate will be distributed upon payment of the July 1, 1968, dues invoice.

XXIV. Information Items:

- A. Report on Progress of Completion of COTH History - Mr. McNulty reported that the "history" is now being worked on by a professional writer.
- B. COTH Hospitals Participating in PAS and MAP - Mr. McNulty reported that less than 50% of COTH hospitals were participating in PAS according to data collected as of January 1, 1968.
- C. Council on Academic Societies Workshop on Graduate Education - This workshop will be held in either fall of 1968 or spring of 1969. Mr. McNulty reported that the COTH staff will continue to offer assistance in planning and development. Mr. Ferguson commented that it will be an effective launching pad for CAS.

XXV. Future Meetings of the Executive Committee:

Mr. Rambeck, Acting Chairman, authorized the COTH staff to have the schedule of meetings sent out to members for response.

XXVI. Other Business:

There was no other business.

XXVII. Adjournment:

The meeting was adjourned at 3:40 p.m. by Acting Chairman Rambeck.

Attachments: Attachment #1-AAMC Reorganization Chart
#2-Proposed Chart of Program Activities for COTH

1.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Annual Assembly of Members

All Deans -	currently 100
C.A.S. - up to 35 -	currently 29
10% of COTH-up to 35 -	currently 34
	163

FEDERATION FOR HEALTH EDUCATION

AMA Council on Medical Education
 Assoc. of Dental Schools
 Assoc. of Schools of Allied Health Professions
 Assoc. of Schools of Public Health
 Assoc. of Schools of Pharmacy
 Assoc. of Amer. Vet. Med. Colleges
 Appropriate Nursing Associations
 AAMC

Nominating Committee

Chairman
 Chairman-elect

Vice Presidents

2.

EXECUTIVE COUNCIL

Chairman	
Chairman-elect	
Chairman Council of Deans	+ 8
Chairman C.A.S.	+ 3
Chairman C.O.T.H.	+ 2
President	
	19

Lifetime President
 as Senior Executive Officer

4.

Executive Committee

Chairman
 Chairman-elect
 President
 3 others elected by Exec. Council
 6

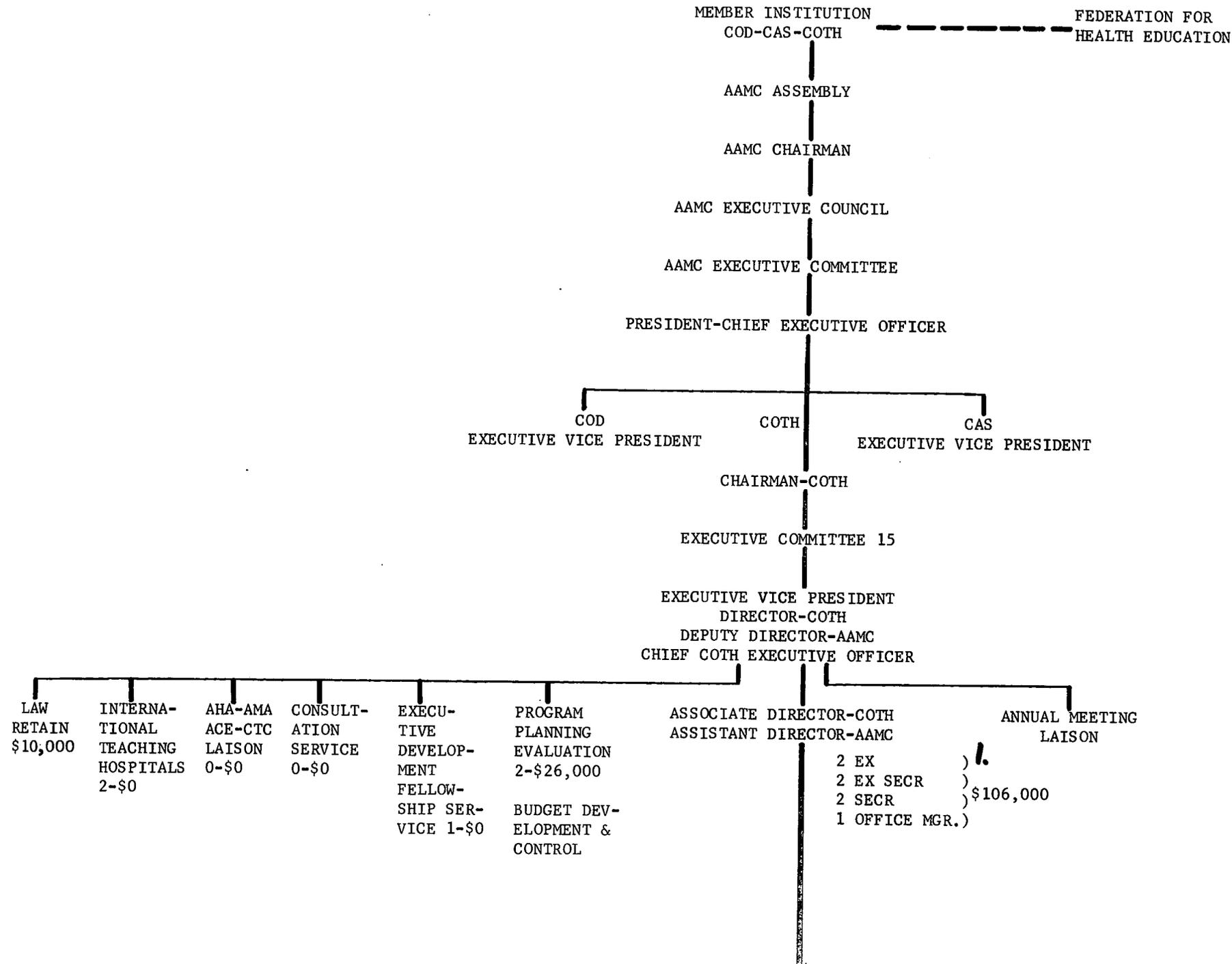
6.

COUNCIL OF DEANS

COUNCIL OF ACADEMIC SOCIETIES

7.

COUNCIL OF TEACHING HOSPITALS



COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
1346 Connecticut Avenue, N.W.
Washington, D.C. 20036
202/223-5364

ACTIONS

EXECUTIVE COMMITTEE MEETING (#68-3)
Hotel Dupont Plaza
1500 New Hampshire Avenue, N.W.
COTH-AAMC Offices
Thursday and Friday, May 9 & 10, '68

- ACTION #1 On motion, seconded and carried, the Executive Committee approved the Minutes of the January 11 & 12, 1968, meeting as presented.
- ACTION #2 Chairman Grapski expressed again the Committee's unanimous endorsement of the contract negotiations between COTH and HEW and its congratulations to the staff on its efforts.
- ACTION #3 Mr. Richwagen moved that the Executive Committee go on record in support of the AAMC reorganization as outlined in the chart revised as of March 29, 1968; and that the COTH members on the present Executive Council request consideration of an increase from 3 to 4 COTH representatives on the proposed Council; and that such representation be made by COTH members at the May 21 Executive Council meeting and pressed within the limits of their judgment as the process develops that evening. The motion was seconded by Mr. Macer and carried unanimously. (SEE TAB 2 a).
- ACTION #4 On motion (Wittrup), seconded (Bates) and carried, the Executive Committee approved the creation of a Committee to review COTH programs, current and projected, and accompanying budget in order to evolve a recommendation for action. Chairman Grapski appointed Dr. Cronkhite Chairman of this Committee. (SEE ITEM 7c).
- ACTION #5 Chairman Grapski requested that the minutes reflect that the mail ballot result was reported to the Executive Committee (Scott & White Memorial, Nussa Municipal Hospital, Grasslands Hospital, Wilford Hall USAF Base Hospital, VA Hospital of Providence, University of Arizona Hospital).

ACTION #6 Mr. Wittrup moved for approval of the application for membership of the Schwab Rehabilitation Hospital, Chicago, Illinois. Mr. Rambeck seconded the motion which was approved unanimously.

ACTION #7 Mr. Ferguson moved that the COTH staff issue membership invitations to those hospitals on the list having three of the five required residencies and internship programs after the 1968 AAMC Annual Meeting. The motion was seconded, and carried unanimously. (VERBAL REPORT).

ACTION #8 Mr. Grapski authorized the invitation of Francis J. Sweeney, Jr., M.D. of the Jefferson Medical College Hospital to join the COTH Committee on Financial Principles for Teaching Hospitals. (VERBAL REPORT).

ACTION #9 Mr. Grapski authorized revision of the minutes of the Financial Principles Committee Meeting of 1/25/68 to include Arthur J. Klippen, M.D., in the list of those present. (VERBAL REPORT).

ACTION #10 Chairman Grapski approved the Resolution as presented and instructed the secretary of COTH to endorse the resolution and forward it to Mrs. Carroll. (TAB 2b).

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

MINUTES
EXECUTIVE COUNCIL MEETING
SPECIAL SESSION

May 21, 1968
Shoreham Hotel
Washington, D. C.

Present: Council Members:

John Parks, Presiding
Eben Alexander, Jr.
William G. Anlyan
Robert M. Bucher
Kenneth R. Crispell
Merlin K. DuVal, Jr.
Robert J. Glaser
T. Stewart Hamilton

Harold H. Hixson
Robert B. Howard
William N. Hubbard, Jr.
Thomas D. Kinney
Russell A. Nelson
Jonathan E. Rhoads
Daniel C. Tosteson
Richard H. Young

Staff:

Robert C. Berson
Thomas J. Campbell
John L. Craner
Matthew F. McNulty, Jr.

Cheves McC. Smythe
Walter G. Rice
Elizabeth A. Burgoyne
Shirley D. Goodwin

The meeting was called to order at 8:30 p.m. on Tuesday, May 21, 1968.

I. Consideration of Minutes of Executive Council Meeting, March 28-29, 1968

ACTION: On motion, seconded and carried, the Executive Council approved the minutes of its meeting of March 28-29, 1968.

II. Recommendation that the AAMC Staff be Moved to Washington

The memorandum and recommendation on this topic which accompanied the agenda led to extended discussion. It was recalled that such a move had been recommended in 1963 by Dr. Deitrick in his Presidential Address, by the Coggeshall Report in 1965, and by the Western Deans in March of 1968.

Advantages of such a move which were discussed included: easy access to Congress, federal agencies important to medical education, and organizations in higher education which are located in Washington; greater efficiency since the AAMC is not likely to have a large enough budget and staff to easily support two offices in different cities; and the use of joint services the American Council on Education will offer its constituent associations when its new building is occupied, such as a specialized library, meeting rooms and a large computer.

Disadvantages which were discussed included: the fact that the AAMC cannot expect to receive a large amount for the building in Evanston since it is located on property owned by Northwestern University and the grant for its construction from the China Medical Board was made to the University; the fact that the American Council on Education's building will not be completed until 1971 and it is not yet certain how much space the AAMC can lease in that building; the fact that a good many members of the staff in Evanston may not be willing to move; and the cost of moving staff and equipment.

Other possibilities which were discussed to a limited extent included: suburban locations such as with the Federation of Societies of Experimental Biology in Bethesda; the AAMC's constructing its own building in Washington and leasing some of the space to other organizations until it is needed by the AAMC; and leasing space in some other building in Washington in which an adequate amount of space can be obtained at a time suitable for the AAMC.

The Council was reminded that the practical aspects of such a move were examined in detail by a task force in 1966. There was agreement that negotiations and discussions with Northwestern University, members of the staff, and the American Council on Education should be begun promptly and handled with tact and consideration. There was agreement also that the practical aspects should be brought up to date as quickly as feasible with appropriate professional real estate advice and legal counsel and presented for the consideration of the Executive Council prior to presenting the matter to the Institutional Members.

ACTION: On motion, seconded and carried, the Executive Council (with one dissenting vote) authorized the consolidation of AAMC offices in Washington, D.C., and requested that at the June 13 meeting staff have prepared a factual analysis of the advantages and disadvantages of locating in the ACE building as opposed to other specific alternatives.

III. Registration Fee for Annual Meeting

The memorandum and recommendation on this topic was considered and discussed. It was recalled that the Council had previously decided that no registration fee should be charged for the 1968 Annual Meeting, if this could be done without reducing the general funds of the Association. It was pointed out that the prospects now are that so few exhibits will be available for the 1968 Annual Meeting that the Association will receive very little income from this source. Several members of the Council expressed the opinion that charging a registration fee would be criticized by a good many people but it is probably a practical necessity.

ACTION: On motion, seconded and carried (one dissent), the Executive Council approved the adoption of a \$15.00 Annual Meeting registration fee for all attendees, excepting award recipients and individuals invited to address the plenary session.

IV. Agenda and Plans for Institutional Meeting

Dr. Parks called attention to the proposed agenda and affirmed that positive action on the recommendations of the Ways and Means Committee would be sought.

Dr. Anlyan noted that the membership had received the necessary 30-days notice of a bylaws change. Dr. Bayson reported that one legal problem exists that makes it impossible for reorganization to become effective immediately upon approval. The Articles of Incorporation in the State of Illinois, which supercede the bylaws, in Article 7, vest voting rights in Institutional Members. The statutes of the State of Illinois require that specific wording to change the Articles of Incorporation must be circulated in writing 30 days in advance of the formal meeting at which they are to be voted on and that the specific wording circulated cannot be amended but can be adopted or rejected. The proposed wording of the bylaws revision was distributed, but members felt it would not be wise to distribute that wording at the Institutional Meeting. It was agreed that the Order of Business should be changed so that a motion for acceptance and endorsement of the Ways and Means Committee's recommendations could be on the floor prior to regional meeting reports. In that way, reports of regional meetings could be incorporated into discussion of the motion.

There was discussion of the two points of disagreement which came up in regional meetings. One is the Midwest-Great Plains region wants AAMC to establish a Council of Faculties, since some people in the region feel very strongly that CAS is not representative of faculties. The people feeling this way had agreed to postpone pressing this point until a more appropriate time. Secondly, some Western regional members wanted the Assembly to consist of all deans, with members from CAS and COTH being limited to 25 representatives each, and to have only deans eligible as Assembly Chairman.

There followed brief discussion of other items on the agenda. Prior to closing the discussion, it was agreed that the Executive Council should vigorously back up its unanimous approval of the recommendations of the Ways and Means Committee as opposed to belaboring points of semantics at this time.

V. Appointment of Dr. Walter G. Rice to Replace Dr. Lee Powers

Dr. Parks noted the resignation of Dr. Powers and welcomed Dr. Walter G. Rice, his successor, to the AAMC staff on behalf of the Executive Council.

VI. Proposed Institute on Family Planning in Medical Education

Dr. Parks called attention to the memorandum concerning the international Institute on Family Planning in Medical Education. It was noted that George Washington University would act as host institution for the event, and that AID would probably provide the financial support and that the AAMC would not be financially responsible in any way.

ACTION: On motion, seconded and carried, the Executive Council endorsed AAMC support of the Institute on Family Planning in Medical Education, to be held in Washington, D.C., on March 23-26, 1969.

VII. Other Business

- A) Dr. Hubbard reported on his curriculum study group on which he would report fully at the Institutional Membership meeting.
- B) After brief discussion, it was agreed that the Agenda for the June meeting of the Council should include the Selective Service status of students who take more than four years to obtain an M.D. degree.

VIII. Adjournment

The meeting was adjourned at 10:45 p.m.

May 22, 1968

Mrs. Augustus J. Carroll
1516 Hinman -- Apt. 201
Evanston, Illinois 60201

Dear Mrs. Carroll:

The attached Commemorative Resolution was unanimously endorsed by the Executive Committee of the Council of Teaching Hospitals at its meeting of May 10, 1968.

The resolution represents the esteem in which we held Gus and the sorrow of the staff and membership. It also brings our additional expression of sympathy on your deep loss.

Warmest personal regards,

Cordially,

MATTHEW F. McNULTY, JR.
Director, COTH
Associate Director, AAMC

MM:eb

Attachment

COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

COMMEMORATIVE RESOLUTION

A. J. "GUS" CARROLL

- WHEREAS: A. J. "Gus" Carroll has been an outstanding member of the staff of the Association of American Medical Colleges; and,
- WHEREAS: He has made notable contributions to the field of fiscal management for both medical schools and teaching hospitals, including a number of important studies for the AAMC; and,
- WHEREAS: His interest in the financing of medical education was exhibited through his many efforts to improve the financial structure of these institutions engaged in medical education; and,
- WHEREAS: He was a distinguished colleague and a warm friend who was greatly esteemed by all of his associates from the Council of Teaching Hospitals; therefore,
- BE IT RESOLVED: That the Executive Committee of the Council of Teaching Hospitals, Association of American Medical Colleges, on behalf of all of its teaching hospital member administrators, note with deepest regret the death of A. J. "Gus" Carroll and wish to commemorate his work as a memorial to his life, while also expressing to Mrs. A. J. Carroll the deepest of sympathy on her loss. The Executive Committee instructs the staff of the Council of Teaching Hospitals to formally express to Mrs. Carroll, through this resolution, the profound sympathy from the membership of the Council of Teaching Hospitals.

May 10, 1968

COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
1346 Connecticut Avenue, N.W.
Washington, D.C. 20036

STATEMENT OF INCOME AND EXPENSE
FOR FISCAL YEARS ENDING JUNE 30, 1966, 67, 68

	1966	1967	1968	Budget Fiscal Year 1969	Projected Expendi- ture for FY 1969 Present Commitment
OPERATING INCOME:.....					
Dues.....	21,303	145,000	164,333.30	170,000	
TOTAL OPERATING INCOME:.....	21,303	145,000	164,333.30	170,000	
OPERATING EXPENSES:.....					
Salaries.....			78,394.41	75,000	
Payroll Taxes.....			2,381.16	2,800	
Pension Costs.....			4,599.96	4,000	
Employee Insurance.....			154.98	200	
Temporary Help.....			2,564.94	2,500	
Travel-Meeting & Meal Expense.....			5,595.23	5,200	
Travel-Lodging.....			3,082.66	3,000	
Travel-Transportation.....			16,271.40	12,000	
Employee Recruitment.....			686.56	1,200	
Honorariums.....			250.00	500	
Contracted Services.....			2,721.13	3,700	
Insurance.....			153.63	100	
Equipment.....			4,248.06	2,400	
Repairs and Maintenance.....			307.26	600	
Rental Equipment & Space.....			3,595.50	3,000	
Dues, Subscriptions & Publications.....			973.17	1,200	
Express & Freight.....			116.83	100	
Postage.....			3,906.58	3,600	
Telephone & Telegraph.....			6,265.00	4,800	
Supplies-General.....			2,377.73	2,400	
Miscellaneous.....			233.57	200	
Graphic Arts O/S.....			513.40	0	
Data Processing O/S.....			204.33	500	
Printing O/S.....			7,647.56	6,000	
Printing Allocated.....			1,507.38	0	
Xerox Charges.....			967.96	0	
Tabulating Allocated.....			1,001.29	0	
Publications Allocated.....			6,909.42	0	
SUB-TOTAL OPERATING EXPENSES:.....	5,279	93,151	157,636.10	135,000	
OVERHEAD EXPENSE TO AAMC:.....	0	0	0	35,000	
TOTAL OPERATING EXPENSE:.....	5,279	93,151	157,636.10	170,000	
EXCESS OF OPERATING INCOME OVER EXPENSES:..	\$ 16,024	\$ 51,849	\$ 6,697.20	0	

Appendix A

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M. C. W.
8.28.68

August 22, 1968

Fred K. Fish
Vice-President Administration
Nassau Hospital
First Street
Mineola, New York 11501

Dear Mr. Fish:

It is my pleasure to inform you that the application of the Nassau Hospital for membership in the Council of Teaching Hospitals was reviewed by mail ballot and endorsed unanimously by the executive Committee of the Council.

Among the many duties of the Council, none is so important as the bilateral communication link it attempts to establish with each member. For this purpose the Council actively engages in conducting and disseminating the results of appropriate studies, organizing educational meetings, and establishing support for activities related to medical education which are planned and executed by its members. The Council, therefore, encourages a reciprocal attitude, vis a vis feedback communication for its members at all times./

The Executive Committee of the Council established membership dues of \$500 per year. For hospitals joining the Council late (April - May - June) in the fiscal year the Executive Committee has authorized confirmation of membership, addition to mailing lists and other benefits, but deferred dues payment to them next fiscal year starting July 1st. We will, therefore, send you an invoice when our regular annual billings go out. Billings are accomplished from the AAMC central billing service at the Evanston, Illinois office. The invoice will be in the amount of \$500 for the fiscal year, July 1, 1968 through June 30, 1969.

You will receive, as of the next mailing date, COTM General and Special Memoranda, the Journal of Medical Education, Datagrams, the AAMC Bulletin, the Advisor, the Dime Dialogues, the COTM Reports, and COTM Profiles. Through these communication media and other periodic publications that may be distributed from time to time, you will be supplied with the developments taking place in medical education and those specifically relating to teaching hospitals.

Fred K. Fish
Page 2
August 20, 1968

The current membership of the Council of Teaching Hospitals includes 333 of the leading teaching hospitals in the United States, Puerto Rico, the Canal Zone and Canada. Your active participation in the work of the Council through regional meetings, annual meetings, other periodic meetings, and correspondence will help both the Council and the Association to further the goals of education and education for all of the health science disciplines.

On behalf of the officers and members of the COTH Executive Committee, and for this office, it is our pleasure to welcome you warmly to membership in COTH.

Cordially,

MATTHEW F. McNULTY, JR.
Director, COTH
Associate Director, AAMC

MEM:hm

cc: William Hollis, M.D.

PLEASE READ INSTRUCTIONS ON REVERSE SIDE

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership
in the
Council of Teaching Hospitals

(Please type)

Hospital: Nassau Hospital

Name

First Street

Street

Mincola, New York 11501

City

State

Zip Code

Principal Administrative Officer: Fred K. Fish

Name

Vice President-Administration

Title

Hospital Statistics:

Date Hospital was Established: 1896

Average Daily Census: 411

Annual Outpatient Clinical Visits: 7,644

Approved Internships:

Type	Date Of Initial Approval by CME of AMA*	Total Internships Offered	Total Internships Filled
Rotating	<u>1936</u>	<u>18</u>	<u>15</u>
Mixed	<u></u>	<u></u>	<u></u>
Straight	<u></u>	<u></u>	<u></u>

Approved Residencies:

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total Residencies Filled
Medicine	<u>1966</u>	<u>9</u>	<u>8</u>
Surgery	<u>1948</u>	<u>8</u>	<u>8</u>
OB-Gyn	<u>1954</u>	<u>3</u>	<u>3</u>
Pediatrics	<u></u>	<u></u>	<u></u>
Psychiatry	<u></u>	<u></u>	<u></u>

Information submitted by:

William C. Hollis, M. D.

Name

Director of Medical Education

Title

July 24, 1968

Date

William C. Hollis

Signature

*Council on Medical Education of the American Medical Association and/or with appropriate A.M.A. Internship and Residency Review Committees.

PLEASE READ INSTRUCTIONS ON REVERSE SIDE

STATE UNIVERSITY OF NEW YORK
AT STONY BROOK

HEALTH SCIENCES CENTER

STONY BROOK, N. Y. 11790

August 19, 1968

Mr. Matthew F. McNulty, Jr., Director
Council of Teaching Hospitals
Association of American Medical Colleges
1346 Connecticut Avenue, N.W.
Washington, D.C. 20036

Dear Matt:

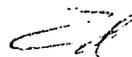
As you know, a University Hospital of 400 to 600 beds is planned as an integral part of the Health Sciences Center at Stony Brook. Pete Rogatz has been appointed Director of the University Hospital and we will be involved for the next several years in its planning and construction.

Pete and I believe that it would be important for the University Hospital to be a member of C.O.T.H. from the outset, even though the institution will not be completed and ready for operation for at least five years.

It is my understanding that you have a category of membership which would encompass hospitals that are in the planning stage and, with this in mind, I am nominating our University Hospital for C.O.T.H. membership. Our application forms are inclosed herewith. Please let me know if you require any additional action on our part.

Kindest regards.

Sincerely,



Edmund D. Pellegrino, M.D.
Dean of School of Medicine
Vice President for the
Health Sciences

EDP:em
cc: Dr. Peter Rogatz

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ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership
in the
Council of Teaching Hospitals

OFFICE OF
MATTHEW E. SHERRY, JR., DIRECTOR
COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
1348 CONGRESS AVENUE, N.W.
WASHINGTON, D.C. 20036
202/223-5364

(Please type)

Hospital: UNIVERSITY HOSPITAL

State University of New York at Stony Brook
Name

Stony Brook, New York
Street

Stony Brook, New York 11790
City State Zip Code

Principal Administrative Officer: Peter Rogatz, M.D.
Name

Director
Title

Hospital Statistics: Date Hospital was Established: Now in early planning -- estimated completion 1974

Average Daily Census: _____

Annual Outpatient Clinical Visits: _____

Approved Internships:

Type	Date Of Initial Approval by CME of AMA*	Total Internships Offered	Total Internships Filled
Rotating	_____	_____	_____
Mixed	_____	_____	_____
Straight	_____	_____	_____

Approved Residencies:

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total Residencies Filled
Medicine	_____	_____	_____
Surgery	_____	_____	_____
OB-Gyn	_____	_____	_____
Pediatrics	_____	_____	_____
Psychiatry	_____	_____	_____

Information submitted by:

Peter Rogatz, M.D.
Name

Director, University Hospital
Title

August 19, 1968
Date

Peter Rogatz
Signature

*Council on Medical Education of the American Medical Association and/or with appropriate A.M.A. Internship and Residency Review Committees.

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Instructions:

Please complete all copies and return three copies to the Council of Teaching Hospitals, Association of American Medical Colleges, 2530 ~~Ridge Avenue, Evanston, Illinois 60201~~, retaining the blue copy for your file.

Membership in the Council:

Hospitals as institutions will be members of the Council and each institution will be represented by a designated person, designated by the hospital, for the purpose of conducting the business of the Council.

Membership in the Council will be annually determined and consist of:

- a. Those hospitals nominated by a medical school member of the AAMC from among the major teaching hospitals affiliated with the school,
and
- b. Teaching hospitals which are either nominated by a medical school member of the AAMC on the basis of important affiliations for the purposes of medical education or which have approved internship programs and full residencies in three of the following five departments: Medicine, Surgery, OB-Gyn, Pediatrics, Psychiatry, and are elected to membership by the members of the Council of Teaching Hospitals.

All members will vote at the annual meeting for officers and members of the Executive Committee. Voting on all other matters will be limited to one representative member for each medical school, who, in order to give broad representation, shall consult with the other teaching hospital members in his geographic region before votes are taken.

If nominated by School of Medicine, complete the following:

Name of School of Medicine College of Medicine, Health Sciences Center

Name of Parent University State University of New York at Stony Brook

Name of Dean of School of Medicine Edmund D. Pellegrino, M.D.

From the Office of: Complete address of School of Medicine College of Medicine

MATTHEW F. MONELY, JR., DIRECTOR

COUNCIL OF TEACHING HOSPITALS

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

1943 CONNELLST AVENUE, N.W.

WASH DC 20036

202-223-2234

Health Sciences Center

State University of New York at Stony Brook

Stony Brook, New York 11790

FOR AAMC OFFICE USE ONLY:

Date _____ Approved _____ Disapproved _____ Pending _____

Remarks: _____

Invoiced _____ Remittance Received _____

THE HARRISBURG POLYCLINIC HOSPITAL

HARRISBURG, PENNSYLVANIA

LAWRENCE H. WARBASSE, JR., M. D.
MEDICAL DIRECTOR

August 15, 1968

Fletcher H. Bingham, Ph.D.
Assistant Director
Council of Teaching Hospitals
1346 Connecticut Avenue N.W.
Washington, D. C. 20036

Dear Dr. Bingham:

We herewith submit our application to the Council of Teaching Hospitals. We have been waiting to hear from the Council on Medical Education, and are delighted to inform you that our application for a Residency in Radiology was approved as of May 2, 1968, although we only recently received this information. We are aware that the Council does not require a Radiology Residency, but we are proud of it nonetheless, since such residencies are hard to establish at the present time.

We are applying for approval on the basis of approved Internships and Residencies in Medicine, Surgery and Pediatrics, since at the present time we are largely an autonomous educational institution. We do have an arrangement to train fourth year medical students from the University of Pennsylvania in Surgery and from the Jefferson Medical College in Pediatrics on an elective basis, and we will probably develop similar programs in other departments during the course of the next year.

At the Polyclinic we believe that it is important that the officials responsible for the education program have authority to match their responsibilities. Thus, rather than a Director of Medical Education, I am a Medical Director, appointed by and answerable to the Board of Directors for both medical education and all medical affairs. Instead of Coordinators of Education Programs in each Department, we have full time Directors, responsible not only for medical education, but for all professional aspects of their Departments. At present we have 21 full time and 114 voluntary physicians on our staff, including full time Chiefs of the Medical Service, the Surgical Service, the Pediatric Service, the Emergency Service, etc. We are the first community hospital in Central Pennsylvania to both initiate and develop such an extensive program of full time chiefs.

RECEIVED
AUG 18 1968
AAMC-WASH, D. C.

August 15, 1968

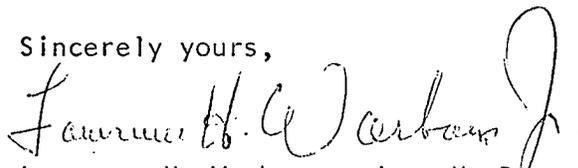
Page 2

Dr. Bingham

Our program has generated considerable interest and has resulted in many visits to our hospital from other hospitals in Pennsylvania and even by one group of physicians from the Miller Hospital in St. Paul, Minnesota. I enclose a recent issue of the Polyclinic Journal which includes an essay of mine summarizing some of our views on Graduate Medical Education in the Community Hospital. Incidentally when our new building is completed, we will have 905 beds and 88 bassinets.

We look forward to exchanging views with other teaching hospitals within the Council of Teaching Hospitals. It was indeed a pleasure to meet you at the Chicago meetings, and I look forward to seeing you in Houston.

Sincerely yours,



Lawrence H. Warbasse, Jr., M. D.

LHW/wc

Enclosures

PLEASE READ INSTRUCTIONS ON REVERSE SIDE

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership
in the
Council of Teaching Hospitals

(Please type)

Hospital: HARRISBURG POLYCLINIC HOSPITAL
Name

THIRD AND RADNOR STREETS
Street

HARRISBURG, PENNSYLVANIA 17105
City State Zip Code

Principal Administrative Officer: J. LINCOLN MACFARLAND
Name

ADMINISTRATOR
Title

Hospital Statistics: Date Hospital was Established: 1909

Average Daily Census: 606

Annual Outpatient Clinical Visits: 32,735

Emergency Department 13,714

Approved Internships:

Type	Date Of Initial Approval by CME of AMA*	Total Internships Offered	Total Internships Filled
Rotating	<u>MAY 24, 1927</u>	<u>24</u>	<u>24**</u>
Mixed	<u></u>	<u></u>	<u></u>
Straight	<u></u>	<u></u>	<u></u>

Approved Residencies:

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total Residencies Filled
Medicine	<u>FEBRUARY 9, 1949</u>	<u>5</u>	<u>3**</u>
Surgery	<u>MARCH 7, 1950</u>	<u>3</u>	<u>3**</u>
OB-Gyn	<u></u>	<u></u>	<u></u>
Pediatrics	<u>JULY 27, 1954</u>	<u>4</u>	<u>3**</u>
Psychiatry	<u></u>	<u></u>	<u></u>
Radiology	<u>MAY 2, 1968</u>	<u>4</u>	<u>1*</u>

Information submitted by:

Lawrence H. Warbasse, Jr., M. D.

Name

August 15, 1968

Date

MEDICAL DIRECTOR

Title

Lawrence H. Warbasse, Jr., M.D.
Signature

*Council on Medical Education of the American Medical Association and/or with appropriate A.M.A. Internship and Residency Review Committees.

** ALL HOUSE OFFICERS ARE AMERICAN GRADUATES.

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ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership
in the
Council of Teaching Hospitals

From the Office of:
MARCELO S. MONTUORI, JR., DIRECTOR
COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
1346 CONNOR STREET AVENUE, N.W.
WASHINGTON, D.C. 20036
202/223-5334

(Please type)

Hospital: Children's Hospital and Adult Medical Center of San Francisco

3700 California Street
San Francisco California 94119
City State Zip Code

Principal Administrative Officer: Rolland E. Wick
Administrator
Name Title

Hospital Statistics: Date Hospital was Established: 1875
Average Daily Census: 263
Annual Outpatient Clinical Visits: 57,519

Approved Internships:

Type	Date Of Initial Approval by CME of AMA*	Total Internships Offered	Total Internships Filled
Rotating	<u>1964</u>	<u>12</u>	<u>12</u>
Mixed	<u>-</u>	<u>-</u>	<u>-</u>
Straight	<u>1962</u>	<u>2</u>	<u>2</u>

Approved Residencies:

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total Residencies Filled
Medicine	<u>1952</u>	<u>8</u>	<u>7</u>
Surgery	<u>July 1, 1968</u>	<u>10</u>	<u>10</u>
OB-Gyn*	<u>July 1, 1968</u>	<u>4</u>	<u>4</u>
Pediatrics	<u>1962</u>	<u>7</u>	<u>5</u>
Psychiatry**	<u>1960</u>	<u>3</u>	<u>3</u>

Information submitted by:

Frank W. Spicer, M.D.

Name

August 16, 1968

Date

Administrator

Title

[Signature]

Signature

*Council on Medical Education of the American Medical Association and/or with appropriate A.M.A. Internship and Residency Review Committees.

RECEIVED

PLEASE READ INSTRUCTIONS ON REVERSE SIDE

AUG 26 1968

* See attached addendum

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Instructions:

Please complete all copies and return three copies to the Council of Teaching Hospitals, Association of American Medical Colleges, ~~2530 Ridge Avenue, Evanston, Illinois 60201~~, retaining the blue copy for your file.

Membership in the Council:

Hospitals as institutions will be members of the Council and each institution will be represented by a designated person, designated by the hospital, for the purpose of conducting the business of the Council.

Membership in the Council will be annually determined and consist of:

- a. Those hospitals nominated by a medical school member of the AAMC from among the major teaching hospitals affiliated with the school,

and

- b. Teaching hospitals which are either nominated by a medical school member of the AAMC on the basis of important affiliations for the purposes of medical education or which have approved internship programs and full residencies in three of the following five departments: Medicine, Surgery, OB-Gyn, Pediatrics, Psychiatry, and are elected to membership by the members of the Council of Teaching Hospitals.

All members will vote at the annual meeting for officers and members of the Executive Committee. Voting on all other matters will be limited to one representative member for each medical school, who, in order to give broad representation, shall consult with the other teaching hospital members in his geographic region before votes are taken.

If nominated by School of Medicine, complete the following:

Name of School of Medicine _____

Name of Parent University _____

Name of Dean of School of Medicine _____

Complete address of School of Medicine _____

From the Office of:

MATTHEW F. LANSLEY, JR., DIRECTOR

COUNCIL OF TEACHING HOSPITALS

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

1001 E. WASHINGTON STREET, CHICAGO, ILL. 60605

60605

FOR AAMC OFFICE USE ONLY:

Date _____ Approved _____ Disapproved _____ Pending _____

Remarks: _____

Invoiced _____ Remittance Received _____

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A D D E N D U M

*Ob/Gyn

Affiliation with the University of California
Program in Obstetrics and Gynecology (San Francisco)
4 years of training.

**Psychiatry

Affiliation with Langley Porter Neuropsychiatric
Institute, University of California, San Francisco
3 years of training.

July 17, 1968

Mr. Matthew F. McNulty, Jr.
Director
Council of Teaching Hospitals
Associate Director
Association of American Medical Colleges
1346 Connecticut Avenue, N.W.
Washington, D.C. 20036

Dear Mr. McNulty:

This letter is written to request reconsideration of our application for membership in the Association of American Medical Colleges.

In your letter of September 26, 1967, to Mr. Rolland Wick, Administrator of this Hospital, you courteously noted that this Hospital did not have independent, approved, full residency training programs in three of the five major disciplines and that this was the reason for rejection of our application.

We do have, now, independent, approved, full residency training programs in Medicine and Pediatrics. As of May 1968, we have an independent, Type 1, four year training program in General Surgery. We also have a new, independent, approved, full, affiliated training program in Obstetrics/Gynecology with the University of California Medical School.

It is possible that because we now have fully independent training programs in three required major areas, we are eligible to make a second application. If this is so, would you be kind enough to send the appropriate forms so that we may proceed.

Sincerely yours,



Frank W. Spicer, M.D.
Director of Medical Education

FWS:jeg

RECEIVED

JUL 24 1968

AAMC-WASH., D. C.

July 27, 1968

Frank W. Spicer, M.D.
Director of Medical Education
Children's Hospital of San Francisco
2700 California Street
San Francisco, California 94119

Dear Doctor Spicer:

Thank you for your letter of July 27th requesting reconsideration of the application for membership in the Council of Teaching Hospitals from the Children's Hospital of San Francisco.

As your institution now meets the criteria for membership in this Council, we are pleased to attach a new membership application form for completion and return to the COTH office. As is standard procedure, the application will then be reviewed by the COTH Executive Committee at its next Committee meeting, which is scheduled for September 5, 1968. You will be informed of their action immediately thereafter.

We look forward to receiving the completed application form from your institution and thank you for your interest in COTH

Cordially,

MATTHEW F. McNULTY, JR.
Director, COTH
Associate Director, AAMC

Mf:eb

Attachment: COTH Membership Application Form

cc: Rolland E. Wick, Administrator
Children's Hospital of San Francisco

HOSPITALS WHICH HAVE WITHDRAWN FROM COTH MEMBERSHIP

ORTHOPAEDIC HOSPITAL AT LOS ANGELES
Lee S. Sanders
Executive Vice President & Administrator
2400 Flower Street, South
Los Angeles, California 90007

DETROIT MEMORIAL HOSPITAL
Franklin D. Carr
Administrator
690 Mullett Street
Detroit, Michigan 48226

METHODIST HOSPITAL
J. M. Crew
Administrator
1265 Union Avenue
Memphis, Tennessee 38104

BAPTIST HOSPITAL
Gene Kidd
Executive Director
2000 Church Street
Nashville, Tennessee 37203

THE VANCOUVER GENERAL HOSPITAL
Ken R. Weaver
Executive Director
12th Avenue, West
Vancouver, 9, B.C., Canada

VICTORIA GENERAL HOSPITAL
C. M. Bethune, M.D.
Administrator
1240 Tower Road
Halifax, N.S., Canada

SAINT JOSEPH'S HOSPITAL
Sister M. Elizabeth
Administrator
Richmond Street, North
London, Ontario, Canada

OTTAWA CIVIC HOSPITAL
Douglas R. Peart
Executive Director
Carling Avenue
Ottawa 3, Ontario, Canada

COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
1346 Connecticut Avenue, N.W.
Washington, D.C. 20036
202/223-5364

STATUS REPORT ON MEMBERSHIP

TOTAL MEMBERSHIP: 339

Nominated by a Dean	223
Qualified by I&R Program	116
Canadian Members	3
Puerto Rican Members	2
Canal Zone Member	1

NUMBER OF VETERANS ADMINISTRATION HOSPITALS IN TOTAL MEMBERSHIP: 51

Western Region	6
Midwest/Great Plains Region	14
Southern Region	18
Northeastern Region	13

NUMBER OF PUBLIC HEALTH SERVICE HOSPITALS IN TOTAL MEMBERSHIP: 4

Western Region	1
Midwest/Great Plains Region	0
Southern Region	2
Northeastern Region	1

MILITARY HOSPITALS: 1 - Wilford Hall U.S. Air Force Hospital, Lackland Air
Force Base, San Antonio, Texas (Southern Region)

DATE: September 4, 1968

STATES WITH NO MEMBER HOSPITALS: 8

Western Region	6 (Alaska, Montana, Nevada, Wyoming, Idaho, New Mexico)
Midwest/Great Plains Region	2 (North Dakota, South Dakota)
Southern Region	0
Northeastern Region	0

DISTRIBUTION OF MEMBER HOSPITALS BY REGION:

Western Region	38 (Includes 2 hospitals in 2 provinces in Canada)
Midwest/Great Plains Region	86
Southern Region	70 (Includes 1 hospital in the Canal Zone)
Northeastern Region	145 (Includes 1 hospital in 1 province in Canada and 2 hospitals in Puerto Rico)

INTERNSHIPS OFFERED IN U.S. HOSPITALS: 13,521

Filled	7,225
COTH Members	5,300
Non-COTH Hospitals	1,925
Internships filled in COTH hospitals as percentage of total filled	73%
Residency positions offered and filled (study yet to be accomplished)	?

COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
1346 Connecticut Avenue, N.W.
Washington, D.C. 20036
202/223-5364

MINUTES

AD HOC COMMITTEE ON PROGRAM DEVELOPMENT

COTH - AAMC Offices
1346 Connecticut Avenue, N.W.
Washington, D.C.
July 29, 1968
10:00 a.m. - 4:00 p.m.

Present:

Members:

Leonard W. Cronkhite , Jr., M.D., Chairman

Invited Guests:

Richard D. Wittrup

Staff:

Matthew F. McNulty, Jr., Director, COTH; Associate Director, AAMC
Fletcher H. Bingham, Ph.D., Assistant Director, COTH
Richard M. Knapp, Ph.D., Project Director, Teaching Hospital
Information Center

Excused:

Stanley A. Ferguson
Dan J. Macer

I. Convening of Meeting:

The meeting was convened at 10:00 a.m. by Chairman Cronkhite.

Attendance was taken as noted above.

II. Method of Approach:

It was noted that there were two methods of approaching the charge to the Committee by the Executive Committee. The first would have been the development of the anticipated program activity in accord with a pre-established amount of income

generated by dues, grants and other sources. The second approach, and the one that it was agreed to follow, was the initial development of the expanded program activity and the subsequent determination of the financial resources necessary to support such a program.

The Committee then reviewed the activities that the Council of Teaching Hospitals could undertake that would be of particular importance to the interests of the membership, as well as other voluntary and governmental agencies. The purpose of this delineation was to insure that the substantive programs under consideration would not duplicate program activities currently being provided on a widespread basis by other organizational bodies. It was agreed also that, occasionally, there may be instances in which the current activity being provided by these other organizations are not sufficiently useful for the particular interests of COTH, and in these selected instances an active COTH program would be highly indicated.

The Committee also carefully reviewed the structure of the Council in terms of its responsibilities to its membership, to its immediate publics including medical schools and other hospitals and to its secondary publics, such as foundations as well as governmental agencies at all levels. Out of these discussions it was agreed that the two major activities that the Council of Teaching Hospitals is now developing, and that it should be urged to continue as rapidly as possible, are the areas of: (1) forecasting; and (2) providing data on which effective decisions and social policy can be based. It was stressed that these two areas of activity would be extraordinarily useful to all

interested in the activities of teaching hospitals, including administrators, boards of trustees, medical staff and the governmental agencies.

III. Committee Review of Projected Organization Chart Presented at May 9 and 10 Executive Committee Meeting:

The Committee reviewed the projected organization chart presented by Mr. McNulty at the May 9 and 10 Executive Committee Meeting (see Attachment A). In this review, it was agreed that major elements serving as criteria for the priority scheduling of various activities would be; (1) the projected functions of the organization, and (2) are the activities capable of being implemented from the standpoint of anticipated financial support? In terms of scheduling the urgency priority, the committee agreed that the following priority would be most accurate:

ACTION #1

THAT THE COMMITTEE RECOMMEND TO THE EXECUTIVE COMMITTEE THAT THE FOLLOWING SCHEDULE OF PRIORITY BE ADHERED TO IN THE IMPLEMENTATION OF ADDITIONAL OR THE STRENGTHENING OF CURRENT ONGOING COTH PROGRAM ACTIVITIES.

<u>Priority Number</u>	<u>Activity Element as represented on Attachment A</u>
1.	7. Representation and General Information Branch
2.	3. Publications Branch
3.	6. Annual Meeting, Regional Meetings, Committee Meetings, Special Meetings, etc.
4.	10. Educational and Development Branch
5.	9. Research Branch

During the discussion of the need to establish priorities for implementation of COTH activity elements, there was constant emphasis on the need to recognize potential problems in the recruitment of capable individuals. The emphasis of this discussion was not the inability of the Council of Teaching Hospitals to recruit individuals in a situation in which "all things were equal". However, there was concern expressed about the particular situation in which the salary scales for staff were established by essential university personnel, and which may not reflect accurately salary levels for those persons involved in hospital operations. Additionally, it was noted that the gap between these two salary opportunities was increasing. The net effect of this process, the Committee noted, may be the increasing difficulty in recruiting talented individuals from operational situations into an educational oriented organization.

IV. Review of Existing Sources of Financial Support:

The Committee agreed that there are four possible sources of financial support available to enlarge the resource base to support the programs outlined above; they are:

(1) Contracts with Foundations and/or Governmental Agencies

A contract in the amount of \$71,000 has been received to support the activity shown on Attachment A, as Number 4, (Teaching Hospital Information Center). Additionally, it was noted that a contract had been pending with the Bureau of Health Manpower (Study of the Effect of Recent Social Legislation on Teaching Hospitals) that could fulfill many of the concepts included in Priority Number 5, (Activity Element 9, Research Branch).

It was agreed that grants and contracts, from both foundation and governmental agencies, would be useful to support activities of the Council, helpful to the membership, as well as many of its publics and that staff should continue to pursue such opportunities.

(2) Increase in Dues for Membership:

The current annual dues for membership are \$500 per American hospital, and \$166.67 for Canadian hospitals. On the basis of the total membership for FY 1967-68, and income in the amount of \$164,833 was generated. Of this approximately 30% represents overhead that accrues to the parent organization, the AAMC.

The Committee agreed that one requirement necessary for any recommendation on this subject was that the dues structure be devised in such a manner that it reflects the inflationary economic impact, as well as provide a financial base for the continued orderly growth in programs of the Council of Teaching Hospitals. Several such criteria for dues, as prepared by the staff, were reviewed. The Committee requested the preparation of an additional schedule reflecting more current information, based on the American Hospital Association's Guide Issue for 1968, to be distributed and reviewed prior to the September 5 and 6 meeting to the Executive Committee. (See Attachment B for suggested Dues Structure based on 1968 AHA Guide Issue).

(3) Broadened Criteria for Membership

The Committee reviewed the existing criteria for membership: (1) nomination by a Dean, or (2) self-nomination on the basis of the hospital having an approved internship and 3 of 5 residencies (Medicine, Surgery, OB-Gyn, Pediatrics and Psychiatry).

The Committee requested the COTH staff to draft a revised set of COTH Rules and Regulations for presentation to the Executive Committee and the September 5 and 6 meeting.

(4) Charges for Specific Services

The Committee reviewed the possibility of increasing COTH revenue by instituting a charge for services for certain program activities.

Two such services mentioned, that could be developed, are a professional placement service for teaching hospital administrators or instituting a service fee to commercial consultants who call upon COTH for information and data to assist them in their consulting activities.

V. Additional Committee Recommendations to Executive Committee:

ACTION #2

THAT THE COMMITTEE RECOMMEND THAT THE SCHEDULE OF PROGRAM PRIORITY AS OUTLINED IN ACTION #1, BE SUBMITTED TO THE EXECUTIVE COMMITTEE FOR APPROVAL IN PRINCIPLE; THAT IF THIS ACTION IS FORTHCOMING, THE COMMITTEE WILL CONTINUE TO WORK WITH STAFF TO REFINE THE CONTENT AND ORGANIZATIONAL FORMAT FOR PRESENTATION AT THE INSTITUTIONAL MEETING.

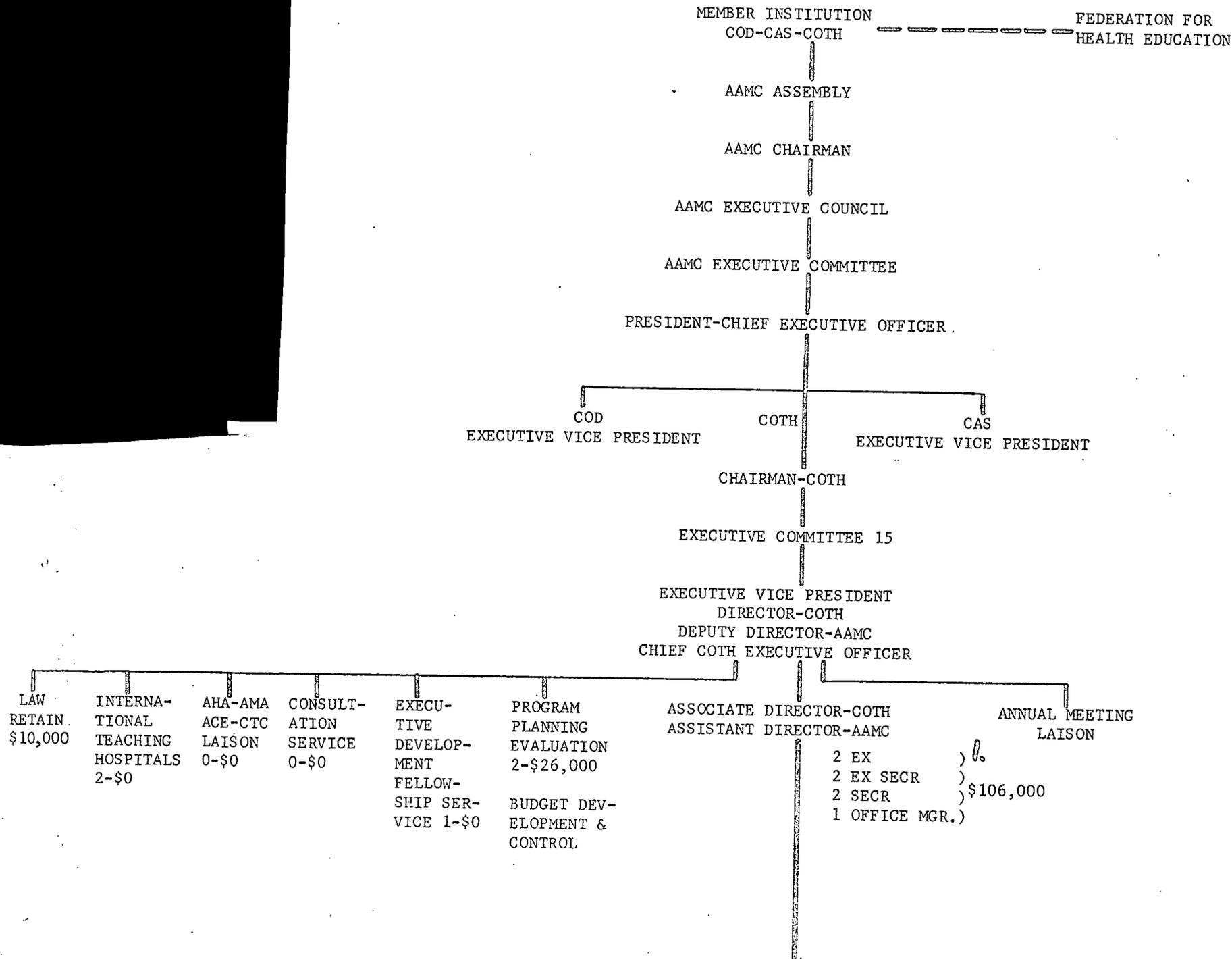
ACTION #3

THAT THE COMMITTEE PRESENT TO THE EXECUTIVE COMMITTEE A STATEMENT ON THE POTENTIAL PROBLEMS OF RECRUITMENT AND RETENTION OF STAFF, THAT IS INTRODUCED BECAUSE OF THE ACADEMIC ORIENTATION OF THE ORGANIZATION.

ACTION #4

THAT VARIOUS METHODS OF EXPANDING THE FINANCIAL RESOURCES OF COTH BE PRESENTED TO THE EXECUTIVE COMMITTEE, ALONG WITH SPECIFIC RECOMMENDATIONS OF THE COMMITTEE BASED ON MATERIAL PREPARED BY STAFF AFTER ISSUANCE OF THE AUGUST, 1968 AHA GUIDE ISSUE, AS WELL AS OPPORTUNITIES FOR BROADENING THE MEMBERSHIP OPPORTUNITIES OF COTH.

VI. There being no further business, the meeting adjourned at 3:15 p.m.



DUES CLASSIFICATION BY
EXPENSE CATEGORY
(Expense Data Abstracted from 1968 AHA Guide Issue)

<u>Total Expense</u> (000) (\$)	<u>Estimated Amount</u> Expended for Medical Education (\$000)	<u>All Hospitals</u> (excluding Veterans Administration Hospitals)	<u>Dues for</u> Expense Category (\$)
Under 6,999	350	81	600
7,000-7,999	375	25	700
8,000-8,999	425	24	800
9,000-9,999	475	22	900
10,000-10,999	525	25	1,000
11,000-11,999	575	12	1,100
12,000-12,999	625	17	1,200
13,000-13,999	675	8	1,300
14,000-14,999	725	8	1,400
15,000-15,999	775	10	1,500
16,000-16,999	825	5	1,600
17,000-17,999	875	3	1,700
18,000-18,999	925	5	1,800
19,000-24,999	1,100	19	2,200
Over 25,000	1,750	11	2,500

Total Hospitals - 275

50 Veterans Administration Hospitals not included in the above categories.

Total Hospitals not listed or not reporting in 1968 AHA Guide Issue - 13

Hospitals not Reported

	<u>Not listed in AHA Guide Issue 8-1-68</u>	<u>Total Expense not reported</u>
University of Arizona	X	
Cook County		X
St. Joseph - Chicago		X
Loyola University	X	
Mt. Sinai - Elmhurst, N.Y.	X	
University of Oklahoma		X
Fitzgerald Mercy - Darby, Pa.		X
Misericordia, Philadelphia		X
Wilford Hall, San Antonio	X	
Milwaukee Psychiatric	X	
V A Gainsville		X
V A Miami	X	
V A Omaha		X
4 Canadian Hospitals	X	

AMERICAN HOSPITAL ASSOCIATION
Proposed Dues Increase

Member Type	Effective Jan. 1, 1969	Effective Jan. 1, 1970
Type I-A (short-term hospitals):		
Total expense:		
First \$2,500,000	67c per M	76c per M
Second \$2,500,000	40c per M	46c per M
Third \$2,500,000	27c per M	31c per M
Balance	13c per M	15c per M
Minimum dues	\$ 200.00*	\$ 225.00*
Maximum dues	\$ 3,333.33*	\$ 3,750.00*
Type I-B (all other hospitals):		
Total expense:		
First \$500,000	67c per M	76c per M
Second \$500,000	40c per M	46c per M
Third \$500,000	27c per M	31c per M
Minimum dues	\$ 200.00*	\$ 225.00*
Maximum dues	\$ 667.00*	\$ 750.00*
Type II (extended care facilities):		
49 beds or less	\$ 200.00*	\$ 225.00*
50-99 beds	\$ 313.00*	\$ 352.00*
100-149 beds	\$ 425.00*	\$ 478.00*
150 beds or over	\$ 667.00*	\$ 750.00*
Type III (clinics):		
Flat rate	\$ 200.00*	\$ 225.00*
Type IV—Regular (Blue Cross Plans in United States):		
Minimum	\$ 421.00*	\$ 474.00*
Maximum	\$ 12,640.00*	\$ 14,220.00*
Rate per subscriber contract	2.633c *	2.96c *
Type IV—Associate (Canadian Blue Cross Plans):		
Minimum	\$ 79.00*	\$ 89.00*
Maximum	\$ 1,583.00*	\$ 1,778.00*
Rate per subscriber contract	3.1 mills*	3.5 mills*
Type V (auxiliaries):		
100 beds or less	\$ 52.67*	\$ 59.25*
101-300 beds	\$ 87.77*	\$ 98.75*
301 beds or over	\$ 175.58*	\$ 197.54*
Type VI (hospitals under construction)		
Transfer to Types I, II and III		
Type VII (areawide planning agencies):		
Flat rate	\$ 200.00*	\$ 225.00*
Type VIII (hospital schools of nursing):		
Flat rate	\$ 300.00	\$ 300.00
Associate:		
Nonprofit	200.00*	225.00*
Profit-making	400.00*	450.00*
Personal:		
Type A	22.50	22.50
Type B	200.00	225.00
Affiliated Societies	22.50 to \$50.00	22.50 to \$50.00
Students	11.25	11.25

*In addition to the changes in dues rates proposed, it is also proposed that, effective Jan. 1, 1969, all minimum and maximum dues and all dues rates (except the expense bracket rates applicable to Types I-A and I-B and except for Type VIII) will vary upward or downward by a percentage determined by comparing the latest published data (in Part 2 of the August 1 Guide Issue of HOSPITALS, J.A.H.A.) of total hospital expense in the United States with the comparable data for the immediate preceding year.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Council of Teaching Hospitals
Rules and Regulations
Revised August 28, 1968

At the meeting of the institutional members of the Association of American Medical Colleges held Tuesday, November 2, 1965, in Philadelphia, the Association acted to convert the Teaching Hospital Section into a "Council of Teaching Hospitals," with its voting membership to be determined in the same way as membership in the Teaching Hospital Section had been and to provide that the Council nominate a person to be elected by the Institutional Membership as a voting member of the Executive Council. The discussion which preceded formal action included the desire for the Teaching Hospital Section to develop and propose appropriate ways to bring into its activities, on the basis of affiliation, other major teaching hospitals. This 1968 Revision reflects certain revisions in the Bylaws of the Association of American Medical Colleges, and incorporates substantive changes in the original Rules and Regulations as approved by the Executive Committee of the Council of Teaching Hospitals and The Executive Council of the AAMC, December 12, 1965.

PURPOSE AND FUNCTION. The Council is organized to provide as part of the program of the AAMC special activity relating to teaching hospitals. For this purpose, a teaching hospital is defined as an institution with a major commitment in undergraduate, post-doctoral, or post-graduate education of physicians. In keeping with the action of the AAMC, each medical school will designate a primary teaching hospital or hospitals and other eligible institutions may be designated by schools or become members by virtue of meeting specific requirements in teaching programs as may be set up by the Council

from time to time. It is expected that the Council will hold educational meetings, conduct and publish studies and take group action on various subjects concerning the teaching hospitals. The Council's program will be subject to the approval of the AAMC.

NATURE OF THE PROGRAM OF THE COUNCIL. As a part of the AAMC, the Council of Teaching Hospitals will develop, through the appointment of specific study groups, information concerning specific items or problems relating to hospital operation as it relates to the furtherance of education in medicine. The Council will conduct meetings for the presentation of papers and studies relating to education in hospitals and would stimulate, in addition to annual meetings, regional and local meetings of the educational type as seems indicated. The Council from time to time will also recommend group action on items considered of importance for the furtherance of medical teaching in hospitals and upon approval of appropriate bodies take action as indicated to further this objective.

MEMBERSHIP IN THE COUNCIL. Hospitals as institutions will be members of the Council and each institution will be represented by a designated person, designated by the hospital, for the purpose of conducting the business of the Council.

Membership in the Council will be annually determined and consist of several classifications of membership.

Type A membership shall consist of:

- (1) Those hospitals nominated by a medical school member of the AAMC from among the major teaching hospitals affiliated with the school, and
- (2) Teaching hospitals which are either nominated by a medical school member of the AAMC on the basis of

important affiliations for the purposes of medical education or which have approved internship programs and full residencies in three of the following five departments: Medicine, Surgery, OB-Gyn, Pediatrics, Psychiatry, and are elected to membership by the members of the Council of Teaching Hospitals.

Type B membership shall consist of:

Those institutions that have approved internship programs and full residencies in five or more departments.

← Associate Membership - Those institutions that do not provide patient care services, but have exhibited ^{or} commitment to medical education, are eligible for Associate Membership without vote. The Executive Committee of COTH, shall serve as the selection committee for this category and shall act upon each application for Associate Membership submitted to the Council.

All Type A and Type B members will vote at the annual meeting for officers and members of the Executive Committee.

OFFICERS AND EXECUTIVE COMMITTEE. Officers and appropriate members of the Executive Committee shall be elected annually by all members, at which time the Chairman, Chairman-Elect, Secretary, and indicated members of the Executive Committee will be chosen.

There shall be nine (9) members of the Executive Committee, serving for three-year terms. Each year three (3) members shall be elected. In addition, the immediate Past Chairman, the Chairman Elect, and the two (2) additional Council of Teaching Hospitals'

representatives on the Executive Council of the AAMC shall be ex-officio members of the Executive Committee. The Executive Committee shall meet as frequently as necessary under the chairmanship of the Chairman of the Council. It shall carry the authority of the members between meetings and all actions shall be considered for ratification at the next meeting of the members.

OPERATION AND RELATIONSHIPS. The Council shall report to the Executive Council of the AAMC. As provided in the Revised Bylaws of Association of American Medical Colleges, there shall be three (3) representatives of the Council of Teaching Hospitals on the Executive Council of the Association. The incumbent Chairman of the Council of Teaching Hospitals will serve as one of these representatives. From time to time, as necessary, two other individuals, who serve as a COTH institutional member's representative, shall be elected to serve as a COTH representative to the AAMC Executive Council. The Council of Teaching Hospitals is entitled to elect 10% of its members, up to a maximum of 35, who shall have a vote in the Assembly of the Association of American Medical Colleges. Creation of standing committees and any major actions shall be taken only after recommendation to and approval from the Executive Council of the AAMC.

STAFF, EXPENSES FOR ATTENDANCE AT MEETINGS, AND DUES.

It is intended that the Council of Teaching Hospitals will be provided adequate staff for the conduct of its work. It is also intended that the Executive Committee of the Council shall have standing and ad hoc committees of its members, which shall meet from time to time, with expenses of these meetings paid for by the Association. In all this, it is understood that the staff and the basic conduct of the program are subject to the approval of the officers and Executive Council of the AAMC.

It is intended that the activities of the Council of Teaching Hospitals shall be financed by its members through appropriate dues established by the membership at the COTM Institutional Membership Meeting at Houston, Texas, November 4, 1968.

COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
1346 Connecticut Avenue, N.W.
Washington, D.C. 20036
202/223-5364

MINUTES

Committee on Modernization and Construction Funds
For Teaching Hospitals
June 28, 1968
Mayflower Hotel
10:00 a.m. - 4:00 p.m.

Present:

Richard T. Viguers, Chairman
Lewis H. Rohrbaugh, Ph.D., Vice Chairman
Robert C. Hardy
J. Theodore Howell, M.D.
Richard D. Vanderwarker
John H. Westermen

Also Present:

Charles W. Eliason, Director, Government Grants Programs,
Cedars-Sinai Medical Center, Los Angeles, California (attended at Dr. Littauer's
request)

Absent:

Charles H. Frenzel
Harold H. Hixson
John H. Knowles, M.D.
David Littauer, M.D.
John W. Kauffman, AHA Representative

Staff:

Matthew F. McNulty, Jr., Director, COTH; Associate Director, AAMC
Fletcher H. Bingham, Ph.D., Assistant Director, COTH
Grace W. Beirne, Staff Assistant, COTH
William G. Reidy, Editor, AAMC Bulletin
Peter A. Weil, Student Assistant, COTH
Valentina A. Weigner, Secretary, COTH

The Committee was joined for lunch at 12:30 p.m. by Howard N. Newman, White
House Fellow assigned to the Director of the Bureau of the Budget (On leave
of absence as Associate Director, Pennsylvania Hospital, Philadelphia, Penn-
sylvania.

I. Call to Order:

Chairman Viguers called the meeting to order and began discussion of the agenda promptly at 10:00 a.m.

II. Approval of Minutes - Meeting of February 19, 1968:

ACTION #1

THE MOTION WAS MADE AND SECONDED THAT THE MINUTES OF THE MEETING OF FEBRUARY 19, 1968 BE APPROVED AS CIRCULATED. IT CARRIED UNANIMOUSLY.

III. Report on Action Items from the February 19, 1968 Meeting (Listing of Action Items from Meeting of February 19th, Attachment A):

Report on Action #2

It was agreed that the question of the AHA definition of "teaching hospital" as opposed to that of COTH (as determined by "White Paper" and membership criteria) be referred to the COTH-AHA Liaison Committee and to the March COTH-AHA Meeting for Coordination.

Mr. McNulty discussed the definition of a teaching hospital. The AHA definition was distributed (copy attached and made a permanent part of these minutes) and it was noted to be extremely broad in scope covering "almost anyone that does anything" with respect to education for health care. The COTH definition to date qualified teaching hospitals by its use of the term "medical education". The possibility that this distinction should be abandoned was indicated by Mr. Westerman's remark that at the University of Minnesota the medical college is on a coequal basis with dentistry, nursing, and so forth. Further, Mr. McNulty indicated that the qualifying adjective "medical" often caused other health practitioners to defend

their particular areas of interest. This coupled with the current efforts of the AAMC to broaden their own views point to a more inclusive definition. Chairman Viguers indicated that in any legislation action the legislation itself would have to define the scope of intent. This is exactly what is being considered by legislators according to Mr. William Reidy who specified that university trained health professionals will be funded through the National Institutes of Health, while those in the "allied health professions" (including nursing and non university affiliates) will be funded through the Health Services and Mental Health Administration. Dr. Howell suggested that the teaching hospital data gathering capability of the Council of Teaching Hospitals of AAMC would have to be much expanded in order to define various types of institutions who qualify especially for use at Congressional hearings and suggested further that COTH attempt to coordinate its data gathering activities with that of AHA.

Mr. McNulty acknowledged these recommendations and indicated that a suitable definition of a teaching hospital will continue to be explored.

Report on Action #4

Mr. Hixson made the motion, seconded by Dr. Littauer, that the Committee forward the question of tax exemption for joint ventures to the Committee on Financial Principles, the AAMC Committee on Federal Health Programs and the AHA with the strong recommendation that these bodies explore the issue and go on record with a statement of concern and suggestion of remedial action.

Mr. McNulty then brought the recent legislation of tax exemption for certain joint hospital service organizations Revenue and Expenditures Control Act of 1968 (Section 109, Tax -Exempt Status of Certain Hospital Service Organizations) to the attention of the committee, noting that joint laundry services

were excluded. He indicated the law was awaiting Presidential signing and then Miss Beirne submitted that once signed, it will apply to corporate taxable years ending after the date the law is enacted.

IV. Report on Distribution of Supplemental Questionnaire to Retest Expressed Expansion Plans for Teaching Hospitals:

Dr. Bingham discussed the results of the questionnaire received from member hospitals indicating a 24,000 bed expansion program in teaching hospitals in the coming decade. A follow-up questionnaire requesting more detailed information has been mailed to member hospitals.

Mr. McNulty indicated that this project could serve as a source of vital data which will provide the base for recommendations to support modernization and expansion legislation. Chairman Viguers noted that the survey may serve still a broader function by providing a mechanism to "upgrade health as a public issue". He noted that public sector is currently concentrating on the need for quantity of health facilities (as opposed to higher quality) and this project capitalizes on that social trend. Thus the project could be politically advantageous.

V. Discussion of Two Recent Federal Health Agency Studies:

(1) Recommendation and Summary: A Program Analysis of Health Care Facilities (Office of Program Planning and Evaluation, Bureau of Health Services) The so called "Michael's Report"

(2) Legislation Relating to Health Facility Construction and to Special Purpose Project Grants (Division of Hospital and Medical Facilities, Bureau of Health Services) The so-called Graning Report".

Mr. McNulty introduced this discussion with a brief summary of the background of the two reports. He noted that essentially the two reports represent divergent approaches to positive action with respect to Federal

assistance for construction and modernization. It was noted that the report being prepared by the National Advisory Commission on Health Facilities had not yet been completed, and that this study might well develop an additional approach.

Dr. Bingham cited the chief characteristics of the two documents, noting that the "Michael's Report" recognizes the problem of obsolescence but that it is not tied specifically to the teaching hospital or to the inner city. Modernization is defined broadly and one can generalize that this report stresses the use of all the elements existing in the administration of Hill-Burton (Harris) funds.

On the other hand, the Graning Report is more specific in its recommendations; for example, recommendation Number 3 specified the type of funding to be employed. Moreover, it differed from the Michael's survey by departing from the system of administration now in use and recommending new tactics such as "Special Purpose Project Grants". The estimates of this program were for the backlog of modernization \$15 billion expenditure, exceeding the "Michael's" projected figures by \$5 billion.

Because the National Advisory Commission on Health Facilities is still to issue its report, Mr. McNulty speculated that the staff led by Dr. William L. Kissick may emphasize the total systems approach: to allow funding to get at the gaps in the delivery of a universal basic standard of health services.

In answer to the compliments of Mr. Westerman to the staff, Mr. McNulty stated that COTH enjoys, at the moment, a good entry into the health facility modernization and construction funding agencies in the federal government along with general acceptance by these groups of the teaching hospital as the principal cutting edge. COTH strategy has been to work with groups designing

legislation and influencing legislators rather than creating schisms within the many health agencies.

VI. Report by Committee Members of Recent Contact with Assigned Members of President's Advisory Commission on Health Facilities. Staff Report on Washington Activities:

Mr. McNulty drew the attention of the Committee to the "General Statement of the Teaching Hospitals' Contribution to the Ideal of Excellence in the Health Care of the Nation", a report submitted to the National Advisory Commission on Health Facilities by COTH. He noted that this statement had been submitted at the request of the Commission's staff.

Chairman Viguers in accord with the other members of the Committee recommended refraining from further contacts with the staff of this Commission until such time as the basis of their judgment should alter significantly.

VII. Discussion and Committee Disposition of Proposed "White Paper" on the Need for Modernization and Construction Funds for Teaching Hospitals - Meeting Society's Expectations for Excellence in Service and Education (Most recent draft distributed May 23, 1968):

The "White Paper" on the Need of Modernization and Construction Funds for Teaching Hospitals entitled, "Meeting Society's Expectations for Excellence in Service and Education" was discussed by all the members of the committee. Effectively four alterations were recommended to the staff as follows:

- (1) Definition of teaching hospitals and non-teaching hospitals be reworded (page 3)
- (2) The cost per square foot for non-teaching hospitals be changed from \$30-35 to \$40-45
- (3) The figures on escalation be revised up.
- (4) That various formulae for federal subsidy be simply listed with an example

in order to permit the federal government to decide which funding program it would prefer. Thus the need for rather than the means by which funds are disbursed is emphasized.

VIII. Report on AAMC Study of Facilities for Health Education and Report on New York Chapter, AIA, Proposal for Health Facilities Laboratory:

Mr. McNulty discussed two reports in a summary form: Report on the AAMC Study of Facilities for Health Education and Report on the New York Chapter, AIA, Proposal for Health Facilities Laboratory.

A proposal by the AAMC to create a data bank on new medical school constitution to replace the outdated PHS, Guide on Construction and Medical Facilities seemed a related area of interest of the COTH organization. Accordingly, Mr. McNulty asked for an expression of interest in this proposal as well as a proposal by a prominent New York architect to create a Health Facilities Laboratory.

Members of the Committee were much in favor of the data bank and the laboratory. Dr. Howell shared his experience with the occasional parochialism of architects and thus recommended an eclectic approach in the study to be undertaken. Chairman Viguers and other members of the Committee concurred with the suggestion.

IX. Statement of the AAMC Before the Subcommittee on Labor-Health Education and Welfare of the Committee on Appropriations - U.S. House of Representatives:

Mr. McNulty pointed out the distinct paragraph dealing with the vital role of the teaching hospitals in the education of health manpower.

X. Bill to Establish a National Health Council and a Joint Congressional Committee on Health:

It was noted that Senator Edward Kennedy's proposed bill was a worthwhile philosophical view. More significantly, it indicates, according to Mr. Reidy

a desire on the part of this Senator to become the new health champion.

It was noted that Senator Mondale of Minnesota had replaced Senator Robert Kennedy on the Senate Subcommittee on Labor and Public Welfare.

XI. New Business:

Chairman Viguers called for new business of which there was none.

XII. Date of Next Meeting:

A future meeting will be on the call of the Chairman.

XIII Adjournment:

The meeting was adjourned at 3:50 p.m.

MEETING SOCIETY'S EXPECTATIONS FOR EXCELLENCE
IN SERVICE AND EDUCATION

A Statement of the Urgent Need for
Modernization and Expansion Funds for
Teaching Hospitals

and

Proposals for the Support of
Teaching Hospitals Facilities by the Federal Government

DRAFT - Not for Publication or
Reproduction
August 28, 1968

INTRODUCTION

The teaching hospitals of this country, many of them closely related physically to a medical school, constitute a significant core of hospital services to sick persons in the communities they serve. In addition, they provide essential facilities for the education and training of students in medicine and the allied health professions, including extensive and varied graduate programs. They also offer opportunities for clinical research. This multiple role places upon teaching hospitals a heavy responsibility to establish and maintain standards of excellence in all three areas of endeavor. One result of these facts is that patient care in a teaching hospital tends to develop greater complexity and duration than is true in the average community hospital. This in turn generates relatively high operating costs and the need for special and usually costly facilities. Obtainable fees for hospital care have proven inadequate to carry this extra load, much less provide for needed modernization and replacement of plant and equipment. Accordingly a program of capital grants in aid is suggested, designed to upgrade the facilities for patient care, education and research, and to conserve and improve the invaluable assets represented by our teaching hospitals.

THE PROBLEMS FACING THE NATION'S TEACHING HOSPITALS

The communities of this nation must take action to provide personal health services to their residents. These services should promote good health through the application of established preventive measures, early detection of disease, prompt and effective treatment, and physical, social and vocational rehabilitation of those with residual disabilities. This

broad range of personal health service has become patterned as a continuum ranging from the promotion of good health to rehabilitation after illness, and involving home care programs, nursing homes, community hospitals and the modern teaching hospital. Each component must have adequate support if the entire health care system is to operate in a comprehensive fashion.

Significant gains have recently been made in removing the economic, geographic and social barriers to the availability of health care. The pace of progress has accelerated in recent months and years. The people of this nation have made it abundantly clear that they demand adequate medical care which is readily available, freely accessible and individually acceptable. Recent social legislation reflects this national resolve. The possibility of progress toward achievement of these new national goals faces the dual obstacles of shortage of manpower and facilities capable of delivering the medical care which society will demand.

The teaching hospitals will be the locus of the confrontation when the forces of rising expectations and effective demand meet head on with the hard facts of acute shortage of manpower and facilities. This nation, and its teaching hospitals, faces a major crisis.

The teaching hospital crisis is due to many factors:

1. The teaching hospital, by virtue of its size and location (usually 300 beds or more in an urban or metropolitan setting) cares for a high percentage of patients from the immediate locality and the surrounding regions, and maintains the resources of physical plant, skilled health personnel, complex equipment and a spectrum of services necessary for comprehensive health care of high quality.

2. The teaching hospital contributes significantly to the education and training of the nation's physicians.
3. The teaching hospital provides national norms and standards for patient care.
4. The teaching hospital is the locus of much of the scientific investigation that is done to advance the state of medical knowledge and patterns of medical care.

A teaching hospital is one in which the education of physicians and other allied personnel is continually taking place. The administration, library, equipment, laboratories, service programs, research activities and staff organization are necessarily designed for and centered on the student and the staff-student management of the patient. This complex of resources and activities must be so arranged and operated that good teaching, good research, as well as good patient care are not compromised. In the non-teaching institutions not focused on the education of physicians, the organization of all resources and activities can be simplified to center on the individual practicing physician and the provision of good care in the management of the patient.

The design and direction of this institutional commitment to medical education may take many forms. The hospital may provide, on the basis of a joint venture with a medical school, the clinical instruction of the medical student. The development of the internship and residency programs which have become such fundamental components of modern medical education has provided additional educational responsibilities. Finally, the teaching hospital may be involved in programs of continuing medical education,

thereby insuring practicing physicians exposure to new diagnostic and therapeutic techniques.

The primary function of any hospital is the care of the sick and injured. Additional responsibilities of the teaching hospital are the expansion of medical knowledge through scientific research, and more recently, efforts related to prevention of disease. Thus the teaching hospital is a social instrument which encompasses the interface where medical knowledge is acquired, disseminated and utilized.

The program of needed education facilities begins with a definition of the educational activities to be housed within the hospital institution. This definition must include the types of teaching and training programs, the numbers and types of persons involved in each, and the location and resources within the hospital that are involved. A teaching hospital requires additional space throughout. Enough space to house the additional functions, people, and equipment of a teaching hospital is its problem, and may increase the total size by as much as 50 percent (from 800 to 900 square feet per bed to 1300 to 1500 square feet for teaching hospitals). In terms of cost, this can reflect a current variation in cost from \$45 to \$50 per square foot for non-teaching hospitals. Teaching hospitals not only require more space, but facilities which are more complicated and sophisticated. Therefore the construction costs for teaching hospitals are currently estimated to be in the range of \$75 to \$80 per square foot, and significantly higher than that in some areas. These additional space needs on the patient floors alone take the form of examination-treatment rooms, designed to support teaching, clinical laboratories, classrooms, seminar-conference rooms and residents' offices. They also tend to require larger patient rooms and a

higher percentage of single rooms.

While there are the more evident needs of teaching hospitals, there are other features of the teaching hospital contributing directly to increased space needs. Patients generally are tested more extensively with a wider range of results in teaching hospitals. This is because the teaching hospital attracts the sicker patients, there are more difficult diagnostic problems and there is a greater variety of available tests. The ultimate result of this is the need for larger clinical laboratories and for more complex diagnostic radiology. The teaching hospital must allow for research and experimentation in operational methods and patient care in addition to the rapidly expanding programs in clinical research. Occasionally specialized research facilities are needed to attract a particular type of staff. Commitments of this nature can, and do, require 1000 square feet of research space per investigator. As the hospital assumes broader patient care responsibilities and increased teaching roles, the full-time staff becomes larger, which requires offices, research and out-patient facilities for them within the hospitals.

The teaching hospital has been assigned other particular responsibilities by society, best characterized by the phrase, "center of medical excellence". The community of teaching hospitals has responded by encouraging the development of such "centers" whose excellence can be related to both the science and technology of medicine. Teaching hospitals have been characterized as the summit of the health care pyramid, the capstone of the nation's hospital system. High standards of clinical practice necessitate accepting referrals from physicians in other hospitals involving patients who present difficult problems of diagnosis or require treatment available solely in the teaching

hospital.

More recently, teaching hospitals have accepted society's additional charge that they become positive "health centers", serving all social and economic classes. This potential development takes on added significance when it is noted that a large portion of the teaching hospitals are located in city centers with all of the accompanying problems. The teaching hospital, as a health center, is becoming the single most effective social and technical instrument available to both the medical educator and practitioner for the solution of medical problems.

The functional demands that are placed on the scarcity of resources of the nation's teaching hospitals promote a certain measure of constant internal stress. The demands for classroom facilities and equipment compete with simultaneous demands for laboratories for scientific investigation, and even further with demands for the development of specialized patient care units. Decisions relating to the conflicting demands for such facilities, equipment and manpower are resolved in an economic calculus, the over-riding determinant of which is a shortage of the major resources including significantly the institutional facilities.

Our nation relies on its teaching hospitals for the graduate education of physicians and other health manpower, the establishment of standards for the promotion of better health, the best care of the sick and injured, the continued advancement of medical knowledge and the transfer of new technology to the patient's bedside. It is imperative that these facilities receive more adequate capital financing support, as a matter of national policy, if they are to remain the social instruments best serving the over-arching interests of the community in matters of health and disease.

THE NEED FOR SOLUTIONS TO THE STATED PROBLEM

Because the problem of facility need for teaching hospitals can only be resolved through a prompt and comprehensive national effort, it is essential that representatives of the teaching hospital community outline the basic capital requirements to accomplish preservation of excellence in these multi-purpose institutions. To this end, the Council of Teaching Hospitals of the Association of American Medical Colleges is suggesting Federal assistance programs for modernization and expansion of teaching institutions. The need for such financing is urgent. The many inter-related facilities for patient care, education, research and community service are continually affected by advances in both clinical medicine and the basic sciences. Correspondingly, there is constant demand on these institutions to provide personnel, equipment and adequate, modern up-to-date buildings.

The problems in financing hospital construction arise mainly from the fact that hospitals are non-profit organizations, being reimbursed for their services most frequently on a cost, or less than cost basis. The economics of such a situation prevent the accumulation of a surplus. Depreciation charges, when received, most often must be used for renovation or for maintenance of existing plant and equipment rather than for modernization or expansion of plant facilities.

In 1967 the Council of Teaching Hospitals of the Association of American Medical Colleges sampled its membership to determine the extent of need for modernization and expansion among 250 of its members. Federal and Canadian hospitals were not included. Replies were received from 214 hospitals, providing an 85% return.

Of the approximately 115,000 beds represented in this survey, 35% were over 35 years old and an additional 16% were between 21 and 35 years old. Of the 85% responding hospitals, 120 planned to replace 27,500 beds over the next ten years, and 142 planned to add 24,000 beds during the same period of time. For all forms of construction, including replacement, renovation and expansion, the estimated attendant cost for the ten year period is \$4 billion.

The reliability and validity of this study have recently been verified by a series of circumstances and events. Governor Rockefeller of New York has estimated that \$1 billion is needed for the construction and modernization of all hospitals in the State of New York alone, and is working toward the development of legislation that will accomplish this purpose.

A study completed by the Hospital Planning Council for Metropolitan Chicago resulted in the determination that \$370 million is needed for modernization, and \$720 million is needed for facility replacement of the 69 hospitals totalling approximately 6,000 beds in that city. This same Council determined that the costs of modernization would approximate \$156 million and the cost of replacement, \$300 million for six teaching hospitals in the metropolitan area. Additionally, in Philadelphia the capital needs for modernization, replacement, and expansion of the hospitals either operated by, or affiliated with, the area's 5 medical schools would total \$278 million as determined by the Philadelphia Hospital Survey Committee in 1967.

Because the teaching hospitals serve a combination of community, regional

and national purposes and because their strength is divided through a diversity of forms of ownership and control, the Council of Teaching Hospitals, Association of American Medical Colleges, favors both Federal and local participation, as well as the use of borrowed capital, in the construction of teaching hospitals.

Federal funds should be provided under conditions that will:

1. be sufficient to encourage action that is both prompt and adequate;
2. encourage the facility modernization and expansion of existing teaching hospitals;
3. encourage an institution's continuing effectiveness in maintaining diversity in its sources of financial support;
4. recognize the indispensibility of the multiple purposes of the teaching hospital, i.e., patient care, education, research and service to the community and the beneficial influences which these multiple functions have on the standards of excellence maintained by the teaching hospital.

PROPOSALS

1. The Council of Teaching Hospitals, Association of American Medical Colleges, recommends that the Congress provide assistance in the form of a grant program, a loan program or a combination grant and loan program as is fiscally indicated.

One such program might be:

- a. The teaching hospital, in applying under the provision of this program, must assure Federal authorities that it has 10% of the proposed construction monies.

- b. The Federal government would grant the applicant 20% of the total estimated cost at the time construction begins.
 - c. The Federal government assures the applicant 35% of the construction monies from government borrowing. The principal and interest would be paid by the government over a period not to exceed 10 years.
 - d. The Federal government would authorize the applicant to borrow 35% on a straight loan or bank issue basis, payable over a period not to exceed 25 years. The government would insure both interest and principle.
2. Because of the severity of the problem and the immediate need for modernization in teaching hospitals, it is further recommended that the Congress appropriate \$220 million per year over a ten year period to provide the necessary financial support for such a program

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DISCUSSION DRAFT

NEEDS OF THE TEACHING HOSPITALS
AND
UNIVERSITY MEDICAL CENTERS

STATEMENT BEFORE
THE NATIONAL ADVISORY COMMISSION
ON HEALTH FACILITIES

September 10, 1968

John Parks, M. D.
Dean, The George Washington University Medical Center
Washington, D. C.

Mr. Jones, and members of the Commission, I am Doctor John Parks, President of the Association of American Medical Colleges. Doctor Robert C. Berson, Executive Director, and Mr. Matthew F. McNulty, Jr., *Associate Director of the AAMC and* Director of the Council of Teaching Hospitals, are here with me to join in a discussion of the needs of the nation's university medical centers and their closely allied teaching hospitals. We are deeply pleased to have this opportunity to share our views on some of the major issues which you have been examining over the past eight months.

The Association of American Medical Colleges represents 101 medical schools of the United States through its Council of Deans; 337 teaching hospitals in the nation through its Council of Teaching Hospitals, and teachers of medicine through the current 27 organizations comprising the Council of Academic Societies.

We shall focus our presentation on health facilities *of* planning, construction, and financing of university medical centers and teaching hospitals.

TEACHING HOSPITALS

For purposes of this discussion, a teaching hospital is one in which the education of physicians and other allied health personnel takes place constantly. In addition to the usual physical accommodations of modern hospitalization, other essential features of the teaching hospital include: its attitude of administration, its library, its laboratory facilities, and *its shared* responsibilities for staff-student care of the patients. This complex of resources and activities is

so arranged and operated that excellent patient care is accompanied by teaching, practices and research interests. In the non-teaching hospital the ~~organization~~ ^{apex} of resources and activities ~~is~~ centered on supplying the individual practicing physician with technically trained assistants to provide good care in the management of patients.

The staff members of teaching hospitals are sensitive indeed to the significant gains that have been made recently in removing economic, geographic, and social barriers to the availability of health care. The teaching hospital has become the locus of a confrontation between the forces of a rising responsibility for patients and the hard facts of acute manpower and facility shortages. This nation and the teaching hospitals face a major crisis.

The teaching hospital crisis is due to many factors:

1. The teaching hospital, by virtue of its size and location (usually 300 beds or more in an urban or metropolitan setting) cares for a high percentage of patients from the immediate locality and surrounding regions, and maintains the ^{an} ~~the~~ ^{essential} ~~resources~~ of physical plant, skilled health personnel, complex equipment and a spectrum of services necessary for comprehensive health care of a high quality;
2. The teaching hospital contributes significantly to the educational training of the nation's physicians;
3. The teaching hospital provides the national norms and standards for patient care, and
4. The teaching hospital is the ^{center} ~~focus~~ of much of the scientific investigation ^{research} that is done to advance the ^{and} ~~state~~ of medical knowledge and ^{models} ~~patterns~~ of medical care.

Our nation relies on its teaching hospitals for the graduate education of physicians and other health manpower; the establishment of standards for the promotion of better health; the best ^{of} care ^{for} of the sick or injured, the continued advancement of medical knowledge and systematic transfer of new technology from the laboratory to the patient's bedside. The demands for classroom facilities and teaching equipment compete with demands for laboratories for scientific investigation and with requests for specialized patient care units. Decisions relating to the conflicting demands for such facilities, equipment and manpower are resolved on an economic basis. ~~for~~ ^{there} ~~which the over-riding problem~~ is a shortage of resources for these much needed total institutional facilities.

The inability of the teaching hospital to launch an immediate, frontal attack on many health problems ~~of an urban and rural nature~~, is a result of the total inadequacy of facilities, commensurate with the services which society is presently expecting it to provide.

In rendering direct patient service, the teaching hospital, like hospitals nationwide, experiences ^{difficulty} ~~problems~~ in financing modernization and expansion proposals, primarily because hospitals are non-profit organizations and are usually reimbursed for their services on a cost basis. Explained another way, those elements of cost reimbursement formulae which provide a "plus" factor to exact reimbursement -- such as accelerated depreciation payments and developmental factors, are seldom sufficient to enable the amortization of large-scale funds needed for modernization and expansion. The economic impact

Mat. is this clear

of these arrangements effectively prevents the accumulation of a capital surplus. Moreover, depreciation charges when received often have to be used for maintaining the existing facilities rather than for ^{of} modernization purposes.

Coupled with the indirect but highly significant role played by teaching hospitals in the provision of health manpower and the housing of medical research, these financial needs become even more pressing. Educational programs require additional space to support teaching laboratories, classrooms, seminar-conference rooms, house staff offices and recreational facilities. Research functions make heavy spatial demands on the teaching hospital. The need for experimentation in different health delivery systems will require space heretofore unplanned in hospital complexes. The rendering of advanced medical care requires highly skilled health practitioners coupled with prodigious technical equipment to aid in performing the many diagnostic, therapeutic and rehabilitative functions that are so much a part of the teaching hospital.

Let me take just a moment to cite several studies that document the magnitude of the problem that faces the nation's teaching hospital:

1. In 1967 the Council of Teaching Hospitals of the Association of American Medical Colleges sampled its membership to determine the extent of need for modernization and expansion among 250 of its members. Federal and Canadian hospitals were not included. Replies were received from 214 hospitals, providing an 85% return. Of the approximately 115,000 beds represented in this survey, 35% were over 35 years old, and an additional 16%

were between 21 and 35 years old. Of the 85% responding hospitals, 120 planned to replace 27, 500 beds over the next ten years, and 142 planned to add 24, 000 beds during the same period of time. For all forms of construction, including replacement, renovation and expansion, the estimated attendant cost of the ten-year period was \$4 billion.

2. The Hospital Planning Council for Metropolitan Chicago, in studying six teaching hospitals in that metropolitan area, determined that the costs of modernization would approximate \$156 million and the costs of replacement, \$300 million.

3. In Philadelphia the capital needs for modernization, replacement, and expansion of the hospitals either operated by or affiliated with the area's 5 medical schools would total \$278 million as determined by the Philadelphia Hospital Survey Committee.

THE UNIVERSITY MEDICAL CENTER

Some universities or medical colleges own and maintain a teaching hospital. These hospitals serve as the major center ^{for the} of teaching, patient care, and clinical research activities for the faculty. Affiliated governmental, voluntary and specialty teaching hospitals provide opportunity for expansion of patient care and research programs under the academic umbrella of the university or medical college.

It is natural then that the university medical center, with its teaching staff, students, allied medical personnel and research facilities should provide today's setting for medical leadership. The American public expects and should have complete, comprehensive medical care. Are our university medical centers prepared to meet this new academic dimension in American medicine?

In the majority of university medical centers the teaching of office practice and home care has occupied a very limited part of the medical student's education. Outpatient departments, located within the framework of these hospitals, have usually been administered at a substantial deficit. Consequently, little space has been allocated to outpatient departments. Clinics have been large, overcrowded, and made up, for the most part, of non-paying patients. For generations, medical schools have used society's least affluent patients for clinical teaching. With many of these patients, the medical history has been unreliable, and disease has advanced so far that there has been little opportunity to develop skill in history taking or to provide preventive medicine. The student's exposure to practice in this environment has not been ideal.

Provided with proper financial aid, university medical centers can expand their facilities to meet the long overdue health needs of society and the urgent requirements of medical education. While programs and procedures will vary with different university medical centers, there are four essential components that comprise the university medical center. These are:

1. The school with its health educational facilities, consisting of lecture halls, laboratories, and libraries;
2. The university hospital, a specialized center for the care of the acutely ill;
3. A clinic facility, greatly expanded to replace the outmoded outpatient department of our university hospitals in order that preventive, diagnostic, and therapeutic care of the whole patient can be accomplished with efficiency, dignity, and proper educational impact; and
4. Greatly expanded emergency units located ideally between the university

hospital and clinic and equipped for research as well as ^{and teaching} service. _{for community}

Such university medical centers should receive and assume a responsibility for a cross section of the community's citizenry. Medical students and allied health personnel working as assistants to members of the teaching staff would learn how to completely care for all people. The clinic, functioning as a full-time university group practice organization or as a university-sponsored facility for part-time faculty members, should utilize medical students and allied health personnel in the care of all ambulatory patients. The university clinic should no longer be divided into private and charity patients. All patients should share the same facilities, personnel, and attention. Savings on duplication of space and personnel will be credited to better care for all concerned and to improved teaching. But such a program will cost more than has ever been spent before, either on medical teaching facilities or on medical care of the poor.

The Hill-Burton program helped bring hospitals to communities throughout our nation. Recently this important federal resource has also been directed to renovation of greatly outdated urban hospitals. What is needed for today and for many years to come are federal, state, and private sources of funds, not only to expand and improve hospital facilities, but also to greatly extend adequate office, neighborhood and home care facilities. Not too many years ago patients went to hospitals as a last resort; today it is difficult to keep them out of hospitals. When one-stop office medical ^{center} care is made as convenient, ^{also} efficient, and ^{also} insurance protected as hospital care, health services will begin to catch up with the known science of preventive

and curative medicine. Many of the university medical centers are ready to experiment with clinical group practice procedures, community health clinics and programs of rehabilitative ^{and} extended home care. These programs will need to be financed by private, community, state or federal resources. In any event, major expansion of facilities consists of greatly expanded and improved teaching clinic and emergency unit space, as well as improved hospital facilities. University medical centers are national assets. They serve as educational centers for students for all parts of the nation and from many allied lands. Models of medical services are completely compatible with excellent medical education and far-reaching research. University medical centers need resources now to extend beyond their own and affiliated hospital services to provide models that may be duplicated outside the university to fill the walking, waking needs of an expanding, ever-changing populace.

COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
1346 Connecticut Avenue, N.W.
Washington, D.C. 20036
202/223-5364

MEETING OF COMMITTEE ON FINANCIAL PRINCIPLES
FOR TEACHING HOSPITALS
O'HARE AIRPORT
CHICAGO, ILLINOIS
JUNE 6, 1968
10:00 a.m. - 4:00 p.m.

Present:

Charles R. Goulet, Chairman
Richard D. Wittrup, Vice Chairman
Vernon L. Harris
Gerhard Hartman, Ph.D.
Reid T. Holmes
Arthur J. Klippen, M.D.
Bernard J. Lachner
Roger B. Nelson, M.D.
Francis J. Sweeney, Jr., M.D.
Irvin G. Wilmot
Robert C. Linde, AHA Representative
Ralph G. Meador, Ph.D., (Deputy Director, Research Administration and
Executive Secretary, Committee on Research, Massachusetts General Hospital,
Boston, Massachusetts) attended at Lawrence E. Martin's request because of
the latter's inability to be present.

Invited Guests from National Institutes of Health:

Thomas J. Kennedy, Jr., M.D., Director
Division of Research Facilities and Resources
National Institutes of Health

William R. DeCesare, M.D., Chief
General Clinical Research Centers Branch
Division of Research Facilities and Resources
National Institutes of Health

Kenneth A. Anderson, Grants Management Officer
Division of Research Facilities and Resources
National Institutes of Health

Robert B. Millman, M.D., Program Specialist
General Clinical Research Centers Branch
Division of Research Facilities and Resources
National Institutes of Health

Staff:

Matthew F. McNulty, Jr., Director, COTH; Associate Director, AAMC
Fletcher H. Bingham, Ph.D., Assistant Director, COTH
Thomas J. Campbell, Assistant Director, Division of Operational Studies, AAMC

Also Present:

John W. Colloton, Assistant Superintendent, University of Iowa Hospitals

I. The Chairman Convened the Meeting Promptly at 10:00 a.m.:

II. Approval of Minutes:

The minutes of the January 25, 1968 meeting were approved as revised and circulated on May 13, 1968

III. Welcome to New Members:

Mr. Goulet, Chairman, welcomed Francis J. Sweeney, Jr., M.D., Hospital Director, Jefferson Medical College Hospital, Philadelphia, Pennsylvania, as a new member of the committee.

IV. Discussion of Budgetary Problems Relating to General Clinical Research Centers:

The Chairman noted that this issue appeared on the agenda largely because of a Memorandum dated May 23rd from Dr. William R. DeCesare's office, addressed to Principal Investigators of CRC units with copies to Program Directors and Financial Officers. He noted additionally that an invitation to officials to attend a meeting of this Committee had been long considered and this event provided the most propitious opportunity to do so.

Serving as a framework for discussion, were the suggestions outlined in Dr. DeCesare's memorandum, a number of recommendations received by COTH headquarters in response to the COTH Special Memorandum of May 28th and possibilities developed in-house by staff (see attached list). A full, frank and cordial four-hour discussion was held at the meeting. Early in

the discussion it was agreed that the existing dynamic fiscal trend does not look promising for either the current grant period (Fiscal Year 1969) and, in all probability, through Fiscal Year 1970. It was also agreed early in the discussions that the concept of discreteness with regard to clinical research centers should be endorsed and preserved whenever possible. There was strong commitment by the entire committee in support of the need for more rather than less clinical research, and the additional need to develop at all levels, mechanisms to avoid "Robin Hood" economics through adequate and purposeful financing of clinical research. However, there was also general agreement that because of the severity of the existing fiscal problem, it is necessary for each grantee institution to assess the opportunities that are available to it within the available alternatives and to use those alternatives, plus any others that an imaginative and thorough review would suggest, in order to develop an individual approach to the resolution of the problem as it affects each particular organization.

Discussion of Alternatives:

The three alternatives suggested in Dr. DeCesare's memorandum: (1) limiting occupancy; (2) reducing levels of personnel funding; and (3) closing centers for limited periods of time, were discussed early. It was generally agreed that each of these suggested alternatives might introduce certain staffing problems and that each of these proposals would suggest the need for accommodation at the grantee institution. However, it was also agreed that each of these alternatives were entirely within the existing guidelines of the program, and that these measures may be those least controversial in their application.

With regard to the alternatives presented by COTH, the following captures the sense of the discussion:

NUMBER 1 - Use Vacant Beds as Revenue-Producing Beds

While this alternative is not available to grantee institutions within the "guidelines" as they exist at the present time, it was the item that possibly drew the most serious discussion. The feasibility of developing "mixed" units, (including CRC supported research patients as well as other patients) through continuing geographic discreteness was introduced as one of the most likely opportunities that could serve as a means resolving the fiscal deficit issue. As will be noted later through presentation of one example, there was discussion of "mixed" units in the discrete unit, maintaining discreteness but utilizing space vacated by closed beds for supportive or non-supportive but related non-bed (such as laboratories) clinical functions. There was discussion of the nature of discreteness, and the need for experimentation to determine whether mixed patient unit, under policies of controlled admissions, would have a detrimental effect on the level of scientific investigation. In general, however, this latter approach seemed to present the best possibility to the discussants. Another possibility, as indicated, was that of using a portion of the space contained within the geographic unit for patient care services closely allied to the function of clinical research. For instance, one institution is considering the feasibility of establishing a "mixed" patient unit by including additional renal transplant patients (the present CRC is already used as a research focus for certain types of renal transplant patients) utilizing the space thereby vacated for the treatment of other acute patients.

NUMBER 2- Deficit in Operation Being Financed by Some Other Funds

It was agreed that this alternative was not new and that a number of the sources

of funds specified had been used by certain institutions to support CRC activities in previous Fiscal Years. Principal investigators funds, categorical institute funds, local and regional foundation funds, individual donor funds, a revolving fund derived from smaller fund sources, state, county and local governmental funds which help support research that is of importance to the local and regional population were among a wide variety of approaches being used or considered.

NUMBER 3- Reduction in Activity of the Unit Tailored to the Availability of Funds

This option is permissible, and actually incorporates several alternatives outlined in Dr. DeCesare's memorandum. For instance it was noted that the closing of the unit for a period of two or more months might effect substantial saving in the individual institution's cost of operations. It was readily recognized that such a proposal would introduce the need for accommodation at the grantee institution level.

NUMBER 4- Elimination of the Unit, but not the Function Achieved Through Maintaining a Scatter-Bed Approach

It was reported that several institutions had been able to supplement CRC funding, with categorical support when the former funding levels were reduced. Again, however, it must be emphasized that there was unanimous endorsement by those at the meeting that the concept of discreteness regarding Clinical Research Centers should be preserved, if at all possible. However, it was also recognized, that in order to preserve the function of clinical investigation, it may be necessary to implement on a temporary basis, some organizational form other than that of a discrete unit.

NUMBER 5- Diversion of All Federal CRC Funds into Only Hospitalization Support

After discussion, it was agreed that there was minimal likelihood that a program of this nature could be effected at this time. There was reported though two instances where if the choice was narrowed to such proposals the Principal Investigators in those locations would "opt" for hospitalization support.

NUMBER 6 - Third-Party Payers

While this alternative appears very attractive as an immediate relief, it becomes extremely problematic after continuing consideration. Additionally, as Dr. DeCesare mentioned in his May 23rd Memorandum, the principle has "been strenuously opposed at all national advisory levels". However, there was agreement that any well-developed proposal would receive thorough consideration, so a plan that is well conceived, fully evaluated and totally endorsed at the institutional level, regarding the possibility of third-party payment, would be studied carefully.

NUMBER 7 - Curtail Activity, but Keep Unit Intact
e.g. 5 Day Operation of Unit

This option was viewed as one that might impose certain administrative difficulties, although it would serve to moderate unit activity. Apparently, from suggestions submitted by members of your COTH staff, there are several units that could operate effectively through a limited operational pattern such as this.

Submission of Budget Proposals:

The Committee discussion closed on the note, that while these seven (7) suggestions represent a compilation and distillation of many sub-groups submitted by COTH members for alternative courses of action as reviewed by this Committee, there was recognition that undoubtedly other measures not described

(or combination, modification, etc. of these seven (7) approaches) could be employed, on an individual basis as a format for a budgetary proposal to the office of Dr. DeCesare. The institutions involved should attempt to devise creative and well-structured recommendations for financing, tailored to the individual operational activity and submit such suggestions to the Clinical Research Centers Branch, Division of Research Facilities and Resources, NIH, Bethesda, Maryland, 20014.

V. Review of Statement of Financial Principles for Teaching Hospitals as Submitted by Subcommittee:

The Subcommittee, consisting of Richard D. Wittrup, Chairman, Bernard J. Lachner and Irvin G. Wilmot reported on the Statement of Financial Principles, (copy of the Subcommittee's draft statement is attached to these minutes). Following a careful review by the subcommittee members of the rationale that provided guidance in this deliberation and final draft statement there was a full discussion of the statement. The following items constitute the major points made by committee members.

1. Is there a need for inclusion of a statement on planning in either the preface or the body of the document?
2. The statement should stress the determination of financial principles within a cost framework rather than an income framework (See Principle #4)
3. Is the Statement sufficiently decisive to distinguish teaching hospitals from the AHA Statement on Financial Requirements for Health Care Institutions - is there a need to stress more distinctive aspects?
4. A greater emphasis should be placed on interns and residents and the attendant costs to teaching hospitals.

5. An area omitted from the Statement, and a distinctive cost to the teaching hospitals is the facilities and services provided to the faculty for their private practice. Should there be recognition of the fact that a portion of the hospital's cost is the medical school's faculty salary earned through private practice?
6. The item "Note" appearing on page 2 under Section 2d, which comments on the income side of the equation, is pertinent, but perhaps is more suited to the preface.
7. There is an absence of the importance on the dependence of patients and physicians in teaching hospitals or of new techniques of diagnosis and therapy.

Following this discussion, it was agreed that the Draft Statement would be referred to the Subcommittee for further refinement on the basis of the Committee's comments and review. It was further agreed that the subsequent draft would be circulated by mail to the full committee for further evaluation and comment. Additionally, it was noted that a draft position statement, being developed by the Committee on Modernization and Construction Funds for Teaching Hospitals would be included in this mailing to allow for comparative review.

ACTION #1

THE DRAFT "STATEMENT ON FINANCIAL PRINCIPLES" WAS REFERRED TO THE SUBCOMMITTEE FOR FURTHER REFINEMENT. UPON COMPLETION OF THIS ASSIGNMENT THE REVISED DOCUMENT WILL BE CIRCULATED TO THE FULL COMMITTEE BY MAIL FOR FURTHER EVALUATION AND COMMENT.

ACTION #2

THE COMMITTEE SHOULD BE WORKING TO MEET A SEPTEMBER 5 AND 6 DEADLINE, THE DATES OF THE NEXT MEETING OF THE COH EXECUTIVE COMMITTEE. AT THAT TIME, IT IS ANTI-

CIPATED THAT A DOCUMENT WILL BE PRESENTED FOR EXECUTIVE COMMITTEE REVIEW,
COMMENT AND DISPOSITION.

VI. Other Business:

The Chairman reviewed the action items from the January 25th meeting and asked Mr. McNulty to comment on the action taken specifically on the following items:

Action #4 - There was an unanimous expression that the 8% ceiling on Indirect Costs for Training Grants was unnecessary hardship on hospitals.

Action #5 - That COTH staff contact Mr. Irving J. Lewis, Deputy Director BOB, strongly urging that the 8% ceiling be removed and further noting that the Council, through the cooperation of hospitals in the Boston area would be willing to provide additional information in support of this request as desired.

Mr. McNulty commented that the Council of Teaching Hospitals had stressed the importance of this issue to Mr. Lewis, as well as to Mr. Nathaniel H. Karol, Director, HEW, Division of Research Grant Policy. He noted that because of Mr. Lewis' departure from the BOB to join the Health Service and Mental Health Administration of HEW, it would not be necessary to develop an additional point of entry into the BOB. Additionally, Mr. McNulty reported that Mr. Lawrence E. Martin had forwarded an extensive financial statement, based on Massachusetts General Hospital's financial statistics, to Mr. Lewis defining clearly the magnitude of the problem.

Action #6 - That the American Hospital Association be urged to consider the advisability of contacting the various appropriate federal agencies in support of the removal of this ceiling.

Mr. Linde commented that he had discussed the issue with Madison E. Brown, M.D., Director, AHA Department of Planning and Development. He was uncertain as to the further action taken, but indicated that he would follow-up and report on the AHA's position on this item.

Mr. McNulty then commented that COTH staff had been receiving a large number of inquiries relating to the recently developed AHA Statement of Financial Requirements for Health Care Institutions and Services. He noted further that to date, he had attempted to maintain a position of neutrality in response to the issue, recognizing that it is representative of the position of another organization. He requested any guidance the committee might offer in this regard, and there was unanimous agreement that the position as he had outlined was the appropriate one.

- VII. It was Agreed that the Next Meeting of the Committee Would be at the Call of the Chairman:
- VIII. There being no Further Business, the Meeting Adjourned at 3:45 p.m.:

Attachment "A"

Proposals Presented by COTH
Relating to CRC Budgetary Problems

1. Use of Vacant Beds as Revenue Producing Beds
2. Deficit in Operation being Financed by Some Other Source
3. Reduction in Activity of the Unit Tailored to the Availability of Funds.
4. Elimination of the Unit, but not the Functions, Achieved Through Maintaining a Scatter-Bed Approach.
5. Division of All Federal CRC Funds into only Hospitalization Support
6. Third-Party Payers
7. Curtail Activity, but Keep Unit Intact, e.g. 5 Day Operation of Unit

Dictated by Telephone to COTH Office

May 23, 1968

TO: PRINCIPAL INVESTIGATORS

FROM: CHIEF, GENERAL CLINICAL RESEARCH CENTERS BRANCH
DIVISION OF RESEARCH FACILITIES AND RESOURCES

SUBJECT: ANNUAL REQUEST FOR CONTINUATION SUPPORT

National fiscal constraints will probably require modification of general clinical research centers program activity in fiscal year 1969. The impact of possible budgetary reduction can be minimized by a joint effort on the part of each center and the General Clinical Research Center Branch.

To prepare for possible budgetary contingencies, we are requesting that you submit by June 15, in addition to the usual application for continuation support due June 1st, two additional budgetary requests. The total ceilings of the appended budget should be as follows:

1. 87.5% of your current operating level
2. 75% of your current operating level

Acknowledged operational difficulties resulting from these reduced funding levels may necessitate different approaches in each case. Some measures which have been suggested to reduce program budget requirements include:

1. limiting occupancy
2. reducing levels of personnel funding
3. closing centers for limited periods of time

Suggestions that third party sources defray part of the hospitalization cost of parts on research centers have been strenuously opposed at all national advisory levels.

The Branch recognizes the need for individual consideration of centers and will be receptive to suggestions as to how best meet this situation.

William DeCesare, Chief, GCRC Branch

cc: Program Directors
Financial Officers

ATTACHMENT "C"

DRAFT STATEMENT OF FINANCIAL
PRINCIPLES FOR TEACHING HOSPITALS

June 6, 1968
Prepared by Subcommittee
Richard D. Wittrup, Chairman
Bernard J. Lachner, Member
Irvin G. Wilmot, Member

DRAFT

STATEMENT OF FINANCIAL PRINCIPLES FOR TEACHING HOSPITALS

The Council of Teaching Hospitals, an integral component of the Association of American Medical Colleges, numbers among its membership the foremost teaching hospitals in the nation. These hospitals in addition to their responsibilities for patient care have a high degree of responsibility for both educational and research activities.

There has been a recognition by the membership of the Council that there is a need for a "Statement of Financial Principles for Teaching Hospitals" which emphasizes both the need for an identification of these costs and the need for reimbursement of such costs.

The following "Statement" is purposefully developed in a broad context to allow for individual institutional adaptation. It is recognized that teaching hospitals are located in a diversity of institution settings with a variety of administrative and organizational relationships. Additionally, as a result of the pressures of demand, growth and rising costs, the financial management problems of teaching hospitals have become more numerous and complex.

An awareness of these two issues; the need for individual institutional adaptation, and the demand for an increase in services have led to the development of the broad context within which the content of these principles are focused.

The membership of the Council is of the firm conviction that these principles can serve as useful guidelines for policy formation, as issues of financial nature are discussed with other individuals and agencies interested in the multipurposed activities that are accomplished in the teaching hospital.

GUIDELINES FOR THE IDENTIFICATION OF PROGRAM COSTS IN TEACHING HOSPITALS

1. Teaching hospitals serve multiple purposes in the teaching, research, and service components of the health industry. A number of public and private agencies are responsible for providing the funds needed to support specific programs conducted by teaching hospitals. Teaching hospitals, therefore, have responsibility for identifying, to a reasonable extent, the costs associated with each program element being so supported. This responsibility is in addition to the general obligation of management to identify and evaluate program costs.

2. The specifics of organizational patterns and institutional objectives vary greatly among teaching hospitals so that each institution must determine for itself the criteria to be used in allocating costs, subject to the following:

- a. To safeguard the financial integrity of the institution it is essential that all costs, including such items as operating and capital costs as appropriate, be identified and allocated to programs.
- b. Criteria for allocating costs should be such as to produce an equitable distribution of costs among the various program elements.
- c. Criteria for allocating costs should be internally recorded and should be available to agencies which provide financial support to the hospital or which, for other reasons, have appropriate need for such information. Teaching hospitals, being public service institutions, should make every reasonable effort, consistent with these guidelines, to agree to the judgments of all agencies as to the reasonableness of the criteria being used. It is appropriate that the hospital's external auditor be required to examine and comment on the reasonableness of the criteria being used.

- d. Criteria for allocating costs, should be maintained with reasonable consistency from year to year. These criteria for allocating costs should be applied consistently among program elements to insure that all costs are allocated.

NOTE: Some agencies providing financial support to teaching hospitals exclude, or limit arbitrarily, certain cost items when calculating the amount of support to be provided. It must be recognized that these exclusions and limitations will make it impossible for teaching hospitals to conform fully to these guidelines.

3. The cost of any activity conducted by a teaching hospital should be allocated equitably among all of the major programs which benefit from it. This is in contradistinction to the incremental approach which allocates to a program only those added costs which a particular program element is believed to create. The incremental approach may be the only practical method applicable to minor and peripheral program elements, but when applied to basic programs tends to produce distorted cost figures and, consequently, to bias decision making procedures inappropriately.

NOTE: It is recognized that the incremental approach to cost allocation is widely prevalent in teaching hospitals and is the basis on which many agencies determine the amount of financial support which they provide to these institutions. It also is recognized that no generally accepted criteria currently exist by which costs may be allocated among programs with dissimilar outputs, i.e., patient care and research. However,

the consequences of the incremental approach are believed to be sufficiently undesirable that immediate effort should be directed towards the identification of methods by which these barriers can be overcome.

4. As a general rule, physician services to patients and hospital services to patients are financed from separate sources, e.g., Blue Cross and Blue Shield. A significant portion of physician services to patients in teaching hospitals commonly is provided by salaried physicians, including faculty members and house staff. Currently, methods of allocating the cost of these salaries vary considerably. To promote uniformity of approach and thus to facilitate the determination of responsibility for financing, teaching hospitals should identify the cost of physician services separately from the cost of hospital services.

5. Except when supported by funds provided specifically for the purpose, stipends and fringe benefits provided to individuals in learning capacities who also render services should be considered to represent the cost of such services and allocated accordingly.

6. The identification of program costs and the reimbursement of such costs to teaching hospitals does not, by itself, provide the institution with a source of funds to support additions to working capital and capital expenditures not financed by depreciation reserves. While the prevailing concept of cost excludes such needs, it is reasonable to expect that each program conducted by a teaching hospital should generate its reasonable share of funds needed for these purposes. The amount of funds to be so generated should be based on a formal plan developed by each teaching hospital which takes into account all sources of such funds, including anticipated grants and loans, and justifies the need for such additions by indicating the approval of recognized planning agencies, where such exist, and by other appropriate means.

August 28, 1968

Introduction to Guidelines
For Allocating Program Costs in Teaching Hospitals

Several current studies are in process which are designed to provide a systematic methodology for accomplishing periodic cost allocation studies in teaching hospitals. These studies are concerned largely with the procedural development and accounting techniques and methods.

While these efforts are welcomed by the Council of Teaching Hospitals as invaluable aids in the implementation of cost allocation programs, the Council is cognizant of the need for selected guidelines that could serve the administrator as he takes a holistic approach to both his institution and to the environment of which it is a part.

The following guidelines are designed for that purpose. These guidelines identify matters of policy, in program cost allocation and serve in a companion relationship to the studies that, when completed, will provide the procedural and methodological alternatives for implementations.

This statement on the program cost allocation in teaching hospitals is the first such statement of its nature offered by the Council of Teaching Hospitals. In order for it to be an effective action document, it is necessary that it be understood clearly by those agencies that provide financial support to teaching hospitals. The Council of Teaching Hospitals stands prepared to assist any of its membership in the implementation of the concept of program cost allocation, or in the institution's discussions with the providers of financial support

regarding the responsibilities that are incumbent on the hospital and the financing agencies through this approach.

DRAFT

GUIDELINES FOR ALLOCATING
PROGRAM COSTS IN TEACHING HOSPITALS

The Council of Teaching Hospitals, an integral component of the Association of American Medical Colleges, includes among its membership most of the leading teaching hospitals in the nation. The Council has recognized the need for the development of general guidelines designed to assure that teaching hospitals are supported adequately and that their sources of financial support are treated equitably.

Many elements of teaching and research in the health field must be integrated operationally with patient care since the teaching function includes the involvement of students in patient care and since data generated by patient care is essential to research. Responsibility for the conduct of these integrated activities is held by the nation's teaching hospitals.

Teaching hospitals play an essential role in the provision of the nation's health manpower, the creation of new medical knowledge, and the development of methods by which such knowledge is applied to the diagnosis and treatment of patients. Because this role is unique, teaching hospitals are strategic to the health of the nation, and their special problems and needs must be of great concern to the public.

The financial support of teaching hospitals comes from many sources. In most cases a particular source provides support for its

specific segment of interest of responsibility within one of the broad program areas of teaching, research, or patient care. Usually, the amount of support provided by a particular source is based directly or indirectly on the cost of the program segment being supported. For the teaching hospital, which conducts these programs as a unified operation, the support received from multiple sources must combine to meet the hospital's total financial requirements.

In view of the above considerations, the Council of Teaching Hospitals had adopted this statement dealing with the subject of allocating program costs.

(1) Teaching hospitals have responsibility for identifying the costs associated with each program element which they conduct.

(2) Teaching hospitals are located in many types of institutional settings with a variety of administrative and organizational relationships, so that the specifics of cost allocation in individual situations may differ. Further, within a given hospital changes in services and programs cause these specifics to vary over time. Therefore, each teaching hospital must determine for itself the bases to be used in allocating costs, subject to the following:

- a. Bases of allocation should be such as to produce an equitable distribution of costs among the various program elements.
- b. Bases of allocation should be documented and available to agencies which provide financial support to the hospital.
- c. Bases of allocation should be related where appropriate to

specific segment of interest of responsibility within one of the broad program areas of teaching, research, or patient care. Usually, the amount of support provided by a particular source is based directly or indirectly on the cost of the program segment being supported. For the teaching hospital, which conducts these programs as a unified operation, the support received from multiple sources must combine to meet the hospital's total financial requirements.

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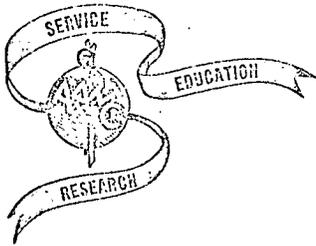
(2) Teaching hospitals are located in many types of institutional settings with a variety of administrative and organizational relationships, so that the specifics of cost allocation in individual situations may differ. Further, within a given hospital changes in services and programs cause these specifics to vary over time within a hospital. Therefore, each teaching hospital must determine for itself the bases to be used in allocating costs, subject to the following:

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- b. Bases of allocation should be documented and available to agencies which provide financial support to the hospital.
- c. Bases of allocation should be related where appropriate to

generally accepted hospital accounting practice. It is appropriate that the hospitals external auditor examine and comment on the reasonableness of such bases.

- d. Bases of allocation should be maintained with reasonable consistency from year to year and should be applied consistently among program elements.

(3) Physician services to patients in teaching hospitals are frequently provided by faculty members and house staff, who are financially supported in full or in part by the hospital. To promote uniformity the cost of physician services to patients should be identified separately from the cost of hospital services.



ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF TEACHING HOSPITALS
1346 CONNECTICUT AVENUE, N.W.
WASHINGTON, D. C. 20036
202/223-5364

MATTHEW F. McNULTY, JR.
DIRECTOR

August 12, 1968

Mr. Nathaniel H. Karol
Director, Division of Grants
Administration Policy
Office of the Secretary
Department of Health, Education and Welfare
330 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Nat:

Thank you for forwarding to us several copies of the Department Staff Manual: Grants Administration, developed by the Division of Grants Administration Policy, Office of the Assistant Secretary Comptroller.

Of the 5 parts contained within the document, the Council of Teaching Hospitals is interested most particularly in Part 2, Research Grants. This interest derives from previous correspondence and meetings we have had with your office relating to several items that are included in the previously published A Guide for Hospitals: Establishing Indirect Cost Rates for Research Grants and Contracts with the Department of Health, Education and Welfare. As you will recall we were particularly concerned by the position of the Department, as stated in this Guide in regard to: depreciation or use charge; interest, fundraising and investment management costs; profits and losses on disposition of plant equipment, or other assets; and bad debts. The immediate source of our concern, as we have expressed several times, is the variance in Departmental policy on these items with previously established and implemented policy as contained in the Principles of Reimbursement for Providing Costs, as published by the Social Security Administration, HEW.

Additionally, we have noted that in the explanation footnote to these items on pages 25, 30, and 34 of Section x-2-66-1 of the newly issued Manual, reference is made as follows:

Differences between the two sets of principles will be subject of continuing study to determine whether such differences cause problems which require that the principles for determining cost of research and development conducted by hospitals be modified.

We have been most interested in this "continuing study" and are interested in its current status. According to our records a Committee was established. Membership on that Committee includes Mr. Charles R. Goulet (Chairman, COTH Committee on Financial Principles for Teaching

Mr. Nathaniel H. Karol
August 12, 1968
Page Two

Hospitals and Superintendent, University of Chicago Hospitals and Clinics), Fletcher H. Bingham, Ph.D., Assistant Director, COTH and myself. This Committee has met once, at which time a subcommittee was appointed to examine the problem and to structure a set of recommendations for review by the full Committee. This subcommittee distributed its report and recommendations.

To date, no further activity relating to this "continuing study" has occurred.

We would appreciate an indication from your office on the status of this study effort. As I have commented in my previous correspondence, we do want to act constructively and responsibly in the public-private relationship, and we hope that this letter displays that intent.

We will await your response. Until then.

Cordially,

MATTHEW F. McNULTY, JR.
Director, COTH
Associate Director, AAMC

cc: Edwin L. Crosby, M.D.
Charles R. Goulet



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
WASHINGTON, D.C. 20201

OFFICE OF THE SECRETARY

August 21, 1968

Mr. Matthew F. McNulty, Jr.
Director, COTH
Associate Director, AAMC
1346 Connecticut Avenue, N. W.
Washington, D. C. 20036

Dear Matthew:

It is always a pleasure to hear from you although I could wish that less of our correspondence was concerned with a single issue on which there appears to be a continuing misunderstanding.

The Department is fully cognizant of the commitment represented by the language in our hospital cost principles which states:

"Differences between the two sets of principles will be subject of continuing study to determine whether such differences cause problems which require that the principles for determining cost of research and development conducted by hospitals be modified."

This commitment was made to the Executive Committee of the American Hospital Association by the Secretary, the Assistant Secretary, Comptroller and myself on the occasion when we met with them in an effort to resolve the conflicting pressures to conform to a standard set of cost principles for hospitals on the one hand and a standard set of cost principles for research (without regard to institution) on the other.

As I have indicated to you on numerous occasions, differences between the Hospital Cost Principles and the Principles of Reimbursement for Provider Costs can only be evaluated as to their impact after some experience with their implementation. The Committee to which your August 12 letter refers was at no time charged with the responsibility of evaluating the differences between the two sets of principles but was instead formed for the purpose of facilitating rapid and effective implementation of the principles. Again, I repeat that only after such implementation will we be in a position to properly evaluate the impact of the principles.

You may be interested however, in the fact that one of the major areas of difference between the medicare cost principles and existing cost principles, namely the treatment of interest on borrowings, has been

identified to the Bureau of the Budget by the National Association of College and University Business Officers as one of the areas in Bureau of the Budget Circular A-21 that should be considered for modification. It is my understanding that the Bureau of the Budget now has this and approximately nine additional items under consideration. Your association may wish to inform itself of the activities of the National Association of College and University Business Officers in this connection.

Cordially,

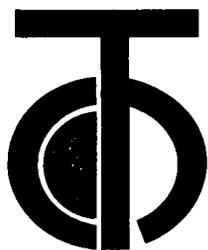


Nathaniel H. Karol
Director, Division of Grants
Administration Policy

cc: Edwin L. Crosby, M.D.
Charles R. Goulet

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COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

1346 CONNECTICUT AVENUE, N. W. • WASHINGTON, D. C. 20036 • (202) 223-5364

COTH
General Membership Memorandum
No. 68-40G
August 26, 1968
Subject: Minutes of Regional Meetings

1. Minutes of Regional Meetings:

Enclosed are the minutes of the four Regional Meetings of the membership of the Council, which were held during the Administrative Year 1967-68. This general summary of the discussions at each meeting is being distributed to all COTH members.

These four meetings encompassed four COTH regions: The Western; the Southern; the Northeastern; the Midwest/Great Plains.

2. Future Regional Meetings:

There was a general consensus expressed by the members present, that it would be most useful to have one such Regional Meeting a year. As in the past, we would anticipate convening the meetings at 10:00 a.m. and adjourning at 4:00 p.m. In order to develop a preliminary schedule for preplanning the future Regional Meetings, the following dates and meeting places are offered as tentative opportunities for such meetings:

Midwest/Great Plains	May 1, 1969	Chicago
Northeast	April 16, 1969	New York
Southern	April 30, 1969	Atlanta
Western	April 4, 1969	San Francisco

As these dates are firmed up, we will be in contact with each member, through the Regional Membership Memoranda series, to finalize the date, place and the program activity.

MATTHEW F. McNULTY, JR.
Director, COTH
Associate Director, AAMC

Enclosures: Minutes of the Western, Northeastern, Southern and Great Plains-Midwestern Regional Meetings

Minutes of COTH Western Regional Meeting
Sheraton Thunderbolt Motel
San Francisco, California
April 4, 1968

There were 33 administrators, or their representatives from 20 institutions present.

The meeting was called to order by Harold H. Hixson, COTH member of the AAMC Executive Council, who introduced the acting secretary of the meeting, Miss Wanda Jones, and presided over introductions of members and guests.

Mr. Hixson stated that a meeting had been scheduled last year for the Western Region members, but it proved too difficult to choose a time since many members had conflicting engagements.

Mr. McNulty, Director of COTH, introduced the other members of the headquarters staff, Fletcher H. Bingham, Ph.D., Assistant Director, COTH and Thomas J. Campbell, Assistant Director, Division of Operational Studies. Mr. McNulty then discussed the history of COTH developments as follows:

Since the mid-30's there have been hospital groups in the Mid-West and on the East Coast who would meet and collect comparative data on the operation of member institutions. Later, some of the groups approached AAMC to suggest meeting on a national level, to discuss national problems. The first meeting in Philadelphia was to discuss management of university hospitals with deans of medical schools. Within three years AAMC had a Teaching Hospital Committee of which Mr. Hixson was the first chairman. The requirement for membership was that appointment was to be made by the dean of the medical school to which the hospital was related. A Teaching Hospital workshop was developed and conducted in Miami, in order to discuss financing, relationships, and possible association with AHA (which wished to avoid internal division along interest group lines).

AAMC commissioned Dr. Lowell T. Coggeshall to study the organization and make a recommendation as to the relationship that should exist between AAMC and the teaching hospital group.

The result of his study was to make the teaching hospital group an integral part of AAMC rather than a separate member of a federation. Mr. McNulty joined the Council in 1967 as Director on a 2-year leave of absence from the University of Alabama. One of the early accomplishments of the council was obtaining a statement of support for medical education from the Federal Government. The relationships with the government were considered important enough that staff was established in Washington, D.C. They included Fletcher H. Bingham, Ph.D. a graduate of the University of Iowa with a Ph.D. in Hospital Administration, and Grace W. Beirne, former administrative assistant to Representative Fogarty. The tasks of the staff are to produce educational and informational material, help formulate policy, and represent the council with the Washington offices of AHA and AAMC.

The Council now consists of 335 hospitals in the United States, Canada, Puerto Rico, Hawaii, and the Canal Zone. (There are no members from Alaska at present). Hospitals may not only be nominated by deans of medical schools, but may be self-nominated if they have a teaching program that includes three of four residency programs: medicine, surgery, OB-Gyn and psychiatry. Even though only approximately 200 hospitals are eligible under this criterion, interest in membership has been shown by 600 hospitals.

The council is represented on the executive council of AAMC by 3 members, T. Stewart Hamilton, M.D. (3 years), Russell A. Nelson, M.D. (2 years), and Harold H. Hixson (1 year). Other members on the executive

council are from the Council of Academic Societies (3 members) and 3 medical school deans. It is hoped that a corporate advisory body similar to AHA's house of delegates will be established that will have 100 representatives from medical school deans, 35 from the Council of Academic Societies and 34 (10%) from COTH. An executive committee of this group would deal with daily business.

In the Western Region, there are 35 members in 13 states with six states having no representative. They are Idaho, Nevada, Montana, New Mexico, Wyoming and Nebraska.

Officers of COTH are:

Chairman - Lad F. Grapski, Allegheny Hospital, Pittsburgh, Pennsylvania

Chairman Elect - LeRoy S. Rambeck, University of Washington, Seattle,
Washington

Immediate Past President - Stanley S. Ferguson, University Hospital
of Cleveland, Ohio.

At the conclusion of Mr. McNulty's presentation, Mr Hixson opened the meeting for discussion. Dr. Samuel Sherman of Mount Zion Hospital, now in the Legislative Committee of AMA agreed with Mr. McNulty on the nature of the Washington power structure and on the necessity of being able to deal with the main actors in the drama of change. Dr. Sherman stated that it is also important that members know not only the way changes are brought about but also the tools that are used, such as PPBS, or Program Planning and Budgeting System. The former approach of AMA was to exercise veto power over undesirable legislation - now they have realized that they will have to propose and support beneficial legislation.

Mr Hixson added that the Boards of Trustees should recognize the need to have outside influence - for the national good as well as the institutional good, otherwise, they would not be fulfilling their responsibility to their institution.

II. Mr. Hixson then introduced Tom Campbell, who discussed the Yale - New Haven study and the AAMC -DHEW Program Cost information study. The latter study was undertaken in 1966 for the purposes of identifying fiscal and management information in Medical Centers, comparing the results, with the requests and needs of the Federal Government with a view to having the government modify its requirements according to the kinds of reports that are normally developed by the institutions. A protocol has been written for the institutions to use in analyzing their financial affairs. Seven representative hospitals will develop operating reports that can be compared and that will be published with the assistance of HEW, AAMC and the Kellogg Foundation. The Yale - New Haven study, supported by AAMC, AMA and AHA and beginning in 1958, attempted to identify the separate elements of costs; teaching, research, patient care and service to the community and to integrate these with the cost-finding methods of AHA.

The target date for publication of the AAMC study is sometime between May and August, 1968. Because of the illness of the prime author of the Yale - New Haven study, Mr. A.J. Carroll, it may not be published until later.

Mr. McNulty then discussed the COTH Committee on Modernization and Construction of Teaching Hospitals which plans to produce a position paper which states the needs and the reasons financial help is required.

Dr. Bingham reported on the COTH Committee on Financial Principles. A subcommittee is producing a working document which will attempt to separate and identify cost elements and demonstrate the need for full reimburse-

ment. Those present commented upon "A Guide for Hospital" which was published in January by HEW without the prior knowledge of COTH.

III. Mr. McNulty reported on the New York issue of house staff stipends; they are now experiencing demands for \$12,000 for an intern and a range that culminates in \$18,500 for a 6th year Chief Resident. It was noted that New York hospitals would have a difficult time operating without house staff. The house staff are organized and expected to continue the demand.

There is also a problem with dwindling "teaching cases" as well as continuing difficulty with "how to bill" for hospital-based physicians, including teaching staff. Under Medi-Cal, a faculty member cannot bill but faculty group practice associations may. No full payments have been made to these groups as yet, however, as there is some question as to whether the faculty member can charge fees for supervision of intern or resident. It was noted that the faculty member may bill if he demonstrates "some participation" in the actual care given. This question is still interpreted differently by each intermediary.

At UCLA, senior residents have been made members of the attending staff so they might collect for the patients they care for. Another open problem with IRS is "non-related income" accruing to non-profit organizations thru the role of advertising, exhibit space or over-the-counter pharmaceuticals, a community service not essential to the service of the hospital. Since it is only an IRS regulation, test cases may succeed in preventing its broad application. A bill proposed by Senator Tydings will

identify non-related activities and have them exempt by law.

Another problem is shared service operated by non-profit organizations jointly. The Hartke - Murphy Bill would declare that they are exempt.

Mr. O'Dell described the Barr Report to the members and urged that they all obtain copies and read them since the suggestions were far-reaching and significant.

Finally, Mr. Hixson complimented the staff and obtained a consensus that the next meeting should be in conjunction with the annual meeting of COTH in Houston, November 1 - 4.

There being no further business, the meeting was adjourned at 3:45 p.m.

MINUTES OF COTH NORTHEASTERN REGIONAL MEETING
New York University Hospital
New York, New York
April 25, 1968

Attachment #2

In attendance were 77 administrators or their representatives from 51 institutions.

I. The meeting was called to order by Mr. Lester E. Richwagen, member of the COTH Executive followed by a brief welcome on behalf of COTH, by Mr. Lad F. Grapski and Mr. Irvin G. Wilmot welcomed the attendees on behalf of the New York University Medical Center.

II. REPORT BY COTH AND AAMC STAFF - Mr. Matthew F. McNulty, Jr. then reported to the members present concerning the partnership between COTH and the AAMC and discussed various aspects of the reorganization of the AAMC and the activities of the various COTH Committees.

Dr. Bingham reported on the activities of the COTH Committee on Financial Principles for Teaching Hospitals, noting particularly that the Committee was in the process of drafting a statement relating to the development of guidelines for program cost allocation in teaching hospitals. He noted several other problem areas that had developed and which the Committee was taking under advisement.

Mr. Thomas J. Campbell, Assistant Director of the AAMC Division of Operational Studies reported on the Yale-New Haven Study and the cost information study that is being undertaken at such medical centers. He stated that the purpose of the current study is to develop methods of criterion that teaching hospitals can use to allocate cost to their various programs. It was reported that the study on the seven medical centers was designed to produce a series of methodologics which would be appreciable to other teaching hospital situations.

III. STIPENDS FOR HOUSE STAFF AND THEIR TAX STATUS - The issue of stipends for interns and residents was combined with the issue of the tax exempt status for house staff. There was considerable expression that there was some inconsistency in these differing positions by house staff. On the one hand, they are demanding increases in stipends because of their service responsibilities, while on the other hand, they want an IRS exemption because of the educational nature of their activity. Because New York is the site in which the Committee on Interns and Residents is pursuing their demands for \$12,000 per annum for interns with a \$1,000 increment per year of residency and an additional \$500 for Chief residents, there was considerable interest in the negotiations between the C.I.R. and New York City.

Mr. Dan Jr. Macer assumed the chair and recommended the meeting follow the luncheon interval.

IV. PHYSICIAN REPRESENTATION ON TEACHING HOSPITAL'S BOARDS OF

TRUSTEES - It was noted that this item had been placed on the agenda because of a request of Mr. Irwin Goldberg, Executive Director, Montefiore Hospital of Pittsburgh. A complete discussion followed and it was agreed that because the American Hospital Association had been investigating this problem and had issued a position statement, that it would be most appropriate for COTH to support this position.

V. PHYSICIAN PAYMENT UNDER TITLES XVIII AND XIX OF P.L. 89 - 97

Mr. McNulty noted that this topic was on the agenda because of problems which had occurred in certain geographic areas, most notably Georgia and California, and or refusal by the agent to pay.

There followed discussion of individual problems that had arisen in the institutions represented, including the relationship with the medical school and the hospital with regard to reimbursement. Related discussion ensued with regard to the AHA Statement of Financial Requirements for Health Care Institutions. Mr. McNulty urged that all attendees who had encountered some difficulty with the third party carriers send to COTH copies of all correspondence they have had with the Social Security Administration with regard to payment of physicians under Title XIX. He noted that several conferences, on a local level, had been held concerning Medicare and Medicaid and that COTH was working on negotiations for a contract to study the effects of that and other legislation on the teaching hospital patient population and other variables.

VI. GENERAL CLINIC RESEARCH CENTERS - The budgetary problems for teaching hospitals were discussed and it was reported that there are 91 clinical research centers in 74 institutions in the country. The 91 centers represent 1,160 beds. At the present time, there are twelve projects up for renewal, plus six new approved applications which have not been funded. It was noted that the administration's budget calls for a slight increase in the budget for clinical research centers during the coming fiscal year and it was suggested that the various hospitals with clinical research centers work hard to stay within their appropriations. Several suggestions were discussed and are as follows: (1) the hospital may assume a portion of the cost; (2) part of the cost might be provided from individual research grants or from private donors; or (3) a reduction in clinical research center beds might be initiated; (4) admissions could be stopped to some clinical research limits for

several months; and (5) beds could be used for service purposes on a unit, if the unit could be discreetly costed on the basis of beds.

MINUTES OF COTH SOUTHERN REGIONAL MEETING
Hilton Inn
Atlanta, Georgia
April 30, 1968

There were 41 administrators, or their representatives, from 27 institutions present.

I. Mr. Charles H. Frenzel, Member, COTH Executive Committee called to meeting to order. Mr. Walter W. Diggs extended greetings to those in attendance on behalf of the Southeastern Hospital Conference, which was meeting concurrently with the meeting of the Council of Teaching Hospitals.

Mr. Frenzel then introduced Mr. McNulty who gave an account of the current activities of the COTH and the AAMC. He stressed particularly the potential reorganization of the AAMC and the effect that such a reorganization would have on the Council of Teaching Hospitals.

Dr. Bingham reported on the activities of the COTH Committee on Financial Principles for Teaching Hospitals, noting particularly that the Committee was in the process of drafting a statement relating to the development of guidelines for program cost allocation in teaching hospitals. He noted several other problem areas that had developed and which the Committee was taking under advisement.

Mr. Thomas J. Campbell, Assistant Director, AAMC Division of Operational Studies reported on the Yale-New Haven Study and the cost information study that is being undertaken at such medical centers.

Discussion commenced concerning stipends for, and definition of, house staff. It was generally agreed that: 1) some type of standard should be established for reimbursement of the services of house staff, especially in light of the growing demands of that group as exemplified by the situation in New York City; 2) that it is desirable

to identify as explicitly as possible the function of the house staff in terms of how much of their role is service, how much is education, and so forth. It was noted that not only the AAMC, but also other interested organizations deeply involved in medical education had studied the question of house officers' role and thus far the 15 to 20 position papers evolved have resulted in no conclusion of the problem.

Taxable Status of House Officers' Stipends: It was agreed that the taxability status of the stipend currently depends upon the interpretation of the individual IRS districts in which the ruling is being sought. Mr. McNulty reported that informal information from the national IRS office indicated that any national ruling would declare the stipends taxable in all likelihood. If no national ruling is sought, the IRS will do nothing to alter district interpretations. Again the question arose as to the definition of the house staff's role, which led further to discussion of the degree of house staff participation in deliberations over the definition. It was generally admitted that their degree of participation was negligible. Further, discussion arose as to participation of house staff and representation thereof within the AAMC. Mr. McNulty noted that the AAMC Group on Student Affairs was representative of them to some extent. For informational purposes, a poll was taken of the attendees concerning the desire for a national policy from the IRS on taxability of stipends, the vote being 25% opposed and 75% in favor of a national ruling. Further discussion, however, seemed to favor the evolution of a definition by parties involved which could be presented to the IRS as guidelines rather than by doing nothing and thus leaving it up to the IRS to define the house staff role. This definition must be evolved

by all disciplines concerned and achieve some kind of national uniformity.

Use of FMG's on House Staff: Mr. McNulty reported on recent changes in the processes of the ECFMG program concerning foreign medical graduates in this country. He noted that minimum standards for practice in this country are being raised so that much fewer foreign medical graduates will be available and that some foreign countries have taken action to prevent a "brain drain"; India, for example, having cut by 1/3 the number of physicians who come to the U.S.

Physician Payment Under Title XIX: Mr. McNulty noted that this topic was on the agenda because of problems which had occurred in California and in Georgia concerning inability and/or refusal to pay. There followed discussion of individual problems that had arisen in the institutions represented, including the relationship with the medical school and the hospital with regard to reimbursement. Related discussion ensued with regard to the AHA Statement of Financial Principles for Health Care Institutions, an official document which only awaits House of Delegates approval. Mr. McNulty urged that all attendees who had encountered some difficulty send to COTH copies of any correspondence they have had with the Social Security Administration with regard to payment of physicians under Title XIX. He noted that several conferences on a local level had been held concerning Medicare and Medicaid and the COTH was working on negotiations for a contract to study the effects of that and other social legislation on teaching hospital patient population and other variables.

COTH Representation Activities in the Public & Private Sectors:

Mr. McNulty reviewed COTH's active liaison with the AHA through meetings of the Presidential officers as well as AHA representation on COTH committees. He noted that there should be more liaison with the AHA, however, which the COTH is now trying to develop. The Brookings Institution is looking to COTH for information concerning its Study on the Cost of Higher Education, which expresses another arm of COTH activity. In exemplifying COTH's activities in the public sector, Mr. McNulty mentioned the COTH Committee on Modernization and Construction Funds for Teaching Hospitals and its activities in "keeping on top" of all legislation that may affect or help teaching hospitals, such as the Ribicoff Committee Hearings, and in developing a White Paper on teaching hospital needs. He also noted that through its three representatives on the AAMC Committee on Federal Health Programs, COTH had spoken if its needs and voiced them well enough that the needs for funds in medical education were reflected in the President's Health Message. He urged that, while COTH tries to represent its constituent's needs in Congress, at HEW and with interested private organizations, much more representation is needed - which can hopefully be achieved as the COTH staff develops. He did strongly urge that the member teaching hospitals go to their local, state and Federal representatives to represent their needs, using local institutions as examples which can be seen by those representatives. Expression of need at the grass roots level is often the most effective manner in which to make the needs heard.

JCAH Position Regarding Medical School Externships: Dr. Bingham reported that the Group on Student Affairs had received many questions on this since the JCAH issued a memorandum on this which has confused many institutions with regard to the definition of externships as an education experience. Again, Mr. Diggs pointed out, there is a need to define the basis of defining "educational experience". For those who were not aware if the issue involved, Dr. Bingham referred them to JCAH Bulletin #47.

Date of Next Meeting: Mr. McNulty said that 2 membership meetings a year seemed practical - one regional and one at the annual meeting. It was approved that the 1969 meeting be held in Atlanta on April 30, 1969, for the Southern region.

Motion from the Floor: Just prior to adjournment William S. Coppage, Jr., M.D., Chief of Staff, Veterans Administration Hospital, Nashville, Tennessee, made the following motion which was carried by a vote of 8 to 5 after being seconded:

I would like to suggest that those meeting petition the Executive Committee, recognizing their concern for and interest in postgraduate medical education, to meet to analyze and define the appropriate role of internship and residency for patient service and education; and have observers from other appropriate bodies such as the AHA and the AMA. And that out of such a study, a definition would come that would define the standpoint of COTH and AAMC and have the definition as a basis for discussion with others. The definition and leadership should come from this body so that there is not a vacuum and the definition does not come from the Federal Government of the IRS.

May 31, 1968

William S. Coppage, Jr., M.D.
Chief of Staff
Veterans Administration Hospital
1310 24th Avenue, South
Nashville, Tennessee 37203

Dear Doctor Coppage:

Re: Appointment of an Ad-Hoc Committee to Develop Guidelines and Position Paper on Interns and Residency Responsibilities and Stipends

As a followup to a subject discussed, and action taken on that subject, at the COME Southern Regional Meeting in Atlanta on Tuesday, April 30, 1968, your COME headquarters office believes you will be interested in knowing that an Ad-Hoc Committee of the total AAMC has been appointed to develop guidelines and if possible, a position paper concerning the essence of post-doctoral medical education at the internship and residency levels and the stipend related to the functional activities of these house staff groups.

The Ad-Hoc Committee has held two meetings. Its membership consists of three eminently qualified medical educators including: a dean who is a past president of this association and a long time student of house staff activity; a practicing surgeon who for fifteen years has been chief-of-staff of a university hospital; and a distinguished director of a freestanding teaching hospital which has had a vigorous involvement in medical education for more than fifty years. This latter individual is a member of the Executive Committee of the Council of Teaching Hospitals.

In addition to indicating to each of you a prompt followup on the recommendation made at the Southern Regional Meeting of April 30th, it is the purpose of this memorandum to solicit any recommendations, observations or drafts of position statements on the subject matter. Such information will be transmitted promptly to the Chairman of the Ad-Hoc Committee for its consideration.

William S. Coppage, Jr., M.D.
May 31, 1968
Page Two

This request for your advice and recommendation is not an idle one. In its meetings to date, the Ad-Hoc Committee has already encountered the very difficult problems experienced by other committees on this subject. Medical professional discipline associations indicate that their definition of house staff function is the one which they intend to support and that essentially they are not interested in any different set of guidelines or definitions. Thus, the three-man Committee, in addition to long experience and outstanding leadership they bring to their assignment, would be appreciative of any creative thoughts, ideas or recommendations that other members of COIH would desire to submit for thorough study and consideration.

Cordially,

MATTHEW F. McNULKY, JR.
Director, COIH
Associate Director, AAMC

MEH/vw

cc: All attendees at COIH Southern Regional Meeting Tuesday, April 30, 1968, Atlanta, Georgia.

bcc: Next Executive Committee Meeting
Suspense - 7/1/68 - any action by Committee?

MINUTES OF COTH MIDWEST - GREAT PLAINS
REGIONAL MEETING
O'Hare Inn
Chicago, Illinois
April 19, 1968

There were 52 administrators, or their representatives, from 40 institutions, present.

I. The meeting was called to order a few minutes after 10:00 a.m. by Mr. Charles R. Goulet followed by a brief welcome by Mr. Stanley A. Ferguson. Mr. Matthew F. McNulty, Jr., then reported to the members present concerning the partnership between COTH and AAMC, discussing the possibility of the reorganization of the AAMC and the activities of the various COTH committees.

Following Mr. McNulty's report several pertinent items were mentioned: one that there seemed to be a significant amount of interest concerned with the 8% overhead factor on training grants, which appears to hospitals to be a ceiling set by federal legislation and this seems to be causing problems in several of the teaching hospitals represented at the meeting. It was reported that the committee on financial principles is trying in a broad sense to develop one set of principles for teaching hospitals with regard to applying depreciation in a uniform way with regard to the various grants and third party payments.

II. Davis G. Johnson, Ph.D. (Director, AAMC Division of Student Affairs) spoke briefly on the history of the Externship Program and also discussed the joint study that was made by the AAMC and the AMA a few years ago to determine why externs took externships. He reported that the main reasons were for the educational experience that the extern could gain and the other was the money involved.

Of a poll taken of the members of teaching hospitals that were present, only two hospitals said that they had Dean-approved externships. Another point was made that Deans of Medical Schools are probably becoming more reluctant to verify that an externship in a community hospital is educational in nature.

The feeling of the group seemed to be that externships were appropriate if they were approved by the Dean of the Medical School and with this approval, the assumption would be that the externship would be an educational experience and that externs would receive the proper supervision. Of course, the issue remains with the community hospital and the legality of the externships.

The question was raised as to the feasibility of developing a uniform recommendation form for senior medical students, enabling hospitals who are looking for interns to more uniformly evaluate individuals. The consensus of the group seemed to be that it is impossible to uniformly evaluate individuals; therefore, such a form would not be of much use to most institutions.

It was also reported that a uniform application is being developed for prospective students applying to medical schools. This would require the applicant to fill out only one form and have only one set of credentials sent to the AAMC headquarters and this information would then be made available to any institution at which the prospective student would like to apply.

III. Mr. Thomas J. Campbell, Assistant Director of AAMC Division of Operational Studies discussed some of the studies in progress and the history of the Yale-New Haven study which began in 1964. He stated the purpose of a current study is to develop methods of

criterion that teaching hospitals can use to allocate cost to their various programs. It was reported that currently a study in seven medical center teaching hospitals is being conducted and these seven hospitals are involved in a "self-study" in an attempt to develop seven different costing methods. A target date for reporting has been set for May 15, 1968. It is hoped that through the study a methodology might be developed which could be applicable and compatible to other teaching hospital situations. It was reported that within two to three months a report will probably be ready for the Health, Education and Welfare Department and the AAMC.

Mr. McNulty discussed the financing of house staff stipends. It was noted that some of the high salaries that are being paid and negotiated for in the New York-Boston area, Los Angeles-San Francisco area and the Seattle area possibly represented payment for service, versus a stipend paid to interns and residents along with the educational experience they are receiving in some of these institutions. This point was not shared by all. It was felt by some that these hospitals that were being forced or asked to provide higher salaries have probably not provided for an adequate medical staff to care for the patients in these hospitals. It was stated that educational excellence versus service seems to be the issue when it comes to bargaining in some of the major metropolitan areas today.

The tax status of interns and residents was discussed with relationship to the Internal Revenue Service. It was felt that there were three basic philosophies: (1) stipends are educational payments; therefore, non-taxable, (2) the first \$3,600 is non-taxable, any amount above that is taxable, and (3) all of the stipend is taxable

which implies service rather than educational experience.

It was stated that the above depends of the various regions of the United States and the interpretation of the Internal Revenue Service Regional offices in those areas.

It was pointed out that several areas would be taking their cases to the courts in the near future in order to "test the law" to determine if intern and resident stipends are truly taxable through activities of the N.A.R.I.

IV. The question of payment for physician services under Title 18 and Title 19 was brought up and stimulated a good discussion. It was pointed out that in some areas both under Title 18 and 19 faculty salaries in group practices are non-collectable whereas other areas seem to be having a little difficulty.

The budgetary problems for teaching hospitals with clinical research centers were discussed and it was reported that there are 91 clinical research centers in 74 institutions in the country. The 91 centers represent 1,160 beds. At the present time, there are twelve projects up for renewal plus six new approved applications which incidentally have not yet been refunded.

The President's budget calls for a slight increase in the budget for clinical research centers during the coming fiscal year and it was suggested that the various hospitals with clinical research centers will have to work very hard to stay within their appropriations. Several suggestions were discussed and are as follows: (1) the hospital may assume a portion of the cost, (2) part of the cost might be provided from individual research grants or from private donors, (3) the reduction in beds for clinical research centers might be initiated,

(4) admissions could be stopped to some clinical research units for several months, and (5) other beds could be used for service purposes on a unit if the unit could be discreetly costed on the basis of beds.

One of the most significant points of the meeting was that teaching hospitals need to be represented by individuals who are aware of the needs, desires, and problems of teaching hospitals and the sentiments need to be expressed to influential leaders and elected officials today more than ever before. Representation is important not only at the local and state levels, but also at the national level. Hospital officials must explain why hospital costs are what they are and what administrators are trying to do about these costs, especially in light of the Presidents concern for health care and its cost to the country.

INTERNSHIP AND RESIDENCY STIPENDS

Changes in the methods of financing all health care require a review of the remuneration of house officers. In the past the better house staff training programs existed in those hospitals with large ward services and a cadre of full-time clinical staff members. The patients on these services received professional care without charge. The stipends of house staff members were generally low and often in inverse proportion to the educational value of the programs. Socially, the majority of house officers were unmarried and had limited financial responsibilities.

Today the large majority of patients in teaching hospitals receive professional care for which either the physician, the hospital, or both, receive compensation. The house staff are usually married and have children, with the additional financial responsibilities often including debt as the result of the costs of their medical education. These responsibilities, plus the fact that Medicare, Medicaid, Blue Shield and other third-party reimbursement programs are paying for professional service, are leading to increasing pressure from house staff for greater remuneration.

The following points must be considered with respect to the present system of house staff training.

1. Interns and residents are physicians holding M. D. degrees. The majority of residents are licensed in the state and are practicing medicine under varying degrees of supervision.

2. Interns and residents are employed by hospitals which in recent years have been able to include the costs of the house staff programs in their charges to third-party carriers of sickness and health insurance.

3. Patient service and clinical experience take priority over the educational opportunities in most programs.

4. Approximately two-thirds of all interns and residents today receive their training in hospitals affiliated with medical colleges. In spite of this fact the colleges have had limited responsibility for the design, approval or financing of the programs.

5. The colleges make a very significant financial contribution to the programs through their support of the salaries of full-time and part-time clinical faculty members in their teaching hospital. In several cost estimate studies 7% to 9% of the total budgets of the medical schools are expended on the instruction and supervision of interns and residents. The dollar value of such expenditure may exceed 1 1/2 million per year.

The programs developed through the cooperation and joint support of medical schools and affiliated teaching hospitals have produced highly competent and experienced physicians. Any changes in the programs should not lower the quality of the product.

Recommendations

1. The service aspect of internships and residencies must be recognized and adequately compensated for so that the house staff member can reasonably meet his social and financial responsibilities.

2. Stipends should be adjusted from year to year on the basis of the cost of living index.

3. House officers should be considered as professional supervisory employees of the hospital and not paid on an hourly or daily rate.

4. Educationally, time should be available for study. This could be done by limiting the service responsibility or providing some free or elective time.

A study of the entire system should be carried out in some depth concerning the following questions:

1. Should the interns and residents continue to be hospital employees or members of the professional staff with charges made for their services to third-party carriers?

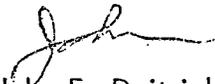
2. Professional medical care is delivered to an increasing extent by groups of specialists. Should not the house staff be considered as part of such a group?

3. Are the systems too rigid, based on time of service rather than the degree of accomplishment and competency?

4. Can a better structure be designed which would allow the individual completing a residency to continue to deliver the amount and quality of service he provided as a chief resident? Today he may spend several years developing a practice which will fully occupy his time and talents.

The AAMC, the Council of Teaching Hospitals, and other interested groups could properly study such questions.

May 17, 1968


John E. Deitrick, M.D.

This draft has been sent to the other members of the committee but has not as yet been approved by them

Ad. L. H. H.

HARTFORD HOSPITAL

MB

HARTFORD HOSPITAL CORPORATION

T. STEWART HAMILTON, M. D.
EXECUTIVE DIRECTOR

June 6, 1968

John E. Deitrick, M.D., Dean
Cornell University Medical College
1300 York Avenue
New York, New York

Dear John:

Many thanks for the draft document. It is hard to disagree with any of the points made, and I think the statement should be of help, especially on getting us started on a much deeper study of the whole problem. I would like, however, to raise a few questions, some immediate and some long term.

A. Immediate:

1. Shouldn't we use remuneration instead of stipend? In the salary range being asked stipend hardly seems to be appropriate any more.
2. Line 4, pg 1, should read "... professional care without direct charge.". The cost is includable in most third party plans.
3. Before the document is released it should go to counsel. I am sure Dr. Berson plans this.

B. Long term: When the final recommendation of a study is carried out it should include (and I'm sure it will) such items as

1. Separating out programs emphasizing education. Accreditation should be based upon the primacy of an educational experience.
2. Other disciplines' methods of combining work for which the student is paid and education for which he pays should be studied. We may well be seeing the breakdown of a system which has grown anachronistic.

I hope these thoughts are of some help.

Cordially,

T. Stewart Hamilton
T. Stewart Hamilton, M.D.
Executive Director

TSH:b
cc to Dr. Alexander, Dr. Berson,

COUNCIL OF TEACHING HOSPITAL
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
1346 Connecticut Ave., N.W.
Washington, D.C. 20036

COMMITTEE ON NOMINATIONS

Stanley A. Ferguson (Chairman)
Executive Director
University Hospitals of Cleveland
University Circle
Cleveland, Ohio 44106

Donald J. Caseley, M.D. (Member)
Medical Director
University of Illinois Research
and Educational Hospitals
840 South Wood Street,
Chicago, Illinois 60680

Harold H. Hixson (Member)
Hospital Administrator
University of California Hospitals
San Francisco, California 94122

Russell A. Nelson, M.D. (Member)
President
The John Hopkins Hospital
Baltimore, Maryland 21205

COUNCIL OF TEACHING HOSPITALS

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Work Sheet for
1968-69 Committee on Nominations

OFFICERS: (One Vacancy)

Chairman -	LeRoy S. Rambeck
Chairman Elect -	_____
Immediate Past Chairman -	Lad F. Grapski
Secretary -	Matthew F. McNulty, Jr.

OTHER MEMBERS - Executive Committee:

Three Year Term Expiring -	Dan J. Macer Lester E. Richwagen Richard D. Wittrup
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Three Vacancies for
Three Year Terms
1968-69 to 1970-71

For COTH Representatives to Executive Council, See Next Page

NUMBER OF COTH REPRESENTATIVES TO BE
NOMINATED FOR AAMC EXECUTIVE COUNCIL
(1968-69 to 1974-75)

AAMC Proposed Bylaws Specify COTH Representation
As COTH Chairman Plus Two Representatives

	<u>1967-68</u>	<u>1968-69</u>	<u>1969-70 & 1972-73</u>	<u>1970-71 & 1973-74</u>	<u>1971-72 & 1974-75</u>
1 year term	Harold H. Hixson	(*1) LeRoy S. Rambeck Russell A. Nelson, M.D.	(*2) Chairman T. Stewart Hamilton, M.D.	(*3) Chairman	(*4) Chairman (**1) Serving
2 year term	Russell A. Nelson, M.D.	T. Stewart Hamilton, M.D.	Not filled	(**1) Serving	(**2) Serving
3 year term	T. Stewart Hamilton, M.D.	Not filled	(**1) To be nominated	(**2) To be nominated	Not filled
	Number to be Nominated	(Chairman)	(Chairman +1)	(Chairman +1)	(Chairman)

* Serves as Chairman of COTH

** Additional Representatives of COTH

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF TEACHING HOSPITALS

Past and Present Chairman

LeRoy S. Rambeck (Chairman - Elect)
Lad F. Grapski
Stanley A. Ferguson
Russell A. Nelson, M.D.
Matthew F. McNulty, Jr.
Harold H. Hixson
Philip D. Bonnet, M.D.
Richard O. Cannon, M.D.
Albert W. Snoke, M.D.
Donald J. Caseley, M.D.
Gerhard Hartman, Ph.D.

Past and Present Secretaries

Matthew F. McNulty, Jr.
Lad F. Grapski
John M. Danielson
Duane E. Johnson

Past and Present Members of The Executive Committee
(Not holding other office)

LeRoy E. Bates, M.D.
A. J. Binkert
Ernest N. Boettcher, M.D.
Leonard O. Bradley, M.D.
Lee D. Cady, M.D.
Leonard W. Cronkhite, Jr., M.D.
Charles H. Frenzel
Kermit H. Gates, M.D. (Deceased)
Charles R. Goulet
T. Stewart Hamilton
Dan J. Macer
Lester E. Richwagen
John E. Sharpe, M.D.
Richard T. Viguers
Richard D. Wittrup

Past and Present COTH Representatives to the
Executive Council

T. Stewart Hamilton, M.D.
Harold H. Hixson
Russell A. Nelson, M.D.

COBERT AND FUCHS
COUNSELLORS AT LAW

EUGENE O. COBERT
BERNARD FUCHS

41 EAST 42ND STREET, NEW YORK, N. Y. 10017

August 12, 1968

Mr. Matthew F. McNulty, Jr.
Director, COTH
Associate Director, AAMC
1346 Connecticut Avenue, N.W.
Washington, D.C. 20036

Dear Mr. McNulty:

We enclose a draft form of Memorandum which may be sent to members of COTH. I believe this complies with our telephone conversation and the suggestion in your letter of July 25, 1968.

The Memorandum would advise your members generally of NARI's efforts to obtain a tax exemption for residents and interns. It also suggests some actions which hospitals can take to cooperate in this effort. Naturally, we anticipate that you will revise the Memorandum to account for any considerations of which we may be unaware.

NARI has been keeping its members informed about progress in the "tax justice" project through its periodical, the "NARI Stethoscope". News of the interest shown by COTH and of your cooperation will appear in the next issue of Stethoscope or in the one following.

The proposed Memorandum speaks only of action to be taken under the present statutory law. Another approach is possible, however, which NARI has not yet begun to pursue.

If Section 117 of the Internal Revenue Code could be amended to cover specifically those residents and interns in tax exempt hospitals whose time is devoted primarily to their own training and education (rather than service as such to patients though that may be incidental) our success would be complete and conclusive. Perhaps your organization has the influence and the resources to undertake such a project. If so we would be pleased to draft a form of statutory amendment

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Mr. Matthew F. McNulty, Jr.

August 12, 1968

which could be proposed. I believe that our effort to lobby for such a change would have a good chance to succeed once it is understood that residents and interns have been unjustly discriminated against in this field.

We appreciate your suggestion concerning a fee for the service involved in preparing the Memorandum, but none will be charged. You may be interested, however, in taking some action for the benefit of the NARI Tax Justice Fund which is briefly described in the Memorandum. I am sure Mr. George Arden, NARI's Executive Director, would be delighted to receive any assistance that can be offered to the fund.

I very much enjoyed our telephone conversation and hope we shall soon have an opportunity to meet in person.

Sincerely yours,

COBERT & FUCHS

Bernard Fuchs
Bernard Fuchs

BF:sbr
Enc.

CURRICULUM VITAE

Name: Knapp, Richard Maitland

Birth: July 23, 1941, Hartford, Connecticut

Marital Status: Single

High School: Torrington High School
Torrington, Connecticut
Graduated, 1959

College: Marietta College
Marietta, Ohio
Graduated, 1963, B.A.

Collegiate Honors: Delta Upsilon Fraternity
Junior Class President, 1962
Student Body President, 1963
Who's Who in American Colleges and
Universities, 1963

Graduate School: University of Iowa
Graduate Program in Hospital
and Health Administration

Master of Arts: June, 1965
Thesis: "The State Health Executive"
Doctor of Philosophy: June, 1968
Dissertation: "The Regional Medical
Program: An Approach to Creative
Federalism"

Scholarships: Public Health Service Traineeship
(1964-1965)
Teaching Assistantship
(1965-1966)

Employment: Instructor Graduate Program in
Hospital and Health Administration,
University of Iowa, Iowa City,
Iowa (9/66-6/68)

Project Director, Teaching Hospital
Information Center, Council of
Teaching Hospitals, Association
of American Medical Colleges,
(7/68 - present)

CV, Knapp, 2

Organizations:

American Hospital Association
American College of Hospital
Administrators
American Public Health Association
Association of American Medical
Colleges

Publications:

Scott Henley, William M. Tester,
and Richard Knapp, "Dissemination
of Drug Information," Hospitals, J.A.H.A.
Vol. 42 (June 16, 1968) p. 99

Aaron Liberman and Richard Knapp,
"Survey Shows Administrators
Dissatisfied with Medicare,"
Hospital Topics (August, 1968), p. 35.

FILE

AAMC/BHS CONTRACT NO. PH. 110-68-41

PROGRESS REPORT

STUDY FOR A TEACHING HOSPITAL
INFORMATION CENTER

THREE-MONTH REPORT, APRIL 26 - JULY 26, 1968

This is the first report under the terms of Contract No. PH 110-68-41, effective July 26, 1968. Pursuant to the stipulations of Article II of the Contract, the report summarizes the services and work performed by the Contractor during the three (3) month reporting period and outlines the work for the next three (3) month period.

I EARLY STAFFING OF THE CONTRACT

As agreed between the Contractor and the Contract officer, the early staffing of the project was accomplished by the allocation of selected portions of time by Matthew F. McNulty, Jr., Director, COTH, and Associate Director, AAMC, and Fletcher H. Bingham, Ph.D., Assistant Director, COTH to the project. Additionally, the clerical services of Miss Elizabeth A. Burgoyne, Secretary, COTH, were utilized during this period. It is anticipated that both Mr. McNulty and Dr. Bingham will continue to assist the newly appointed Project Director on the Contract but at no expense to the contract.

II PROJECT DIRECTOR

The Contractor appointed Richard M. Knapp, Ph.D., to serve as Project Director, on a full-time basis, effective July 15, 1968. Dr. Knapp recently received his doctorate degree in Hospital and Health Administration. He has served as a member of the Faculty of the College of Medicine at the

University of Iowa for two years. The Bureau of Health Services, through its Project officer, approved the appointment of Dr. Knapp, per letter of June 25, 1968, to the Contract officer. Miss Helen R. McMahon has been hired to serve as secretary to the Project Director, Miss McMahon's services became effective July 9, 1968.

III PUBLICITY BY THE CONTRACTOR REGARDING THE CONTRACT
AND RESPONSE FROM VARIOUS HEALTH RELATED ORGANIZATIONS

In order to insure early and prompt recognition by the health community of the nature of the project, a news release dated May 9, 1968, was circulated widely by the Contractor. A copy of the news release and a representative portion of responses from various health related organizations are attached as Appendix A.

IV EARLY INFORMATION GATHERING, EVALUATION, AND
DISSEMINATION ACTIVITIES OF THE CONTRACTOR

Since the announcement of the Contract award, the Contractor has received many requests for information that are of particular interest to those responsible for the administration of teaching hospitals. A wide range of subject areas have been developed, and selected representative letters from teaching hospitals requesting information are attached as Appendix B.

V OTHER ACTIVITIES

Preliminary study and examination has been made, by review of the literature, of various existing information dissemination activities. As is reported below in "Work Plans for the Next Three (3) Months," the Contractor anticipates visitation to a number of these organizations to determine the

extent to which existing methodological mechanisms are applicable to the performance of the Contract. Effective communication and working relationships are being developed with these organizations.

VI WORK PLANS FOR THE NEXT THREE (3) MONTH PERIOD
(JULY 26, 1968 - OCTOBER 26, 1968)

Major activities of the next three months will consist of the following:

(1) Selection and appointment of a Steering Committee, composed of individuals knowledgeable of current health services research, to serve as an advisory body to the Contractor in the performance of this Project.

(2) Development of a research design and survey instrument to determine the need, priority of various categories of information and most appropriate methods of dissemination. Subsequent to approval by BHS and BOB, the survey instrument will be given widespread distribution to administrators of teaching hospitals. This survey instrument will also serve as a built-in evaluative mechanism, by operating administrators, to the feasibility of a teaching hospital information center.

(3) Initiate in-depth examinations of various existing efforts of information accumulation, evaluation and dissemination to determine those segments that may be applicable or not applicable for the performance of this Contract.

(4) Visitation to, and subsequent evaluation of, various individual researchers, teaching hospitals or other appropriate health related organizations that are conducting research, experimentation or demonstration activities which may be beneficial to those involved in the administration

of teaching hospitals. Plans are in progress to visit two regional teaching hospital groups:

(a) August 1, 1968: University Teaching Hospital Council Meeting, Columbus, Ohio, "Hospital Administrative Systems"

(b) October 30-31, 1968: University Hospital Council Meeting, Denver, Colorado

(5) Continuation of information efforts in order to develop recognition, by as many segments of the health care field as possible, of the activities of the Contractor on this Project for the opportunities of information and "feed back" such individuals and/or activities will provide.

(6) Stimulation of teaching hospital and medical school and broad medical center interest through the participation of Thomas McCarthy, Ph.D., Deputy Director, National Center for Health Services Research and Development, in the 79th Annual Meeting of the Association of American Medical Colleges and the 11th Annual Meeting of the Council of Teaching Hospitals. Dr. McCarthy will present a principal paper at the meeting on the subject of partnership opportunities between Teaching Hospitals and the National Center for Health Services Research and Development, followed the next day by a four-hour discussion of the subject matter.

(7) Investigation of several other "Information Center" concepts such as "ERIC" or the Educational Resources Information Center concept as it may apply to the Teaching Hospital Information Center. Interviews are planned at the Center for Applied Linguistics and the Council for Exceptional Children.

OFFICE COMMUNICATION

DATE April 15, 1968
TO Edwin L. Crosby, M.D.
FROM Frederick N. Elliott, M.D.
SUBJECT Advisory Panel Report -- Comments on Millis Commission Report

The advisory panel to study the Report of the Citizens Commission on Graduate Medical Education (the Millis Commission) has held a number of meetings and telephone conferences and considerable correspondence in preparing a report to be submitted to you.

Attached is the advisory panels report, as finally approved by all members of the panel, who were:

Albert W. Snoke, M.D., chairman
Allan B. Caldwell, M.D.
Charles P. Cardwell Jr.
Colin Churchill
George W. Graham, M.D.
Frederick N. Elliott, M.D., secretary

sjc
attch.

COMMENTS ON THE REPORT OF THE CITIZENS COMMISSION ON GRADUATE MEDICAL EDUCATION

Prepared by Advisory Panel To Study Report of
Citizens Commission on Graduate Medical Education

April 15, 1968

The American Hospital Association advisory panel concurs with the judgment of the Citizens Commission on Graduate Medical Education that medical education should be a progressive and articulated continuum, and that the years of formal undergraduate study in the medical school should be followed by a carefully structured, coordinated program of graduate education, to assure the physician-in-training of an orderly progression through the entire program. At the present time graduate medical education, in the forms of internships, residencies, and fellowships, is confusing and inefficient, marked by diffusion of responsibility, organization, and control. The panel believes that the interests of patients, the public, students, the profession, and hospitals would be better served by a more effectively integrated system.

It is recognized that the concept of a more unified organization and responsibility for graduate medical education has far-reaching implications. Many of the recommendations of the commission may challenge the traditional medical service point of view of hospitals and medical staffs. While the panel agrees that the primary function of physicians and hospitals is to meet the service needs of patients, it is of the opinion that these needs can best be met through the direct involvement of practicing physicians, rather than through the utilization of interns and residents in service functions misrepresented as educational.

Following are recommendations of the commission on various subjects, followed by the advisory panel's comments.

Corporate Responsibility

"We recommend that each teaching hospital organize its staff, through an educational council, a committee on graduate education, or some similar means, so as to make its programs of graduate medical education a corporate responsibility rather than the individual responsibilities of particular medical or surgical services or heads of services." - (page 61 of the commissions report)

The advisory panel concurs with the principle of this recommendation: the acceptance by teaching hospitals of corporate responsibility for medical education. Of all the elements involved in graduate medical education, the greatest commitment is on the part of hospitals. This commitment includes responsibility for the safety and welfare of patients, accountability to the community for effective development and coordination of health care resources, concentration of the professional element through the instrumentality of the organized hospital medical staff, concentration and effective use of costly facilities, equipment, and technical skills, and the

provision of administrative services and support as well as capital and operational financing. Moreover, the hospital is in a unique position to participate objectively in the continuing assessment of changing public need and expectation, factors that should have a more active influence in determining to proper goals of medical education.

The panel suggests that the recommendation of the commission be expanded to include formal commitment of the hospital's governing board, its administration, and its medical staff in the corporate responsibility for graduate medical education. The panel does not believe that this would entail any substantive changes in the financial, legal, or administrative responsibilities of hospitals beyond those that currently exist. The recommendations do, however, imply a substantial policy change with the consolidation of the previously disparate programs of graduate medical education in the hospital. The committee believes that this consolidation holds promise of definable responsibility and authority and of resulting improvement in the quality of graduate medical education.

Educational Goals and Curricula

"Because educational programs properly differ from one institution to another we recommend that each medical school faculty and each teaching hospital staff, acting as a corporate body, explicitly formulate, and periodically revise, their own educational goals and curricula. To do so would be a healthy exercise for medical educators and a fundamental step toward the solution of many of their education problems." - (page 29 of the commission's report)

The intent of this recommendation is rendered unclear by the phrase, "acting as a corporate body." If this is intended to require formal incorporation of either the medical school faculty or the teaching hospital medical staff, it would introduce a confusing and unnecessary element, and should be deleted. The medical school faculty or the teaching hospital medical staff do not need to be incorporated to do the things suggested in this recommendation.

On the other hand, the advisory panel accepts and supports the necessity for continuous evaluation and revision of educational curricula and goals by the institutions that are jointly responsible for graduate medical education.

Comprehensive Health Care and the Primary Physician

"First, simple rotation among several services, in the manner of the classical rotating internship - even though extending over a longer period of time - will not be sufficient. Knowledge and skill in the several areas are essential, but the teaching should stress continuing and comprehensive patient responsibility rather than the episodic handling of acute conditions in the several areas." - (page 48 of the commission report)

"Second, some experience in the handling of emergency cases and knowledge of the specialized care required before and following surgery should be included." - (page 50)

"Third, there should be taught a new body of knowledge in addition to the medical specialties that constitute the bulk of the program." - (page 51)

"Fourth, there should be opportunities for individual variations in the graduate program." - (page 52)

"Fifth, the level of training should be on a par with that of other specialties. A two-year graduate program is insufficient." - (page 53)

The panel agrees in principle with the identification of the need for recruitment, education, and retention of physicians who are concerned with comprehensive, continuing care of patients, as contrasted with more specialized and episodic care. The panel agrees that such a category of physicians should have training and status comparable with other disciplines in medicine. The panel is aware of the problem of integrating these recommended training programs and clinical services in many hospitals that already have highly and traditionally organized medical staffs. The panel considers such problems to be a proper area of concern for the permanent Commission on Graduate Medical Education proposed later in the report.

Elimination of the Internship

"We recommend that the internship, as a separate and distinct portion of medical education, be abandoned, and that the internship and residency years be combined into a single period of graduate medical education called a residency and planned as a unified whole." - (page 62 of the commission report)

The panel agrees with the recommendation that the internship, as a separate and distinct portion of medical education, be abandoned. It believes, however, that the implementation of this recommendation presents serious problems in timing, acceptance, and adjustment. The panel is aware that medical schools are not uniform in their curricula or in the practical training that they provide for their students.

The desire of hospitals to have internship programs so that service needs can be met, regardless of the educational quality of the program, and the difficulties encountered in the past by the Council on Medical Education in withdrawing approval from internship programs of poor quality, are factors that must be recognized and dealt with. Licensing laws, current residency approval requirements, tradition, and inertia will make the elimination of the internship a most difficult task.

"We recommend that state licensure acts and statements of certification requirements be amended to eliminate the requirement of a separate internship and to substitute therefor an appropriately described period of graduate medical education." - (page 63)

"We therefore recommend that graduation from medical school be recognized as the end of general medical education, and that specialized training begin with the start of graduate medical education." - (page 65)

The panel, with respect to these two recommendations, is aware that graduate medical education has been modified in many hospitals to recognize the fact that some medical schools have currently reorganized their curricula to give emphasis to specialized training during the last years of medical school. State licensure acts should be amended as necessary for implementation of the commission's suggestion that specialized training should appropriately begin with graduate medical education in the hospital setting.

The panel is strongly of the opinion that, in keeping with the American Medical Association's and the American Hospital Association's sincere desire to upgrade graduate medical education programs, the recommendation dealing with a combined internship-residency program with all of its implications be endorsed. The panel further suggests that during the interim period steps be taken within the existing framework of the approval mechanism to improve or eliminate poor internship programs.

New Graduate Internship Programs

- A. "We recommend that hospitals experiment with several forms of basic residency training, and that the specialty boards and residency review committees encourage experimentation by interpreting liberally those statements in the residency requirements that now inhibit this form of educational organization." - (page 70 of the commission report)
- B. "We recommend that the specialty boards, in amending their regulations concerning eligibility for examination for certification, not increase the required length of residency training to compensate for dropping the requirement of a separate internship. This can be done by retaining present wording concerning length of residency training and deleting statements concerning internship training." - (page 71)
- C. "We recommend that programs of graduate medical education be approved by the residency review committees only if they cover the entire span from the first year of graduate medical education through completion of the residency. (This does not mean that each teaching hospital should be required to offer programs in all specialties.)" - (page 73)
- D. "We recommend that programs of graduate medical education not be approved unless the teaching staff, the related services, and the other facilities are judged adequate in size and quality, and that, if these tests are met, approval be formally given to the institution rather than to the particular medical or surgical service most directly involved." - (page 74)
- E. "We recommend that staff members of university medical centers and other teaching hospitals explore the possibility of organizing an intensive effort to study the problems of graduate medical education and, where such development appears feasible, they seek to arrange for the development of improved materials and techniques that can be widely used in graduate medical education." - (page 85)

The panel agrees in principle with the five recommendations concerning the new graduate education programs. However, it cautions against the possibility that, under recommendation A, there might be substituted another type of universal rotating internship with another name.

The panel suggests that recommendation C not only refer to the approval program covering the entire span from the first year of graduate medical education through the completion of the residency, but also include specific provision for the possibility of involvement of several hospitals in a single cooperative residency program, such as is mentioned on page 75 of the commission's text.

The panel recognizes the substantive change in policy in recommendation D, that formal approval be given to the institution rather than to the particular medical or surgical service most directly involved. It believes that this provides a better organizational approach to authority and responsibility.

Commission on Graduate Medical Education

"We therefore recommend that a newly created Commission on Graduate Medical Education be established specifically for the purpose of planning, coordinating and procedures for reviewing and approving the institutions in which that education is offered." - (page 100 of the commission report)

The panel concurs with the recommendation that a commission on graduate medical education be created. This appears to be a reasonable approach to the object of bringing order out of considerable chaos and providing an instrument capable of implementing other acceptable recommendations of the Millis Commission. In supporting this recommendation, the panel recognizes, and wishes to identify, some of the implications, the substantive changes entailed, and the difficulties to be anticipated.

The advisory panel takes strong exception both to the recommended method of appointment of members and the proposed composition of the commission. Recommendation by the Millis Commission of a commission on graduate medical education without participation by hospitals is completely inconsistent with the recommendation that hospitals be asked to accept corporate responsibility for graduate medical education. A basic implication of the latter recommendation is that, in accepting such corporate responsibility, hospitals must be prepared to devote a significant portion of their assets in time, resources, and money, and to commit their responsibilities for service, patient welfare, and quality of care, to a program of education.

Hence, participation by hospitals, through the American Hospital Association as the national membership organization, in the formation and operation of the proposed commission seems not only logical, but imperative. Without the inclusion in this new venture of those most heavily committed, the possibility of success appears remote.

No single organization or society should have a dominant role in the appointment or composition of this commission. Certainly representation of the practicing medical profession, medical and general educators, and

scientists is necessary. The panel recommends that representatives of the informed public, and the Health, Education, and Welfare departments of government also be included. Certainly the participation of hospitals, by which the greatest material commitment will be made is essential.

Aside from the question of appropriate representation of all of the effectively contributing elements in graduate medical education, the panel believes that members of the commission should be free of constraint from their appointing organizations. They should function as statesmen and trustees, guided by their personal skills and experience, on behalf of the welfare of graduate medical education. The panel recognizes this to be a difficult role under varying circumstances, but believes that the commission, once established and truly representative, should exercise independence of thought and action in the interest of public and professional welfare through graduate medical education.

The American Hospital Association advisory panel considers the report of the Citizens Commission on Graduate Medical Education to be constructive and sound. It recognizes that acceptance of its recommendations may adversely affect many institutions from an operational or financial point of view during the period of transition. It will have a profound effect on hospitals, on specialty boards and specialty training, and on the future of the primary physician and the profession. Such a program as is recommended in the commission report can succeed only if there is wholehearted cooperation by all parties concerned, and understanding on the part of all of the many forces to be involved.

The panel urges, as a first step by all agencies who are identified with responsibility for graduate medical education, the formation of a national commission, adequately representative and supported by staff, financing, and advisory resources, that will be charged with the creation of a program of graduate medical education to meet the obligations of the medical profession and the hospitals, and the rightful expectations of the public.

OFFICE COMMUNICATION

Date: February 7, 1968
To: Edwin L. Crosby, M.D.
From: George A. Hay, Trustee
Subject: Comments of Advisory Panel To Study Report of National Advisory Commission on Health Manpower

On December 1, 1967, you appointed an advisory panel to study the report of the National Advisory Commission on Health Manpower, composed of Edward J. Connors, Pat N. Groner, and me. You asked me to serve as chairman. The staff team consisted of James E. Hague, secretary of the Association, Allan B. Caldwell, M.D., of the Division of Professional Services, James L. Howard of the Washington Service Bureau, and Jon D. Miller of the Division of Research. Mr. Hague served as secretary to the panel. It was quite fortuitous that Mr. Miller had served as one of the two full-time members of the staff of the commission throughout its life before joining the Association's staff last August.

The members of the panel met twice, reviewed staff commentaries on each of the 51 recommendations of the commission, shared their own comments, and reviewed a synthesis of these comments. They submit the final version as the attachment to this memorandum.

COMMENTS ON RECOMMENDATIONS
OF NATIONAL ADVISORY COMMISSION ON HEALTH MANPOWER

Prepared by Advisory Panel to Study Report of
National Advisory Commission on Health Manpower
February 7, 1968

GENERAL

The National Advisory Commission on Health Manpower took the broadest possible view of its assignment and its report is far more than a collection of numbers and needs, and statistical projections on manpower; it is rather a critical analysis of the system in which the manpower operates. There are many recommendations of substantial significance to the Association.

The report turns to the federal government as the solver of most of the ills it details. The panel took especial exception to this, Mr. Pat N. Groner calling it "excessive resort to the federal government for funds and initiation of programs. The most effective, fastest, and least expensive way innovation usually occurs is when the innovator is also the implementor."

There is much of value in the report and some items that are potentially very unsound.

SPECIFIC

Supply of Physicians

Recommendation 1: "The United States should produce a sufficient number of physicians to meet its needs and, further, it should assist other countries, particularly developing nations, to improve their systems of medical education and their levels of medical practice and public health."

Comment: It seems unarguable that the United States should produce a sufficient number of physicians to meet its need and should assist other countries, but it seems unrealistic to believe that in the near future the U.S. will be turning out sufficient physicians to cut off entirely the foreign flow, let alone provide a surplus with which to meet the recognized needs of other nations.

Recommendation 2: "The production of physicians should be increased beyond presently planned levels by a substantial expansion in the capacity of existing medical schools, and by continued development of new schools."

Comment: Full agreement, with specific support for the statement in the report that initially "primary dependence must be placed upon expanding the capacity of existing medical schools." Chairman George A. Hay said that in his opinion the federal government would have to provide the bulk of the funds, in the order of 85 per cent.

Recommendation 3: "Federal funds in support of capital or operating costs of education should be provided to a medical school in such a way that they create economic incentives for the school to expand enrollment while improving its quality. Such incentives should be based on increases in the absolute numbers of medical students."

Comment: Agreement. It should be recognized that some schools are below generally accepted minimum standards and first priority should be given in such instances to elevation of educational quality to the minimum rather than to expansion. In no case should the focus on quality of education be lost.

Supply of Dentists

Recommendation 4: "In order to increase further the production of new dentists, schools and students of dentistry should be provided the same incentives of those recommended in this report for schools and students of medicine."

Comment: The Association should intensify its effort to encourage interdependence of hospitals and dentists, stressing the team approach.

Supply of Nurses

Recommendation 5: "Nursing should be made a more attractive profession by such measures as appropriate utilization of nursing skills, increased levels of professional responsibilities, improved salaries, more flexible hours for married women, and better retirement provisions."

Comment: The commission's discussion of nursing places far too little emphasis on nursing role definition, and any AHA comments should stress the primacy of this need. Proper utilization of the nurse is certainly as important as getting nonpracticing nurses back into nursing. Flexibility of hours is desirable to promote better correlation of staffing and work load. Allan B. Caldwell, M.D., commented: "I feel that when one speaks only to nursing educators, especially of degree programs, one gets a very vocal and strong minority opinion that has little relationship to the feelings of nurses actually giving the patient care in our hospitals."

Education of Health Professionals

Recommendation 6: "The federal government should carefully explore ways to provide support directly for the educational function of medical schools."

Comment: Complete support for the direct approach. The current backdoor route, the research road, is expensive and undesirable. Mr. Hay recommended that there be a minimal block grant to meet the needs that all institutions have regardless of size, and a capitation method of additional support to relate aid to size.

Recommendation 7: "The federal government should revise and expand present Health Professions Education Assistance Programs to make available to any medical student loans to cover the full costs of tuition and living expenses during formal professional education...The student should be able to choose between repaying the loan from earnings over a period of years and giving two years of his time to approved national service apart from Selective Service obligations."

Comment: Mr. Groner said he would want to be sure that all private resources had been utilized in full before turning to governmental aid. The panel agreed that the principle of entitlement should not apply here and that some reasonable needs test, in line with standard Association policy, should be included. Mr. James E. Hague objected strenuously to putting a dollar sign on national service. No conclusion was reached as to whether a direct subsidy should be substituted for a loan but Mr. Groner repeated his belief in primary dependence upon private resources with government as an alternate. He stressed that he did not have the facts on whether or not these resources were indeed available. Mr. Edward J. Connors said that the primary responsibility for disbursement of student aid funds should be left with the medical school and should include a program of tuition remission grants, used selectively as the medical school determined.

Recommendation 8: "A national, computerized matching program should be developed to facilitate admission procedures for medical schools."

Comment: Disagreement. One panel member noted that under this "the rich get richer and the poor get poorer" and another said it would widen the quality gap between existing schools.

Recommendation 9: "The federal government should markedly expand support specifically designated for research in the educational process for physicians and other health personnel."

Comment: If the Association takes a position on this it should be that curriculum review is necessary but that this should be conducted in selected places of proven leadership. Is it possible that the medical profession through its organizations might take the leadership?

Recommendation 10: "Formal education for all health professionals should be conducted under the supervision of universities. This would include graduate training such as internships, residencies, and their equivalents."

Comment: AHA endorsement of this recommendation would be construed as a desertion of its position on diploma schools and its position on the hospital as an educational institution.

Recommendation 11: "Health professional schools should study their positions in the continuum of education and develop and implement curricula revisions aimed at increasing intellectual stimulation and flexibility. Concurrently, health professional schools should initiate a continuing functional analysis of health care against which the substance of current curricula should be continuously revised."

Recommendation 12: "The federal government should give high priority to the support under university direction of experimental programs which train and utilize new categories of health professionals."

Comment: Agreement.

Gaps in Distribution and Quality of Health Care

THE DISADVANTAGED

Recommendation 13: "Programs for health care of the disadvantaged should be given highest priority and made available wherever needed."

Recommendation 14: "Innovations introduced experimentally for the care of the disadvantaged should be carefully examined for their applicability to the care of all persons. Conversely, programs for the care of the disadvantaged should incorporate elements from existing methods of medical care, wherever appropriate."

Recommendation 15: "Experimental programs to develop new methods of health care for the disadvantaged should be enlarged and should become the combined responsibility of physicians in private practice, universities, hospitals, voluntary agencies, and government at all levels."

Comment: The overwhelming dimensions of financing wide programs for the disadvantaged, including the poor, should be recognized. The point of access problem is a key one. The Association should recognize the gravity of the situation and participate in its solution. The solution should be in accord with the general Association policy that these special needs should be met in such a way that they complement the existing system rather than compete with it or replace units of it.

Licensure of Health Professionals

Recommendation 16: "Professional societies, universities, and state governments should undertake, with federal support, studies on the development of guidelines for state licensure codes for health personnel."

Comment: Mr. Groner believes that, though guidelines to determine competence should be developed, the preferable role is voluntary certification.

Recommendation 17: "Professional societies and state governments should explore the possibility of periodic relicensing of physicians and other health professionals. Relicensure should be granted either upon certification of acceptable performance in continuing education programs or upon the basis of challenge examinations in the practitioner's specialty."

Comment: Such a relicensure program could be of material assistance to hospitals wrestling with the problem of denying or curtailing privileges.

Foreign Medical Graduates

Recommendation 18: "At a minimum, foreign-trained physicians who will have responsibility for patient care should pass tests equivalent to those for graduates of U.S. medical schools. The National Board of Medical Examiners provides an objective testing service which should be utilized just as it is for graduates of U.S. schools. Issuance of an immigrant visa on the basis of Third Preference should be contingent upon satisfactory performance in the examination."

Recommendation 19: "Before foreign medical graduates are permitted to enter training programs with responsibility for the care of patients, they should be required to participate in an orientation and educational program during which their competence in the basic and clinical medical sciences, in English, and other appropriate fields would be assessed, and remedial instruction provided where necessary. Such orientation programs should be conducted by a consortium of medical schools, hospitals, and education institutions on a regional basis."

Comment: These seem salutary suggestions and should be supported by the AHA. This is the part of the report on which the AMA's representative, the incoming president, feels most strongly.

Recommendation 20: "A Commission on Foreign Medical Graduates should be established outside of government."

Comment: We should broaden the Educational Council for Foreign Medical Graduates rather than set up a whole new commission.

Monitoring New Technologies

Recommendation 21: "The National Bureau of Standards should extend its interest in the field of medical devices and technology."

Comment: The Association supports determination of the efficacy and safety of medical devices as well as of drugs. One panel member thought that the job was of such magnitude that it had to be left to some federal agency but not necessarily the National Bureau of Standards, noting that the Food and Drug Administration is already doing some of this. Mr. Groner called this recommendation "a good example of the commission's tendency to stray from its purpose ... the danger of retarding progress by introducing the bureaucratic filtering process is far greater than any problems we have now."

Recommendation 22: "The Secretary of Health, Education, and Welfare, with advice and assistance of appropriate nongovernment groups, should develop methods of assuring the accuracy of test results produced by medical laboratories, both in and out of hospitals. Such methods could be used as a basis for the certification of medical laboratories to participate in Medicare and Medicaid."

Comment: Again with a general caveat toward the emphasis on federal government activity, there was agreement that this was a matter of great importance.

Peer Review

Recommendation 23: "Professional societies, health insurance organizations, and government should extend the development and effective use of a variety of peer review procedures in maintaining high quality health and medical care. These procedures should incorporate the following principles:

"Peer review should be performed at the local level with professional societies acting as sponsors and supervisors.

"Assurance must be provided that the evaluation groups perform their tasks in an impartial and effective manner.

"Emphasis should be placed on assuring high quality of performance and on discovering and preventing unsatisfactory performance.

"The more objective the quality evaluation procedures, the more effective the review bodies can be. To enable greater objectivity, there should be a substantial program of research to develop improved criteria for evaluation, data collection methods, and techniques of analysis."

Comment: The suggestion that "peer review should be performed at the local level with professional societies acting as sponsors and supervisors" raised the specter of the evaluation of the quality of care in the hospital being conducted under the sponsorship and supervision of the county medical society. All agreed that peer review was essential but that the omission of any reference in the discussion by the commission to the responsibility of the organized medical staff in this regard was most unfortunate. The panel believed that the recognition of the organized medical staff of the hospital as the agency clearly responsible for peer review should be stressed.

Emergency Care

Recommendation 24: "The federal government should utilize the existing and detailed reports of the National Academy of Sciences, the American College of Surgeons, the American Medical Association, the American Hospital Association, and the Department of Health, Education, and Welfare as guidelines to implement a major program of research, development, and the application of methods to prevent accidents and to provide emergency medical care. Such experiments should stimulate medical and administrative staffs of hospitals to try innovative methods which would bypass usual procedures and regulations, and would develop innovations in diagnosis and therapy."

Comment: This is an area deserving the fullest support by the Association, but this support should be expressed by bringing this urgent problem to the attention of the areawide planning agencies so that it maybe solved at the local level and not by federal fiat.

Civilian/Military Maldistribution of Critical Manpower

Recommendation 25: "The Selective Service Act should be amended to provide for the automatic transfer of the records of every draft-eligible health professional, upon his graduation from professional school, from the local board of his original registration to the local board in whose jurisdiction he works and for subsequent transfer with each change in the location of his work."

Comment: No comment.

Recommendation 26: "The Selective Service Act should be amended to provide equal draft-liability for U.S. and foreign medical graduates, provided that the foreign medical graduate has an immigrant visa and that he has not previously served in the armed services of an allied nation."

Comment: No comment.

Recommendation 27: "The federal government should establish a national computer file of draft-eligible health professionals."

Comment: No comment.

Recommendation 28: "Service with the U.S. Public Health Service should be phased out as a substitute for the military obligation of health professionals."

Comment: Mr. Connors thought this a matter of minor concern to the Association.

Civilian/Military Maldistribution of Critical Manpower

Recommendation 29: "The Department of Defense should be instructed to encourage the greater use of the Military Medicare Amendments of 1965 and should study the feasibility of utilizing voluntarily obtained health professionals in military facilities located in the United States."

Comment: The language of the report leading up to this recommendation is somewhat confusing. It endorses the use of community health resources at government expense but then states that the commissioners were "not wholly sanguine about placing military dependents and retired personnel into the inadequate system of medical care to which most of this report is directed," noting that "government provision of such care, rather than simple financing of it, might prove no more expensive to the government and, what is more important, could provide an opportunity for experimentation with new and improved methods of care." This is not in accord with Association policy.

Insofar as this encourages greater use of civilian facilities under the Military Medical Care Amendments of 1965, as is suggested by the first clause of recommendation 29, the panel would be in favor of it. Serious objections were raised by one panel member to the second clause as producing an unwarranted drain on already sorely taxed manpower resources.

Improving Hospital Efficiency

Recommendation 30: "The federal government and health insurance organizations should take immediate steps to introduce new formulas of payment on a highly selective but broad experimental basis. The payments should provide rewards for efficiency and high-quality care, and they should provide better hospitals with a basis for obtaining funds to expand their scope of operation. No amount of research, model evaluation, or simulation will provide the necessary information to design the optimum arrangements. This information can be gained only through experience.

"The following principles should be observed in the development of new payment methods:

"The reward for increased quality must be sufficient to make it unprofitable for a hospital to reduce quality and community service in order to lower costs.

"The guiding, theoretical principle should be the payment of equal amounts to all hospitals in a locality for an equal quantity and quality of service. Because of the differential flow of funds among hospitals, those which are the most efficient and of the highest quality would prosper and expand in the long run, while the poorest and least desirable hospitals would become a diminishing portion of the total hospital sector."

Comment: The panel was informed that the commission had considered two methods of reaching this desirable goal. One was reliance on effective planning, shutting out the undeserving. The other was a reimbursement method to reward the good and punish the bad. The commission's panel that considered this subject, under the chairmanship of Russell A. Nelson, M.D., chose the incentive rather than the planning route. This matter is now under consideration by the Secretary's Advisory Committee on Hospital Effectiveness (Barr Committee). Also, the AHA Board of Trustees will be receiving a proposal that it take a policy position in this matter. The panel, therefore, deferred comment.

Improving Hospital Facilities

Recommendation 31: "Steps to increase the availability of capital in the hospital sector should be coupled with the introduction of incentives into the payment system."

Recommendation 32: "The amount by which payments to the hospitals should exceed average cost is a matter which will require extensive study. The margin should be sufficiently large so that for the better hospitals, net income, commercial borrowing made possible by the anticipated future net income, and depreciation funds will be adequate to meet most of the needs for expansion and upgrading of hospital services."

Comment: The same comment as under recommendation 30 applies.

Recommendation 33: "Federal assistance in the form of grants and loans (or loan guarantees) should be provided to obsolete hospitals in those areas where modernization needs are so extensive that nongovernment sources of capital funds will be clearly insufficient."

Comment: This is covered in the policy AHA recently adopted in its consideration of the proposals to extend and revise Hill-Burton.

Recommendation 34: "Before any decision is made to finance modernization on a large scale, state and federal governments should carry out a careful study to determine criteria for deciding between modernization and replacement."

Comment: This recommendation was made by the commission because of some indications that it is sometimes cheaper to replace than to modernize. The advisory panel agreed that this fact should be taken into consideration, but by the planning agency and not by the state and federal government.

Improving Hospital Facilities

Recommendation 35: "The federal government should provide major support for research and development of improved hospital facilities."

Comment: The panel again noted the reliance, perhaps inescapable, upon the federal government to cure the ills of the world. However, it believed that research and development were very good ideas.

Improving Hospital Organization and Management

Recommendation 36: "Health insurance organizations, private foundations, and hospitals with assistance from the federal government, where needed, should underwrite educational programs for members of hospital boards of control."

These programs should make the board members familiar with hospital operations in general and intimately knowledgeable about the comparative performance of their own institutions. Concomitantly, these programs should offer advice and assistance for cost reduction and quality improvement."

Comment: A splendid idea. The AHA should, in the words of one panel member, "get on the stick," and participate to the utmost.

Recommendation 37: "Medical and hospital associations should jointly explore means to increase the physician's responsibility for the successful and economical management of hospital operations. These explorations should include consideration of providing physicians with a financial stake in the operation of the hospitals, and of including physicians in the membership of hospital board of control."

Comment: There was enthusiastic endorsement of the first sentence of this recommendation but a great degree of apprehension concerning the proposal that physicians somehow be provided with a "financial stake in the operation of hospitals." This recommendation was presumably triggered by the commission's study of the physician incentive approach used by Kaiser-Permanente. The panel wasn't convinced that as complete information was available about the total picture in the Kaiser-Permanente area to initiate this potentially dangerous "financial stake" philosophy throughout the hospital system. The words of the commission on page 64 touched upon the possible perils by referring to the for-profit hospitals and the notorious lack of quality in many such institutions, in most of which the physicians have a direct "financial stake." The commission then puts in reassuring phrases to the effect that these ills could be avoided through quality controls. The panel wasn't convinced.

The third aspect of this recommendation is that having to do with physician membership on the governing board. It goes without saying that Dwight L. Wilbur, M.D., AMA's president-elect and a member of the commission, was fully aware of the recent position taken by the AMA in favor not only of board membership for physicians but also of their election and appointment by the medical staff where feasible (exception was to cover those states where physician membership on hospital governing boards is prohibited). However, neither the commission's discussion of this matter nor the recommendation itself includes even a mention

of the matter of election or appointment by medical staff. This omission could be significant. The panel supports the recommendation of the commission as long as nothing more than physician membership on the board is read into it. Mr. Groner distributed a document discussing the pros and cons of physician membership, concluding that physician membership on the board was quite proper in some circumstances but that physician membership as an elected or appointed representative of the medical staff was completely wrong.

Controlling Utilization

Recommendation 38: "Health insurance organizations should develop workable plans to provide coverage of outpatient as well as inpatient health services."

Comment: Absolutely.

Recommendation 39: "Medicare and Medicaid payments to organizations providing prepaid comprehensive care should be changed from a cost reimbursement basis to one which will permit these organizations to share in the savings they achieve by effective control of utilization."

Comment: Concern was expressed about the discriminatory language of this recommendation. It seems to imply that savings achieved by effective control of utilization would be shared only by prepaid comprehensive care plans. However, the panel believed it should defer further comment until the report of the Barr Committee had been studied. See comment under recommendation 30.

Recommendation 40: "The federal government should underwrite a variety of experiments aimed at reducing utilization. As successful methods of controlling utilization are developed, Medicare and Medicaid should share the savings on the same basis used for prepaid comprehensive care plans."

Comment: The language of the recommendation again indicates the prevailing preoccupation with "reducing" utilization. The panel believes that the Association should make it abundantly clear that it favors studies and programs to achieve optimum utilization but is opposed to programs that take the a priori view that utilization should be reduced.

Recommendation 41: "All health insurance organizations should be encouraged to revise their payment methods to share savings with health care purveyors that demonstrate better control over utilization."

Comment: This also seems to be within the area of the Barr Committee's charge and therefore the panel deferred comment.

Controlling Utilization

Recommendation 42: "Peer review should be widely applied to hospital utilization."

Comment: This seems desirable.

Recommendation 43: "The federal government should continue support of planning agencies at regional, state, and local levels to collect, analyze, and distribute information regarding the need for medical care facilities."

Comment: The panel generally supported this resolution but the note was made that collection, analysis, and distribution of information are really rather limited functions. This recommendation should be considered in light of the statement on financial needs that is going to the Board and its view of the planning function.

Recommendation 44: "Mechanisms should be established to provide peer review - on a routine basis - of the appropriateness and proficiency of physicians' practice."

Comment: If peer review in hospitals is sound, then it is also sound, but probably very difficult, in other loci where health services are provided.

Recommendation 45: "The federal government should consider establishing on an experimental basis a central patient data bank for federally operated hospitals whose patient load characteristics approximate those of the general population."

Comment: This carries a real threat to the confidentiality of the patient's records. Mr. Connors agrees but suggests that a record linkage does need study but in a more traditional, and thus less authoritative, environment than a federal hospital system.

Improving the Organization Framework

Recommendation 46: "Highest priority should be given by community health councils to developing methods which will assure access to adequate health care for all those in the community they serve."

Comment: Anything that improves the point of access to our health care system improves our health care generally and should be vigorously promoted.

Responding to Changes in Society, Medicine, and Technology

Recommendation 47: "The Congress should attach a high priority to the support of the Center for Health Services Research and Development and the Secretary of Health, Education, and Welfare should locate the center in his department in such a way that its effectiveness will not be reduced by the parochial interests of any constituent agency."

Comment: There were divergent views on this. Centralization was feared. The Washington Service Bureau representative commented that it seemed a bad administrative practice but, on balance, it seemed worthy of support, providing that peer review was built into the activities of the center so that accomplishment of preconceived bureaucratic notions could be avoided.

Recommendation 48: "Financial support should be made available for large-scale experimental projects of integrated health service systems under a variety of auspices including physicians in private practice, universities, hospitals, voluntary agencies, and government. These systems should include but not be limited to, programs which are comprehensive, serve a cross-section of socioeconomic groups on a community or areawide basis, and emphasize organized services for ambulatory patients."

Comment: Sounds expensive but might be productive if used sparingly.

Improving Government Policy Decisions

Recommendation 49: "The Bureau of the Budget should consider delegating to the National Center for Health Statistics the responsibility for supervising the collection, analysis, and dissemination of health data. This center would act as a focal agency to assure that the collection of health data by federal agencies is coordinated and that the results are analyzed and disseminated in compatible forms."

Comment: The whole matter of data collection, analysis, and dissemination is under close study. The panel believes that the Association should have a major role in this activity and that it should not be abdicated in toto to government.

Recommendation 50: "The Secretary of Health, Education, and Welfare should have within his own office a greatly expanded analytic capability, and should be provided with substantial funds to contract for assistance outside the government."

Comment: Seems to the panel like an intragovernmental fight for funds.

Recommendation 51: "A Council of Health Advisers should be established."

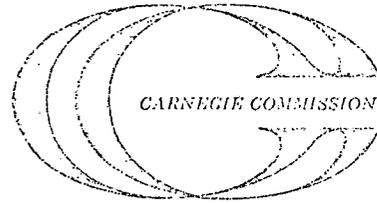
Comment: The second Hoover Commission recommended this also.

Panel Members

George A. Hay, Trustee, chairman
Pat N. Groner, Trustee
Edward J. Connors, chairman, Advisory
Council to Hospital Research and
Educational Trust

Staff

James E. Hague, secretary of AHA
Allan B. Caldwell, M.D.,
Division of Professional
Practice
James L. Howard, Washington
Service Bureau
Jon D. Miller, Division of
Research



CARNEGIE COMMISSION ON HIGHER EDUCATION

Federal Aid to
Higher Education:
an essential
investment in the
nation's future

A Statement by the
Carnegie Commission on
Higher Education
July 1953

In early 1967 the Carnegie Foundation for the Advancement of Teaching established a Commission on Higher Education to examine and recommend upon the many vital issues facing higher education in the United States as we approach the year 2000. The Commission has initiated a number of longer-range research projects and has held a series of meetings to consider topics of more immediate consequence. One that has quickly emerged as urgent is the financing of higher education. It is now clear that new and substantial levels of federal aid are essential if higher education is to continue to expand its vital services to the nation. The Commission is preparing a detailed proposal on federal aid which will be available prior to the next session of Congress. Meantime, because of the urgency of the subject and our wish to stimulate the widest possible consideration and discussion, the Commission is issuing this brief general statement on federal aid to higher education.

RALPH M. BESSE
President, The Cleveland
Electric Illuminating Co.

JOSEPH P. COSAND
President, The Junior
College District of St. Louis

WILLIAM FRIDAY
President, University of
North Carolina

DAVID D. HENRY
President, University of
Illinois

**THEODORE M.
HESBURGH C.S.C.**
President, University of
Notre Dame

CARL KAYSEN
Director, Institute for
Advanced Study at
Princeton

ROY E. LARSEN
Chairman of the Executive
Committee, Time, Inc.

KATHERINE E. McBRIDE
President, Bryn Mawr
College

JAMES A. PERKINS
President, Cornell
University

CLIFTON W. PHALEN
Chairman of the Executive
Committee, New York
Telephone Company

NATHAN M. PUSEY
President, Harvard
University

DAVID RIESMAN
Professor of Social
Sciences, Harvard
University

**THE HONORABLE
WILLIAM W. SCRANTON**

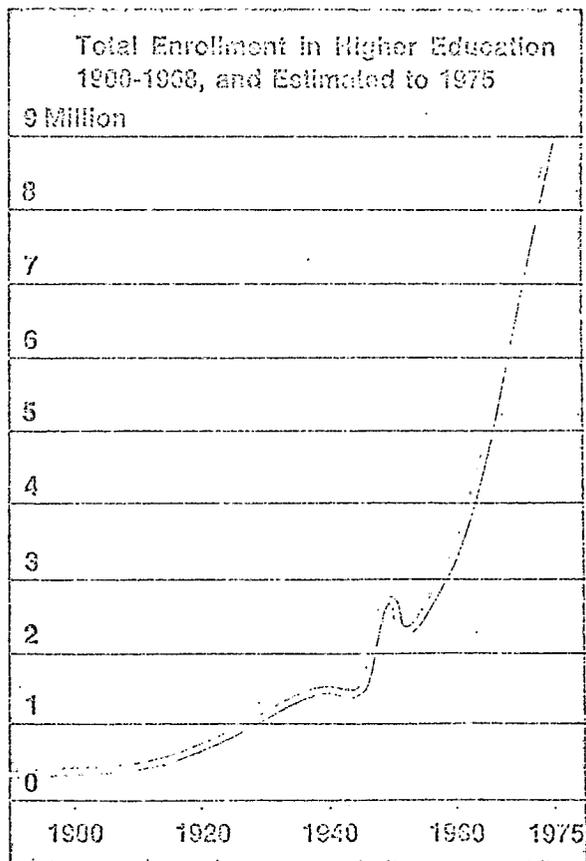
NORTON SIMON
Hunt Food and
Industries, Inc.

CLARK KERR
Chairman

The history of American higher education is one of steady, rapid, and accelerating growth, in both magnitude and quality. Two great social forces underly this remarkable growth:

- The aspirations of individual citizens for maximum realization of their potential abilities, and
- The widespread recognition that higher education is imperative to the economic, social, cultural, and scientific progress of the nation.

Today these two forces are propelling higher education through the period of its greatest growth in our national history.



Student enrollment has soared from 3 million in 1956 to 6 million in 1967. Estimates indicate it will reach 9 million in 1975.

Higher education has almost always received some federal assistance, but the chief financing burden has been borne by state and local governments and private donors. It is a striking testimonial to their faith in higher education that they have financed the enormous expansion to date, and that they are girding to do still more in the future. But it is unmistakably evident that a much greater federal investment is now essential if the growth of higher education is not to be curbed at the very time when the need is so crucial for our best intellectual efforts, skills, and ideas.

The Historic Role of Education in the United States

From the beginnings of the Republic, education at various levels has played a vital role in the building of a strong democratic society—

- Responding to the aspirations of the people for a constantly better life
- Providing an informed electorate as the basis for our democratic institutions
- Bringing new waves of citizens into the mainstream of American life
- Expressing the religious concerns of the several faiths
- Raising the skill attainments of the labor force to ever higher levels
- Building the nation's cultural and scientific talent to levels of worldwide distinction.

At earlier stages in the nation's development, these functions were chiefly the responsibility of the primary and secondary institutions. Now, as education through high school has become almost universal, as knowledge has exploded, as the professional and intellectual demands of modern society have become ever more complex and exacting, the responsibility has shifted increasingly to America's colleges and universities.

The Broadening Responsibilities of Higher Education

Today, the nation looks to our institutions of higher learning to meet many of our most important needs:

- For more and more Americans, aspirations for a better life assume the necessity of a college education.

A century ago, 2% of young Americans entered college. Now, the figure is 50%, and still rising. In a Gallup poll 97% of all parents questioned said they wanted their children to enter college.

- Equality of opportunity through education, including higher education, is beginning to appear as a realistic goal for the less privileged young members of our society.

"That there should one man die ignorant who had the capacity for knowledge, this I call a tragedy." — Thomas Carlyle

- The economy is increasingly dependent upon basic research and advancing technology, and upon the higher skills needed to make that technology effective, to assure national economic growth and well-being.

40% of the increase in the total national income is now attributable to advances in knowledge and the rising skill levels of the labor force.

- More managers, teachers, and professionals of all sorts are required to serve our complex society. More health personnel are essential to staff the fastest growing segment of the national endeavor.
- The cultural contributions of higher education take on new dimensions as growing affluence and leisure make possible a new concern with the quality of life in the United States.

☐ Above all, the nation and the world depend crucially upon rigorous and creative ideas for the solution to profoundly complex issues.

"Knowledge is more than equivalent to force."
Samuel Johnson

"Mind is the great lever of all things; human thought is the process by which human ends are ultimately answered."
Daniel Webster

Priorities for Further Expansion

☐ New facilities must be provided for the estimated 2 million additional students by 1975 and for the continuing climb in enrollment beyond then. In particular, there is urgent need for more two year colleges, and for more urban institutions in areas now inadequately served.

In 1966-67, 72 new institutions of higher learning were established. There will need to be at least 2 new colleges per week for the next several years to meet predicted demands.

☐ In addition, places must be created for those students with appropriate achievement and motivation whose lack of financial resources now bar a college education, and adequate support must be provided for these students.

Percentage of U.S. Undergraduate Students by Family Income Quartiles, 1966-67

High Quartile	48%
Second Quartile	28%
Third Quartile	17%
Low Quartile	7%

If financial barriers were removed, it is estimated that an additional 1 million students would be enrolled in higher education by 1975.

☐ The ablest Ph.D. candidates and the institutions that serve them must be supported at the highest level of scholarship and scientific discovery; these students and institutions are invaluable national resources.

☐ Medical schools must be created in population centers without such facilities, and substantial numbers of new doctors and related health personnel must be educated.

Facilities to train 60% more medical students and 60% more Ph.D.'s will be needed by 1975 to meet the nation's requirements for doctors, researchers, and teachers.

☐ Research support must be gradually but steadily expanded to serve greater numbers of graduate students and to help finance additional institutions and additional areas of investigation appropriate to national needs.

☐ Smaller colleges must be assured assistance through support of cooperative facilities, such as research libraries and computers, to guarantee that their unique contributions may be continued and improved.

The Costs

Costs of higher education are rising rapidly. For many other activities of society, rising costs can be offset in part by rising productivity. Despite improvements in college management and experiments in programmed learning and other new techniques, no major ways are likely to be found to shorten or streamline the effort of turning out a rigorously-disciplined human mind. Beyond that, there is more to know today, and more sophisticated and costly research tools are required.

Total expenditures for higher education climbed from 4.1 billion in 1955 to 15.5 billion in 1965.

Higher education's share of the Gross National Product was 1% in 1955 and 2.2% in 1965. It will need to be at least 3% by 1975.

State, local, and private sources are now the chief supporters of higher education. But state and local governments cannot provide additional support of the magnitude needed with the speed required, because of their presently inadequate tax base resources. The federal government, with revenues available from the sharply graduated income tax, is the only source now realistically able to raise its revenues faster than the GNP and thus able to provide higher education with an added share of the GNP.

State, local, and private sources combined now pay about 76% of total higher education costs, and the federal government pays 22%. While the absolute amounts paid by all sectors will continue to rise substantially, federal support levels in dollar terms will need to double in the immediate future. The federal government's proportionate share may rise to approximately 33% by 1975.

Programs of Federal Support

The best immediate means of federal support for the further expansion of higher education is basically the strengthening and augmentation of programs already underway at the federal level:

□ Grants and loans to individual students, who, with the advice of parents and counselors, will then constitute the market for the selection of institutions and programs to meet their current needs.

□ Support to institutions to expand and strengthen areas of particular national concern.

□ Extension of support for research, for construction, and for special programs.

Two other widely discussed approaches are not considered as desirable as are extensions of existing programs. These are tax credits to parents of children in college, a measure which would favor middle-income families where the need is greatest; and general subsidies to the several states, which would increase the authority over higher education of state governments while failing to assure expansion of programs of primary national concern.

Whatever the particular form of federal assistance, it should be designed not to replace but to supplement the optimum support from the states and from private sources.

The Special Character of American Higher Education

Higher education in the United States has evolved in directions unique to the special needs of this country and of our free society. It is the conviction of this Commission that higher education will best continue to serve the nation as it:

- Creates opportunities for all able young people.
- Provides free choice of institutions to students.
- Relies upon multiple sources of income.
- Preserves its diversity of programs and control.

We believe that federal assistance of the type proposed in this statement will help the colleges and universities of the United States to preserve and enhance the special character that has made the best of them models for institutions of higher learning around the world.

The Essential Actions

The Carnegie Commission on Higher Education believes that the most urgent national priorities for higher education between now and 1975 are:

- Provision for 1 million additional students who are now barred for financial reasons from our colleges and universities.
- Training facilities for 60% more medical students to serve the nation's essential health needs.
- Places for 60% more Ph.D. candidates to provide the teachers and researchers required to keep pace with the explosion of knowledge.

To enable our colleges and universities to meet these national priorities and to continue expanding other essential programs, the Commission urges that the present levels of federal aid to higher education be doubled in the immediate future — from \$4 billion to \$8 billion per year.



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
BALTIMORE, MARYLAND 21235

REFER TO: HI:R:MI

AUG 16 1968

Douglas B. Kendrick, M.D.
Member
The Medical Trust Fund Committee
Grady Memorial Hospital
80 Butler Street, S.E.
Atlanta, Georgia 30303

Dear Dr. Kendrick:

This will confirm the agreements reached on the issues you raised in your letter of July 19, 1968 concerning Medicare reimbursement for the services of attending physicians on the faculty of Emory University School of Medicine who render services at Grady Memorial Hospital. These agreements, which were made during discussions at a meeting in Atlanta, Georgia, on August 7, 1968 between representatives of John Hancock Mutual Life Insurance Company, Atlanta Blue Cross, Grady Memorial Hospital, the faculty of the Emory University School of Medicine, and the Social Security Administration, are as follows:

1. With regard to the issue that the compensation paid to the attending physicians is for hospital services only and therefore they may bill their customary charges in private practice for direct medical services to patients, we agreed that the activities of these physicians at Grady Memorial Hospital will be the determinant in deciding whether their salaries should be apportioned between hospital services reimbursable under Part A of the Medicare program and direct medical services reimbursable under the Part B Supplementary Medical Insurance program. We all recognize that the physicians in question are involved not only in supervising and teaching of interns and residents but also have substantial involvement in performing direct patient services in the Grady Memorial Hospital. Therefore, it will be necessary to estimate the portion of each physician's activities which are attributable to teaching, supervision, and other hospital services which are reimbursable under Part A and the portion of his activities which are attributable to direct patient services, reimbursable under Part B. To the extent that a portion of these services is attributable to direct patient services, the salaries of these physicians may not be reimbursable as allowable costs under Part A.

Representatives of the attending physicians on the faculty of Emory University School of Medicine (known as the Medical Fund) and the Grady Memorial Hospital will cooperate with the intermediary and carrier to arrive at reasonable estimates of the apportionment of the physician's activities between Part A and Part B services. Based on these estimates the intermediary (Atlanta Blue Cross) will make appropriate adjustments in the cost reports submitted by Grady Memorial Hospital to exclude from allowable Part A costs the portion of the salaries of the physicians attributable to direct patient services. These adjustments will be made beginning with October 1967, the month in which the Medical Fund was established. Because the involvement of these physicians in rendering direct patient services to the patients of Grady Memorial Hospital apparently was minor in nature before October 1967 and the physicians themselves, as we understand, did not bill for these services, and for other practical considerations, the Social Security Administration agrees to waive the requirement for adjustments in allowable costs for the period before October 1967.

2. With regard to resumption of payments by the Part B carrier for claims received for services rendered by the attending physicians, we understand that the carrier has received a uniform schedule of charges for the services of these physicians and that it is satisfied that this schedule of charges meets the requirements of SSA policies and guidelines. We have been informed that this schedule incorporates the customary charges of the physicians who have a significant private practice, principally at the Emory University Clinic, and where physicians do not have a private practice the schedule incorporates the charges based on the portion of their compensation attributable to direct patient services. In total, therefore, the uniform schedule of charges will yield reimbursement under the Medicare program which will not exceed what the physicians comprising the Medical Fund would have charged had they billed individually. We are asking the carrier to explore this area further to assure that they have an adequate basis for determining that a physician has a private practice. However, the carrier will resume reimbursement for the services of these physicians, using the existing uniform schedule of charges.

3. Concerning anesthesiologists, radiologists, and pathologists on the faculty of Emory University School of Medicine, we agreed that physicians in these specialties would not be considered attending physicians as defined in section 405.521 of the regulations except in those situations where the radiologist performs radiation therapy or cobalt therapy and is designated the attending physician during the period when he renders such

services. These physicians generally will be classified as hospital-based physicians, and reimbursement for their services under the Medicare program will be based on the principles covering such physicians. That is, Medicare reimbursement for any direct patient services they perform in the Grady Memorial Hospital will be based on the professional component of their compensation. The portion of their compensation attributable to activities of a hospital nature such as supervision, administration, etc. will be reimbursed as allowable reasonable costs under the Part A program. Except for the radiation therapy and cobalt therapy services rendered by radiologists under the conditions mentioned above, the charges for direct patient services rendered by physicians in each of these specialties may not be considered for the purpose of establishing the uniform schedule of charges used for reimbursing the attending physicians represented by the Medical Fund, nor may this uniform schedule be used to reimburse these physicians under the Medicare program.

At the meeting in Atlanta a question arose as to whether consultative services rendered by physicians in these specialties could be reimbursed on the basis of the charges they make in private practice, or if they have no private practice, if they could use the charges made by their confreres. While the Medicare program recognizes charges submitted by physicians for consultative services, any such services rendered by those physicians at Grady Memorial Hospital must be considered within the framework of the provider-based physician principles, and would be reimbursable based on the portion of their compensation attributable to the Part B program.

We were gratified to learn at the meeting that the attending physicians on the staff of the Emory University School of Medicine have agreed not to file claims for Medicare reimbursement unless they rendered services which were strictly in compliance with the meaning of applicable regulations and, in particular, section 405.521 of the Federal regulations concerning services of attending physicians supervising interns and residents. You recognize, I am sure, that Congressional intent in these regulations was to provide Medicare reimbursement under the Supplementary Medical Insurance program only in those situations where the physician's direct involvement is required to assure that the patient receives that extra level of care necessary to assure better quality care. Thus, where the physician needs to render a direct personal and identifiable service to the patient, the regulations spell out the manner in which he can demonstrate this, such as reviewing the patient's history and physical examination and personally examining the patient within a reasonable period after admission, confirming or revising diagnosis, determining

the course of treatment to be followed, assuring that any supervision needed by interns and residents was furnished, and by making frequent reviews of the patient's progress.

However, we would not expect a physician merely to use those criteria for deciding to bill for his services. A physician who during the course of the day is engaged basically in teaching interns and residents would not ordinarily be expected to submit claims under the Supplementary Medical Insurance program unless it is necessary for him to become directly involved in the patient's care. For example, we would not expect a physician to file a claim for a service while he was on grand rounds because during his participation in such tours, the physician is considered to be performing in a supervisory and teaching capacity only. Also, section 405.521(d) states, in part, "It is recognized that there will necessarily be situations where a patient will receive medical services in the teaching setting for which payment on the basis of reasonable charges will not be applicable. For example, there will be instances where it will neither be necessary from the standpoint of the medical needs of the patient nor appropriate from the standpoint of the continuing development of the residents' competence for there to be an attending physician who carries out the responsibilities referred to in paragraph (b) of this section" The responsibilities referred to are outlined above.

We enjoyed working with you and the other parties involved in resolving the issues which you called to our attention. Please let me know if you have any other questions on this matter.

Sincerely yours,

Harris Berman

Harris Berman
Assistant Bureau Director
Division of Reimbursement
Bureau of Health Insurance

*Mr. McHulley
Per our discussions
J.P.C.*

80 BUTLER STREET, S. E., ATLANTA, GEORGIA 30303

Grady Memorial Hospital.

August 30, 1968

RECEIVED
AUG 30 1968
COMMUNICATIONS DIVISION

Dear Mr. Berman:

This will acknowledge receipt of your letter discussing the meeting in Atlanta, Georgia on August 7, 1968 between representatives of John Hancock Mutual Life Insurance Company, Atlanta Blue Cross, Grady Memorial Hospital, Emory University School of Medicine, and the Social Security Administration.

Your letter indicates that it is written to "confirm the agreements reached on the issues you raised in your letter of July 19, 1968 concerning Medicare reimbursement . . ."

We are more than appreciative of the opportunity to have had this conference, but feel compelled to note for the record that while your letter concerning the conference is a reasonable statement of the position taken by representatives of John Hancock Mutual Life Insurance Company, Atlanta Blue Cross, and the Social Security Administration, it is not a confirmation of "agreements reached" since both Emory University and Grady Memorial Hospital and representatives of these institutions disagree with certain of the positions taken by the Social Security Administration, Atlanta Blue Cross and John Hancock Mutual Life Insurance Company at this meeting.

Specifically, both Grady and Emory are not in agreement with respect to the position taken at the meeting concerning reimbursement of anesthesiologists, radiologists, and pathologists on the faculty of Emory University School of Medicine and assigned to Grady Memorial Hospital. Because of the importance of the issues involved, we would not want the record to erroneously indicate that the August 7, 1968 meeting resolved our differences with respect to these vital issues. We feel compelled to reserve the right at the proper time to seek further review and consideration of these issues through appropriate channels without prejudice.

At our conference we tried to make clear the basis of our disagreements concerning the position taken with respect to anesthesiologists, radiologists, and pathologists. If you are not clear with respect to what we are saying concerning these specialists, we will be pleased to further clarify our position. Essentially, it is our view that we can see no basis for radiologists, pathologists, and anesthesiologists at Grady Memorial Hospital to be treated any differently than these same specialists at other institutions. In short, we find no justification either in the statutes, the legislative history or the applicable regulations to justify the different limitations which are being placed on reimbursement for the professional services of radiologists, pathologists and anesthesiologists at Grady Memorial Hospital.

We, of course, stand ready at all times to discuss this further with you or your representatives and would welcome the opportunity to do so. We will cooperate in every way to reach agreement to correct what we believe to be an unfair distinction and interpretation.

Yours truly,


DOUGLAS B. KENDRICK, M.D.
Medical Director
Associate Dean, Emory University
School of Medicine

DBK/hm

Mr. Harris Berman
Assistant Bureau Director
Division of Reimbursement
Bureau of Health Insurance
Department of Health, Education and Welfare
Social Security Administration
Baltimore, Maryland 21235

Duke University Medical Center

DURHAM, NORTH CAROLINA

August 21, 1968

OFFICE OF THE
HOSPITAL DIRECTOR

POSTAL CODE 27706
TELEPHONE 919-684-8111

Dr. Robert C. Berson
Executive Director
Association of American Medical Colleges
1346 Connecticut Avenue, N. W.
Washington, D. C. 20036

Dear Bob:

The enclosed memo is the result of discussions here which Dr. Anlyan thought might serve as starting point for discussion at the next meeting of the Executive Council of the AAMC.

During the short time since leaving NIH the problem of financial support for "teaching beds" has appeared on more agendas than any other one topic. It is clearly a problem of major importance. I am looking forward to hearing more about this from your vantage.

Sincerely yours,


Stuart M. Sessoms,
Director

SMS:cw
CC: Dr. William G. Anlyan

Duke University Medical Center

DURHAM, NORTH CAROLINA

OFFICE OF THE DEAN
SCHOOL OF MEDICINE

POSTAL CODE 27706
TELEPHONE 919-684-3439

August 22, 1968

TO: Dr. Robert C. Berson, Executive Director
Association of American Medical Colleges

FROM: Dr. William G. Anlyan, Dean
Duke University School of Medicine

SUBJECT: Teaching Hospitals - Financial Support for the
Medically Indigent

Statement of Current Problem:

"Teaching" or "staff" beds are essential components of the teaching hospital. These must be supported. Adequate financial support is not at present available from either educational or medical care resources. Therefore, the deficit created must be covered by funds usually intended and more appropriately used for other purposes. In the absence of such funds the teaching hospital is faced with serious operational difficulties.

History and Background:

It has been customary over the years to distribute among the various sources of teaching hospital income, its aggregate operating costs. Much of this has been from private patients. Through this process most of the costs of the teaching beds, frequently occupied by the medically indigent, were absorbed. The introduction of multiple sources of support for hospital costs (federal, state and private), and relevant accounting practices necessary, make this financial approach to the cost of teaching beds impossible in those instances in which the private patient is the major source of income. The hospital then must elect one of several courses of action, or possibly a combination, to meet the financial burden of the teaching beds when occupied by patients without adequate financial resources.

Some examples of the problems and the manner in which some hospitals are attempting to solve them are as follows:

Hospital A:

This 630 bed teaching hospital is University owned, has an annual budget of \$20 million and operates with an annual deficit of \$200,000 to \$400,000. This deficit is covered with University funds.

Hospital B:

This 1100 bed teaching hospital has an annual budget of \$34 million and operates with an annual deficit in excess of \$1 million. This has been covered by drawing upon endowment funds which has resulted in a \$20 million depletion of its \$50 million endowment over a period of 10-15 years. In 1967 the deficit was met to a major extent by Medicaid but as a result of a change in the level of funding from this source, the institution again faces a major deficit.

Hospital C:

This 300 bed teaching hospital which is operated as part of a State University Medical Center has an annual budget of \$10 million of which \$3.8 million comes from State appropriated funds.

Hospital D:

Another teaching hospital functioning as part of a State University Medical Center receives \$4.877 million of its annual operating costs from State appropriated funds.

Hospital E:

This teaching hospital is operated under a two-county authority. In 1967 the operating budget was \$16.5 million of which \$9.2 million came from the tax levies of the two counties concerned.

Alternatives:

- o Restrict admissions to those who have a guaranteed resource from which the hospital costs will be funded, and those who are appropriately classified as emergencies:

Unfortunately, this would deny medical care to those in geographic localities without other sources of medical care such as that financed through the operation of "city" or "county" hospitals. In addition, it would reduce to an inadequate level, or eliminate, that functional component of hospital beds essential to its teaching mission.

- o Direct operational support from state appropriated funds:

This mechanism is being used to some extent in state-supported teaching hospitals. However, it is a mechanism that is not available to private institutions and is, in general, as inappropriate operational mechanism for the funding of medical care and teaching in private institutions.

- o Endowment funds:

These funds are being used to meet, in part, some of the need. However, endowment resources are not growing at a rate sufficient to meet the needs of the medically indigent in teaching hospitals, do not constitute a logical means of meeting these financial needs of society, and are needed desperately for funding capital improvements and new ventures.

- o Expansion or modification of existing types of coverage:

This would appear to be the most logical solution and, when viewed from the long range point of view, probably the only one. This might be accomplished through a broader definition of mechanisms such as Medicare, compulsory insurance coverage, or some appropriate modification of these or related mechanisms.

Recommended Action:

That this subject be brought to the Executive Council of the Association of American Medical Colleges for consideration as an issue of National importance that requires immediate attention.

/e

11TH ANNUAL MEETING
COUNCIL OF TEACHING HOSPITALS
79TH ANNUAL MEETING
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

THE DATES

Thursday Evening (6:00 p.m.) Reception
October 31, 1968
through
Monday Afternoon (1:30-3:30 p.m.) Annual COTH Institutional Membership Meeting
November 4, 1968

THE PLACE

Shamrock Hilton Hotel
South Main & Holcombe Boulevard
Houston, Texas
713/MO 8-9211

THE THEME

Medical Education - Physician Manpower - The Teaching Hospital

COTH SPEAKERS

Honorable Boisfeuillet Jones, Chairman, National Advisory Commission on Health Facilities, and President, Emily and Ernest Woodruff Foundation
Ray E. Brown, Executive Vice President, Affiliated (Harvard) Hospitals Center, Boston, Massachusetts
Thomas McCarthy, Ph.D., Deputy Director, National Center for Health Services Research and Development, Health Services and Mental Health Administration, DHEW
Thomas M. Tierney, Director, Bureau of Health Insurance, Social Security Administration, DHEW

COTH CONCURRENT DISCUSSION SESSIONS

Modernization and Expansion of Teaching Hospitals - A Look to the Future
Realigning the Hospital System: Emerging Forces and Evolving Patterns
National Center for Health Services Research and Development - Opportunity for Partnership
Medicare and the Financing of Teaching Hospitals

PRESIDING OFFICIALS

1:30 p.m. - 3:00 p.m., Friday, November 1, 1968: Lad F. Grapski, Chairman,
Council of Teaching Hospitals
3:15 p.m. - 5:00 p.m., Friday, November 1, 1968: LeRoy S. Rambeck, Chairman-
Elect, Council of Teaching Hospitals

OTHER AAMC PROGRAM OPPORTUNITIES

Honorable Wilbur J. Cohen, Secretary, Department of Health, Education and Welfare
Lord Robert Todd, Chairman, Royal Commission on Medical Education, Christ College,
Cambridge, England
John Parks, M.D., President, AAMC, Presidential Address
Robert J. Glaser, M.D., President-Elect, AAMC
Robert C. Berson, M.D., Executive Director, AAMC, Annual Report
John H. Knowles, M.D., General Director, Massachusetts General Hospital
Martin Cherkasky, M.D., Director, Montefiore Hospital and Medical Center, New York
E. Todd Wheeler, Architectural Consultant, E. Todd Wheeler and Perkins and Will
Partnership
Dwight L. Wilbur, M.D., President, American Medical Association

TWELVE AAMC PANEL DISCUSSIONS

Sunday, November 3, 1968
"What Can Be Done Now"

AAMC-COTH PLENARY SESSION

Monday morning, November 4, 1968
Recommendations and Conclusions

COTH ANNUAL INSTITUTIONAL MEMBERSHIP MEETING

Monday afternoon, 1:30 p.m. - 3:30 p.m.
November 4, 1968
Lad F. Grapski, Chairman, COTH, Presiding

AAMC ANNUAL INSTITUTIONAL MEMBERSHIP MEETING

Monday afternoon, 1:30 p.m. - 5:00 p.m.
November 4, 1968
AAMC Reorganization - New General Assembly of Elected Members

SEE YOU IN HOUSTON!

ANNUAL MEETING
CONDENSATION OF COTH ACTIVITIES

Thursday, October 31, 1968:

2:00 p.m. - 5:00 p.m. COTH Executive Committee Meeting
6:00 p.m. - 8:00 p.m. COTH Reception

Friday, November 1, 1968:

7:30 a.m. Joint Meeting with GSA
9:00 a.m. - 12:30 p.m. AAMC Plenary Session
12:30 p.m. - 1:45 p.m. COTH Luncheon
2:00 p.m. - 5:00 p.m. COTH General Session
5:15 p.m. - 6:00 p.m. COTH Nominating Committee

Saturday, November 2, 1968:

9:00 a.m. - 12:30 p.m. AAMC Plenary Session
9:00 a.m. -- John H. Knowles, M.D., General Director, Massachusetts General Hospital, "Manpower Shortages: Quantity vs. Quality" -- Panel Discussion Group includes Martin Cherkasky, M.D., Director, Montefiore Hospital and Medical Center, New York City
12:30 p.m. - 1:30 p.m. COTH Nominating Committee
1:30 p.m. - 5:00 p.m. COTH Discussion Groups
Group #1
Group #2
Group #3
Group #4

Sunday, November 3, 1968:

9:00 a.m. - 10:30 a.m. AAMC Plenary Session
10:30 a.m. - 12:30 p.m. AAMC -- 6 panel discussions
2:00 p.m. - 4:00 p.m. AAMC -- 6 panel discussions

Monday, November 4, 1968:

9:00 a.m. - 12:00 noon

AAMC Plenary Session

1:30 p.m. - 3:30 p.m.

COTH Institutional Membership Business Meeting

3:30 p.m. - 5:00 p.m.

COTH Executive Committee Meeting

Listing of Individuals Receiving Special
Tribute from the Council of Teaching Hospitals
In Recognition of Their Assistance in its Formation and Development

George N. Aagard, M.D.	President, AAMC 1960-61 (Chairman, AAMC Committee on Medical School-Affiliated Hospital Relationships 1961-1964)
Donald G. Anderson, M.D.	President, AAMC, 1961-62 (Member, AAMC Committee on Medical School Affiliated Hospital Relation- ships 1960)
Robert C. Berson, M.D.	President, AAMC, 1963-64
Philip D. Bonnett, M.D.	Chairman, AAMC Medical School- Teaching Hospital Section, 1962-63
Donald J. Casely, M.D.	Chairman, AAMC Medical School- Teaching Hospital Section, 1959-1960
Richard O. Cannon, M.D.	Chairman, AAMC Medical School- Teaching Hospital Section, 1961-62
Lowell T. Coggeshall, M.D.	President, AAMC 1957-58
John M. Danielson	Secretary, AAMC, Medical School- Teaching Hospital Section, 1961-64
Ward Darley, M.D.	Executive Director, AAMC 1956-64
Stanley A. Ferguson	Chairman, AAMC Council of Teaching Hospitals 1966-67
Lad F. Grapski	Chairman, AAMC Council of Teaching Hospitals, 1967-68
Gerhard Hartman, Ph.D.	Chairman, AAMC Medical School- Teaching Hospital Section, 1958-59
Harold H. Hixson	Chairman, AAMC Medical School- Teaching Hospital Section 1963-64
William N. Hubbard, Jr., M.D.	President, AAMC 1966-67

Duane E. Johnson

Secretary, AAMC Medical School-
Teaching Hospital Section, 1958-1961

Matthew F. McNulty, Jr.

Chairman, AAMC Medical School-
Teaching Hospital Section, 1964-65

C. Arden Miller, M.D.

Chairman, AAMC Committee on Medical
School-Affiliated Hospital
Relationships 1964-65

Russell A. Nelson, M.D.

Chairman, AAMC Council of Teaching
Hospitals 1965-66

John Parks, M.D.

President, AAMC, 1967-68

Albert W. Snoke, M.D.

Chairman, AAMC Medical School-
Teaching Hospital Section 1960-61

Thomas B. Turner, M.D.

President, AAMC, 1965-66

George A. Wolf, Jr., M.D.

President, AAMC, 1964-65

SUGGESTED RECIPIENTS FOR COTH

ANNUAL AWARD, 1968 ANNUAL MEETING

Edwin L. Crosby, M.D.
Executive Vice President and Director
American Hospital Association

Honorable Lister Hill
United States Senator
State of Alabama

Boisfeuillet Jones
President, Emily & Ernest Woodruff Foundation, &
Chairman, National Advisory Commission on Health Facilities

James A. Shannon, M.D., Ph.D.
Special Advisor to the President,
National Academy of Sciences and
Retired Director, National Institutes of Health
Department of Health, Education and Welfare

August 17, 1968

Robert C. Barson, M.D., Executive Director, AAMC

Matthew F. McNulty, Jr., Director, COTM - Associate Director AAMC

Move of the Evanston Office of the AAMC to Washington, D.C.

Concurrently supplementing and then subsequently adding a follow-up to the carefully prepared and thoughtfully executed 9-page draft on this subject matter from Dale (Dale E. Mattson, Ph.D.), you and I have completed the visual survey of sites in Bethesda, the 70-3 scientific corridor from Bethesda to Frederickburg, the sites in Virginia and the various site possibilities in Washington, D.C. Also we have met with officials of the Brookings Institute and officials of the American Council on Education.

From this considerable but I trust profitable investment of time to obtain first hand all of the information and background necessary for decision recommending to the Executive Council of the AAMC and have developed several categories of emphasis as follows:

1. There is a good 50-50 chance that the AAMC can develop a corporately owned or effectively corporately shared with long-range ownership potential structure benefiting a first class organization here in Washington.
2. That the construction and/or other type of acquisition of such a headquarters be considered the second step of a two-phase sequential move.
3. That in the interest of morale and the organizational productivity that results from this contribution of employee interest the move of the Evanston office to Washington, D.C. should be definitely scheduled for the summer of 1969.
4. Careful planning and generous consideration of all Evanston employees should be the standard for implementing a move in the summer of next year.
5. A temporary location (company leasing a lease arrangement of from 3 to 5 years with privilege of early upset subsequent to 3 years) be evolved for the first step of the two-phase move.
6. Insofar as possible the location for the Washington office be definitely established. Our site surveys have convinced us that there is very little economic benefit to be gained in one site location in the Washington area as opposed to any other.

Dale E. Mattson, Ph.D., Director, Division of Educational Measurement and Research, 2570 Ridge Ave, Evanston, Ill. 60001

Chever H.C. Smythe, M.D., Assoc. Director, Association of American Medical Colleges, 1110 Ridge Ave., Evanston, Ill. 60001

Land acquisition costs in Bethesda and North are generally offset by the amount of land that needs to be purchased, the type of structure involved, the dependency on eating arrangements, etc. In fact for any of the sites visited there could be mounted equally strong economic support, arguments or economic detracting arguments. It is difficult in fact to enumerate a series of criteria of quantitative measure on which judgment could be rendered. In fact, I suspect that with the Executive Council of diversified background the decision of location by that group might too be difficult. Viewing the subject from a long range evaluation it seems that a downtown Washington, D.C. location would be an investment from which the Association could recover full value presuming that the economy of the country continues in the future as it has in the past.

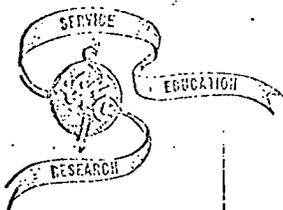
In summary the foregoing listing is to emphasize the recommendations that I trust at its September meeting the Executive Council would concur and give decisions to at least three items:

1. A decision to move in 1959.
2. A decision that the best interests of the Association would be served by a two-phase move.
3. A decision as to where in the Washington, D.C. area the headquarters would be located.

To be of further assistance to you and as a somewhat different division of the excellent projections made by Dale on pages 5, 6, 7 and 8 of his draft I have attached a detailed analysis of a site I looked at on 13th and H Street just off Connecticut Avenue and immediately adjacent a scheduled station for the projected D.C. Subway. I have indicated property description, construction description, project costs, rental possibilities, operating expenses, possibilities and alternate approaches. I have also attached but only to the original of this memorandum for I had only one copy the proposal from John S. Doan and Sons, Inc., for a site at 1722-25 Massachusetts Avenue, N.W.

As you now I will be in Venezuela for the next week but I will be returned by the last week in August and available for any other discussions or activity that you may suggest or that Dale may desire.

Enclosures



ASSOCIATION OF AMERICAN MEDICAL COLLEGES

INTER-OFFICE MEMO

DATE August 19, 1968

Retain - 6 mos.

1 yr.

5 yrs.

Permanently
Follow-up Date

TO: Robert C. Berson, M.D., Executive Director

FROM: Walter G. Rice, M.D., Director
Division of Operational Studies

SUBJECT: Notes on Meeting with AMA Staff and Drs. Sherman and White

An informal meeting was held at the AMA building with Dr. Lowell White and Dr. John Sherman representing the Advisory Committee on Grants Administration Policy. Attending from AMA were Dr. C. H. William Ruhe, Dr. John C. Nunemaker, and Dr. Hayden Nicholson and myself from AAMC. (Tom Campbell could not be there.)

The meeting was an informal discussion of the concern of Drs. Sherman and White regarding possible problems for residency programs arising from multiple sources of federal funds (RMP, training grants, Title XVIII, Title XIX, etc.) and the interest that is developing in this problem from the financial officials within the federal government.

There was a general, free discussion of the issues without development of any specific recommendations. The need for a firm base of information on the role of the resident in the various categories of teaching hospitals, in analysis of the nature of his responsibility for the delivery of patient care, for participation in the teaching programs of undergraduate medical students and others, for participation in research and for self-learning was emphasized.

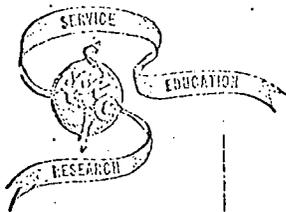
It was also mentioned that there was need to head off the "trade union" movement by treating residents as physicians rather than indentured hospital employees. (Dr. White)

The differences in residency requirements and staffing of major medical school teaching hospitals and other teaching hospitals was also discussed.

It was suggested that the AMA reopen this matter with its constituents via the Committee for Postgraduate Education. However, without specific, objective information this will be difficult to handle.

The need for information on the total cost of a residency, and accurate information on resident income was also mentioned.

COPIES TO:



ASSOCIATION OF AMERICAN MEDICAL COLLEGES

INTER-OFFICE MEMO

DATE August 19, 1968

Retain - 6 mos.

1 yr.

5 yrs.

Permanently
Follow-up Date

TO: Robert C. Berson, M.D.
FROM: Walter G. Rice, M.D.
SUBJECT: Notes on Meeting with AMA Staff and Drs. Sherman and White

Summary

There is a probability that federal financial officials will be increasingly critical of the funding of residencies from multiple sources. The role of the resident in delivery of health care, especially in the teaching hospital, needs to be carefully analyzed and the present national policies regarding residents need review.

WGR/mw

COPIES TO: Cheves McC. Smythe, M.D.
Matthew P. McNulty, Jr.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

INTER-OFFICE MEMO

DATE September 2, 1968

Retain -- 6 mos.	<input type="checkbox"/>
1 yr.	<input type="checkbox"/>
5 yrs.	<input type="checkbox"/>
Permanently	<input type="checkbox"/>
Follow-up Date	<input type="checkbox"/>

TO: Walter G. Rice, M.D., Director, Division of Operational Studies, AAMC

FROM: Matthew F. McNulty, Jr., Director, COMH; Associate Director, AAMC

SUBJECT: Notes on Meeting With American Medical Association Staff and John F. Sherman, Ph.D., Deputy Director, NIH and Lowell E. White, Jr., M.D., Associate Dean, University of Washington Medical School (both individuals being members of the Advisory Committee on Grants Administration Policy)

Appreciated the courtesy copy of your memorandum of August 19th to Robert C. Berson, M.D., Executive Director, AAMC. The memorandum awaited my return from Venezuela.

Some months previous to receiving your memorandum, I had had the opportunity of informal discussion with John Sherman on this subject but in a setting which was not conducive to reaching definitive conclusions. I intend to place the matter on the agenda of the COMH Executive Committee which meets this Thursday and Friday, September 5th and 6th. However, because of an already overcrowded session program, it may not receive the thorough discussion that I would desire. One reason for trying to obtain the reaction from fourteen different leading teaching hospitals (the officers and members of the Executive Committee will be present) results from my previous action following the mentioned informal discussion with John Sherman when I did telephone-sample twenty teaching hospitals to determine if, from such quick and obviously inadequate sampling, there was any concern that residents might be receiving duplicate or multiple payments from Federal sources for the same hours of performance. I believe I alerted those twenty institutions to a potential problem but to the best of our knowledge, and by subsequent follow-up, there was no known reported abuse of Federal funds.

The question of funding residency activities from multiple sources is a far different question than the concern as to whether residents are receiving financial support from several different Federal avenues for an identical performance contribution.

As you know, hospitals, not unlike most every other business, receive revenue based on a system of charge that is multiple in terms of avenues of income. These funds usually become identified in a "general fund" from which general expenditures are allocated. So long as multiple Federal agencies are engaged in one way or another in pursuing service from teaching hospitals, I don't see how there can be other than multiple sources of income which in turn provides a generic base for underwriting the multiple costs of rendering the service including the educational cost component that is part of the teaching hospital existence. Teaching hospitals receive Federal funds from the Social Security Administration, from the Medicaid Administration, from the Childrens Bureau, from Vocational Rehabilitation, from the Veterans Administration, to mention but a few sources. The National Institutes of Health, in addition to their training-fellowship

COPIES TO:

Walter G. Rice, M.D.
September 2, 1968
Page Two

programs, underwrite clinical research centers, myocardial infarction centers and other demonstrative or outright patient care units, all of which provide income to the teaching hospital.

There is undoubtedly some ingredient of these discussions that I am missing. Let's be sure to pursue this matter further at the first opportunity, for I sense from my conversation with John Sherman that he "wants to do something" with the emphasis on action. I am not sure just what "action" he has in mind and I could not gather any specifics from a telephone conversation on this subject of last Friday, August 30th. I may be over-sensitive, but I thought I detected in John's conversation, a note of anxiety concerning the need for retrenchment and that if trainees and fellows can be financed from some other source, then the elimination or reduction of trainee and fellowship grants by the National Institutes of Health is a retrenchment possibility.

So that we both may obtain a better perspective of this subject, I am taking the liberty - to which I presume you would have no objection - of sending a copy of your memorandum to LeRoy S. Rambeck, Director, University Hospital, Seattle, Washington. Roy is Chairman-Elect of the Council of Teaching Hospitals and in addition is a good friend of Lowell White. If Roy has a chance before coming east for our Executive Committee meeting, he could explore with Doctor White the perspective that Lowell may have had from discussions with John Sherman.

In any event, I hope that you and I can pursue this subject matter further and perhaps at the Council of Academic Societies Workshop in early October or sooner by telephone or personal visit either to Chicago or to Washington - to which I would be quite amenable (either way, I go to Chicago or you come to Washington) or by telephone if you detect, as I may be over-emphasizing, a note of early action in this area.

cc: Robert C. Berson, M.D., Executive Director, AAMC
Cheves McC. Smythe, M.D., Associate Director, AAMC

P.S. Your comment in summary concerning the need for careful analysis of the present policies regarding residents is quite valid. In fact, the Council of Teaching Hospitals is pursuing as quickly as our limited manpower permits the feasibility investigation and we believe the subsequent operational approach to the broader subject of the financing of teaching hospitals. It seems to us that this total area needs a philosophical and practical review to determine the present state of the art, why that state exists, how it came about, the elements of benefits and liabilities at present, the possibility for improvement on behalf of institutions, individuals and society and the methodology by which such change might be evolved.

✓ BCC: Fletcher H. Bingham, Ph.D., Assistant Director, COTM -- Should we add this to the Executive Committee agenda? - just to see if anyone else sees a problem as we do not.



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
BALTIMORE, MARYLAND 21235

OFFICE OF THE COMMISSIONER

REFER TO: HI:PS:H

AUG 06 1969

Mr. Matthew F. McNulty, Jr.
Director, Council of Teaching Hospitals
1346 Connecticut Avenue, NW.
Washington, D.C. 20036

Dear Mr. McNulty:

As I stated at our recent meeting, we very much appreciate the assistance of the Council on Teaching Hospitals in evaluating utilization review in hospitals and in seeking measures to make it more effective.

Certainly any statistical data you could provide that would afford us a better insight into utilization review would be very worthwhile. We are presently surveying a sample of almost 500 hospital utilization committees to collect data on their membership characteristics and procedures as well as the number and type of substantive recommendations that they have made. We hope to have substantially all the responses to the questionnaires (a copy is enclosed) by the end of September. Hospitals not included in the sample will be queried when they are visited by State agencies in connection with the recertification process. We also plan to survey utilization review operations in extended care facilities. We would appreciate having your suggestions on the kinds of supplementary information that you might provide that would throw additional light on utilization review.

I believe that your most valuable contribution would be in the development and demonstration of techniques to make utilization review more effective both in COTH hospitals and in other institutions--particularly small hospitals and extended care facilities. As you know, one possible approach that we believe you might want to consider would be to arrange for one or more teaching hospitals to make members of its medical staff who have utilization review expertise available to assist smaller hospitals and extended care facilities in the community. The teaching institution might even perform the review function, including collection and analysis of pertinent data, for one or more less adequately staffed institutions. Another possibility would be to develop predetermined medical criteria for the more important diagnoses to supplement committee members' understanding

of what is accepted in the community as being proper utilization. Your support of utilization review, both through policy statements and informational programs, would also be of great value and a publication of the research findings and recommendations of an organization like yours would give an impetus to follow the models you have found to be successful.

I am looking forward to having your advice and recommendations on the projects you might wish to undertake. Please let us know if we can assist you in any way.

Sincerely yours,



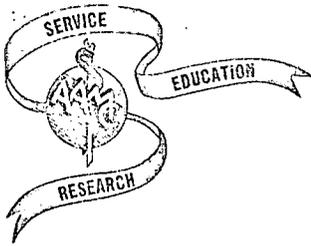
Thomas M. Tierney, Director
Bureau of Health Insurance

Enclosure

cc:
Robert C. Berson, M.D.

RECEIVED
MAY 2 1967
U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE

mailed 8/5



ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF TEACHING HOSPITALS
1346 CONNECTICUT AVENUE, N.W.
WASHINGTON, D. C. 20036
202/223-5364

MATTHEW F. McNULTY, JR.
DIRECTOR August 5, 1968

TO: COTH Committee on Modernization and Construction Funds for Teaching Hospitals:

- Richard T. Viguers, Chairman
- Lewis H. Rohrbaugh, Ph.D., Vice-Chairman
- Robert C. Hardy
- John H. Knowles, M.D.
- David Littauer, M.D.
- Richard D. Vanderwarker
- John H. Westerman
- John W. Kauffman, AHA Representative

COTH Members on AAMC Committee on Federal Health Programs:

- Charles H. Frenzel
- Harold H. Hixson
- James T. Howell, M.D.

Undoubtedly, you have seen General Membership Memorandum No. 1968-34G, subject: Hospital and Medical Facilities Assistance Amendments of 1967, dated July 29, 1968, and General Membership Memorandum No. 1968-35G, subject: Legislation to Provide Mortgage Insurance for Nonprofit Hospitals, dated July 29, 1968, concerning the possibilities of extending authority for Hill-Burton benefits and the proposed Housing and Urban Development Act of 1968 respectively. The Housing and Urban Development Act of 1968 was signed into Public Law 90-448 on August 1, 1968.

In regard to the foregoing, it is the purpose of this note to report to you that the "White Paper" under final development by the COTH Committee on Modernization and Construction Funds for Teaching Hospitals has been very helpful even in its preliminary final draft form as a mechanism of information, logic and persuasion in keeping alive in both the executive branch and the legislative branch an interest in creating some modernization authority in this, the last session of the 90th Congress.

You will note my stress on the word "authorization". At this stage, the opportunity for affirmative action in the House of Representatives concerning the Hill-Burton extension addition to the Regional Medical Programs bill is still doubtful, but yet a chance now exists where none was present previously.

General Membership Memorandum No. 1968-34G indicates the possible conferees from the House of Representatives that will serve on the Conference Committee to resolve House-Senate differences. However, if the Hill-Eurton authorization remains in the RHP bill and becomes law, it is still only an "authorization". The same can be said for the mortgage insurance feature for nonprofit hospitals in the Housing and Urban Development Act of 1968 (P.L. 90-448). That act also provides only "authorization".

Said another way, with regard to the foregoing, only one-half of the objective is realized when authorizations are accomplished. Funding through appropriations legislation will have to come later. In fact, at this time it appears that such funding would be unlikely in this Congress though it is difficult to be too positive. The two national political conventions could introduce an entirely different complexion on the present "economy campaign".

Finally, this memorandum closes on the note of repetition which indicates that results may not be immediately forthcoming, but the work of the Committee on Modernization and Construction Funds for Teaching Hospitals has had an impact in the private sector with the President's Advisory Commission on Health Facilities and in the public sector with legislative and executive leaders.

Cordially,



MATTHEW F. McNULTY, JR.
Director, COTH
Associate Director, AAMC

Attachments: COTH General Membership Memorandum No. 1968-34G
COTH General Membership Memorandum No. 1968-35G

cc: COTH Executive Committee (with attachments)
COTH Committee on Financial Principles for Teaching Hospitals (with attachments)

June 7, 1968

"THE ROLE OF THE UNIVERSITY IN GRADUATE MEDICAL EDUCATION"

The Council of Academic Societies is organizing a Workshop on Graduate Medical Education October 2-5, 1968 at the Marriott Twin Bridges Motor Hotel in Washington, D.C. Attendance is expected to be about 125 and will be by invitation.

Background:

For more than a decade, that all is not well in the American system of medical education has been widely recognized. Three reports are judged to articulate particularly lucidly the challenge to the medical educational system.

1. Planning for Medical Progress Through Education - Lowell T. Coggeshall, Association of American Medical Colleges, April, 1965 - The result of a study commissioned by the Association of American Medical Colleges, this report emphasizes that medical education should be a continuum. The discrete components of high school, college, medical school, internship, and residency, each with their own set of requirements, leads to wasteful use of both students' and teachers' time.
2. The Graduate Education of Physicians - Report of the Citizens Commission on Graduate Medical Education - John S. Millis, American Medical Association, August, 1966 - This report, the result of a study commissioned by the American Medical Association, not only examines the many accomplishments of American graduate medical education but describes its defects and makes a number of specific recommendations designed to strengthen the system. Such recommendations as elimination of the internship, repeated examination of goals and objectives by institutions sponsoring training programs, early specialization, modification of rigid licensure requirements, and graduate programs for primary physicians, if adopted, could result in significantly more efficient utilization of a more productive period in each young physician's life.
3. Report of the National Advisory Commission on Health Manpower (Volume I) - U.S. Government Printing Office, November, 1967 - This report of a Presidential Commission calls for a number of measures to increase both the number and productivity of physicians. One of its major emphases is that the mere increase of the number of physicians acting in today's system of health care distribution will not solve many of this system's worst weaknesses. Rather, there must be changes in the system itself.

Through all these reports run the mandate for qualitative change and more than increases in numbers.

The Association of American Medical Colleges (AAMC) is going about fitting itself for a productive role in a rapidly changing health education system. Incorporation of a Council of Academic Societies constitutes a significant change in the format of the AAMC. This Council, comprised of representatives from the associations of professors in the various disciplines and of the distinguished medical societies, has been designed to bring the voice of medical faculties into the policy-determining process of the Association. This Council has focused on the discrepancy and incongruity between the lack of active involvement by the AAMC in the problems of graduate medical education vis-à-vis the huge programmatic and monetary commitments of its Institutional Members (the medical schools) and the members of the Council of Academic Societies to graduate education.

The professorial societies are composed of the heads of departments of all schools in the country. The Council of Academic Societies has, therefore, a mechanism by which positions taken on matters of policy can be rapidly transmitted to those most influential in determining the course of graduate medical education--the clinical department chairman.

Against this background, the Council of Academic Societies has determined to conduct a Workshop on Graduate Medical Education on October 2, 3, 4, and 5, 1968.

Approximately 125 will be asked to participate. Two or three representatives from each of these societies now members of the Council (list attached), representatives from the Specialty Boards of the disciplines represented in the Council, representatives from the Council of Teaching Hospitals of the AAMC, the Council on Medical Education of the AMA, the American Hospital Association, the National Board of Medical Examiners, and the Bureau of Health Manpower will be invited. Finally, those individuals who are playing significant roles in the evolution of thinking about graduate education will also be asked to attend. Support for the workshop is being sought from the Bureau of Health Manpower.

Objectives of Workshop

The objectives of the workshop will be the formulation of policy recommendations by the Council of Academic Societies on certain aspects of graduate medical education to be outlined below. Subsequently, these positions will be articulated into those of the AAMC where they can be expected in time to be a force bringing about changes resulting in greater effectiveness and economy in graduate medical education. Other objectives of this workshop will include:

1. To inventory what is happening in (the state of the art) graduate education in selected fields at a time when major changes in this area of education are to be expected.
2. To reach for a quantitative estimate of the meaning of the assumption of a major defined responsibility in graduate education by the universities.
3. To compare the experiences of four specialty groups which have been chosen to prepare for change by examining their activities in graduate medical education.

4. To cooperate with four specialty groups in the presentation of data relevant to graduate education in the fields of internal medicine, pediatrics, neurological surgery, and orthopedic surgery. Numbers of men in training, their origin, their schools, their intellectual characteristics, their performance on Board and other examinations will be examined. As a generalization, an attempt will be made to explore the relation of input into a training program to its output. Data on economics of graduate medical education will be collected and presented. Changes in examination techniques and objectives will be noted, but this is not to be a workshop on examinations.
5. To stimulate the collection of data by other professorial organizations and their specialty boards relevant to a definition of the university component in graduate medical education.

DRAFT 6/7/68

TENTATIVE PROGRAM FOR WORKSHOP

"ROLE OF THE UNIVERSITY IN GRADUATE MEDICAL EDUCATION"

WEDNESDAY, OCTOBER 2, 1968

4:00 to 6:00 PM	Registration
5:30 to 6:30 PM	Social Hour
6:30 to 8:00 PM	Dinner
8:00 PM	Address - The Role of the University in Graduate Biomedical Education

Speaker: A University President with broad experience in this area has been invited.

THURSDAY, OCTOBER 3, 1968

7:00 to 8:00 AM	Breakfast
8:30 AM	Plenary Session
8:30 to 9:00 AM	Orthopedics and the Impact of Learning Theory Dr. Charles F. Gregory - Professor of Orthopedics, University of Texas, Southwestern Medical School, Dallas (Tentative)
9:10 to 9:40 AM	Pediatrics, Multiple Tracks and the Relation of Training to Eventual Social Function Dr. Robert B. Lawson - Professor of Pediatrics, Northwestern University Medical School (Tentative)
9:50 to 10:20 AM	Cores and Training for Internal Medicine Dr. Jack D. Myers - Professor of Medicine, University of Pittsburgh School of Medicine (Tentative)
10:20 to 10:40 AM	Break
10:40 to 11:10 AM	Neurological Surgery and the Assessment of Accomplishment - Speaker to be selected
11:20 to 11:50 AM	Physiology - Speaker to be selected
12:00 to 1:30 PM	Lunch
1:30 to 3:00 PM	Panel - Basic Science Input into Training: Its Nature and Content (Representatives from anatomy, microbiology, pathology, pharmacology and biochemistry)
3:00 to 3:30 PM	Break

3:30 to 4:00 PM

Plenary Session

Organization of Discussion Groups, Objectives of Conference, and Necessity for Final Recommendations

4:00 to 5:00 PM

Initial Meetings of Discussion Groups

5:30 to 6:30 PM

Social Hour

6:30 to 8:00 PM

Dinner

8:00 PM

Address - The Economics of Graduate Education

Speaker: A Medical Executive with broad university and governmental experience has been invited.

FRIDAY, OCTOBER 4, 1968

7:00 to 8:00 AM

Breakfast

8:30 to 9:00 AM

Preservation of Sociologic Awareness and the Reward System - The Other Face of Economics
Speaker to be Selected.

9:00 to 12:00 AM

Discussion Groups with Breaks

12:00 to 1:30 PM

Lunch

1:30 to 2:00 PM

The Second Graduation - Or The Boards as Quasi-Licensing Bodies

Speaker to be Selected.

2:00 to 3:30 PM

Continuation of Group Discussions

3:00 to 5:00 PM

Formulation of Recommendations from Discussion Groups

6:00 PM

Social Hour

No Evening Program Planned

SATURDAY, OCTOBER 5, 1968

7:00 to 8:00 AM

Breakfast

8:30 to 10:30 AM

Report from Discussion Group Leaders

10:30 to 11:00 AM

Break

11:00 to 12:00 AM

Final Report of Conference Chairman

Topics For Discussion

The workshop will be divided into discussion groups. Each group will be assigned one of the topics listed below and requested to bring in its recommendations concerning the assigned topic. Each group will also be encouraged to address itself and return its opinions about other topics.

TOPICS

1. In terms of authorization and control, graduate medical education today is essentially proprietary as related to the role of the individual in the program and is in somewhat the same stage of development as undergraduate medical education was in 1910.
2. Each medical school faculty and each teaching hospital staff acting as a corporate body should explicitly formulate and periodically revise their own educational goals and curricula.
3. Each teaching hospital or its medical school faculty should organize its staff through an educational council, a committee on graduate education, or some similar means so as to make its programs of graduate medical education a corporate responsibility rather than the individual responsibility of particular medical-surgical services or heads of services.
4. The medical schools and their teaching hospitals, collectively and individually, have the responsibility for designing a program in graduate education training which will produce physicians prepared and committed to deliver continuous and comprehensive medical care. A number of specific programs designed to realize this goal must be introduced simultaneously in a variety of different settings across the country.
5. The internship as a separate and distinct portion of medical education should be abandoned and the internship and residency areas should be combined under a single period of graduate medical education called a residency and planned as a unified whole.
6. The end of general medical education may occur either while a man is still in school or upon his graduation from medical school, but specialized training should begin upon graduation from medical school. This statement should be seen as encouraging experimentation relating to the continuity of undergraduate and graduate medical education.
7. Although the specialty board should be discouraged from amending their regulations concerning eligibility for examination and certification in a manner to increase the required length of residency training to

compensate for any removal of the internship, an attitude of permissiveness and allowance of experimentation in this area should be encouraged.

8. The residency review committees of the specialty boards should include members from outside of that particular specialty. Hospitals should be encouraged to experiment with different forms of basic residency training. Specialty boards and residency review committees should be encouraged to allow experimentation by interpreting liberally those statements of resident requirements that now inhibit new forms of educational organization.
9. Programs of graduate medical education should be approved only if they cover the entire span of training from the first year of graduate medical education through completion of specialty training. The appropriate agencies should work in concert so that state licensure acts and statements of certification be amended to eliminate a requirement of separate internship and substitute for it an appropriately described period of graduate medical education. Cooperative arrangements between many hospitals in a given area and an academic medical center should be encouraged.
10. In an effort to strengthen training programs from area to area, a commission on graduate medical education specifically charged with the responsibility for planning, coordinating and periodically reviewing standards for graduate medical education and procedures for its review and the approval of the institutions in which that education is offered should be created. The commission on graduate medical education should number in its membership representatives from the Council on Medical Education and the Association of American Medical Colleges, the Advisory Board for Medical Specialties, the American Hospital Association and members from societies-at-large.
11. The introduction of cores in training in internal medicine and surgery represents an extension of the medical school curriculum. The imposition of a school on a school will result in forces leading to even greater concentration of graduate training around academic medical centers.
12. The desire to accumulate more data on characteristics - both intellectual and non-intellectual - of men in graduate training raises the issue of privacy. On the other hand, the emergence of the Boards as virtual licensing bodies creates a climate in which the Boards may expect demands to have made public their methods and standards of evaluations as well as criteria for passing or failing their examinations.

COUNCIL OF ACADEMIC SOCIETIES

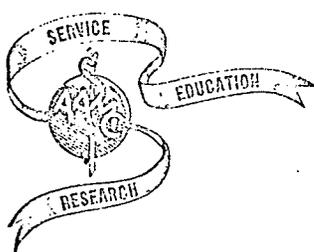
Academic Clinical Laboratory Physicians and Scientists
American Academy of Microbiology
American Association of Anatomists
American Association of Chairmen of Departments of Psychiatry
American Association Chairmen of Medical School Departments of Pathology, Inc.
American Association of Neurological Surgeons
American Association of Pathologists and Bacteriologists
American Gynecological Society
American Neurological Association
American Pediatric Society
American Physiological Society
American Society of Biological Chemists, Inc.
American Surgical Association
Association of American Physicians
Association of Chairmen of Departments of Physiology
Association of Medical School Pediatric Chairmen
Association of Professors of Dermatology
Association of Professors of Gynecology and Obstetrics
Association of Professors of Medicine
Association of Teachers of Preventive Medicine
Association of University Anesthetists
Association of University Professors of Ophthalmology
Association of University Radiologists
Joint Committee on Orthopaedic Research and Educational Seminars
Society of Academic Radiology Chairmen
Society of Surgical Chairmen
Society of University Otolaryngologists
Society of University Urologists

(DRAFT - 7/17/68)

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Mw
9.2.68

Workshop on
MEDICAL SCHOOL CURRICULUM



SEPTEMBER 18-22, 1968
ATLANTA, GEORGIA
ATLANTA HILTON INN

ASSOCIATION OF
AMERICAN MEDICAL COLLEGES

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DRAFT
7-17-68

PROGRAM

WORKSHOP ON MEDICAL SCHOOL CURRICULUM

Hilton Inn, Atlanta, Georgia, September 18-22, 1968

WEDNESDAY, SEPTEMBER 18

Chairman: Dr. George Harrell

(11:00 a. m. - 1:00 p. m. Luncheon meeting of steering committee members, discussion group chairmen, discussion group reporters.)

11:00 a. m. - 1:00 p. m.

REGISTRATION

1:00 p. m. - 2:30 p. m.

PLENARY SESSION

Introduction: Dr. William N. Hubbard, Jr.

"The Institutional Change Process to Achieve Educational Goals"

- . Dr. Ralph Tyler
- . Dr. John A. D. Cooper

2:30 p. m. - 3:00 p. m.

BREAK

3:00 p. m. - 4:00 p. m.

PLENARY SESSION

"Analysis of Questionnaire and School Visit Data"

- . Dr. George R. DeMuth
- . Dr. John A. Gronvall

4:00 p. m. - 5:30 p. m.

SMALL GROUP DISCUSSIONS

(to include discussion of format of remainder of the workshop)

6:00 p. m. - 7:00 p. m.

RECEPTION

(6:30 p. m. - 8:30 p. m. Dinner meeting of discussion group reporters with Dr. Hubbard to plan Thursday morning plenary session report.)

THURSDAY, SEPTEMBER 19

Chairman: Dr. William N. Hubbard

9:00 a. m. - 10:00 a. m.

PLENARY SESSION

Reports from Wednesday Discussion Groups.
General Discussion.

10:00 a. m. - 10:30 a. m.

BREAK

10:30 a. m. - 12:00 noon

PLENARY SESSION

✓ "Social Needs of the Health Care Delivery System" ✓

- . Dr. Philip R. Lee
- . Dr. E. Richard Weirnerman

12:00 noon - 1:30 p. m.

LUNCH

1:30 p. m. - 3:30 p. m.

SMALL GROUP DISCUSSIONS

3:30 p. m. - 4:00 p. m.

PLENARY SESSION

General Discussion.

(6:30 p. m. - 8:30 p. m. Dinner meeting of discussion group reporters with Dr. Lippard to plan Friday morning plenary session report.)

FRIDAY, SEPTEMBER 20

Chairman: Dr. Vernon W. Lippard

9:00 a. m. - 10:00 a. m. PLENARY SESSION

Reports from Thursday Discussion Groups.
General Discussion.

10:00 a. m. - 10:30 a. m. BREAK

10:30 a. m. - 12:00 noon PLENARY SESSION

"Utilization of Current Knowledge of the
Educational Process"

- . Dr. Lee Shulman
- . Dr. Stephen Abrahamson

12:00 noon - 1:30 p. m. LUNCH

1:30 p. m. - 3:30 p. m. SMALL GROUP DISCUSSIONS

3:30 p. m. - 4:00 p. m. BREAK

4:00 p. m. - 5:00 p. m. PLENARY SESSION

General Discussion

(6:30 p. m. - 8:30 p. m. Dinner meeting of discussion
group reporters with Dr. Peter Lee to plan Saturday
morning plenary session report.)

SATURDAY, SEPTEMBER 21

Chairman: Dr. Peter V. Lee

9:00 a. m. - 10:00 a. m. PLENARY SESSION

Reports from Friday Discussion Groups.
General Discussion.

10:00 a. m. - 10:30 a. m. BREAK

10:30 a. m. - 12:00 noon PLENARY SESSION

"The Response to the Demand for Numbers and
Availability of Physicians"

. Dr. Frank McKee
. Dr. Peter F. Regan

12:00 noon - 1:30 p. m.

LUNCH

1:30 p. m. - 3:30 p. m.

SMALL GROUP DISCUSSIONS

(3:30 p. m. - 5:30 p. m. Discussion group reporters
complete reports.)

(6:30 p. m. - 9:00 p. m. Dinner meeting of steering
committee members, discussion group chairmen, and
plenary session speakers to plan Sunday session.)

SUNDAY, SEPTEMBER 22

Chairman: Dr. William N. Hubbard, Jr.

9:00 a. m. - 10:00 a. m.

PLENARY SESSION

Round Table Discussion by Discussion Group
Chairmen.

10:00 a. m. - 10:30 a. m.

BREAK

Distribution of Outline Report

10:30 a. m. - 12:00 noon

PLENARY SESSION

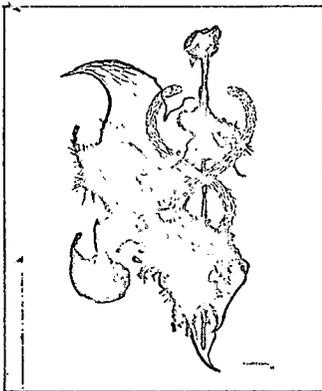
General Discussion of Report Recommendations.
Summary

12:00 noon

ADJOURN

PROGRAM NOTES

1. Structure of Small Group Discussions
 - a. 8-10 members each group, groups assigned and remain constant throughout workshop.
 - b. Discussion group chairman assigned to each group, serves throughout workshop.
 - c. Two reporters assigned to each group, to alternate duties (each reporter prepares reports for two of the four days of small group discussion).
 - d. Steering committee members not to serve as chairmen or reporters.
 - e. Topics to be discussed will correlate with panel topics to be discussed at the AAMC Annual Meeting, Houston, Texas, Nov. 1-4, 1968.
2. Reporting of Small Group Discussions
 - a. Reports prepared each evening.
 - b. Reports transcribed each night, duplicated.
 - c. Reports distributed next morning after first plenary session.
3. Plenary Sessions
 - a. Session chairman (steering committee member) for each day, presides entire day.
 - b. All sessions stenotyped or tape recorded.
 - c. Sunday session - Round table discussion format to be worked out Saturday night, presented in the format of the meeting report. Outline of report prepared Saturday night, transcribed and duplicated Sunday morning, distributed after Round Table Discussion.



II CONFERENCIA PANAMERICANA DE EDUCACION MEDICA

II CONFERENCIA GENERAL DE LA FEDERACION PANAMERICANA DE ASOCIACIONES DE FACULTADES (ESCUELAS) DE MEDICINA

SECOND PANAMERICAN CONFERENCE ON MEDICAL EDUCATION

SECOND GENERAL CONFERENCE OF THE PANAMERICAN FEDERATION OF THE ASSOCIATIONS OF MEDICAL SCHOOLS

Favor dirigir correspondencia a:

Dr. Raymundo Collada C.
Facultad de Medicina. UNAM.
México 20, D. F. 6
Apartado Postal 7-1068
México 7, D. F.

COMISION ORGANIZADORA DE LA CONFERENCIA

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DR. MIGUEL VALLE BUENO

VOCAL PROFESOR DE LA
FACULTAD DE MEDICINA: U.N.A.M.

DR. FERNANDO MARTINEZ CORTES

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DR. MIGUEL BARRIOS

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TESORERO

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ASESORES

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DR. JOSE FELIX PATIÑO

SR. KURT L. GOLDSTUECKER

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(ARGENTINA)

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(CHAD)

DR. JUAN JOSE FERNANDEZ

(REP. EL SALVADOR)

DIRECTOR EJECUTIVO:

DR. JOSE FELIX PATIÑO

(COLOMBIA)

INSCRIPTION

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Post.....

Arriving date..... Leaving date.....

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1. Name..... Last name.....

Address..... City..... State.....Zip.....

Language Spoken: English...French...Spanish...Portuguese...

2. Name..... Last name.....

Address..... City... .. State.....Zip.....

Language Spoken: English...French...Spanish...Portuguese...

THIS FORM SHOULD BE FILLED OUT AND SENT WITH A CHECK OR MONEY ORDER FOR US \$10.00 to:

Dr. Raymundo Collada
Facultad de Medicina
U. N. A. M.
Ciudad Universitaria
México 7, D. F. - MEXICO

or: Apartado Postal 7-1068
México 7, D. F.
MEXICO

II CONFERENCIA PANAMERICANA DE EDUCACION MEDICA

II CONFERENCIA GENERAL DE LA FEDERACION PANAMERICANA DE ASOCIACIONES DE FACULTADES (ESCUELAS) DE MEDICINA

SECOND PANAMERICAN CONFERENCE ON MEDICAL EDUCATION

SECOND GENERAL CONFERENCE OF THE PANAMERICAN FEDERATION OF
THE ASSOCIATIONS OF MEDICAL SCHOOLS

HOTEL RESERVATION

Favor dirigir correspondencia a:

Dr. Raymundo Collada C.
Facultad de Medicina. UNAM.
México 20, D. F. ó
Apartado Postal 7-1068
México 7, D. F.

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**VOCAL PROFESOR DE LA
FACULTAD DE MEDICINA: U.N.A.M.**
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DR. JOSE FELIX PATIÑO
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FEDERACION PANAMERICANA DE ASOCIACIONES DE FACULTADES (ESCUELAS) DE MEDICINA.

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DIRECTOR EJECUTIVO:
DR. JOSE FELIX PATIÑO
(COLOMBIA)

NAME.....
ACCOMPANIED BY.....
ADDRESS.....CITY.....STATE.....COUNTRY.....
SELECTED HOTEL.....
DOUBLE ROOM USCY \$.....
SINGLE ROOM USCY \$.....

Reservation for tours need 10% deposit total per person.

Important note: The month of November is a big month for Tourism in Mexico. Your hotel reservation will not be guaranteed unless a deposit of at least two nights is made before the 1st. of October, 1968. The hotels where a limited number of rooms have been reserved are:

Official hotel for the Conference:

HOTEL CAMINO REAL

Single room USCY \$16.00
Double room USCY \$20.00

HOTEL DEL ANGEL

Single room USCY \$10.00
Double room USCY \$12.00

HOTEL ROMFEL

Single room USCY \$ 6.00
Double room USCY \$ 8.00

TOUR "A"

USCY \$24.00 PACKAGE PRICE PER
PERSON

TOUR "B"

Nov. 22 -- 24
Nov. 29 -- Dec. 1
PRICE PER PERSON:
Double room USCY \$117.00
Single room USCY \$103.00

TOUR "C"

Nov. 22 -- 24
Nov. 29 -- Dec. 1
PRICE PER PERSON:
Double room USCY \$102.00
Single room USCY \$ 92.00

NOTE: Reservations to Tourist spots such as Acapulco, must be made with anticipation and deposit, since November and December are important vacation season in Mexico.

THIS FORM SHOULD BE FILLED OUT AND SENT WITH A CHECK OR MONEY ORDER TO:

Miss María Elena Vivanco
VIBSA, Oficina Matriz
Av. Insurgentes 300-23 B
México 7, D. F. MEXICO

Mr. Matthew F. McNulty, Jr.
Director, COTH
Associate Director, AAMC
1346 Connecticut Avenue, N.W.
Washington D.C. 20036

Please note a change in address from:

LeRoy E. Bates M.D.
Director
Palo Alto Stanford Hospital Center
300 Pasteur Drive
Palo Alto, California 94304

to:

LeRoy E. Bates, M.D.
1336 Cowper Street
Palo Alto, California 94301

MEMBER HOSPITALS, U. S.: ALABAMA

Hospital, Address, Telephone, Administrator, Approval and Facility Codes	Classification Codes			Inpatient Data				Out Patient De- partment Visits	Expenses (Thousands of dollars)		Personnel
	Control	Service	Stay	Beds	Census	Basinsets	Newborn		Total	Payroll	

For definitions and explanations
of Approvals and Facility
Codes see page —.

ALABAMA

Mobile

Mobile General Hospital Winston C. Whitfield, Administrator 2451 Fillingim Street, Mobile Alabama 36603 205/473-0341 A-1-3-4-5-6-9 F-1-2-3-5-6-9-10-11-12- 14-15-16-17-18-19-22-27-28-29-33-ECF	13	10	S	247	..	40	2,465	88,972	3,678	2,067	510
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ARIZONA

Phoenix

Good Samaritan Hospital Stephen M. Morris, President 1033 East McDowell Road, Phoenix, Arizona 85006 602/AL2-6611 A-1-3-4-6-9 F-1-2-3-4-5-6-7-8-9-10-11- 12-13-14-15-16-17-18-19-20-21-22-23-24- 25-27-29-30-ECF	23	10	1	483	69	..	3,985	87,340	5,468	..	1,213
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Phoenix

Saint Joseph's Hospital Sister Mary de Paul, Administrator P. O. Box 2071, Phoenix, Arizona 85001 602/277-6611 A-16-9 F-1-2-3-4-5-6-7-8-9-10-11-12- 14-15-16-17-18-19-20-21-22-23-27-29	21	10	1	462	80	..	3,665	..	8,578	6,449	1,058
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ARKANSAS

Little Rock

University Hospital Robert E. Sleight, Administrator 4301 West Markham Street Little Rock, Arkansas 72205 501/MO 4-5000 A-1-2-3-4-5-6-9 F-1-2-3-4-5-6-7-8-9-11- 12-14-15-16-17-18-19-21-22-24-26-27-28- 31	12	10	1	329	..	56	2,011	84,574	7,004	4,968	962
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CALIFORNIA

Loma Linda

Loma Linda University Hospital C. Victor Way, Administrator 11055 Anderson Street Loma Linda, California 92354 714/796-7311 A-3-9 F-1-2-3-4-6-7-8-9-10-11-12-13-14- 15-16-17-18-19-20-21-22-25-26-27	21	10	1	186	..	24	693	38,715	4,386	2,562	588
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Long Beach

Memorial Hospital of Long Beach Donald C. Carner, Executive Vice- President 2801 Atlantic Avenue Long Beach, California 90806 213/426-2121 A-1-3-4-5-9 F-1-2-3-4-6-7-8-9-10-11-12- 14-15-16-17-18-19-20-21-22-23-24-25-30	23	10	1	494	..	46	2,201	103,653	10,109	5,681	958
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MEMBER HOSPITALS, U. S.: ALABAMA

Medical School Affiliation	Internships		Residencies		Approved Graduate and Undergraduate Educational Programs			
	For Codes see page —.	Filled	Offered	Filled	Offered	Internships By Type	Residencies By Specialty	Other Graduate Programs

M-11x	33	303	404	505	Rotating Mix, Oth.	Anes, Derm, Med, Neur, Oph Ortho, Ped A, Ped, Ped C, Psych, OB/G, Rad, Surg, Thor Urol	Continuing Education	Hosp Adm, Med Tech, Prof Nursing Phr, X-ray, GCRI
M-12x	23	24	28	505	Rotating St. Med, Surg, Pathology	Med, Path, Psych OB/G, Surg	..	Prof Nursing, Phr, Phys Ther, X-ray
L-95	34	36	47	68	Rotating Surg	G. P. Med, Path Ped, OB/G, Rad	Continuing Education	Med Tech, X-ray
G-10	33	40	10	455	Rotating	Med, Ortho, Path, Ped, OB/G, Surg	..	Prof Nursing
..	32	44	52	60	Rotating	G. P. Path, Ped, OB/G, Surg	..	Med Tech, Prof Nursing
..	101	34	98	60	Rotating	G. P. Path, Ped OB/G, Surg	..	X-ray

C O T H

E X E C U T I V E C O M M I T T E E

MEETING DATES

- #68-5 Thursday, October 31, 1968
 2:00 p.m.
 Houston, Texas
- #69-1 Monday, November 4, 1968
 3:30 p.m.
 Houston, Texas
- #69-2 Thursday and Friday
 January 9 and 10, 1969
 Washington, D.C.
- #69-3 Thursday and Friday
 May 8 and 9, 1969
 Washington, D.C.
- #69-4 Thursday and Friday
 September 11 and 12, 1969
 Washington, D.C.
- #69-5 Thursday, October 30, 1969
 Cincinnati, Ohio
 (CO TH-AAMC Annual Meeting, Cincinnati,
 October 30, 1969 - November 3, 1969)