COTH EXECUTIVE COMMITTEE MEETING
The Embassy Row Hotel
Chancery Room
April 14, 1971

AGENDA

I.	Approval of Minutes	TAB A
II.	Status Report on Health Maintenance Organizations	
III.	Report on Faculty Reimbursement Study	
IV.	Corporate Responsibility for Graduate Medical Education(Report on House Staff Conference)	TAB C TAB D
V.	Report on VA-COTH Relationships	TAB E
VI.	Preliminary Budget Review and Possible Financing Problems - Organizational Changes	
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ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF TEACHING HOSPITALS

EXECUTIVE COMMITTEE MEETING
Palmer House
Chicago, Illinois
February 12, 1971

Present:

Irvin G. Wilmot, Chairman
George E. Cartmill, Chairman-Elect
T. Stewart Hamilton, M.D., Immediate Past Chairman
John H. Westerman, Secretary
Don L. Arnwine
Joe S. Greathouse, Jr.
L.H. Gunter
Bernard J. Lachner
Sidney Lewine
Herluf V. Olsen
Merle S. Bacastow, M.D., AHA Representative

Staff:

John M. Danielson
Fletcher H. Bingham, Ph.D.
Richard M. Knapp, Ph.D.
Grace W. Beirne
Catharine A. Rivera

I. Call to Order:

Mr. Wilmot called the meeting to order at 9:00 a.m. in Private Dining Room #5 of the Palmer House Hotel, Chicago, Illinois.

II. Consideration of Minutes:

The minutes of the meeting of October 29, 1970 were approved as presented. Mr. Danielson stated that the special meeting of the Executive Committee on January 24th was considered an informal session. However, a summary report of that meeting will be included for the record in the April 14th Agenda.

III. Nominating Committee:

Dr. Hamilton reported on a breakfast meeting of the Nominating Committee. The following positions are open for nominations:

Chairman-Elect

Three Executive Committee Members with Terms Expiring

L.H. Gunter
Sidney Lewine
David Odell

Eleven Representatives to the AAMC Assembly

Dr. Hamilton requested the staff to solicit COTH members for suggestions, and forward this information to the Nominating Committee.

IV. Discussion of the Variability of Expenditures of COTH Member Hospitals as they Relate to Prospective Rate Setting:

Material prepared by the staff was distributed. The material attempted to show the wide variance of expenditures per patient day for COTH member hospitals. Expenditures were grouped according to ownership and control, size of the house staff as well as several other variables. It was recognized that the dimension of expenditures per patient day was not a reliable or valid statistic for comparative purposes, but it was the only one available at the moment and should be explored.

Based on current groupings and the crudeness of the statistic, it became apparent that no specific trends were discernible. Mr. Wilmot pointed out that in New York City, expenditures per day varied as much as $40.00 for several affiliated hospitals. It was generally agreed that while the educational programs contributed to higher expenditures, the variance of expenditures was largely reflected by the different, more complex and more expensive service programs. Concerning this matter, the following statement appears in the front of the new 1970-71 COTH Directory:

The criteria set forth to obtain membership in the Council of Teaching Hospitals were established to provide a basis from which hospitals could organize and promote the hospital as an educational institution. Hospitals differ greatly in the extent of their commitment to educational purposes. Membership in COTH-AAMC should not be utilized for administrative or research purposes, for example to determine reimbursement or classify hospitals in a research project.

At least three major dimensions must be considered when attempting to classify or characterize teaching hospitals:

(1) the severity of illness and complexity of diagnosis which patients bring to the hospital;

(2) the comprehensiveness and/or intensiveness of services provided by the hospital;

(3) the institutional commitment to the incremental costs of providing the environment for undergraduate and graduate medical education.

There is a great variation in the extent to which each teaching hospital meets these dimensions. Any attempt to characterize or classify the COTH membership must recognize the limitations of grouping all teaching hospitals based upon their membership in COTH.

Following extensive discussion, it became clear that two issues were emerging: (1) factors associated with the higher costs of providing care in teaching hospitals; (2) the current and future composition, goals and objectives of the Council of Teaching Hospitals.

ACTION #1

IT WAS MOVED, SECONDED AND CARRIED THAT THE CHAIRMAN, IN CONSULTATION WITH THE STAFF APPOINT TWO AD HOC TASK FORCES TO ADDRESS THESE TWO ISSUES.

It was agreed that the composition of these ad hoc task forces be reviewed at the April 14th meeting and a specific charge to the task forces be discussed at that time.

Further, there was a consensus that the reports of these task forces be the program content for the COTH portion of the AAMC Annual Meeting in the fall. This would give the groups a deadline, and also provide a good opportunity for members to participate in policy determination.

V. CAS Committee on Graduate Medical Education Report, "Corporate Responsibility For Graduate Medical Education":

The report was distributed and reviewed by the Committee. After discussion, there was agreement with the general thrust of the report. However, it was stated that two specific points needed further development: (1) the role of unaffiliated hospitals and the use of the word "corporate";(2) the implication on page eight that the university would be allocating resources of affiliated hospitals.

Messrs. Lachner, Lewine and Olsen were requested to prepare a statement outlining the Executive Committee's position for review after lunch.

The Committee recessed for lunch at 12:00 o'clock. Dr. William Anlyan, Chairman of the AAMC Executive Council joined the group for lunch. He outlined the agenda of the late afternoon Assembly meeting and specifically discussed the matter of student participation in the governance of the AAMC.

The Committee reconvened at 1:15p.m. Messrs. Lachner, Lewine and Olsen presented their proposed statement. After brief discussion, the following action was taken:

ACTION #2

IT WAS MOVED, SECONDED AND CARRIED THAT THE FOLLOWING STATEMENT OF POSITION BY THE COTH EXECUTIVE COMMITTEE BE PLACED BEFORE THE EXECUTIVE COMMITTEE OF THE AAMC EXECUTIVE COUNCIL.

The COTH Executive Committee supports in principle the concept of education of the intern, resident and fellow as a continuum in the setting of the academic community as proposed in the CAS Committee Report. However, sufficient clarity and separation of role needs to be expressed concerning:

1. the role of hospitals whose corporate responsibility to the community is the provision of patient care, but in whose environment the graduate medical education of physicians takes place;
2. the role of the intern, resident and fellow in the provision of health services;
3. the role of the non-affiliated major teaching hospitals which constitute the environment for the education of a significant number of interns and fellows.

There are many practical concerns that need to be considered in the relationship between the university and the hospital. It is therefore recommended that the committee report be referred to a joint committee of the three Councils before any further action, for consideration of the above stated concerns.

It was further suggested that a joint COTH-CAS-COD committee be convened to review a redraft of this statement on graduate medical education.

VI. Report on Medicare and Medicaid:

Mr. Danielson reviewed and interpreted the Amendments to the Medicare/Medicaid law as reported out of the Senate Finance Committee on December 11, 1970. No action was taken, but the staff was requested to continue pursuing any new developments.

VII. Report on AAMC Position on National Health Insurance:

The draft of the position statement was presented by Mr. Danielson. After discussion, the following action was taken:

ACTION #3

IT WAS MOVED, SECONDED AND CARRIED THAT THE COTH EXECUTIVE COMMITTEE APPROVE THE AAMC POLICY STATEMENT ON NATIONAL HEALTH CARE PLANS WITH THE FOLLOWING RECOMMENDATIONS:

(1) A. Paragraph 1, Sentence 4
Insert "both public and private" after "prepayment;"

Sentence 5
Insert "national" before "system;
Change "consumer" to "public"

(2) B. Paragraph 1, Sentence 1
Insert "and essential" after "special."

A copy of the revised recommended statement is attached as Appendix A to these minutes.

VIII. Report on Health Maintenance Organizations and the Academic Health Center:

Mr. Danielson reported on legislation prepared by AAMC which has been introduced as H.R. 4170 in the House and S.935 in the Senate. That portion of the legislation of most importance to hospital directors is embodied in Title II, Part A entitled, "Grants To Assist Academic Health Centers In Planning And Initiating Health Maintenance Organizations." The Committee was unanimous in its belief that the positive initiative such as represented by these legislative proposals is more effective than reaction to proposals made by other agencies.

IX. Report on House Staff Organizations:

Dr. Knapp reported that a National House Staff Conference will be held on March 18-21, 1971 in St. Louis, The AAMC has responded to requests for information and participated in a consultative capacity with the Steering Committee for the Conference. However, no official position for or against the Conference has been taken.

Dr. Knapp and Mr. Checker will attend the Conference and report on deliberations.

X. Proposed By-Laws - Student Representative in AAMC Affairs:

Mr. Wilmot and Mr. Danielson presented the changes in the By-Laws.

ACTION #4

IT WAS MOVED, SECONDED AND CARRIED THAT THE COTH EXECUTIVE COMMITTEE APPROVE THE BY-LAWS AS PROPOSED.

Following the approval of student participation in AAMC governance, Mr. Wilmot stated that the question of house staff participation in AAMC affairs was being discussed. Action of the COTH Executive Committee February 12, 1971

ACTION #5

IT WAS MOVED, SECONDED AND CARRIED THAT THE CHAIRMAN, IN CONSULTATION WITH STAFF, APPOINT MEMBERS TO A JOINT COTH-CAS-COD AD HOC COMMITTEE CHARGED WITH THE RESPONSIBILITY OF STUDYING THE MATTER AND MAKE RECOMMENDATIONS CONCERNING APPROPRIATE PARTICIPATION OF HOUSE STAFF IN AAMC ACTIVITIES.

XI. Veterans Administration Discussion Paper:

Dr. Bingham presented a discussion paper prepared as an outline for action to strengthen the function of the AAMC-VA Liaison Committee. The Committee accepted the discussion paper as an information item.

XII. Adjournment:

There being no further business, the meeting adjourned at 3:00 p.m.

APPENDIX A

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

February 18, 1971

A Policy Statement of the Association of American Medical Colleges on National Health Care

Position on National Health Plans

The Association of American Medical Colleges supports the concept that adequate health care and maintenance is a right of all citizens. It believes that this right can be best served by means of health insurance and progressive change in the health care delivery system. The system must be a national one, with adequate provision for varying regional requirements. Financing should be based on prepayment, both public and private. Control of the system and fixing of national health goals and priorities requires appropriate balance between public and provider inputs.

Any such system must assure access to primary care and prompt referral, in accordance with individual patients' needs, to progressively more sophisticated facilities and personnel. It must also provide for, and emphasize, preventive as well as curative care on an ambulatory basis.

The system should optimize quality of care and economy; and should utilize incentives as an aid in cost-control and in developing a more effective and responsive national mechanism for delivery of health services. It must include a continuing and dynamic method for evaluating overall operation and performance of providers.

Position on the Special Role of Academic Health Centers

The education of health manpower must take place within the system for providing health services. In those settings where both health services and education are provided, costs will be greater than in those settings in which care alone is provided. This fact should be reflected in reimbursement policies under any health care plan.

Because of their special and essential role in educating health professionals, conducting research, and in developing new methods, academic health centers must be recognized as national resources. Within the Centers, biomedical research and those elements of educational cost not directly related to provisions of patient services should be separately funded from multiple sources, including the Federal Government.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF TEACHING HOSPITALS

COTH EXECUTIVE COMMITTEE
Washington-Hilton Hotel
January 24, 1971

MINUTES

Present:

Irvin G. Wilmot, Chairman
Don L. Arnwine
Herluf V. Olsen, Jr.
Stuart M. Sessoms, M.D.
Joe S. Greathouse, Jr.
Bernard J. Lachner
Sidney Lewine
David Odell
Roy S. Rambeck
Merle S. Bacastow, M.D.

Excused:

George E. Cartmill
T. Stewart Hamilton, M.D.
John H. Westerman
Edward J. Connors
L.H. Gunter
Russell A. Nelson, M.D.

Staff:

John M. Danielson
Fletcher H. Bingham, Ph.D.
Grace W. Beirne

Five major items of discussion were taken up at this meeting.

(1) General review of present status of amendments for PL 89-97 Medicare and Medicaid and a review of a questionnaire to be sent by the Social Security Administration to a selected group of hospitals.

(2) Copies of the new By-Laws were distributed and major items of consideration were discussed.

(3) Staff presented a draft document to be used as a basis of formal legislation concerning Health Maintenance Organizations and Teaching Hospital Centers. It was pointed out that with some minor revisions, this document would be used as the basis of part of a bill to be presented by the AAMC to Congressman Staggers dealing primarily with the financing of the medical education community.

(4) The report submitted by the Council of Academic Societies entitled Corporate Responsibility for Graduate Medical Education was discussed at length, in anticipation to what might be appropriate action by the Executive Committee of COTH and the AAMC Executive Council at the meeting in Chicago in February.

(5) The Committee was apprised of the problems relating to the definition of a teaching hospital, particularly as it relates to grouping of such institutions for prospective rate setting.

This meeting was considered to be one of discussion and preparation for the Meeting of the Executive Committee to be held in Chicago on February 12, 1971, and therefore no definitive action was taken on any of the items.

STATUS REPORT ON MEMBERSHIP

Dues Outstanding for Fiscal Year 1970-71 (See Listing Attached)	13
Dues Outstanding for Fiscal Year 1971-72	104
Hospitals requesting removal from COTH membership for Fiscal year 1971-72 (See listing attached)	10

HOSPITALS WHICH HAVE REQUESTED REMOVAL FROM THE COTH MEMBERSHIP

BROOKE GENERAL HOSPITAL
David E. Thomas, M.D., Brigadier General, MC
Commanding General
Brooke Army Medical Center
Fort Sam Houston, Texas 78234

THE BUFFALO GENERAL HOSPITAL
Theodore T. Jacobs, M.D.
Director
100 High Street
Buffalo, New York 14203

FITZSIMONS GENERAL HOSPITAL
A. J. Schoepflin, M.D., Colonel, MC
Acting Commander
Denver, Colorado 80240

HARRISBURG POLYCLINIC HOSPITAL
J. Lincoln McFarland
Administrator
Third and Radnor Streets
Harrisburg, Pennsylvania 17105

MAIMONIDES MEDICAL CENTER
Murray Grant, M.D.
Executive Vice-President
4802 10th Avenue
Brooklyn, New York 11219

MOUNT CARMEL MERCY HOSPITAL
Sister Mary Leila, R.S.M.
Administrator
6071 West Outer Drive
Detroit, Michigan 48235

UNIVERSITY OF MIAMI HOSPITALS & CLINICS
NATIONAL CHILDREN'S CARDIAC HOSPITAL
H. M. Hoff, Assistant to the Dean,
School of Medicine, and Administrator
1475 N. W. 12th Avenue
P. O. BOX 875, Biscayne Annex
Miami, Florida 33152

ST. LUKE'S HOSPITAL OF BETHLEHEM, PENNSYLVANIA
Richard L. Suck
Administrator
801 Ostrum Street
Bethlehem, Pennsylvania 18015

ST. VINCENT'S HOSPITAL & MEDICAL CENTER OF NEW YORK
Sister Margaret Sweeney
Director
153 West 11th Street
New York, New York 10011

WILLIAM BEAUMONT GENERAL HOSPITAL
Poe R. Corn, Major, MSC
Acting Adjutant
El Paso, Texas 79920

HOSPITALS WHOSE DUES ARE OUTSTANDING FOR FISCAL YEAR 1970-71

BERNALILLO COUNTY MEDICAL CENTER
Fred E. Mondragon
Administrator
2211 Lomas Boulevard, N.E.
Albuquerque, New Mexico 87106

BROOKLYN-CUMBERLAND MEDICAL CENTER
Robert Markowitz
Executive Director
121 DeKalb Avenue
Brooklyn, New York 11201

CATHOLIC MEDICAL CENTER OF BROOKLYN & QUEENS, INC.
Alvin J. Conway
Executive Director
88-25 153rd Street
Jamaica, New York 11432

NEW YORK MEDICAL COLLEGE-
FLOWER & FIFTH AVENUE HOSPITALS
J. A. Rosenkrantz, M.D.
Executive Director and Associate
Dean for Hospital Administration
Fifth Avenue at 106th Street
New York, New York 10029

JERSEY CITY MEDICAL CENTER
Anthony S. Dickens
Executive Director
50 Baldwin Avenue
Jersey City, New Jersey 07304

GRASSLANDS HOSPITAL
Benjamin G. Dinin, M.D.
Commissioner-Medical Director
Valhalla, New York 10595

HOSPITAL OF THE MEDICAL COLLEGE OF OHIO
(Formerly Maumee Valley Hospital)
Richard F. Binnig
Administrator
2025 Arlington Avenue
Toledo, Ohio 43609

QUEEN'S HOSPITAL CENTER
Robert A. Vitello
Administrator
82-68 164th Street
Jamaica, New York 11432

VETERANS ADMINISTRATION HOSPITAL
Paul O. Battisti
Hospital Director
150 Muir Road
Martinez, California 94553

NORTH CAROLINA MEMORIAL HOSPITAL
Harold P. Coston
Administrator
Chapel Hill, North Carolina 27514

ST. BONIFACE GENERAL HOSPITAL
L. A. Quaglia
Executive Director
409 Tache Avenue
St. Boniface 6, Manitoba, Canada

THE WINNIPEG GENERAL HOSPITAL
Peter E. Swerhone
Executive Director
700 William Avenue
Winnipeg 3, Manitoba, Canada

UNIVERSITY HOSPITAL
Earl L. Dick
Executive Director
Saskatoon, Saskatchewan, Canada

DATE April 2, 1971

TO: Peyton Stapp

FROM: Dick Knapp

SUBJECT: Health Services Statistics

According to the most recent copy of the AMA Directory of Internships and Residencies (1969-70), there are 1,449 hospitals in the United States which participate in the graduate education of physicians. According to Table 24A on page 17 of that Directory these hospitals were distributed as follows:

Major Affiliates	376
Limited Affiliates	182
Graduate Affiliates	141
Hospitals without Affiliation	750
Total with Approved Programs	1,449

According to page 84 of the Directory, hospitals have been identified as major affiliates when a medical school has indicated that the hospital is a major unit in the school's teaching program. Hospitals are defined as limited affiliates when a medical school has indicated that the hospital is used to a limited extent in the school's teaching program. Graduate affiliates are used by the school for graduate training programs only. These definitions are somewhat general and lack precision; however, the AMA has informed me that they do not have a definition with any more substance.

Additionally, an actual count of the affiliated hospitals in the Directory reveals a descrepancy with the published table. Thus, the figures have been corrected as follows:

Major Affiliates	350
Limited Affiliates	168
Graduate Affiliates	126

COPIES TO:

Finally, included in the above group are long-term hospitals, defined as those which have an average length of stay over 30 days. It was felt that these long-term hospitals should be excluded from the analysis. The final grouping is as follows:

Major Affiliates	289
Limited Affiliates	129
Graduate Affiliates	95
Total	513

Therefore, the attached tables reflect services provided in short-term general and other special hospitals (federal and non-federal).

Attachments:

SELECTED STATISTICS: [illegible]

TABLE I

Affiliated vs. All Hospitals
(Federal and nonfederal short-term general and other special)

	Affiliated Hospitals	All Hospitals	% Affil.
Number of Hospitals	513	6,272	8%
Beds	237,408	926,581	25%
Average Daily Census	183,751	732,476	25%
Admissions	6,246,493	29,807,453	20%
Patient Days	67,069,115	267,353,740	25%
Personnel	569,255	1,969,879	28%
Payroll Expense	$ 3,078,007,000	$ 11,003,697,000	27%
Total Expense	$ 5,699,844,000	$ 18,298,654,000	31%

TABLE II

	Major Affiliates	All Hospitals	% Affil.
Number of Hospitals	289	6,272	4%
Beds	150,552	926,581	16%
Average Daily Census	115,591	732,476	15%
Admissions	3,755,556	29,807,453	12%
Patient Days	42,190,715	267,353,740	15%
Personnel	380,009	1,969,879	19%
Payroll Expense	$ 2,106,442,000	$ 11,003,697,000	19%
Total Expense	$ 3,837,794,000	$ 18,298,654,000	20%

TABLE III

	Graduate Affiliates	All Hospitals	% Affil.
Number of Hospitals	95	6,272	1%
Beds	36,768	926,581	3%
Average Daily Census	29,925	732,476	4%
Admissions	1,028,020	29,807,453	3%
Patient Days	10,922,625	267,353,740	4%
Personnel	78,019	1,969,879	3%
Payroll Expense	$ 414,985,000	$ 11,003,697,000	3%
Total Expense	$ 772,180,000	$ 18,298,654,000	4%

TABLE IV

	Limited Affiliates	All Hospitals	% Limited
Number of Hospitals	129	6,272	2%
Beds	50,088	926,581	5%
Average Daily Census	38,235	732,476	5%
Admissions	1,462,907	29,807,453	4%
Patient Days	13,955,775	267,353,740	5%
Personnel	111,227	1,969,879	5%
Payroll Expense	555,580,000	$ 11,003,697,000	5%
Total Expense	$ 1,089,870,000	$ 18,298,654,000	5%

TABLE V

	COTH Hospitals	All Hospitals	% COTH
Number of Hospitals	372	6,272	5%
Beds	209,978	926,581	22%
Average Daily Census	167,730	732,476	22%
Admissions	5,624,933	29,807,453	18%
Patient Days	61,221,450	267,353,740	22%
Personnel	561,709	1,969,879	28%
Payroll Expense	$ 3,725,849,000	$ 11,003,697,000	33%
Total Expense	$ 5,593,028,000	$ 18,298,654,000	30%

TABLE VI

COTH Affiliated Hospitals As
A Percentage of All Affiliated Hospitals

	COTH	Total	% COTH
Major Affil.	211	289	73%
Limited Affil.	55	129	42%
Graduate Affil.	38	95	40%
Total	304	513	59%

[a]Affiliations have been taken from the AMA Directory of Approved Internships and Residencies, November, 1969; service statistics are from Hospitals, Guide Issue, August 1, 1970.

THE IMPLICATIONS OF CORPORATE RESPONSIBILITY FOR GRADUATE MEDICAL EDUCATION

Introduction

The years since the end of World War II have seen the responsibilities of the university-related academic medical complex for all forms of clinical education and training grow. The education and training of postdoctoral clinical students has become one of the largest programs of the unviersity medical center. Yet the relation of such programs to regulatory agencies independent of the university remains unchanged. Simultaneously problems of financing these programs have become much more involved. The resulting fragmentation of authority and responsibility has been deplored repeatedly. In 1965, in its report, Planning for Medical Progress Through Education, the Association of American Medical Colleges (AAMC) called for broadened university responsibility for graduate medical education (1). The American Medical Association (AMA) has also been deeply concerned with these developments. The two organizations, working in conjunction through the Liaison Committee on Medical Education, have determined to become involved in graduate medical education, initially through careful reexamination of procedures for accreditation of these programs.

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1. Coggeshall, L. T. Planning for Medical Progress Through Education. Evanston, Illinois: Association of American Medical Colleges, 1965.

In 1969 the AAMC published a report on The Role of the University in Graduate Medical Education, advocating less fragmentation of authority in this area and the focusing of responsibility in the university (2). In light of their growing role in graduate medical education, the constituent academic medical centers of the AAMC authorized this study of the implications of corporate responsibility for graduate medical education.

Definition

Corporate responsibility for graduate medical education is defined as the assumption by the academic center and its faculty of the classic responsibilities and authority of an academic institution for all its students and programs in medical education. This implies that the faculty of the medical school would collectively assume the responsibility for the education of clinical graduate students* (interns, residents, and clinical fellows) in all departments and that the education of these students would no longer be the sole prerogative of groups of faculty oriented to individual departments or single areas of specialty practice.

Advantages

Among the advantages inherent in vesting responsibility for graduate medical education in a single identifiable body rather than continuing departmental fragmentation

2. Smythe, C. Mc., Kinney, T. D., and Littlemeyer, M. H. The Role of the University in Graduate Medical Education. J. Med. Educ., 44: September, Special Issue, 1969.

* The use of the word student in this document requires definition. The individuals discussed here have received

are the following:

1. easier implementation of the continuum concept in medical education;

2. more effective adaption to individual student's rates of progress through the educational process;

3. fostering multiple methods for conducting graduate education and thereby enhancing innovation;

4. enrichment of graduate medical education by bringing to it more of the resources of the university and its faculties;

5. promoting the introduction of greater efficiency and flexibility in the use of faculty and facilities;

6. enhancing the principle of determination over educational programs by the individual universities; and

7. promotion of a comprehensive rather than a fragmented pattern of medical training and practice.

The major drawback to such an objective is the hazard of incurring some of the inflexibilities of university procedures and/or dangers of bureaucratization.

Fragmentation of Responsibility for Graduate Education

A further significant fact is that, despite oft repeated disclaimers, specialty board certification does represent a second degree and is the significant license

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their doctorate and are engaged in an intensive post-doctoral program of training to become a specialist in one of the areas of medical practice. They are basically students, but usually have important commitments to medical care and teaching. They are, therefore, in some sense practicing physicians and faculty members. There is usually no degree goal, but certification by a specialty board or public acceptance of specialty status are the rewards of this training. In view of these considerations, no single word accurately describes persons in this role and with these reservations the word student will be used in this discussion.

for almost all American physicians. The evidence for this allegation is all around us but is found most importantly in attitudes and behavior of the men in practice and of those who make hospital appointments and decide on professional reward systems, both pecuniary and nonpecuniary.

This state of affairs is a significant departure from the usually stated theory of license to practice. In the usual formulation, civil government, because of its obligation to protect the people, grants to agencies which it controls the authority and responsibility to decide who shall be admitted to the practice of a profession. Such agencies characteristically have as their primary charge protection of the best interests of the people. In one fashion or another, through either appointment or election, in the United States they are answerable to state governments. If the specialty boards are indeed de facto licensing agencies, current practices in which they are primarily responsible to their colleagues in their specialties are far removed from usually accepted theories of the nature of civil license.

Graduate clinical training or graduate medical education is now carried out in highly variable clinical settings and since the clinical graduate students are frequently licensed physicians but are primarily in a learning role, the status of these students remains ambiguous. Classically, interns and residents are considered employees of hospitals although medical schools

or other professional groups may contribute to their stipends. Interns and residents are denied the practice privileges of physicians not in teaching programs, especially as regards the management of fees for services to patients. They are not usually considered members of the university community especially as regards the management of fees for services to patients, yet their salaries are largely derived from third-party payments based on patient services. Still these students are not usually considered members of the university community.

In the majority of instances, such house officers are pursuing specialty board certification or publicly ascertainlable qualification in one of the medical specialties. The duration, content, progress through training, and determination of elegibility for admission to the specialty board examinations are now determined largely by individual boards. Such boards are characteristically private, not-for-profit organization that have substantial autonomy. Universities or hospitals have no direct influence on their policies or actions.

All internships are approved by the Internship Committee of the Council on Medical Education of the AMA. All residency programs are accredited by the Residency Review Committees of the AMA, with the exception of Pathology. The American Board of Pathology directly examines and accredits its residency training programs. The Residency Review Committees are made up of appointees of the specialty sections of the AMA and the appropriate

boards, and many of them also have additional appointees from the appropriate Colleges or Academies. The Residency Review Committees are autonomous except for matters of policy and do not have to report back to their parent organizations for ratification of their decisions. The graduate education section of the Council on Medical Education of the AMA provides secretarial assistance and administrative support for the operation of all Residency Review Committees.

The concern of the Council on Medical Education for all facets of medical education is a matter of historical record. In the area of graduate education, however, the Council has essentially no direct authority over either the boards or the Residency Review Committees since both function independently and autonomously. However, in practice, its influence is significant. It should be noted that the AMA has its roots in the practice of medicine, and its policies will inevitably and properly always be strongly influenced by current conceptions of the interests of practicing physicians whose direct contact with education has either ended or become a secondary part of their professional activity.

The individual to whom the resident is responsible is his service chief, program director, or departmental head. Such an individual always has a major hospital appointment, and his authority over a clinical service, and hence over its residents, relates to his role in the

hospital. He may or may not have a university connection of significance, ranging from major to only ceremonial. This service chief has direct responsibility for the content of the program in accord with the requirements of the specialty boards and the Residency Review Committees. Although service chiefs may work closely with members of their own departments, insofar as content and process of residency education, such chiefs have a considerable autonomy within broad policies.

The medical school or university through its faculty members and affiliated hospitals sponsors and influences a large segment of graduate medical education and accordingly should be considered for a more formal role in its design and operation. It has a very real authority, through its influence over hospital policies and the appointments of service chiefs, but it may or may not have real operational responsibility.

In summary, control of graduate medical education is fragmented among the following settings:

1. hospitals which employ trainees and provide the classrooms and laboratories for their education;

2. specialty boards which determine duration and a portion of the content of training and act as de facto licensing agencies;

3. Residency Review Committees which accredit on a programmatic basis;

4. service chiefs who on a programmatic basis determine the balance of content and all of the process of graduate medical education; and

5. medical schools and universities which exert considerable authority through the individuals whom they appoint but accept little direct operational responsibility as institutions.

Attributes of Current System

Today's system has consistently and reliably produced specialists well equiped to care for the disease-related content of their areas of medical practice. In terms of its goals, it has been an acceptably successful, pragmatic solution; adaptable to the variety of conditions found in so large and diverse a nation as the United States. If its goals, the replication of highly categorized specialists were now acceptable in terms of the needs of the public, its ambiguities would be tolerable. Before any new arrangement is adopted, it should be noted that these are major strengths of this pluralistic system.

The degree of specialization which has been brought about by advancing knowledge has resulted in the evolution of a very complex structure for graduate medical education. It is this complexity which has created demands for a more holistic approach to the total duration and content of medical education. A corporate approach in graduate medical education could help provide this.

Unification or Corporate Responsibility in Undergraduate Medical Education

In many ways the situation in graduate medical education today is not unlike that of undergraduate medical education 70 years ago. It is widely recognized that

the medical school and its parent university have assumed corporate responsibility for undergraduate medical education. This was the significant reform of 1890 to 1925. The issues facing graduate medical education in the 1970's contain many striking parallels and the solution being suggested here has many features of that which worked so well for undergraduate medical education two generations ago.

In the 1960's medical schools began major undergraduate curricular revisions. These efforts to make undergraduate education more responsive to perceived public needs are generally based on the assumption that the undergraduate educational process is preparing students to enter into a period of postdoctoral training. This combination of predoctoral and postdoctoral education finally produces the polished professional clinician. If corporate responsibility were adopted, the professional schools would have as large a stake in the postdoctoral educational process as they now have in the predoctoral.

Corporate Responsibility

The responsibility which would be assigned to the academic medical center faculties may be inumerated as follows:

1. determination of educational objectives and goals;
2. establish policies for the allocation of resources and facilities of the entire medical center to permit realization of these goals;
3. appointment of faculty;
4. selection of students;
5. determination of content, process and length of educational program;

6. evaluation of each student's progress; and

7. designation of completion of program.

These responsibilities as applied to graduate medical education would be vested in the university then would be delegated to its medical faculty and teaching hospitals which in turn would create a program of educational advancement protecting the rights of students while responding to the requirements of society.

The medical faculty would have a concern for creating an appropriate environment for graduate medical education. They would be responsible for selecting their fellow faculty members and for approving the design of programs in graduate medical education, including concern for the processes used, the duration and content of learning, and the coordination and interrelation between various units of the faculty. As a faculty, they would have a voice in the selection of students, with concern for their quality and number. They would also be expected to institute procedures which would allow them to determine their students' achievement of an appropriate educational level and their readiness to take examinations for certification by the appropriate specialty boards.

Implications of the Acceptance by the Universities of Responsibility for Graduate Medical Education

So many agencies and people would be affected by pulling today's fragmented responsibilities together and assigning to universities both the reponsibility and authority for the graduate medical education now carried out in

their spheres of influence, that the only way to analyze implications of these changes is to look at the various forces involved one at a time.

The University

Administrative, financial, and organizational relations existing between parent universities and their medical schools would not be appreciably altered by this change. Long-range changes could be expected, and these will be touched upon in the following sections.

The Medical School Faculty

There would need to be relatively little immediate change in the day-to-day climate of the clinical faculties of medical schools. More significant would be the slow but predictable and desirable increase of interaction with other faculties in the university. There would also be greater coordination of educational activity within the clinical faculty. Presumably, there would be more effective integration of various units of the medical center both medical and nonmedical, and this integration could be expected to produce different educational and patient care alignments. Possibly, the medical faculty might develop course-work, a credit system and examinations similar to those now operated for undergraduate education.

These organizational patterns would likely precipitate decisions about which aspects of specialty training should precede and which should follow the M.D. degree. These questions must be faced in any event, and the recognition of medical education as a

continuum--the responsibility of a single unified faculty--would be a great advantage.

The Graduate School

Assignment of such corporate responsibility within the university would become an important consideration. Although it is conceivable that the graduate school could be the assigned area for such programs, graduate clinical education is so eminently the business of physicians that it makes little sense to locate it in a general university graduate school but rather to retain it in the medical school setting. Actually multiple solutions are possible, and such ambiguities seem tolerable.

Another Degree

The issues of advanced and intermediate degrees in medicine are not trivial. Residents now get unimportant pieces of paper from hospitals (certificates of service) and an important piece of paper from specialty boards (certification of specialty status). The advanced clinical degree has not caught on in this country despits its trial, especially in Minnesota, and despite practices abroad. A corporate arrangement would demand some formal recognition of the end of the educational sequence. A degree pattern of some sort would almost certainly emerge in time, probably in discoordinate fashion from school to school. As an obstacle to a new plan or organization, the degree issue need not be settled early. However, some will advocate a preliminary degree after medical school,

perhaps an intermediate degree a year or two later, and some final degree such as master of surgical science or the like as the university's certification of what each graduate student had accomplished. Any move to imperil the strength of the M.D. degree would be very strenuously resisted. The public has a firm impression of the meaning of the M.D. degree, and any change in university structure that might alter its significance should be considered with circumspection.

Hospitals

Here truly significant problems begin to emerge. The major educational program of a hospital would become the responsibility of an agency, in some instances external to the hospital and governed by a different board. This is a significant shift, and it can be expected that hospitals everywhere will analyze this implication with their own interests in mind, as is only proper. The realities of getting a group of community hospitals or a community and university hospital to organize a single corporate educational program will call for intensive bargaining. It can be predicted that there will be orders of difficulty, from least in a situation in which hospital and medical school are jointly owned and administered by a single board, to most where hospital ownership, operation, financing, and location are all separate. As far as financing goes, there would be few differences from today's practices. Organizationally, there might be shifts in the influence of single departments.

Operationally, this might emerge as another force toward more comprehensive medical care. In terms of accreditation or approval, the hospital educational program would be approved as a unit. This would mean the number, duration, type of training, and coordination of training offered would be returned to local control by the joint medical school-hospital faculty.

The University, Graduate Education, and Nonaffiliated Hospitals

Although the university medical center initally assumes a corporate responsibility for the graduate education of physicians in its affiliated hospitals, ultimately the need for the university's influence on graduate programs in nonaffiliated hospitals would be necessary for several reasons:

1. A considerable segment of all graduate education is now conducted in nonaffiliated hospitals.

2. University medical centers and their affiliated hospitals cannot educate effectively the total number and type of physicians required.

The relationship created might vary from one institution to another depending upon the educational capability of the nonaffiliated hospital, financial support required, and the desire of the nonaffiliated hospital to participate in a university designed and directed educational program. All such arrangements for cooperative or integrated efforts would be completely voluntary and obviously to the advantage of both institutions.

The Student

At first, there would be very few changes for the people in training. However, more ready access to other departments, readier availability of the resources of other units of the university, and better coordination in training could be expected to lead to stronger, shorter, and more varied educational programs. These would all eventually work to the advantage of the students and this result for them must be seen as one of the major benefits expected from the change. Admission to, progress through, and certification of completion of training would become more formal, less casual, and more subject to general university procedures. These university procedures would carry with them the benefits of easier access to all areas of the university.

Financing the Educational Component

There is obviously a cost involved in graduate medical education. For years this cost has been absorbed by the residents by deferral of earnings, by the clinical faculties through donation of their time, and by the patients, through direct charges for hospital services. This system is now challenged by everyone: the residents in their demand for higher salaries, the faculties through the emergence of the full-time system, and the patients who through large third-party payers are challenging the inclusion of any educational costs in charges to patients.

The organization of clinical faculties along

corporate rather than departmental lines would have no direct effect on these issues, except for their probable clarification. Expenses should not increase except as academic functions increase. The emerging acceptance of the need to fund service functions by beneficiaries of these services and educational functions by the beneficiaries of these services will shortly bring to a head responsibility for funding of the educational component of clinical graduate training. The university will be unable to assume this burden unless it in turn is financed. The general trend to spread costs of higher education widely through society by any of a number of mechanisms is seen as the only way to handle this issue.

The Specialty Boards

The role of the specialty boards would change primarily toward their becoming certifying agencies not exercising direct control over duration or content of training. This again also seems to be a change which in one form or another is clearly on us. The boards would continue to have a mjaor role in graduate medical education through the design and provision of examinations and the certifying of candidates who complete them successfully.

External Accrediting Agencies

The Liaison Committee on Medical Education, the Council on Medical Education of the American Medical Association, Residency Review Committees, and the Joint Commission on Hospital Accreditation are examples of external

accrediting agencies. This function must be carried out in order to protect the public. One of the fundamental assumptions surrounding the proposed corporate responsibility for graduate medical education is that the corporate body itself, in matters pertaining to accreditation, would relate primarily to a single external agency and be accredited by it. The proposed Commission on Medical Education is an effort to create such an agency at this time. Its emergence remains in doubt, but if the change to corporate responsibility does not come about, the universities would need and would indeed demand the organization of some external-accrediting and standard-maintaining body, rather than being answerable to many as they are today. The Liaison Committee on Medical Education is already taking some steps to assure greater responsibility for accreditation in graduate medical education.

Patients and Consumers

No immediate effect on patients and consumers can be predicted at this time. However, since the raison d'etre of the whole health care and health education system is to serve the people, the vitality of corporate medical education must eventually rest in its ability to serve the people well. Public input is desirable and has been proposed at a national level. It should be locally determined from medical center to medical center based on local considerations.

COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

ONE DUPONT CIRCLE, N. W. • WASHINGTON, D. C. 20036 • (202) 466-5123

General Membership Memorandum
No. 71-5G
March 22, 1971
Subject: National House Staff Conference

1. National House Staff Conference, March 18-21, 1971:

On March 18-21, 1971 approximately 175 house officers met in St. Louis, Missouri to discuss and present their views concerning major health issues facing the nation. Some of these house officers came with a mandate to represent their local house staff associations. Others came only to present or contribute their personal opinions. A copy of the conference program is attached for your review.

2. Task Force Reports

Task force reports were prepared on thirteen issues and were ratified by conference participants at a plenary session. Copies of the entire conference proceedings will be available in approximately two months time. Interested persons should write to the following address to be placed on the mailing list to receive a published copy of the proceedings:

Department of Social Medicine
Montefiore Hospital & Medical Center
111 East 210th Street
Bronx, New York 10467

At the final plenary session, a twelve man committee was appointed and charged with the responsibility of raising funds for another house staff conference within the next six to twelve months. The primary purpose of this next conference is the formal establishment of a national house staff organization. The development of such an organization now appears to be a foregone conclusion.

3. Task Force on House Economics:

The task force on house staff economics is the report of most immediate concern to hospital directors. The report contains a recommended written agreement or contract with specific minimal requirements. This report will be mailed to all house officers in the country. A copy is attached for your information and possible utilization.

JOHN M. DANIELSON
Director
Council of Teaching Hospitals

Attachments (2)

NATIONAL HOUSE STAFF CONFERENCE #5

TASK FORCE ON HOUSE STAFF ECONOMICS

Rather than submit a report of our proceedngs, the group felt best able to serve our function by preparing a list of recommendations which could be distributed to all teaching hospitals, house officer organizations, medical schools and medical students.

WE RECOMMEND A UNIFORM WRITTENWORK AGREEMENT OR CONTRACT BE CONSTRUCTED BETWEEN EACH HOSPITAL WITH HOUSE STAFF AND ITS HOUSE OFFICERS TO EMBRACE THE FOLLOWING:

MINIMAL RECOMMENDATIONS:

A. Stipends or wages.

1. The minimum stipend or wage for each nearest metropolitan geographical area should meet the Bureau of Labor Statistics' unadjusted "annual costs of an intermediate budget for a four person family?and be updated yearly to meet the statistics as determined by the above-mentioned Bureau for the current year (see appended list).

2. The minimum stipend or wage applies to the internship year and there shall be a yearly increment of $900 for each house officer for each additional year of training.*

3. Special additional recompense shall be provided for house officers with special responsibilities (i.e., chief residents).

B. Vacation and Educational Leave.

1. Vacation schedules shall be at least 3 weeks paid vacations for interns and four weeks for residents.

2. Travel time and funds shall be provided in addition to vacation time for attendance by house staff to at least one academic meeting per year.

C. Meals

1. Meals shall be provided free while on call and shall include in addition a night-time snack.

D. Insurance

1. Malpractice insurance shall be provided at a minimal level of coverage of $100,000/$300,000 or more as required with coverage to include all hospitals to which the house officer is assigned.

2. Disability Insurance

a) For an injury or illness sustained during the house officer training peridd the hospital of employment

will continue the house officer's stipend or wages through that house officer's period of proposed traineeship or for a period of at least one year.

b) Group disability insurance shall be made available for the individual house officer to either purchase on his own and/or continue beyond his period of house officer traineeship.

3. Life Insurance in the form of a $50,000 term life insurance policy shall be provided.

4. Health Insurance - Acomplete, comprehensive health insurance program shall be provided by the hospital.

E. While it is recognized that house officer training is considered a demanding assignment, responsibilities of house officers to their educational program (patient care responsibilities as well as graduate or didactic aspects) vary considerably from specialty to specialty. A house officer is expected to have free time--time available for rest, recreation and other pursuits as he may choose.

* The only change in this document prior to conference ratification was the substitution of the phrase, "post-graduate house officership" each time the word "training" appears.

Table 2. Annual costs of an intermediate budget for a 4-person family, 1/ spring 1970

Area	Total budget	Cost of family consumption							Other costs 5/	Social security and disability insurance	Personal income taxes
		Total	Food	Housing 2/	Transportation 3/	Clothing and personal care	Medical care 4/	Other family consumption			
Urban United States	$ 10,664	$ 8,205	$ 2,452	$ 2,501	$ 912	$ 1,137	$ 564	$ 639	$ 539	$ 387	$ 1,533
Metropolitan areas 6/	10,933	8,382	2,491	2,579	916	1,153	582	661	576	389	1,586
Nonmetropolitan areas 7/	9,600	7,421	2,281	2,158	894	1,065	483	540	509	377	1,293
Northeast:											
Boston, Mass	12,037	9,128	2,653	3,120	937	1,166	562	690	571	374	1,964
Buffalo, N.Y	11,425	8,667	2,606	2,712	1,005	1,163	514	667	555	390	1,813
Hartford, Conn	11,584	9,074	2,717	2,918	985	1,197	550	707	570	374	1,566
Lancaster, Pa	10,301	7,994	2,533	2,323	928	1,094	512	604	532	374	1,401
New York-Northeastern N.J	12,134	9,178	2,792	3,071	865	1,151	600	699	573	393	1,990
Philadelphia, Pa.-N.J	10,875	8,308	2,653	2,448	879	1,115	550	663	543	378	1,646
Pittsburgh, Pa	10,236	7,926	2,536	2,237	910	1,100	492	651	529	374	1,407
Portland, Maine	10,835	8,481	2,599	2,460	983	1,198	542	699	549	374	1,431
Nonmetropolitan areas 7/	10,419	8,028	2,478	2,508	931	1,056	504	551	533	388	1,470
North Central:											
Cedar Rapids, Iowa	10,614	8,126	2,263	2,561	945	1,191	521	640	536	374	1,578
Champaign-Urbana, Ill	10,864	8,456	2,372	2,776	949	1,159	561	639	548	374	1,486
Chicago, Ill.-Northwestern Ind	11,120	8,655	2,482	2,774	961	1,175	592	671	555	374	1,536
Cincinnati, Ohio-Ky.-Ind	10,220	7,921	2,372	2,371	921	1,137	481	639	529	374	1,396
Cleveland, Ohio	11,184	8,673	2,465	2,839	929	1,201	561	678	556	374	1,581
Dayton, Ohio	10,094	7,846	2,363	2,244	901	1,167	497	674	527	374	1,347
Detroit, Mich	10,588	8,137	2,507	2,354	906	1,162	560	648	537	374	1,540
Green Bay, Wis	10,596	7,911	2,222	2,441	917	1,210	502	619	529	374	1,782
Indianapolis, Ind	10,892	8,421	2,435	2,626	994	1,143	559	664	547	374	1,550
Kansas City, Mo.-Kans	10,599	8,191	2,441	2,429	931	1,196	543	651	539	374	1,495
Milwaukee, Wis	11,405	8,470	2,291	2,892	902	1,178	542	665	548	374	2,013
Minneapolis-St. Paul, Minn	10,897	8,129	2,366	2,441	936	1,187	543	656	537	374	1,857
St. Louis, Mo.-Ill	10,546	8,156	2,513	2,399	939	1,131	533	641	537	374	1,479
Wichita, Kans	10,105	7,828	2,318	2,376	881	1,085	544	624	526	374	1,377
Nonmetropolitan areas 7/	9,862	7,607	2,266	2,347	900	1,075	473	546	518	374	1,363
South:											
Atlanta, Ga	9,523	7,415	2,283	1,977	883	1,099	522	651	512	374	1,222
Austin, Tex	9,212	7,257	2,215	1,860	905	1,087	554	636	506	374	1,075
Baltimore, Md	10,580	7,935	2,394	2,231	923	1,156	579	652	530	374	1,741
Baton Rouge, La	9,704	7,605	2,400	2,050	931	1,087	508	629	518	374	1,207
Dallas, Tex	9,894	7,788	2,286	2,140	904	1,114	679	665	525	374	1,207
Durham, N.C	10,187	7,753	2,264	2,305	856	1,104	578	646	523	374	1,537
Houston, Tex	9,645	7,603	2,311	2,026	947	1,084	603	632	518	374	1,150
Nashville, Tenn	9,665	7,604	2,228	2,223	914	1,082	501	656	518	374	1,169
Orlando, Fla	9,469	7,451	2,201	2,141	847	1,048	569	645	513	374	1,131
Washington, D.C.-Md.-Va	11,047	8,365	2,489	2,547	955	1,120	574	680	545	374	1,763
Nonmetropolitan areas 7/	9,041	7,035	2,214	1,904	881	1,034	466	536	498	375	1,133
West:											
Bakersfield, Calif	10,040	7,785	2,331	2,127	942	1,128	651	606	524	448	1,283
Denver, Colo	10,326	7,985	2,298	2,346	932	1,227	550	632	531	374	1,436
Los Angeles-Long Beach, Calif	10,770	8,307	2,373	2,476	902	1,207	710	639	543	448	1,472
San Diego, Calif	10,467	8,083	2,298	2,397	909	1,173	667	639	535	448	1,401
San Francisco-Oakland, Calif	11,381	8,761	2,461	2,813	957	1,228	640	662	557	448	1,613
Seattle-Everett, Wash	11,012	8,649	2,575	2,590	948	1,239	632	665	553	374	1,434
Honolulu, Hawaii	12,776	9,428	2,855	3,064	1,057	1,171	594	687	586	374	2,392
Nonmetropolitan areas 7/	9,885	7,555	2,245	2,227	867	1,170	516	530	496	374	1,460
Anchorage, Alaska	14,535	10,826	2,833	3,992	1,163	1,347	885	606	606	417	2,686

1/ The family consists of an employed husband, age 38, a wife not employed outside the home, an 8-year-old girl, and a 13-year-old boy.

2/ Housing includes shelter, household operations, and housefurnishings. The average costs of shelter are weighted by the following proportions: 25 percent for rental costs, 75 percent for homeowner costs.

3/ The average costs of automobile owners and nonowners are weighted by the following proportions: Boston, Chicago, New York, and Philadelphia, 80 percent for owners, 20 percent for nonowners; Baltimore, Cleveland, Detroit, Los Angeles, Pittsburgh, San Francisco, St. Louis, and Washington, with 1.4 million of population or more in 1960, 95 percent for automobile owners, and 5 percent for nonowners; all other areas, 100 percent for automobile owners.

4/ In total medical care, the average costs of medical insurance were weighted by the following proportions: 30 percent for families paying full cost of insurance; 26 percent for families paying half cost; 44 percent for families covered by noncontributory insurance plans (paid by employer).

5/ Includes allowances for gifts and contributions, life insurance, and occupational expenses.

6/ As defined in 1960-61. For a detailed description of current and previous geographical boundaries, see the 1967 edition of Standard Metropolitan Statistical Areas, prepared by the Bureau of the Budget.

7/ Places with populations of 2,500 to 50,000.

In any discussion of house staff economics, the method of obtaining the economical benefits is an integral part. It is for this reason the Task Force submits the following in hopes it will add direction to those House Staff Associations seeking improvement. There are two major components to this problem--house staff organizational structure and the actual operational techniques.

ORGANIZATIONAL STRUCTURE

1. Form a formal organization with officers and constitution.

2. Develop united house staff support by:

   a) payment of dues
   b) communication with members by means of newsletter
   c) identification of common goals, both professional and social

3. Determine what groups are sympathetic with your cause, i.e., medical student, attending staff, administrators and enlist their active support.

4. Obtain voting representation on hospital committees and boards, such as executive and educational policy committees.

OPERATIONAL TECHNIQUE

1. No method must compromise PATIENT CARE.

2. Adapt technique to local situation, i.e., private vs. university hospital, influence of existing local and state legislation.

3. Be absolutely certain that your group is unified and enthusiastically in support of your goals. Be aware that extreme pressure may be brought to bear on your elected representatives by unsympathetic administrators.

4. Define and separate long and short term goals.

5. Collect data from your house staff that is accurate, complete and pertinent. See enclosure #1.

6. Utilize existing statistics from other sources, such as, Bureau of Labor Statistics, Dept. of Labor, Washington, D.C. 20212, Congressional Record, 91st Congress, page S2235, Feb. 24, 1970, and "House Staff Benefits, a National Survey," Association of American Medical Colleges, 1346 Connecticut Ave., N.W., Washington, D.C. 20036.

7. Prepare written proposal of needs with supportive data and present to hospital administration.

8. Conduct verbal negotiation on professional level. Always maintain your professional attitude even if others do not.

9. Present statement from other groups supporting your position--medical students, staff, etc.

10. Utilize news media cautiously -- avoid confusion, emphasis on monetary issues, and distortion of fact. One member of your organization MUST be designated as spokesman. Written statements are far superior to impromptu press conferences.

11. If at this point, all else fails, legal counsel is to be considered remembering that this is expensive, time consuming and often ineffective. This is a special legal area which many attorneys do not comprehend.

12. During this important phase of your negotiation, maintain contact with other organizations involved in similar situations.

13. If legal counsel is ineffective threats of other action may be made, remembering that many times the threat is as effective as the act itself.

14. These actions include mass resignations, letters to prospective interns throughout the country discouraging them from coming to your hospital and various forms of job action.

15. More drastic measures include the heal-in. This is of diminished value without a sympathetic press. It is extremely dangerous without proper planning.

16. The ultimate threat is a strike.

17. The above are not recommendations of this conference but are listed only as a guide for those organizations wishing to utilize them.

SAMPLE HOUSE OFFICER SURVEY

Average age: 29.0 years
Average years since medical school graduation: 3.6

Married: 83%
Average married household: 3.24 persons
Wives now pregnant: 12%
Households with babies in the past year: 27%
Average cost of delivery to H.O.: $590 (range $35 to $1000)

Average debt: $4275
Outside source of additional income: 36%
Moonlighting: 19%
Wives who work: 56%
Borrowed in the past year: 52%

Average hours worked per week: 105
Additional hours on call per week (applies to 16%): 58

Average hours per week spent in teaching sessions: 5.1
Average hours per week doing work within the scope of nurses, technicians, or secretaries: 8.1

Support for Postgraduate Medical Education

All bona fide internship and residency programs involve education as well as service. Teaching has traditionally been the weak sister of the teaching-research-patient care triad, no less at the postgraduate than undergraduate level. In the recent past, both levels have been surreptitiously supported by grants for research. As research grants dry up and the government increasingly subsidizes patient care, we can anticipate the appearance of subterfuges to finance medical education from patient care funds (such as Medicare Part B). Our concern is: should the patient who goes to the teaching hospital have to pay the bill for medical education?

Government hospitals aside, patients and their insurers have generally borne the cost of postgraduate medical education, As the cost of living of employees and professionals rise and the demands of scientific medicine become more and more expensive, educational expenses become harder for hospitals to bear, and more at risk of reduction. Educated physicians are a national resource, and it is inappropriate that the cost of their education is borne on such a narrow base as the present one.

Medical education should be supported frankly, for its own sake, both at the undergraduate and postgraduate levels. Otherwise it will remain out of the reach of the poor and the black. Furthermore, those who complete their training should not be compelled by debt to seek lucrative private practices, but encouraged to serve in areas of geographical, social, and specialty need.

Laws have already been passed to support training in certain specialty areas, such as psychiatry and family practice. Improved federal loans are now available for medical undergraduates. Many postgraduate trainees have been helped by the GI Bill. The "Health Security act" (the "Kennedy" Bill, S.4323 in the 91st Congress and S.3 in the 92nd) has a built-in Resource Development Fund to tackle this problem.

A most healthful approach is taken by Senators Javits, Baker, Beall, Bellman, Bennett, Cooper, Dole, Dominick, Fannin, Fong, Griffin, Jordan of Idaho, Percy, Prouty, Scott, Stevens, Taft, Tower, Weicker, and Young, in their "Health Manpower Assistance Act of 1971" (Congressional Record S.2792 - S.2800, March 10, 1971), which provides capitation grants of $6000 to schools of medicine, dentistry, and osteopathy. We believe this principle should be extended to cover the teaching hospitals with accredited programs. This would relieve hospitals and their patients of the great load of educational expenses which they have shouldered so patiently and so well in the past.

Brief Note on the IRS: The Internal Revenue Service has no clear national policy on house officers income, but there are numerous regional rulings and court cases, most of which disallow any deductions for training. Should any house officers or house officers group choose to take the deduction, it might be wise to place the funds in the bank against having to return them plus 6% interest.

COMMITTEE FOR A NATIONAL HOUSE STAFF CONFERENCE

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NATIONAL HOUSE STAFF CONFERENCE SCHEDULE

Thursday, March 18, 1971

P.M. Arrival of Partipicants
Registration and Room Assignment

8:00-11:00 P.M.—Informal Social Hour

Friday, March 19, 1971

8:30 A.M.—Opening of Conference—
The Starlight Room
David A. Kindig, M.D., Chairman

9:00 A.M.—Welcome—
Victor W. Sidel, M.D., Project Director

9:05 A.M.—Keynote Addresses:
"The Sorcerer's Apprentice—The History of the Activism Movement Among Young Health Professionals"
Anthony Bottone, M.D.
(Tony Bottone is a resident in pathology and a graduate student in the history of medicine, UCSF)

"Health, Hospitals and House Staff"
Fitzhugh Mullan, M.D.
(Fitz Mullan is a resident in pediatrics, Lincoln Hospital, N.Y.C.)

Introduction to Conference
Committee Meeting Rooms

10:30 A.M.—Break.

11:00 A.M.—Discussion Groups: General Discussions of the problems facing house staff currently and in their future practices.

1:30 P.M.—Lunch Break.

3:00 P.M.—Task Forces I

		Room No.*
A.	What's Wrong with the Hospital?	.....
B.	Who Pays?: Health Care Financing	.....
C.	The Doctor Draft	.....
D.	Needed & Unheeded: The Foreign Medical Graduate	.....
E.	New Modes of Health Care: Group Practice, Neighborhood Centers, etc.	.....
F.	House Staff Economics	.....
G.	Issues in House Officer Training	.....
H.	Occupational Hazards: Divorce, Disease, Disenchantment	.....
I.	Ethical Issues in Medicine	.....
J.	Who's the Boss?: Community Control	.....
K.	Sexism & Racism: Medical Minorities Report	.....

*to be announced

7:00 P.M.—Ad Hoc Committee
Purpose: to plan and organize the Agenda for the Sunday plenary session.

Saturday, March 20, 1971

9:00 A.M.—Task Forces II

	Room No.
A.	.....
B.	.....
C.	.....
D.	.....
E.	.....
F.	.....
G.	.....
H.	.....
I.	.....
J.	.....
K.	.....

3:00 P.M.—Staff Room Opened .....
(Secretarial staff prepared to receive rough drafts of Task Force Reports: Mrs. Estelle Holt).

*to be announced

Sunday, March 21, 1971

8:30 A.M. - 1:00 P.M.—PLENARY SESSION
Steven G. McCloy, M.D., Chairman

1:00 P.M.—Close of Conference

COMA

—for A-70-112

STONED ON REASON
into the action
count spiders
stare at Medusa
dig the asterixis
note the bottles
in his brain.
HEIGH HO & AWAY
with the neomycin drip
stat units & pit.

MIDNIGHT ROUND FOUR AM & FORTY YEARS
he slipped away
(between intravenous drips)
to a cold steel crypt
to be resurrected
on the thirty-third day,
a curator's case.
THE CROSS CARVED,
eviscerate:
—hard hobnailed hepar flipped out
—the liver lungs bulged like cut clouds
—jaundiced guts, spleen & kidneys, too.

THE CHARTS WERE SEVENTY POUNDS THICK
told of a thousand visits
forty million five hundred and eighty six thousand
lab tests
and ten megatons of drugs
eaten, shot or infused by vein or
rectal enema.

THE DOCTORS
had written as much as one Byzantine encyclopedist
(seventy volumes and a *Synopsis),*
given as many orders as Hannibal crossing
the Alps,
thought two thousand computer years of
diagnosis, prognosis & pathophysiology,
had experienced 360 NIH grants,
spent a billion dollars and man-hours,
and had taught two generations of
students
about Dr. Laënnec & his liver.

(salvaged were thirty-two paraffin blocks)

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NATIONAL HOUSE STAFF CONFERENCE

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CHASE-PARK PLAZA HOTEL
212 N. KINGSHIGHWAY BLVD.
ST. LOUIS, MO.

MARCH 18-21, 1971

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

EDUCATION RESEARCH

INTER-OFFICE MEMO

Retain – 6 mos. ☐
1 yr. ☐
5 yrs. ☐
Permanently ☐
Follow-up Date

DATE March 25, 1971

TO: John Danielson

FROM: Dick Knapp

SUBJECT: National Conference of House Staff

On March 18-21 Armand and I attended the National House Staff Conference in St. Louis. A copy of the program is attached. You'll note the conference was supported by HSMHA.

Thirteen working task forces were convened, and their reports were debated and ratified by the group at a lengthy plenary session on Saturday evening which ran from 8:00 P.M. -- 1:00 A.M. Copies of each of the task force reports are attached for your review. The report of most immediate interest is #5 which deals with house staff economics. I have sent a Memo to COTH members with a copy of the economics report. This went this morning, March 25, and is also attached.

The quality of the task force reports is variable. In my opinion, the most thoughtful (although you might not agree with what they say) are the reports on the doctor draft, the foreign medical graduate, house staff economics and minorities in medicine. The most disappointing one to me was entitled "Issues In House Officer Training."

The fact that 2 AMA Board members were present is indicative of their nervousness about this group. Dr. Sawyer went home midway through the conference, but Dr. Kernoble was tougher skinned and did communicate fairly well with some of the group.

There were the usual power struggles, although they would deny it. On this form of behavior, the leaders find it difficult to admit that their behavior is no different than any other group. Struggles were over regional representativeness and accusations that those who used to run SAMA are now trying to create another organization to use. There may be some truth in the latter point.

At any rate, the group for the most part was a responsible one. And I think it's noteworthy that they managed to avoid a resolution condemning the Viet Nam War.

COPIES TO:

A steering committee of 12 was appointed to find the money for a second conference, the purpose of which would be to formally organize a national organization. This group will meet in May in Chicago.

cc: Dr. Cooper
Dr. Swanson
Mr. Murtaugh
Dr. Johnson
Dr. Wilson

AGENDA

THE WORKING PARTNERSHIP BETWEEN THE VA MEDICAL DEPARTMENT AND THE ACADEMIC MEDICAL CENTERS

SESSION ONE

Prologue

Philosophy and Goals of the VA Medical Department - J. M. Musser

Philosophy and Goals of the Academic Medical Centers - W. Anlyan

Program Commitments of Both Partners - General Discussion

SESSION TWO

Organizational Relationships of the Partners
General Discussion

SESSION THREE

Future Courses of Action
General Discussion

Outlines below are the major points which should be considered during the discussion.

I. The Interdependency--What's in it for both participants?

For the Veterans Administration

1. The recruitment and retention of high-quality professional staff.
2. Special program development for quality secondary and tertiary care.
3. Benefits of participation in the academic environment.

For the Medical School

1. Faculty support.
2. Clinical teaching resources for undergraduate and graduate students.
3. Research resources for faculty.

II. What are the impediments to full benefit from the association?

1. Local

   a. Lack of understanding of the nature of the relationship.

   b. Tenuous administrative ties between VA teaching hospitals and medical centers.

   c. Poor integration of fiscal and personnel resources.

   d. Poor coordination of program planning and development.

   e. Policies and priorities which inhibit full integration of professional staffs (government regulations versus academic freedom).

   f. Lack of uniformity in academic department commitments to VA service.

2. National

a. Autonomy of teaching VA hospitals for programmatic planning often disrupted by centralized authority.

b. Medical centers focused primarily on program development in their own hospitals.

c. The differentiation between VA teaching hospitals from non-teaching hospitals in policy and budget making.

d. Policies of medical centers rarely allow for cost or facility sharing with VA hospitals.

e. VA income levels are non-competitive for higher faculty ranks.

f. Supplementation rules for VA personnel make medical center assistance difficult.

g. Neither participant has sufficient funds.

III. Possible Solutions

1. Cooperative national policy development between VA Central Office and the AAMC.

2. Local program planning and budget allocation decisions shared between VA administration and medical center administration.

3. Establishing strong administrative inter-ties between the VA teaching hospital and the academic medical center with joint administrative titles.

4. Academic medical centers contract for health care of veterans.

AGENDA

COUNCIL OF TEACHING HOSPITALS
SOUTHERN REGIONAL MEETING
AIR HOST INN
Aviation East Room
Atlanta, Georgia
Tuesday, April 20, 1971

I. Call to Order: 10:00 a.m.

II. Report on National Conference of House Staff held in St. Louis, March 18-21, 1971
   A. Discussion of Possible Participation of House Officers in COTH and/or AAMC Activities

III. Discussion of Council of Academic Societies' Statement entitled "The Implications of Corporate Responsibility for Graduate Medical Education"

IV. Legislative Report

V. Veterans Administration - AAMC Relationships

VI. Lunch - A Cash bar will be open at 12 noon in the Aviation Executive Room to be followed by a joint buffet luncheon with the Southern deans from 12:30 - 1:30 p.m.

   Speaker: John M. Danielson
   "The Implications of the HMO for the Academic Health Center"

VII. Discussion of the Present and Future Status of Health Maintenance Organizations
   A. AAMC Legislative Proposal - S.935, H.R. 4170
   B. Report on the Kaiser-Permanente Foundation Conference on Prepaid Group Practice

VIII. Opportunity for Regional Membership Comment on Two Recently Appointed COTH Task Forces
   A. Task Force on Goals, Objectives and Criteria for Membership in COTH
   B. Task Force on High Cost of Teaching Hospitals

IX. Further Program and Financial Support of COTH/AAMC

X. Other Business

XI. Date of Next Year's Southern Regional Meeting

XII. Adjournment

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