

COUNCIL OF TEACHING HOSPITALS
Administrative Board Meeting Agenda
Private Dining Room
Palmer House
Chicago, Illinois
August 22, 1971

- I. Call to Order - 9:00 a.m.
- II. Approval of Minutes: Meeting of April 14, 1971 (TAB A)
- III. Membership
- A) New Applications For Membership (TAB B)
1. The Stamford Hospital, Stamford, Connecticut
 2. Saginaw Cooperative Hospitals, Inc., Saginaw, Mich.
- B) Confirmation of Mail Ballots
1. Charles S. Wilson Memorial Hospital, Johnson City, N.Y.
 2. Confederate Memorial Medical Center, Shreveport, La.
 3. Milton S. Hershey Medical Center Hospital, Hershey, Pa.
 4. Mobile General Hospital, Mobile, Ala.
- C) Special Situations (TAB C)
1. Presbyterian Hospital of Dallas
 2. University of California, Irvine
 3. Bataan Memorial Hospital, Albuquerque, N.M.
 4. Presbyterian Hospital, Albuquerque, N.M.
- D) Status Report on Membership (TAB D)
- IV. Status Report: Development of Division of Health Services
- V. Implications of Variable Graduation Dates for Medical Students (TAB E)
- VI. Possible Endorsement of the Report of the National Commission for the Study of Nursing and Nursing Education (TAB F)
- VII. Report on Regional Meetings
- 1) Dues Increase
 - 2) Discussion of House Staff
- VIII. Report on AAMC/VA Liaison Committee Meeting held at Airlie House, May 26, 1971 (TAB G)
- 1) Veterans Administration Task Force on Sharing
- IX. Brief Legislative Status Report
- 1) National Health Insurance. House Ways and Means Committee will hold hearings after Labor Day
 - 2) HMO Legislation. Initial hearings held on July 20, 21 to be resumed after Labor Day by Senator Kennedy's Health Subcommittee of the Senate Labor and Public Welfare Committee
 - 3) Medicare
 - 4) Hill Burton Proposed Guidelines. Published in the Federal Register, July 29, 1971 (TAB H)

X. Discussion of Annual Meeting

- 1) Nominating Committee Report
- 2) Reports of the Ad Hoc Committee and two Task Forces

A) Committee On House Staff Relationships to to the Hospital and the AAMC (TAB I)

B) Task Force to Analyze the Higher Costs of Teaching Hospitals

C) Task Force to Recommend Goals and Objectives For COTH as Well as Future Criteria for Membership (TAB J)

XI. Other Business

XII. Adjournment

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF TEACHING HOSPITALS

MINUTES

EXECUTIVE COMMITTEE MEETING

The Embassy Row Hotel

Washington, D.C.

April 14, 1971

Present:

Irvin G. Wilmot, Chairman
Joe S. Greathouse
L. H. Gunter
T. Stewart Hamilton, M.D.
Bernard J. Lachner
Sidney Lewine
David Odell
Stuart M. Sessoms, M.D.
John H. Westerman
Merle S. Bacastow, M.D., AHA Representative

Staff:

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

I. Call to Order:

Mr. Wilmot called the meeting to order at 9:00 a.m. in the Chancery Room of the Embassy Row Hotel in Washington, D.C. At the suggestion of Mr. Danielson, the committee directed the staff to send a telegram to Mr. Mark Berke congratulating him on receipt of the Citizen of Merit Award.

II. Consideration of Minutes:

The minutes of the meeting of February 12, 1971 were approved as distributed. A report of the special meeting of the Executive Committee held in Washington, D.C. on January 24, 1971 was distributed for the record.

III. Status Report on Health Maintenance Organizations:

Mr. Danielson reported that HEW Secretary Richardson has given the responsibility for the conceptual and operational development of HMO's to Vernon Wilson, M.D., Administrator, HSMHA. Money will be allocated during the next eighteen months to five basic types of organizations for the

examination and model development of HMO's. The five basic types of organizations are as follows:

- 1) medical societies or foundations;
- 2) proprietary organizations;
- 3) large public hospitals;
- 4) group practice clinics;
- 5) academic medical centers.

The HSMHA approach is to award contract funds to a national organization representing each of the five groups, which would in turn sub-contract and work cooperatively with a management consulting firm. The joint effort would then evolve a research and development project involving two or more institutions. While conditions and arrangements are not ideal, it would be inappropriate for the AAMC to decline such an opportunity.

Mr. Stephen Ackerman, Consultant to the Division of Health Services, is preparing a preliminary proposal which will soon be submitted to HSMHA. Peat, Marwick & Mitchell and the Equitable Life Insurance Company are the two management firms being considered for involvement.

Mr. Danielson reported that plans are being made to hold a workshop on HMO's which would utilize the academic and management talents of the staffs involved in the efforts at Harvard, Yale and Johns Hopkins.

IV. Report on Faculty Reimbursement Study:

A) On March 31, 1971, Mr. Danielson attended the first of what may become a series of Medicare appeals from university-owned hospitals concerning the disallowance of teaching costs for interns and residents charged under Part A of Medicare.

At the beginning of the program in 1967, the major issues involved in the Temple University Hospital case dealt with that part of the Medicare legislation that allows for the costs of teaching interns and residents under Part A, but in the regulation states that any identification of such costs cannot be a transference or redistribution for costs elsewhere in the budget to the hospital educational cost centers.

Temple University argues that at the advent of PL 89-97, the University did not have any cost distribution for teaching. Therefore, at the end of 1966 there was an initial distribution of costs which identified the cost of educating interns and residents for the first time, and therefore this could not be considered a redistribution of costs since it has never before been distributed.

The second major issue affects all of the university-owned teaching hospitals, since a policy matter must be decided as to whether the university or the hospital is the provider in those cases where the university owns the hospital.

it was reported that the Executive Committee of the Council of Academic Societies passed a motion urging the implementation of faculty participation. However, that Committee was unable to reach a consensus regarding how such action should best be accomplished.

Following brief discussion of the two alternatives, the following motion was made and seconded:

ACTION #1 : IT WAS MOVED AND SECONDED
THAT THE COTH EXECUTIVE COMMITTEE URGE
FACULTY PARTICIPATION IN THE AAMC BE
MADE ACCESSIBLE BY RESTRUCTURING THE
COUNCIL OF ACADEMIC SOCIETIES

Following the introduction of the motion, discussion shifted to the more fundamental question whether any change should take place to provide faculty participation. The interchange centered around three basis issues:

- 1) the question of representation based upon institutional executive responsibility versus some other form of "grass rootism";
- 2) at what point does the question of representation terminate; there are other groups in the academic health center who would request participation following the faculty;
- 3) the inexactness of the goals, and the contributions this group can make.

Other points raised included the fact that as the organization becomes more complex, it becomes more and more difficult to take definitive action positions; further, such a development would have implications for the administrative structure of individual medical centers. At this point, the previous motion and second were withdrawn.

No specific action by the Executive Committee was taken; however, Mr. Wilmot stated he would be guided by this group's discussion when he met with other members of the Executive Committee of the Executive Council.

Dr. Anlyan and Dr. Cooper left the meeting at 11:45 a.m.

VI. National House Staff Conference:

Dr. Knapp briefly reported on the National House Staff Conference held in St. Louis on March 18-21, 1971. A General Memorandum was mailed on March 22, 1971 to the COTH membership outlining the results of the Conference Workshop on House Staff Economics.

C) Dr. Bingham indicated that there had been, and continues to be, a great deal of interest within the Association, and elsewhere, in analyzing and describing medical service plans. Mr. Augustus Carroll had devoted a chapter in his book, Medical College Costs to the subject and more recently Mr. Clyde Hardy had completed some analysis on the subject.

Additionally, the American Medical Association, although not having faced directly the issue of medical service plans, does have a position on the reimbursement of medical school faculty.

The basic purpose of this study will be to examine as carefully as possible the various plans now in existence, or that are contemplated, and attempt to develop a series of models that can be applicable on a broad basis. Additionally, it may lead to a position statement which the Association can take on the subject.

V. Dr. Anlyan and Dr. Cooper joined the committee at 10:15 a.m. to discuss the participation of medical school faculty in the governance of the AAMC:

The committee was reminded that at the February 13, 1971 meeting of the AAMC Assembly the following resolution was adopted:

BE IT RESOLVED by the Assembly of the AAMC that there be an organization of the faculties of the member institutions represented in the governance of the Association. THEREFORE, the Assembly direct the Chairman and the President of the AAMC together with such other officers of the Association as the Chairman may designate, to meet with appropriate faculty representatives as well as the Executive Committees of COD, CAS, and the COTH to work out a proposed organizational arrangement for this purpose to be presented to the Executive Council at its next meeting and to be incorporated in ByLaw Revisions for presentation to the AAMC Assembly at the Annual Meeting in November, 1971.

It was stated that the resolution represents a degree of unrest, and the issue is thus being re-examined. Dr. Anlyan reported that two alternatives are seriously being considered:

1) The creation of an organization of faculty representatives (OFR) similar to the organization of student representatives (OSR) which would function as a subdivision of the Council of Deans;

2) The restructuring of the Council of Academic Societies into three divisions; academic societies, professional societies, and faculty representatives.

Two other alternatives - to take no action, or create a separate Council of Faculties - were in general felt to be inappropriate. Further,

it was reported that the Executive Committee of the Council of Academic Societies passed a motion urging the implementation of faculty participation. However, that Committee was unable to reach a consensus regarding how such action should best be accomplished.

Following brief discussion of the two alternatives, the following motion was made and seconded:

ACTION #1 : IT WAS MOVED AND SECONDED

 : THAT THE COTH EXECUTIVE COMMITTEE URGE

 : FACULTY PARTICIPATION IN THE AAMC BE

 : MADE ACCESSIBLE BY RESTRUCTURING THE

 : COUNCIL OF ACADEMIC SOCIETIES

Following the introduction of the motion, discussion shifted to the more fundamental question whether any change should take place to provide faculty participation. The interchange centered around three basis issues:

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- 2) at what point does the question of representation terminate; there are other groups in the academic health center who would request participation following the faculty;
- 3) the inexactness of the goals, and the contributions this group can make.

Other points raised included the fact that as the organization becomes more complex, it becomes more and more difficult to take definitive action positions; further, such a development would have implications for the administrative structure of individual medical centers. At this point, the previous motion and second were withdrawn.

No specific action by the Executive Committee was taken; however, Mr. Wilmot stated he would be guided by this group's discussion when he met with other members of the Executive Committee of the Executive Council.

Dr. Anlyan and Dr. Cooper left the meeting at 11:45 a.m.

VI. National House Staff Conference:

Dr. Knapp briefly reported on the National House Staff Conference held in St. Louis on March 18-21, 1971. A General Memorandum was mailed on March 22, 1971 to the COTH membership outlining the results of the Conference Workshop on House Staff Economics.

Task Force Reports were prepared on thirteen issues; copies of the entire Conference proceedings will be available from:

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

At the final plenary session of the Conference, a twenty man committee was appointed and charged with the responsibility of raising funds for another house staff conference within the next twelve months. The purpose of this next conference will be the formal establishment of a national house staff organization.

The staff was directed to keep current with future developments of this group, and requested that this matter appear on the agenda of the first meeting of the Committee on House Staff Relationships to the AAMC.

The Committee recessed for lunch at 12:05 p.m. During the recess for lunch Mr. Danielson briefly discussed recent developments with the Division of International Medical Education. There was a concensus by the Committee that COTH should become involved to the extent that time and funds allowed, but that this subject should not be given major priority.

VII . Corporate Responsibility for Graduate Medical Education:

Mr. Danielson reviewed the issue of graduate medical education as it has been discussed in the "Millis Report", the "Report of the Carnegie Commission" and the "AHA Report of the Perloff Committee". At this point a copy of a one page statement derived from the original document was distributed for view and comment. This statement represents the work of a committee of Drs. Thompson, Kinney and Parks which met with the staff on the previous day, April 13, 1971.

ACTION #2 IT WAS MOVED, SECONDED AND CARRIED THAT

THE COTH EXECUTIVE COMMITTEE ACCEPT THE

POLICY STATEMENT, DIRECT THE STAFF TO

PRESENT IT AT THE UPCOMING REGIONAL

MEETINGS, AND RECOMMEND THE FOLLOWING CHANGES:

- 1) Paragraph 2, sentence 1;
 - a) delete the word "corporate";
 - b) delete the phrase
"of the faculties";
- 2) Paragraph 3, sentence 1;
 - a) insert the word "academic" after "by"

(these changes have been made, and the most current version appears on the next page)

TO: Council of Deans
Council of Academic Societies
Council of Teaching Hospitals

The Ad Hoc Committee on Corporate Responsibility for Graduate Medical Education submitted a report to the Councils of the Association at the February 1971 meeting. It was recommended by the Executive Council that the title of the report be modified, indicating that the report was a study of the implications of corporate responsibility for graduate medical education rather than a policy statement. The Executive Council also requested that a brief policy statement be derived from the report and submitted to the Councils for study.

This policy statement was developed by the Committee listed below and is respectfully submitted for study by the Councils of the Association.

Thomas D. Kinney, M.D., Council of Academic Societies
John Parks, M.D., Council of Deans
David Thompson, M.D., Council of Teaching Hospitals
Mr. John M. Danielson, Staff
Marjorie P. Wilson, M.D., Staff
August G. Swanson, M.D., Staff

April 13, 1971

The modifications indicated either by ~~deletions~~ or by additions in *italics* were recommended by the COTH Administrative Board and the Executive Committee of the Executive Council.

April 15, 1971

The policy statement set forth below was derived from a report on the "Implications of Corporate Responsibility for Graduate Medical Education". That document should be used for guidance in the development of the assumption of responsibility for graduate medical education by academic medical centers.

POLICY STATEMENT ON THE
CORPORATE RESPONSIBILITY FOR
GRADUATE MEDICAL EDUCATION

The Association of American Medical Colleges endorses the concept that graduate medical education should become

a corporate responsibility of the faculties of the academic medical centers. Through this endorsement the Association urges the faculties of academic medical centers to develop in conjunction with their parent universities and their teaching hospitals, programmatic plans for taking responsibility for graduate medical education in a manner analogous to presently established procedures for undergraduate medical education.

Assumption of this responsibility by *academic* medical center faculties means that the entire faculty will establish mechanisms to: determine the general objectives and goals of its graduate programs and the nature of their teaching environment, review curricula and instructional plans for each specific program, arrange for evaluating graduate student progress periodically, and confirm student readiness to sit for examinations by appropriate specialty boards.

The Association encourages hospitals with extensive, multiple graduate education programs, which are not now affiliated with academic medical centers to develop their own internal procedures for student selection, specific program review and proficiency examinations. The accrediting agency is urged initially to accredit the entire graduate program of these hospitals. Ultimately, these institutions should either develop affiliations with degree-granting academic medical centers or seek academic recognition as free-standing graduate medical schools. Hospitals with limited graduate programs desiring to continue their educational endeavors, should seek affiliation with an accredited academic medical center.

The Association urges that the Liaison Committee on Medical Education, the Residency Review committees of the AMA and the several Specialty Boards continue their efforts toward developing procedures which will provide for accrediting an entire institution's graduate medical education program by one accrediting agency.

The Association further urges that the specialty boards continue to develop test instruments for measuring achievement of individual candidates that avoid superimposing rigid program requirements on the academic medical centers.

The development of graduate education curricula and instructional programs should take cognizance of appropriate financing for both the service and educational components of the graduate experience.

Concern was expressed by several members regarding the premature timing of the document if an accompanying statement outlining the proposal for implementation is not prepared. The experience of the position statement of the American Nurses Association with regard to baccalaureate nursing programs was recalled as an example. Mr. Danielson stated the staff is aware of this concern, but no specific action has yet been taken.

VIII. Report on VA-COTH Relationships:

Mr. Danielson reviewed the agenda of a retreat to be held by the VA-AAMC Liaison Committee to be held beginning May 26 through 28 at the Airlie House in Warrenton, Virginia. Mr. Gunter discussed the comparability of the problems of VA teaching hospitals with other private and public hospitals, and expressed satisfaction that the retreat would be a good beginning to a more effective relationship of the Association and the Council to the VA.

IX. Preliminary Budget Review and Possible Financing Problems - Organizational Changes:

Mr. Danielson indicated that the formation of the Division of Health Services is now actively being formulated. Dr. Robert Kalinowski has been recruited to serve as Director of that Division beginning July 1, 1971.

The development of this Division will require approximately \$60,000 in new funding, and Mr. Danielson stated that he hoped to generate a second \$60,000 to help support the Department of Planning and Policy Development and it's Division of Operational Studies.

In order to generate new funds, the problem of raising the dues from the present flat rate of \$700 per year for each institution was discussed. Given the present size of the Council (approximately 400 members), an increase of \$300 per institution would generate the \$120,000 necessary to meet program requirements.

After discussion, the following action was taken:

ACTION #3 IT WAS MOVED, SECONDED AND CARRIED THAT THE
STAFF PRESENT THE POSSIBILITY OF A \$300 YEARLY
INCREASE IN DUES AT THE REGIONAL MEETINGS, AND
THAT THIS ISSUE BE INCLUDED IN THE CHARGE TO
THE "TASK FORCE TO RECOMMEND GOALS AND OBJECTIVES
OF COTH", THE RESULTS OF WHICH ARE TO BE PRESENTED
AT THE ANNUAL MEETING IN OCTOBER.

X. Discussion of Annual Meeting - Regional Meetings; Committee Reports

Reports of the three recently appointed committees will serve as the basis for the annual meeting program. The Annual Meeting is scheduled to be held here in Washington, D.C. at the Washington Hilton Hotel (October 29 - November 1, 1971). The committees are as follows:

- 1) Committee on House Staff Relationships to the Hospital and the AAMC;
- 2) Task Force to Analyze the Higher Costs of Teaching Hospitals;
- 3) Task Force to Recommend Goals and Objectives for the Council of Teaching Hospitals as well as Future Criteria for Membership.

The Committee reviewed the committee appointments and asked the staff to be sure that no duplicate appointments occur. It was also requested that these committees begin meeting as soon as possible so that the reports will be ready for presentation at the Annual Meeting.

Mr. Danielson briefly reviewed the agenda for the regional meetings, and stated that judging from the postal card returns, attendance will most likely be higher than in previous years.

XI. Adjournment:

There being no further business, the meeting adjourned at 2:45 p.m. The next meeting of the Executive Committee will be held on Sunday, August 22, 1971 in Chicago. Additional details will be mailed two weeks prior to the meeting.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership
in the
Council of Teaching Hospitals

(Please type)

Hospital: The Stamford Hospital

<u>Stamford</u>	<u>Name</u>
<u>City</u>	<u>Shelburne Road and West Broad Street</u>
<u>Connecticut</u>	<u>Street</u>
<u>State</u>	<u>06902</u>
	<u>Zip Code</u>

Principle Administrative Officer: Mr. Edgar L. Geibel

Name
Executive Vice-President
Title

Date Hospital was Established 1896

Approved Internships:

<u>Type</u>	<u>Date Of Initial Approval</u> <u>by CME of AMA*</u>	<u>Total Internships</u> <u>Offered</u>	<u>Total Internships</u> <u>Filled</u>
Rotating	<u>1934</u>	<u>15</u>	<u>15</u>
Straight			

Approved Residencies:


<u>Specialties</u>	<u>Date Of Initial Approval</u> <u>by CME of AMA*</u>	<u>Total Residencies</u> <u>Offered</u>	<u>Total Residencies</u> <u>Filled</u>
Medicine	<u>October, 1966</u>	<u>8</u>	<u>8</u>
Surgery	<u>March, 1962</u>	<u>7</u>	<u>7</u>
OB-Gyn	<u>June, 1964</u>	<u>3</u>	<u>3</u>
Pediatrics	<u>--</u>		
Psychiatry	<u>--</u>		
Other Pathology	<u>July, 1949</u>	<u>3</u>	<u>3</u>

Information Submitted By:

Mr. Edgar L. Geibel
Name

July 30, 1971
Date

Executive Vice-President
Title of Hospital Chief Executive


Signature of Hospital Chief Executive

*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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ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership
in the
Council of Teaching Hospitals

(Please type)

Hospital: Saginaw Cooperative Hospitals, Inc.
Name
Saginaw 830 South Jefferson Avenue
City Street
Michigan 48601
State Zip Code

Principle Administrative Officer: Peter Ways, M.D.
Name
Director of Medical Education
Title

Date Hospital was Established 1968

Approved Internships: (Year ending June 30, 1971)

Type	Date of Initial Approval by CME of AMA*	Total Internships Offered	Total Internships Filled
Rotating	<u>1969</u>	<u>14</u>	<u>4</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>-</u>	<u>-</u>	<u>-</u>
Surgery	<u>1969</u>	<u>8</u>	<u>7</u>
OB-Gyn	<u>1970</u>	<u>6</u>	<u>3</u>
Pediatrics	<u>1969</u>	<u>2</u>	<u>2</u>
Psychiatry	<u>-</u>	<u>-</u>	<u>-</u>
Other			
Family Practice	<u>1970</u>	<u>18</u>	<u>7</u>
Pathology	<u>1969</u>	<u>4</u>	<u>0</u>

Information Submitted By:

Peter Ways, M.D.
Name *Peter Ways*

Director of Medical Education
Title of Hospital Chief Executive

July 23, 1971
Date

Signature of Hospital Chief Executive

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

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership
in the
Council of Teaching Hospitals

(Please type)

Hospital: Charles S. Wilson Memorial
Name

Johnson City 33-57 Harrison
City Street

New York 13790
State Zip Code

Principle Administrative Officer: Marion C. Stith
Name

Administrator
Title

Date Hospital was Established 1912

Approved Internships:

Type	Date Of Initial Approval by CME of AMA*	Total Internships Offered	Total Internships Filled
Rotating	<u>1940</u>	<u>14</u>	<u>10</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>1967</u>	<u>8</u>	<u>6</u>
Surgery	<u>1971</u>	<u>10</u>	<u>6</u>
OB-Gyn	<u>1940</u>	<u>3</u>	<u>2</u>
Pediatrics	<u></u>	<u></u>	<u></u>
Psychiatry	<u></u>	<u></u>	<u></u>
Other	<u>1948 Pathology</u>	<u>4</u>	<u>1</u>
	<u>1971 Family Practice</u>	<u>8</u>	<u>4</u>

Information Submitted By:

Eugene M. Wyso, M.D.
Name

Director of Medical Education
Title of Hospital Chief Executive

April 22, 1971
Date

Eugene M. Wyso
Signature of Hospital Chief Executive

*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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ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership
in the
Council of Teaching Hospitals

(Please type)

Hospital: Confederate Memorial Medical Center
Name
1541 Kings Highway
Street
Shreveport, / Louisiana 71103
City State Zip Code
Principal Administrative Officer: Edgar Galloway, M. D.
Name
Director
Title

Hospital Statistics: Date Hospital was Established: 1876 (formerly Shreveport Charity Hospital)
Average Daily Census: 494
Annual Outpatient Clinical Visits: 128,601

Approved Internships:

Type	Date Of Initial Approval by CME of AMA*	Total Internships Offered	Total Internships Filled
Rotating	<u>1932</u>	<u>37</u>	<u>32</u>
Mixed			
Straight	<u>Ped.2-1968;Med.3-1970</u>	<u>5</u>	<u>1</u>
	<u>Oral Surgery</u>	<u>2</u>	<u>2</u>
		<u>44</u>	<u>35</u>

Approved Residencies:

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total Residencies Filled
Medicine	<u>1946</u>	<u>12</u>	<u>9</u>
Surgery	<u>1946</u>	<u>18</u>	<u>18</u>
OB-Gyn	<u>1946</u>	<u>9</u>	<u>7</u>
Pediatrics	<u>1946</u>	<u>6</u>	<u>4</u>
Psychiatry	<u>1966</u>	<u>9</u>	<u>3</u>

Information submitted by:

Edgar Galloway, M. D.
~~Edgar Galloway, M.D.~~
April 28, 1971
Date

Director, Confederate Memorial Medical Center
Title
Edgar Galloway, M.D.
Signature

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

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership
in the
Council of Teaching Hospitals

(Please type)

Hospital: The Milton S. Hershey Medical Center Teaching Hospital
Name
Hershey 500 University Drive
City Street
Pennsylvania 17033
State Zip Code

Principle Administrative Officer: John A. Russell
Name
Hospital Administrator
Title

Date Hospital was Established Opened for patient care October 14, 1970

Approved Internships:

Type	Date Of Initial Approval by CME of AMA*	Total Internships Offered	Total Internships Filled
Rotating	<u>August 25, 1970 (Surgery)</u>	<u>5</u>	<u>3</u>
Straight	<u>March 18, 1971 (Medicine)</u>	<u>9</u>	<u>8</u>

Approved Residencies:

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total Residencies Filled
Medicine	<u>March 18, 1971</u>	<u>18</u>	<u>4 + 1 in Family Med.</u>
Surgery	<u>August 6, 1970</u>	<u>12</u>	<u>5</u>
OB-Gyn	<u>Awaiting approval</u>	<u>8</u>	<u>1</u>
Pediatrics	<u>Awaiting approval</u>	<u>6</u>	
Psychiatry			
Other Family Practice	<u>Feb. 25, 1971</u>	<u>9</u>	
Pathology		<u>3</u>	<u>2</u>
Urology	<u>Awaiting approval</u>		

Information Submitted By:

John A. Russell
Name

Hospital Administrator
Title of Hospital Chief Executive

May 6, 1971
Date

John A. Russell
Signature of Hospital Chief Executive

*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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NOTE: Our hospital opened Oct. 14, 1970, therefore programs are not in full operation.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership
in the
Council of Teaching Hospitals

(Please type)

Hospital: Mobile General Hospital
Name
2451 Fillingim Street
City Street
Mobile, Alabama 36617
State Zip Code

Principle Administrative Officer: Winston C. Whitfield
Name
Administrator
Title

Date Hospital was Established 1830

Approved Internships:	Date Of Initial Approval by CME of AMA*	July 1, 1971	July 1, 1971
		Total Internships Offered	Total Internships Filled
Rotating	<u>Prior to 1914</u>	<u>15</u>	<u>12</u>
Straight	<u></u>	<u>0</u>	<u>0</u>

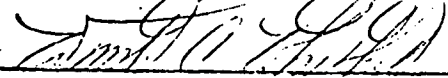
Approved Residencies:	Date Of Initial Approval by CME of AMA*	July 1, 1971	July 1, 1971
		Total Residencies Offered	Total Residencies Filled
Medicine	<u>Prior to 1950</u>	<u>6</u>	<u>5</u>
Surgery	<u>Prior to 1950</u>	<u>13</u>	<u>11</u>
OB-Gyn	<u>1960</u>	<u>6</u>	<u>6</u>
Pediatrics	<u>Prior to 1950</u>	<u>4</u>	<u>2</u>
Psychiatry	<u></u>	<u>0</u>	<u>0</u>
Other	<u>Orthopedics 1963</u>	<u>4</u>	<u>3</u>
	<u>Pathology 1952</u>	<u>2</u>	<u>0</u>

Information Submitted By:

Winston C. Whitfield
Name

May 4, 1971
Date

Administrator
Title of Hospital Chief Executive


Signature of Hospital Chief Executive

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

THE UNIVERSITY OF TEXAS
SOUTHWESTERN
MEDICAL SCHOOL AT DALLAS

OFFICE OF THE DEAN

5923 HARRY HINES BLVD.
DALLAS, TEXAS 75235

May 20, 1970

Mr. John M. Danielson
Director, Department of Health
Services and Teaching Hospitals
Association of American Medical Colleges
One Dupont Circle
Washington, D. C. 20036


Dear John:

Attached is an application from the Presbyterian Hospital of Dallas for membership in the Council of Teaching Hospitals. I am very pleased to nominate them for membership as I anticipate we will have an increasingly important relationship with this institution.

While the hospital is relatively new, they have made rapid progress, and I anticipate that in the future it will be one of our principal affiliated institutions.

With kind regards.

Sincerely,


Charles C. Sprague, M.D.
Dean

CCS/s

Enclosure

cc: Mr. Rod Bell - Presbyterian Hospital

July 14, 1971

Charles C. Sprague, M.D.
Dean
The University of Texas
Southwestern
Medical School at Dallas
5323 Harry Hines Boulevard
Dallas, Texas 75235

Dear Charles:

I apologize for the communications problems concerning the application of the Presbyterian Hospital of Dallas for membership in the Council of Teaching Hospitals. The application was received on May 25 and circulated at that time to the COTH Executive Committee, which also serves as the selection committee. At the September 12 meeting of the Executive Committee the application was not approved for membership. Inadvertently, this decision was not communicated to you or Mr. Bell.

In view of our conversation yesterday, I plan to place the application before the Executive Committee once again at the August 22, 1971 meeting in Chicago. I hope this is satisfactory.

Cordially,

JOHN M. DANIELSON
Director
Department of Health Services
and Teaching Hospitals

cc: Roderic Bell
Administrator
Presbyterian Hospital of Dallas

JMD/plf

THE UNIVERSITY OF TEXAS
SOUTHWESTERN
MEDICAL SCHOOL AT DALLAS

Office of the Dean

5323 Harry Hines Blvd.
Dallas, Texas 75235

July 20, 1971

Mr. John M. Danielson
Association of American Medical Colleges
Council of Teaching Hospitals
One DuPont Circle, N.W.
Washington, D.C. 20036

Dear John:

Many thanks for your letter of July 14 concerning the application of Presbyterian Hospital for membership in the Council of Teaching Hospitals.

Inasmuch as you plan to place the application before the executive committee again at the August 22, 1971 meeting in Chicago, I presume that you are going to ask that an exception be made in the case of Presbyterian because they do not have their required number of graduate programs to qualify for a membership according to the existing rules of the Council. That was my interpretation of our conversation in Washington last week when we discussed this matter. As I told you at that time, we do have an affiliation with Presbyterian, and are expanding appreciably our programs at that institution. It would be very helpful to them, as well as to us, if they become members of the Council.

I'm most appreciative of your efforts and hope that we can arrange to have you down some time in the fall as we discussed recently.

Sincerely,



Charles C. Sprague, M.D.
Dean

CCS:jn

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership
in the
Council of Teaching Hospitals

(Please type)

Hospital: Presbyterian Hospital of Dallas
 Name
Dallas 8400 Walnut Hill Lane
 City Street
Texas 75231
 State Zip Code

Principle Administrative Officer: Roderic M. Bell
 Name
Administrator
 Title
 Date Hospital was Established May 2, 1966

Approved Internships:

Type	Date Of Initial Approval by CME of AMA*	Total Internships Offered	Total Internships Filled
Rotating	AMA Nov. 12, 1968	12	0
Straight			

Approved Residencies:

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total Residencies Filled
Medicine	<u>Presbyterian Hospital is an affiliated teaching hospital with</u>		
Surgery	<u>The University of Texas Southwestern Medical School, Dallas, Texas</u>		
OB-Gyn	<u>Residency Programs are affiliated with Southwestern</u>		
Pediatrics	<u>Medical School</u>		
Psychiatry			
Other			

Information Submitted By:

Roderic M. Bell
 Name
May 11, 1970
 Date

Administrator
 Title of Hospital Chief Executive
Roderic M. Bell
 Signature of Hospital Chief Executive

*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, One Dupont Circle, N.W., Washington, D.C. 20036, retaining the Blue Copy for your files.

Membership in the Council of Teaching Hospitals:

Teaching Hospital members shall be organizations operated exclusively for educational, scientific, or charitable purposes. Hospitals as institutions will be members of the Council and each institution will be represented by a person designated by the hospital for the purpose of voting at business meetings of the Council. All members will vote at the Annual Meeting for officers and members of the Executive Committee.

Membership to the Council will be determined by the following criteria:

- a. those hospitals nominated by a medical school Institutional Member or Provisional Institutional Member of the AAMC from among the major Teaching Hospitals affiliated with the Members and elected by the Council of Teaching Hospitals, or
- b. teaching hospitals which have approved internship programs and full, approved residencies in at least 4 recognized specialties including 2 of the following: Medicine, Surgery, Obstetrics-Gynecology, Pediatrics, and Psychiatry, and are elected by the Council of Teaching Hospitals

The voting rights of the Council of Teaching Hospitals in the Assembly of the AAMC shall be as follows: The Council of Teaching Hospitals shall designate 10 percent of its members, up to a maximum of 35, each of whom shall have 1 vote in the Assembly.

If nominated by a School of Medicine, complete the following:

Name of School of Medicine The University of Texas Southwestern Medical School

Name of Dean Charles C. Sprague, M.D.

Address of School of Medicine 5323 Harry Hines Boulevard

Dallas, Texas 75235

FOR COFH OFFICE USE ONLY

Date _____ Approved _____ Disapproved _____ Pending _____

Remarks _____

Invoiced _____ Remittance Received _____



CALIFORNIA COLLEGE OF MEDICINE
OFFICE OF THE DEAN

IRVINE, CALIFORNIA 92664

July 16, 1971

Mr. John M. Danielson
Director
Council of Teaching Hospitals and
Health Services
Association of American Medical Colleges
One Dupont Circle
Washington, D. C. 20036


Dear Mr. Danielson:

This is a note to formally ask the best way to fit the new Hospital Administrator, Mr. William Schmidt, into the activities of the Council on Teaching Hospitals.

As you know, our University teaching hospital is in the planning stage with architects appointed and general design underway. It is to be on the campus and directly associated with the College of Medicine so there is no doubt that he will be the Administrator of our major teaching hospital. I do not know what memberships you have for an Administrator at this particular stage of his hospital's development. I would like very much to nominate him for whatever membership or involvement is appropriate. If you do not have a specific category, I would appreciate it if you could make it possible for him to be involved with as much activity as is consistent with your bylaws and regulations.

It was pleasant to see you the other evening after your whirlwind trip to the West Coast. I hope you had a good trip back.

Cordial personal regards,


Warren L. Bostick, M. D.
Dean

WLB:dag

July 21, 1971

Warren L. Bostick, M.D.
Dean
University of California, Irvine
California College of Medicine
Irvine, California 92664

Dear Warren:

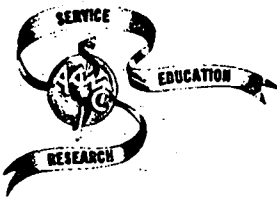
In response to your July 16 letter concerning the involvement of William Schmidt in the activities of the Council of Teaching Hospitals I shall place his name on our complimentary mailing list. This means he will receive the COTH REPORT, special publication and memoranda mailings, and announcements of regional and other meetings. As you know the COTH meetings are open and he would be free to attend. Please send me the address he'll be using and I'll get this done immediately.

Secondly, I'm taking the liberty of placing your letter on our Executive Committee agenda for its August 22 meeting. This Committee also serves as the selection committee. On occasion, it has been agreed that a particular teaching hospital under construction is eligible for membership. If membership is forthcoming, the normal dues of \$700.00 per year would be in effect. I'll pursue this unless I hear otherwise from you.

Cordially,

JOHN M. DANIELSON
Director
Department of Health
and Teaching Hospitals

JMD:car



ASSOCIATION OF AMERICAN MEDICAL COLLEGES

INTER-OFFICE MEMO

DATE August 2, 1971

Retain - 6 mos.	<input type="checkbox"/>
1 yr.	<input type="checkbox"/>
5 yrs.	<input type="checkbox"/>
_____	<input type="checkbox"/>
Permanently Follow-up Date	<input type="checkbox"/>

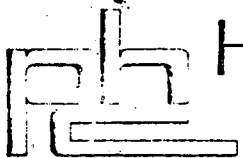
TO: John Danielson

FROM: Dick Knapp

SUBJECT: COTH membership for Bataan Memorial and Presbyterian hospitals in Albuquerque, New Mexico

- 1) Presbyterian is not listed in the AMA Directory of Approved Internships and Residencies
- 2) Bataan offers a total of 26 residency positions in five programs: Surgery, Medicine, Pathology, Pediatrics and Radiology. Twelve of these positions were filled in 1968, five with foreign trained students.

COPIES TO:

 PRESBYTERIAN
HOSPITAL
CENTER

SERVICE THROUGH EXCELLENCE

ANNA KASEMAN HOSPITAL

PRESBYTERIAN HOSPITAL

11000 1st Avenue, S.E.

Albany, Oregon 97321, Oregon U.S.A.

503-241-9111

RAY WOODHAM, Executive Director

April 27, 1971

Mr. John M. Danielson, Director
Department of Health Services and
Teaching Hospitals
Association of American Medical Colleges
One Dupont Circle, N.W.
Washington, D. C. 20036

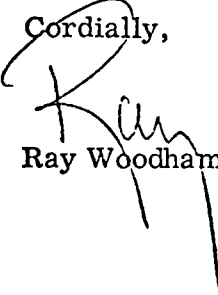
Dear Danny:

Attached is a copy of a letter from Bob Stone to you concerning our possible membership in the Council of Teaching Hospitals.

If there is any way you can give us consideration for membership, I would be most grateful:

Best wishes.

Cordially,


Ray Woodham



THE UNIVERSITY OF NEW MEXICO □ ALBUQUERQUE, NEW MEXICO 87106

OFFICE OF THE DEAN □ SCHOOL OF MEDICINE

915 S.W. FORD DR., N.E. □ TELEPHONE 505: 277-2321

April 20, 1971

Mr. John M. Danielson, Director
Department of Health Services and
Teaching Hospitals
Association of American Medical Colleges
One Dupont Circle, N. W.
Washington, D. C. 20036

Dear John,

As this medical school continues its development and as the faculty of the School, together with the physicians in the community, gradually evolve a modus vivendi, it is clear to me at least that there will be a much closer relationship between the School and the community hospitals. In particular, two of the hospitals in Albuquerque, the Bataan Memorial Hospital and the Presbyterian Hospital, have begun to accommodate both undergraduate medical instruction programs and graduate training programs.

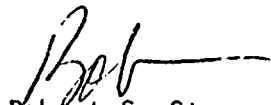
I believe that the administrators of those hospitals, Mr. H. Mikkel Kelly and Mr. Richard R. Barr, would enjoy becoming more closely associated with the health education system and I propose that invitations to join the Council of Teaching Hospitals be tendered to both institutions through their respective administrators. Although at the present time, the medical education programs at the Presbyterian Hospital fall quantitatively below that required for membership in the Council of Teaching Hospitals, I am confident that our associations are going to be strengthened in the near future and, in fact, would view membership in the COTH as facilitating that outcome. With respect to Bataan Hospital, for some time that institution has had graduate training programs of a scope which would qualify it for membership. More recently, there is developing a gradual affiliation for integration of those programs with the ones established under the sponsorship of the School at Bernalillo County Medical Center and the Albuquerque Veterans Administration Hospital.

If I can supply additional information which will assist consideration of these nominations, I would be pleased to do so. It is appropriate, I

April 20, 1971
Mr. John M. Danielson
Page 2

presume that you will communicate with the administrators of the two hospitals and offer them each an opportunity to consider membership. Thank you for your consideration.

Yours truly,



Robert S. Stone, M. D.
Dean

RSS:bb

CC: Mr. Barr
Mr. Kelly

June 15, 1971

Robert S. Stone, M.D.
Dean
The University of New Mexico
School of Medicine
915 Stanford Drive, N.E.
Albuquerque, New Mexico 87106

Dear Bob:

Please excuse the belated answer to your query concerning the possible COTH membership of Bataan Memorial Hospital and Presbyterian Hospital.

As of now, Bataan Memorial Hospital clearly qualifies, whereas Presbyterian does not meet the criteria for membership.

As you know we are in the process of reviewing the criteria for membership and I hope we will develop a category that those hospitals that relate to programs of the medical school will be eligible.

Meanwhile would you write an official request that these two hospitals be offered membership so that the Executive Committee can act on this matter as soon as possible.

Cordially,

JOHN M. DANIELSON
Director
Department of Health Services
and Teaching Hospitals

JJD:car

*Krueger
Matter for
at Ten
comm. info
4/1/71*

UNM

THE UNIVERSITY OF NEW MEXICO □ ALBUQUERQUE, NEW MEXICO 87106
OFFICE OF THE DEAN □ SCHOOL OF MEDICINE
915 STANFORD DR., N.E. □ TELEPHONE 505: 277-2321

July 29, 1971

Mr. John M. Danielson, Director
Department of Health Services
and Teaching Hospitals
Council of Teaching Hospitals
Association of American Medical Colleges
One Dupont Circle, N. W.
Washington, D. C. 20036

Dear John,

Consistent with the brief exchange of correspondence we have had, and your letter to me of June 15, 1971, I am pleased to formally request that the Executive Committee of the Council of Teaching Hospitals offer membership to the Bataan Memorial Hospital and the Presbyterian Hospital, both of Albuquerque. For purposes of communication the names and addresses of the administrators of the two institutions are as follows:

Mr. H. Mikkel Kelly
Executive Vice President
Bataan Memorial Hospital
5400 Gibson Boulevard, S. E.
Albuquerque, New Mexico 87108

Mr. Richard R. Barr
Administrator
Presbyterian Hospital Center
1100 Central Avenue, S. E.
Albuquerque, New Mexico 87106

I believe that the development of Health Science Education Programs, both in collaboration with the School of Medicine and autonomously in both of those Hospitals, would be greatly strengthened if the Institutions participated in, and had access to, the resources of the Council of Teaching Hospitals. Both of the Hospitals are respected locally, and I believe nationally, for the quality of their administration and the highly ethical professional standards which they maintain. In both instances, I believe that the involvement of the Hospital in educational programs should be viewed not only historically, but prospectively, as well. Consideration of intentions for future development and high potential are, perhaps, particularly significant in this area where the participation by a School of Medicine is still relatively new.

The sympathetic and, hopefully, favorable consideration by the Executive Committee will be greatly appreciated.

Sincerely,



Robert S. Stone, M. D.
Dean

RSS:sc

STATUS REPORT ON MEMBERSHIP

Present COTH Membership:

398

Institutions Which Have Dropped In
The Fiscal Year Beginning July 1, 1970:

Mobile General Hospital
Mobile, Alabama

St. Vincent's Hospital
Jacksonville, Florida

Lincoln Hospital
Bronx, New York

Institutions Which Have Dropped In
The Fiscal Year Beginning July 1, 1971:

Queens Hospital Center
Jamaica, N.Y.

St. Luke's Hospital of
Bethlehem, Pennsylvania

St. Vincent's Hospital &
Medical Center of N.Y.

National Children's Cardiac
Hospital, Miami, Florida

Mount Carmel Mercy Hospital
Detroit, Michigan

Maimonides Medical Center
Brooklyn, N.Y.

The Harrisburg Polyclinic
Hospital, Harrisburg, Pa.

Fitzsimons General Hospital
Denver, Colorado

Buffalo General Hospital
Buffalo, N.Y.

Brooke General Hospital
Fort Sam Houston, Texas

Sisters of Charity Hospital
Buffalo, N.Y.

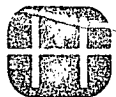
William Beaumont General
Hospital, El Paso, Texas

Dues Outstanding from Fiscal Year 1970-71:

Jersey City Medical Center
Jersey City, N.J.

Dues Outstanding from Fiscal Year 1971-72:

66 institutions (332 paid)



HARPER HOSPITAL

July 13, 1971

Mr. John M. Danielson
Director
Council of Teaching Hospitals
One Dupont Circle, N.W.
Washington, D. C. 20036

Dear John

The Deans of the Medical Schools in Michigan meet periodically. This morning one of them called me to tell me of some discussions they are having concerning variable terminal dates for medical school graduates. There is some talk, for example, that one of the Michigan Medical Schools may set March as a finishing date for its graduating class. I understand that conversations along this line are occurring in other parts of the country.

He is under the impression that the Council of Deans of the AAMC has this matter in its hopper for discussion. He has asked me to institute discussions in the Council of Teaching Hospitals, and I have assured him that we will get it on our agenda as rapidly as possible.

The problem so far as the teaching hospitals is concerned will revolve around the starting date for the internship--or as it is now known, the "first year of post-graduate training."

My snap opinion to him was it probably would make very little difference to the average teaching hospital, but that the effect on the National Intern and Resident Matching Plan might be complicated.

Would there be room on our agenda for the meeting of COIH on August 22 in Chicago? You might also have more knowledge about what the Council of Deans is talking about.

Sincerely

George E. Cartmill
President

GEC:bjm

PROPOSED ENDORSEMENT OF
THE REPORT OF THE NATIONAL COMMISSION FOR THE STUDY OF
NURSING AND NURSING EDUCATION

The Administrative Board of the Council of Teaching Hospitals endorses the major recommendations of the report of the National Commission for the Study of Nursing and Nursing Education. While this endorsement encompasses the fifteen recommendations in the report, the Board wishes to emphasize two of these recommendations which it believes require particular attention:

- 1) #1-The Federal Division of Nursing, The National Center for Health Services Research and Development, other governmental agencies, and private foundations appropriate grant funds or research contracts to investigate the impact of nursing practice on the quality, effectiveness, and economy of health care.
- 2) #5-A national Joint Commission, with state counterpart committees, be established between Medicine and Nursing to discuss and make recommendations concerning the congruent roles of the physician and the nurse in providing quality health care, with particular attention to: the rise of the nurse clinician; the introduction of the physician's assistant; the increased activity of other professions and para-professions in areas long assumed to be the concern solely of the physician and/or the nurse.

The Board commends the Commission for its intensive investigation, and believes the report merits the attention of the educational community as well as those individuals and groups engaged in the provision of health services.

VETERANS ADMINISTRATION SHARING TASK FORCE

Joe S. Greathouse, Jr., *Chairman*
Director
Vanderbilt University Hospital
1116 21st Avenue, South
Nashville, Tennessee 37203

Clyde G. Cox
Director
Veterans Administration Hospital
619 South 19th Street
Birmingham, Alabama 35233

Kenneth J. O'Brien
Director
Veterans Administration Hospital
North Little Rock Division
Little Rock, Arkansas 72206

Hugh R. Vickerstaff, M.D.
Hospital Director
Veterans Administration Hospital
1310 24th Avenue, South
Nashville, Tennessee 37203

James T. Varnun
Superintendent
University of Wisconsin Hospitals
1300 University Avenue
Madison, Wisconsin 53706

John Reinertsen
Administrator
University Hospital
University of Utah
50 N. Medical Drive
Salt Lake City, Utah 84112

DRAFT
7/26/71

MINUTES OF AAMC/VA LIAISON COMMITTEE MEETING
AIRLIE HOUSE, WARRENTON, VIRGINIA

May 26, 1971 to May 28, 1971

Present:

VETERANS ADMINISTRATION

Marc J. Musser, M.D.
John D. Chase, M.D.
Laurence Foye, M.D.
Lyndon E. Lee, M.D.
A. Wendell Musser, M.D.
James A. Pittman, M.D.
Daniel Rosen
Edward M. Friedlander
Elliott Wells
Marlin Bowers

OFFICE OF MANPOWER & BUDGET

James D. Tschirgi

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COMMITTEE MEMBERS

William G. Anlyan, M.D.
John A.D. Cooper, M.D.
Richard V. Ebert, M.D.
S. Richardson Hill, Jr., M.D.
Sherman M. Mellinkoff, M.D.
Russell A. Nelson, M.D.
John C. Rose, M.D.
John M. Stagl
Randolph Batson, M.D.

STAFF

John M. Danielson
Joseph S. Murtaugh
August S. Swanson, M.D.
Marjorie P. Wilson, M.D.
Fletcher H. Bingham, Ph.D.

Dr. Musser opened the meeting with a discussion of the philosophy and goals of the Veterans Administration as developed in a paper in preparation by SMAG. The paper is included as Appendix A of these minutes. It explores the role of the VA medical care system in extension of services to include comprehensive care (including ambulatory care) to veterans and their dependents.

Dr. Anlyan discussed V.A. - medical school relations from the vantage point of the academic medical centers and the AAMC. He made the following major points:

- (1) The national pattern that has developed for the provision of health services had concentrated on the compartmentalization of the provision of these services and the academic medical center is responsible for the manpower training for each of these compartments.
- (2) There is unevenness in accessibility and quality of health care.
- (3) The VA medical system has a focus on central control and planning. The academic medical center must deal with a multicompartment system with more focus on local contract and planning.
- (4) The mission of the academic medical center is thwarted both in the service and educational programs by the restriction of appropriate financial support. Primary

care is a low priority while secondary and tertiary care excell, which tends to skew the service objectives.

- (5) Although the medical school-V.A. relationship continues to be substantially good, it appears that the V.A. has plateaued while the other members of the academic medical center have advanced the quality and quantity of health care. Inherent in this were problems at the supra-V.A. level. Financial judgments made by the OMB and the White House seem to preempt local options while at the same time suffering from the weaknesses that result from remote decisions. Higher level policies made within the V.A. system itself and the need for development of a definite system involving all levels of health care within the V.A. need coordination.
- (6) Another level of problems involves the direct, local interface between institutions, specifically in terms of extension of the contract mechanism, greater sharing of programs and facilities, as well as appropriate staff quality and compensation. The costs inherent in this relationship would be negotiated and shared between both parties.

Dr. Musser agreed that one of the outcomes of this meeting should be some agreement on how V.A. hospitals and medical schools at the local levels can come to grips with common long and short range planning.

GENERAL DISCUSSION

THE VETERANS ADMINISTRATION

Recruitment and Retention of High Quality Professional Staff

Dr. Chase indicated that last year the V.A. had interviewed a larger number of candidates of higher quality. He noted that pathology, radiology, anesthesiology and the surgical subspecialties continue to be scarce categories.

The overall turnover of physicians in all categories remain constant at about 10%. The reasons for leaving the V.A. are: salary level, undesirable working environment, lack of job satisfaction and location.

Possible corrections suggested were:

- (a) increase in "7/8" time appointments;
- (b) development of uniform policies in collaboration with AAMC;
- (c) more rapid promotion;
- (d) improve salaries.

Dr. Mellinkoff cited the relationship between the UCLA School of Medicine and Harborview Hospital, a county institution. A fund is provided to the university to be used as required for adding personnel, salary supplementation, purchase of equipment, research support, etc. The question was raised about whether a similar allocation of funds could be made to a Deans Committee. He felt that this would allow the necessary flexibility at the local level. Dr. Musser agreed to review the UCLA-Harborview affiliation contract as a possible model.

Dr. Cooper and others stressed that the situation and relationships between medical schools and V.A. hospitals is not the same as that when Policy Memorandum No. 2 was developed. The various institutions making up the academic medical center cannot operate with the independence that was possible when they were concerned largely with primary and secondary care. The demands for highly trained personnel and expensive equipment and facilities in the delivery of complex tertiary care requires maximal coordination and sharing among the components of the centers. It is not rational on either an economic or professional basis to duplicate these efforts.

The new situation requires more flexibility by the V.A. at the local level permitting better integration of their programs into the overall activities of the academic medical centers, within national policies and priorities established by the central office. Dr. Musser discussed the program of regionalization being introduced by the V.A. and suggested the medical schools might be in position to provide professional services for such regions. If medical schools were willing to undertake such a responsibility there is a possibility of providing grants over and above the normal payments for services.

Drs. Nelson and Anlyan suggested the possibility of exploring the development of institutional contracts or grants for the provision of medical services in V.A. hospitals by medical schools. An example of such contract services might be in the area of professional care to a targeted population with the V.A. physicians acting as a group practice. The medical school might be of significant assistance in

such an experiment (i.e. Johns Hopkins and Columbia Project). Dr. Musser indicated that the V.A. does not have such authority except in limited amounts for such programs as the exchange of medical information.

Program Development for Quality Primary, Secondary and Tertiary Care

The committee reviewed the mechanism for the determination of sites for various special medical programs in special care centers, open heart, drug abuse, renal dialysis, etc. It was suggested that it might be feasible for the V.A. in combination with the AAMC, to establish an advisory committee to review local proposals for the development of special medical programs. The present function of the Dean's Committee in regard to these programs was questioned. It was noted that the way the money flows for establishing special programs causes the V.A. to deal with individuals within the academic medical center rather than the totality of the medical center.

There was a general discussion of the future role of the V.A. system. It was suggested that the V.A. should not develop a total direct care program for veterans. It should concentrate on the special needs of the veteran while at the same time develop an interdependency with the academic medical center and the community hospital system with commitments from both sectors, in providing for general needs.

It was further suggested that we may need a "Carnegie Type" non-government, nonpolitical review on the relations of the V.A. medical

program to the academic medical centers and its involvement in the future health care delivery.

In summation, Dr. Musser noted that he believed five key issues had been developed in the discussion:

- (a) Broader planning at both the programmatic and operational levels within the academic medical center, and better communication between the V.A. central office and the medical schools in this regard.
- (b) An expansion of the sharing concept and broader use of V.A. resources with exploration of extending V.A. services to non-V.A. patients. The latter regard would require discussion with service organizations.
- (c) Exploration of new types of contractual arrangements.
- (d) Review of the present mechanisms for instituting special medical programs and consideration of establishing a national peer review body to determine appropriate sites.
- (e) Establishing an ad hoc committee to review contracts between V.A. and academic medical centers.

May 27, 1971

General Discussion--Organizational and Fundamental Relationships

of the Partners

Developing Maximum Benefits from the Partnership

Creating Administrative Ties Between V.A.

Teaching Hospitals and Academic Medical

Centers

Various problems relating to the development of closer ties between the local V.A. hospital and the medical school and possible solutions were discussed. Among useful devices suggested were appointing the V.A. Chief of Staff an assistant dean and a member of the dean's staff; permitting the university to play a more important role in the V.A. Chief of Staff and hospital director appointment; appointing the hospital director to the dean's executive committee, involving the V.A. in planning activities of the center and in delivering overall programmatic and operational priorities.

Discussion then focused on the function of the dean's committee. Dr. Musser noted that there is no uniformity in the way these operate and the responsibility they assume. Yet, there is clearly a need for greater assumption of responsibility by some coordinating committee at the local level. A confidential incomplete draft document entitled "A Guide for Veterans Administration - Medical School Affiliation" was distributed, and it was noted that one section of the "Guide" dealt with the "Functions of the Dean's Committee." There was general

agreement that the functions of the Dean's Committee, or its equivalent should be expanded.

Dr. Musser then recommended that if the Liaison Committee approved the items contained in "A Guide for Veterans Administration-Medical School Affiliations" than an Ad Hoc Committee be formed to put it in final form after which it would be widely circulated. There was unanimous agreement to this proposal.

Research Facilities and Resources

Discussion centered on the policy revision relating to Part I (Project Grants) and Part II (Institutional Grants). Dr. Musser explained that the V.A. research program was designed to create a more scientific environment for delivery of patient care and to attract a competent full-time staff. He indicated that it was the V.A.'s belief that funds should be equally divided between project support and institutional support at each station. He reported that the V.A. was moving toward decentralization of the Project peer review mechanism with more delegation of responsibility for recommending awards to the local level. A national review of the programs would be made to assure that the programs were of good quality. Allocation of funds by central office would be based on these retrospective and prospective reviews. He also noted that certain established programs (animal surgery, nuclear medicine) that had been considered as research activities are being transferred to

the patient care budget. Dr. Cooper indicated that the AAMC would testify for an increase in V.A. research budget above the \$62 million contained in the administration's recommendation.

New Ground Rules for Salary Supplementation

Mr. Rosen indicated that the new policy was one year old and provided certain data on the experience over that period of time. It was also noted that there are plans to resubmit the policy to General Council for review particularly with regard to the need for timecards and other issues dealing with the tour of duty. It was also indicated that the problem of V.A. physicians receiving Medicare payments may have been eliminated by the SSA general counsel ruling that SSA actually pays the beneficiary and the beneficiary assign the payment to the physician. Thus there is not a direct Federal payment to the physician.

Differentiation between V.A. Teaching Hospitals and Nonteaching Hospitals in Policy and Budget

Dr. Chase indicated that while the majority of affiliations between V.A. hospitals and medical schools had progressed quite smoothly there were several that had presented certain problems. He indicated further that there was a need for a review by some neutral party of these various arrangements.

Dr. Mellinkoff suggested and the other members of the Committee agreed, that the Liaison Committee should explore the possibility of establishing an informal body to review these various affiliation agreements. Dr. Chase suggested, and the Committee concurred that all affiliation arrangements be reviewed to determine why some are good and some bad and establish a peer review body which would have some normative values available to it.

Discussion continued on the varying patient care missions of the affiliated and nonaffiliated hospitals and the corresponding differential in funding. It was noted that a concern has become evident on the issue of maldistribution of services. The Carnegie Commission's recommendation for area health education centers was cited as one instance that will put a new light on the nonaffiliated hospitals which could mean an increased funding level for them. The program of regionalization of V.A. hospitals was discussed in an attempt to implement some of these proposals and Dr. Musser noted that this is being developed on a pilot basis.

House Resolution 464 introduced by Mr. Teague was discussed briefly. Dr. Musser indicated that the V.A. does not under any circumstances want to compromise the quality of medical education if new schools are established under the provisions of the resolution.

Cost of Facility Sharing with V.A. Hospitals

The many problems relating to legislative or regulatory policies on sharing the cost of facility construction between the V.A. and

and medical schools were discussed at length. This is an important aspect of the requirement for closer and more effective cooperation in overall academic medical center programs.

Dr. Anlyan noted the development of ambulatory care centers within academic medical centers. The interest of the V.A. now in expanding their programs of ambulatory care suggests that this is an important area to develop a program of joint capitalization for facilities.

Dr. Anlyan also suggested, and other members of the committee agreed that an appropriate ad hoc committee be formed to develop a checklist that constituents could use in future program and facility planning within the academic medical center. Included on the checklist would be potential opportunities for joint capitalization of programs and facilities.

Development of Cooperative Mechanisms for Creating National Policy
Between V.A. Central Office and the AAMC

It was noted that there are essentially two views on the V.A.-medical school relationships. On the one hand medical schools have a growing feeling that the V.A. hospital is not carrying its full share of the affiliation agreement. On the other hand, the V.A. does not feel it is getting the necessary support from the academic medical centers.

While at the national level the relationships between the V.A. and AAMC have become closer with enhancement by the Liaison Committee,

this has not developed at the local level. Drs. Anlyan and Cooper suggested a positive step that could be undertaken, on a pilot basis. The review of V.A.-medical school affiliation arrangements in the LCME accreditation program, particularly in those instances in which the affiliation is seriously threatened. Dr. Anlyan made some specific suggestions in this regard: (1) the identification by joint staffs of the data base needed prior to such visits; (2) include a V.A. staff member or someone with special competence in such affairs on accreditation visits on an experimental basis; and (3) work with centers in which there are problems with affiliations and recommend positive actions that could be taken to strengthen the relationships.

The committee discussed, at some length, various pieces of legislation that had been introduced that were of mutual interest to the Veterans Administration and medical schools. Among items of legislation discussed was H.R. 37, introduced by Mr. Teague which would permit the V.A. to:

- (a) provide hospitalization care for the dependents of certain veterans;
- (b) authorize broader contract possibilities for patient care;
- (c) provide a separate line item within the V.A. budget for training and education of health service personnel;
- (d) allow authority to establish regional medical programs within the V.A.; and
- (e) extension of outpatient care for certain veterans.

National Conference of Deans and V.A. Hospital Directors

There was unanimous agreement that a national meeting of deans and hospital directors should be organized to discuss issues that had been considered at this meeting. It was recommended that the AAMC and V.A. staffs should propose an agenda and recommend an appropriate time and place for such a meeting.

EXECUTIVE COMMITTEE DRAFT

THE POTENTIAL ROLE OF THE VETERANS ADMINISTRATION'S HEALTH CARE
SYSTEM IN MEETING THE HEALTH CARE NEEDS OF ALL THE PEOPLE

(A Report to the Administrator of the Veterans Administration
by the Special Medical Advisory Group of the Department of
Medicine and Surgery)

*This Draft was revised and approved by the Executive Committee
of the Special Medical Advisory Group meeting on April 27, 1971.
It is now being forwarded to the full membership of the Special
Medical Advisory Group for its review and approval. As indicated,
if such approval is given, it will then be forwarded as a Report
to the Administrator of the Veterans Administration.

Preface

At no time in modern history has there been a greater need for expanding and coordinating the existing elements of the health care system in America. The demands on this system have been created by a number of factors which can be expected to continue to increase for the foreseeable future. Included are. . .

- . Greater public expectations and demands for improved quality of care as a result of new knowledge and technical advances made possible by biomedical and social research in disease, health, and medical care.
- . The desire for maximum application to all the people of that knowledge for the maintenance of health, the prevention of disease, and the treatment of illness at reasonable cost.
- . Greater expectations for increased and more equitable availability of quality health care to all segments of the population.
- . Extension of existing voluntary and legislated pre-payment plans and the creation of new systems for purchasing health care for the entire population.
- . Increased amount and scope of social legislation.
- . Changing age distribution of population, with increasing numbers at both ends of the age spectrum.

- Ever-increasing need for continuing education of the health professions and the public for the appropriate and efficient utilization of health care knowledge and resources.

It is evident that the present and future health care needs of all the people cannot be met without improving the delivery systems. In view of this, it is inevitable that some form of national health care program will be adopted within the next few years to meet this need. This will further increase the demand on the system, and exert ever-increasing pressures on the existing resources and those that can be developed in the immediate future.

Although a variety of studies for meeting these health care needs have resulted in legislative proposals in the Congress, none yet appears to have achieved a critical mass of acceptance or coordinated support. At this point in time, no single proposal can be identified as acceptable to all of the organizations, institutions, socio-political forces or individuals involved in the nation's health care system as either deliverers or consumers.

A Health Care System

If all people are to receive the maximum benefits of our ever-increasing knowledge of health maintenance and disease, a health care system must be devised which will work in a coordinated manner.

By definition, a comprehensive health care system is a viable formal or informal dynamic, cooperative, cohesive, unified, and coordinated organization of health care agencies, facilities

and staff designed to render a full spectrum of health care ranging from primary prevention to extended care to all segments of a geographically defined population.

A creatively developed health care delivery system must meet certain professional and economic requirements.

These are as follows:

- . A functional integration of the health services and resources of any region and their effective utilization for the transmission and encouragement of new knowledge and techniques in order to provide high quality care, and make optimal use of all health manpower.
- . Comprehensive health care services available, accessible, and economically feasible for all U.S. citizens, with participation by the recipient in the financing of the service, depending on his ability to pay.
- . Maintenance of alternatives of the type of service and of the professional providing the service.
- . Maintenance of the quality of health services through peer review, continuing education and continuing professional evaluation of all health professionals.

Built-in tangible and scaled incentives for both professionals and institutions for effecting economy of operation.

Built-in mechanisms for production of necessary traditional and new types of health manpower and facilities, and for continuous evaluation and improvements in the system for health care delivery.

Built-in mechanisms for maintaining a steady progress in the state of the art and science of health through research.

Improved awareness by those who use the system of where and how services are available and assurance that they will be available and continue as long as needed.

Provision of health services by a method that enhances not only the dignity and self-respect of the individual, but which contributes to the total society of which he is a part.

There is need for vigorous leadership to accomplish these objectives.

Historical Framework of the Current Veterans Administration System

Some systems already exist as models for meeting some of these requirements. They have potential for improving the delivery of health care. One such system is that operated by the Department of Medicine and Surgery of the Veterans Administration.

The Veterans Administration's medical program is the largest health care system under centralized management in the United States today. Its antecedents can be traced to the first programs of

hospital and domiciliary care established by the Federal Government in national homes for disabled volunteer soldiers in 1865.

From that time until 1918, there were no essential changes in this elementary system, except that it was complemented by the legislatures of many of the States of the Union, and of the old Confederacy by the establishment of "Soldier's Homes" with associated hospital-type facilities.

Parenthetically, it should be noted that, except for the expansion of its institutions and their activities in gross terms, there were few significant changes in the non-veteran health care systems during this same period.

After World War I responding to the needs of a large number of returning veterans with service-connected disabilities, the Congress established a more organized and comprehensive Federal medical care system as its first effort to provide both in-and-out-patient care.

During the subsequent decades, further laws entitled veterans to receive care in Veterans Administration hospitals if they were not able to pay the cost of private care. This program required these veterans to declare themselves unable to pay for their own care.

Unfortunately, but quite naturally, the initial laws which established the Veterans Administration as a provider of health care, and subsequent extensions of those laws have resulted in anomalies in terms of today's practice of medicine and the system for delivery of care.

The fact is that entitlements to service are not in terms of groups of veterans, but in terms of disabilities. While a veteran with a service-connected condition could be given care on an inpatient or outpatient basis, a veteran with a non-service-connected condition could only be treated on an inpatient basis. Simply put, this meant that the applicant for care of a non-service connected condition not only had to have a condition sufficiently serious to require hospital care, but also had no legal right to pre- or post-hospital care. No provision was made for illnesses which can be prevented or stabilized outside the hospital in terms of preventive medicine or ambulatory care.

As time passed, the hospitals of the Veterans Administration became increasingly the entry point into that health care delivery system. This resulted in legislative and administrative accommodations to the aforementioned inconsistencies to ensure that the system remained workable and responsive to professional, social, and economic changes.

The developments and changes within the Veterans Administration system have been well documented.* The important events of the 1960's are of great significance to the issues and suggestions

1. Kracke, Roy E., M.D. Journal of the American Medical Association, August 12, 1950.
2. Armstrong, George E., M.D., Journal of the American Medical Association, October 3, 1959.
3. Hill, S. Richardson Jr., M.D. "Degrees of Freedom Open to New and Developing Medical Schools in the Utilization of Veterans Administration Hospitals" (Delivered to the panel on "Developing Medical Schools" at the 80th Annual Meeting of the Association of American Medical Colleges, Cincinnati, Ohio, November 2, 1969)
4. Lewis, Benjamin J., Ph.D. "VA Medical Program in Relation to Medical Schools" (House Committee Print No. 170, 91st Congress, 2nd Session) January 19, 1970.
The Journal of Medical Education, Vol 45, pp 564-570, August 1970 6.

contained in this report. In general, during that period certain legislation and its implementation made inroads toward correcting some of the anomalies referred to earlier, and to broadening entitlements to care within the Veterans Administration system. Specifically. . .

- . Pre-bed care and post-hospital care were authorized and utilized as an initial method for meeting the pressing need for out-patient services.
- . Nursing home care was established both as a service within Veterans Administration facilities and contracted for in community nursing homes.
- . A grant-in-aid program was authorized to provide assistance to states for construction of additional nursing homes for veterans' care.
- . Authority was established to provide for sharing of scarce medical resources and facilities between and among the Veterans Administration system and those of the private sector.
- . Authority was provided for the Department of Medicine and Surgery to engage in programs for exchange of medical information to provide a system for continuing education of physicians and other allied health professions.
- . Comprehensive care was authorized for veterans totally disabled as a result of service connected conditions.

- . The requirement, that veterans aged 65 or more certify their inability to defray the cost of hospital care for non-service connected conditions, was removed.

As the decade of the 1970's began, another legislative change was made which has had a significant effect on Veterans Administration medical practice. The Congress dropped the requirement that a certain minimum average daily census be maintained to preclude loss of appropriated dollars. This led to a sharp drop in the average length of patient stay and this trend has continued

Strength and Potential of the Current Veterans Administration Health Care System

The laws under which the Veterans Administration health care system operates limit its ability to provide many of those services and facilities that are recognized as essential to the new patterns of care. However, there are many strengths and potentials in the system that commend it as a model for the future

- . It is a system in being for some 25 years, and represents a Federal investment in excess of \$50 billion for operating funds and capitalization.
- . That system and a commitment to support it can be expected to continue as an integral part of the Federal government's responsibility to veterans.
- . As such, it is not only essentially a prepayment system, for an identified section of the population, but it is a functional system for the delivery of care to those who are so "insured".

The geographic locations of its facilities provide accessibility, through an excellent pattern for regionalization so that a facility is within 100 miles or a two hour drive from 90 percent of the 28 million veterans.

Its current plans for regionalization not only involve a potential for maximum use of existing facilities and professional manpower, but also provide a potential for a viable and expandable network of continuing education and collaborative research activities.

As already implemented, such regionalization permits both a minimum of expensive duplication and a maximum potential for integration with health facilities in the private sector.

This latter potential, made possible by the sharing law (P.L. 89-785), becomes even more promising in helping to alleviate the concern with increased quality and availability of care and the optimum use of health facilities and manpower in providing care to all the people.

The flexibility of the system has potential for various possibilities, including expansion of either the facilities and services, on the one hand, and/or the population served, on the other.

By its working affiliations with some 81 schools of medicine and with other professional *and* technical schools located in some 400 universities, colleges, and junior colleges, together with its own intramural educational activities, the Veterans Administration has one of the nation's largest educational and training capabilities for the development and interaction of health manpower. The autonomy and resources of the Veterans Administration system permit experiments and innovations in research and development in both health care and administration, and the immediate system-wide use of those results which have proved themselves. Its centralized administration permits cooperative purchasing and distribution techniques for supplies and equipment that result in sizable economies. Because of health information established during and following service in the armed forces of its target population, it has available to it a health data base of some 28 million individuals or one-eighth of the total population with, in many cases, similar information on members of their families. Its system for the delivery of health care provides the potential for the widest possible latitude in modes of patient care.

- . Its one-class service for all patients provides a model to help meet the current demand for equity and equality to match efficiency and economy in the total health care system.

Recommendations for Improvements of the Veterans Administration Health Care System

It is recognized that no health care system is, or perhaps ever should be, considered complete in all of its facilities, services or administration. However, there are certain specific activities that should be considered in changing and extending the current Veterans Administration health care program in order to build into that system improved service to its patients, and to realize a maximum of cost benefit consistent with its past investment and expected future commitment.

- . Extend comprehensive, ambulatory and preventive care limited initially to the dependents of veterans who died in service and those with total disabilities, so that the care of the veteran family can be enhanced.
- . Expand services to eligible veterans to include a full spectrum of comprehensive care with special emphasis on preventive medicine and maintenance of health through such services as periodic physical appraisal and multiphasic screening appropriate to age and risk groupings.
- . Develop further resources for ambulatory care and home services thereby conforming with new concepts

of health delivery. This provides for planning for continuity of services thereby changing the antiquated practice of in-hospital care for all but necessary cases, and its attendant evils of forced institutionalization and over-utilization of expensive hospital facilities.

Extend the contract arrangements of service for veterans health care to other established and developing resources to provide easier access to care.

Provide a progressive hospital care system based on the most economic and efficient use of facilities and personnel.

Encourage new, imaginative and innovative efforts by those already in the system through a new program of leaves for study and participation in activities and programs of professional societies.

Encourage the recruitment of new young health leaders from the graduating classes of professional schools of health and health care administration by providing opportunities, salaries, and advancement competitive with other segments of the health field.

Recommendations for Veterans Administration Contributions to the Expansion and Improvement of Health Care to All the People

The Veterans Administration health care system can be expected to remain an identifiable service for the foreseeable

future consistent with its legislated mandate and mission. However, there is a need to consider this system as it might relate to the probable development of some form of universal comprehensive health care.

If and when this occurs, in addition to sustaining the entitlement of veterans with service connected disabilities, it may become necessary to define entirely new criteria of eligibility for care of other veterans in Veterans Administration hospitals. It also becomes a possibility that certain types of services might be provided to larger numbers of broader categories including dependents of veterans and other non-veterans. There are any number of alternatives in this regard, and any one or combination of them could significantly change the composition of patients in Veterans Administration, university, public, private and community hospitals.

In any event, the potential of the Veterans Administration health care system will be essential in contributing to and participating with other components of the Nation's total health delivery system in order to meet the expanding national needs. To assure mutual benefits to both systems, and to the patients cared for by them, the Veterans Administration should consider the immediate expansion of some ongoing activities, the implementation of new activities and concepts, and in some cases combinations of both.

It is therefore suggested that the Veterans Administration health care system. . .

- . Develop and extend the on-going and suggested new approaches already listed which can be of benefit to the nation's health care delivery systems and to the people of the geographic areas in which Veterans Administration health facilities are now operating.
- . Extend mutual sharing of services that may be in short supply with other teaching and community hospitals and health facilities in the area.
- . Encourage and extend these relationships and services to include mutually beneficial working arrangements with those who actually deliver health care, including the extension of visiting and courtesy privileges to physicians who care for veterans on a private basis when such patients are hospitalized in Veterans Administration hospitals.
- . Develop programs by which laboratory, x-ray and other services and facilities can be fully shared and utilized to their maximum capability, without duplication, between and among Veterans Administration Hospitals, University and Community Hospitals, and other health care organizations in the community.

Extend and implement arrangements whereby payment can be made and received by the Veterans Administration for services provided to veterans with non-service connected disabilities and their families who qualify for Medicare or Medicaid; those who have private insurance; and from other institutions and individuals who utilize Veterans Administration health facilities and manpower on an extended sharing basis.

Continue and expand the relationship with university health science centers including both medical, dental and other health professional and technical schools in educational and training activities.

necessary to make the maximum contribution to the health manpower resources of the country.

Serve as the geographical base and clinical resource for the development of new medical, dental and other health professional and technical schools.

Actively engage in and accept the commitment to cooperative health planning and regionalization of all health services.

Make more information available to all veterans concerning their entitlements and available health services.

Conclusion

The Special Medical Advisory Group has developed this report after careful consideration not only of the Veterans Administration health care system, but also of the voluntary systems of health care, and also of all of the related elements including the critical problems of financing both. It recognizes that the recommendations made are not necessarily consonant with present legislative authorization of the Veterans Administration. However, they reflect the concern for the total public interest and are designed to anticipate the health care demands which will be made in the years immediately ahead and in which the Veterans Administration must involve itself if it is to continue to be an important part of the health care program of our country. Therefore, it is the considered belief of this Group that its responsibility is to bring these issues to the attention of the Administrator.

All recommendations contained in this report are made in the full awareness not only of the existing mission of the Veterans Administration Department of Medicine and Surgery, but in the belief that this system must be responsive to the comprehensive health needs of veterans and hence must engage itself with the total health care system if indeed all the people are to be assured of their inherent right to quality health care.

CONFIDENTIAL

A Guide For Veterans Administration - Medical

School Affiliation

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1. Introduction to the Veterans Administration - Medical School

Relationship

a. Background

The Veterans Administration is charged by law with providing a complete medical and hospital service, including medical research, for the medical care and treatment of veterans. In order to accomplish this mission more effectively, the Agency also has the legal mandate to carry out a program of training and education of health service personnel, in cooperation with schools of medicine, dentistry, osteopathy, nursing, and other public or nonprofit medical care and educational institutions.

Recognizing that any health care delivery system, particularly one concerned with so large a proportion of the nation's population, cannot stand isolated from the medical community if the quality of medical care provided is to be excellent, the Veterans Administration began, in 1946, a program of affiliation with most of the nation's medical schools. There is universal agreement that this has been to the benefit of both the country's veterans and to the medical schools. As an over-simplification, it can be stated that while, for the Veterans Administration, the introduction of an academic climate in VA hospitals has assured a high quality of medical care, the availability of VA hospitals for medical teaching and research has permitted, at the same time, an expansion of the quality and quantity of the educational productivity of the medical schools.

*how can one call
"complete
medical care" when
ambulatory care
is excluded?*

There now exist irreversible social pressures on all systems of health care delivery to combine their strengths in the interests of the health of all citizens. These pressures are reflected in such legislation as for the establishment of regional medical programs and for the sharing by VA hospitals of specialized medical resources and medical information with the medical community. Each of the original partners in the VA-medical school affiliation now has legal and ethical responsibilities and capabilities which transcend those which they had a quarter of a century ago. Further, they are not the same institutions that they were a quarter of a century ago.

Most VA hospitals today have teaching and/or research activities, and many are in some manner making these activities available to health and educational institutions and to individual practitioners in the localities. Some medical schools, as pointed out in the recent report of the Carnegie Commission on Higher Education, are evolving from the traditional Flexner-type research models into health care delivery models, or into integrated science models, or into various combinations of these models. Many schools are no longer just medical schools but are "university medical centers," which have become "loci of sophisticated diagnosis and treatment," and whose influence "extends to the practitioners of the surrounding communities, resulting in a general increase in the quality of health in the areas."

Expanded - in part it was possible for VA medical centers to exist side by side but eventually independent. This was because each having primary or secondary and medical care units highly complex apparatus and equipment facilities and equipment not an issue. Now the academic medical center has a much more important role in history, as well as function as a complex medical care complex.

In 1946, there was no medical institution on the horizon other than the medical school with which the Veterans Administration could logically affiliate for its medical care purposes. Today, the Veterans Administration engages in joint programs with many other institutions, including universities and colleges proper, nursing and other health profession schools, junior colleges, and technical institutes. Nevertheless, for the medical care agency which the Veterans Administration has remained to the present time, the central core of its affiliation must still be with the medical school, the harvester, refiner, repositor, and transmitter of medical knowledges and skills in the form in which these reach the patient in the hospital directly. Thus, VA associations with other institutions, though extremely important, must be channeled through the apex mechanism whereby the VA-medical school relationship functions, the Deans Committee, which committee will be discussed elsewhere in this "Guide."

2. Policy Memorandum No. 2

The basic document of the VA-medical school affiliation was Policy Memorandum No. 2, January 30, 1946, authored by Dr. Paul R. Hawley, the first VA Chief Medical Director. (Appendix "A") Functionally, some of its provisions are outdated. It will be noted also that the Memorandum addresses itself to patient care and graduate education and training as the ingredients of the VA-medical school relationship. There is no reference to undergraduate medical education or to medical research, though these have also been ingredients of the relationship from its very inception. It can be conjectured that these were omitted from a formal presentation for the following reasons: research, because this was a relatively small and disorganized medical school activity in the immediate postwar years; undergraduate medical education, because the political climate of the time was not receptive to the idea of medical students, persons who were not yet physicians, participating in the care of veteran patients.

3. Attitudes of the Partners in Affiliation

Philosophically, Policy Memorandum No. 2 is as applicable currently as it was when written. To highlight the attitudes expected today of both parties in the VA-medical school relationship, Section 1a of the Memorandum, entitled "Necessity for Mutual Understanding and Cooperation", is quoted below as an integral part of this "Guide":

Necessity for Mutual Understanding and Cooperation. The Department of Medicine and Surgery of the Veterans' Administration is embarking upon a program that is without precedent in the history of Federal hospitalization. It would, therefore, be most unusual if numerous problems did not arise for which no fully satisfactory solution were immediately apparent. Such problems frequently can be solved only by trial and error; and, until workable solutions are found, both parties in the program must exercise tolerance if the program is not to fail.

There can be no doubt of the good faith of both parties. The schools of medicine and other teaching centers are cooperating with the three-fold purpose of giving the veteran the highest quality of medical care, of affording the medical veteran the opportunity for postgraduate study which he was compelled to forego in serving his country, and of raising generally the standard of medical practice in the United States by the expression of facilities for graduate education.

The purpose of the Veterans' Administration is simple: affording the veteran a much higher standard of medical care than could be given him with a wholly full-time medical service.

The purposes of both parties being unselfish, and there being no conflict of objectives, there can be no serious disagreement over methods. It will be recognized that the Veterans' Administration is charged with certain legal responsibilities in connection with the medical care of veterans which it cannot delegate, if it would. Yet the discharge of these responsibilities need not interfere with the exercise by the schools of their prerogatives in the field of education.

All medical authorities of the Veterans' Administration will cooperate fully at all times with the representatives of associated schools and other centers. It is the earnest desire of the Acting Chief Medical Director that our relations with our colleagues be cordial as well as productive.

4. The Desirability of Affiliation

- a. For the Veterans Administration. The best medical treatment and hospital care are invariably provided in an environment where there is a genuine interest in both teaching and learning, and where the spirit of inquiry and investigation exists. To assure itself of such environment, the Department of Medicine and Surgery of the Veterans Administration strongly supports a broad policy of cooperation and professional interchange with medical schools and medical centers. The Veterans Administration obtains through affiliation the services of highly qualified faculty as part-time employees and as consultants and attendings for patient care, education, and research, and receives the full and active interest of the medical school in all its activities. Also, VA staff may render certain authorized teaching and consultant services to the schools on a paid basis.
- b. For the medical schools. Different medical schools will find different benefits weightier than others accruing to them through affiliation with the Veterans Administration. As a generality, in the VA hospitals, the schools will find clinical outlets for undergraduate and graduate medical education, with well-qualified VA staff available for faculty appointment and for the teaching of their students, interns, and residents. They will also find opportunities for their faculty members to render paid services in various capacities to the VA hospitals.

c. For the Veterans Administration and the medical schools.

Showing

Through affiliation, there is facilitated the sharing of specialized medical resources, the exchange of medical information, and mutual help in the recruitment of VA medical staff and of medical school faculty. Staff of each institution may serve on committees of the other, and can engage in joint programs of continuing education. There may be opportunities for collaborative medical research and for the joint application of research findings to patient care. Both institutions, by virtue of their close association, can work together in the development of regional medical programs and of programs designed to improve medical care in the community. In conclusion, that affiliation is most successful in which the stronger capability of one partner in any particular field serves to build to equal strength the weaker capability of the other partner in that field.

*This section calls
for sharing of
both people and
resources.*

5. Responsibilities Within the Affiliation

- a. General. All specific responsibilities flow from a division of fundamental responsibilities. Both institutions are involved in an intermeshing effort to assure a continuing level of high quality patient care. This means an active mutual interest in " " all mechanisms which bear on the quality of patient care-- medical and allied medical practice, medical administration, education, and research. The ultimate and legal responsibility for the care of veteran patients resides in the Veterans Administration. However, the school, through advice and recommendation, through the setting of standards, and through the direct supervision of certain VA activities by its faculty, is a significant participant, up to the final point of legal responsibility, in shaping the quality of patient care. All professional and administrative functions are performed by individuals who hold journalized VA staff appointment (including school faculty during VA service) and are the responsibility of the Veterans Administration. There has been much evidence that differences of opinion between the parties is reconcilable at the local level; where this is not possible, the services of central office will always be available to assist in arriving at an amicable resolution of differences.
- b. Specific. The following responsibilities, identified as "specific," are not all-inclusive. Other specific responsibilities are

assignable locally, based on the principles enunciated under "a" above:

(1) The Medical School

- (a) Will organize a Deans Committee, composed of senior faculty members of the affiliated medical school.
- (b) Will nominate to the Director on an annual basis a staff of consultants and attendings in the number and with the qualifications agreed upon by the Deans Committee and the Veterans Administration.
- (c) Will supervise, through the Director and the staff of consultants and attendings, the education and training programs of the Veterans Administration and such programs as are operated jointly by the Veterans Administration and the medical school.
- (d) Will nominate all physicians for residency or other graduate education and training programs in the numbers and with the qualifications agreed upon by the Deans Committee and the Veterans Administration.
- (e) Will appoint to its faculty, such full-time physicians as are appointed to the Veterans Administration upon nomination by the Deans Committee.

(2) The Veterans Administration

- (a) Will operate and administer the hospital.
- (b) Will appoint qualified physicians to the full-time and regular part-time staff of the hospital. Nominations to the Director by the Deans Committee for full-time and regular part-time positions will be welcomed; and,

1. This does not include participation in budget preparation and review.
2. Selection of chief of staff
3. Appointment of chief of staff to administrative part
4.

unless there be impelling reasons to the contrary, will be approved wherever vacancies exist. The regularly appointed staff, including the chiefs of service, are fully responsible to their immediate superiors in the Veterans Administration.

- (c) Will appoint the attending and consulting staff and the physician trainees nominated by the Deans Committee and approved by the Veterans Administration.
- (d) Will cooperate fully with the medical schools in the conduct of appropriate programs of education and training and of research.

(3) Hospital Directors

- (a) Are fully responsible for the operation of their hospitals.
- (b) Will cooperate with the Deans Committee in the conduct of education and training and research programs, and in evaluation of all participating individuals and groups.

(4) Chiefs of Service

- (a) Are responsible to their superiors in the Veterans Administration for the conduct of their services.
- (b) Will, in cooperation with the consulting and attending staff, supervise through the Director the education and training programs within their respective services.

5) Attending Staff

- (a) Will be responsible to the respective chiefs of service.
- (b) Will accept full responsibility for the proper care and treatment of patients in their charge upon delegation by the Director or person acting for him.

- (c) Will give adequate training to residents and interns assigned to their service.
- (d) Will hold faculty appointment in the affiliated medical school, or will be outstanding members of the profession with equivalent professional qualifications.

(6) Consultants

- (a) Will be members of the faculty, of professorial rank, in the affiliated medical school.
- (b) Will, as representatives of the affiliated medical school serving on the VA staff, participate in and take responsibility for the graduate education and training programs of the VA hospital.
- (c) Will afford to the Director, Chief of Staff, and the proper chief of service the benefit of their professional advice and counsel.

6. Functions of the Deans Committee

The following functions are not all-inclusive. As a viable, flexible entity, each Deans Committee will undoubtedly assume functions not indicated herein, but which are geared to local circumstances and are consistent with the extent and responsibilities of VA-medical school affiliation. The functions presented below are those which as a minimum should characterize the work of every Deans Committee:

- a. Endeavors to assure reasonable comparability of staffing, physical facilities, and equipment between the VA hospital and the university hospital, where there is one.
- b. Makes recommendations, as it considers appropriate, for levels of station budgets to the Director, and reviews and comments upon budgets as approved by central office and as distributed internally by station management.
- c. Establishes standards of patient care in the VA hospital and monitors the quality of patient care.
- d. Maintains a favorable environment for medical, professional, and allied and administrative education and training, and maintains a reasonable balance between these activities and patient care.
- e. Cooperates with VA personnel in establishing medical residency, internship, and undergraduate medical programs, and in determining their scope, organization, standards of performance, and the adequacy of facilities.

Planned

- f. Upon advice of concurrence between appropriate chiefs of service in both the medical school and the VA hospital, nominates to the Director candidates for graduate education and training in the various medical specialties.
- g. Selects and nominates to the Director the attending and consulting staff, and, in collaboration with the Director or Chief of Staff, recommends their schedule of attendance at the station.
- h. Collaborates with the Director, Chief of Staff, or chiefs of service in the supervision of their residents and in supervising the activities of the attending and consulting staff.
- i. Establishes standards of all medical research activities except those Special Research Laboratories under direction of the Director, Research Service.
- j. Nominates to the Director full-time and regular part-time physicians of the professional staff of the hospital, including the chiefs of service.

k. Planning

l. Coordination & services of academic medical center

7. The Deans Committee as the Voice of the Medical School

The Deans Committee is what the name connotes--a committee representing the Dean of the medical school. Though, as will be seen below, its membership is open to certain non-medical school staff, generally at the discretion of the Dean, the strength of the committee historically has resided in its autonomy and independence as a committee which speaks clearly for the medical school vis à vis its affiliated VA hospital. It is essential that this autonomy and independence be continued. Thereby, the Congress, the Office of Management and Budget, the veterans, the public, and the Veterans Administration itself know unmistakably what the academic sector of medicine, which has been the VA's goal and partner since 1946 in the quest for excellence, considers in the best interests of the medical care of veterans.

8. The Deans Committee: Membership, Meetings, and Other Conditions

a. Membership

- (1) The Deans Committee is composed of senior faculty members of the medical school affiliated with the VA hospital. These faculty members should relate to the major professional services of the hospital, particularly those services engaged in education and training.
- (2) Where there is allied medical or administrative training conducted at the VA hospital in cooperation with schools or departments of the university medical center or of other health-oriented institutions such as independent schools of allied health, or junior colleges, membership on the Deans Committee may be provided to representatives of these schools, departments, or other institutions, as considered appropriate by the Dean of the medical school. As an alternative to this method, the Deans Committee may appoint non-medical school staff to subcommittees or ad hoc committees, to serve as liaisons with the Deans Committee, for their schools, departments, or other institutions. Such appointments do not require the Chief Medical Director's approval.
- (3) The Director and Chief of Staff of the VA hospital will serve and attend regularly as ex-officio members of the Deans Committee.

- (4) A member of the VA house staff will serve and attend regularly as an ex-officio member of the Deans Committee. This member will be elected by the hospital's house staff as soon as feasible after July 1st of each calendar year.
- (5) All members of the Deans Committee, other than the ex-officio members, will be nominated by the Dean of the medical school, through the Director of the hospital, and will be appointed by the Chief Medical Director.
- (6) Details of tenure, rotation, etc. of membership will be established by each Deans Committee.
- (7) A Deans Committee affiliated with more than one VA hospital may choose to designate a subcommittee to represent it in the conduct of affairs at a single hospital. The membership of such a subcommittee will be nominated by the Deans Committee through the Director of the hospital, and will be appointed by the Chief Medical Director. This subcommittee is responsible to the parent Deans Committee. It is advisable that the Chairman of such a Deans Subcommittee be a member of the parent Deans Committee. The Director and Chief of Staff of the hospital will serve and attend regularly as ex-officio members.
- (8) At the request of the Chairman, any VA employee may attend meetings of a Deans Committee or Subcommittee of the type mentioned in (7) above, though not in a membership capacity if he is not the Director or Chief of Staff of the hospital.

(9) The Deans Committee may appoint ad hoc committees or subcommittees for the accomplishment of specific tasks or for the cognizance of certain duties for which the Deans Committee is responsible. VA employees may be members of such ad hoc committees or subcommittees. The Chief Medical Director's approval is not required for the appointment of VA or non-VA personnel to membership.

b. Meetings

- (1) Frequency of meetings will be determined by the Deans Committee in accordance with local needs and conditions. It is advisable that meetings be held at regular intervals. Experience has demonstrated that monthly meetings are quite productive.
- (2) Whenever possible, meetings of the Deans Committee should be held at the VA hospital. Stenographic facilities will be made available by the Director of the hospital.
- (3) Copies of the minutes and the recommendations of the Deans Committee should be sent to the Director of the hospital, and, unless of purely local concern, to the appropriate Regional Medical Director and the Chief Medical Director. Such information can be of great value in the formulation of future policy.

c. Other conditions

- (1) Members of the Deans Committee are not entitled to a consultant or attending fee for attending a meeting of the

Deans Committee or for discharging any other duty of the committee.

- (2) Members of the Deans Committee as individuals may serve as consultants or attendings within the VA hospital and are encouraged to do so.

18. Literature for Those Active in VA-Medical School Affiliation

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January 30, 1946

POLICY MEMORANDUM NO. 2

SUBJECT: Policy in Association of Veterans' Hospitals with Medical Schools.

1. GENERAL CONSIDERATIONS:

a. Necessity for Mutual Understanding and Cooperation. The Department of Medicine and Surgery of the Veterans' Administration is embarking upon a program that is without precedent in the history of Federal hospitalization. It would, therefore, be most unusual if numerous problems did not arise for which no fully satisfactory solution were immediately apparent. Such problems frequently can be solved only by trial and error, and, until workable solutions are found, both parties in the program must exercise tolerance if the program is not to fail.

There can be no doubt of the good faith of both parties. The schools of medicine and other teaching centers are cooperating with the three-fold purpose of giving the veteran the highest quality of medical care, of affording the medical veteran the opportunity for post-graduate study which he was compelled to forego in serving his country, and of raising generally the standard of medical practice in the United States by the expression of facilities for graduate education.

The purpose of the Veterans' Administration is simple: affording the veteran a much higher standard of medical care than could be given him with a wholly full-time medical service.

The purposes of both parties being unselfish, and there being no conflict of objectives, there can be no serious disagreement over methods. It will be recognized that the Veterans' Administration is charged with certain legal responsibilities in connection with the medical care of veterans which it cannot delegate, if it would. Yet the discharge of these responsibilities need not interfere with the exercise by the schools of their prerogatives in the field of education.

All medical authorities of the Veterans' Administration will cooperate fully at all times with the representatives of associated schools and other centers. It is the earnest desire of the Acting Chief Medical Director that our relations with our colleagues be cordial as well as productive.

b. General Division of Responsibility: The Veterans' Administration retains full responsibility for the care of patients, including professional treatment, and the school of medicine accepts responsibility for all graduate education and training.

2. THE VETERANS' ADMINISTRATION:

a. Operates and administers the hospital.

b. As rapidly as fully qualified men can be had, will furnish full-time chiefs of all services (see paragraph 5 below) who will supervise and direct the work of their respective staffs, including the part-time attending staff furnished from the School of Medicine, insofar as the professional care of patients is concerned. Nominations by Deans' Committees for such full-time positions will be welcomed; and, unless there be impelling reasons to the contrary, will be approved wherever vacancies exist. These service chiefs are fully responsible to their immediate superior in the Veterans' Administration.

c. Appoint the consultants, the part-time attending staff and the residents nominated by the Deans' Committee and approved by the Veterans' Administration.

d. Cooperate fully with the Schools of Medicine in the graduate education and training program.

3. THE SCHOOLS OF MEDICINE:

a. Will organize a Deans' Committee, composed of senior faculty members from all schools cooperating in each project, whether or not furnishing any of the attending or resident staff.

b. Will nominate an attending staff of diplomates of specialty-boards in the numbers and qualifications agreed upon by the Deans' Committee and the Veterans' Administration. (See 6c)

- c. Will nominate, from applicants, the residents for graduate education and training.
- d. Will supervise and direct, through the Manager of the hospital and the Consultants, the training of residents.
- e. Will nominate the consultants for appointment by the Veterans' Administration.

4. HOSPITAL MANAGERS:

- a. Are fully responsible for the operation of their hospitals.
- b. Will cooperate with the Deans' Committee, bringing to its attention any dereliction of duty on the part of any of its nominees.

5. CHIEFS OF SERVICE:

- a. Are responsible to their superior in the Veterans' Administration for the conduct of their services.
- b. Will bring to the attention of their superior, for his action, such cases as they are unable to deal with personally of dereliction of duty or incompetence on the part of any full-time or part-time staffs under their control.
- c. Will, together with the part-time attending staff, under the direction of the Manager, supervise the education and training program.
- d. When full-time employees of the Veterans' Administration, will be diplomates of their respective boards and will be acceptable to the Deans' Committee and to the specialty boards concerned. It is the urgent purpose of the Veterans' Administration to place full-time fully qualified and certified chiefs of service for all services in each hospital associated with a School of Medicine. Except in cases where the chief selected has local affiliations, which might embarrass or prejudice his relations with one or another of the associated schools, his initial assignment may not be cleared through the Deans' Committee. In all cases, when it has been conclusively demonstrated that a chief of service cannot cooperate with a Deans' Committee, he will be transferred (if efficient otherwise) and replaced by another.

Until this purpose can be fully accomplished, however, in order that a hospital may obtain approval for resident training by one or another specialty board, it may be necessary to appoint part-time chiefs of services who meet the requirements of the boards. This will be done; but it will be done with the understanding that the part-time chiefs will be replaced with qualified full-time chiefs as rapidly as they become available. The duties and responsibilities of part-time chiefs will be the same as those of full-time chiefs.

6. PART-TIME ATTENDING STAFF:

- a. Will be responsible to the respective chiefs of service.
- b. Will accept full responsibility for the proper care and treatment of patients in their charge.
- c. Will give adequate training to residents assigned to their service.
- d. Will be veterans unless approval in each case has been given by the Chief Medical Director.
- e. Will be diplomates of their respective boards and acceptable to such boards for direction of resident training. Exception may be made in the case of a veteran who has completed the first part of his board examination, but whose completion of the examination was interrupted by the exigencies of the military service.

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POLICY MEMORANDUM NO. 2

f. Will hold faculty appointments in one or another of the associated Schools of Medicine, or will be outstanding members of the profession of the caliber of faculty members.

7. CONSULTANTS:

a. Will be veterans unless approval in each case has been given by the Chief Medical Director.

b. Will be members of the faculty, of professorial rank, of one or another of the associated Schools of Medicine.

c. Will, as representatives of the Schools of Medicine, direct and be responsible for the educational training of residents.

d. Will afford to the Manager and the proper Chief of Service the benefit of their professional experience and counsel.

e. Will conduct their duties through, and in cooperation with, the Manager and the proper Chief of Service, and also, in matters of education and training, with the part-time Attending Staff--always, however, coordinating with the Chief of Service.

Disease Control.—The bill includes \$94,425,000, an increase of \$3,000,000 above the request, and an increase of \$47,757,000 above the amount appropriated for 1971.

This appropriation covers a broad range of activities in connection with the prevention and control of communicable diseases, including the Foreign Quarantine Service. It covers administration of the Clinical Laboratories Improvement Act of 1967; the Department of Health, Education, and Welfare's responsibilities under the Occupational Safety and Health Act of 1970 and some other smaller, related activities. Most of these activities would be held by the budget for 1972 to the 1971 level or less. However, the activity "Occupational health" is budgeted for \$17,662,000 in 1971 and \$25,216,000 for 1972. This is accounted for primarily by the fact that activities under the Occupational Safety and Health Act of 1970 began during the last half of 1971, but the program will be in operation during all of 1972.

The only other budgeted program increase is \$2,000,000 for carrying out the provisions of the Lead-Based Paint Poisoning Prevention Act. It is, of course, difficult to estimate just what a new and innovative program like this will cost, but it appeared to the Committee that the Department's estimate was extremely conservative. The Committee has, therefore, included \$5,000,000 in the bill for this program.

Medical facilities construction.—The bill includes \$266,704,000, an increase of \$127,827,000 above the request, and an increase of \$39,867,000 above the amount appropriated for 1971.

The budget requested no funds for grants for hospitals and public health centers for which \$16,400,000 was available in 1971, it requested no funds for grants for long-term care facilities for which \$20,800,000 was available in 1971, and requested no funds for grants for modernization for which \$50,000,000 was available in 1971. These omissions total \$87,200,000. The increase recommended by the Committee includes \$87,200,000 to restore these cuts in total, leaving flexibility in the exact allocation of the total among the three parts.

The District of Columbia Medical Facilities Construction Act authorized the appropriation of \$40,052,000 for grants and \$40,575,000 for loans. The remaining authorization, after deducting appropriations already made, is \$24,052,000 for grants and \$16,575,000 for loans. The unique problems of the District of Columbia in raising funds for such things as medical facilities are widely recognized. Among them is the lack of industrial growth that has occurred in most cities the size of Washington, and the fact that so many of its people have legal residences elsewhere and make most of their charitable contributions there. There is no doubt of the need for more funds for many of Washington's hospitals. Members of the Committee are personally acquainted with serious problems at Providence, Rogers, Children's, and Georgetown University hospitals. The Committee has added to the bill the full amount of the remaining authorization which will at least partially alleviate these situations.

The Committee has approved the remainder of the budget for medical facilities construction as submitted. This includes the request for \$20,300,000 for interest subsidies on guaranteed loans for construction of hospitals, long-term care, and other health facilities, an increase of \$15,300,000 over the \$5,000,000 appropriated for 1971, none of which has been obligated since the regulations still have not been promulgated. The Committee is disappointed that this program, which the

Administration appears to hold in high regard, has been mired down in paper-work for over a year. If this program gets started in time, the amount in the bill plus the carryover from 1971 will support interest subsidy payments on up to \$1 billion worth of mortgage loans.

Patient care and special health services.—The bill includes \$71,682,000, the amount of the request, and a reduction of \$14,223,000 below the amount appropriated for 1971. This reduction was occasioned by a proposal to transfer some or all of the hospitals and clinics for other use. Since the budget was prepared it was decided to hold this proposal in abeyance pending further study, and the Committee has been assured, as have other Congressional committees, that no such action will be taken until after further advice to, and discussion with, interested Members and committees of Congress. It is, therefore, obvious that the amount in the budget and in the bill is going to be insufficient to maintain an adequate level of service during fiscal year 1972. Since the exact size of the supplemental appropriation which will be required cannot be ascertained at this time, the Committee has simply approved the budget as it now stands and will deal with the problem of a supplemental appropriation at a later date.

National health statistics.—The bill includes \$15,900,000, the amount of the request, and an increase of \$5,557,000 above the amount appropriated for 1971. Activities financed by the "Regional medical programs" at a level of \$2,500,000 in 1971 will be financed under this appropriation in 1972. Taking this and four much smaller adjustments into consideration the increase, on a comparable basis, is \$2,848,000 of which \$446,000 is for such things as pay costs and annualization of 1971 health insurance contribution, leaving a program increase of \$2,402,000. This amount includes \$1,201,000 to substantially reduce the existing delays of up to one and one-half years in making national vital statistics available to the many users of this very important data. The Director of the National Center for Health Statistics testified that it would require about 45 clerks during 1972 and 1973 and at that point the staff would be reduced by 30. When one of the Committee members complimented him on his flat statement that he would reduce this personnel by 30 at the end of 1973, the witness stated "That is a promise". The Committee will remember.

The remainder of the increase is in two parts. The first is \$700,000 to begin field work on the National Family Growth Survey which Congress authorized to be initiated in 1971. This survey encompasses desired and expected family size, birth spacing, family planning practices, etc., which will aid in the evaluation of those factors affecting future trends in child bearing and population growth, and will provide information needed for infant and maternal programs and for evaluation of national and local family planning programs. The remaining \$501,000 of the increase is to make operational the National Family Planning Reporting System which was also authorized to be developed in 1971.

Retirement pay and medical benefits for commissioned officers.—It is estimated that this indefinite appropriation will amount to \$23,196,000 in 1972 compared with \$19,501,000 in 1971. This appropriation covers certain administratively uncontrollable expenses—retirement pay for public health service officers, payments to the survivors of deceased retired officers who had received retirement payments under the provisions of the Retired Servicemen's Family Protection Plan, and

POLICY STATEMENT ON THE
RESPONSIBILITY OF ACADEMIC MEDICAL CENTERS
FOR GRADUATE MEDICAL EDUCATION

The Association of American Medical Colleges endorses the concept that graduate medical education should become a responsibility of academic medical centers. Through this endorsement the Association urges the faculties of academic medical centers to develop in conjunction with their parent universities and their teaching hospitals, programmatic plans for taking responsibility for graduate medical education in a manner analogous to presently established procedures for undergraduate medical education.

Assumption of this responsibility by academic medical center faculties means that the entire faculty will establish mechanisms to: determine the general objectives and goals of its graduate programs and the nature of their teaching environment, review curricula and instructional plans for each specific program, arrange for evaluating graduate student progress periodically, and confirm student readiness to sit for examinations by appropriate specialty boards.

The Association encourages hospitals with extensive, multiple graduate education programs, which are not now affiliated with academic medical centers to develop their own internal procedures for student selection, specific program review and proficiency examinations. The accrediting agency is urged initially to accredit the entire graduate program of these hospitals. Ultimately, these institutions should either develop affiliations with degree-granting academic medical centers or seek academic recognition as free-standing graduate medical schools.

The Association urges that the Liaison Committee on Medical Education, the Residency Review committees and the Specialty Boards establish procedures which will provide for adequate accreditation of an entire institution's graduate medical education program by one accrediting agency.

The Association further urges that the specialty boards continue to develop test instruments for measuring achievement of individual candidates that avoid superimposing rigid program requirements on the academic medical centers.

It is essential that all related components (including hospitals) of academic medical centers jointly develop appropriate financing for the program costs of graduate medical education.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF TEACHING HOSPITALS

MINUTES

COMMITTEE ON HOUSE STAFF RELATIONSHIPS
TO THE HOSPITAL AND AAMC

AAMC Headquarters
One Dupont Circle
June 2, 1971

Present:

Bernard J. Lachner, CHAIRMAN
Administrator
Ohio State University Hospitals
Columbus, Ohio

Malcom Randall
Hospital Director
Veterans Administration Hospital
Gainesville, Florida

David L. Everhart
Executive Director
New England Medical Center Hospitals
Boston, Massachusetts

William L. Wilson
Executive Director
Mary Hitchcock Memorial Hospital
Hanover, New Hampshire

Betty Eberle, Ph.D.
Assistant Professor
Department of Community Medicine
The University of New Mexico
School of Medicine

Maurice A. Mufson, M.D.
Associate Chief of Staff
West Side VA Hospital
Chicago, Illinois

H. Robert Cathcart
President
Pennsylvania Hospital
Philadelphia, Pennsylvania

Richard M. Loughery
Administrator
Washington Hospital Center
Washington, D.C.

Donald E. Detmer, M.D.
Senior Resident in Surgery
Duke University Hospital
Durham, North Carolina

John G. Freymann, M.D.
Director of Education
Hartford Hospital
Hartford, Connecticut

Excused:

S. David Pomrinse, M.D.
Director
The Mount Sinai Hospital
New York, New York

Paul A. Marks, M.D.
Dean, Faculty of Medicine
Vice President for Medical Affairs
Columbia University
New York, New York

Julius R. Krevans, M.D.
Dean, University of California
San Francisco Medical Center
School of Medicine

Earl N. Metz, M.D.
Associate Professor
Department of Medicine
The Ohio State University Hospitals
Columbus, Ohio

Staff:

Grace W. Beirne
Tom Campbell
Armand Checker
Jody Williams

John A.D. Cooper, M.D.
John M. Danielson
Richard M. Knapp, Ph.D.

I. Following the call to order and introduction of members, John A.D. Cooper, M.D., AAMC President, spoke to the committee. He pointed out that the Committee on House Staff Relationships is one of three COTH committees set up to provide guidance to the AAMC on issues relating to the academic medical center and its hospitals.

A number of public and governmental bodies have shown interest in house staff and their role; the Carnegie Commission, the Social Security Administration and the Congress with its concern that current house staff salaries contradict their educational roles as students have all been reviewing the changing role of the intern and resident. This particular committee reflects AAMC concern with the more general problem of financing medical education. In addition to the House Staff Relationship Committee, four other committees are to examine and provide information for policy and guidance germane to the financing of medical education.

The committees are the following:

- 1) Ad Hoc Committee on Biomedical Research Policy
- 2) Task Force on the Cost of Undergraduate Medical Education
- 3) Task Force to Analyze the Higher Costs of Teaching Hospitals
- 4) Task Force on Construction

II. Richard Knapp noted the other COTH Committees are the Task Force on Goals and Objectives of COTH and the Task Force on the Higher Costs of Teaching Hospitals. At this year's AAMC Annual Meeting, the interim reports developed by these Task Forces and Committees will be presented at the COTH Annual Institutional Membership Meeting on Friday, October 29, 1971. Bernie Lachner outlined the charge to this committee to examine:

- 1) The nature of participation of house staff in the AAMC.
- 2) Response to the national house staff organization particularly to the resolution submitted to COTH at the Los Angeles meeting and the letter to Irvin Wilmot requesting participation in the AAMC.
- 3) Reimbursement of house staff costs with particular regard to the Pennsylvania Blue Cross-Insurance Commission or conflict over reimbursement. In essence, what is needed is a position statement on financing graduate medical education.

III. Robert Cathcart outlined the Philadelphia Blue Cross situation. Philadelphia Blue Cross had requested a rate increase and this request led to public hearings by the State Insurance Commissioner, Herbert S. Dennenberg. Dr. Dennenberg is an economist and a former member of the faculty of the Wharton School of the University of Pennsylvania. He has questioned the propriety of house staff reimbursement under Blue Cross and in the light of an avowed concern for protection of the consumer has indicated that educational costs should be subject to public scrutiny.

However, there does not seem to be the immediate prospect of such costs being separated from reimbursement. Commissioner Dennenberg has requested that these costs be separated for "recognition" within about six weeks time. Dr. Dennenberg's contention is that the education costs of academic medical centers are growing faster than their service costs, that house staff are actually working for the attending physicians and that in the academic medical center patients receive service they would not receive or pay for in institutions outside the academic medical center. In the academic medical center, the consumer, the patient, in Dr. Dennenberg's opinion is thus paying twice for services.

Compounding this problem are situations created by a Pennsylvania law passed last October that permits public employees to organize themselves as bargaining units. An organization of house staff, the Philadelphia Association of Interns and Residents (PAIR), has petitioned three hospitals as collective bargaining units under this legislation. Because of the volume of petitions from new public and hospital employee organizations, the Labor Relations Board of the Commonwealth has been delayed in making a decision as to whether or not PAIR constitutes a legitimate collective bargaining unit. Central to the LRB decision will be determining if house staff are students or employees of the hospital.

IV. ACTION

The Committee chairman requested at this point in the meeting that the COTH staff draft a position statement on financing of graduate medical education and that this paper be circulated for comment and to be the subject of a subsequent meeting if necessary. This matter was to be discussed more substantively later in the meeting after John

Danielson joined the committee members.

V. Discussion of an appropriate avenue for house staff participation was introduced by a review of the AAMC reorganization resulting from the Coggeshall Report. Almost from the time the three constituent bodies, the Council of Deans, the Council of Academic Societies and Council of Teaching Hospitals, were established, the problem of appropriate involvement of faculties, ranging from establishment of a separate Council of Faculties to establishment of a separate group under CAS, has been an issue. A resolution from the Assembly in February, 1971 requested reexamination of faculty representation in the AAMC [to date, both the COTH Executive Committee and CAS took no specific immediate action in the faculty participation questioned].

The Council of Deans at their institutional meeting on May 20, 1971 passed the following resolution with regard to faculty participation:

The COD recommends to the Assembly that the Association at this time not consider any further mechanisms of representation of the faculties in the national association and that such existing mechanisms be strengthened and utilized to increase opportunity for the faculty to make (input).

When student participation in AAMC was petitioned and approved, COD was made the avenue of that participation. Now since the Annual Meeting, COTH has itself been confronted by the question of house staff involvement.

There is at present no representative national organization of house staff for COTH to deal with. The National Association of

Residents and Interns (NARI), a group principally concerned with salaries, job security and other employment issues, has stated publicly that house staff are not students. A National Conference of House Staff, spearheaded by Clement Lucus, formerly President of SAMA, and now a physician serving in the Public Health Service, was held this spring with funds granted from HSMHA. This conference was in no way related to the NARI organization. Richard Knapp and Armand Checker along with representatives of the AMA attended the meeting as observers. Broader issues than economic ones were discussed during the meeting although education per se was not a major concern. A committee appointed during the conference was charged with responsibility for putting together a national house staff organization. To date the group has set up an information clearinghouse, begun publishing a newsletter and begun arrangements for a future conference. It does appear that this new organization will come to fruition.

VI. Dr. Knapp mentioned that in selecting a house staff representative for the meeting, no member of the incipient organization was selected because this would have been tacit acceptance of this group as representatives of all house staff.

Donald Detmer, physician and chief resident in surgery at Duke University Hospital, although selected as house staff representative to the committee, emphasized that at the meeting he was speaking only for himself. He pointed out that NARI as a national organization principally represents house staff at the large urban hospitals, frequently municipal and county hospitals, and not the university, VA

or community hospitals used for teaching, and that in university hospitals, in his opinion, house staff have different problems from those staff in the public hospitals. House staff in his view have the following attributes:

- 1) they are not the employees of attending or faculty physicians;
- 2) in a sense they are captives in training programs which they must complete in order to obtain board certification;
- 3) they are not students in the strict sense of the word since they are licensed physicians and can legally practice as fully responsible physicians;
- 4) their primary loyalty is based on their educational endeavors in the hospital;
- 5) as a group, house staff are wary of a national organization speaking for them. There is disagreement within the group as to which direction is most appropriate - to work within the system or to formulate an adversary role. Dr. Detmer personally prefers the former.

VII. A general discussion of house staff participation followed. Some of the points mentioned were as follows:

- Medical education depends on hospitals. As institutions, we cannot represent the individual interests of individual groups within the hospital.

- Student AAMC representation in the AAMC has been provided under the Council of Deans. [This seems proper] because a dean is clearly responsible for students and decisions about their full course of experience in the medical school. It seems less clear as to who is responsible for education of house staff in hospitals. Responsibility is diffuse for interns; and more concentrated in chiefs-of-service for residents with the concentration of responsibility increasing as the resident advances. This is true enough, but there are different house staff arrangements in different types of hospitals-- urban, community, university -- who it represents and for what.

- Another point of view on who house staff relate to is that they relate to specific clinical people at each level - an overall chief at the beginning levels, and a single chief with responsibility at the sub-specialty level. There are problems here because the professional road is determined by another outside group so that the chief in the hospital does not have complete autonomy in setting-up the course of the house officer's experience.

For discussion purposes, one member stated the following proposition: "the student is to the dean as the house officer is to the director of the hospital." In this sense house officers are already represented in the AAMC, but they may not feel this is so. There was not full agreement with the statement or the concept.

House staff are related to different individuals for different purposes -- hospital administration for employee benefits and some aspects of patient care, and to clinical chairmen or chiefs-of-service for education and other patient care responsibilities.

VIII. Resolution of house staff representation question has implications for the total AAMC. Some viewpoints expressed were:

- If there is formal recognition of house staff, what about other groups within the academic medical center and their representation in AAMC? For example, nurses or allied health may be next.
- There is something unsound about jumping ahead to representation within AAMC rather than looking for vehicles within councils of faculties or medical staff in the schools and hospital at the local level.
- The Teaching Hospital Information Center survey showed that there is some house staff involvement at the local level, mainly through participation on committees - utilization, library, and so on. However, representation at the executive or management level is not widespread.

IX. Dr. Freymann described the Hartford Hospital approach to house staff participation. House staff are regarded as a body with a community of interest and a reactivated house staff council has responsibility for administering house staff affairs. When this re-activation was accomplished, house staff were set-up as a component

of the hospital medical staff. They now serve on all medical staff committees except the executive committee.

One problem at Hartford was the question of votes - how they should be distributed among house staff with more seniority and house staff who were rotaters in relation to those based at the hospital for most of the residency. House staff elected to have no vote since house staff council and committee participation had assured them a chance to be heard. Through this arrangement, house staff recognize that they are physicians who relate to the hospital as do other physicians salaried by the hospital.

X . This description initiated a discussion of the advantages of promoting more house staff participation at a local level rather than formally in AAMC.

- One problem is financing. AAMC is supported by dues from medical schools, hospitals and academic and clinical societies. Student participation is now supported from general funds. If house staff do not come in under the umbrella of present groups, they will have to organize and pay dues for their own groups. If this occurs, it may appear the AAMC is forcing organization into the medical schools and hospitals it now represents.

- On a national basis, house staffs are evanescent, temporally and geographically.

- National representation would tend to set policies for individual house staff without their having anything to say about these policies.

- House staff have to establish the role of their group at individual hospitals and once they are integrated in hospital structure locally, then representation nationally.
- Hospital as an environment for teaching and learning is the concern of the AAMC. Teaching and services are not always consonant goals. Recent salary increases suggest that house staff are being paid for service. Representation of house staff within AAMC should be tied to their educational function and this may already be satisfied.

XI . The issue is not solely one of representation. Administrators have not known where to turn for help on house staff and have turned most often to the Council on Medical Education of the AMA. AAMC should become a national resource that hospitals, chiefs-of-staff, and medical faculties could turn to for information on house staff.

This possible function was discussed in relation to the AAMC Policy Statement on "Corporate Responsibility for Graduate Medical Education." (The most recent version under a new title, is attached as Appendix A to these minutes)

XII . This phase of the discussion terminated with some stimulating arguments for positions and some proposals.

- A. A resolution -- "whereas" etc., recommending that AAMC encourage house staff participation at the local level -- including both situations in which representation

can be channeled through the hospital or the medical school depending on the local policy making structure.

B. If AAMC does have a role in graduate medical education, there is a "good reason" why there should be representation of house staffs, and that such representation should be within COTH:

1. Hospital appoint house staff;
2. Hospitals pay house staff;
3. House staff do provide services to a hospital in a management sense;
4. Hospitals have on occasion collected fees, where available from services of house staff;
5. Chiefs of services are program directors and programs are approved on behalf of the hospital;
6. Hospitals according to the JCAH are to provide an environment for teaching and learning;
7. What happens if the hospital is no longer reimbursed for education?
8. Hospital's liability for employees.

C. Some of the "good reasons" for opposing such representation:

1. AAMC should be concerned about graduate and undergraduate medical education, not the problems of individuals which can be more appropriately dealt with on the local level;
2. Financing of house staff participation is probably not possible without formal house staff organization;

3. Promoting a formal house staff organization is potentially divisive within AAMC constituency;
4. In some instances the medical school, not the hospital, appoints residents;
5. House staff are not like faculty. They are evanescent, temporally and geographically;
6. House staff represent a specific group rather than institutional responsibility;

The following three alternatives were discussed:

- a) House staff involvement could be a total AAMC function and addressed by all three councils as necessary. Specific problems could be dealt with by staff, as directed by Dr. Cooper,
- b) A division of House Staff Affairs could be established and provide a diffuse arrangement for problem solving, not representation.
- c) The precedent already established could be broken by asking for disassociation of student participation

XIII. It was noted that presence of the Committee members who are deans would have afforded more adequate representation of the educational interests and responsibilities of house staff, along with financial aspects of the house staff programs within the academic medical center and would have provided another essential point of view as to if and, if so, where house staff involvement should be focused within the AAMC.

XIV. Following lunch, John Danielson, who had earlier addressed the national meeting of the Group Health Association of America on the subject of HMO's in the academic medical center, joined the committee for a discussion of house staff financing.

Both AAMC as a whole and COTH specifically have an interest in graduate medical education. The issue of financing is not unrelated to the issue of house staff representation since the locus of representation can be used as a definition of the principal function or role of house staff and of the sources from which house staff should be financed. A glance at old copies of the AMA Green Book would show that until the mid 60's low salaries used to be associated with highly desirable residencies and internships and with the hospital success in recruitment.

The first break in this trend came when house staff in city hospitals affiliated with medical schools threatened strikes if the hospitals did not pay house staff for their services as physicians. As the pricing for house staff recruitment increased, other hospitals followed suit. The elements of indentured servitude and tuition had not been priced out nor was this accomplished as salaries continued to increase and Medicare and Medicaid brought the issues to the surface.

The following diagram was used to demonstrate the components of total house staff function and a means of suggesting sources of reimbursement and of locating house staff within the existing AAMC structure:

HOUSE STAFF FUNCTION

	Institutional Service	Professional Relationship to Physician	Education
Group Served	Hospital	Hospital medical staff	a) Teachers of other house staff and students b) students
Financing	Patient care Revenue		a) reimbursement for teaching b) deduction for tuition
<hr/>			
Representation in AAMC	COTH	CAS, or in some instances no representation	CAS

Tom Campbell reported that in the AAMC cost allocation studies forty medical centers are now involved. Cost determination of the teaching and research functions of teaching hospitals is being carried out; the costs of specific house staff functions within the teaching hospital are not included in the study. There was some discussion of studies which have attempted to determine how interns and residents spend their time. In view of the controversy over these efforts, there was suggestion that perhaps concentration should be placed upon what "should be" rather than what "is", and develop sources of finance on that basis.

XV. From the point of view of the VA system, house staff programs are regarded as educational programs. Present stipends rates are based on a system of matching the index hospital in the academic medical center with which the VA hospital is affiliated. At the present

time, these stipends are regarded as educational expenditures in the VA budget.

XVI. This was followed by more general discussion of financing:

- Support of house staff salaries from professional fees of faculty has been practiced in only a few institutions, but has been recently suggested as a desirable means of financing by the Pennsylvania Insurance Commissioner.
- Mary Hitchcock Memorial Hospital already has such an arrangement. Other precedents are also available. Partial payment of house staff from the professional side according to one committee member might be acceptable if it were carefully done.
- Another member suggested that there will be an attempt to cut back numbers of interns and residents to fit available dollars.
- A national policy on the number of house staffs slots may be forthcoming and this leads to questions about who should control graduate medical education and who should pay for it, and the proposed federal capitation of \$1,500- \$3,000 suggests that the federal government is prepared to pay for a piece of it(Eagleton amendment to S. 934).
- The termination of federal support for clinical fellows is raising problems about how the services they provided will now be supported.

- Tuition could be regarded as a negative income tax on the doctors for service employment

- This still creates a need for pricing out for graduate education the costs of tuition, teaching and service.

The education phase of graduate education may be a university function in the future, but it is important to remember, too, that without the teaching provided by interns and residents, the medical students environment would be deficient.

XVII. Mr. Danielson pointed out that although the AAMC does not want to be in a position of negotiating contracts for house staff salaries, it is in the unique position of having constituent organizational members with responsibility for all three areas of house staff functions.

AAMC could speak to the issue of division of responsibility and clearly a dollar value can be ascribed to each of these three areas. Whether or not AAMC wants to decide these issues or have it decided for its members by government or someone else is the matter of concern here. The National Association of Residents and Interns and the new, developing house staff organization could see the AAMC position and this would have an influence on their deliberation.

XVIII. Because the committee was not prepared to make a final decision on the matter of house staff representation at this meeting, they were asked by Mr. Danielson to put down on paper their suggestions on how house staff representation should be handled within the context of the cost allocation diagram.

XIX. A distillate of the discussion at this meeting will be circulated to the committee membership.

XX. At the next committee meeting in July, the staff paper on the financing of graduate medical education and the committee statements on house staff financing will be presented and discussed.

APPENDIX A

POLICY STATEMENT ON THE
RESPONSIBILITY OF ACADEMIC MEDICAL CENTERS
FOR GRADUATE MEDICAL EDUCATION

The Association of American Medical Colleges endorses the concept that graduate medical education should become a responsibility of academic medical centers. Through this endorsement the Association urges the faculties of academic medical centers to develop in conjunction with their parent universities and their teaching hospitals, programmatic plans for taking responsibility for graduate medical education in a manner analogous to presently established procedures for undergraduate medical education.

Assumption of this responsibility by academic medical center faculties means that the entire faculty will establish mechanisms to: determine the general objectives and goals of its graduate programs and the nature of their teaching environment; review curricula and instructional plans for each specific program; arrange for evaluating graduate student progress periodically; and confirm student readiness to sit for examinations by appropriate specialty boards.

The Association encourages hospitals with extensive, multiple graduate education programs, which are not now affiliated with academic medical centers to develop their own internal procedures for student selection, specific program review and proficiency examinations. The accrediting agency is urged initially to accredit the entire graduate program of these hospitals. Ultimately, these institutions should either develop affiliations with degree-granting academic medical centers or seek academic recognition as free-standing graduate medical schools.

The Association urges that the Liaison Committee on Medical Education, the Residency Review Committees and the Specialty Boards establish procedures which will provide for adequate accreditation of an entire institution's graduate medical education program by one accrediting agency.

The Association further urges that the specialty boards continue to develop test instruments for measuring achievement of individual candidates that avoid superimposing rigid program requirements on the academic medical centers.

It is essential that all related components (including hospitals) of academic medical centers jointly develop appropriate financing for the program costs of graduate medical education.