AGENDA

COTH ADMINISTRATIVE BOARD MEETING
Georgetown West Room
Washington Hilton Hotel
Washington, D.C.
October 28, 1971.

I. Call To Order - 3:00 p.m.

II. Presentation by members of the Staff of The Institute for the Study of Health and Society: TAB A

III. Approval of Minutes, Meeting of August 22, 1971 TAB B

1) Reconsideration of Action #7, Page 17

IV. Membership: TAB C

1) VA Hospital, Biloxi, Mississippi

2) VA Hospital, Sepulveda, California

V. Report of the Nominating Committee - Dr. Hamilton

VI. Task Force Reports:

1) Task Force to Recommend Goals and Objectives for COTH As Well As Future Criteria for Membership TAB D

2) Committee On House Staff Relationships To The Hospital and the AAMC TAB E

VII. Health Services Advisory Committee Meeting

VIII. AAMC-AHA Relationships

IX. Other Business

X. Adjournment

THE INSTITUTE FOR THE STUDY OF HEALTH AND SOCIETY
1050 Potomac Street, N. W. Washington, D. C. 20007 202-338-7055

October 8, 1971

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

Dear John:

I enjoyed talking to you today with regard to the Second National House Staff Conference, which will be held March 2-5, 1972, in Atlanta.

As you know, we at the Institute are quite concerned that key house officers from the teaching hospitals in this country be identified to participate. Additionally, we feel very strongly that the focus for this meeting should be on health care issues and the future role of house staff in providing better health care rather than on furthering self interests, i. e., fringe benefits, higher salaries, etc.

I hope that it will be possible in the near future for me to meet with the COTH executive committee to discuss the possibility of your aiding us in the identification of key house officers for this meeting through encouraging the COTH members to cooperate with us in identifying their local house staff officers or senior residents, etc. It is vital not only to the success of the Conference but also to the direction taken by the house officers of this country.

Thank you again for your interest, and I look forward to discussing this in further detail in the near future.

Very truly yours,

Christian N. Ramsey, Jr., M. D.
President

CNR:ve

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF TEACHING HOSPITALS

EXECUTIVE COMMITTEE MEETING
Palmer House
Chicago, Illinois
August 22, 1971

Present:

Irvin G. Wilmot, Chairman
T. Stewart Hamilton, M.D., Immediate Past Chairman
John H. Westerman, Secretary
Don L. Arnwine
Joe S. Greathouse, Jr.
L.H. Gunter
Bernard J. Lachner
Sidney Lewine
Roy S. Rambeck
Stuart M. Sessoms, M.D.
Merle S. Bacastow, M.D., AHA Representative

Staff:

John M. Danielson
Richard M. Knapp, Ph.D.
Robert H. Kalinowski, M.D.
Catharine A. Rivera

I. Call to Order:

Mr. Wilmot called the meeting to order at 9:00 a.m. in Private Dining Room #6 of the Palmer House.

II. Consideration of Minutes:

The minutes of the meeting of April 14, 1971 were approved as distributed.

III. Membership:

A. New Applications for Membership

ACTION #1 IT WAS MOVED, SECONDED AND CARRIED THAT THE STAMFORD HOSPITAL BE APPROVED FOR MEMBERSHIP.

1. The Saginaw Cooperative Hospitals, Inc. is a separate corporation, organized to manage the graduate medical education programs of four hospitals in Saginaw, Michigan. After brief discussion, there was consensus that since the corporation cannot be defined as a "hospital" it does not meet requirements for membership as set forth in the current rules and regulations.

ACTION #2 IT WAS MOVED, SECONDED AND CARRIED THAT THE SAGINAW COOPERATIVE HOSPITALS, INC. APPLICATION FOR MEMBERSHIP IN COTH BE REJECTED. THE STAFF WAS DIRECTED TO EXPLAIN THE REASONS FOR REJECTION TO DR. PETER WAYS, INDICATING THAT THE APPLICATION COULD BE RECONSIDERED IN THE FUTURE IF THE RULES AND REGULATIONS ARE CHANGED.

B. Confirmation of Mail Ballots

ACTION #3 IT WAS MOVED, SECONDED AND CARRIED THAT THE FOLLOWING APPLICATIONS FOR MEMBERSHIP IN COTH BE APPROVED:

ACTION #3 cont...

1. CHARLES S. WILSON MEMORIAL HOSPITAL
   JOHNSON, NEW YORK

2. CONFEDERATE MEMORIAL MEDICAL CENTER,
   SHREVEPORT, LOUISIANA

3. MILTON S. HERSHEY MEDICAL CENTER HOSPITAL
   HERSHEY, PENNSYLVANIA

4. MOBILE GENERAL HOSPITAL
   MOBILE, ALABAMA

It was noted that the application of the Charles S. Wilson Memorial Hospital was submitted and signed by the Director of Medical Education. The staff was requested to inform Marion C. Stith, the hospital administrator, of the application and approved membership.

C. Special Situations

ACTION #4 IT WAS MOVED, SECONDED AND CARRIED THAT THE FOLLOWING APPLICATIONS, SUBMITTED BY MEDICAL SCHOOL DEANS, FOR MEMBERSHIP IN COTH BE APPROVED:

1. PRESBYTERIAN HOSPITAL OF DALLAS
   DALLAS, TEXAS

2. BATAAN MEMORIAL HOSPITAL
   ALBUQUERQUE, NEW MEXICO

3. PRESBYTERIAN HOSPTIAL
   ALBUQUERQUE, NEW MEXICO

ACTION #5 IT WAS MOVED, SECONDED AND CARRIED THAT THE UNIVERSITY OF CALIFORNIA, IRVINE APPLICATION FOR MEMBERSHIP IN COTH BE APPROVED. IT WAS STATED THAT THIS APPROVAL IS GRANTED ON THE

ACTION #5 cont... ASSUMPTION THAT THE UNIVERSITY HOSPITAL WILL BE BUILT, ANY CHANGE IN THIS ASSUMPTION SHOULD RESULT IN A REEXAMINATION OF THE APPLICATION.

D. Status Report on Membership

Dr. Knapp made the following report:

1. Three members resigned in the fiscal year ending June 30, 1971. Mobile General, one of the three, has since reapplied and been accepted.
2. Twelve members resigned thus far in the current fiscal year beginning July 1, 1971.
3. Jersey City Medical Center has not paid dues for the past two years. The hospital was accepted for membership in November of 1970. Dues for that year as well as the current year are outstanding.
4. Dues for the current year have been received from 340 of the 398 members. This situation is an improvement over previous years.

The staff was directed to inform the Jersey City Medical Center of the current status of its dues, indicating membership would be terminated if payment is not received.

Concern was expressed that several of the hospitals which have resigned are institutions which have high quality educational programs. It was suggested that a letter be sent to each hospital which drops its membership, stating the concern of the Council over the institution's resignation. Further, the Chairman recommended this procedure be followed

for each similar situation in the future.

IV. Status Report: Development of the Division of Health Services:

The new Division was formally established on May 25, 1971 with the announcement that Robert H. Kalinowski, M.D. would become its first Director, effective August 1, 1971. Mr. Danielson introduced Dr. Kalinowski, who was formerly Deputy Director, Office of Health Affairs, Office of Economic Opportunity. (Dr. Kalinowski's Curriculum Vitae is attached to these minutes)

Dr. Kalinowski reported on the activities initiated thus far by the Division. As a preliminary to the establishment of the new Division a number of developmental activities were undertaken to provide background data and information for program planning and development purposes. These activities were carried out through the Department Director's Office with the assistance of Stephen J. Ackerman as a part-time consultant and included:

--Development of plans for a workship-conference to bring together key staff from a selected group of medical schools for the purpose of developing insight and perspective concerning the appropriate participation of the academic medical center in the delivery of health services. While failure to secure funding curtailed action at this particular time, a foundation of basic data and plans was developed for possible future application.

--An analysis and synthesis was prepared of a number of recent major reports dealing with problems of health care delivery in our nation.

--A survey of the role, function, and future outlook of departments of Community Medicine was carried out and summary feedback supplied to all medical schools. A number of favorable comments concerning the value of this information have been received.

--An inventory of HMO-type activity among the medical schools was made. This survey produced some very interesting and valuable information concerning the nature and extent of the HMO trend in the university medical center environment; this information was also shared with all schools and teaching hosptials.

--The nucleus of a library of material relevant to the subject of health services and university medical center relationships in this regard has been set up and planning for its development instituted.

--An application and plan for "HMO Program Development in the University Medical Center" was developed which was the basis for an award of some $127,000 from HEW to the new Division of Health Services. Major objectives include fostering the development of HMO's in the university medical center environment through policies and guidelines derived from a planned series of prototype HMO projects: improving the educational and research function of medical schools insofar as health care delivery is concerned; and advancing the effective integration of medical education and medical care

--A Health Services Advisory Committee to provide policy guidance and expert advice with regard to the development of the Division of Health Services has been appointed by Dr. John A.D. Cooper, President of the AAMC. Their first task involves development of policy guidelines for the HMO project, at a meeting scheduled for September 29, 1971.

--Application has been made to the W.K. Kellogg Fouccation for support for the initial organization and development of the Division of Health Services.

At this point, the agenda was reordered to permit discussion of matters pertinent to the Annual Meeting Program

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V. Discussion of Annual Meeting:

1) Nominating Committee Report

Dr. Hamilton, Chairman of the Nominating Committee requested that the committee meet immediately prior to lunch.

2) Mr. Lachner briefly outlined the deliberations of the AAMC Ad Hoc Committee on the Relationship of the House Staff to the Hospital and to the AAMC

The following Draft Position Statement: Financing Graduate Medical Education was distributed for discussion:

The Council of Teaching Hospitals recommends the following proposal for the future development of financing graduate medical education:

SINCE:

Analysis indicates education to be approximately one third of the time and effort expended by house staff, the remaining two-thirds of time and effort are divided as follows:

-- a portion is professional services on behalf of the medical staff;

-- a portion is expended on behalf of the hospital for institutional service of stand-by professional coverage and patient care management.

THEREFORE:

I. The AAMC supports in principle the Carnegie Commission Report on Higher Education recommendation that there be capitation subsidy from the Federal government for graduate medical education.

We recommend that a subsidy (Federal, state or a combination) be considered as payment for tuition amounting to one-third of the graduate medical student's expense and that these funds be paid to the institution obligated to provide the education.

II. The AAMC advocates the principle that a significant service is rendered to the physician by the graduate medical student in rendering professional care to the patient.

We recommend that a portion of the graduate medical student's compensation be charged to a physician's fund that is generated from fee-for-service at reasonable and prevailing rates.

We further recommend that the various departments rendering professional care be considered, for purposes of billing, in the same category as any group practice that guarantees professional service by a total group, rather than a single physician.

III. The AAMC recognizes the legal and moral responsibility of the hospital to provide stand-by professional service for its patients and to appropriately manage the

supportive care for all patients. It further recognizes the responsibility of the teaching hosptial to provide a proper environment for patient care and education.

We recommend that the portion of the graduate medical student's compensation remaining (after part I and II) be reimbursable out of patient care funds.

With this type of identification of responsibility which more appropriately relates financing to services rendered, provision can be made for the control and necessary incentive sought by both the provider of education and patient care as well as the carrier responsible for their support.

The specific points raised were as follows:

a. Paragraph #2 under I

1. Substitute for the last three words, "provide the education" the phrase "compensate the student."

b. Paragraph #2 under II

1. Substitute "physicians' compensation" for "fee for service".

c. Paragraph #3 under II

1. The wording should be strengthened, and the point be given more emphasis.

d. Paragraph #3 under III

2. The entire paragraph should be placed in the preamble.

Other issues were related to policy matters and the difficulty of financing during the transition from the present model to the one outlined in the draft position statement. These were as follows:

a. It appears from the discussion that the statement is directed to the financing of house staff stipends and fringe benefits; however, this point is not made clear in the document. Additionally, this is only half of the problem - the matter of financing teaching and supervisory clinicians is not addressed.

b. It must be emphasized that in the policy transition, one-hundred percent financing must be ensured. Concern was expressed that third parties would implement the statement, while the federal subsidy would be slow in forthcoming, and insufficient in amount of dollars.

c. A number of individuals questioned the willingness of physicians to devote portions of their fees to the educational program.

d. It was pointed out that the complexities of three-part financing could lead to a greater number of problems and negotiations than the present method of financing.

e. Finally, it was stated a number of times that the timing for "making a trade" was drawing short. The "trade" is basically the point outlined in paragraph #3 under II as a trade-off for the implementation of the policy statement.

There was a consensus that the issue must be faced; however, no action was taken. The position statement was received as information, and the staff was requested to place the statement before the AAMC Executive Council. Further, the position should be reviewed by Mr. Lachner's

ad hoc committee. Finally, the statement ought to be presented as one approach to the issue at the Annual Meeting. (The redrafted statementment appears as Appendix B to these minutes)

3) Dr. Hamilton reported on the first meeting of the Task Force to Recommend Goals and Objectives for COTH As Well as Future Criteria for Membership. At this point Dr. Hamilton distributed a document entitled, "The Role of the Organized Medical Staff in the Council of Teaching Hospitals", which follows:

At the February 13, 1971 meeting of the AAMC Assembly the following resolution was passed:

> "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 directs 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 the 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"

During the past six months, a variety of proposals have been discussed as a method for implementation of this resolution.

SINCE:

---- the organized medical staff in many instances is identical to the medical school faculty;

---- the organized medical staff is responsible for the quality and quantity of professional care rendered in the academic medical center;

---- the hospital is the clinical environment of the academic medical center;

---- the organized medical staff of the hospital has an ever increasing obligation to influence a change in the delivery of health care in their community;

---- no presently constituted national organization or association (other than the individual hospital) represents the medical staff of our teaching hospitals.

THEREFORE:

We recommend that the Council of Teaching Hospitals sponsor the organization of teaching hospital staffs within the framework of the COTH and the Department of Health Services and Teaching Hospitals.

PURPOSE:

To advance the quality and quantity of health services in the teaching hospital in such a way as to harmonize with the changes in medical education and research.

FUNCTIONS:

To Render Advice and Assistance

1) in establishing new and/or improved methods of delivery of health services;
2) in the resolution of problems related to government programs effecting health care delivery;
3) in developing more effective and useful organizational patterns to improve communication and decision making;
4) through expert counsel on regional planning of health services and facilities;
5) in effectuating more appropriate, accurate, retional and efficient medical record systems;
6) in the development of affiliations between institutions and professionals to insure a greater continuity of care and a broader range of educational opportunities;
7) concerning the appropriateness of programs in graduate medical education;
8) to the Council of Teaching Hospitals and the Department of Health Services on matters relevant to their expertise.

IMPLEMENTATION:

Two possible alternatives are available. The first would be the establishment of a Medical Staff Section, the formation of which might be accomplished as follows:

A) members would be appointed by the medical staff executive committee of the hospitals who are members of the Council of Teaching Hospitals;

B) the Medical Staff Section of the AAMC would be divided into four regional for purposes of communication concerning regional interest as well as the ease of establishing discussion and consensus;

c) each region would have a chairman and vice-chairman;

D) regional meetings will be annual or on call;

E) the elected officers of the various regions shall constitute an executive committee which would serve on call;

F) a national chairman shall be ex officio member of the Administrative Board of the Council of Teaching Hospitals.

The second alternative is the possibility of fully integrating this concept into the present COTH organization by establishing two representatives from each teaching hosptial - the chief executive officer of the institution, and a physician appointed by a

mechanism to be determined by each individual hospital member of COTH. Administrative Board membership and other appointments would be adjusted accordingly.

Following discussion, there was a general consensus that the second alternative would be most appropriate if such a reorganization were undertaken.

The issue which recieved most intensive examination concerned the method by which the physician should be chosen, and whether or not such a physician should have an educational orientation. There was agreement that the matter should be left to local determination.

The document was received as information, and no action was taken. Dr. Hamilton's Task Force will review the document and make a recommendation concerning future action to be presented at the October annual meeting.

The Administrative Board recessed for lunch at 12:15 p.m. During lunch, the remaining items on the agenda were discussed.

4) Dr. Knapp distributed the minutes and reported briefly on the first meeting of the Task Force to Analyze the Higher Costs of Teaching Hospitals. The Task Force will not meet again prior to the annual meeting, but the Chairman, Mr. Ferguson will make an interim report at the annual meeting.

VI. Implications of Variable Graduation Dates for Medical Students:

There was consensus that hospitals would have minimal difficulty in accommodating to variable graduation dates. However, it was agreed that the matter could pose significant problems for the NIRMP if large numbers of students become involved.

VII. Possible Endorsement of the Report of the National Commission for the Study of Nursing and Nursing Education:

It was pointed out that the document in the agenda book is a staff summary of the Report. There was consensus that the Board endorse the report in principle rather than making a statement concerning any specific recommendations.

ACTION #6

IT WAS MOVED, SECONDED AND CARRIED UNANIMOUSLY THAT THE ADMINISTRATIVE BOARD OF THE COUNCIL OF TEACHING HOSPITALS ENDORSES IN PRINCIPLE THE REPORT OF THE NATIONAL COMMISSION FOR THE STUDY OF NURSING AND NURSING EDUCATION. 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 ENGAGED IN THE PROVISION OF HEALTH SERVICES.

VIII. Report on Regional Meetings:

Mr. Danielson reported on the regional meetings held in the spring. He indicated that discussion focused heavily on the issue of financing house staff. Attendance was better than average.

It was recalled that ACTION #3 at the Board meeting on April 14, 1971 directed the staff to present the possibility of a $300 yearly increase in dues at the regional meetings, and that this issue be included in the charge to Dr. Hamilton's Task Force. Mr. Danielson stated that the dues increase was presented at the regional meetings. Opposition ranged from minimal to nonexistent.

After discussion, the following action was taken:

ACTION #7 — IT WAS MOVED, SECONDED AND CARRIED WITH ONE NEGATIVE VOTE CAST BY MR. WESTERMAN THAT THE ADMINISTRATIVE BOARD OF COTH RECOMMENDS THE DUES BE INCREASED FROM $700 TO $1,000 ANNUALLY TO BECOME EFFECTIVE JULY 1, 1972. FURTHER, IT WAS RECOMMENDED THAT THIS RECOMMENDATION BE PRESENTED TO THE MEMBERSHIP AS PART OF THE REPORT OF THE TASK FORCE TO RECOMMEND GOALS AND OBJECTIVES FOR COTH

IX. Report on AAMC/VA Liaison Committee Meeting held at the Airlie House, May 26, 1971:

Mr. Danielson reported on the improving relationship of the AAMC and the VA as exemplified in the minutes of that meeting. An example of the improved relationship is the establishment of the Veterans Administration Sharing Task Force to be chaired by Mr. Greathouse. The first meeting of the Task Force will be held on October 7. Other members of the Task Force are as follows:

Clyde G. Cox	VA-Birmingham
Kenneth J. O'Brien	VA North Little Rock
John Reinertsen	University Hospital - Utah
James T. Varnum	University of Wisconsin Hospitals
Hugh R. Vickerstaff	VA Nashville

X. Brief Legislative Status Report:

National Health Insurance, Medicare, HMO Legislation and the Proposed Hill-Burton Guidelines were briefly reviewed by the staff.

XI. Other Business:

Dr. Hamilton circulated a letter directed to him expressing the concern of the clinical faculty SUNY Upstate Medical Canter about "...recent and imminent actions to abolish the internship." There was consensus that COTH is not in a position to evaluate the issue, and is not the appropriate organization which makes or affects policy with regard to this matter.

XII. Adjournment:

There being no further business, the meeting adjourned at 3:40 p.m. The next meeting of the Administrative Board will be held on October 1971

OFFICE OF ECONOMIC OPPORTUNITY
OFFICE OF HEALTH AFFAIRS

BIOGRAPHICAL SKETCH

Name:	Robert H. Kalinowski, M.D.
Positions:	Deputy Director Office of Health Affairs
	Associate Chief for Program Development Comprehensive Health Services
Birthplace	Hartford, Connecticut
Birthdate	March 9, 1933
Education:	Trinity College Hartford, Connecticut B.S. 1954
	Tufts University School of Medicine Boston, Massachusetts M.D. 1959
	Intern, Medical Resident Hartford Hospital Hartford, Connecticut 1959 - 1961
Experience:	Deputy Director Office of Health Affairs Office of Economic Opportunity 1969 to present
	Associate Chief, Program Development Comprehensive Health Services Office of Economic Opportunity 1967 to present
	Resident in Anesthesia Hartford Hospital Hartford, Connecticut 1965 - 1967
	Chief Medical Officer Peace Corps Manila, Philippines 1963 - 1965

Experience:

Chief, Outpatient Clinic
U.S. Public Health Service
Honolulu, Hawaii
1961 - 1963

Fellow, American College
of Anesthesiologists
1968

Diplomate, American Board
of Anesthesiologists
1969

Clinical Assistant Professor
in Anesthesiology
Georgetown University School
of Medicine
1967 to present

DRAFT POSITION STATEMENT:

APPENDIX B

FINANCING GRADUATE MEDICAL EDUCATION

The following position statement on the responsibility for graduate medical education will be placed before the AAMC Assembly on Saturday, October 31, 1971:

> 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.

# # #

The Council of Teaching Hospitals recommends the following proposal for the future development of financing graduate medical education:

SINCE: Analysis indicates education to be approximately one-third of the time and effort expended by graduate medical students; the remaining two-thirds of time and effort are divided as follows:

- a portion is expended providing professional services on behalf of the medical staff;

- a portion is expended on behalf of the hospital for institutional service of stand-by professional coverage and patient care management

There is a definite need for the type of identification of responsibility which more appropriately relates financing to services rendered, so that provision can be made for the control and necessary incentive sought by both the provider of education and patient care as well as the carrier responsible for their support. The following proposal is directed toward future financing of the cash stipend and fringe benefits paid to graduate medical students. Further, the proposal must be viewed in its fullest context. Full 100 percent financing must be insured until each portion of this proposal is implemented.

THEREFORE:

I. The AAMC supports in principle the Carnegie Commission Report on Higher Education recommendation that there be a capitation subsidy from the Federal government for graduate medical education.

We recommend that a subsidy (Federal, state or a combination) be considered as payment amounting to one-third of the expense incurred to pay cash stipends and fringe benefits to graduate medical students, and that these funds be paid to the institution obligated to compensate the student.

II. The AAMC advocates the principle that a significant service is rendered for the physician by the graduate medical student in rendering professional care to the patient.

We recommend that a portion of the graduate medical student's compensation be charged to a physicians' fund that is generated from physicians' compensation at reasonable and prevailing rates.

We believe that there should be a single standard of establishing professional fees, and that this standard should be uniformly applied in the teaching and non-teaching setting with recognition of graduate medical student participation. We further recommend that the various departments rendering professional care be considered, for purposes of billing, in the same category as any group practice that guarantees professional service by a total group, rather than a single physician.

III. The AAMC recognizes the legal and moral responsibility of the hospital to provide stand-by professional service for its patients and to appropriately manage the supportive care for all patients. It further recognizes the responsibility of the teaching hospital to provide a proper environment for patient care and education.

We recommend that the portion of the graduate medical student's compensation remaining (after Part I & II) be considered as a legitimate hospital expense which should be reimbursable out of patient care funds.

Application for Membership
in the
Council of Teaching Hospitals

(Please type)

Hospital: Veterans Administration Center
Name

Biloxi
City

Mississippi
State

Street
39531
Zip Code

Principle Administrative Officer: William B. Sheppard
Name

Center Director
Title

Date Hospital was Established 1921

Approved Internships:

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

Approved Residencies:

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total Residencies Filled
Medicine			
Surgery			
OB-Gyn			
Pediatrics			
Psychiatry	August 18, 1948	10	
Other			

Information Submitted By:

William B. Sheppard
Name

Center Director
Title of Hospital Chief Executive

August 26, 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.

PLEASE READ INSTRUCTIONS ON REVERSE SIDE

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 Louisiana State University School of Medicine

Name of Dean Norman C. Nelson, M. D.

Address of School of Medicine 1542 Tulane Avenue, New Orleans, La. 70112

FOR COTH OFFICE USE ONLY

Date_____ Approved_____ Disapproved_____ Pending_____

Remarks_____

Invoiced_____ Remittance Received_____

LOUISIANA STATE UNIVERSITY MEDICAL CENTER
1542 TULANE AVENUE · NEW ORLEANS · LOUISIANA · 70112
School of Medicine in New Orleans

OFFICE OF THE DEAN

August 23, 1971

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

Dear Mr. Danielson:

The Veterans Administration Center, Biloxi, Mississippi, 39531, is nominated for membership in the Council of Teaching Hospitals.

This Center has affiliation with the Louisiana State University School of Medicine and the Tulane University School of Medicine, and has a Sub-committee of the Deans Committee for the two schools.

Mr. William B. Sheppard, Director of the Biloxi Center, is submitting an application for membership and I trust it will receive favorable action.

Sincerely yours,

Norman C. Nelson

Norman C. Nelson, M.D.
Dean

NCN/sm

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership in the Council of Teaching Hospitals

(Please type)

Hospital: VETERANS ADMINISTRATION HOSPITAL
Name

SEPULVEDA — 16111 PLUMMER ST.
City — Street

CALIFORNIA — 91343
State — Zip Code

Principle Administrative Officer: James R. Harrison
Name

Hospital Director
Title

Date Hospital was Established April 15, 1955

Approved Internships:

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

Approved Residencies:

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total Residencies Filled
Medicine	July 14, 1967	15	14
Surgery	June 24, 1964	6	6
OB-Gyn	None		
Pediatrics	None		
Psychiatry	April 11, 1957	12	12
Other			

Information Submitted By:

JAMES R. HARRISON
Name

HOSPITAL DIRECTOR
Title of Hospital Chief Executive

October 4, 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.

PLEASE READ INSTRUCTIONS ON REVERSE SIDE

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 UNIVERSITY OF CALIFORNIA AT LOS ANGELES

Name of Dean SHERMAN MELLINKOFF, M.D.

Address of School of Medicine LOS ANGELES, CALIFORNIA 90024

FOR COTH OFFICE USE ONLY

Date_____ Approved_____ Disapproved_____ Pending_____

Remarks_____

Invoiced_____ Remittance Received_____

UNIVERSITY OF CALIFORNIA, LOS ANGELES

BERKELEY · DAVIS · IRVINE · LOS ANGELES · RIVERSIDE · SAN DIEGO · SAN FRANCISCO · SANTA BARBARA · SANTA CRUZ

OFFICE OF THE DEAN
SCHOOL OF MEDICINE
THE CENTER FOR THE HEALTH SCIENCES
LOS ANGELES, CALIFORNIA 90024

20 September 1971
BB 9116

Dr. John A. D. Cooper, President
Association of American Medical Colleges
One Dupont Circle, N.W.
Washington, D. C. 20036

Dear Dr. Cooper:

I understand that the Sepulveda Veterans Administration Hospital is eligible for membership in the AAMC Council of Teaching Hospitals, since a significant amount of our teaching is conducted there and internships and residencies are established there under UCLA's aegis. May I, therefore, request that the Director of Sepulveda VA Hospital, Dr. James R. Harrison, be designated as that teaching hospital's representative?

Sincerely,

Byron Backlar
Assistant Dean
for Administration

BB:lw

cc: Dr. James Harrison
Director, Sepulveda VA Hospital

Endorsed: Sherman Mellinkoff

S. M. Mellinkoff, M.D.
Dean, School of Medicine

MINUTES

TASK FORCE TO RECOMMEND GOALS & OBJECTIVES FOR COTH AS WELL AS FUTURE CRITERIA FOR MEMBERSHIP

AAMC Headquarters
One Dupont Circle
September 24, 1971

PRESENT:

T. Stewart Hamilton, M.D., *Chairman*
Daniel W. Capps
Christopher C. Fordham, III, M.D.
Otto Janke
Arthur J. Klippen, M.D.
P. Whitney Spaulding

EXCUSED:

Saul J. Farber, M.D.
Stanley R. Nelson
David Odell
Herluf V. Olsen, Jr.
Clayton Rich, M.D.

I. The meeting was called to order at 10:00 a.m. by the Chairman, Dr. Hamilton.

II. Review of the Minutes of the June 7th meeting of the Task Force.

Dr. Fordham raised a question concerning the last sentence on page 4 of the Minutes which reads as follows:

> "After discussion, there was general agreement that in the future the vice-president will be the chief executive officer of the academic medical center with a variety of individuals reporting to him, one of whom would be the dean of the medical school"

After discussion, it was agreed that the prior sentence expresses the point of view that the role, function and responsibility of these relatively new positions have not fully matured. This being the case, there was agreement that the final sentence be deleted from the Minutes.

The Minutes of the meeting of June 7th were approved with the deletion as stated above.

III. Current Status ot Action #1 Passed at the June 7th Meeting.

The action reads as follows:

> "All deliberations and recommendations of this task force are based upon the assumption that the AAMC is the appropriate organization to represent the 'academic medical center'.
>
> Further, the assumption is made that an appropriate method will be established to achieve an effective integration of staff and policy committees that will facilitate coordination of university matters concerning medical schools, teaching hospitals and academic affairs through the AAMC organizational structure.
>
> A number of alternative courses of action are available. The attached chart is one direction that should be explored. The Vice-President's organization is urged to organize their efforts concerning other members of the 'academic medical center' through their own organization which would be staffed by joint AAMC and Vice-President's organization staff"

Mr. Danielson briefly reviewed the history of the Vice-President's organization. Further, he noted that the organization had recently adopted a new set of by-laws, collection of dues ($300 per year), changed it's name to the Association of Academic Medical Centers, and has in

general made the transition from a personal membership organization to an institutionally based organization. Further, spokesmen for the group have indicated that they represent and are concerned about matters other than medical education.

The Action item has been implemented in a very limited way. The chairman of the Association of American Medical Colleges is invited to executive board meetings of the Association of Academic Medical Centers* and vice versa. This arrangement implies some recognition of the problem, but an unwillingness at the moment to firmly come to grips with it.

In this regard, the following points were made:

-- "Who is speaking for the medical schools and medical centers?" The public may well be confused by an apparently dual approach. We cannot afford to approach the public or government with a divided house at this crucial time;

-- The initials (AAMC) of the two organizations are now the same.* This development could affect the credibility and acceptance which we have achieved, and the generally accepted meaning of these initials;

-- The use of the word "colleges" in the present name is restrictive in nature; there had been consideration in the past given to changing the word to "centers";

-- The collection of dues problem may be a matter of contraction; the more important issue is the "scope of issues" which we should represent.

* NOTE: Since the time of this Task Force meeting, it has been confirmed that the name of this new organization is the Association of Academic Health Centers

At this point, Mr. Danielson reviewed current activity underway involving discussion of efforts to deal with matters of participation, governance and identification. The Council of Deans is concerned, and the Council of Academic Societies is attempting to grapple with the issue of faculty representation. Further, COTH Chairman, Irvin Wilmot presented the proposal, "The Role of the Organized Medical Staff In COTH" at the recent Executive Council meeting. After listening to a number of proposals, the Executive Council decided that a moratorium was appropriate, and that this whole subject should be the major issue for discussion at the Annual Officers Retreat in December with other appropriate individuals being invited.

There was consensus that the Task Force should reiterate its deep concern and conviction on this matter. The following statement was unanimously endorsed by the Task Force:

ACTION #1-- THE NEXT TWO YEARS WILL BE A PERIOD OF CRUCIAL CONCERN FOR ACADEMIC MEDICAL CENTERS. THE TASK FORCE WISHES TO REITERATE ITS DEEP CONCERN THAT THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES IS THE APPROPRIATE ORGANIZATION TO REPRESENT THE "ACADEMIC MEDICAL CENTER".

EFFORTS SHOULD BE VIGOROUSLY PURSUED TO ACHIEVE AN EFFECTIVE INTEGRATION OF STAFF AND POLICY COMMITTEES WITH THE ASSOCIATION OF ACADEMIC HEALTH CENTERS THAT WILL FACILITATE COORDINATION OF UNIVERSITY MATTERS CONCERNING MEDICAL SCHOOLS, TEACHING HOSPITALS AND ACADEMIC AFFAIRS THROUGH THE AAMC ORGANIZATIONAL STRUCTURE.

IV. Current Status of COTH Membership.

A) The Future of Unaffiliated Hospitals in COTH--

There are presently 68 COTH members which are not affiliated with a medical school, according to most recent source books. However, it was stated that the data are over two years old, and that probably fifty percent of these 68 have since become affiliated.

It was suggested that if in fact the AAMC represents the academic medical center, affiliation with a school of medicine should be a criterion for membership in COTH. The existing Rules and Regulations were reviewed. Current eligibility criteria are as follows:

a) 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, which are elected by the Council of Teaching Hospitals;

or,

b) Those hospitals nominated by an AAMC Medical School Institutional Member or Provisional Institutional Member, from among the major Teaching Hospitals affiliated with the Member and elected by the Council of Teaching Hospitals

After discussion, there was general agreement that appropriate affiliation with a school of medicine should be a criterion for COTH membership. It was pointed out that if this is the only criterion for

membership, this would expand the potential pool of COTH members substantially.

Detailed discussion ensued which resulted in the following proposal for determining COTH membership.

ELIGIBILITY

Eligibility for membership in the Council of Teaching Hospitals is determined on the basis that the hospital has an appropriate, documented, affiliation arrangement with a school of medicine for the purpose of undergraduate and/or graduate medical education.

REQUIREMENT

1. Approval by the COTH Administrative Board;
2. Approval by the AAMC Executive Council.

PROCEDURE FOR APPLICATION

1. Application by the hospital with an endorsement by the dean of the affiliated school of medicine;

or

2. Nomination of the hospital by the dean of the school of medicine.

ACTION #2 THE TASK FORCE TO RECOMMEND GOALS AND OBJECTIVES FOR COTH AS WELL AS FUTURE CRITERIA FOR MEMBERSHIP RECOMMENDS THAT AN APPROPRIATE AFFILIATION WITH A SCHOOL OF MEDICINE BE A CRITERION FOR COTH MEMBERSHIP AND THAT THE AFOREMENTIONED ELIGIBILITY, REQUIREMENT AND PROCEDURE FOR APPLICATION BE PRESENTED FOR DISCUSSION AT THE COTH ANNUAL MEETING.

There was also agreement that present unaffiliated members be urged to become so, but that a "grandfather clause" be assured to permit their continuing membership.

B) Should the COTH membership be Grouped or Classified? If so, What Are the Appropriate Criteria to Utilize?

A number of proposals were put forth as possibilities which would set forth the matrix of variables which might distinguish the various types of teaching hospitals. Variables included ownership and affiliation, faculty appointments as well as others.

At this point the fundamental question was raised, "Why do we want to classify the membership?" The purposes were outlined as follows:

1) different types of services should be provided to the various types of members;
2) dues might be assessed based upon membership classification;
3) it is inappropriate for COTH to convey the impression that all teaching hospitals are alike.

It was pointed out that the first two purposes could be served internally without a formal, public classification of teaching hospitals.

Dr. Fordham suggested that perhaps the staff could be asked to draft a statement, supported by data, outlining the various types of teaching hospitals which could be used by all AAMC constituents.

The following statement appears in the introduction of the COTH Directory:

> The criteria set forth to obtain membership in the Council of Teaching Hospitals were established to provide a basis from which hospitals could organize and promote the hospital as an educational institution. Hospitals differ greatly in the extent of their commitment to

educational purposes. Membership in COTH-AAMC should not be utilized for administrative or research purposes, for example to determine reimbursement or classify hospitals in a research project.

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

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

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

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

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

After discussion, it was agreed that the above statement should be strengthened and more fully articulate the nature of the problem. Thus, a strong statement should be pursued, the purpose of which would be to outline the basic nature of a teaching hospital and those characteristics which should be examined which distinguish teaching hospitals from each other as well as community hospitals.

The staff stated that the matter of grouping or classifying the membership will continue to be studied and pursued.

C) The Role of the Organized Medical Staff In COTH--

The Philosophy of the proposal was presented, and the following points were made:

-- if the AAMC has a major concern for the delivery of health services, this proposal is a logical and necessary development following the establishment of the Division of Health Services;

-- such a proposal could intensify the breach between the clinical and basic science faculty. It was stated that this proposal should not be viewed as an effort to solve the faculty representation problem.

-- a key element for managerial effectiveness is a good working relationship between physicians and administrators. This proposal is a method of approaching that goal.

In view of these comments, it was recommended that the Assembly resolution and the first proposal for implementation be deleted.

ACTION #3 IT WAS MOVED, SECONDED AND CARRIED UNANIMOUSLY THAT THE PROPOSAL WHICH READS AS FOLLOWS BE PRESENTED TO THE INSTITUTIONAL MEMBERSHIP AT THE COTH ANNUAL MEETING AND BE FORWARDED FOR REVIEW THROUGH PROPER AAMC CHANNELS.

SINCE: -- the organized medical staff is responsible for the quality and quantity of professional care rendered in the academic medical center;

-- the hospital is the clinical environment of the academic medical center;

-- the organized medical staff of the hospital has an ever increasing obligation to influence a change in the delivery of health care in their community;

-- no presently constituted national organization or association (other than the individual hospital) represents the medical staff of our teaching hospitals.

THEREFORE: We recommend that the Council of Teaching Hospitals sponsor the organization of teaching hospital staffs within the framework of the COTH and the Department of Health Services and Teaching Hospitals.

PURPOSE: To advance the quality and quantity of health services in the teaching hospital in such a way as to harmonize with the changes in medical education and research.

FUNCTIONS: To Render Advice and Assistance;

1) in establishing new and/or improved methods of delivery of health services;
2) in the resolution of problems related to government programs effecting health care delivery;
3) in developing more effective and useful organizational patterns to improve communication and decision making;
4) through expert counsel on regional planning of health services and facilities;
5) in effectuating more appropriate, accurate, rational and efficient medical record systems;
6) in the development of affiliations between institutions and professionals to insure a greater continuity of care and a broader range of educational opportunities;

7) concerning the appropriateness of programs in graduate medical education;

8) to the Council of Teaching Hospitals and the Department of Health Services and Teaching Hospitals on matters relevant to their expertise.

IMPLEMENTATION: This concept should be fully integrated into the present COTH Organization by establishing two representatives from each teaching hospital - the chief executive officer of the institution, and a physician appointed by a mechanism to be determined by each individual hospital member of COTH. Administrative Board membership and other appointments would be adjusted accordingly.

V. Review of Current COTH Programs.

The survey of COTH members to determine what issues deserve the most time and attention was reviewed. The five top ranked issues were:

-- Present and future sources to finance the costs of graduate medical education;

-- Justifying the higher costs associated with teaching hospitals;

-- The feasibility of establishing "health maintenance organizations" by teaching hospitals;

-- The organizational relationship of the teaching hospital to the university medical center;

-- The role of the teaching hospital and medical school in community medical care problems.

In reviewing these five issues, there was general consensus that through the Divisions of Health Services and Teaching Hospitals, as well as the legislative activities, COTH and the Department are to a large degree meeting the needs of the constituents.

There was considerable discussion of the respective responsibilities of the two divisions as well as the role and function of the Health Services Advisory Committee. After a relatively detailed discussion of the organization framework of the AAMC, there was general agreement that one of the goals of COTH is to improve the management and effectiveness of teaching hospitals, and assist and contribute wherever possible to improve the management of the academic medical center.

V. Evaluation of Current COTH Dues Structure.

Dr. Hamilton stated that since the Task Force has been charged with a responsibility to review the overall COTH program, it is appropriate that there be discussion of the financial needs to carry out the program. In February, the Administrative Board directed the staff to present the possibility of a dues increase at the Spring COTH regional meetings. This was accomplished, and an increase of $300 annually per hospital has been recommended by the staff, which would raise the dues to $1,000. The COTH Administrative Board recommended the $300 increase at its August 22, 1971 meeting.

There was some question as to the appropriateness of raising the dues under the present economic environment. There was a consensus that the question ow when the increase would become effective is a matter which depends on the overall financial status of the AAMC as well as contemporary economic conditions.

It was suggested that the Task Force recommend the dues increase, but leave the determination of the date of implementation to the judgment of the COTH

Administrative Board.

ACTION #4 — IT WAS MOVED, SECONDED AND CARRIED UNANIMOUSLY THAT THE TASK FORCE RECOMMEND A $300 ANNUAL INSTITUTIONAL DUES INCREASE, BUT LEAVE THE DATE OF IMPLEMENTATION TO THE JUDGMENT OF THE COTH ADMINISTRATIVE BOARD

There was recognition of the fact that the recommended change in membership criteria may require a change in the method of determining dues payment. For instance, different assessments might be made on the basis of established criteria for different types of institutions. The staff was requested to pursue this matter with a degree of urgency.

VII. Future Task Force Action.

Dr. Hamilton will make a full report of Task Force deliberations at the COTH General Session of the AAMC Annual Meeting on October 29th. The Chairman thanked the members for their time and effort, and stated that while individuals might be called together on an ad hoc basis, the Task Force had completed its charge.

VIII. The Meeting was adjourned at 2:45 p.m.

ANALYSIS OF 1971 HPEA LEGISLATION

PROVISION	EXISTING LAW	COMPREHENSIVE HEALTH MANPOWER TRAINING ACT OF 1971 HR 8629 - as approved by Congress 1/
Construction 1. Appropriation authorization (Sec. 720)	1970 $170,000,000 1971 $225,000,000	1972 $225,000,000 1973 250,000,000 1974 275,000,000
2. Availability of funds (Sec. 720)	Two years	Repeals existing law
3. Clinical facilities (Sec. 721)	Affiliated hospitals	Affiliated hospitals and outpatient facilities
4. Eligibility for sponsorship of clinical facilities	Schools of medicine and osteopathy.	Schools of medicine, osteopathy and dentistry
5. Federal share of cost of construction (Sec. 722)	75 percent: Public health schools 66 2/3 percent: New school or major expansion 50 percent: All other, but 66 2/3 percent in "unusual circumstances"	75 percent: public health schools 80 percent: new school or major expansion 70 percent: all other; but 80 percent in unusual circumstances "such as school in doctor shortage area"

1/ Expands purpose of grants to include aid under Title VII, Part A (Health Research Facilities Grant)

PROVISION	EXISTING LAW	COMPREHENSIVE HEALTH MANPOWER TRAINING ACT OF 1971 HR 8629 - as approved by Congress
A. Construction (con't)		
6. Definition of construction (Sec. 724)	Excludes acquisition of existing buildings	Includes cost of building acquisition Adds aid for interim facilities
7. National Advisory Council on Education for Health Professions	Requires consultation before action	Consolidates function into new 21-man National Advisory Council on Health Professions Education which shall include two student-members
8. Loan Guarantees	No comparable provision	Provides 90 percent loan guarantee and 3 percent interest subsidy for private nonprofit HPEA schools Limits appropriations for interest subsidy payments: 1972, $8,000,000; 1973, $16,000,000; 1974, $24,000,000 Prohibits loan guarantees and interest subsidies whenever such guarantees and subsidies would cause the cumulative total of guaranteed, subsidized loans to exceed obligated grant funds in the same fiscal year, unless obligated grant funds equal appropriations

PROVISION	EXISTING LAW	COMPREHENSIVE HEALTH MANPOWER TRAINING ACT OF 1971 HR 8629 - as approved by Congress
Construction (con't)		
9. Application priorities	No comparable provision.	Requires priority consideration of applications for new schools of medicine, osteopathy, dentistry in which assurances are provided that use of existing facilities (including federal medical, dental facilities) will accelerate opening date
10. Review by state planning agencies	No comparable provision	Requires review by section 314 planning agencies of projects which include the provision of health services
11. Waiver of enrollment increase	No comparable provision	Enrollment increase required for construction grant (sec. 721 (c)(2)) may be waived by Secretary if the school also has a waiver for lack of physical facilities of the enrollment increase required for an institutional support grant and provides assurances that first-year enrollment in first year after completion and nine succeeding years will match the enrollment increase required for an institutional support grant.

ANALYSIS OF 1971 HPEA LEGISLATION

PROVISION	EXISTING LAW	COMPREHENSIVE HEALTH MANPOWER TRAINING ACT OF 1971 HR 8629 - as approved by Congress
Student Loans		
1. Annual maximum award per student (Sec. 741)	$2,500	$3,500
2. Authorization (Sec. 742)	1971 $35,000,000	1972 $50,000,000 1973 $55,000,000 1974 $60,000,000
3. Eligibility for forgiveness (Sec. 741)	Students of medicine, osteopathy, optometry, dentistry	All HPEA students
4. Forgiveness provisions	10%/year in shortage areas, up to 50% of principal with interest (15%/year in low-income areas) Excludes up to 5 years of advanced professional training from repayment period.	30 percent of any educational loan for each of first two years, 25 percent for third year of practice in shortage area; authorizes payment, up to the maximum, by Secretary of any loan maturing within the 3-year period

PROVISION	EXISTING LAW	COMPREHENSIVE HEALTH MANPOWER TRAINING ACT OF 1971 HR 8629 - as approved by Congress
B. Student Loans (con't)		
4. Forgiveness provisions (con't)		Full forgiveness for disadvantaged students unable to complete studies Eliminates 5-year limitation on length of advanced professionsl training to be excluded from repayment period
5. Loans to U.S. students studying abroad	No comparable provision	Authorizes $1,750,000 annually for HPEA loans under certain conditions to U.S. students enrolled at foreign medical schools

ANALYSIS OF 1971 HPEA LEGISLATION

PROVISION	EXISTING LAW	COMPREHENSIVE HEALTH MANPOWER TRAINING ACT OF 1971 HR 8629 - as approved by Congress
Institutional Support		
1. Authorization for appropriation	1970 $117,000,000 1971 168,000,000 The Secretary of HEW determines the division between formula and project grants	For capitation grants: 1972 $200,000,000 for medicine, osteopathy, and dentistry 34,000,000 for optometry, pharmacy, podiatry and veterinary medicine 1973 $213,000,000 for medicine, osteopathy, and dentistry 37,000,000 for optometry, pharmacy, podiatry and veterinary medicine 1974 $238,000,000 for medicine, osteopathy, and dentistry 41,000,000 for optometry, pharmacy, podiatry and veterinary medicine

PROVISION	EXISTING LAW	COMPREHENSIVE HEALTH MANPOWER TRAINING ACT OF 1971 HR 8629 - as approved by Congress
Institutional Support (con't)		
1. Authorization for appropriations (con't)		For special project grants: 1972 $118,000,000 1973 138,000,000 1974 156,000,000
2. Base grant	$25,000	$50,000 for no more than two years for schools of medicine, osteopathy and dentistry receiving first institutional grant after June 30, 1971, which have a first-year class of 50 or less
3. Formula grants	Approximately $600 per student per year	$2,500 for first-, second-, or third-year student of medicine, osteopathy or dentistry; plus $1,000 per enrollment bonus student (provided such student not also subject to grant under start-up assistance program or program for physicians' or dentists' assistants); plus $1,000 per student training as physicians' assistant or dental therapist; plus $4,000 per graduate completing studies in more than 3 years; $6,000 per graduate completing studies in no more than 3 years. Two-year medical school to get $2,500 per student; plus $1,000 per enrollment bonus student (subject to same proviso); plus $1,000 per student training as physicians' assistant

PROVISION	EXISTING LAW	COMPREHENSIVE HEALTH MANPOWER TRAINING ACT OF 1971 HR 8629 - as approved by Congress
Institutional Support (con't)		
3. Formula grants (con't).		$1,750 per student in veterinary medicine; plus $700 per enrollment bonus student
		$800 per student in optometry, podiatry, pharmacy, plus $320 per enrollment bonus student; except pharmacy course exceeding four years, to be aided only in last four years
		Provides for pro-rating grants if approved applications exceed appropriation
		Requires that capitation be limited to accredited schools
		Enrollment bonus student grant limited to $150,000 per class

PROVISION	EXISTING LAW	COMPREHENSIVE HEALTH MANPOWER TRAINING ACT OF 1971 HR 8629 - as approved by Congress
nstitutional Support (con't)		
Formula grants (con't)		
First-year enrollment expansion requirement	2 1/2 percent, or 5 students, whichever is greater, over the average of the two highest first year enrollments during the period 1963-68. This requirement may be waived by the Secretary because of limitations of physical facilities	10 percent over first-year enrollment in fall 1970; if such enrollment was not more than 100 5 percent or 10 students, whichever is greater, over first-year enrollment in fall, 1970, if such enrollment was more than 100.
a. Enrollment bonus students	No comparable provisions	Defines enrollment bonus student as a member of a first-year class which exceeds certain enrollment standards (generally 5 percent or 5 students, whichever is greater, above the preceding first-year class) Provides that such a student shall be so considered in each succeeding year of his enrollment Standards for 71-72 school year: Fall 1971 first-year class must exceed fall 1970 first-year class by 5 percent or 5 students, whichever is greater The school must provide assurances that succeeding first-year classes will not be less than the fall 1971 enrollment plus 10 percent of the fall 1970 first-year class (if such class was 100 or less) or 5 percent or 10 students, whichever is greater (if such class was more than 100)

PROVISION	EXISTING LAW	COMPREHENSIVE HEALTH MANPOWER TRAINING ACT OF 1971 HR 8629 - as approved by Congress
4 a. Enrollment bonus student (con't)		Standards for later school years: For a school without a previous enrollment bonus student grant, the first-year class must not be less than the required enrollment (see 4 above) plus 5 percent of such enrollment or 5 students, whichever is greater. For a school that has previously qualified for an enrollment bonus student grant, the first-year class must not be less than the assured enrollment plus 5 percent of such enrollment or 5 students, whichever is greater. The school must provide assurances that succeeding first-year classes will not be less than the enrollment required to qualify for an enrollment bonus student grant.

PROVISION	EXISTING LAW	COMPREHENSIVE HEALTH MANPOWER TRAINING ACT OF 1971 HR 8629 - as approved by Congress
Institutional Support (con't)		
5. Eligible Institutions for Special Project Grants (Sec. 772)	Accredited schools covered by HPEA Act.	Accredited schools covered by the HPEA Act Secretary may enter into contracts with public and private health and educational entities to carry out projects
Purpose of special project grants (Sec. 772)	Projects to: develop, plan, or establish programs of education in HPEA professions; Improve curriculum of HPEA schools; Conduct research in fields related to HPEA education;	To effect significant curriculum improvements, with emphasis on programs for training in family medicine To develop interdisciplinary training among HPEA schools plus schools of nursing, allied health, public health, to include training in team approach To develop training programs for new types of health personnel To conduct research in fields related to HPEA education To improve geographic and specialty group distribution of health professionals

PROVISION	EXISTING LAW	COMPREHENSIVE HEALTH MANPOWER TRAINING ACT OF 1971 HR 8629 - as approved by Congress
Institutional Support (con't)		
6. Purpose of special project grants (Sec. 772) (con't)		To develop programs for teaching organization, evaluation of health care
		To encourage enrollment in HPEA schools of students likely to practice in shortage areas
		To encourage minority enrollment
		To plan experimental teaching programs
		To provide student traineeships under a preceptor in family practice, pediatrics, internal medicine, or other Secretary-designated field
		To encourage more effective approaches to the organization and delivery of health services through team approach and use of computer technology
		To acquire necessary information or to renovate facilities for any such project
		To increase training in alcoholism, drug abuse control and the science of human nutrition

PROVISION	EXISTING LAW	COMPREHENSIVE HEALTH MANPOWER TRAINING ACT OF 1971 HR 8629 - as approved by Congress
C. Institutional Support (con't)		
7. Start-up assistance	No comparable provision	Provides grant to aid new schools of medicine, osteopathy or dentistry which begin instruction after enactment of HR 8629 Prohibits aid unless enrollment in first academic year of operation exceeds 23 Defines a new school as one which is in the year before its first students are enrolled, in the year its first students are enrolled, and in the next two years. Limits grants to $10,000 per anticipated student in the year preceding the first year of operation, $7,500 per student in the first year of operation, $5,000 per student in second year of operation, $2,500 per student in third year of operation Requires priority consideration of application in which assurances are provided that use of existing facilities (including federal medical dental facilities) will accelerate opening date Authorizes appropriations of $10 million each year for fiscal 1972-74

PROVISION	EXISTING LAW	COMPREHENSIVE HEALTH MANPOWER TRAINING ACT OF 1971 HR 8629 - as approved by Congress
Institutional Support (con't)		
8. Health Manpower Education Initiative Awards	No comparable provision	Authorizes grants to public or private nonprofit health or educational entities, plus contracts with public or private health or educational entities: to aid shortage areas; to initiate or improve training, continuing education and advanced training of health personnel: to emphasize team approach to health delivery; to aid regional arrangements to carry out such purposes; to alter or renovate necessary facilities. Authorizes grants to public or private nonprofit educational entities to meet cost of special projects to encourage enrollment in HPEA schools of students likely to practice in shortage areas; to encourage minority enrollment (appropriations for these purposes not to exceed 15 per cent of total but not to be less than $5 million)

PROVISION	EXISTING LAW	COMPREHENSIVE HEALTH MANPOWER TRAINING ACT OF 1971 HR 8629 - as approved by Congress
Institutional Support (con't)		
8. Health Manpower Education Initiative Awards (con't)		Authorizes appropriations: 1972 $45,000,000 1973 90,000,000 1974 135,000,000
9. National Advisory Council on Health Professions Educational Assistance	Requires consultation before action	Consolidates function into new 21-man National Advisory Council on Health Professions Education which shall include two student-members

ANALYSIS OF 1971 HPEA LEGISLATION

PROVISION	EXISTING LAW	COMPREHENSIVE HEALTH MANPOWER TRAINING ACT OF 1971 HR 8629 - as approved by Congress
Institutional Support (con't)		
10. Required plan in application for formula grant	No comparable provision	Requires first application for formula grant, after June 30, 1971, to contain a plan to establish and carry out over the next two school years projects in at least three of the following categories: To improve curriculum (including shortening of degree program) To develop interdisciplinary training among HPEA schools plus schools of nursing, allied health, public health, to include training in team approach To develop training programs for new types of health personnel To develop programs for teaching organization, evaluation of health care To assist in increasing supply of health personnel

PROVISION	EXISTING LAW	COMPREHENSIVE HEALTH MANPOWER TRAINING ACT OF 1971 HR 8629 - as approved by Congress
C. Institutional Support (con't)		
10. Required plan in application for formula grant (con't)		To increase training in alcoholism, drug abuse control, and the science of nutrition. To encourage minority enrollment To train primary care health professionals, with particular emphasis on programs of family medicine Provides for site visits to monitor projects Requires HEW progress reports to appropriate legislative committees by January 1, 1973, and by September 1, 1974.
11. Special assistance for two-year schools	No comparable provision	Provides grants to aid public, nonprofit schools of basic medical science (that will be affiliated with an accredited hospital) desiring to become schools of medicine Amount of grant to be $50,000 per third-year student in year grant is made Prohibits more than one grant per school

PROVISION	EXISTING LAW	COMPREHENSIVE HEALTH MANPOWER TRAINING ACT OF 1971. HR 8629 - as approved by Congress
C. Institutional Support (con't)		
12. Relief from financial distress	Included in special project grants	
a. Authorization		1972 $20,000,000 1973 15,000,000 1974 10,000,000
b. Eligible institutions		All HPEA schools
c. Purpose of grants		To meet operation costs of schools in serious financial straits; to aid schools needing financial assistance to meet accreditation requirements
		Provides that financial distress grant shall be conditioned on school disclosing Secretary-determined financial data, conducting cost analysis study, implementing Secretary- recommended reforms

ANALYSIS OF 1971 HPEA LEGISLATION

PROVISION	EXISTING LAW	COMPREHENSIVE HEALTH MANPOWER TRAINING ACT OF 1971 HR 8629 - as approved by Congress
Scholarships		
1. Annual maximum award per student (Sec. 780)	$2,500	$3,500
2. Formula for appropriations and allocations (Sec. 780)	$2,000 multiplied by ten percent of enrollment	$3,000 multiplied by 10 per cent of enrollment for fiscal 1972 $3,000 multiplied by number of disadvantaged students or by 10 percent of total enrollment, whichever is greater for fiscal 1973,1974
3. National Advisory Council on Health Professions Educational Assistance	Requires consent	Consolidates functions into new 21-man National Advisory Council on Health Professions Education which shall include two student-members
4. Scholarships to U.S. students studying abroad	No comparable provision	Authorizes $150,000 annually for HPEA scholarships under certain conditions to U.S. students enrolled at foreign medical schools

PROVISION	EXISTING LAW	COMPREHENSIVE HEALTH MANPOWER TRAINING ACT OF 1971 HR 8629 - as approved by Congress
D. Scholarships (con't)		
5. Shortage area scholarship program	No comparable provision	
a. Authorization		1972 $2,500,000 1973 3,000,000 1974 3,500,000
b. Eligible students		Students of medicine who agree after completion of professional training to engage in practice of primary care in underserved area or area that assures a substantial portion of such practice will consist of migratory agricultural workers or their families
c. Maximum annual award		$5,000 -- requires one year of practice for each year of scholarship aid, provided that a student receiving such grants for 4 years shall be deemed to have received grants for only 3 years if he serves all his internship and residency in an area with substantial migratory workers or shortage area

PROVISION	EXISTING LAW	COMPREHENSIVE HEALTH MANPOWER TRAINING ACT OF 1971 HR 8629 - as approved by Congress
D. Scholarships (con't)		
5. Shortage area scholarship program (con't)		
d. Priority of assistance		First: applicant from low-income family, resides in an underserved area and agrees to return there and practice primary care Second: applicant who resides in an underserved area and agree to return there and practice primary care Third: applicant from low-income family Fourth: all other applicants

ANALYSIS OF 1971 HPEA LEGISLATION

PROVISION	EXISTING LAW	COMPREHENSIVE HEALTH MANPOWER TRAINING ACT OF 1971 HR 8629 - as approved by Congress 1/
Special Training Traineeships, Fellowships	No comparable provision	
1. Authorization		For health professions teaching personnel: 1972 $10,000,000 1973 15,000,000 1974 20,000,000 Not less than 75 per cent of any grant to be used for traineeships, fellowships For family medicine: 1972 $25,000,000 1973 35,000,000 1974 40,000,000
2. Eligible institutions		For health professions teaching personnel: public, private nonprofit schools of medicine, osteopathy, dentistry, optometry, podiatry, pharmacy, veterinary medicine For family medicine: public, private nonprofit hospitals

1/ Adds new provisions to Title VII, Part D -- Mental Retardation Research Centers which is renamed: Grants for Family Medicine, Training, Traineeships and Fellowships and Computer Technology Health Care Demonstration Programs

ANALYSIS OF 1971 HPEA LEGISLATION

PROVISION	EXISTING LAW	COMPREHENSIVE HEALTH MANPOWER TRAINING ACT OF 1971 HR 8629 - as approved by Congress
Special Training Traineeships, Fellowships (con't)		
3. Purpose of grants		To improve teaching in HPEA schools To plan, develop, operate approved training program in family medicine for students, interns, residents, practicing M.D.s; to provide financial aid to participants in such programs; to plan, develop, operate, participate in other approved programs in family medicine
4. Amount of grant		Determined by Secretary

ANALYSIS OF 1971 HPEA LEGISLATION

PROVISION	EXISTING LAW	COMPREHENSIVE HEALTH MANPOWER TRAINING ACT OF 1971 HR 8629 - as approved by Congress 1/
F. Postgraduate medical, dental training	No comparable provision	
1. Authorization		1973 $7,500,000 1974 15,000,000
2. Eligible institutions		Public, private nonprofit accredited schools of medicine, osteopathy, dentistry, unaffiliated hospitals with Secretary-approved training programs
3. Purpose of grants		To support educational costs (to be defined by Secretary) of approved graduate training programs
4. Amount of grant		$3,000 per medical, dental graduate trainee in primary health care (as later defined by Secretary) or other Secretary-designated specialty

1/ Adds new provisions to Title VII, Part D -- Mental Retardation Research Centers which is renamed: Grants for Family Medicine, Training, Traineeships and Fellowships and Computer Technology Health Care Demonstration Programs

PROVISION	EXISTING LAW	COMPREHENSIVE HEALTH MANPOWER TRAINING ACT OF 1971. HR 8629 - as approved by Congress
Postgraduate medical, dental training (con't)		
4. Amount of grant (con't)		Provides that only first-year graduate trainees be counted in fiscal 1973; first-, second-year in fiscal 1974
5. Application procedures		Requires application to describe specific actions taken by the school or hospital to encourage specialization in primary health care or other Secretary-designated specialty Requires application to indicate that the school or hospital will increase positions open to primary health care or other priority specialists Provides for adequate fiscal and other Secretary-designated control Requires explanation of how grant will be applied to meet the appropriate educational costs
6. Mandatory increase in trainees		Requires Secretary to set annual, mandatory increases in numbers of trainees which must be met as a condition of a grant
7. National Advisory Council on Health Professions Education		Requires consultation with new 21-man National Council on Health Professions Education which shall include two student members

ANALYSIS OF 1971 HPEA LEGISLATION

PROVISION	EXISTING LAW	COMPREHENSIVE HEALTH MANPOWER TRAINING ACT OF 1971 HR 8629 - as approved by Congress 1/
Computer demonstration grants	No comparable provision	
1. Authorization		1972 $5,000,000 1973 10,000,000 1974 15,000,000
2. Eligible institutions		Public, private nonprofit schools, agencies, organizations, institutions or combinations
3. Purpose of grants		To plan, develop free-standing or university-based computer labs for processing of biomedical information To research through computers physician functions to determine which functions could be performed by other properly trained personnel

1/ Adds new provisions to Title VII, Part D -- Mental Retardation Research Centers which is renamed: Grants for Family Medicine, Training, Traineeships and Fellowships and Computer Technology Health Care Demonstration Programs

ANALYSIS OF 1971 HPEA LEGISLATION

PROVISION	EXISTING LAW	COMPREHENSIVE HEALTH MANPOWER TRAINING ACT OF 1971 HR 8629 - as approved by Congress
H. Miscellaneous		
1. Report on administration of HPEA Act	Required by June 30, 1970.	Requires by June 30, 1974
2. Joint funding of programs	Limited to Title IX (Heart, Cancer, Stroke) of PHS Act	Broadens to include Titles VII, VIII (HPEA, Allied Health, Nurse Training)
3. Advanced funding	Authorizes advance appropriations for Part G (Allied Health) of Title VII of PHS Act	Broadens to include all of Title VII and sections 306 and 309 (Traineeships and project grants for Public Health Training)
4. Study of health professions educational costs	No comparable provision	Requires the HEW Secretary to arrange for study to determine the national average annual per-student cost of HPEA and nursing schools in providing education programs leading to an appropriate degree Study to be conducted by National Academy of Sciences or any appropriate private nonprofit group or association Report due by January 1, 19[illegible]

ROVISION	EXISTING LAW	COMPREHENSIVE HEALTH MANPOWER TRAINING ACT OF 1971. HR 8629 - as approved by Congress
Miscellaneous (con't)		
5. National Health Manpower Clearinghouse	No comparable provision	Establishes a National Health Manpower Clearinghouse in DHEW to match health workers and communities with health professional needs Authorizes such sums as may be necessary
6. Study of health facilities construction costs	No comparable provision	Requires a one-year study by Comptroller General
7. Assignment of PHS physicians to certain counties	No comparable provision	Requires the HEW Secretary to use his best efforts to provide to all but the most sparsely populated counties at least one PHS physician who shall physically live in his assigned county
8. Sex discrimination		Prohibits grants, loan guarantees and interest subsidy payments under Title VII of the PHS Act unless application contains Secretary-approved assurances that there is no sex discrimination in admission of persons to eligible schools, institutions, or programs

MINUTES

COMMITTEE ON HOUSE STAFF RELATIONSHIPS TO THE HOSPITAL AND THE AAMC

AAMC Headquarters
One Dupont Circle
September 23, 1971

PRESENT:

Bernard J. Lachner, *CHAIRMAN*
Vice-President for Administration
Ohio State University
Columbus, Ohio

Malcom Randall
Hospital Director
VA Hospital
Gainesville, Florida

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

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

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

EXCUSED:

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

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

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

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

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

STAFF:

John M. Danielson
Robert H. Kalinowski, M.D.
Richard M. Knapp, Ph.D.

Grace W. Beirne
Armand Checker
Jody Williams

I. Bernard J. Lachner, Chairman, presided at the second meeting of this committee. After the call to order, Minutes of the previous meeting were approved as distributed.

II. The first item on the Agenda was the "Draft Position Statement: Financing Graduate Medical Education." The statement has been reviewed by the COTH Administrative Board and is being discussed with the Council of Academic Societies and the Executive Committee of the Executive Council. No formal approval or disapproval has been requested at any of these discussion sessions. A position paper incorporating the major provision of the earlier statement, entitled, "Responsibility for Graduate Medical Education", will be presented before the AAMC Assembly at the Annual Meeting and appears on the following page. The COTH statement on financing of graduate medical education will be discussed separately as a part of the COTH program at the Annual Meeting; however, this statement will not be included as part of the position paper to be presented to the Assembly.

John Danielson pointed out that in looking for ways to assure that legislation such as H.R. 1 takes into account the financing requirements of graduate medical education and teaching hospitals, an approach to financing seems more likely to be influential than a hardline statement. This statement of AAMC policy and the COTH recommendations on an approach will be used in discussions with the Senate Finance Committee and SSA. With regard to anticipated reaction of the COTH constituency to a policy requiring an

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.

affiliation with a medical school for approval of graduate programs, Mr. Danielson reported that the statement had been presented at all the regional meetings and emphasized that unaffiliated hospitals do have an additional alternative in that they may develop as free-standing post graduate schools of medicine.

The use of the term student in these statements refers to physicians who may be regarded as graduate medical students.

Bernie Lachner noted that this statement should also be related to efforts of the Liaison Committee on Medical Education to move in the direction of accreditation of both undergraduate and graduate program in the same accreditation process.

In answer to questions about how the distribution of financing was arrived at, Mr. Danielson explained that it was considered unlikely that exactly one-third support could be required from each of the three parties - hospital, medical staff and an educational grant or subsidy (regardless of the source of this last portion). A hard line on this could make insurance commissioners and other third parties enforce a one-third share as the maximum hospital share. A distribution in which the three parties would participate is necessary, but the hospital share will most likely be complementary and represent more than one-third of the total house staff budget. The present one-third for education equals teaching plus learning and is derived from the Gus Carroll's study, "Program Cost Estimating In A Teaching Hospital: A Pilot Study", in which the house officer interviewed said that they spent one-third of their time in educational endeavors. This distribution also reflects the data collected and analyzed through the AAMC

cost allocation study. This time and effort distribution, it was reasoned, could be applied to a distribution of costs.

Robert Cathcart reported that in Philadelphia one of the conditions of settling the Blue Cross contract was a requirement that a study be done to determine the current time and effort allocations for house officers. This will be done in the next three months probably by a management consulting firm.

Don Detmer reported that he had conducted informal survey among the house staff at Duke, asking interns, assistant residents and chief residents in Medicine, Surgery and Pediatrics what percent of their working time was spent teaching and what percent was spent as a student. Also asked was what percent of work was actually "scrutwork" that might have been done more appropriately by someone other than a member of the house staff. "Scrutwork" and teaching-learning percentages are not additive. The remaining component in the house staff time is medical professional services. The results of his informal survey are as follows:

		Intern	Assistant Resident	Chief Resident
Time Spent As:			(% of working time)	
TEACHER	Medicine	5	10	50
	Surgery	20	30	50
	Pediatrics	20	30	70
Time Spent As:				
STUDENT	Medicine	50	20	5
	Surgery	40	25	5
	Pediatrics	75	40	5

Some of the comments on this presentation were as follows:

Why do Pediatrics Staff spend a greater proportion of time in education component? The response in this case was that Pediatrics is a two year residency, and more has to be learned in a short period.

- These figures reflect the attitudes of the persons involved, but the "scrutwork" factor is real.
- These figures suggest that the distribution of time and effort is 50-50 with the service component including both institutional and professional proportions.

In summary, it is not possible to get a realistic time distribution for financial purposes so that accountants will accept the logic of the allocations to each component. Furthermore, in the teaching setting, professional service itself has an educational component. An arbitrary approach therefore is really the only one possible.

John Danielson then asked this question, "With the distribution of time found in this survey, how can we rationalize house officers' presenting themselves as employees?"

Dr. Detmer's response was that this position cannot be rationalized. In Dr. Detmer's opinion, there are three types of training programs, the academic centers, community hospitals staffed primarily by foreign medical graduates, and the municipal hospital programs. The solution to the problem of attaining quality training in community hospitals is to give the community hospitals support for depth in their programs by providing rotations for teaching staff and for house staff.

It was suggested that the distribution of financing will ultimately be decided by the availability of funds. John Danielson suggested that the

climate now seems right for front-end funding of graduate medical education. This is due to the influence of the Carnegie Commission and also to the conviction of some members of Congress that separation of education and service is possible. He also stated that at this point we want to get the concept accepted, perhaps, in the next Congress. The support at the outset is unlikely to be one-third the total cost, however.

Other points in the proposal for financing of house staff were discussed - the source of the hospital share, precedents for paying residents to teach, and particularly the recommendation that "a portion of the graduate medical student's compensation be charged to a physicians' fund that is generated from physicians' compensation at reasonable and prevailing rates".

There is some precedent for paying house staff from professional fees. Funds from private practice of medical faculty have in the past been used to pay part of house staff salaries in a number of institutions. If professional fees are to be applied to house staff salaries, a principle of importance to the AAMC and its constituents should be accepted, that professional fees not be at a lessor rate in the teaching setting. If this principle is not accepted by federal and other third parties, it will lead ultimately to an erosion of the fee-for-service practice now conducted in academic medical centers. The rationale to be accepted is that the graduate medical student is a member of the medical staff and that his salary comes from fees generated by a group or a partnership in which he participates. It was pointed out that in some settings, however, this principle would mean that fees would come out of the private practice income of individual physicians. Further, in hospitals with very large house staffs, there may not be available sufficient professional fee income to meet one-third the total budget of house staff salaries.

The proposal as it now stands is presented as Appendix A. While no vote was taken, there was a general consensus that John Danielson should pursue this approach in negotiating with the Social Security Administration and other third party representatives, recognizing that there is flexibility of percentage allocation in the three part funding approach. Further, one hundred percent financing must be ensured no matter how the percentage distribution is allocated.

III. The next item on the Agenda was the question of house staff participation in the AAMC. Since the COTH Administrative Board has adopted a position that the organized medical staffs of hospitals will be represented in the AAMC through COTH as an integral part with vote and equal representation, the following question was raised, "If house staff - graduate medical students - are members of the medical staff, could they be appropriately represented by the medical staff?". Opinions on this varied, but it was agreed that despite some commonality of interests, the interests of house staff probably could not be fully represented by an overall medical staff delegate.

Another factor was cited in terms of the current status of the national house staff organization and how its emergence would effect the requests of house officers for AAMC representation. Dr. Detmer reaffirmed his request for a trial period with house staff participation on all the AAMC Councils. This suggestion was not adopted.

John Danielson noted that other groups are concerned about appropriate representation in the AAMC and an officer's retreat to review the total organization of the AAMC is planned for December, 1971. Following a brief discussion, the following action was taken:

ACTION #1 IT WAS MOVED, SECONDED AND CARRIED BY A VOTE OF SIX TO ONE THAT THE COMMITTEE ON HOUSE STAFF RELATIONSHIPS TO THE HOSPITAL AND THE AAMC RECOMMENDS THAT CONSIDERATION OF REPRESENTATION OF HOUSE STAFF IN THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES IN ANY DETERMINATION OF THE OVERALL MAKEUP OF REPRESENTATION WITHIN THE AAMC BE DISCUSSED AT THE OFFICER'S RETREAT IN DECEMBER, 1971. FURTHER, IT IS THE SENSE OF THIS COMMITTEE'S DELIBERATIONS THAT BECAUSE HOUSE OFFICERS ARE INVOLVED IN AND ACTIVELY PARTICIPATE IN EDUCATION AND MEDICAL PRACTICE IT IS APPROPRIATE THAT THEY HAVE REPRESENTATION IN THE AFFAIRS AND GOVERNANCE OF THE AAMC.

It should be stated that one member questioned the term "medical practice" in this statement in view of the current definition applied to it.

Action on whether participation of house staff should be within COTH or how such representation should be accomplished was deferred in view of the total reassessment of AAMC organization and representation that will be undertaken at the AAMC Officers' retreat. There was a consensus that a house officer should be invited to present his views at the retreat, and that Dr. Detmer would be an excellent choice for such an invitation.

IV. The deliberations of the committee will be presented by the Chairman, Bernie Lachner, and discussed during the COTH General Session at the AAMC Annual Meeting on October 29, 1971.

V. The meeting was adjourned at 2:20 p.m.

APPENDIX A:

The Council of Teaching Hospitals recommends the following proposal for the future development of financing graduate medical education:

SINCE: Analysis indicates education to be approximately one-third of the time and effort expended by graduate medical students; the remaining two-thirds of time and effort are divided as follows:

- a portion is expended providing professional services on behalf of the medical staff;
- a portion is expended on behalf of the hospital for institutional service of stand-by professional coverage and patient care management

There is a definite need for the type of identification of responsibility which more appropriately relates financing to services rendered, so that provision can be made for the control and necessary incentive sought by both the provider of education and patient care as well as the carrier responsible for their support. The following proposal is directed toward future financing of the cash stipend and fringe benefits paid to graduate medical students. Further, the proposal must be viewed in its fullest context. Full 100 percent financing must be insured until each portion of this proposal is implemented.

THEREFORE:

I. The AAMC supports in principle the Carnegie Commission Report on Higher Education recommendation that there be a capitation subsidy from the Federal government for graduate medical education.

We recommend that a subsidy (Federal, state or a combination) be considered as payment amounting to one-third of the expense incurred to pay cash stipends and fringe benefits to graduate medical students, and that these funds be paid to the institution obligated to compensate the student.

II. The AAMC advocates the principle that a significant service is rendered for the physician by the graduate medical student in rendering professional care to the patient.

We recommend that a portion of the graduate medical student's compensation be charged to a physicians' fund that is generated from physicians' compensation at reasonable and prevailing rates.

We believe that there should be a single standard of establishing professional fees, and that this standard should be uniformly applied in the teaching and non-teaching setting with recognition of graduate medical student participation. We further recommend that the various departments rendering professional care be considered, for purposes of billing, in the same category as any group practice that guarantees professional service by a total group, rather than a single physician.

III. The AAMC recognizes the legal and moral responsibility of the hospital to provide stand-by professional service for its patients and to appropriately manage the supportive care for all patients. It further recognizes the responsibility of the teaching hospital to provide a proper environment for patient care and education.

We recommend that the portion of the graduate medical student's compensation remaining (after Part I & II) be considered as a legitimate hospital expense which should be reimbursable out of patient care funds.