

COTH ADMINISTRATIVE BOARD
Thursday, June 21, 1973
Embassy Row Hotel
Envoy C
9:00 a.m.-3:00 p.m.

AGENDA

*Substitutable for
George C. at J. Lee
Ex Council meeting*

- I. Call to Order
- II. Approval of Minutes
- III. Membership Applications
 - A. Veterans Administration Hospital
Tampa, Florida
 - B. Veterans Administration Hospital
San Diego, California
 - C. Mount Sinai Hospital
Minneapolis, Minnesota
- IV. The Patient In The Teaching Setting
- V. Regional Meeting Reports
- VI. Report on AAMC/AHA Liaison Committee Meeting
- VII. COTH Annual Meeting
- VIII. Special Study: Educational Costs of Teaching Hospitals
-Kersey B. Dastur of the Institute of Medicine Staff
- IX. Report on Physician Assistant Programs - Thomas Piemme, M.D.
 - C. Information Items
 - A. SSA Intermediary Letter Concerning "Moonlighting"
 - B. Ad Hoc Committee to Review Pertinent Sections
of H.R. 1 (P.L. 92-603)
 - C. OSR-NIRMP Proposal "Role of OSR and GSA Representatives
in Monitoring Procedures of the NIRMP"
 - D. Legislative Summary
 - E. Future of the Freestanding Internship *Call Dave Thompson*
- XI. Other Business
- XII. Adjournment

TAB A

TAB B

*Call John & ask
him to check out*

TAB C

TAB D

TAB E

TAB E

TAB F

TAB G

TAB H

TAB H

TAB H

NEXT MEETING OF THE ADMINISTRATIVE BOARD
Sunday, August 19, 1973
Palmer House
Chicago, Illinois

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COTH ADMINISTRATIVE BOARD MEETING
Embassy Row Hotel
Washington, D.C.
March 15, 1973

PRESENT:

Leonard W. Cronkhite, Jr., M.D., Chairman
George E. Cartmill, Immediate Past Chairman
John H. Westerman, Secretary
Daniel W. Capps
David H. Hitt
Arthur J. Klippen, M.D.
Sidney Lewine
Herluf V. Olsen, Jr.
Stuart M. Sessoms, M.D.
Eugene L. Staples
David D. Thompson, M.D.
Charles B. Womer

EXCUSED:

Robert A. Derzon, Chairman-Elect
Thomas H. Ainsworth, Jr., M.D.

STAFF:

Richard M. Knapp, Ph.D.
Robert H. Kalinowski, M.D.
Grace W. Beirne
Catharine A. Rivera

I. Call to Order:

Dr. Cronkhite called the meeting to order at 9:00 a.m. in Envoy B of the Embassy Row Hotel.

II. Consideration of Minutes:

The minutes of the meeting of November 2, 1972 were approved as distributed.

III. Status Report on MCAT Development Activity:

Dr. James Erdmann, Director, Division of Educational Measurement and Research and Jim Angel, Coordinator MCAT Test Development, reported on efforts to update and expand the purposes of the Medical College Admission Test. A systematic effort is underway to obtain the views of all interested AAMC constituents. Interested individuals were urged to contact Dr. Erdmann directly. A brief outline of this activity appears as Appendix A to these minutes.

IV. Membership Applications:

ACTION #1

IT WAS MOVED, SECONDED AND CARRIED THAT THE FOLLOWING APPLICATIONS FOR MEMBERSHIP IN THE COUNCIL OF TEACHING HOSPITALS BE APPROVED:

BRYN MAWR HOSPITAL
BRYN MAWR, PENNSYLVANIA

RIVERSIDE METHODIST HOSPITAL
COLUMBUS, OHIO

WATERBURY HOSPITAL
WATERBURY, CONNECTICUT

VETERANS ADMINISTRATION HOSPITAL
BALTIMORE, MARYLAND

VETERANS ADMINISTRATION HOSPITAL
COLUMBIA, MISSOURI

VETERANS ADMINISTRATION HOSPITAL
LOS ANGELES, CALIFORNIA

ACTION #2

IT WAS MOVED, SECONDED AND CARRIED THAT THE FOLLOWING APPLICATIONS FOR MEMBERSHIP IN THE COUNCIL OF TEACHING HOSPITALS BE REJECTED:

COMMUNITY HOSPITAL OF INDIANAPOLIS
INDIANAPOLIS, INDIANA

ST. JOHNS HOSPITAL
SPRINGFIELD, ILLINOIS

Document from the collections of the AAMC Not to be reproduced without permission

ACTION #2. . .

MEMORIAL HOSPITAL OF SPRINGFIELD
SPRINGFIELD, ILLINOISRARITAN VALLEY HOSPITAL
GREENBROOK, NEW JERSEYV. Regional Meetings:

Regional meetings are to be held in late April and early May, and the following individuals will be working with the staff in planning the meetings.

April 27	Western	Pacific Grove, CA	Mr. Derzon
April 30	Midwest/Great Plains	Chicago	Mr. Westerman
May 4	Southern	Atlanta	Dr. Sessoms
May 14	Northeastern	Boston	Dr. Cronkhite

VI. Professional Standards Review Organizations:

Dr. Kalinowski discussed the current role of HEW, SSA and HSMHA in the development of policy to implement the PSRO's mandated in P.L. 92-603. Additionally, he reported that the sub-committee on quality of care will be meeting on April 12-13.

The policy statement which was presented for review appears on the following page.

After brief discussion the following action was taken:

ACTION #3 IT WAS MOVED, SECONDED AND CARRIED THAT THE
COOH ADMINISTRATIVE BOARD APPROVE THE RECOMMENDED
POLICY STATEMENT ON PSRO'S WITH THE FOLLOWING
CHANGES:

- (1) "ORGANIZED MEDICAL STAFF" BE INSERTED
FOLLOWING THE WORD "RESPONSIBILITY"
ON LINE 3:
- (2) "AND HOUSE OFFICERS" BE INSERTED
FOLLOWING "MEDICAL STUDENTS" ON LINE 6.

Policy Statement of the AAMC on PSROs

TITLE XI of Public Law 92-603, the Social Security Amendments of 1972, calls for the establishment of PSROs nationwide to monitor and evaluate the costs and quality of health care for Medicare and Medicaid patients. At present, the Federal responsibility for developing this program has been divided among three agencies. HSMHA has been assigned the task of developing norms and standards as well as designing methodologies for collecting the necessary data in a uniform manner; SSA, because of its operational experience in administering the Medicare program, will assimilate the data through its EDP facilities, utilizing the capabilities of its carriers and intermediaries.

The PSRO office under the direction of the Secretary of HEW will have overall policy determination over both HSMHA and the SSA.

\$10M this fiscal year and \$30M next fiscal year have been requested for PSRO activities. Most of these funds will be utilized for contracts to prototype PSROs with some monies for central office operations and a small amount for research. The majority of the PSRO staff positions will be within the BHI of the SSA.

Although PSRO regulations will not be developed anytime within the near future, it is anticipated that some preliminary guidelines will be distributed for the use of "early" PSRO programs, as well as those organizations with plans to become PSROs (under Section 1169 of the Law, funds are provided for feasibility and planning grants to PSRO prototype projects).

By January 1, 1974, the Secretary of HEW will have designated the geographical areas for PSROs. Nationally there will be approximately 150-200 PSROs which will be established mostly below the state level.

The PSRO will be required to develop a series of profiles on institutions, physicians and patients. Although rudimentary patient and physician profiles now exist in the computer tapes of the intermediaries and carriers; they must be expanded to include additional data and must be collated to produce the requisite information.

Utilizing EDP techniques, matrices will be developed by PSROs which will facilitate the evaluation of practitioner and institutional performance in multiple areas of health care services.

The preparation, distribution and validation of data, starting at the local level and channelled through the PSRO central office and back to the local organizations will constitute a substantial administrative task to be performed by the 100 carriers and intermediaries for Medicare and a large number of different carriers and intermediaries for Medicaid. Changes will also have to be made in the present EDP system of the SSA to accommodate the demand for additional and different types of data.

Within the teaching hospital, the U.R. Committee could be used as a mechanism for developing an internal review system to meet the operating requirements of the local PSRO. If the norms, criteria and standards developed by the U.R. Committee are judged to be acceptable to the PSRO, the hospital can then be made responsible for reviewing its own health

care services subject to periodic sample auditing by the PSRO. In such cases, the U.R. Committee can make decisions in regard to patient care which are binding upon the carrier as well as the SSA.

Records and data will have to be reviewed to determine such things as appropriateness of admission, parameters of acceptable care for various disease states and perhaps comparison of surgical rates, for example, of hysterectomies and tonsillectomies with those of other hospitals in the area.

With the realization that the PSRO legislation needs to be more clearly interpreted, the Federal Government may develop a PSRO Model Review System to describe how a PSRO could be organized. This package would include a model charter, by-laws, membership guidelines, a budget, an appropriate data system and a reporting mechanism. The early directives to be distributed with this package could suggest the types of activities that should be conducted by a PSRO, e.g. pre-admission certifications program, development of a model treatment plan, etc.

In developing their programs, PSROs will be assisted by the technical and regional staffs of HSMHA and SSA. Once geographical areas have been designated, it is recognized that institutions such as teaching hospitals will require additional staff and resources to assist their U.R. Committees in meeting the requirements of the local PSROs.

The Association's Subcommittee on Quality of Care (Dr. Robert Weiss, Chairman; Dr. Clement Brown; Dr. David Challoner; Dr. Christopher Fordham; Dr. Richard Meiling; and Mr. John Westerman) will meet in April to develop further the AAMC's relationship to the evolving federal presence in quality and cost review.

The Subcommittee intends to meet with Dr. Bauer, Director of PSRO, and the Senate Finance Committee staff, and develop recommendations for teaching hospitals to meet PSRO criteria through multiple mechanisms. In addition, the dissemination of information, where teaching hospitals have successfully worked out mechanisms with prototype PSROs, will be one of the major goals of the Subcommittee:

- ▶ Approval by the EC of a policy statement on the appropriate involvement of the AAMC membership in the development of PSROs is desirable at this time.

RECOMMENDATION

It is recommended that the Executive Council approve the following statement as an AAMC policy on PSROs:

The AAMC believes that the development and implementation of norms and standards for assessing the quality of health care is a vital responsibility of the medical schools and teaching hospitals. A major part of this responsibility is the incorporation of quality-of-care assessment into clinical educational programs to develop in medical students a life-long concern for quality in their practice.

The AAMC, therefore, strongly recommends that its member institutions become intimately involved in the development and operation of Peer Standards Review Organizations.

VI. RMP/CHP Legislative Renewals:

Dr. Kalinowksi reported that the authorizing legislation for CHP and RMP terminate on June 30, 1973. A proposal has been drafted setting forth the AAMC's views on the future of these two agencies and their respective objectives. A lengthy discussion ensued.

No action was taken, but the following statement summarizes discussion of the issue.

The basis of the discussion at the COTH Administrative Board meeting concerns the fact that this proposal attacks one segment of the various health services control and regulatory mechanisms in isolation from all the others.

In reviewing current regulatory and control agencies from the standpoint of their responsibilities, they seem to divide themselves into about seven general categories:

- (1) Control of capital input better known as the "certificate of need" phenomenon;
- (2) The control of planning. How much institutional planning must be done, and to how many public bodies must it be reported.
- (3) Control of costing and pricing, for example, rate setting commissions;
- (4) Control of the data base and method of outcome measurement;
- (5) Control of the quality of care;
- (6) Control of the benefit package so that it can be matched with the dollars that are available in setting of priorities;
- (7) Control of manpower output, so that what is produced relates to what society needs. There are bills in various state legislature concerning this issue.

There is concern that although nobody can argue that it is not in the public interest to have these controls and regulations for these activities, but that the method by which they are administered must be set forth in an organized rational manner so that the providers can live with them.

If one is going to tackle how government controls and regulates, one must have about six assurances written in all of them, and all the controls should be reviewed together.

- (1) The first one is the general competence of the controllers vis a vis those controlled. This has all sorts of implications including the matter of getting them out of civil service, letting them buy quality.
- (2) Second concerns the development of devices which make the controller as apolitical as possible. Namely that he isn't the surrogate of the appointing authority and serves at his pleasure, but has a term of his own, so that he is really out of the political arena as much as possible;
- (3) Thirdly, that some sort of administrative appeal mechanism be designed which is timely, so that if a public official in a controlling position makes a capricious decision or one which is against public policy, recourse is in a very immediate fashion along a very specified course of events;
- (4) Fourthly, that the industry being controlled is at least represented on the controlling authority;
- (5) And next, that performance audits and fiscal audits are done by agencies independent of the controlling agencies so that it is a disinterested audit;

- (6) And lastly, that the data bank be a common one, and that access to it be available to any legitimate interested party, so that no one group manipulates the data to get the answer they want; other agencies should use the same raw data in order that there exist a reasonable check and balance.

VII. Social Security Amendments:

Dr. Knapp reported that Administration plans to introduce legislation which would increase the deductible and coinsurance provisions of the Medicare law.

Legislation to be proposed would replace the current health insurance cost-sharing system with a new system under which the beneficiary would pay daily amounts equal to ten percent of actual hospital, extended care facility, or home health agency charges for that day, after having met an initial hospital deductible amount equal to one day's actual room and board charges. Thus, the proposed system would tie cost-sharing to actual charges and services used. It is theoretically intended to establish a cost awareness on the part of the medical care consumer which, besides its effect on over-utilization, should assumedly inhibit hospital price increases.

Two legislative changes also are proposed in the supplementary medical insurance program. The first increases the initial deductible to \$85 from its present \$60, while the second increases the percentage amount of subsequent bills which the beneficiary pays from 20 to 25 percent.

ACTION #4 IT WAS MOVED, SECONDED AND CARRIED THAT THE
 COTH ADMINISTRATIVE BOARD RECOMMENDS OPPOSITION
 TO PROPOSED LEGISLATIVE CHANGES IN THE MEDICARE
 PROGRAM WHICH WOULD INCREASE DEDUCTIBLE AND CO-
 INSURANCE PROVISIONS OF THE LAW

There was also a brief discussion of two sections of P.L.92-603 which should be monitored closely to determine their possible implications for teaching hospitals. These are as follows:

Section 221 - "Federal Participation in Capital Financing"

Section 223 - "Limitations On Coverage of Costs Under Medicare"

Dr. Cronkhite agreed to appoint an ad hoc committee to review regulations to implement these sections as they become available. Membership of the committee is as follows:

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

John W. Colloton
University of Iowa
Hospitals and Clinics

John M. Stagl
Northwestern Memorial Hospital

Charles B. Womer
Yale-New Haven Hospital

VIII. Hill-Burton Legislative Extension:

Legislation which authorizes the continuance of the Hill-Burton Program expires on June 30, 1973. A bill sponsored by Senator Dominick of Colorado was reviewed. After brief discussion, the following action was taken.

ACTION #5 IT WAS MOVED, SECONDED AND CARRIED THAT THE
COIH ADMINISTRATIVE BOARD RECOMMENDS SUPPORT
OF HILL-BURTON LEGISLATIVE EXPENSION WITH
EMPHASIS ON MODERNIZATION IN URBAN AREAS.

IX. COIH House Staff Survey:

The Board briefly reviewed the current house staff survey questionnaire. It was suggested that the terminology referring to interns and residents be

updated, and that a question be added concerning length of vacation time. The new questionnaire appears as Appendix B to these minutes.

X. Proposal for COTH Research Awards:

Dr. Knapp suggested that one way the Department of Teaching Hospitals can expand its investigative activities in the absence of acquiring additional staff is to provide modest support for ongoing doctoral research in areas of interest to the COTH membership.

The proposed program would establish two COTH \$2,500 research support grants to doctoral candidates in the organizational and/or behavioral sciences, e.g., Departments of Economics or Programs in Hospital and Health Administration. The applicants shall be full-time doctoral degree candidates who have passed their comprehensive examination and who have a formally approved dissertation proposal. The subject matter area addressed in the research proposal should be directly related to the financing, organization and/or provision of health services in an academic medical center environment. The applicants themselves and their research proposals would be screened by the staff; selection of award recipients would be made by the Administrative Board.

ACTION #6 IT WAS MOVED, SECONDED AND CARRIED THAT THE
COTH ADMINISTRATIVE BOARD APPROVE THE "PROPOSAL
FOR COTH RESEARCH AWARDS."

XI. COTH Annual Meeting:

It was agreed that format used in 1972 should be continued. This means that a COTH luncheon would be planned for Monday, November 5, 1973. The luncheon would be followed by the business meeting and COTH general session. There was a consensus that speakers at the general session be two in number and follow the general theme of teaching hospital experience with various

regulatory agencies including rate review, certificate of need and Phase III.

XII. Guidelines For Academic Medical Centers Planning To Assume Institutional Responsibility For Graduate Medical Education:

The guidelines reviewed appear as Appendix C to these minutes. There was a general discussion of the financing house staff programs since the guidelines offer little in the way of suggestions for future financing alternatives to the present sources. However, it was agreed that this particular document did not provide the proper opportunity to proceed further with this issue.

ACTION #7 IT WAS MOVED, SECONDED AND CARRIED THAT THE STATEMENT BE APPROVED WITH THE FOLLOWING RECOMMENDED CHANGES:

- (1) ITEM 4 ON PAGE 10 SHOULD BE REWORDED. THE STATEMENT IS PRESENTLY A NONSEQUITOR WHICH IMPLIES THAT FACULTY WHO TEACH GRADUATE EDUCATION ONLY ARE NOT INCLUDED:
- (2) UNDER 3.2 ON PAGE 14, THE WORD "DIRECT" SHOULD BE DELETED FROM THE THIRD LINE:
- (3) THE TWO SENTENCES IN THE FIRST PARAGRAPH ON PAGE 21 SHOULD BE REWORDED. IF THE INTENT IS TO ALLOW SENIOR RESIDENTS TO BILL FOR PROFESSIONAL SERVICES, THIS SHOULD BE CLEARLY STATED. SOME CONCERN WAS ALSO EXPRESSED THAT THE PHRASE "AND EDUCATIONAL PROGRAMS" IN THE SECOND SENTENCE WOULD BE A RED FLAG IN THE REPORT.

XIII. Report From the Ad Hoc Committee on Continuing Education:

ACTION #8 IT WAS MOVED, SECONDED AND CARRIED THAT THE
COMMITTEE REPORT BE APPROVED WITHOUT COMMENT.

XIV. Adjournment:

Several members requested that the next meeting include reports on physician assistants and nurse practitioners as well as activities in primary and ambulatory care. There being no further business, the meeting adjourned at 3:00 p.m.

Status Report on

MCAT DEVELOPMENT ACTIVITY

A provisional name has been designated - Medical College Admission Assessment Program (MCAAP). The key word is "assessment". This word was deliberately chosen to suggest a broader range of data collection beyond that ordinarily implied by a testing format, e.g. biographical information. The purpose of the program is to update and expand the MCAT and increase the amount of useful information available during the admissions process.

A systematic effort is suggested for obtaining constituent input and consensus on instrument construction and research and development activity. This effort began in a serious way about a year ago when your response to a "Proposal for a Program of Pre-enrollment Assessment" was requested. Some concrete topics for discussion were identified which hopefully will provide a departure point for discussion at the spring meetings of the appropriate councils and subcouncilar units of the Association. Jim Angel, program director of MCAAP, will be working with the various regional chairmen to identify a regional representative who will facilitate discussions within regions where possible, organize the regional input, and supply continuity in later discussions.

Following regional meetings, the current plan is to organize regional conferences in June sponsored by MCAAP and devoted exclusively to discussion of plans and priorities for program development. Participation would be open to all interested representatives from all constituent bodies of the AAMC within that region. The various regional representatives previously identified would play a major role in transmitting the concerns of their organization at these discussions and in representing a synthesis of these concerns at a task force to take place in July. Invitation to the task force sessions would include the regional representatives and a few at-large members. The primary objective of the task force sessions would be consensus on immediate plans and priorities for test construction activities and research effort.

Concurrently, a contractor will be identified to interact with the constituency at these various opportunities and draw up a set of specifications which will also include its independent recommendations.

Finally, an advisory body will be identified from those contributing to the ultimate consensus in order to provide continuing guidance to the developing program.

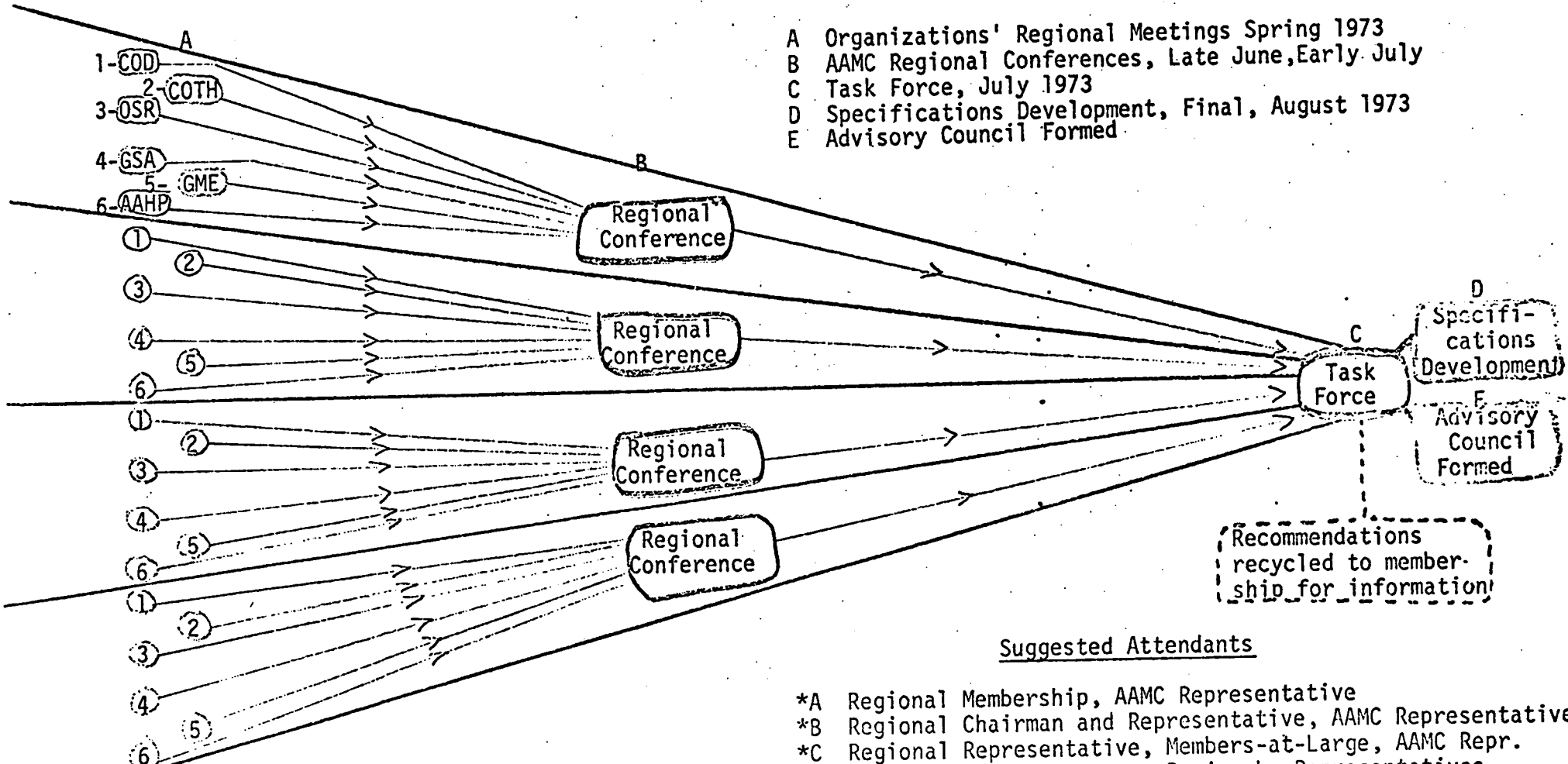
AAMC
2/73

DIAGRAM OF COUNCIL/GROUP AND TASK FORCE INVOLVEMENT¹

MCAT Revision Planning

Meetings

- A Organizations' Regional Meetings Spring 1973
- B AAMC Regional Conferences, Late June, Early July
- C Task Force, July 1973
- D Specifications Development, Final, August 1973
- E Advisory Council Formed



Recommendations recycled to membership for information

Suggested Attendants

- *A Regional Membership, AAMC Representative
- *B Regional Chairman and Representative, AAMC Representative
- *C Regional Representative, Members-at-Large, AAMC Repr.
- D AAMC Staff, Contractors, Review by Representatives
- E Persons recommended by task force, AAMC Exec. Council
- *Some meetings possibly attended by contractor representative

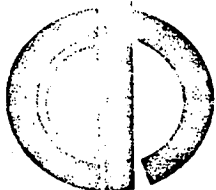
¹ Plans being formulated for CAS participation also.

- 1 Council of Deans
- 2 Council of Teaching Hospitals
- 3 Organization of Student Representatives
- 4 Group on Student Affairs
- 5 Group on Medical Education
- 6 Association of Advisors to the Health Professions

¹ Not named is Council of Academic Societies, which may have involvement of some dimension.

ACAAP/JLA
2/7/73

COTH Survey of House Staff Policy



March 1973

To Be Completed and Returned to:

COTH-AAMC, One Dupont Circle, N.W., Washington, D. C. 20036

HOSPITAL NAME: _____

A. INTERNS AND RESIDENTS

For the purpose of this survey, please report as follows: Intern = 1st post-MD year; 1st year resident = 2nd post-MD year; etc.

	Interns	Residents	Clinical Fellows	Total
1. How many house staff positions did you fill in 1972-1973?	_____	_____	_____	_____
2. How many house staff positions are you offering for 1973-1974? (If you share house staff with another institution, please estimate the full-time equivalencies for your hospital)	_____	_____	_____	_____

3. What is the minimum cash stipend per year?

	1972-73	1973-74
1st Post-MD year:	\$ _____	\$ _____
2nd post MD year	_____	_____
3rd post MD year	_____	_____
4th post MD year	_____	_____
5th post MD year	_____	_____
6th post MD year	_____	_____
Clinical Fellowships: 1st year	_____	_____
2nd year	_____	_____

1973-74 stipends are estimated:

Yes _____

No _____

Cannot Estimate _____

4. If minimum stipends vary by department, in which departments do they vary, and how much in 1972-73 was the difference for 2nd post MD year?

Departments	\$Amount
a. _____	+ _____
b. _____	+ _____
c. _____	+ _____
d. _____	+ _____

5. Do you have a dependency allowance? YES _____ NO _____

6. What is the estimated total dollars to be spent for intern and residents' stipends for 1972-73? \$ _____

7. What is the estimated cost of fringe benefits (including insurance) to your institution for house staff during 1972-73? \$ _____

8. What percent of your 1972-73 operational budget is allocated to the costs of stipends and fringe benefits for house staff? _____ %

9. What sources are used to pay your costs (stipends and fringe benefits) for interns and residents? (i.e. hospital charges, federal grants, medical school funds)

Sources	\$	% of Contribution
a. _____	_____	_____ %
b. _____	_____	_____ %
c. _____	_____	_____ %

10. What sources are used to pay your costs for clinical fellowships?

Sources	\$	% of Contribution
a. _____	_____	_____ %
b. _____	_____	_____ %
c. _____	_____	_____ %

Document from the collections of the AAMC Not to be reproduced without permission

11. Will there be a change in the total number of funded house officer positions for July, 1973? Net Number Increased _____
 Net Number Decreased _____
 No Change _____

B. FRINGE BENEFITS

1. Please check the health insurance benefits for which you pay the *full* costs of the premiums to insure

	House Officers	Dependents
Hospitalization	_____	_____
Medical Surgical	_____	_____
Major Medical	_____	_____

2. Please indicate the perquisites which you furnish at *reduced rates* or at *no cost* to your house officers.

_____ Laundry	_____ Professional Meetings (travel, room or board)
_____ Duty Uniforms	_____ Housing (cash allowances or domicile)
_____ Parking	_____ Meals (other than on-call or snacks)
_____ Malpractice Insurance	
_____ Life Insurance: Face Value of Policy \$ _____	
_____ Other: (please specify): _____	
_____ None of the above mentioned	

3. How many weeks of vacation are available to 2nd year Post-MD's? _____ weeks

4. During the past year, which fringe benefits were:

Added?	Increased?	Eliminated?	Decreased?
_____	_____	_____	_____
_____	_____	_____	_____

C. HOUSE OFFICER EMPLOYMENT POLICIES

1. In addition to their regularly prescribed duties, are your house officers permitted to engage in the delivery of other medical services *at your hospital*, such as staffing your emergency room, for which they earn additional money (moonlighting)? YES _____ NO _____

2. Does your hospital policy permit house officers to "moonlight" outside your institution? YES _____ NO _____

3. If NO, is the policy strictly enforced? YES _____ NO _____

4. Does your hospital ever hire house officers from other institutions to staff your emergency room or a similar service? YES _____ NO _____

D. COLLECTIVE BARGAINING

1. Has your hospital, since January 1, 1972, received a request for *collective bargaining recognition* from any formally constituted group seeking to represent your house staff regarding wages, fringe benefits, and/or terms and conditions of employment? YES _____ NO _____

2. Does your hospital now have a negotiated *collective bargaining contract* with any segment of your house staff regarding wages, fringe benefits, and/or terms and conditions of employment? YES _____ NO _____

3. Has your hospital, since January 1, 1972, experienced any type of job action (e.g., work stoppage, strike, "admit-in," mass resignation, "sick-out," etc.) by any segment of your house staff? YES _____ NO _____

4. Is any portion of your non-house staff personnel (full-time physician faculty, nurses, paramedical, non-professional) covered by a negotiated collective bargaining contract? YES _____ NO _____

E. OTHER

1. What is the procedure in the following two departments for "nights on"?

a. In *Medicine*, 2nd year Post-MD's are assigned a "night on" every _____ weekday and every _____ weekend.

b. In *Surgery*, 2nd year Post-MD's are assigned a "night on" every _____ weekday and every _____ weekend.

Document from the collections of the AAMC Not to be reproduced without permission

THE GRADUATE MEDICAL EDUCATION COMMITTEE

APPENDIX C

William G. Anlyan, M.D., CHAIRMAN
Vice President for Health Affairs
Duke University
School of Medicine

Sam L. Clark, Jr., M.D.
Chairman, Department of Anatomy
University of Massachusetts
School of Medicine

William J. Grove, M.D.
Executive Dean
University of Illinois
College of Medicine

William D. Holden, M.D.
Chairman, Department of Surgery
Case Western Reserve University
School of Medicine

Thomas D. Kinney, M.D.
Director of Medical Education
Duke University
School of Medicine

Julius R. Krevans, M.D.
Dean
University of California, SF
School of Medicine

Christian Ramsey, M.D.
President
Institute for the Study of
Health and Society

Arnold S. Relman, M.D.
Chairman, Department of Medicine
University of Pennsylvania
School of Medicine

David B. Wilson, M.D.
Asst. Dir. of the Medical Center
(For Special Projects and Health
Care Planning)
University of Mississippi
School of Medicine

Dr. Dael L. Wolfle
Professor
University of Washington
Graduate School of Public Affairs

Prepared by:

August G. Swanson, M.D.
Director, Dept. of Academic Affairs
Association of American Medical Colleges

GUIDELINES FOR ACADEMIC MEDICAL CENTERS
PLANNING TO ASSUME INSTITUTIONAL RESPONSIBILITY
FOR GRADUATE MEDICAL EDUCATION

CONTENTS

Foreword	i
I. Introduction	1
II. Historical Summary	1
III. Guidelines	9
A. Definitions	9
1. Graduate medical education	9
2. Graduate medical students	10
3. A graduate medical education program	10
4. The graduate medical education faculty	10
5. Academic medical centers with institu- tional responsibility for graduate medi- cal education	11
B. The Institutional Setting	11
1. Introduction	11
2. Governance	12
a. Role of the Governing Board	12
b. Role of the Faculty	13
c. Role of the Residents and Fellows	13
3. Administrative Arrangements	14
C. Resident Selection, Evaluation of Progress and Graduation	15
1. Selection	15
2. Evaluation of Progress	15
a. General	15
b. Evaluation of Readiness for Increased Patient Care Responsibilities	16
3. Graduation	17
4. Resident Counseling	18
D. Curriculum and the Learning Environment	18
1. Curriculum Development	18
2. Balancing Service and Education	19
3. Continued Intellectual Growth	19
E. Financing	20
1. Institutional Financing	20
2. Resident Financing	21
F. Guidelines Concerned with Related Issues	22
1. Patient Records	22
2. Attitudinal Development	23
3. Education with Other Health Professionals	23
4. Primary Patient Care	24
5. Manpower Distribution by Specialty and Geographic Location	25

FOREWORD

The Assembly of the AAMC approved a statement in November of 1971 urging that the academic medical centers assume institutional responsibility for graduate medical education. These guidelines have been developed to assist faculties seeking to develop a plan for institutional assumption of responsibility for the various internship and residency programs in their academic centers.

In developing this document, the Graduate Medical Education Committee and the staff drew heavily upon earlier committee reports. These are mentioned in the Historical Summary and should be referred to by faculties and their planning committees. The Historical Summary also sets forth the rapid and accelerating change in graduate medical education in the United States.

Because the rate of change in graduate medical education has been paralleled by an increasing complexity of academic medical centers, it has been necessary to keep these guidelines broad. Major conceptual ideas for which policies and administrative detail must be developed are set forth. It was not intended that a single best solution be promulgated.

The value of these guidelines will be enhanced if the specific problems which are met and resolved (or not resolved) by the institutions as they attempt to meet the Assembly's challenge are communicated on a national level. From the aggregate experience plans for specific studies in national policy development can be derived.

I. INTRODUCTION

Graduate medical education is the process that differentiates the multipotential holder of the M.D. degree into a competent, professional physician who has the requisite knowledge, skills and judgement to begin a lifelong career of service and learning in a delimited area of medical practice.

This document sets forth guidelines for the development of overall institutional responsibility for graduate medical education. It is particularly directed towards academic medical centers with medical schools conducting undergraduate programs leading to the M.D. degree, but it has broad applicability to all institutions conducting programs for the graduate education and training of medical specialists.

II. HISTORICAL SUMMARY

Attaining the M.D. degree now signifies that the recipient is prepared for further education rather than for an independent professional career. The degree is a benchmark of transition from the first phase of formal medical education to the second. In the first phase the goal is to educate and train students in the basic and clinical sciences to the point that they are capable of obtaining clinical, social, and cultural data from a variety of patients; are able to assimilate and record these data in a logical and coherent fashion and

correlate this information, to a limited degree, with the existing body of biomedical, scientific knowledge in arriving at diagnostic and therapeutic decisions. As the body of knowledge has grown and the skills for collecting data and providing therapy have become more and more complex, the undergraduate phase of medical education and training has been complemented by a formalized graduate phase.

This phase, largely based upon direct responsibility for patient care, has developed as an apprenticeship system, supervised and controlled by each specialty discipline. National standards for accreditation of graduate programs and for certification of individuals by examination have been evolved by each specialty. Directors for each specialty graduate program are principally guided by these national standards.

In general the system has been successful and has produced highly trained and skilled specialists. However, the reliance on national policies, established solely by specialists in each discipline, for accreditation and certification has not been optimally responsive to societal needs and has produced a relatively inflexible graduate medical educational system which tends to neglect the variations in residents, institutional characteristics, institutional missions and national and regional health service needs.

The nation's medical schools are now providing staff and facilities for the graduate education of 80% of their M.D.

recipients. Therefore, these institutions and their affiliated teaching hospitals should properly assume a larger degree of responsibility for the conceptual development of the graduate phase of medical education and for setting the standards of accomplishment for the students whom they educate and train.

Granting the M.D. degree has been the responsibility of academic institutions for the past fifty years. The assumption of this responsibility terminated the era when medical education was controlled largely by the practicing profession. As a result, new standards derived from the broad perspective of the universities promoted an adherence to excellence in scientific and clinical education and created institutions capable of scientific investigation and the application of new biomedical knowledge to medicine.

Medical schools, as they became components of universities, established their medical educational programs by achieving a consensus of the entire faculty of the school. This involved both basic scientists and clinicians. Criteria for student selection and standards for promotion and graduation also were considered to be a responsibility of the entire faculty. While constrained to a degree by state licensure laws, accreditation standards, and the "conventional wisdom" of the medical establishment, schools could develop special curricula and instructional techniques peculiarly suited to their students, their resources, and the needs of their communities or regions. Until the mid-50's, few schools made sig-

nificant experiments in modifying the conventional (i.e., 2 basic science years, 2 clinical years) mode of the traditional four-year undergraduate education for the M.D. degree. During the past fifteen years, and particularly during the past five, new approaches to undergraduate education have been common. The forces promoting curricular experimentation are complex, and they vary from one institution to another. The opportunity to depart from tradition is in large measure afforded by the willingness of the accrediting agency (the Liaison Committee on Medical Education), state examining boards and other public agencies to trust that the "corporate wisdom" of the entire faculty of a medical school will assure maintenance of basic and fundamental academic standards. This trust has been enhanced by the emergence of large full-time faculties in both the clinical and basic science departments. These faculties are considered to be of such high quality that they can be permitted a large degree of institutional self-determination for undergraduate medical education.

During the period when undergraduate education was traditional and essentially standardized, and most M.D. recipients entered practice after one year of internship, the purpose of graduate medical education was to produce a few qualified specialists in those clinical areas which required detailed knowledge and skills not ordinarily provided in the formal medical education program. It is not surprising that the first four boards established during the period from 1916

to 1932 were in Ophthalmology, Otolaryngology, Obstetrics and Gynecology, Dermatology and Syphilology. Individuals in these disciplines, concerned with assuring high standards of education and training for those who called themselves specialists, promoted the establishment of Boards to lay down national standards for program length and content and national examinations to assure the competence of those certified as specialists.

Reliance upon rather rigid standards for program characteristics and individual certification was necessitated by the diversity of settings for graduate medical education. Hospitals, both those affiliated with and not affiliated with medical schools, were the institutions for graduate medical education; and in either setting, the program for each specialty discipline was considered the sole responsibility of the specialists involved in that discipline. A broad institutional responsibility for graduate education, similar to that taken by the entire faculty for undergraduate medical education, did not evolve, even as the number of specialty Boards increased and as the setting for graduate medical education moved more and more into the academic environment of the medical schools.

While initially graduate education was largely conducted by full-time practitioner-specialists in the context of their own practice, the development of full-time, clinician-academics in medical schools gradually moved the major responsibility for graduate medical education into the province

of academic medicine. Students promoted this transition by preferentially choosing programs established in academic settings over those lacking academic affiliations. During the past decade, Board members have been increasingly drawn from physicians in the academic environment.

In 1966 the AMA-sponsored Citizens' Commission on Graduate Medical Education, recognizing the significant engagement of academic medical centers with graduate medical education, recommended that the universities assume full responsibility for all of graduate medical education in the nation.¹ In 1968 the Council of Academic Societies of the AAMC published a report of a major conference on "The Role of the University in Graduate Medical Education." This report pointed out that although the setting for graduate medical education had shifted into the academic medical centers, there was insufficient recognition that these graduate programs were now a major responsibility of these institutions.² In 1971 the Assembly of the AAMC approved a statement urging the constituent members of the Association to assume responsibility for graduate medical education in a manner analogous to their assumption of responsibility for undergraduate medical education.^{3,4}

The foregoing has related the movement of graduate medical education into the academic environment largely to the development of full-time clinical faculties and to student preference for the academic setting. Several other factors have been operant in this evolution.

The explosion in biomedical knowledge and technology largely is a product of the university-based medical school, and the most comprehensive exposure to this new information can be gained at the university centers. University centers have also commanded more resources for procuring advanced equipment and specialized personnel. While such expenditures have generally been for research purposes, the opportunity to learn the latest methodologies for patient care has been provided to graduate medical students in these settings.

Training programs supported by federal funds have largely gone to university-based medical centers. Thus, direct support for individuals seeking graduate education has been more available in programs directed by full-time, academic clinicians.

The ascendancy of graduate programs in the academic institutions has been significantly related to external forces, particularly those promoting research and increased specialization in medicine. The institutions, either individually or in the aggregate, have only recently realized that they must become concerned with the impact of their large graduate medical education commitments, on their resources and upon the characteristics and quality of medical practice in their communities and the nation.

During the past several years, significant changes have begun to develop in the national approach to accreditation of graduate programs and the certification of specialists.

These changes can provide opportunities for the faculties of graduate medical educational institutions to move toward a broader responsibility.

In the accreditation arena, the formation of the Coordinating Council on Medical Education and the Liaison Committee on Graduate Medical Education has established for the first time an opportunity for five major national organizations to participate in remodeling the accreditation of both undergraduate and graduate medical education. The parent organizations are: the American Medical Association, the Association of American Medical Colleges, the American Board of Medical Specialties, the American Hospital Association and the Council of Medical Specialty Societies. These provide for broad input into both the Coordinating Council and the Liaison Committee on both undergraduate and graduate medical education. It is likely that proposals for innovative improvements in educational programs will receive interested and sympathetic attention by these newly-formed bodies.

During the past decade, the specialty Boards have been seeking to improve their certification procedures for individuals. Increasingly they have turned to the National Board of Medical Examiners for advice and assistance. The National Board, recognizing that rapid changes are occurring in both undergraduate and graduate medical education, is in the process of reorganizing itself so that it can provide more effec-

tive service for certifying that recipients of the M.D. degree are prepared for entering graduate education and also assisting the Boards in developing assessment systems of high quality and validity.

In the discussion and debates which have led to the establishment of a new accrediting system and the reorganization of the National Board of Medical Examiners, it has been repeatedly emphasized by many who participated that the institutions of higher education which conduct programs for the education of physicians must assume greater responsibility for the quality of all programs conducted under their aegis. Further, there is general recognition that in a complex, pluralistic society, national agencies cannot effectively oversee either accreditation or certification without delegating responsibility to institutions which are dedicated to maintaining and improving quality.

At this point in time, the reorganization which has been accomplished on the national scene provides both an opportunity and a challenge to the academic medical centers to assume greater responsibility for and greater authority over graduate medical education.

III. GUIDELINES

A. DEFINITIONS

1. Graduate medical education is that period in the formal education and training of a physician which usually fol-

lows the granting of the M.D. degree and culminates in qualifying for certification in a specific clinical discipline. Certification is obtained by the satisfactory completion of a program of education and training, and passing an examination or examinations conceived and administered by a national body (Board) representing the discipline.

2. Graduate medical students are individuals, usually with an M.D. degree, who are enrolled in a graduate medical institution and are pursuing education and training in a program leading to certification in a clinical discipline. The traditional titles "intern", "resident", "clinical fellow" or "house officer" recognize the hospital-physician role of these individuals. Although such titles do not convey their semi-student status or their role in health care delivery outside the conventional hospital setting, the titles "resident" or "clinical fellow" are widely understood and are preferable to "student" or "trainee".

3. A graduate medical education program is a complete educational and training experience which prepares residents to assume independent responsibility for patient care in a specific clinical discipline.

4. The graduate medical education faculty in an institution ordinarily should include all the full-time and part-time faculty normally responsible for undergraduate medical education. The need to incorporate learning opportunities in the basic sciences into graduate programs will provide a

special challenge to the basic science faculty and their clinical colleagues. Institutions utilizing part-time clinician-teachers are encouraged to provide these individuals with appropriate input into program planning and appropriate recognition.

5. Academic medical centers with institutional responsibility for graduate medical education are institutions or institutional consortia which provide the spectrum of scientific and clinical faculty, the facilities, and the administrative capability necessary to plan, conduct and evaluate graduate education and training based upon policies and goals derived on an institution-wide basis.

B. THE INSTITUTIONAL SETTING

1. Introduction

Graduate medical education requires a special institutional setting. Academic medical centers planning to assume responsibility for graduate medical education must recognize the need for an institutional system capable of delivering health-care services, ranging from primary to tertiary, in a variety of settings.

In developing the health services appropriate for graduate programs, the centers will need to encourage the participation of individuals, institutions and agencies having primarily a service commitment, but willing to make a commitment to the academic mission. The new institutional form

derived from this amalgamation will have both special characteristics and special problems which may require changes in the conventional management and governing policies of either the academic or the health service institution. The academic programs and the service programs must be blended. The faculty must be composed of individuals with a variety of academic and professional capabilities; and as a faculty, must be capable of recognizing the contribution of all its segments to the common goals of education, service, and research.

Financing, although derived from multiple sources, must be apportioned to assure that the various missions of the institution remain in dynamic and effective balance.

2. Governance

a. Role of the Governing Board. The academic medical center which broadens its responsibilities to include graduate medical education must be cognizant of the need for a governing board made up of individuals who can understand its special problems and make policy decisions which range from those related to academic governance to those required in the institutional delivery of health care services. Where the academic center is a consortium of institutions with their own governing boards, a governance mechanism representing all institutions should be established to implement policy decisions related to the overall educational mission of the center and to articulate these policies with the service missions of the several constituent institutions.

The provision of health services to the community is essential for accomplishing the graduate medical education mission, and the board must be sensitive to the needs of the community for health services. There should be provisions made for input to the board from recipients of these services.

b. Role of the Faculty. Faculty should be responsible for policy development and program review of all facets of graduate medical education. Faculty from both basic and clinical academic departments should expect to contribute to the teaching programs of the various disciplines. In most institutions, mechanisms for ensuring that the faculty exercises this responsibility have been well developed for the undergraduate program leading to the M.D. degree. Because of the greater complexity of graduate education, it is particularly important that broad participation of members of the faculty, ranging from basic scientists to practicing clinicians, be engaged in setting standards for student selection, reviewing and approving curriculum plans, assessing the validity of resident evaluation procedures, and ratifying the graduation of residents from various graduate medical programs. This will necessitate establishing a multidisciplinary review system for each graduate program. An overall faculty committee for broad policy development and the adjudication of disagreements will surely be needed.

c. Role of the Residents and Fellows. Because residents and fellows are expected to educate and train those junior to

them and are also expected to share in the supervision of patient care provided by those with lesser experience, they should be provided appropriate involvement in the affairs of the institution. This involvement should be particularly directed toward enhancing their teaching and supervisory skills.

3. Administrative Arrangements

Administrative systems will vary depending upon the size and complexity of the academic medical center. The importance of providing for the following relationships is emphasized:

a. The ultimate responsibility and authority for the educational programs of the academic center should be lodged with an individual who has direct access to, and is also responsible to, the governing board. When the graduate medical institution is a consortium of institutions, the relationship of this administrative officer to each institutional member should be explicitly stated.

b. The undergraduate and graduate medical education programs should be administratively linked.

c. Because of the differential nature of graduate medical education, the specific programs leading to different disciplinary careers should be planned and implemented by faculty members specifically responsible for each program. However, the autonomous discretion of these program directors should be limited. The individual with overall responsibility for the center's educational programs should have administrative authority over each program director and should assure

that the selection of students, appointment of faculty, development of curricula, assessment of residents, evaluation of the educational process and outcomes and the commitment of resources for all programs are commensurate with the policies for graduate medical education established by the entire faculty.

d. Because administering a health services delivery system is a complex task, it is likely that an individual with particular skills will be delegated this task. It is extremely important that this individual and his staff understand the interdependence of the service and educational programs of the center and that he be a member of the team of individuals responsible for the educational mission.

C. RESIDENT SELECTION, EVALUATION OF PROGRESS AND GRADUATION

1. Selection

Residents selected should ordinarily have achieved the M.D. degree or its equivalent. This is not to be construed to interdict programs which coordinate their curricula with the undergraduate medical school curricula of students who have made early career decisions for a specific discipline. Specific criteria for selection for each program should be developed and approved by the general faculty or a representative body of the faculty.

2. Evaluation of Progress

a. General. Procedures for evaluation and reporting the progress of residents in each program should be developed.

These procedures should include an assessment of knowledge, skills, performance and judgement in the particular discipline pursued and an overall assessment of attitudinal development. No specific examination or rating system is recommended but evaluation should be carried out by faculty members both within and without the resident's discipline. There should be clear evidence that progress is periodically evaluated (at least annually) and reports of these evaluations should be on file in a central office of the institution. Provision should be made for regularly apprising residents of the faculty's evaluation of their progress. This feedback is essential. Evaluation reports should be utilized to verify that residents are ready to graduate and be certified as prepared for Board examinations.

b. Evaluation of Readiness for Increased Patient Care Responsibility. A fundamental educational technique of graduate medical education is caring for patients in a carefully supervised setting. As residents achieve increasing knowledge, skills and judgement, increased responsibility for making decisions and providing services is necessary. Faculty supervision of residents is an important and intricate matter. On one hand, failure to allow residents to grow into increasing responsibility inhibits their professional development, while on the other hand, permitting premature assumption of responsibility endangers patients and may encourage the development of undesirable attitudes and behaviors which will

prove detrimental far beyond the training years. This difficult problem of matching responsibility with achievement cannot be resolved by arbitrarily assuming that after fixed periods of time in a program, all residents are ready for similar levels of responsibility. Verifiable and auditable methods of determining readiness for the next level of patient-care responsibility should be developed. These may include reports of direct observations of residents in the patient-care setting by several faculty members, audits of a resident's patient records, the use of simulation techniques, and written or oral examinations to determine knowledge. Specific and measurable criteria should be determined in advance in order to achieve optimal evaluation.

3. Graduation

Certification that an individual is prepared for independent patient-care responsibility is a dual function shared by the graduate medical institution and the Boards. Graduation should be acknowledged by the awarding of a certificate which signifies that the entire faculty recognizes that the individual awarded the certificate has met all of the requirements set forth by that faculty. The institution should place the same stress on its public accountability for the awarding of such a certificate as do institutions of higher education in awarding advanced degrees.

Examination by the appropriate specialty board completes the certification procedure.

4. Resident Counseling

An advising and counseling service should be available to graduate medical residents.

D. CURRICULUM AND THE LEARNING ENVIRONMENT

1. Curriculum Development

It is recognized that each graduate discipline in medicine has its special body of knowledge and skills. Nevertheless, it is not necessary that all graduate programs in a discipline have either identical content or identical requirements for length of training. Broad guidelines indicating the expectations of achievement for professionals in each discipline are achieved through a national consensus and promulgated by the Boards. Program directors, faculty and residents are encouraged to develop their own curriculum for each discipline taught within the institution and to experiment with the development of new disciplines which can provide patient care more effectively.

In developing curricula, careful attention should be paid to the special distinctions which make each resident unique. These include prior educational background and cognitive, perceptual and manual skills. Opportunities should be provided to residents to plan a significant portion of their programs with the advice and counsel of faculty.

Effective performance in any specialized discipline of medicine is founded upon general knowledge and skills common

to all physicians. Undergraduate medical school curricula are designed to provide students with these basic skills. However, if residents have not had a sufficiently broad experience in the general clinical areas relevant to their specialty, this type of experience should be provided. The timing when residents in various disciplines achieve optimal basic knowledge and clinical skills is of lesser importance than ensuring that these skills are achieved before the residents are certified for graduation.

2. Balancing Service and Education

It has been repeatedly emphasized that graduate medical education is based upon the provision of personal health care services to patients. A willingness to serve patients is an important professional attitude for physicians. The obligation to provide patient services must be a part of the learning experience for all residents. Graduate medical residents are expected to assume increasing service loads as they grow and mature into their full professional roles, and must therefore willingly accept the responsibility of serving the needs of patients in all settings. This emphasis on patient service must not be construed as condoning excessive dependence by institutions upon residents and clinical fellows for the provision of patient services.

3. Continued Intellectual Growth

While learning in the setting of direct patient care is important in graduate medical education, it is essential to

balance the educational strategy with a similar emphasis on continued intellectual growth in biomedical knowledge. Residents should be taught how to continue to expand their fund of knowledge in an organized fashion while fulfilling the demands of accepting increasing responsibility for patient care.

The development of a learning environment which maintains residents' interest in the basic biomedical sciences during the graduate years is both an opportunity and a challenge for the faculties of academic medical centers. Basic scientists and clinicians should work together to maintain and stimulate the intellectual curiosity of these older, now differentiating residents. The instructional techniques for this group must be especially tailored. Adherence to the techniques which are effective for undifferentiated, undergraduate medical students frequently will not succeed.

Centers assuming responsibility for graduate medical education should plan to support enlarged basic science faculties and should seek to recruit basic scientists who can teach effectively in the clinical setting.

E. FINANCING

1. Institutional Financing

Institutions seeking accreditation for graduate medical education must develop sufficient financial resources for supporting educational programs to ensure that administrators

and faculty with primary responsibility for education can devote their principal energies to conducting the various programs.

Because teaching and practicing clinical medicine are inextricably related, it is expected that faculty having teaching responsibilities will also care for patients. Payment for patient services delivered in the teaching setting by both faculty and advanced residents is appropriate and essential. Funds so generated should be collected and managed in such fashion that the financial needs of faculty, residents and educational programs are met effectively and fairly. This plan should be formally established, agreed to by the faculty, and its administration should be periodically reviewed by the governing board.

Residents and faculty both contribute to the services provided patients by hospitals. Hospitals providing facilities for graduate medical education must, therefore, contribute to the budget for graduate medical education.

2. Resident Financing

Because the graduate education and training of residents is long and the intensity of their responsibility precludes their earning extra income, the costs cannot be borne solely by most residents.

Residents, as they advance through their training, provide essential services to patients both on behalf of hospitals and their physician-teachers. The financing of resi-

dents should recognize these services, and income derived from both hospital charges and professional fees should be budgeted for their stipends.

F. GUIDELINES CONCERNED WITH RELATED ISSUES

1. Patient Records

Effective learning and effective evaluation of the learner in the clinical setting are dependent upon the excellence of patient record systems. Academic medical centers should make every effort to maintain high quality patient record systems. The goals should be:

a. To make the patient record an effective instrument for ensuring excellence in the provision of care to each individual patient.

b. To make the patient record an effective instrument for learning by displaying all data legibly and in a manner which assures that the rationale for each decision is clearly evident.

c. To make the patient record an effective instrument for evaluating the quality of performance of the resident by making the records auditable. Accomplishing an audit should not require extraordinary investment of time by the reviewer.

An optimal learning environment requires that the learners and their teachers participate directly in patient care and record their observations, opinions and decisions directly in the patient record.

2. Attitudinal Development

Graduate medical education has developed because of the need to provide specialized knowledge and skills to physicians in delimited areas of medical practice. This thrust has placed an emphasis on the attainment of such knowledge and skills, often to the exclusion of cultivating a professional awareness of the emotional needs and cultural characteristics of patients as individuals or as members of specific populations. Graduate medical institutions should be aware that an essential portion of their educational mission is the maintenance and cultivation of helping attitudes in their residents. Many institutions have available to them faculties in the behavioral sciences. These faculties are showing an increasing interest in participating in medical education and they should be encouraged. However, the faculty responsible for graduate medical education must assume primary responsibility for maintaining and cultivating an awareness of the physician's responsibility for encompassing all facets of patients' needs--physical, emotional and cultural.

3. Education With Other Health Professionals

Increasingly, physicians are dependent upon the knowledge and skills of other health professionals. Optimal provision of personal health services to an expanding population with increasing expectations for health care can only be met by the efficient utilization of all available talent. The period of graduate medical education provides special opportu-

nities for training physicians to work with other health professionals. Most academic medical centers are educating several types of health professionals other than physicians. In developing educational policy, curriculum, and instructional plans, members of the faculty responsible for other health professional programs should be consulted; and mechanisms for their meaningful input should be developed. In the graduate setting, differentiating physicians should learn to work with students in other health professions in the real context of patient care. Having residents develop an understanding of the special abilities of other health professionals, coupled with learning how to delegate responsibilities to those colleagues, should be a major goal.

4. Primary Patient Care

An emphasis on specialism in American medicine has resulted in a graduate medical education system focused principally on educating and training physicians for highly specialized roles in the treatment of disease. The generalist, prepared to assume primary responsibility for patients, has not received major attention. Institutions for graduate medical education are encouraged to experiment with the development of delivery systems and educational programs which will encourage a significant proportion of their residents to develop careers as primary care physicians.

5. Manpower Distribution by Specialty and Geographic Location

a. Specialty distribution:

Academic medical centers should plan their program in graduate medical education in accord with specialty manpower needs of both their regions and the nation. In a nation which is undergoing significant changes in its health care delivery system, projecting manpower needs requires complex planning technology. The geographic mobility of physicians further complicates local and regional forecasting. Institutions are urged to utilize resources available locally in developing manpower projections and to cooperate in national efforts to estimate the types of specialists needed in medicine.

b. Geographic distribution:

Solving the problems of getting physicians to settle and work in medically underserved areas is complicated. While there are many financial and cultural factors which influence physicians in their decisions for location, the professional experiences provided during their graduate education may be influential. Learning while caring for patients in well-run ambulatory settings remote from the acute-care teaching hospital may provide insights into the feasibility of establishing a practice in more remote areas. By extending graduate education opportunities into remote settings, academic medical centers will also provide opportunities for continued participation in medical education by physicians who choose to establish their practices in these areas.

REFERENCES

1. Millis, J. S. (Chairman). The Graduate Education of Physicians. Report of the Citizens Committee on Graduate Medical Education. Chicago: American Medical Association, 1966.
2. Smythe, C. McC., Kinney, T. D., Littlemeyer, M. H. (Eds.). The Role of the University in Graduate Medical Education. Evanston, Illinois: Association of American Medical Colleges.
3. Bulletin of the Association of American Medical Colleges, VI: 9: 3, 1971.
4. Kinney, T. D. (Chairman). Implications of Academic Medical Centers Taking Responsibility for Graduate Medical Education. Report of the Ad Hoc Committee on Graduate Medical Education. J. Med. Educ., 47: 77-84, 1971.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership
in the
Council of Teaching Hospitals

(Please type)

Hospital: VETERANS ADMINISTRATION HOSPITAL
TAMPA 13000 N. 30th Street
City Street
FLORIDA 33612
State Zip Code

Principle Administrative Officer: GEORGE R. HISKEY
HOSPITAL DIRECTOR
Title
Date Hospital was Established AUGUST 21, 1972

Approved Internships:

Type	Date Of Initial Approval by CME of AMA*	Total Internships Offered	Total Internships Filed
Rotating	Offered under Univ. of So. Florida Affiliated Hospitals	12	Pending NIRMP Matching
Straight			

Approved Residencies: (Figures shown are FY-74 Residency & Internship Commitments)

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total Residencies Filed
Medicine	Offered under Univ. of So. Florida Affiliated Hospitals	20	20
Surgery	" " "	12	12
OB-Gyn	-	-	-
Pediatrics	-	-	-
Psychiatry	Offered under Univ. of So. Florida Affiliated Hospitals	6	6
Other Pathology	" " "	4	4
Radiology	" " "	3	3
Ophthalmology	" " "	1	1

Information Submitted By:

ROSS C. KORY, M.D., Chief of Staff
Name
April 27, 1973
Date

G. R. HISKEY, Hospital Director
Title of Hospital Chief Executive
GR Hiskey
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.

Document from the collections of the AAMC. Not to be reproduced without permission.

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 SOUTH FLORIDA COLLEGE OF MEDICINE

Name of Dean DONN L. SMITH, M.D., Ph.D.

Address of School of Medicine 4202 Fowler Avenue, Tampa, Florida 33620

FOR COTH OFFICE USE ONLY			
Date _____	Approved _____	Disapproved _____	Pending _____
Remarks _____			

Invoiced _____	Remittance Received _____		

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership
in the
Council of Teaching Hospitals

(Please type)

Hospital: Veterans Administration Hospital
 Name
3350 La Jolla Village Drive
 City San Diego, California Street 92161
 State _____ Zip Code _____

Principle Administrative Officer: TURNER CAMP, M.D.
 Name
Hospital Director
 Title

Date Hospital was Established February 7, 1972 (First Patients Accepted)

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	<u>July 17, 1972</u>	<u>34</u>	<u>34</u>
Surgery	<u>August 11, 1972</u>	<u>41</u>	<u>27</u>
OB-Gyn	<u>N.A.</u>	<u>-</u>	<u>-</u>
Pediatrics	<u>N.A.</u>	<u>-</u>	<u>-</u>
Psychiatry	<u>June 1, 1972</u>	<u>15</u>	<u>15</u>
GERI Neurology	<u>June 1, 1972</u>	<u>8</u>	<u>8</u>
Pathology	<u>June 20, 1972</u>	<u>10</u>	<u>10</u>
Radiology	<u>June 7, 1972</u>	<u>11</u>	<u>9</u>

Information Submitted By:

TURNER CAMP, M.D.
 Name
March 22, 1973
 Date

Hospital Director
 Title of Hospital Chief Executive

 Signature of Hospital Chief Executive

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

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-San Diego
Name of Dean Clifford Grobstein, Ph.D.
Address of School of Medicine Post Office Box 109
La Jolla, California 92037

FOR COTT OFFICE USE ONLY

Date _____ Approved _____ Disapproved _____ Pending _____

Remarks _____

Invoiced _____ Remittance Received _____

CONTENTS
CHAPTER 1. GENERAL

PARAGRAPH	PAGE
1.01 Purpose - - - - -	1-1
1.02 Objectives - - - - -	1-1
1.03 Relation of VA Hospitals With Medical Schools - - - - -	1-1
1.04 Relation of VA Hospitals With Schools of Dentistry - - - - -	1-3
1.05 Relation of VA Hospitals With Other Institutions of Higher Learning - - - - -	1-3
1.06 Administrative Relations and Responsibilities - - - - -	1-4
1.07 Committee Relations and Functions - - - - -	1-4
1.08 Relation of VA Education Programs With the Medical Community - - - - -	1-8
1.09 Relation of Teaching Programs to Admission of Patients - - - - -	1-8
1.09.1 Gifts or Donations - - - - -	1-8

Document from the collections of the AAMC Not to be reproduced without permission

CHAPTER 1. GENERAL

1.01 PURPOSE

The purpose of this chapter is to outline general policies for the guidance of education and training programs within the Department of Medicine and Surgery.

1.02 OBJECTIVES

The education and training programs described in this manual are directed toward the following broad objectives:

a. To provide employees of the Department of Medicine and Surgery with opportunities for education and training in their respective fields of specialization. The primary purpose and demonstrated consequence of this effort is improved medical and hospital care for the veteran patient.

b. To attract and retain qualified professional, technical, and administrative staff by providing them the opportunity to keep abreast of the latest techniques and developments in their fields through detail to postgraduate and inservice courses, attendance at professional meetings and conferences, and liberal interchange with teaching programs at affiliated institutions of higher learning.

c. To provide to VA employees the vital link between medical research and medical practice using all appropriate channels of communication, such as lectures, conferences, interhospital educational details, publications, and so on.

d. To provide through Medical Illustration Laboratories the visual aids and photographic record services essential to a modern progressive program of patient care and a sound program of education and research.

e. To foster through the sponsorship of Medical Record Library Service the proper accumulation, storage, and use of medical data as an integral part of individual patient care and an important support of research and education functions.

1.03 RELATION OF VA HOSPITALS WITH MEDICAL SCHOOLS

a. General Considerations

- (1) The best medical treatment and hospital care are invariably provided in an environment where the spirit of inquiry and investigation exists in combination with a genuine interest in both teaching and learning. To assure itself of such environment, the Department of Medicine and Surgery strongly supports a broad policy of cooperation and professional interchange with schools of medicine wherever an affiliation is feasible. Many years of experience have confirmed the practicality of this policy and have brought to all concerned a satisfying reward in terms of improved standards of medical practice, increased facilities for graduate education, and tangible contributions to the health services of the Nation.
- (2) Experience has also shown that no conflict of objectives exists between the schools of medicine and the medical services of the VA. There has been no essential disagreement over methods. It is recognized that the VA is charged with certain legal responsibilities in connection with the medical care of veterans which it cannot delegate. The discharge of these responsibilities is materially supported by the exercise of educational functions within the prerogative of the medical school.
- (3) Because of the nature and history of this association, the diverse local circumstances, and the desirability of a dynamic and flexible relation between ourselves and the medical schools, the responsibilities and functions of the two parties are presented only in the broadest generality.

b. Division of Responsibilities. By entering upon affiliation with a VA medical facility, the school of medicine accepts advisory responsibility for all education and training programs conducted therein. The VA retains to itself full responsibility for the care of patients, including all administrative and professional functions directly pertaining thereto.

(1) The School of Medicine

- (a) Will organize a Deans Committee, composed of senior faculty members from all schools cooperating in the affiliation.
- (b) Will nominate to the Manager on an annual basis a staff of consulting and attending specialists in the number and with the qualifications agreed upon by the Deans Committee and the VA.
- (c) Will supervise, through the Manager and the staff of consulting and attending specialists, the education and training programs of the VA and such programs as are operated jointly by the VA and the medical school.
- (d) Will nominate all physicians for residency or other graduate education and training programs in the numbers and with the qualifications agreed upon by the Deans Committee and the VA.

(2) The VA

- (a) Will operate and administer the hospital.
- (b) Will appoint qualified physicians to the full-time and regular part-time staff of the hospital. Nominations to the Manager by the Deans Committee for full-time and regular part-time positions will be welcomed; and, unless there be impelling reasons to the contrary, will be approved wherever vacancies exist. The regularly appointed staff, including the chiefs of service, are fully responsible to their immediate superiors in the VA.
- (c) Will appoint the attending and consulting staff and the physician trainees nominated by the Deans Committee and approved by the VA.
- (d) Will cooperate fully with the schools of medicine in the conduct of appropriate programs of education and training.

(3) Hospital Managers

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

(4) Chiefs of Service

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

(5) Attending Staff

- (a) Will be responsible to the respective chiefs of service.

July 30, 1959

M-3, Part II

- (b) Will accept full responsibility for the proper care and treatment of patients in their charge upon delegation by the Manager or person acting for him.
- (c) Will give adequate training to residents assigned to their service.
- (d) Will hold faculty appointment in one or another of the associated schools of medicine, or will be outstanding members of the profession with equivalent professional qualifications.

(6) Consultants

- (a) Will be members of the faculty, of professorial rank, in one of the associated schools of medicine.
- (b) Will, as representatives of the schools of medicine, participate in and take responsibility for the education and training programs of the VA hospital.
- (c) Will afford to the Manager, Director, Professional Services, and the proper Chief of Service the benefit of their professional advice and counsel.

see
II 10-66-9 → c.
1.04 RELATION OF VA HOSPITALS WITH SCHOOLS OF DENTISTRY

a. All considerations bearing upon the desirability and practical advantage of VA-medical school relations apply with equal force to Dental Services and their relation to schools of dentistry. Hence, an analogous system of cooperation between VA hospitals and schools of dentistry is encouraged wherever feasible.

b. The appointment of a dental member of the Deans Committee will be recommended by the Deans Committee concerned. The appointment ~~will~~ be finalized by the Chief Medical Director on advice from the Assistant Chief Medical Director for Dentistry. [may] (c.1)

c. The Deans Committee may nominate dental consultants and attendings only when there is a dental member on the committee.

may
d. In VA hospitals having a dental internship or residency training program, a Dental Training Committee will be appointed by the Chief Medical Director on recommendation from the Assistant Chief Medical Director for Dentistry and the Dean of the School of Dentistry associated with the program. The Dental Training Committee will be responsible to the Deans Committee. It is desirable that the chairman of this committee be a member of the Deans Committee.

1.05 RELATION OF VA HOSPITALS WITH OTHER INSTITUTIONS OF HIGHER LEARNING

a. In order to fulfill its educational objectives and to secure optimum benefits of the program for its staff and trainees, it often becomes necessary for a VA hospital to effect and maintain associations with institutions of higher learning other than schools of medicine and dentistry.

b. Approval of the Chief Medical Director must be secured before such an association is formed. Request for approval should indicate in adequate detail the objectives of the proposed program, functional and administrative plans, and the responsibilities of all major parties to the agreement.

c. The Manager will promptly advise the Department of Medicine and Surgery (152), Central Office, in writing when any change in the status or conditions of the association takes place.

1.06 ADMINISTRATIVE RELATIONS AND RESPONSIBILITIES

a. General Considerations. Due to the fact that educational functions, obligations, and opportunities are extended to every element of the Department of Medicine and Surgery, administrative relations and responsibilities involve a very large number of individuals in widely diversified activities. It becomes, therefore, exceedingly difficult to press these relations in a unified and generally applicable procedure. It has been found, however, that the educational programs, guided by a flexible, informal, and broadly cooperative policy, function effectively and require a minimal amount of administrative intervention.

b. Education Service

- (1) Within the Central Office, Education Service, operating through the Assistant Chief Medical Director for Research and Education, serves in staff and liaison function between the Chief Medical Director and other Central Office elements on the one hand and area and field station units on the other.
- (2) All communications to Central Office which originate at VA stations and which relate to or involve the administration of education and training activities will be transmitted through, or by, the Manager. An information copy will be sent to the Area Medical Director. Such communications will be addressed to the Department of Medicine and Surgery (152), Central Office.

c. Area Medical Directors. Area Medical Directors cooperate with the Director, Education Service, and with other Central Office elements in the development and conduct of inservice training programs, intra-VA educational details, area-directed conferences, visits by physicians-in-residence, certain phases of the lecture program, and so on. It is imperative that the Area Medical Director be fully informed of all educational activities at the stations and of all transactions which impinge upon these activities.

d. Director, Professional Services

- (1) Within the VA hospital, the Director, Professional Services, is responsible to the Manager for the overall coordination of education and training activities, and for the preparation of correspondence and reports relating to these functions. The Director, Professional Services, is the hospital's liaison officer in all matters having to do with education and training. He assists the Manager in his relations with the Deans Committee or Medical Advisory Committee, and he should be in regular attendance at the meetings of these committees as an ex officio member.
- (2) When authorized and directed by the Chief Medical Director, the position of Assistant Director, Professional Services for Education, will be established at VA hospitals.

1.07 COMMITTEE RELATIONS AND FUNCTIONS

a. General Considerations. The education and training programs of the Department of Medicine and Surgery are broadly integrated with similar activities in institutions of higher learning throughout the country. The committees are selected and organized to provide the best available advices from medical, scientific, and educational experts.

b. The Advisory Committee on Education. This committee advises the Chief Medical Director, the Assistant Chief Medical Director for Research and Education, and the Director, Education Service, on all aspects of the education and training programs of the Department of Medicine and Surgery. The committee maintains a special interest in all matters pertaining to VA-medical school relation. The committee reports its activities at regular intervals to the Special Medical Advisory Group.

c. The Deans Committee

- (1) The Deans Committee is the fundamental administrative unit for development, control, and evaluation of educational programs at affiliated hospitals. (See par. 1.03b(i).) It is composed of senior faculty members of the school(s) of medicine associated with the VA hospital. Members are appointed by the Chief Medical Director on nomination by the dean(s) concerned. []
- (2) Membership of the Deans Committee should represent the major professional services of the hospital and particularly those services engaged in education and training functions. Details of membership, tenure, rotation, and so on will be established by the individual committee.
- (3) The Chairman of the Deans Committee may either be designated by the dean(s) representing the school(s) of medicine involved or may be elected from the duly appointed members of the committee.
- (4) Whenever possible, meetings of the Deans Committee should be held at the VA hospital. Stenographic facilities will be made available by the [Director.]
- (5) The [hospital Director and/or Chief of Staff] should be in regular attendance at the meetings of the committee as [] *ex officio* [members.] At the request of the Chairman, other employees of the VA will attend meetings of the committee when their presence is required in connection with the discussion of a particular matter.
- (6) Frequency of meetings will be determined by the Deans Committee in accordance with local needs and conditions. It is advisable that meetings be held at regular intervals.
- (7) Copies of the minutes and the recommendations of the committee should be sent to the [Director] of the hospital(s), and, unless of purely local concern, to the [appropriate Regional] Medical Director and the Chief Medical Director [(10).] Such information can be of great value in the formulation of future policy.
- (8) A Deans Committee associated with more than one VA hospital may choose to designate a subcommittee to represent it in the conduct of affairs at a single hospital. The membership of a subcommittee will be nominated by the Deans Committee and appointed by the Chief Medical Director. The subcommittee is responsible to the parent Deans Committee. It is advisable that the Chairman of a Deans Subcommittee be a member of the parent Deans Committee.
- (9) VA hospitals having predominantly psychiatric and neurologic patients [] should be served by a regularly constituted Deans Committee and not be a committee or subcommittee representing only these particular specialties.
- (10) The Deans Committee may appoint ad hoc committees [or subcommittees] for the accomplishment of specific tasks or for the cognizance of certain duties for which the Deans Committee is responsible. The creation of such a committee and the appointment of its members does not require approval of the Chief Medical Director.
- (11) Members of the Deans Committee as individuals may serve as consultants or attending physicians within the VA hospital and are encouraged to do so.
- (12) Members of the Deans Committee are not entitled to a consultant or attending fee for attending a meeting of the Deans Committee or for discharging any other duty of the committee.

(13) The Deans Committee performs the following functions:

- (a) Cooperates with VA personnel in establishing medical residency programs and in determining their scope, organization, standards of performance, and the adequacy of facilities.
- (b) Upon advice of concurrence between appropriate chiefs of service in both the medical school and the VA hospital, nominates to the [Director] candidates for graduate education and training in the various medical specialties.
- (c) Selects and nominates to the [Director] the attending and consulting staff, and, in collaboration with the [Director or Chief of Staff] recommends their schedule of attendance at the station.
- (d) Collaborates with the [Director, Chief of Staff,] or chiefs of service in the supervision of their residents and in supervising the activities of the attending and consulting staff.
- (e) Assumes responsibility for the standards of all medical research activities except those Special Research Laboratories under direction of the Director, Research Service.
- (f) Nominates to the [Director] full-time and regular part-time physicians of the professional staff of the hospital, including the chiefs of service.

d. The Medical Advisory Committee

- (1) In selected hospitals not associated with schools of medicine or dentistry, a Medical Advisory Committee may be established to serve in a manner similar to the Deans Committee at affiliated hospitals. [Regional] Medical Directors and the Director, Education Service, will cooperate with [Directors] in the development of such committees.
- (2) When the Chief Medical Director approves the establishment of a Medical Advisory Committee, he will appoint members nominated by the [Directors] and the [Regional] Medical Director.
- (3) Insofar as practicable, the policies governing VA-medical school relations will be observed.
- (4) Members of the Medical Advisory Committee are encouraged to accept appointments as consultants and are expected to take active part in the care of patients as well as the education program of the VA hospital.
- (5) The Medical Advisory Committee performs the following functions:
 - (a) Cooperates with VA personnel in establishing sound programs for medical treatment and hospital care and in prescribing the number and qualifications of the attending and consulting staff.
 - (b) Assumes responsibility for standards of postgraduate and inservice training including residency programs where authorized.
 - (c) When appropriate, selects and nominates to the [Director] medical residents, formulates, supervises, and evaluates their course of study, both within the VA hospital and during outside affiliated training.

(d) Selects and nominates to the Director attending and consulting staff and, in collaboration with the Director, formulates their schedules of attendance at the station, supervises their activities, and evaluates the effectiveness of their services.

(e) Promotes in every way a wholesome and effective relationship between the VA hospital and the medical and health professions of the community.

e. Hospital Research and Education Committee

(1) **General.** The Hospital Research and Education Committee serves, in an advisory capacity to the Director and the Chief of Staff in the development and operation of the research and education programs. The committee is responsible for correlation of graduate training and research programs. Training of residents shall be given maximal support by planning for their participation in appropriate phases of the research program for which they are qualified.

(2) **Membership and Organization.** This committee shall consist of the chiefs of the major professional services, such as medicine, surgery, dentistry, laboratory, radiology, psychiatry, radioisotopes, and at least two members or representatives of the Deans Committee. Other members with special scientific qualifications may be included at the discretion of the committee. The Director and the Chief of Staff are *ex officio* members of this committee. The Chairman, who shall be a physician, shall be elected annually by the committee. The Secretary, who shall serve as Associate Chief of Staff, shall be recommended by the committee, usually from among the full-time VA physicians. In NP hospitals, a Ph.D. with special scientific qualifications may be considered for appointment as Secretary of the Research and Education Committee but may not serve as Associate Chief of Staff. Since both positions, Secretary of the Committee and Associate Chief of Staff, are centralized, they must have the prior approval of the Chief Medical Director. When no suitable full-time physician is available, approval for the appointment of a part-time physician may be sought. Where no Associate Chief of Staff is needed or desired, the Chief of Staff may serve as Secretary of the Research and Education Committee with approval of the Assistant Chief Medical Director for Research and Education.

(3) **Research Duties.** See DM&S Manual M-3, part I, chapter 2.

(4) **Education Duties**

(a) Serves in an advisory capacity to the Director in all matters having to do with the medical and dental education programs at the station.

(b) Advises the Director relative to the need and utilization of all staff elements in the education programs of the hospital.

(c) Makes recommendations to the Director regarding the roles of the Medical Library, Medical Administration Division, and other services and divisions in support of education and training programs.

(d) Reviews and evaluates for the Director the effect of the education and training programs on the quality of patient care.

(e) Makes recommendations to the Director for maintaining and improving VA-medical and dental school relations.

1.08 RELATION OF VA EDUCATION PROGRAMS WITH THE MEDICAL COMMUNITY

a. **General.** The VA recognizes the tremendous contribution which has been made by American medicine to the care and treatment of veteran-patients. Education and training programs provide the ideal medium through which this valuable and cordial relation is developed and maintained. Every proper effort should be made to foster mutually beneficial exchanges between the professional staff of VA stations and the medical, dental, and health service personnel of the community.

b. Professional personnel of the Department of Medicine and Surgery are encouraged to seek appropriate membership in local, county, and State societies and to participate actively in their scientific programs.

c. Arrangements for joint meetings with local or county societies are encouraged, and VA hospital facilities may be used for such meetings.

d. The attendance of medical and dental students and of qualified physicians and dentists who are not VA employees is permitted at clinics, conferences, ward rounds, clinical demonstrations, and similar activities conducted within VA hospitals. It is understood that such attendance will be at the invitation of the Director for his authorized representative.

e. The VA may not conduct or sponsor courses of instruction or other educational activities primarily for individuals who are not employees of the VA. However, VA facilities may be used by non-VA organizations for such activities when, in the judgment of the Director, the activities are clearly in the interest of the agency.

1.09 RELATION OF TEACHING PROGRAMS TO ADMISSION OF PATIENTS

a. The sole criteria to be applied to all applicants for admission to VA hospitals are the legal requirements for admission and the necessity for hospitalization.

b. Teaching programs in VA hospitals were established for the primary purpose of raising the standards of medical care of the veteran-patient. They will survive or perish solely upon this principle. The veteran is a private patient, the costs of his medical care are paid by the Government, and he has not the slightest obligation to pay any part of his care in terms of his usefulness as a subject of teaching.

c. Under no circumstances will primary considerations of the education and training programs influence the selection of patients to receive hospital care or other medical and dental services.

d. Deans Committees, Medical Advisory Committees, and their representatives are urged to cooperate with the Director and his professional staff in the enforcement of these admission policies.

1.09.1 GIFTS OR DONATIONS

Donations of funds, equipment, or supplies for medical education purposes may be accepted by the Hospital Director after considering the recommendations of the Research and Education Committee. Donors will be informed that acceptance of their gifts implies no endorsement of the donating organization or its products. The funds will be earmarked for education and deposited in the General Post Fund. Unless restricted by stipulations of the donor, these funds may be used in support of education projects including necessary related travel, in the same manner as appropriated funds.

1.10 PROFESSIONAL ACTIVITIES—PUBLICATION OF PROFESSIONAL PAPERS

a. Policy

(1) The preparation and promulgation of professional papers is encouraged to provide VA employees a vehicle for contributing to the advancement of medical education and practice within the VA and the medical community.

(2) Directors will have basic authority to review and approve professional papers in accordance with the procedures outlined in subparagraph b below. Each Director will insure that (a) the privacy of veteran-patients is preserved and (b) VA or station policy is not misrepresented.

(3) The identity of the patient will not be disclosed in any paper. When photographs of the recognizable features of any patients are to accompany the article, the written consent of the patient or, if he is mentally

December 24, 1970

M-3, Part II
Change 20

incompetent, of his guardian or nearest relative, must be obtained and submitted with the request for approval. VA Form 10-3203, Consent for Use of Picture and Voice, will be completed in accordance with MP-1, part I, paragraph 410.08. (See also MP-1, pt. II, ch. 11, par. 2g.)

(4) Theses or projects required in partial fulfillment of academic requirements and in which VA information, records, or patients are to be used by trainees will be cleared at their inception and completion by the chief of the professional or technical unit concerned.

b. Procedure

(1) At his discretion, the Director will determine suitable administrative review procedures for papers prepared by members of the staff (including attendings and consultants if VA matters are involved). These procedures will relate to those considered necessary to augment current regulations designed to protect the VA, its personnel, and its patients.

(2) The Director is encouraged to rely on established editorial expertise and publication practices of recognized scientific journals to evaluate the substantive content of professional contributions. However, when the nature of the paper or the local situation warrants, the Director may seek the advice of competent advisors on his staff, including the Research and Education Committee. If such advice is not available or obtainable, the Director will refer the paper to Central Office for review and recommendation. Using appropriate region number and mail routing symbol, address request to REGIONAL MEDICAL DIRECTOR, REGION NO. ____ ().

(3) Two reprints of each publication will be sent to Central Office. Using appropriate region number, address reprints to REGIONAL MEDICAL DIRECTOR, REGION NO. ____ (15C).

Veterans Administration (104)
Department of Health, Education and Welfare
Washington, D. C. 20420
Los Angeles Office, 1200 N. Main St.
Los Angeles, California 90012

December 7, 1970

Chief Medical Director (10)
VA Central Office
810 Vermont Avenue, N. W.
Washington, D. C. 20420

SUBJ: Nominations for Deans Committee - VAH San Diego, California

1. The Vice Chancellor for the Health Sciences and Dean of the School of Medicine, University of California, San Diego, has recommended for nomination the following individuals:

Dr. Averill Liebow	-	Pathology (Chairman)
Dr. Marshall Orloff	-	Surgery
Dr. Eugene Braunwald	-	Medicine
Dr. James Nelson	-	Neurology
Dr. Elliott Lasser	-	Radiology
Dr. Arnold Mandell	-	Psychiatry
Dr. Henrik Bendixen	-	Anesthesiology
Dr. Richard A. Lockwood	-	Director, Hospitals and Clinics

2. It is suggested that Dr. Turner Camp, Director, VA Hospital, San Diego, be designated as an ex officio member of this Committee.

3. Your approval to these nominations is solicited.

R. G. ST. PIERRE, M. D.
Medical Director

cc: Dr. Turner Camp
Director (OO) VAH San Diego

Dr. Clifford Grobstein
Dean, School of Medicine
University of California, San Diego
La Jolla, California 92037

November 30, 1970

Marc Nusser, M.D.
Chief Medical Director
Department of Medicine and Surgery
Veterans Administration Central Office
810 Vermont Ave, N.W.
Washington, D. C. 20420

Dear Dr. Nusser:

I have designated the following to serve as a Dean's Committee in connection with education and training programs of the UCSD School of Medicine in the San Diego VA Hospital.

Dr. Averill Liebow - Pathology (Chairman)
Dr. Marshall Orloff - Surgery
Dr. Eugene Braunwald - Medicine
Dr. James Nelson - Neurology
Dr. Elliott Lasser - Radiology
Dr. Arnold Mandell - Psychiatry
Dr. Henrik Bendixen - Anesthesiology
Dr. Richard A. Lockwood - Director, Hospitals and Clinics

The UCSD School of Medicine looks forward to the closest cooperation with the VA to further the mutual objectives of the two organizations.

Sincerely yours,

Original signed by
Clifford Grobstein

Clifford Grobstein
Vice Chancellor for the Health Sciences and
Dean of the School of Medicine

cc: Dr. Roderick St. Pierre
Dr. Turner Camp
Dr. Averill Liebow

MINUTES, DEANS COMMITTEE MEETING, MAY 1, 1973, VAH, SAN DIEGO, CA

The regular meeting of the Deans Committee was held May 1, 1973, in the Deans Conference Room, at the Medical School.

Present:

Clifford Grobstein, Ph.D., Chmn
Vice Chancellor for Health Sciences
Dean, School of Medicine, UCSD
Wm. S. Coppage, Jr., M.D.
Chief of Staff
Associate Dean
Averill A. Liebow, M.D.
Chmn, Dept of Pathology
John O'Brien, M.D.
Chmn, Dept of Neurosciences
Michael B. Shimkin, M.D.
Dept of Community Medicine
Arnold J. Mandell, M.D.
Chmn, Dept of Psychiatry
Elliott C. Lasser, M.D.
Chmn, Dept of Radiology
John Alksne, M.D.
Dept of Surgery

Richard Carleton, M.D.
Act Chief, Medical Svc
Wigbert Wiederholt, M.D.
Chief, Neurology Svc
Gerald W. Peskin, M.D.
Chief, Surgery Svc
Edward C. Elson, M.D.
Act Chief, Laboratory Svc
Lewis L. Judd, M.D.
Act Chief, Psychiatry Svc

APPROVAL OF MINUTES

The minutes of the meeting of April 17, were approved as distributed.

FACULTY-STAFF, FY '73-'74

Distribution of staff positions has never been resolved. Statistics on clinical activities were reviewed. It was the feeling of the Committee that present total FTE of 65 faculty/staff positions and the distribution of this number among the Services is insufficient for the workload which is steadily increasing. It was also the feeling that Ph.D.'s should be excluded from the FTE staff count. There are two questions involved: (1) What specific numbers can each Service count on? (2) Whether these numbers are appropriate. There are a total of 8 Ph.D. positions involved. This would give partial relief to the problem of total staff positions. It was agreed that the staffing pattern of all services should be reviewed in an effort to find additional positions.

Motion by Dr. Liebow, seconded by Dr. O'Brien that the total number of FTE's should be 65, not including Ph.D.'s, and that appropriate consideration be made as to staffing patterns in various services on that basis. Motion carried.

This will be discussed further at the next meeting.

May 1, 1973

DISPOSITION OF ADDITIONAL STAFF POSITIONS
BASED ON 7/8 FUNDING

In those instances where people have been put on 7/8ths time, should the remaining 1/8th remain with the Service or go into a general pool. Discussion should determine whether this Committee concurs in the decision of the FCFC that these 1/8ths be accumulated in a general pool and that recommendations for their dispersal be made by the Committee. The FCFC has made a recommendation that will have no force unless the Deans Committee acts on it. If the remaining 1/8ths are placed in a pool, it would be possible to place additional persons into the staffing pattern. However, if the Service which created the 1/8th were allowed to retain it, it would eliminate another problem of dividing the positions accumulated in the pool.

Motion by Dr. Lasser, seconded by Dr. Judd that the fractions stay in the Service that creates them; the vacated 1/8th remain for use of the Department concerned.

Motion was made by Dr. Liebow, seconded by Dr. O'Brien, to table this motion for discussion at a later date. Vote: For, 4; opposed, 1. Motion carried.

STAFF APPOINTMENTS, VA HOSPITAL

Dr. Judd apprised the Committee of an appointment which is pending at the direction of VA Central Office. This is over the objections of the Department of Psychiatry and this Committee. He asked that some stronger action be taken than previously to prohibit this appointment and possible future similar actions. This is in direct violation of the agreement between the School and the VA that all staff appointees both Ph.D.'s and M.D.'s will have academic appointments.

Motion made by Dr. Liebow, seconded by Dr. Judd that a teletype be sent to Dr. Musser informing him of the contents of the message relative to the proposed appointment, and a specific deadline date (Friday, May 4) be mentioned at which time the message will be dispatched to Members of Congress unless definite assurance is received from the VA that the appointment will not go through. Vote: For, 7; against, 1. Motion carried.

Motion by Dr. O'Brien that a telegram signed by all members of the Committee be sent to Dr. Musser (in addition to the above wire) earlier, saying in effect that this appointment can not be accepted since it is in violation of the principals established by this Committee. That such appointment could disrupt the affiliation of the School and the Hospital. Motion seconded by Dr. Judd; carried.

Dr. Grobstein was instructed to send the telegram; Dr. O'Brien will obtain the signatures. Dr. Liebow to prepare the second telegram. Dr. Grobstein will contact Dr. Musser by phone in the morning (May 2).

Caroline F. Hille
CAROLINE F. HILLE, Secretary,
Hospital Director, Recorder

DISTRIBUTION: Each member

Application for Membership
in the
Council of Teaching Hospitals

(Please type)

Hospital: Mount Sinai Hospital
Minneapolis Name 2215 Park Avenue
City Street
Minnesota 55404
State Zip Code

Principle Administrative Officer: Samuel Davis
Name
Executive President
Title

Date Hospital was Established November 5, 1945

Approved Internships:

<u>Type</u>	<u>Date Of Initial Approval by CME of AMA*</u>	<u>Total Internships Offered</u>	<u>Total Internships Filled</u>
Rotating	1965	14*	4
Straight			

*No longer offered.

Approved Residencies:

<u>Specialties</u>	<u>Date Of Initial Approval by CME of AMA*</u>	<u>Total Residencies Offered</u>	<u>Total Residencies Filled</u>
Medicine	1965	**	12
Surgery	1968		5
OB-Gyn	1965		1
Pediatrics			
Psychiatry			
Other			
Hematology	1965		1

Information Submitted By:

Samuel Davis
Name

March 23, 1973
Date

**University of Mn.

determines number of residents
to be sent each year.

Executive President

Title of Hospital Chief Executive

Signature of Hospital Chief Executive

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

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 Minnesota Medical School

Name of Dean N. L. Gault, Jr., M.D.

Address of School of Medicine 1360 Mayo Memorial Building

Minneapolis, Minnesota 55455

FOR COFH OFFICE USE ONLY			
Date _____	Approved _____	Disapproved _____	Pending _____
Remarks _____			

Invoiced _____		Remittance Received _____	

MAJOR AFFILIATION AGREEMENT

THIS AGREEMENT, made and entered into this 2nd day of September, 19 70, by and between

MOUNT SINAI HOSPITAL (hereinafter referred to as "Hospital")

and

REGENTS OF UNIVERSITY OF MINNESOTA
for the UNIVERSITY OF MINNESOTA
MEDICAL SCHOOL (hereinafter referred to as "University")

W I T N E S S E T H:

WHEREAS, University maintains and operates a College of Medical Sciences offering medical instruction and training to students in many medical fields, among which are Medicine, Surgery and Laboratory Medicine, and

WHEREAS, in furtherance of the medical education of said students, it is necessary to provide them with clinical instruction, experience and research as a supplement to classroom instruction, not all of which can conveniently be provided at University's own hospital facilities, and

WHEREAS, Hospital is an accredited hospital institution well equipped with modern facilities, equipment and laboratories, providing medical care to patients of all types in many medical fields, among which are Medicine, Surgery and Laboratory Medicine, and

WHEREAS, Hospital recognizes the value of a teaching affiliation to its roll of providing high quality medical care to its patients, and

WHEREAS, Hospital and University have maintained an affiliated relationship of increasing complexity on an informal basis since 1951, and

WHEREAS, both parties now consider it to their mutual advantage to formalize their affiliated relationship and to establish formal procedures for the administration and control of the affiliated program,

NOW, THEREFORE, in consideration of the mutual covenants herein set forth, the parties agree as follows:

1. The parties agree to affiliate during the term of this agreement for the purpose of providing clinical instruction, experience, and research to University's medical students in the fields of Medicine, Surgery and Laboratory Medicine. This agreement may be amended, from time to time, to include such additional medical fields as may be mutually agreed upon by the parties.

2. University shall for the purposes of this agreement assign to Hospital students, interns and residents, and shall appoint to its faculty members of Hospital's Medical Staff as further provided hereinbelow.

3. Hospital shall for the purposes of this agreement make available adequate and suitable facilities and equipment, including patient and clinic rooms, classroom facilities, laboratories, office space for full-time faculty members, an up-to-date medical library, and ancillary facilities such as a modern medical records system, on-call rooms, and dining and parking facilities for faculty.

4. The assignment, rotation, and program for medical students shall be the joint responsibility of the appropriate University department head and the corresponding Chief of department of Hospital. The curriculum and structure of the program shall correspond to that

currently in force at the University. Assigned undergraduate medical students shall be responsibly involved in the management of the care of the patient under the supervision of the Hospital Medical Staff. The medical students' activities shall include doing patient histories and physical examinations, stating tentative diagnoses, proposing diagnostic and therapeutic procedures, and proposing recommendations for discharge, and the course of the patient care should include out-patient and other extensions of available services to the fullest degree possible.

5. The selection, appointment, assignment, education and supervision of University medical fellows and interns shall be jointly determined by the head of the appropriate University department and the Chief of the corresponding department of Hospital.

6. All patients of Hospital shall be made available for the purposes of the affiliated program unless the physician specifically provides to the contrary; provided, however, that patients shall not be unreasonably withheld from the program.

7. The affiliated educational program shall be supervised by a committee to be known as the Professional and Educational Practices Committee (hereinafter referred to as "PEPC"). The membership of the PEPC shall be as follows: (a) Six members to be appointed by and from the Board of Governors of Hospital; (b) The Chief of the Medical Staff of Hospital and five members to be appointed by him from among those members of the Executive Committee (other than department Chiefs) who are active in the teaching program; (c) One member to be appointed by the University from the Office of the Dean of the Medical School, and one member from each University department actively participating in the teaching program at Hospital; (d) The Chief of each corresponding department of Hospital, together with the Chiefs of the Department of Radiology and the Department of Anesthesiology.

It is recognized that the membership of groups (a) and (b) shall at all times constitute a majority of the membership of the PEPC.

The President of the Board of Governors of Hospital shall select one of the appointees to the PEPC from said Board to act as Chairman of the PEPC. Said Chairman may appoint a temporary chairman to preside over meetings of the PEPC in his absence.

The PEPC shall meet quarterly or more often as needed, and shall annually undertake a thorough evaluation of the effectiveness of the affiliated program.

The PEPC shall be responsible for the supervision of all aspects of the affiliated program, and its decisions with respect to interpretations of this agreement or disputes arising hereunder shall be final.

In order for business to be transacted at any meeting of the PEPC, the following quorum must be present: four (4) members of group (a); four (4) members of group (b); three (3) members of group (c); and three (3) members of group (d).

Each of the four groups comprising the PEPC may designate an alternate or alternates to attend and participate in meetings in the absence of the regular member or members.

The action of the PEPC shall be controlled by the vote of a majority of the members present at any meeting, so long as a quorum is present. Any issue which cannot be resolved by such majority vote shall be referred to a referee to be appointed by the President of the Board of Governors of Hospital. The decision of the referee shall be final.

8. The Chiefs of the departments of Hospital hereinbefore named shall be appointed to University's faculty if they are not already members thereof. Each Chief shall have the authority and responsibility

for carrying on the day-to-day operation of his respective department, including the formulation and administration of policies, procedures, programs, and facility and equipment requirements for patient care, education, and research within said department.

Each Chief shall consult the Hospital Administration and the appropriate established committee or committees of the Medical Staff with respect to the establishment of any new major policy, procedure, program, or facility or equipment requirement within his department. It is understood that the definition of "major" must necessarily evolve from local practice and experience, and cannot be precisely set forth herein. Upon the request of the department Chief, the Hospital Administration, or the Executive Committee of the Medical Staff, any dispute over the establishment of new major policies, procedures, programs, or facility or equipment requirements shall be referred to the PEPC for review and resolution.

In the event that a vacancy occurs in the position of Chief of any of the departments covered hereunder, said vacancy shall be filled in the following manner. The PEPC shall appoint a subcommittee from its own membership comprised of one representative each from the Board of Governors of Hospital, the attending Medical Staff of Hospital, the full-time Medical Staff of Hospital, and the University for the purpose of recommending appointees. The PEPC shall either accept the recommendation of the subcommittee, or shall refer the matter back to the subcommittee for a new recommendation.

9. If the Chief of any department of Hospital covered hereunder wishes to create any new full-time Medical Staff position within his department, he shall first seek the advice and consultation of both the appropriate departmental Medical Staff committee and the full Medical Staff of the department. The result of said consultation shall be presented to the Executive Committee of the Medical Staff

for its advice. If the Executive Committee of the Medical Staff concurs in the creation of the new position, and if the Chief obtains the written approval of the Hospital Administration and the Chairman of the Joint Conference and Operating Committees of the Board of Governors, said position shall be considered created and the Chief may recruit applicants therefor. If the Executive Committee of the Medical Staff does not concur in the creation of said position, the matter shall be referred to the PEPC for final review and decision.

10. All physicians who as of the effective date of this agreement are (1) members of the Medical Staff of Hospital, and (2) active in the teaching program at Hospital shall be appointed by the University to its medical faculty. Full-time active medical staff members shall be appointed to full-time and/or clinical faculty positions, and attending medical staff members shall be appointed to clinical faculty positions. Said faculty appointments shall be on a year to year basis in conformity with existing University rules and procedures.

11. Subsequent to the effective date of this agreement, any physician who wishes to participate in the teaching program must be qualified for, and receive, an appointment to the clinical faculty of the appropriate department of the University. Those physicians who elect not to participate in the teaching program or who are unable to qualify for faculty appointments shall remain on the Hospital staff as non-teaching attending physicians. Non-participation in the teaching program shall not in any way affect a physician's membership on Hospital's Medical Staff or any rights or privileges attendant thereto.

The University shall set forth in writing the objective qualifications necessary for appointment to clinical positions on its medical faculty. In general, these shall include the basic professional qualifications, a willingness to participate in the teaching program,

and an acceptability to both students and faculty in the University department involved.

Faculty appointments once made hereunder shall be on a year-to-year basis in conformity with existing University rules and procedures.

12. Members of University's faculty serving as full-time members of Hospital's Medical Staff shall, in general, enjoy the same ranks and privileges and shall have the same obligations as other comparable University faculty members.

13. Any questions which may arise concerning the professional competence of any full-time member of the Medical Staff of Hospital who is also a University faculty member serving in one of the departments of Hospital involved hereunder shall be referred to the PEPC for its recommendation.

14. Compensation for the various positions pursuant to this Agreement shall be as mutually agreed upon by the parties, provided that the legal and financial limitations of Hospital shall be considered in any such agreement. The responsibility and procedure for compensation shall be as follows:

A. Medical fellows, interns, and residents shall be compensated by Hospital through University at the rates set by University, provided that said rates shall be comparable to those set for similar positions at University and other affiliated hospitals.

B. Hospital shall be responsible for the compensation of the Chiefs of the departments covered hereunder, whether by means of salary or through some other agreement with said Chiefs.

C. Hospital and University shall share responsibility for the compensation of salaried faculty members

of University serving as full-time members of the Medical Staff of the Departments of Hospital covered hereunder. The respective proportions of compensation, including fringe benefits, to be paid by University and Hospital with respect to each such person shall be negotiated each year by the parties hereto. Regardless of the source of such compensation or any portion thereof, each such individual shall have the option of receiving his entire salary directly from Hospital, or a portion thereof through the University and the remainder directly from Hospital.

1. If received entirely directly from Hospital, Hospital fringe benefits shall apply.

2. If received partially through University, University fringe benefits shall apply to that portion of the salary which represents the University's basic salary for such individual, and Hospital fringe benefits shall apply to the remainder.

3. If the individual is classified as "strict full time" by the University, his fringe benefits will be based on strict full time salary.

D. Payment for the salary and fringe benefits of staff members receiving their compensation or some portion thereof through the University will be provided by Hospital through quarterly advances of funds to the University in an amount equal to one-fourth (1/4) of the currently applicable budget contained in the addenda to this Agreement. Advances of funds by Hospital and actual costs incurred by the University will be reconciled annually, as of the last day of the annual budget period. Within sixty (60) days of the close of the annual budget period, any advances of funds in excess of actual costs will be refunded by the University; likewise,

any actual costs incurred by the University in excess of such advances of funds will be billed to and paid by Hospital.

15. A financial addendum to this Agreement shall be prepared on an annual basis showing the financial commitments of both parties with respect to the compensation of the various positions set forth herein.

16. This Agreement shall be binding on the parties' successors and assigns.

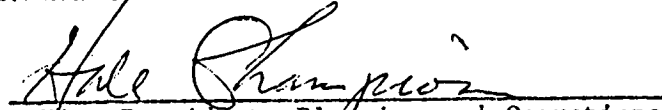
17. This Agreement shall be in effect for an original term commencing on the date of its execution and continuing to and including June 30, 1975, and shall be renewed for additional terms of five years each unless written notice of termination is given by either party at least two years prior to the end of the original term or any renewal thereof.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed the day and year first above written.

UNIVERSITY OF MINNESOTA COLLEGE OF MEDICAL
SCIENCES

By 
Dean of the College of Medical Sciences


UNIVERSITY OF MINNESOTA

By 
Vice President, Planning and Operations

MOUNT SINAI HOSPITAL OF MINNEAPOLIS

By 
Executive Vice President

MOUNT SINAI HOSPITAL BOARD OF GOVERNORS

By 
President

AAMC POLICY STATEMENT

THE PATIENT IN THE TEACHING SETTING

The medical faculties and staff of the nation's medical schools and teaching hospitals are committed to the provision of the highest quality of personal health services. The interrelationship between the health care, educational and research functions of these institutions contribute to the assurance of these high standards of patient care. Patients seeking care in the teaching setting are not only provided high quality health services, but also an opportunity to share in the training of the nation's future health care professional personnel through participation in clinical education.

It is the policy of the Association of American Medical Colleges that all patients, regardless of economic status, service classification nature of illness or other categorization should have the opportunity to participate in the clinical education program of the hospital, clinic or other delivery setting to which they are admitted or from which they seek care.

In order to assure a single standard of high quality patient care, and to reinforce student perspectives and attitudes regarding patient rights and responsibilities, the AAMC reaffirms that:

- Selection of patients for participation in teaching programs shall not be based on the race or socio-economic status of the patient.

→ *right to a responsible physician*

- Responsible physicians have the obligation to discuss with the patient both general and specific aspects of student participation in the medical care process.

Provision of patient care is a confidential process. Relationships between the patient, health professional and student, regarding examinations, treatment, case discussion and consultations should be treated with due respect to the patient's right to privacy.

Each patient has the right to be treated with respect and dignity. Individual differences, including cultural and educational background, must be recognized in designing each patient's care program.

Every teaching institution should have programs and procedures whereby patient grievances can be addressed in responsive and timely fashion.

The Association of American Medical Colleges believes that the reaffirmation of these principles in medical schools and teaching hospitals will contribute to the best interests of patients and ensure the most appropriate educational environment for the training of future health professionals.

Affirmed by the Board of Trustees
of the
American Hospital Association
November 17, 1972

THE American Hospital Association presents a Patient's Bill of Rights with the expectation that observance of these rights will contribute to more effective patient care and greater satisfaction for the patient, his physician, and the hospital organization. Further, the Association presents these rights in the expectation that they will be supported by the hospital on behalf of its patients, as an integral part of the healing process. It is recognized that a personal relationship between the physician and the patient is essential for the provision of proper medical care. The traditional physician-patient relationship takes on a new dimension when care is rendered within an organizational structure. Legal precedent has established that the institution itself also has a responsibility to the patient. It is in recognition of these factors that these rights are affirmed.

1. The patient has the right to considerate and respectful care.
2. The patient has the right to obtain from his physician complete current information concerning his diagnosis, treatment, and prognosis in terms the patient can be reasonably expected to understand. When it is not medically advisable to give such information to the patient, the information should be made available to an appropriate person in his behalf. He has the right to know, by name, the physician responsible for coordinating his care.
3. The patient has the right to receive from his physician information necessary to give informed consent prior to the

start of any procedure and/or treatment. Except in emergency situations, such information and informed consent should include but not necessarily be limited to the specific procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation. Where medically significant alternatives for care or treatment exist, or when the patient requests information concerning medical alternatives, the patient has the right to such information. The patient also has the right to know the name of the person responsible for the procedure and/or treatment.

4. The patient has the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of his action.
5. The patient has the right to every consideration of his privacy concerning his own medical care program. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly. Those not directly involved in his care must have the permission of the patient to be present.
6. The patient has the right to expect that all communications and records pertaining to his care should be treated as confidential.
7. The patient has the right to expect that within its capacity a hospital must make reasonable response to the request of a patient for services. The hospital must provide evaluation,

S74

©1972 by the
American Hospital Association
810 North Lake Shore Drive
Chicago, Illinois 60611
All rights reserved
Printed in the U.S.A.
5011-1713-2059

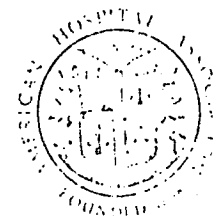
- service, and/or referral as indicated by the urgency of the case. When medically permissible, a patient may be transferred to another facility only after he has received complete information and explanation concerning the needs for and alternatives to such a transfer. The institution to which the patient is to be transferred must first have accepted the patient for transfer.
8. The patient has the right to obtain information as to any relation hip of his hospital to other health care and educational institutions insofar as his care is concerned. The patient has the right to obtain information as to the existence of any professional relationships among individuals, by name, who are treating him.
 9. The patient has the right to be advised if the hospital proposes to engage in or perform human experimentation affecting his care or treatment. The patient has the right to refuse to participate in such research projects.
 10. The patient has the right to expect reasonable continuity of care. He has the right to know in advance what appointment times and physicians are available and where. The patient has the right to expect that the hospital will provide a mechanism whereby he is informed by his physician or a delegate of the physician of the patient's continuing health care requirements following discharge.
 11. The patient has the right to

examine and receive an explanation of his bill regardless of source of payment.

12. The patient has the right to know what hospital rules and regulations apply to his conduct as a patient.

No catalog of rights can guarantee for the patient the kind of treatment he has a right to expect. A hospital has many functions to perform, including the prevention and treatment of disease, the education of both health professionals and patients, and the conduct of clinical research. All these activities must be conducted with an overriding concern for the patient, and, above all, the recognition of his dignity as a human being. Success in achieving this recognition assures success in the defense of the rights of the patient.

Statement on a Patient's Bill of Rights



RESOLUTIONS

Adopted by the
GOVERNING COUNCIL
of the
AMERICAN PUBLIC HEALTH ASSOCIATION
November 15, 1972

Group C—MANPOWER AND TRAINING

Increased Utilization of Dental Auxiliaries

Supporting Statement

The acute shortage of dental manpower in the United States cannot be alleviated economically solely by the training of additional numbers of dentists. Thus, the productivity of the available dentists must be increased. Although great advances in dental technology have been made in the past two decades, the major factor in increasing the productivity of dentists has been the increased use of dental auxiliaries. Recent studies have shown that properly trained auxiliaries can perform additional duties, maintain a comparable quality of services, and generate substantial increases in the productivity.

Resolution

The expanded utilization of dental auxiliaries appears to be the most practical, economical, and efficient approach to delivering high-quality dental care to more people.

The American Public Health Association recommends and urges that a program of federal support be implemented for the accelerated development of training programs to expand the function of dental auxiliaries, such programs to include support for construction of facilities, operation of programs, training of faculties, and financial incentives to dental schools that teach students the use of expanded function auxiliaries, and be it further resolved, that each state dental society and board of examiners be urged that formal programs of continuing education be developed to prepare presently practicing dentists to utilize expanded function auxiliaries.

Expanded Role of the Nurse in Health Care

Traditional patterns in the delivery of health care are changing rapidly. One of the most positive and potentially beneficial innovations in personnel utilization involves the expanded role of the nurse in primary care.

This concept, which was accepted by APHA's Governing Council in 1970, has gained widespread support from the health community, as well as the public. However, there has been an unbridled proliferation of short-term training programs to prepare nurse practitioners without the concomitant development of standards to provide adequate safeguards for the practitioner and the public.

APHA reaffirms and extends its position in regard to the utilization of the nurse in extended medical and nursing functions. Specifically, APHA recommends that:

- The expanded role of nurses in medical and health care be developed jointly by the professionals in medicine and nursing;

- Guidelines and standards for programs to prepare the nurse in an expanded role should continue to be developed and refined by national nursing organizations and medical specialty groups;
- Experimentation continue under the auspices of duly accredited institutions;
- Affiliates stimulate the development of responsible educational programs within established guidelines and the appropriate use of practitioners who have successfully completed such programs.

Selection of Teaching Patients

For over a century most of the patients chosen for clinical teaching in medicine, dentistry, and other related health fields, have been so selected, directly or indirectly, because they are poor. In addition, the majority of these patients have been designated as teaching cases without choice on their part. The justification of such selection has been that teaching services have provided health care services to many who could not have otherwise afforded it. While there are still many who cannot obtain adequate health care, the American Public Health Association considers this means of designating patients for clinical teaching programs undesirable.

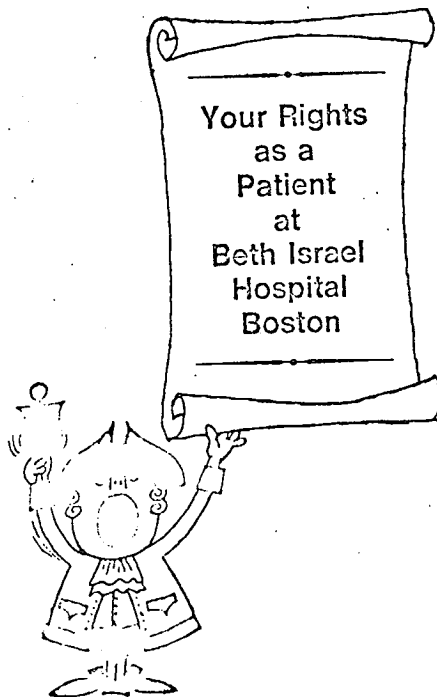
The present means of selecting teaching patients perpetuates a two-class health system which is based upon income and social status. Not only is this socially undesirable, but it is particularly inappropriate in settings where student practitioners are developing perspectives which will persist throughout their professional lives. Most important, however, selection based on economic criteria is inconsistent with the goal of APHA to assure equality of access to and quality of health care for all.

APHA urges the American Medical Association, American Osteopathic Association, the American Hospital Association, the American Dental Association, the American Association of Dental Schools, the Association of American Medical Colleges, the National League for Nursing, and other appropriate professional associations to join with APHA in instituting such resolutions as:

1. Participation of all patients in clinical teaching programs shall be based on the patient's approval by both patient and
2. Selection of patients for teaching programs shall not be based on the race or socioeconomic status of the patient.

Restoration of Environmental Manpower Training Funds

The Environmental Protection Agency, in response to an apparent surplus of certain types of engineers, has curtailed funds allocated for graduate level, professional training of categorical specialists in such fields as solid wastes management, radiation protection, water pollution control, and air pollution control.



Beth Israel Hospital, its doctors, nurses and entire staff are committed to assure you excellent care as our patient. It has always been our policy to respect your individuality and your dignity. This listing is published to be certain that you know of the long-standing rights that are yours as a Beth Israel patient.

1. You have the right to the best care medically indicated for your problem, that is, to the most appropriate treatment available without considerations such as race, color, religion, national origin or the source of payment for your care.
2. You have the right to be treated respectfully by others; to be addressed by your proper name and without undue familiarity; to be listened to when you have a question or desire more information and to receive an appropriate and helpful response.
3. You have the right to expect that your individuality will be respected and that differences in cultural and educational background will be taken into account.
4. You have the right to privacy. In the clinics, you should be able to talk with your doctor, nurse, other health worker or an administrative officer in private, and know that the information you supply will not be overheard nor given to others without your permission. In the Hospital, when you are in a semi-private room, you can expect a reasonable attempt to keep the

1

conversation private. When you are examined, you are entitled to privacy — to have the curtains drawn, to know what role any observer may have in your care, to have any observers unrelated to your care leave if you so request. If you are hospitalized, no outsiders can see you without your permission. Your hospital records are private as well, and no person or agency beyond those caring for you can learn the information in your medical record without your specific permission.

5. You have the right to know the name of the doctor who is responsible for your care; to talk with that doctor and any others who give you care; to receive all the information necessary for you to understand your medical problems, the planned course of treatment (including a full explanation about each day's procedures and tests) and the prognosis or medical outlook for your future; to receive adequate instruction in self-care, prevention of disability and maintenance of health. You have the right to ask the doctor any questions that concern you about your health. You have the right to know who will perform a test or an operation, and the right to refuse it. Because this is a university hospital, you may come across doctors, nurses and other health workers in training, or you may be asked to participate in special studies. We believe that the presence of students adds to the quality of care. Nevertheless, you have the right to have a full explanation of any research study or any training program for students before you agree to participate in it, and the right to refuse to participate. If you

2

agree to the diagnostic and therapeutic procedures recommended by your doctor, you may be asked to sign a consent form, but if you refuse, you have the right to receive the best help that the Hospital can still offer under the circumstances.

6. You have the right to leave the Hospital even if your doctors advise against it, unless you have certain infectious diseases which may influence the health of others, or if you are incapable of maintaining your own safety, as defined by law. If you do decide to leave before the doctors advise, the Hospital will not be responsible for any harm that this may cause you and you will be asked to sign a "Discharge Against Advice" form.

7. You have the right to inquire about the possibility of financial aid to help in the payment of your Hospital bills and the right to receive information and assistance in securing such aid.

Patients also have certain responsibilities which should be carried out in their own best interests:

Please keep appointments, or telephone the Hospital when you cannot keep a scheduled appointment; bring with you information about past illnesses, hospitalizations, medications and other matters relating to your health; be open and honest with us about instructions you receive concerning your health, that is, let us know immediately if you do not understand

3

them or if you feel that the instructions are such that you cannot follow them.

You have the responsibility to be considerate of other patients, and to see that your visitors are considerate as well, particularly with reference to noise and smoking, which are usually very annoying to nearby patients.

You also have a responsibility to be prompt about payment of Hospital bills, to provide information necessary for insurance processing of your bills, and to be prompt about asking any questions you may have concerning your bills.

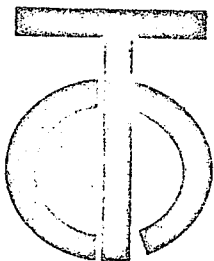
Beth Israel Hospital is interested in keeping you in the best health possible. If you feel you are not being treated fairly or properly, you have the right to discuss this with your doctor, nurse, unit manager, other health worker, or the Assistant Director on Call. You may also write a letter to the General Director, Beth Israel Hospital, Boston 02215. All correspondence will receive prompt and personal attention.

This message reflects the interest and philosophy of the entire staff of Beth Israel Hospital.

Mitchell T. Rabkin, M.D.

Mitchell T. Rabkin, M.D.
General Director

4



COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

ONE DUPONT CIRCLE, N. W. • WASHINGTON, D. C. 20036 • (202) 466-5123
(202) 466-5127

COTH Regional Membership Memorandum
Northeast Region

April 10, 1973

Subject: Call to Meeting - Northeastern
Regional Meeting, Monday,
May 14, 1973, Boston, Massachusetts

It is the purpose of this memorandum to serve as the Call to Meeting for the COTH Northeastern Regional Meeting to be held in Boston, Massachusetts on Monday, May 14th from 10:00 a.m. to 3:00 p.m. The meeting will be held at the Research Building of the Children's Hospital Medical Center, 300 Longwood Avenue.

Featured as the morning speaker will be John D. Twiname, *Executive Director for Health at the Cost of Living Council*, who will discuss the control of health care costs under Phase III of the Economic Stabilization Program.

An informal luncheon will be served at approximately 12:30 p.m. We need to know the number attending in order to determine the number of lunches required. In that regard, it would be helpful if you would complete the attached postal card indicating the number of persons from your institution planning to attend. Also, a block of rooms has been reserved for the attendees at The Children's Inn at 324 Longwood Avenue. If you desire hotel accommodations we would appreciate your contacting the Inn directly and indicating that your reservation is in connection with the AAMC meeting. For those in the Boston area who will be attending the meeting, parking will be available at the Children's Hospital garage.

It would be helpful if you would return the attached postal card by May 4th. I look forward to seeing you then.

RICHARD M. KNAPP, PH.D.
Director
Department of Teaching Hospitals

Enclosure: postal card

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF TEACHING HOSPITALS

COTH SOUTHERN REGIONAL MEETING

May 4, 1973

Hilton Inn

Atlanta Airport

Atlanta, Georgia

Terrace Room

10:00 a.m.-4:00 p.m.

AGENDA

10:00 AM Call to Order and Welcome - Stuart M. Sessoms, M.D.

10:15 John E. Lynch
Chief Executive Officer
North Carolina Baptist Hospitals, Inc.
Winston-Salem, North Carolina

"FEDERAL CUTBACKS ON MEDICAL SCHOOL FUNDING:
IMPLICATIONS FOR THE TEACHING HOSPITAL"

10:45 Discussion and Questions

11:15 Stuart M. Sessoms, M.D.
Director
Duke University Hospital
Durham, North Carolina

George M. Stockbridge
Executive Secretary
Health Planning Council of Central North Carolina

"CERTIFICATE OF NEED LEGISLATION: THE NORTH CAROLINA
DECISION"

12:00 Informal Reception

12:30 Lunch

1:30 Lawrence E. Martin
Associate Director and Comptroller
Massachusetts General Hospital
Boston, Massachusetts

"RATE REVIEW LEGISLATION: SPECIAL IMPLICATIONS
FOR TEACHING HOSPITALS"

2:00 PM

Discussion and Questions

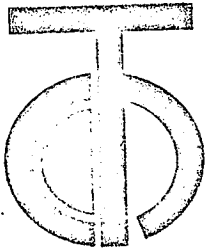
2:30

Staff Reports

Robert H. Kalinowski, M.D. and Richard M. Knapp, Ph.D.

Open Forum

Membership



COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES
ONE DUPONT CIRCLE, N. W. • WASHINGTON, D. C. 20036 • (202) 466-5123

COTH Regional Membership Memorandum
Western Region
April 2, 1973
Subject: Call to Meeting - Western
Regional Meeting, Friday,
April 27, 1973

It is the purpose of this memorandum to serve as the Call to Meeting for the COTH Western Regional Meeting. The University Hospital Council has agreed to share the first day of their Spring meeting to host the COTH regional meeting.

The meeting will be held on Friday, April 27 at the Asilomar Conference Grounds in Pacific Grove, California beginning at 9:30 a.m. The featured speaker will be John Kasonic of Arthur Young & Company, who will discuss "The Implications of H.R. 1 on the Provision of Professional Services in the Teaching Setting." The remainder of the session, until 4:30 p.m., will take the form of a seminar concerning the determination of cost and future financing of the teaching hospital.

The Asilomar Conference Grounds are a short distance from the Monterey Airport. It is suggested that you make arrangements for the evening of April 26 at a motel in the Monterey area and take a morning taxi to Asilomar. We note two motels in the area are the Del Monte Hyatt House (408/373-3721) and the Holiday Inn (408/372-8161). You may be familiar with or have preferences for others.

An informal luncheon will be served. We need to know the number attending in order to determine the number of lunches required. In that regard, it would be helpful if you would complete the attached postal card indicating the number of persons from your institution planning to attend. We would appreciate return of the postal card by Monday, April 23. We look forward to seeing you then.

ROBERT M. DERZON
Chairman-Elect
Council of Teaching Hospitals

Attachment: Postal Card

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF TEACHING HOSPITALS

COTH MIDWEST-GREAT PLAINS REGIONAL MEETING
Sheraton-O'Hare Motor Hotel
6810 North Mannheim Road
Rosemont, Illinois

Stuart Room
10:00 a.m. - 4:00 p.m.

AGENDA

- 10:00 A.M. Review of Agenda - Program Committee
- 10:15 Mr. Al Whitehall
Assistant Executive Director
New Mexico Foundation for Medical Care
Albuquerque, New Mexico
"OPERATING EXPERIENCES OF A FOUNDATION PLAN"
- 10:35 Dr. Thomas S. McConnell
Chief, Pathology Service & Associate Professor
Department of Pathology
University of New Mexico School of Medicine
and Bernalillo County Medical Center
"IMPACT OF A FOUNDATION PLAN ON A TEACHING HOSPITAL"
- 10:55 Dr. Vernon Weckwerth, Professor, Program in Health
Administration, School of Public Health, University
of Minnesota, and President, Minnesota Systems
Research, Inc.
"AN ANALYSIS OF THE ISSUES INVOLVED IN QUALITY
ASSURANCE PROPOSALS"
- 11:15 - 12:15 Panel Discussion and Questions
- 12:15 Lunch
Dr. Robert Laur, Associate Administrator
Health Services and Mental Health Administration
Department of Health, Education, and Welfare
Washington, D.C.
"FEDERAL SHIFTS IN PROGRAMS AND IMPLICATIONS
FOR TEACHING HOSPITALS"

1:30

Dr. Robert Kalinowski and Dr. Richard Knapp

Staff Report

AAMC Retreat Agenda Items
HMO Contract Developments
Subcommittee on Quality of Care
House Staff Developments
Relations with the AHA
AAMC Ad Hoc Committee on H.R. 1

Open Forum

Membership

Regional Program Planning Committee

John H. Westerman, Chairman, Minnesota*
Edward Connors, Michigan
Stanley R. Nelson, Michigan
Dean Roe, Wisconsin
James Varnum, Wisconsin
Sidney Lewine, Ohio*
John W. Colloton, Iowa
F. Regis Kenna, Illinois
Bernard J. Lachner, Illinois
Arthur J. Klippen, M.D., Minnesota*

* Members, COTH Administrative Board

SPECIAL STUDY: EDUCATIONAL COSTS OF TEACHING HOSPITALS.

The extent of teaching hospitals' support of education and of the additional expenses incurred in providing educational support is not known, but is estimated to be a major proportion of educational cost. The study group therefore plans to study these costs at a small sample of teaching hospitals.

National comparisons show that teaching hospitals, as compared with non-teaching hospitals of approximately the same size, have 35 percent higher per day costs, 9 percent more in-patient days per case, and 5 percent more out-patient visits. The result is greater overall costs in teaching hospitals. Income sources, areas of expenditure, and internal organization also differ in teaching and non-teaching hospitals. Some of these differences are caused by the particular patient care and public service roles served by teaching hospitals--many are a major source of specialty health care (a more expensive group of patients), trauma and emergency care, indigent care, and continuing education. Differences in cost also result from the special role teaching hospitals play in the community and from the requirements of their educational role, especially the training of medical students and house officers.

Because previous studies of educational costs of teaching hospitals either have covered a very limited sample, often only one hospital, or have dealt only with portions of potential costs, they are inadequate for the purposes of this study.

The proposed methodology for gathering data on teaching hospitals is to combine existing national data with detailed studies in a limited but representative sample of teaching hospitals. For the most part, the detailed studies will overlap with the detailed field data to be obtained from the sample of the health sciences schools. The activity analyses of faculty time will be applicable for both purposes. The study of educational costs of teaching hospitals will

- rely on completed activity analysis of faculty,
- conduct special studies of house officer activities,
- examine the major departments where educational functions may require additional resources; out-patient department and clinics, laboratory and diagnostic procedures, nursing and other personnel support, space and services provided to volunteer faculty, financially uneconomical departments considered essential for teaching, and indirect support costs,
- pursue alternative means for valuing the outputs of students,
- discuss causes of variation in costs among teaching hospitals.

TASK FORCE ON COST OF GRADUATE MEDICAL EDUCATION AND FACULTY PRACTICE PLANS

The first concern of the Task Force has been with the problem of deriving cost estimates of the patient care component of undergraduate medical education, defined as costs covered in the teaching hospital budget.

Some tentative conclusions have been reached which may be summarized as follows:

- (1) There are readily discernable costs in a teaching hospital budget which can be appropriately defined as undergraduate medical instruction costs, such as the efforts of teaching physicians, house staff, and other hospital staff (nurses, technicians) in instructing medical students. These costs have already been covered in the methodology developed in the cost allocation study. The Task Force summarized its view of this aspect of the patient care cost as follows:

Given the general attributes of a teaching hospital in terms of the presence of graduate medical educational programs, the character of its patient population, the scope of services provided, and the staffing levels implicit in the discharge of such activities, the conduct of an undergraduate medical educational program in such a setting has only a minor effect (probably not exceeding 1-3%) on the overall patient care costs of such institutions. The Task Force will review cost study data when it becomes available to determine if there is a need to reconsider its position.

- (2) The presence of undergraduate medical students may result in increased hospital operating costs resulting from the conduct of teaching functions within the clinical setting, such as increased laboratory or radiological studies, and a longer patient length of stay which allegedly results from the conduct of undergraduate medical teaching programs, but there is no agreed upon methodology, nor the necessary data, to quantify these costs. The Task Force summarized its view as follows:

The current evidence available concerning the additional effect of the presence of medical students on laboratory, x-ray and other service utilization cannot be considered sufficient or conclusive. Further, if any part of the costs of such increased services are considered educational in nature, they would in large part be attributed to graduate rather than undergraduate medical education.

- (3) In addition to the patient care costs discussed in (1) and (2) above, the task force considered the question of whether any part of the remaining body of patient care costs should be allocated to undergraduate medical education. This is essentially a conceptual problem,

arising from the agreed upon fact that the conduct of an undergraduate medical education program requires access to the students to a particular volume of patient care activity. Without such access there can be no education program, but at the same time, the patient care activity provides needed hospital care for the sick. Thus, some or all of the patient care activity in an academic medical center serves more than one objective - and may be considered a joint endeavor serving a dual purpose. Since this patient care activity is essential to each program, it could be argued that the costs should be distributed to both education and patient care objectives. The Task Force concluded, however, that the provision of health care must be considered as the essential activity in either the teaching or non-teaching hospital, and not be subordinated to other objectives - such as education; that the patient care would take place regardless of the presence or absence of any other activity, and therefore, the cost of patient care in an academic health center must be primarily attributed to the health care objective; any teaching activity associated with that patient care is derivative of and incremental to the basic patient care function. The Task Force emphasized that not all the difference between patient care costs in the teaching versus non-teaching hospital setting can be ascribed to education. Significant differences in cost result from greater illness severity that characterizes the patient population of a teaching institution, the range and extent of technical services provided, qualitative differences in the provision of identical services, and the greater acceptance of indigent patients.

The Task Force thus concluded that the requisite conditions do not exist for treating patient care activity in an academic health center as a joint cost with education.



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
BALTIMORE, MARYLAND 21223

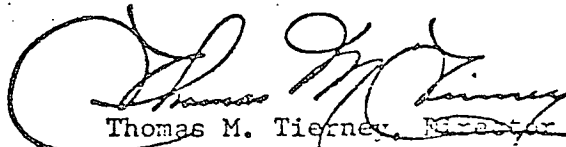
PART
B

March 1973

INTERMEDIARY MANUAL
REVISION TRANSMITTAL NO. 320

<u>New Material</u>	<u>Page No.</u>	<u>Replaced Pages</u>
Sec. 6102.6-6102.8	21-21.1 (2 pp.)	21-21.1 (2 pp.)

Section 6102.7, Interns and Residents, has been revised to include within the definition of "physicians' services" services performed by interns and residents outside their regular training program in a hospital other than the hospital in which they are in training under such program provided that they are fully licensed to practice medicine in the State in which the services are rendered and are not compensated by a provider. Any services rendered in the hospital with the approved teaching program under which the interns or residents are in training continue to be reimbursable, if at all, only as provider services. This policy is effective on receipt and is applicable to claims not yet adjudicated as well as to adjudicated claims coming to the carriers' attention. Files should not be searched, however, to locate previously denied claims.


Thomas M. Tierney, Director
Bureau of Health Insurance

Action Note: Add to the last paragraph of § 6012, "(See, however, § 6102.7B regarding circumstances under which services of certain moonlighting residents are reimbursable on a reasonable charge basis.)"

6102.6 Provider-Based Physicians' Services.--The services of provider-based physicians (e.g., those on a salary, or percentage arrangement, etc., whether or not they bill patients directly) include two distinct elements: the patient-care component, and the provider component. (The services of interns and residents are reimbursable to the provider on a reasonable cost basis even though the intern or resident is a licensed physician.)

A. The Professional Component.--The patient-care component of provider-based physicians' services includes those services directly related to the medical care of the individual patient. (No Part B charge can be recognized for autopsy services.) When such services are performed by a faculty member of a medical, osteopathic, dental, or podiatry school billing may be by the school with the physician's authorization. See § 6330 for form and procedures for billing for services of provider-based physicians. See § A6015 for limitations on reassignment under the 1972 Amendments.

B. The Provider Component.--Provider-based physicians often perform professional services other than those directly related to the medical care of individual patients. These may involve teaching, administrative, and autopsy services, and other services that benefit the provider's patients as a group. Such physician services, not directly related to an individual patient, if compensated, must be considered in computing reimbursable provider costs. Reimbursement for such costs is made under Part A where they relate to inpatient services and under Part B where they relate to outpatient services and inpatient ancillary services where there are no benefits payable under Part A. (See § 6852.2 on distinguishing between professional and provider components for reimbursable purpose.)

C. The Roles of the Fiscal Intermediary and Carrier.--The provider's Part A intermediary will obtain from the provider information it and the Part B carrier need to make payment determinations where the services of provider-based physicians are involved. The Part A intermediary has the responsibility for reviewing and approving the reasonableness of the agreement between provider and physician on the allocation of physician compensation (received from or through the provider) between (1) the portion attributable to provider services, i.e., services to the institution and (2) the portion attributable to physician services, i.e., identifiable services rendered by the physician to individual patients. If the provider and physician fail to agree or if their agreement appears unreasonable, the Part A intermediary and the Part B carrier will jointly assist in resolving the issue (§ 6852.6). The Part B carrier is responsible for review and approval, in accordance with the applicable principles, of the basis for Part B charges for services of provider-based physicians, i.e., the schedule of such charges if the item-by-item method of determination is used, the uniform percentage if the optional method of determination is used, or the unit charge if the per diem or per visit method is used (§§ 6856ff.).

Group practice prepayment plans which deal directly with the Social Security Administration may make a written agreement with a hospital, or with physicians in a hospital, to reimburse the professional component of the hospital-based physician's charge for services to plan-members entitled to Part B. These claims will not be processed by carriers.

6102.7 Interns and Residents.—

A. General.—For Medicare purposes, the terms "interns" and "residents" include physicians participating in approved postgraduate training programs and physicians who are not in approved programs but who are authorized to practice only in a hospital setting (e.g., unlicensed graduates of foreign medical schools). As a general rule, services of interns and residents are reimbursed on a reasonable cost basis by the Part A intermediary. However, the services of an intern or resident are reimbursable by the carrier on a reasonable charge basis as physicians' services where the individual: (1) renders the services off provider premises (however, see also B below, regarding certain "moonlighting" interns and residents); (2) is not compensated by a provider; and (3) is fully licensed to practice medicine by the State in which the services are performed. (See §§ 6704.5 and 6806 regarding the reasonable charge determination.)

See §§ 3101.6 and 3115 of the Part A Intermediary Manual (HIM-13) regarding approved programs and coverage as a provider service under hospital and medical insurance.

B. "Moonlighting" Interns and Residents.—Services a moonlighting intern or resident performs in the outpatient department or emergency room of the hospital which has the training program in which he is participating are reimbursable only on a Part B reasonable cost basis (i.e., all services performed in the hospital with the training program are treated as part of the training program). In addition, any services a "moonlighting" intern or resident furnishes in the hospital other than the one with the approved training program under which the intern or resident is in training are reimbursable on a Part B reasonable cost basis if he is paid for such services on a salary or other fixed compensation basis by the hospital in which such services are rendered (or by another hospital). However, such services are reimbursable by the carrier on a reasonable charge basis as physicians' services if the intern or resident is not so compensated and if he is fully licensed to practice medicine in the State in which the services are performed.

6102.8 Supervising Physicians in the Teaching Setting.—Medical insurance covers the services attending physicians (other than interns and residents) render in the teaching setting to individual patients.

AD HOC COMMITTEE TO REVIEW PERTINENT SECTIONS OF H.R. 1 (P.L. 92-602)

S. David Pomrinse, M.D., CHAIRMAN
Director
The Mount Sinai Hospital
11 East 100th Street
New York, New York 10029

John W. Colloton
Director
University of Iowa
Hospitals and Clinics
Newton Road
Iowa City, Iowa 52240

John M. Stagl
Executive Vice President
Northwestern Memorial Hospital
303 East Superior Street
Chicago, Illinois 60611

Charles B. Womer
Director
Yale New Haven Hospital
New Haven, Connecticut 06511

SERVICE
EDUCATION
RESEARCH

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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

May 15, 1973

Thomas M. Tierney
Director
Bureau of Health Insurance
Social Security Administration
East Building Room 700
Baltimore, Maryland 21235

Dear Mr. Tierney:

As requested in your letter of April 19, we have reviewed the proposed policies for implementing section 1122 (Limitation on Federal Participation for Capital Expenditures). Our comments concerning the "Discussion Paper" are set forth as follows:

.. In reviewing the language of the law as well as the Committee reports, the intent to review projects which do not exceed \$100,000 is not clear. From the standpoint of efficient administration, it would appear burdensome for designated planning agencies to review projects which require the expenditure of less than \$100,000. This is particularly important for large teaching hospitals which constantly are in the process of changing bed distribution as well as clinic and other service components. In most instances, these changes entail relatively minor capital expenditures.

.. In regard to the point above, the sentence beginning on the bottom on page nine, is important, and reads as follows: "The 'change in capacity' is defined as any change in the facility's total number of beds or any change in the total number of beds assigned for a specific type of patient care." We would hope that some guidance would be provided in the regulations so that designated planning agencies would not make an unnecessarily narrow interpretation of this sentence. It would seem worthwhile to include an example which demonstrates that the redistribution of beds between sub-specialties (e.g., from cardiology to gastroenterology) are not included within the intent of this sentence.

.. Nowhere in the regulations are the terms project or program specifically defined, except by example on page three of the "Implementing Section." The definition of these terms is particularly important in instances where a facility is proposing a large number

of capital expenditures. These proposed expenditures could be reviewed on either a case by case or a total program basis. In this regard we would hope that designated planning agencies would be encouraged to approach these multiple expenditures from an overall perspective. For example, one large midwestern teaching hospital expects to have 41 identifiable capital expenditures over the next three years which would most likely require approval. If reviewed individually, the energy of the planning agency would almost be totally consumed in reviewing the proposed expenditures of this facility.

.. In administering the regulations, we would hope that designated planning agencies would exclude from review the normal replacement of capital equipment in excess of \$100,000 dollars which does not substantially change the services provided. For instance, many teaching hospitals would engage in the replacement of over \$500,000 dollars worth of capital equipment each year. Example B on page three of the "Implementing Section" makes no distinction between normal replacement and the acquisition of equipment which would substantially change the capacity or type of service. Additionally, we assume that if the three separate and independent pieces of equipment referred to in the example are in three different departments (e.g., laundry, laboratory and x-ray), the expenditures would not be subject to review.

.. With the exception of the Reconsideration Determination on page 22, each step of the review process sets forth time limits for decision making. To ensure an orderly and efficient process, we would suggest that a time limit also be included for reconsideration determinations by the Secretary.

.. On page 16 of the draft regulations four guidelines are cited on which designated planning agencies may base decisions, the first of which states that "...the project is needed in the community in terms of health services required." Decisions based upon considerations of community of need or the community served varies considerably according to the mix of specialized services provided by the facility. For example, the community of need for primary care services may be the city or county in which the hospital is located, whereas the community of need for highly specialized services most frequently extends beyond local jurisdictions and is interstate and regional in character. Thus, our concern is focused on the possibility of local agency denial of capital projects for highly specialized services having a community of need which extends beyond the local community and is referral in nature.

.. Related to the above is the fact that institutions providing highly specialized services are most frequently engaged in manpower training and clinical research. Therefore, we would suggest that an additional

Mr. Tierney
Page Three

guideline be added which recognizes that the manpower training and research functions of teaching hospitals are essential to their role as regional tertiary care centers.

We appreciate very much the opportunity to review the "Discussion Paper" and I hope that our comments are of some assistance to you. If I can in any way provide further clarification of our comments, please let me know.

Sincerely,

John A.D. Cooper, M.D.
President

cc: Maurice Hartman
Division of State Operations



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
BALTIMORE, MARYLAND 21235

REFER TO:
HI:O:OFO

APR 19 1973

Mr. Richard Knapp
Association of American Medical Colleges
1 Dupont Circle
Washington, D.C. 20036

Dear Mr. Knapp:

Enclosed are the proposed policies for implementing section 1122 (Limitation on Federal Participation for Capital Expenditures). I would appreciate receiving your comments by May 11. Please address your comments to: Division of State Operations, Bureau of Health Insurance, Room 305, East Building, 6401 Security Boulevard, Baltimore, Maryland 21235.

Sincerely yours,

Maurice Hartman
Division of State Operations
Bureau of Health Insurance

Enclosure



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
BALTIMORE, MARYLAND 21235

APR 19 1973

REFER TO:

HI:O:OFO

John A.D. Cooper, M.D., Ph.D., President
Association of American Medical Colleges
One Dupont Circle
Washington, D.C. 20036

Dear Dr. Cooper:

Section 221 of Public Law 92-603 provides for limitation on Federal reimbursement under titles V, XVIII, and XIX of the Social Security Act for certain reimbursement for capital expenditures found not in accordance with State and local comprehensive health plans. Enclosed are the proposed implementing policies for this provision. We would appreciate receiving your comments on this material by May 11. Please address your comments to: Division of State Operations, Bureau of Health Insurance, Room 305, East Building, 6401 Security Boulevard, Baltimore, Maryland 21235.

Sincerely yours,

Thomas M. Tierney, Director
Bureau of Health Insurance

Enclosure

DISCUSSION PAPER ONLY

Limitation on Federal Participation for Capital Expenditures

- A. General
- B. Effective Date
- C. Definitions
- D. Health Care Facility and Health Maintenance Organization Responsibilities
- E. Hearings
- F. Determinations by the Secretary
- G. Reconsiderations by the Secretary

DISCUSSION PAPER ONLY

A. General

Section 221 of P.L. 92-603, enacted October 30, 1972, adds a new section, 1122, to title XI of the Social Security Act. This section provides for the Secretary of Health, Education, and Welfare to reduce certain Federal reimbursement under titles V, XVIII, and XIX of the Social Security Act whenever a "health care facility" or "health maintenance organization" (1) fails to notify the appropriate State comprehensive health planning agency of a proposed capital expenditure; or (2) undertakes a capital expenditure although the State comprehensive health planning agency having jurisdiction has recommended the expenditure not be undertaken and such recommendation is concurred in by the Secretary. Capital expenditures covered under the Act and the following regulations are those that exceed \$100,000, provide a substantial change in service, or change bed capacity.

Section 1122 of the Act provides that the Secretary of Health, Education, and Welfare shall enter into an agreement with a State willing and able to do so, under which a Designated Planning Agency will submit a recommendation to the Secretary to the extent its findings and the findings of other health planning agencies with jurisdiction indicate that a capital expenditure proposed by or on behalf of a health care facility or health maintenance organization is not consistent with standards, criteria, or plans developed pursuant to the Public Health Service Act or the Mental Retardation Facilities

and Community Mental Health Centers Construction Act of 1963 to meet the need for adequate health care facilities or health maintenance organizations in the area covered by the plan.

The Designated Planning Agency, before submitting a recommendation to the Secretary, will grant the health care facility or health maintenance organization the opportunity to request a hearing of the recommendation at the State level. The hearing will be conducted by an agency or person, designated by the Governor, other than the Designated Planning Agency.

After notice of the Designated Planning Agency's recommendation has been sent to the Secretary of Health, Education, and Welfare, the Secretary will provide written notice of his determination under section 1122 of title XI of the Social Security Act to the party proposing the capital expenditure. If such party is dissatisfied with the determination, he has the right to request a reconsideration by the Secretary. As provided in section 1122(f) of the Act, a reconsidered determination by the Secretary will not be subject to further administrative or judicial review.

Nothing in this section is intended to modify State comprehensive health planning operations. To the extent that a Designated Planning Agency or another health planning agency in a State provides public hearings or is entitled under State law, regulations, or procedures to a hearing in its own right under a practice or authority other than section 1122 of the Act, nothing herein should be construed to require a change in such practice or authority.

B. Effective Date

[The implementation date of this provision is being separately considered.]

The provisions of section 1122 doesnot apply to Christian Science Sanatoriums operated or listed and certified by the First Church of Christ, Scientist, Boston, Massachusetts, nor do they apply to a health care facility providing health care services as of December 18, 1970, which was committed to a formal plan of expansion or replacement where preliminary expenditures of at least \$100,000 essential to such a plan had been made during the 3-year period ending prior to December 19, 1970, with the exemption applicable only to those capital items included in such plan.

C. Definitions

Health Care Facility

The term "health care facility" for the purpose of this section includes: all hospitals, including psychiatric hospitals, tuberculosis hospitals, and emergency service hospitals; and skilled nursing facilities; home health agencies; outpatient physical therapy providers or suppliers (including speech pathology services) as defined in section 1861(e), (f), (g), (j), (o), and (p) respectively of the Social Security Act (except outpatient physical therapy services performed by a physical therapist in his office or in a patient's home); freestanding hemodialysis units; and all intermediate care facilities, as defined in section 1905(c) of the Act.

In addition, the term health care facility applies to any proposed or existing health care facility of the type described in the preceding paragraph not now providing services under titles V, XVIII, or XIX but which provides services under these titles at a future date. Reimbursement for disapproved or nontimely submitted capital expenditures will be excluded under these titles for such future participating facilities at such time as they provide services under these titles or in the case of a hospital providing emergency services at such time as they become a participating provider under title XVIII. This provision applies to both present and future owners.

Health Maintenance Organization

The term "health maintenance organization" for the purposes of section 1122 means a public or private organization which is defined in section 1876(b) of the Social Security Act as:

- (1) provides, either directly or through arrangements with others, health services to individuals enrolled with such organization on the basis of a predetermined periodic rate without regard to the frequency or extent of services furnished to any particular enrollee;
- (2) provides, either directly or through arrangements with others to the extent applicable in section 1876(c) of the Social Security Act (through institutions, entities, and persons meeting the applicable requirements of section 1861 of the Act) all of the services and benefits covered under Parts A and B of title

- XVIII which are available to individuals residing in the geographic area served by the health maintenance organization;
- (3) provides physicians' services primarily (A) directly through physicians who are either employees or partners of such organization, or (B) under arrangements with one or more groups of physicians (organized on a group practice or individual practice basis) under which each such group is reimbursed for its services primarily on the basis of an aggregate fixed sum or on a per capita basis, regardless of whether the individual physician members of any such group are paid on a fee-for-service or other basis;
 - (4) provides either directly or under arrangements with others, the services of a sufficient number of primary care and specialty care physicians to meet the health needs of its members; for purposes of this section the term "specialty care physician" means a physician who is either board certified or eligible for board certification, except that the Secretary may by regulation prescribe conditions under which physicians who have a record of demonstrated proficiency but who are not eligible for board certification may, on the basis of training and experience, be recognized as specialty care physicians;
 - (5) has effective arrangements to assure that its members have access to qualified practitioners in those specialties which are generally available in the geographic area served by the health maintenance organization;

- (6) demonstrates to the satisfaction of the Secretary proof of financial responsibility and proof of capability to provide comprehensive health care services, including institutional services, efficiently, effectively, and economically;
- (7) except as provided in section 1876(h) of the Act, has at least half of its enrolled members consisting of individuals under age 65;
- (8) assures that the health services required by its members are received promptly and appropriately and that the services that are received measure up to quality standards which it establishes in accordance with regulations; and
- (9) has an open enrollment period at least every year under which it accepts up to the limits of its capacity and without restrictions, except as may be authorized in regulations, individuals who are eligible to enroll under section 1876(d) of the Act in the order in which they apply for enrollment (unless to do so would result in failure to meet the requirements of paragraph (7)) or would result in enrollment of enrollees substantially nonrepresentative, as determined in accordance with regulations of the Secretary, of the population in the geographic area served by such health maintenance organization.

Designated Planning Agency

The term "Designated Planning Agency" means a planning agency which has been designated by the Governor or other chief executive officer of a

State to implement the provisions of this section which is: (a) a State planning agency established pursuant to sections 314(a) or 604(a) of the Public Health Service Act; or (b) a public or non-profit private agency or organization responsible for the comprehensive regional, metropolitan area, or other local area plan or plans which is referred to in section 314(b) of the Public Health Service Act and which covers the area in which the health care facility or health maintenance organization proposing a capital expenditure is located; or (c) a public or nonprofit private agency or organization which performs functions similar to those agencies described in (a) or (b) above and which has a governing body or advisory board at least half of whose members represent consumer interests.

Other Health Planning Agency

The term "other health planning agency" means any planning agency included in the definition of a Designated Planning Agency except that no agency serving as the Designated Planning Agency may also be an "other health planning agency."

Party

The term "party" means a person (individual, partnership, corporation, association, or other entity) proposing a capital expenditure by or on behalf of a health care facility or health maintenance organization.

Capital Expenditure

"Capital expenditure" is one which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance and (1) exceeds \$100,000, or (2) changes the bed capacity of the facility , or (3) substantially changes the services of the facility. In determining if a capital expenditure exceeds \$100,000, the cost of studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, modernization, expansion, or replacement of the land, plant, buildings, and equipment are included. Also included are expenditures directly or indirectly related to capital expenditures, including expenses with respect to grading, paving, broker commissions, taxes assessed during the construction period, and costs involved in demolishing or razing structures on land. In determining whether a capital expenditure exceeds \$100,000, it is necessary to take account of all direct and indirect expenditures, regardless of the manner in which they are recorded in the provider's records. Transactions which are separated in time but are components of an overall plan or patient care objective are viewed in their entirety without regard to their timing.

Other costs related to such capital expenditure include title fees, permit and license fees, broker commissions, architect, legal, accounting, and appraisal fees; interest, finance, or carrying charges on bonds, notes, and other costs incurred for borrowing funds.

Substantial Change in Service

A "substantial change in service" means any new service to be offered or department to be established, or any change in the scope or type of an existing service or department, or in the capability for providing such service. This regulation applies both to those services and departments that any comprehensive health planning agency participating in the capital expenditure limitation program is required or authorized to review pursuant to State law or regulations and to all other services and departments such planning agencies choose to review for purposes of section 1122. (See section .)

The Designated Planning Agency will make public the kinds of capital expenditure proposals of \$100,000 or less involving changes in services required to be reviewed by health planning agencies in the State within their respective fields of responsibility. To the extent that State law or regulations require health care facilities or health maintenance organizations to submit for review to health planning agencies capital expenditure proposals involving changes in services on January 1, 1973, or later, such proposals will be subject to the provisions of section 1122 notwithstanding the special public notice required above.

Change in Bed Capacity

A "change in bed capacity" is defined as any change in the facility's total number of beds or any change in the total number of beds assigned

for a specific type of patient care. It is not intended that temporary increases in beds would be subject to this provision.

The Designated Planning Agency will make public the extent to which changes in bed capacity are required to be reviewed for purposes of section 1122 by health planning agencies in the State within their respective fields of responsibility. To the extent that State law or regulations require health care facilities to submit proposals on changes in beds to health planning agencies on January 1, 1973, or later, such proposals will be considered subject to the provisions of section 1122 of title XI notwithstanding the special public notice required above.

Obligation

An "obligation" means any valid contract which is binding on the health care facility or health maintenance organization and which is entered into for the construction, acquisition, or for the permanent financing of a capital asset.

Nonallowable Costs

"Nonallowable costs" means depreciation, interest on borrowed funds, return on equity capital (in the case of proprietary facilities), and any other costs attributable to capital expenditures where such capital expenditures are not consistent with the standards, plans, or criteria developed by States to meet the need for adequate health care facilities.

Costs claimed by a health care facility or health maintenance organization in connection with capital assets which are donated or transferred to such health care facility or health maintenance organization are also subject to the application of section 1122 of the Act. This section also applies to the reasonable equivalent of that portion of any rental expense incurred pursuant to a lease or a comparable arrangement (and to any amounts deposited under the terms of such a lease or comparable arrangement in computing the return on equity capital) that would have been excluded had the health care facility or health maintenance organization acquired such by purchase. The amounts excluded are not subject to reimbursement under any other provisions of titles V, XVIII, or XIX.

Exceptions to Nonallowable Costs

Reasonable costs incurred by a health care facility for studies, surveys, etc., which are conducted to properly determine whether the proposed capital expenditure would be in compliance with the Designated Planning Agency's need criteria, are allowable, whether or not the expenditure is approved.

In addition, as provided in section 1122(d)(2) of the Act, the Secretary, after consulting with the advisory council designated under section 1122(i) may determine that expenses related to a capital expenditure not be excluded from a health care facility's or health maintenance organization's reimbursement, if he determines that

such exclusion would discourage the operation or expansion of such facility or health maintenance organization, or of any facility of such organization, which has demonstrated to his satisfaction proof of capability to provide comprehensive health care services (including institutional services) efficiently, effectively, and economically, or would otherwise be inconsistent with the effective administration of title V, XVIII, or XIX.

D. Health Care Facility and Health Maintenance Organization Responsibilities

Timely Notice

Any party proposing a capital expenditure by or on behalf of a health care facility or health maintenance organization must give the Designated Planning Agency at least 60 days written notice prior to incurring an obligation for such expenditure. Written notice means that the proposed capital expenditure must be submitted in such form, detail, and in accordance with such laws, regulations, or procedures as may be applicable in the State or prescribed by the Designated Planning Agency. The Designated Planning Agency is not considered to have received such written (timely) notice until the date, as determined by such agency, when a notice which is in such full compliance has been received.

An obligation for a capital expenditure which is not subject to the exclusion of reimbursement under section 1122 of the Act may be incurred when timely notice has been given and the Designated Planning Agency has: (1) notified the party proposing the capital

expenditure of approval of the capital project; or (2) elected not to review the proposal for purposes of section 1122 of the Act and has so notified the party; or (3) has failed to respond to the party within 60 calendar days following the receipt of his timely notice; or (4) where the Designated Planning Agency has given notice within 60 days that it is considering the proposals, has not notified the party proposing the capital expenditure within 90 days following the receipt of timely notice of such proposal that it has been found to be inconsistent with standards, criteria, and plans described in section .

If within 60 calendar days following the date of receipt of a timely notice the Designated Planning Agency has notified in writing the party submitting the notice that additional time is necessary to evaluate the proposed capital project, the Designated Planning Agency may have up to 90 days from the date of receipt of such timely notice so defined in section to render a recommendation on the proposed capital expenditure. If such a recommendation is not completed within such 90-day period and the party proposing such capital expenditure is not notified in writing of the results of the Designated Planning Agency's recommendation, the expenditure would not be subject to the exclusion of reimbursement under the provisions of section 1122.

If the Designated Planning Agency, after receiving a purported notice of a proposed capital expenditure and after attempting to secure additional information about such notice before making a recommendation determines that the party submitting such proposal is either unable or

unwilling to submit such information, it will notify the party that the purported notice is insufficient to make a recommendation in accordance with the State's standards, criteria, and plans with respect to the proposed capital expenditure, and that if the party should incur an obligation with respect to such expenditure, it will be subject to the exclusion of reimbursement under the provisions of section 1122.

- The Designated Planning Agency may, if it chooses to do so, delegate under State procedures the responsibility for receipt and review of capital expenditure proposals to other health planning agencies. In such cases, proposals submitted to other health planning agencies will be deemed to have been submitted to the Designated Planning Agency.

Revising a Capital Expenditure Proposal

Any party who has submitted a capital expenditure proposal and who intends to revise or modify the scope of such proposals as submitted to or approved by the Designated Planning Agency, must provide such agency with timely notice (see section) or such intent prior to incurring an obligation for such expenditure. Upon receipt of a notice to revise or modify such proposals, the Designated Planning Agency will determine and notify the party making the capital expenditure proposal whether such notice constitutes a new proposal or whether it can be acted upon within the 90-day time limit for the original proposal (see section).

Withdrawal of Notice

Any party proposing a capital expenditure may withdraw without prejudice his timely notice of a capital expenditure proposal at any time by notifying the Designated Planning Agency in writing of his wish to do so.

Acknowledgment of Withdrawal

The Designated Planning Agency, following the receipt of the withdrawal request, will notify in writing the party submitting the purported or timely notice that his request for withdrawal has been approved.

When such withdrawal request is approved, it is presumed for purposes of this part that an obligation for the proposed capital expenditure will not be incurred.

Obligation for Capital Expenditure Not Incurred Following Its Approval

Any health care facility or health maintenance organization which has received notice of approval of a capital expenditure and which has not incurred an obligation for such expenditure within the time period provided in State law or regulations shall, having failed to do so, resubmit its capital expenditure proposal and provide required, timely notice prior to incurring an obligation in accordance with section

Designated Planning Agency's Recommendation to the Secretary

The Designated Planning Agency, after receiving the findings and recommendations of the 314(b), 604(a) or other health planning agency having jurisdiction with respect to a capital expenditure proposed by

or on behalf of a health care facility or health maintenance organization will prepare a recommendation for submittal to the Secretary if the proposed capital expenditure is considered to be inconsistent with standards, criteria, or plans developed pursuant to the Public Health Service Act (or the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963) to meet the need for adequate health care facilities in the area covered by the plan or plans so developed. Such standards, criteria, and plans should, upon request, be made available for review by health care facilities and health maintenance organizations and the public at large. Such recommendation shall include a summary of the findings of the Designated Planning Agency and of the findings and recommendations of other planning agencies submitted to the Designated Planning Agency with respect to the proposal. The Designated Planning Agency's recommendation may be predicated on whether: (1) the proposed project is needed in the community in terms of health services required; (2) the project can be adequately staffed and operated when completed; (3) the capital expense to be incurred can be accommodated in the health care facility's or health maintenance organization's patient charge structure without unreasonable increases; and (4) the project will foster cost control through improved efficiency and productivity, including promotion of cost-effective preventive health care services.

Parties to a Designated Planning Agency Recommendation

The parties to the Designated Planning Agency recommendation shall be all those persons or their designated representatives who within the judgment of the Designated Planning Agency have submitted timely notice of the same or similar capital expenditure proposals which compete with each other.

Notice of Designated Planning Agency Recommendations

The Designated Planning Agency must notify the party or parties proposing a capital expenditure by or on behalf of a health care facility or health maintenance organization of an adverse finding with respect to such expenditure and must advise such party (or parties) of his right to request a hearing, the place and manner of requesting a hearing, and the time limit during which a hearing must be requested. If more than one party has proposed the same or a similar capital expenditure, each such party must be notified of the adverse recommendation with respect to his particular proposal. If such a hearing has not been requested by such party within 30 days from the date of the notification of the inconsistent findings, the Designated Planning Agency shall submit its recommendations regarding the proposal to the Secretary.

E. Hearings

Right to a Hearing

- (1) General--Any party who has received a notice from the Designated Planning Agency of an adverse recommendation with respect to all or part of his proposed capital expenditure shall be entitled to a hearing if such party makes a timely request in writing.

- (2) Place--The hearing request will be made to the Office of the Designated Planning Agency.
- (3) Time--The Designated Planning Agency will provide a period of not more than 30 days after the date of the notice of the recommendation to the Secretary within which a party to such recommendation may request a hearing. The hearing officer may, at his discretion, extend the period for requesting a hearing upon a request by the party affected, but not for a time period to exceed an additional 30 days.

Parties to a Hearing

The parties to a hearing shall be the persons who were parties to the Designated Planning Agency's recommendation or their designated representatives. (See section .) Several persons may have submitted the same or similar capital expenditure proposals and would be parties to the hearing.)

Hearing Officer

The hearing shall be conducted by an agency or person designated by the Governor (or other chief executive officer) other than the Designated Planning Agency except that no agency or person contributing findings and recommendations with respect to, or otherwise involved in, the Designated Planning Agency's recommendation to the Secretary, may conduct the hearing. The qualifications of the hearing officer shall be in keeping with established conditions required by State law or where such conditions do not exist, the State shall be required to submit

such qualifications to the Secretary for approval. Notice of any objection with respect to the hearing officer who will conduct the hearing shall be made to the hearing officer at the earliest opportunity prior to the date of the hearing. The hearing officer shall consider such objection and shall, at his discretion, withdraw. If the hearing officer does not withdraw, the objecting party may present his objection to the Governor or his delegate. This official's judgment will prevail as to whether another hearing officer should be appointed to conduct the hearing of issue.

Record of a Hearing

A complete record of the proceedings at the hearings shall be made. The testimony shall be transcribed and copies of other documentary evidence shall be reproduced in any case when directed by the hearing officer, the Designated Planning Agency, or the Secretary. The record may be reproduced at the request of a party to the hearing provided he bears the cost thereof.

Hearing Officer's Decision

As soon as practicable after the conduct of the hearing, the hearing officer shall make a decision on the recommendation in question and the findings upon which it was based; and upon the basis of the evidence considered in connection with the recommendation and whatever other evidence is introduced as a result of the hearing request.

The decision shall be made in writing and contain findings of fact and statement of reasons and will affirm, or revise in whole or in

part, the recommendation in question. A copy of the decision will be mailed to each party to the hearing at his last known address and to the Designated Planning Agency.

Any decision by the hearing officer which affirms or revises in part the adverse recommendation of the Designated Planning Agency will be submitted along with the Designated Planning Agency's recommendation, through the Designated Planning Agency to the Secretary for a determination.

Effect of Hearing Officer's Decision

The Secretary will accept the finding of the hearing officer as the final recommendation of the Designated Planning Agency, unless there shall also be forwarded a contrary finding made by a State agency appellate jurisdiction on an appeal taken from the finding of the hearing officer.

Authority of the Hearing Officer

The hearing officer in exercising his authority to conduct a hearing under section 1122(b)(3) of the Act may conduct the hearing in accordance with State law, regulations, or procedures to the extent that he complies with all the provisions of title XI of the Act and regulations issued thereunder, as well as with policy statements, instructions, and other guides issued by the Secretary in accordance with the Secretary's agreement with the State.

F. Determinations by the Secretary

Notice of the Secretary's Determination

The Secretary must notify the party proposing the capital expenditure of his determination and the basis for and consequences thereof. In making such determination, the Secretary will consider: (1) the recommendation of the Designated Planning Agency, which will include the findings of such agency and the findings and recommendations of other health planning agencies; (2) the decision of the hearing officer; and (3) any evidence submitted in connection with the capital expenditure proposal prior to the notification of the party of the Secretary's determination.

G. Reconsideration by the Secretary

Reconsideration of the Secretary's Determination

Any party (as defined in section) dissatisfied with a determination by the Secretary may request that it be reconsidered.

Right to Reconsideration

General--The Secretary will reconsider an initial determination upon receipt of a request for a reconsideration in writing by the party to the initial determination. The reconsideration determination shall be made by a person or group other than the person or group making the initial determination.

Request for Reconsideration

A request for reconsideration must be an expression in writing by a party to the initial determination which indicates he disagrees with the Secretary's determination with respect to the capital expenditure

and wishes to appeal. The request should include an explanation for the basis of the reconsideration request, as well as include any new evidence to be submitted.

Place--The request for reconsideration should be directed to the Office of the Secretary identified in the notice of the initial determination.

Time--The request for reconsideration must be received by the Secretary or his designee within 6 months after the date of mailing of the notice of the initial determination.

Parties to the Reconsideration

The parties to the reconsideration shall be the persons who were parties to the Secretary's initial determination or their designated representatives.

Reconsideration Determination

The Secretary in reconsidering the initial determination will review such determination and will take into consideration: (1) the findings and recommendations of the Designated Planning Agency; (2) the findings and recommendations of other health planning agencies; (3) the decision of the hearing officer; (4) the transcript of the hearing; (5) the evidence considered in connection with the initial determination and any other pertinent new evidence submitted by the parties to the initial determination, or otherwise obtained by the Secretary, relating to the capital expenditure (any such new evidence received by the Secretary will be submitted to the Designated Planning Agency for its comments);

and (6) the recommendation, if any, of the advisory council in accordance with section 1122(i) of the Act. On the basis of the above, the Secretary shall make a reconsidered determination which shall affirm or revise in whole or in part, the initial determination. The reconsideration determination will contain the basis for and consequences thereof, and notice of the determination will be mailed to the contesting party at his last known address and to the Designated Planning Agency.

Effect of Reconsideration Determination

For the purpose of this section, the reconsideration determination shall be final and binding upon all parties to the reconsideration and will not be subject to further administrative or judicial review.

[For purposes of reconsideration by the Secretary, an alternate has been suggested which would prescribe that any person or organization which has or can show a legitimate interest in the project for which the capital expenditure is proposed can request a reconsideration. This would include, in addition to the person or organization proposing the project, consumer groups, the Designated Planning Agency, and other health planning agencies.]

IMPLEMENTING SECTION 1122 OF TITLE XVIII
(LIMITATION ON FEDERAL PARTICIPATION FOR CAPITAL EXPENDITURES)

405.431. Nonallowable Costs Related to Certain Capital Expenditures.--

(a) Principle.--Depreciation, interest on borrowed funds, return on equity capital (in the case of proprietary providers), and any other costs attributable to capital expenditures where such capital expenditures are not consistent with the standards, plans, or criteria developed to meet the need for adequate health care facilities (as defined in .) are not allowable.

(b) Application.--Under this principle, any costs related to capital expenditures incurred by or on behalf of a provider subsequent to 1972 (except as described in paragraph (d)) are not allowable where the capital expenditures are determined not to be consistent with the standards, plans, or criteria developed by the designated planning agency, or other health planning agency in the State, to meet the need for adequate health care facilities in the area covered by the plan or plans so developed (see section .). Costs claimed by a provider in connection with capital assets which are donated or transferred to a provider are also subject to the application of this principle. This principle also applies to the reasonable equivalent of that portion of any rental expense incurred pursuant to a lease or a comparable arrangement (and to any amounts deposited under the terms of such a lease or comparable

arrangement in computing the return on equity capital) that would have been excluded had the provider acquired such a facility by purchase. The amounts excluded are not subject to reimbursement under any other provisions of title XVIII.

(c) Capital Expenditures.--(1) For the purposes of this section, a capital expenditure is one which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance and (i) exceeds \$100,000, or (ii) changes the bed capacity of the facility (see section . . .), or (iii) substantially changes the services of the facility (see section . . .). In determining if a capital expenditure exceeds \$100,000, the cost of studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, modernization, expansion, or replacement of the land, plant, buildings, and equipment are included. Also included are expenditures directly or indirectly related to capital expenditures, including expenses with respect to grading, paving, broker commissions, taxes assessed during the construction period, and costs involved in demolishing or razing structures on land. (2) In determining whether a capital expenditure exceeds \$100,000, it is necessary to take account of all direct and indirect expenditures, regardless of the manner in which they are recorded in the provider's records. (3) Transactions which are separated in time but are components of an overall plan or patient care objective are viewed in their entirety without regard to their timing.

Example A: In 1970, a corporation or other entity acquires land and clears it of all existing structures. No further action is taken immediately thereafter. However, in 1973, plans are made to extend a wing of the health care facility to this land. The costs incurred in the acquisition and clearing of the land are combined with the estimate of the proposed construction cost for the purpose of determining whether the capital expenditure exceeds \$100,000.

Example B: A hospital board approved purchases for its radiology department of three separate and independent pieces of X-ray equipment during the next fiscal year. Individually, the cost of each piece of equipment is less than \$100,000. Collectively, the total cost of the project exceeds \$100,000. Planning approval is needed as the planned project expenditures, as a totality, exceed \$100,000.

Example C: A hospital decides to renovate or expand its dietary department at a cost estimated to exceed \$100,000. The renovation or expansion is made in several stages during a 3-year period. In no one accounting period does the expenditure exceed \$100,000. However, planning approval is needed because expenditures related to the various stages of an overall plan of renovation or expansion are part of a specific patient care activity or objective of the board or administration of the health care facility.

Example D: A hospital closes a 20-bed wing and converts the space to an outpatient service. The total cost incurred is less than \$100,000. Planning approval is required since instituting an outpatient service constitutes a substantial change in service of the facility. If planning approval is denied, the depreciation and other costs, as discussed in 405.431(a), which are attributable to the ^{conversion to} outpatient service are not allowable.

(4) Other costs related to such capital expenditure include title fees, permit and license fees, broker commissions, architect, legal, accounting, and appraisal fees; interest, finance, or carrying charges on bonds, notes, and other costs incurred for borrowing funds. However, reasonable costs incurred by a provider for studies, surveys, etc., which are conducted to enable the provider to properly determine whether the proposed capital expenditure would be in compliance with the State planning agency's need criteria are allowable, whether or not the expenditure is approved.

(d) Exceptions.--The limitation on recognition of costs attributable to capital expenditures discussed in this section does not apply to

(1) a health care facility providing health care services as of December 18, 1970, which was committed to a formal plan of expansion or replacement where preliminary expenditures of at least \$100,000 essential to such a plan had been made during the 3-year period ending prior to December 18, 1970, with the exemption applicable only to those capital items included in such plan, or (2) Christian Science Sanatoriums, operated, or listed and certified, by the First Church of Christ,

Scientist, Boston, Massachusetts, or (3) to capital expenditures the obligations for which are incurred by or on behalf of a provider prior to 1973. An obligation is any valid contract which is binding on the provider and which is entered into for the construction, acquisition, or for the permanent financing of a capital asset.

of the lease to deposit such funds (net of noncurrent debt related to such investment or deposited funds), and (2) net working capital maintained for necessary and proper operation of patient care activities (excluding the amount of any current payment made pursuant to § 405.454(g)(1)). However, debt representing loans from partners, stockholders, or related organizations on which interest payments would be allowable as costs but for the provisions of § 405.419(b)(3)(ii), is not subtracted in computing the amount of (1) and (2), in order that the proceeds from such loans be treated as a part of the provider's equity capital. In computing the amount of equity capital upon which a return is allowable, investment in facilities is recognized on the basis of the historical cost, or other basis, used for depreciation and other purposes under the health insurance program. The excess of the price paid for a facility or for tangible net assets over the historical cost, as determined under § 405.415(b) or the cost basis as determined under § 405.415(g), is not includable in equity capital and loans made to finance that portion of the cost of acquisition are excluded in computing equity capital. For purposes of computing the allowable return the amount of equity capital is the average investment during the reporting period. The rate of return allowed, as derived from time to time based upon interest rates in accordance with this principle, is determined by the Social Security Administration and communicated through intermediaries. Return on investment as an element of allowable costs is subject to apportionment in the same manner as other elements of allowable costs. For the purposes of this regulation, the term "proprietary providers" is intended to distinguish providers, whether sole proprietorships, partnerships, or corporations, that are organized and operated with the expectation of earning profit for the owners, from other providers that are organized and operated on a nonprofit basis.

§ 405.430 Inpatient routine nursing salary cost differential.

(3) A provider's investment in plant, property, and equipment related to patient care, and funds deposited by a provider which leases plant, property, or equipment related to patient care found to be expenditures not consistent with health facility planning requirements (see § 405.431) are not included in the provider's equity capital for computing the allowance for a reasonable return on equity capital.

§ 405.430 Inpatient routine nursing salary cost differential.

(k) Principle. In recognition of the above average cost of inpatient routine

used, particularly at the beginning of the program, to take account of the great differences in the present state of development of recordkeeping.

(5) That the principles should result in the equitable treatment of both non-profit organizations and profitmaking organizations.

(6) That there should be a recognition of the need of hospitals and other providers to keep pace with growing needs and to make improvements.

(c) As formulated herein, the principles give recognition to such factors as depreciation, interest, bad debts, educational costs, compensation of owners, and an allowance for a reasonable return on equity capital of proprietary facilities. With respect to allowable costs some items of inclusion and exclusion are:

(1) An appropriate part of the net cost of approved educational activities will be included.

(2) Costs incurred for research purposes, over and above usual patient care, will not be included.

(3) Grants, gifts, and income from endowments will not be deducted from operating costs unless they are designated by the donor for the payment of specific operating costs.

(4) The value of services provided by nonpaid workers, as members of an organization (including services of members of religious orders) having an agreement with the provider to furnish such services, is includible in the amount that would be paid others for similar work.

(5) Discounts and allowances received on the purchase of goods or services are reductions of the cost to which they relate.

(6) Bad debts growing out of the failure of a beneficiary to pay the deductible, or the coinsurance, will be reimbursed (after bona fide efforts at collection).

(7) Charity and courtesy allowances are not includable, although "fringe benefit" allowances for employees under a formal plan will be includable as part of their compensation.

(8) A reasonable allowance of compensation for the services of owners in profitmaking organizations will be allowed providing their services are actually performed in a necessary function.

(d) In developing these principles of reimbursement for the health insurance program, all of the considerations inherent in allowances for depreciation were studied. The principles, as presented, provide options to meet varied

However, costs such as depreciation, interest on borrowed funds, return on equity capital (in the case of proprietary providers), and other costs related to certain capital expenditures are subject to the provisions of §405.431, "Nonallowable Costs Related to Certain Capital Expenditures."

(2) The fair market value at the time of donation under a bona fide donation of the asset (subject to the limitations set forth under paragraph (j) of this section). An asset is considered donated when a governmental entity acquires the asset without assuming the functions for which the transferor used the asset or making any payment for it in the form of cash, property, or services.

(3) If neither subparagraph (1) nor (2) of this paragraph applies, e.g., the transfer was solely to facilitate administration or to reallocate jurisdictional responsibility or the transfer constituted a taking over in whole or in part of the function of one governmental entity by another governmental entity, the basis for depreciation shall be:

(i) With respect to an asset on which the transferor has claimed depreciation under the health insurance program, the transferor's basis under the health insurance program prior to the transfer. The method of depreciation used by the transferee may be the same as that used by the transferor, or the transferee may change the method, as permitted under subparagraph (d) (2) of this section.

(ii) With respect to an asset on which the transferor has not claimed depreciation under the health insurance program, the cost incurred by the transferor in acquiring the asset (not to exceed the basis that would have been recognized had the transferor participated in the health insurance program) less depreciation calculated on the straight-line basis over the life of the asset to the time of transfer.

(j) *Basis of assets used under the program and donated to a provider.* Where an asset that has been used or depreciated under the program is donated to a provider, the basis of depreciation for the asset shall be the lesser of the fair market value or the net book value of the asset in the hands of the owner last participating in the program. The net book value of the asset is defined as the depreciable basis used under the program by the asset's last participating owner less the depreciation recognized under the program.

(35 F.R. 12330, Aug. 1, 1970; 37 F.R. 4711, Mar. 4, 1972)

(k) Limitation on Federal Participation for Capital Expenditures. See §105.431, "Nonallowable Costs Related to Certain Capital Expenditures" for situations where allowance for depreciation is not an allowable cost.

(d) *Loans not reasonably related to patient care.*

—Loans made to finance that portion of the cost of acquisition of a facility that exceeds historical cost as determined under § 405.415(b) or the cost basis as determined under § 405.415(g) are not considered to be for a purpose reasonably related to patient care. In determining whether a loan was made for this purpose, it should be assumed that any owner's investment or funds are applied first to the tangible assets, then to the intangible assets other than goodwill and lastly to the goodwill. Where the owner's investment or funds are not sufficient to cover the cost allowed for tangible assets, funds borrowed to finance the acquisition are applied to the portion of the allowed cost of the tangible assets not covered by the owner's investment, then to the intangible assets other than goodwill and lastly to the goodwill.

(Par. (d) added 8-1-70.)

405.420. *Bad Debts, Charity, and Courtesy Allowances.*—(a) *Principle.*—Bad debts, charity, and courtesy allowances are deductions from revenue and are not to be included in allowable cost; however, bad debts attributable to the deductibles and coinsurance amounts are reimbursable under the program.

(b) *Definitions.*—(1) *Bad Debts.*—Bad debts are amounts considered to be uncollectible from accounts and notes receivable which were created or acquired in providing services. "Accounts receivable" and "notes receivable" are designations for claims arising from the rendering of services, and are collectible in money in the relatively near future.

(2) *Charity Allowances.*—Charity allowances are reductions in charges made by the provider of services because of the indigence or medical indigence of the patient.

(3) *Courtesy Allowances.*—Courtesy allowances indicate a reduction in charges in the form of an allowance to physicians, clergy, members of religious orders, and others as approved by the governing body of the provider, for services received from the provider. Employee fringe benefits, such as hospitalization and personnel health programs, are not considered to be courtesy allowances.

(c) *Normal Accounting Treatment; Reduction in Revenue.*—Bad debts, charity, and courtesy allowances represent reductions in revenue. The failure to collect charges for services rendered does not add to the cost of providing the services. Such costs have already been incurred in the production of the services.

(e) Limitation on Federal Participation for Capital Expenditures. See §405.431 "Nonallowable Costs Related to Certain Capital Expenditures" for situations where interest on borrowed funds is not an allowable cost.

ROLE OF OSR AND GSA REPRESENTATIVES IN MONITORING PROCEDURES
OF THE NATIONAL INTERN AND RESIDENT MATCHING PROGRAM (NIRMP)

Background

At its business meeting in November 1972, the AAMC Group on Student Affairs (GSA) adopted a resolution urging that the National Intern and Resident Matching Program (NIRMP) improve its enforcement of the "all or none" principle for hospital participation in the program. Similarly, at its November business meeting, the AAMC Organization of Student Representatives (OSR) adopted a resolution to establish a system of investigating NIRMP violations and reporting them to appropriate authorities.

In response to these actions, staff of the Division of Student Affairs developed a proposal for the role of OSR and GSA representatives in monitoring the procedures of NIRMP. This staff proposal was approved in principle by Western OSR and GSA members at their regional meeting in Asilomar, California, in March.

The program outlined below, which is a modification of the original staff proposal, was drafted and approved by the Southern region of OSR at its meeting in Williamsburg in April. This program was subsequently supported in principle by Southern GSA at the same meeting.

The basic elements of the Southern region's NIRMP monitoring program were also approved by the Central region of OSR at its meeting in Starved Rock, Illinois, in May. Just prior to this meeting, the NIRMP Board of Directors had agreed that one of its three student members could be appointed by the OSR Administrative Board, so the Central region version of these procedures included the concept that the OSR National NIRMP Monitor would also be a member of the NIRMP Board. Central region OSR also suggested that the Coordinating Council for Graduate Medical Education be included among the recipients of violation reports in lieu of the AAMC Executive Committee and developed a procedure under which CCGME could eventually deny accreditation to any institution of graduate medical education having a program found to be in repeated violation of NIRMP rules. Central GSA approved the Central OSR version of the basic monitoring program but did not act on those portions of the Central OSR proposal concerning accreditation.

It is presently planned that AAMC will assume all staffing responsibility for the functions of the OSR National NIRMP Monitor. Reports of violations will be sent to the Monitor at AAMC Headquarters and AAMC staff will conduct correspondence and take action as appropriate in his/her name, with copies of all materials forwarded to the Monitor.

At its meeting on June 8, the OSR Administrative Board expects to develop a final proposal for OSR monitoring of NIRMP violations, based on the versions approved by OSR and GSA in the three regions which have met this spring, and to select an OSR National NIRMP Monitor for the coming year. Assuming Executive Council approval of this program, the final proposal and the name of the Monitor would be promptly circulated to GSA and OSR members, so implementation of the OSR role in monitoring NIRMP violations may begin this summer.

Program

(1) The role of the AAMC Organization of Student Representatives and Group on Student Affairs in assisting in the maintenance of the NIRMP should be mainly one of channeling student reports of non-compliance to a committee established to review such problems by the dean of each medical school.

(2) The membership of this committee shall include a representative of the OSR and of the GSA as well as any other members appointed by the dean.

(3) When the NIRMP is explained to the rising seniors, the importance of working within established procedures should be stressed to them by this committee. Students shall be asked to report to any member of this committee evidence of any internship or first-year graduate program trying to seek contract agreements outside of the established arrangement for matching.

(4) The committee shall (a) guarantee anonymity to a complaining student, and (b) be responsible for securing all pertinent data in a form pre-established by the complaint review committee. As necessary, any committee member may request a meeting of the committee to determine whether data submitted merit follow-up. If it is agreed that violations exist and that the hospital program in question does not intend to abide by its contract agreements, the committee will (a) advise the dean, and (b) report the violating hospital and department to the OSR National NIRMP Monitor.

(5) The OSR Monitor shall send a report of such violations to the NIRMP Board of Directors and to the AAMC Executive Committee. This report shall state only that X number of various types of violations have been reported concerning Institution Y, Department Z. The Monitor will request that NIRMP acknowledge receipt of such reports and advise him that appropriate action will be taken. It shall then be up to the NIRMP to see that prompt appropriate action is taken by them and/or by the AAMC Executive Committee as needed.

(6) If the National Monitor has reason to believe that appropriate action on a reported violation is not being taken by NIRMP, the Monitor may at his discretion resubmit the report in question to the NIRMP Board of Directors, indicating that this is a second notice.

(7) The National Monitor shall determine, by the time of the AAMC annual meeting, whether (a) all reports of violations forwarded to the NIRMP Board of Directors and AAMC Executive Committee have been received, and (b) the NIRMP has taken action on them. The Monitor shall report these results at the OSR annual meeting.

(8) The OSR Monitor shall be selected by a majority vote of the OSR Administrative Board during the annual meeting. Assuming agreement with this procedure by the Central and Northeast GSA and OSR at their 1973 regional meetings, a temporary National Monitor will be appointed by the OSR national chairman to serve until the 1973 OSR annual meeting.

(9) This procedure shall be reviewed every three years.

EXPIRING LEGISLATION

Following is a listing of health legislation expiring 6/30/73 and the various legislative approaches for dealing with these expiring authorities:

HEALTH LEGISLATION EXPIRING 6/30/73:	FY 1974 FUNDS REQUESTED:	ADMINISTRATION LEGISLATION:	CONGRESSIONAL LEGISLATION:	INCLUDED IN OMNIBUS BILLS S 1136/HR 7806:	
PUBLIC HEALTH SERVICE ACT	Health Services Research, Development (Sec. 304)	Yes	S 1633 HR 6590	HR 7274	Yes
	Health Statistics (Sec. 305)	Yes	S 1515 HR 6586	HR 7274	Yes
	Public Health Training (Sec. 306 and 309)	No			Yes
	Migrant Health (Sec. 310)	Yes	to be supported through 314(e)		Yes
	Comprehensive Health Planning (Sec. 314)	Yes	S 1632 HR 6588		Yes
	Medical Libraries (Sec. 393-398)	Yes	S 1450 HR 6387	HR 7274	Yes
	Hill-Burton Construction, Modernization (Title VI)	No		S 1006	Yes
	Allied Health Training (Title VII, Part G)	No			Yes
	Regional Medical Programs (Title IX)	No			Yes
	Population Research and Family Planning (Title X)	Yes	to be supported through 314(e)		Yes
CMHC ACT	Developmental Disabilities (Title I)	Yes	S 1654 HR 6589		Yes
	Community Mental Health Centers (Title II, Part A,B)	Yes	} S 1634 HR 6587		Yes
	Alcohol and Drug Abuse (Title II, Parts C,D,E)	Yes			Yes
	Mental Health of Children (Title II, Part F)	Yes			Yes
PL 91-296	Mandatory Spending (Sec. 601)	NA			Yes
SSA	Maternal & Child Health Project Grants (Title V)	No		S 1543 HR 708	No

STATUS OF LEGISLATIVE APPROACHES:

Labor-HEW Appropriations, FY 1974: hearings underway in Senate and House.

Senate bills:

S 1006 pending before health subcommittee
 1136 cleared for Presidential action 6/5
 1450 pending before health subcommittee
 1515 pending before health subcommittee
 1543 pending before finance committee
 1632 pending before health subcommittee
 1633 pending before health subcommittee
 1634 pending before health subcommittee
 1654 pending before health subcommittee

House bills:

HR 708 pending before health subcommittee
 (7806) cleared for Presidential action as S 1136
 6387 considered with HR 7274
 6586 considered with HR 7274
 6587 pending before health subcommittee
 6588 considered with HR 5608 and HR 7274
 6589 pending before health subcommittee
 6590 considered with HR 7274
 7274 hearings concluded, health subcommittee

6/5/73

CORNELL UNIVERSITY
MEDICAL COLLEGE
1300 YORK AVENUE
NEW YORK, N. Y. 10021

MAY 5 1973

OFFICE OF THE DEAN

May 4, 1973

Marjorie P. Wilson, M.D.
Director
Department of Institutional Development
Association of American Medical Colleges
Suite 200
One DuPont Circle, N.W.
Washington, D. C. 20036

Dear Marjorie:

Several recent events have focused my attention on the need to review the closeout of the freestanding internship scheduled for 1975. These events include:

- a. This year we experienced a sharp increase in the number of our students who did not match for internships. This also occurred at several other established and respected schools with which I am familiar.

In the course of our efforts to place these individuals, we discovered far fewer unmatched hospital positions than in former years. This undoubtedly reflects the influx of American citizens from foreign medical schools and the accomplished closure of many internships of the freestanding variety.

- b. Many specialty residency directors are urging applicants to take a year of general, "mixed" or rotating internships before entering specialty training. This creates a special demand for one-year programs more commonly found in the "freestanding" state than in major teaching centers where the first and second postdoctoral years of general surgery and internal medicine programs are commonly coupled.
- c. The requirements of the Academy of Family Practice are presently so inflexible as to threaten well-established mixed internships in many of the larger community hospitals where a family practice residency would otherwise be the logical solution to the problem. This situation exists in Duluth, Minnesota and though it is critical to the new medical school there, a satisfactory outcome probably cannot be negotiated before the 1975 deadline.

Marjorie P. Wilson, M.D.

Page 2

May 4, 1973

- d. The demise of NIH support for clinical fellowships will increase the demand for residency openings which are not likely to be made available in our university medical teaching centers because of the current fiscal crisis. Thus, a solution we should be seeking is the establishment of more residency programs, the majority geared to produce "generalists" rather than simply to abolish freestanding internships. This would, of course, require our community hospitals to spend money on staffing such programs but it would also greatly improve the quality of medicine in those communities while meeting a growing national need in medical education.

The foregoing is but a partial discussion of a very important constellation of issues related to the future of freestanding internships. I would, therefore, request that this item be placed on the agenda for the June 1973 meeting of the COD Administrative Board.

Thank you.

Sincerely,



J. Robert Buchanan, M.D.

Dean

JRB:hw