COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

ONE DUPONT CIRCLE, N. W. • WASHINGTON, D. C. 20036 • (202) 466-5123
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COTH ADMINISTRATIVE BOARD
Memorandum 74-9AB
June 6, 1974

Officers and Administrative Board:

Robert A. Derzon, Chairman*
Sidney Lewine, Chairman-Elect*
Leonard W. Cronkhite, Jr., M.D., Immediate Past Chairman*
David L. Everhart, Secretary
Daniel W. Capps
David A. Gee
David H. Hitt
Arthur J. Klippen, M.D.
J. W. Pinkston, Jr.
S. David Pomrinse, M.D.
John M. Stagl
David D. Thompson, M.D.
Charles B. Womer
Madison Brown, M.D., AHA Representative

Subject: COTH Administrative Board Meeting - June 19-20, 1974

Attached is the agenda for the COTH Administrative Board meeting on Wednesday evening and Thursday, June 19-20, 1974. As noted in my memorandum of May 21, the meeting will commence at 6:30 p.m. on Wednesday evening in the Dupont Plaza Hotel with a joint reception to be followed by dinner with the Council of Academic Societies Administrative Board. The room assignment for the reception will be posted in the lobby of the Dupont Plaza Hotel.

In order to assure that you are fully informed of AAMC Executive Council activities, the agenda for the Executive Council meeting is also enclosed. Please bring this agenda to the June meeting, since we will be using it in cases where the COTH agenda requires discussion and action on Executive Council items.

Final regulations to implement Section 223 of P.L. 92-603 were published this morning and are attached to this memorandum. I look forward to seeing you on June 19.

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

RMK:car

COUNCIL OF TEACHING HOSPITALS
Administrative Board Meeting
June 20, 1974
Dupont Plaza Hotel

Washington, D.C.
9:00 a.m. - 3:00 p.m.

AGENDA

I.	Call to Order	
II.	Approval of Minutes	TAB A
III.	Date of Next Board Meeting	TAB B
IV.	Membership	
	A. Applications	TAB C
	(1) Memorial Medical Center, Springfield, Illinois	
	(2) New York Infirmary, New York City	
	(3) Wake County Hospital Systems, Inc., Raleigh, N.C.	
	(4) St. John's Hospital, Springfield, Illinois	
	B. Report of the Ad Hoc Membership Committee	
	C. Background Information on the Membership	TAB D
V.	Regulations to Implement Section 223 of P.L. 92-603	TAB E
VI.	Report of the Committee on JCAH Standards	TAB F
VII.	COTH-AAMC Annual Meeting	TAB G
VIII.	Suggested Amendment to the AAMC Position on Foreign Medical Graduates	EXECUTIVE COUNCIL AGENDA Page 23
IX.	Report of the Committee on Financing Medical Education	SEPARATE ATTACHMENT
X.	AAMC Statement on Moonlighting by House Officers	COUNCIL AGENDA - page 55
XI.	Issues, Policies and Programs of the AAMC	SEPARATE ATTACHMENT
XII.	Report of the National Health Insurance Task Force	COUNCIL AGENDA - page 35
XIII.	Statement on the Responsibilities of Institutions, Organizations and Agencies Offering Graduate Medical Education	COUNCIL AGENDA - page 31
XIV.	New Business	
XV.	Adjournment	

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COTH ADMINISTRATIVE BOARD MEETING
Dupont Plaza Hotel
Washington, D.C.
March 21, 1974

PRESENT:

Robert A. Derzon, Chairman
Sidney Lewine, Chairman-Elect
Leonard W. Cronkhite, Jr., M.D., Immediate Past Chairman
David L. Everhart, Secretary
Daniel W. Capps
David Gee
David H. Hitt
Arthur J. Klippen, M.D.
J. W. Pinkston, Jr.
John M. Stagl
David D. Thompson, M.D.
Charles B. Womer
Madison Brown, M.D., AHA Representative

GUEST:

John H. Westerman

STAFF:

Richard M. Knapp, Ph.D.
Dennis D. Pointer, Ph.D.
James I. Hudson, M.D.
Catharine A. Rivera
Jean White

I. Call to Order:

Mr. Derzon called the meeting to order at 9:00 a.m. in the Dupont Room of the Dupont Plaza Hotel.

II. Consideration of Minutes:

The minutes of the Administrative Board meeting of December 14, 1973 were approved as distributed.

III. Presentation by Group on Public Relations:

Mr. Joseph Sigler, Chairman of the AAMC Group on Public Relations, gave a presentation to the board regarding the need for greater coordination between the Group on Public Relations of the AAMC and public relations directors of teaching hospitals. He indicated that membership in the AAMC Group on Public Relations is currently limited to those individuals nominated by the deans of medical schools. Mr. Sigler made the proposal that present nomination rules should be changed so that COTH member hospitals be permitted to nominate individuals for membership in the Group on Public Relations. He indicated that such a proposal would be placed before the Executive Committee on March 22 and requested that the COTH Administrative Board endorse this proposal.

ACTION # 1

IT WAS MOVED, SECONDED AND CARRIED THAT THE COTH ADMINISTRATIVE BOARD ENCOURAGE THE EXECUTIVE COMMITTEE OF THE ASSOCIATION TO ENDORSE THE PROPOSAL THAT COTH MEMBER HOSPITALS BE PERMITTED TO NOMINATE INDIVIDUALS FOR MEMBERSHIP IN THE GROUP ON PUBLIC RELATIONS.

IV. AAMC Priorities:

Dr. Knapp discussed staff recommendations regarding the process through which the AAMC sets its priorities. He indicated that there has been some discussion in the past regarding the timing of the AAMC Retreat and the manner in which items are placed upon the Retreat agenda.

ACTION # 2

IT WAS MOVED, SECONDED AND CARRIED THAT THE COTH ADMINISTRATIVE BOARD ENDORSE THE RECOMMENDATIONS CONTAINED IN THE STAFF REPORT ENTITLED, "THE SETTING OF AAMC PRIORITIES."

V. JCAH Standards Task Force: Status Report:

Mr. John Westerman presented to the board a status report regarding the ongoing activities of the Council's JCAH Standards Task Force. He indicated that letters have been received from member hospitals regarding the JCAH standards adopted in 1970. A literature search has been undertaken and that analysis of accreditation reports from selected university hospitals has been completed. Mr. Westerman indicated that the Task Force agreed at its first meeting that the documentation and standards employed by the JCAH were good and that most hospitals viewed the process of preparing for the accreditation visit as beneficial. However, he indicated that most individuals felt that quality of the actual visit ranged from a disaster

to a minor embarrassment. Mr. Westerman indicated that the Task Force felt that it would be beneficial to establish a peer review system to make the actual visit more meaningful for teaching hospitals. In response to the preliminary task force report, Mr. Lewine suggested that the JCAH data and site visit review documents could be used as the basis for a peer review outside the JCAH system; he indicated that a teaching hospital audit separate from the actual JCAH site visit might be beneficial.

Mr. Westerman indicated that the Task Force hopes to have its formal recommendations prepared by the next Administrative Board meeting in June. He indicated that two separate reports would be completed; one would be sent to the JCAH in response to its request for assistance in reviewing the standards; the second would be for possible distribution to member COTH hospitals.

IV. AAMC Task Force on Foreign Medical Graduates:

Dr. Emanuel Suter, Director, Department of International Medical Education, briefly reviewed a report recently completed by the Task Force on Foreign Medical Graduates entitled, "Graduates of Foreign Medical Schools in the United States: A Challenge to Medical Education." Dr. Suter indicated that the recommendations of the Task Force would be presented as an action item to the Executive Council at its meeting of March 22, 1974. Dr. Suter requested that the COTH Administrative Board take action on the Task Force recommendations:

ACTION # 3

IT WAS MOVED, SECONDED AND CARRIED THAT: 1) RECOMMENDATIONS 1-6 BE APPROVED AS WRITTEN IN THE TASK FORCE REPORT; 2) THAT THE FIRST PARAGRAPH OF RECOMMENDATION #7 BE CHANGED TO READ AS FOLLOWS:

7. Special Categories

The Task Force recognizes two categories of FMG's, which require special attention. The first category includes FMG's who are seeking limited educational objectives in this country with the full intent of returning to their home country. They may be accepted into special programs without the qualifications contained in the second recommendation of this report, provided these trainees are not permitted to assume any independent and/or patient care obligations usually required of the members of the hosue staff and provided the training thus obtained is not credited toward specialty board qualifications in this country.

ACTION # 3 . . . 3) THAT RECOMMENDATION #8 AS CONTAINED IN THE TASK FORCE RECOMMENDATIONS BE ALTERED TO READ AS FOLLOWS:

8. Time Table

A realistic time table should be established for the implementation of these recommendations. Particular attention should be given to avoid abrupt disruptions of patient care services in teaching hospitals and the potential economic impact.

VII. Discussion of COTH Membership Criteria:

Dr. Andrew Hunt, Dean, Michigan State University College of Human Medicine, made a presentation regarding the need for reexamination of COTH membership criteria. He described several situations where medical schools are affiliated with hospitals which do not participate significantly in graduate medical education. Given current membership criteria these hospitals would be denied membership in COTH. Dr. Hunt noted that he believed that COTH membership criteria should be periodically reviewed in the light of developing relationships between medical schools and the hospitals that serve as sites for undergraduate clinical experiences. After extensive discussion, the following action was taken:

ACTION # 4 IT WAS MOVED, SECONDED AND CARRIED THAT MR. CHARLES WOMER BE APPOINTED TO CHAIR AN AD HOC COMMITTEE ON MEMBERSHIP CRITERIA OF THE COUNCIL OF TEACHING HOSPITALS. IT WAS SUGGESTED THAT MEMBERSHIP OF THE COMMITTEE BE REPRESENTATIVE OF A CROSS SECTION OF PRESENT COTH MEMBERSHIP AND THAT THE COMMITTEE SHOULD FORWARD TO THE BOARD ITS FINDINGS WITHIN A REASONABLE TIME PERIOD.

VIII. Membership Applications:

Dr. Knapp indicated that he had received a letter from Dr. William R. Drucker, Dean of the University of Virginia School of Medicine in Charlottesville, Virginia, requesting that the application for membership in COTH by the Veterans Administration Hospital in Salem, Virginia be reviewed (the application for membership of this hospital was rejected at the December 14, 1973 Board meeting). Dr. Knapp resubmitted the application of this hospital to the Board for reconsideration.

ACTION # 5

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

VETERANS ADMINISTRATION HOSPITAL
SALEM, VIRGINIA

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

FAULKNER HOSPITAL
BOSTON, MASSACHUSETTS

Dr. Knapp distributed to the Board an application for membership submitted by the New York Infirmary. After some discussion, it was suggested that consideration of this application be deferred until the June meeting of the Administrative Board.

XI. Role of the Organized Medical Staff:

Mr. Derzon expressed the appreciation of the Administrative Board to Mr. John Westerman for the role that the University of Minnesota and the University of Michigan Hospitals have played in developing a conference and working papers on the role of the organized medical staff in the university-owned teaching hospital. He indicated that the Board is encouraged by the progress made to date and suggested that the effort be continued. He expressed the hope that the group would report back on its progress to the Council of Deans, the Council of Academic Societies, and the Council of Teaching Hospitals.

X. Section 233 of P.L. 92-603, "Limitations on the Coverage of Costs Under Medicare"

Dr. Pointer reviewed for the Board the proposed regulations to implement Section 233 of Public Law 92-603 that were published in the Federal Register on March 19, 1974. Dr. Pointer described the hospital classification system and discussed the manner in which limitation in the individual cells were constructed. He indicated that the regulations were particularly troublesome in that: 1) the formula for calculating the limitations can be altered easily at any time - given past experiences, a lowering of the ceilings would be expected; 2) legislative language allows extension of this methodology to aggregate costs per diem; 3) the procedures utilized to construct the classifications doe not accomplish what the original legislation intended - such procedures run counter to a sizable body of research focused upon isolating factors that influence the cost structures of hospitals; and, 4) the approval of excess charges provision of the regulations is neither called for in the legisaltion nor mentioned in the committee report.

There was consensus of the Board that the Committee, chaired by Mr. Lewine to examine the implications of Phase IV should be reconvened to address the Section 223 proposed regulations. The Board felt that it would be advisable to have Association legal counsel examine the legislation, the committee report and the proposed regulations to ascertain whether or not legal action should be undertaken by the Association. All members of the Board felt that these regulations are particularly onerous and that a major effort should be undertaken to forestall their implementation.

XI. Resolution on Safeguarding Data Systems:

Dr. Knapp presented to the Board suggestions regarding the development of a resolution on safeguarding data systems that was prepared by the OSR Administrative Board. There was no formal action on this item, but the Administrative Board unanimously agreed that the resolution, if passed, should be applied only with regard to medical students in the medical schools and that the wording of the resolution should be changed to clearly indicate this fact. Mr. Derzon stated he would express the concerns of the group at the Executive Council meeting.

XII. I.O.M. Report:

Dr. Knapp indicated that the report of the Institute of Medicine study, Cost of Education in the Health Professions, was released on February 26. Due to some printing errors, only a limited number of copies were released at that time. He indicated that it will be necessary for the AAMC to react officially to the I.O.M. report, particularly when discussing renewal of the expiring health manpower authority.

ACTION # 6 — IT WAS MOVED, SECONDED AND CARRIED THAT THE RECOMMENDATIONS CONTAINED IN THE STAFF REPORT ENTITLED, "AAMC RESPONSE TO THE I.O.M. REPORT" BE APPROVED.

XIII. Modification of Hill-Burton Program:

Dr. Knapp stated that legislative authority for the Hill-Burton Hospital Construction Assistance Program is to expire on June 30, 1974. The President's fiscal year 1975 budget requested no new funds for the program, and the Administration is not currently proposing to request extension or modification of the program. Dr. Knapp indicated that Congress is almost certain to consider legislation to modify and continue some form of Federal assistance in the hospital construction area.

After much discussion the following action was undertaken:

ACTION # 7

THE COTH BOARD ENDORSES THE EXTENSION AND MODIFICATION OF THE HILL-BURTON GRANT PROGRAM AS PROPOSED IN A 1972 AAMC STAFF MEMORANDUM: SHIFTING THE EMPHASIS FROM CONSTRUCTION OF NEW HOSPITALS TO MODERNIZATION OF EXISTING FACILITIES AND CONSTRUCTION OF OUT-PATIENT FACILITIES: REPLACING THE RURAL BIASED ALLOTMENT FORMULA WITH A MORE EQUITABLE FORMULA BASED UPON NEED: INCREASING THE EMPHASIS ON ASSISTANCE FOR TEACHING HOSPITAL AND OUTPATIENT FACILITIES. IT WAS FURTHER RECOM-MENDED THAT THE SENTENCE REFERRING TO INNOVATIVE AND EXPERIMENTAL CON-STRUCTION BE REMOVED FROM THE STATEMENT.

IVX. RMP-CHP Program:

Dr. Knapp discussed with the Board current proposals before this session of Congress to integrate the functions of comprehensive health planning and regional medical programs. An AAMC report on the modi-fications of RMP-CHP programs and legislation introduced by Representative Rogers and Representative Roy regarding this issue were discussed in some depth. Due to the complexities of the issues involved, it was agreed that Mr. Derzon should recommend to the Executive Council that a small task force be convened to address proposed legislation on the consolidation of CHP and RMP and to prepare proposed AAMC position regarding this matter. It was suggested that Dr. Leonard Cronkhite be the COTH representative to this task force.

XV. Relationship of the AAHC and AAMC:

Dr. Knapp circulated to the Board copies of the paper entitled "Relationships of AAHC and AAMC." After a brief discussion the follow-ing action was taken:

ACTION # 8

IT WAS MOVED, SECONDED AND CARRIED THAT RECOMMENDATIONS CONTAINED IN THE STAFF REPORT ENTITLED,"RELATION-SHIPS OF THE AAHC AND AAMC" BE APPROVED.

XVI. Annual Meeting:

Dr. Knapp indicated that the AAMC Annual Meeting would be held November 12-16 in Chicago, Illinois. He indicated that he would like to work with the Chairman, Chairman-Elect and Immediate Past Chairman on preparing a COTH agenda for the meeting. Dr. Knapp also indicated that some thought should be given to holding a joint meeting with the Council of Deans in addition to the regular session of COTH. Although no action was taken on this last item, there was general agreement that such a joint meeting would be beneficial.

XVIII. Adjournment:

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

NATIONAL ACADEMY OF SCIENCES
2101 CONSTITUTION AVENUE
WASHINGTON, D. C. 20418

INSTITUTE OF MEDICINE

May 6, 1974

Michael F. Ball, M.D.
Association of American
Medical Colleges
1 Dupont Circle
Washington, D.C. 20036

Dear Mike Ball:

Larry Tancredi has filled me in on the discussions that he has been having with you and Marjorie Wilson concerning the possibilities of a one-day workshop on the teaching of medical ethics. He indicated to me that the initial plans were to hold this conference sometime early June for the medical students, hospital administrators and deans involved with the various councils of the AAMC when they meet at that time. As you know, Larry felt on reflection that it would be difficult to organize a meaningful one-day conference in such a short period of time. He recommended instead that we hold this workshop at the September meeting of the AAMC councils.

The intention of the workshop as I understand it is to examine some of the broad medical socioeconomic issues of an ethical nature from the standpoint of how these issues can be imparted to students in the teaching situation. Larry felt that as a starting point for preliminary discussions with your staff, we might consider having the following papers presented with adequate time for questions from those attending the conference.

The introductory paper should present an overview of the educational objectives that are to be achieved in the teaching of ethical issues involving medical care. No doubt, the presenter of this topic would look at the areas of traditional medical ethics, that is, those value problems that emerge in the individualized physician-patient relationship, be it in therapy or in experimentation, and demonstrate how these issues are related to the broader social justice issues concerning the distribution of medical services.

The presentations following the introductory remarks would deal with specific topic areas:

1. The justice issues of how money and resources should be allocated in health care. This topic would deal with the concept of the preciousness of life from the standpoint of government decision making. For example, it might include an analysis of the implications of the recent passage of the provision in the social security amendments which cover treatment of end-stage renal disease. In selecting one category of disease, what happens to those who are suffering from other conditions which may also be very expensive and require life-saving technology? How are decisions made regarding government allocation programs and what are the value questions that should be elucidated when such decisions are being made?

2. The ethical responsibility of those participating in accountability and accreditation processes. Hospital committees such as tissue review and utilization committees as well as accreditation bodies as the JCAH and the Liaison Committee on Medical Education are empowered to assess and monitor various functions in the medical system. These committees receive their authority from society and therefore are invested with an ordering of responsibilities not only to the providers of medical care but also to the consumers and the society in general. With the emergence of large-scale peer review through PSRO's, the issues surrounding the ethical responsibility of such monitoring groups becomes particularly important. The medical students of today are more and more likely to become participants in one way or another on such review committees.

3. The value assumptions of various settings for providing care to patients. This area is receiving particular attention at the present time with the possible development of a national health insurance system. The care settings which range from the individual proprietorship or fee-for-service medicine to highly organized prepaid settings such as health maintenance organizations affect considerably the way in which care is provided to consumers. Each of these settings creates its own incentives for the provider of care and thereby influences the benefits which are received by the patient. Inevitably some of the ethical considerations surrounding medical settings are related closely to those involved in decisions regarding resource allocation.

In addition to presentations of specific ethical concerns in the broader socioeconomic features of medical care, there should also be a general presentation at the conclusion of the workshop which presents an overview of some of the existing programs in the teaching of medical ethics. This overview should discuss not only the advantages but also the pitfalls and limitations of various teaching programs.

If the AAMC is interested in our proposal for a workshop, we would strongly recommend that it be a joint effort. The Institute of Medicine would be willing to pay the travel and living expenses of the speakers as well as the remuneration for commissioned papers. We would intend that these papers be submitted in a publishable form so that in addition to a conference, we might be able to more widely distribute the results of the workshop.

The above outline for the one-day workshop is tentative, and we would very much like your reaction to it and suggestions for appropriate speakers. We could hold the conference in one of the lecture rooms of the National Academy of Sciences if it would be acceptable to you. Please let us know as soon as possible your response to this proposal and your willingness to enter into a joint effort with the Institute of Medicine. Perhaps we can plan on scheduling the one-day workshop for September 19th which I understand would be free according to your schedule for the various councils.

Looking forward to hearing from you as soon as possible.

Sincerely yours,

Roger

Roger J. Bulger, M.D.
Executive Officer

MAY 9 - 1974

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership
in the
Council of Teaching Hospitals

(Please type)
Hospital: Memorial Medical Center (Southern Illinois University School of Medicine and Affiliated Hospitals.)
Name

Springfield, First & Miller Streets
City Street

Illinois 62705
State Zip Code

Principle Administrative Officer: George C. Phillips, Jr.
Name

President
Title

Date Hospital was Established April 19, 1897

Approved Internships:

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

Approved Residencies: (all Residencies; classified as 1st, 2nd, 3rd year, 4th year & 5th year)
Straight-Residency

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total Residencies Filled
Medicine	Fall-1972	26	14
Surgery	Dec. 1972	18	6
OB-Gyn	Oct. 1972	6	4
Pediatrics	Nov. 1972	6	1½
Psychiatry	Apr. 1973	6	1.5
Other Anesthesiology	(awaiting approval)	2	0
Family Practice	--Dec. 1971	11	11
Pathology	--Nov. 1973	4	1
Diagnostic Radiology	--Apr. 1974	4	0
Urology	Dec. 1973	3	0

Information Submitted By:

Name

Director of Medical Programs
Title of Hospital Chief Executive

May 2, 1974
Date

G. C. Phillips, Jr.
Signature of Hospital Chief Executive

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

PLEASE READ INSTRUCTIONS ON REVERSE SIDE

AFFILIATION AGREEMENT

THIS AGREEMENT, made this 1 th day of DECEMBER, 1970, by and between the Board of Directors of MEMORIAL HOSPITAL OF SPRINGFIELD, a not-for-profit corporation of the State of Illinois, located at Springfield, Illinois, hereinafter termed the "Hospital", and the Board of Trustees of SOUTHERN ILLINOIS UNIVERSITY, a body politic and corporate of the State of Illinois, located at Carbondale, Illinois, hereinafter termed the "University",

WITNESSETH:

WHEREAS, the policy of the State of Illinois as set forth in the "Report on Education in the Health Fields of Illinois" recommended that the State could and should expand its capacity for medical education through the existing university system and existing clinical facilities, which report contained general guide lines as to how the costs for implementing its recommendations should be divided between medical schools and affiliated hospitals, and

WHEREAS, the governing body of the hospital and the medical community have clearly accepted the concept that development of strong medical education programs is an important and desirable element in assuring the availability of physician resources in the future as well as continuing improvement in the levels and quality of health care to the people of Springfield and Central Illinois, and

WHEREAS, there exists a community of understanding between the parties hereto that the purpose of the school of medicine recently established in the University is the education of practicing physicians and that the responsibility of the university and its school of medicine continues substantially beyond granting degrees and on to the preparation of the physician for practice and even to his continuing education, and that the Southern Illinois University School of Medicine, as well as the Hospital, has a responsibility for exerting major leadership in the development of internship and residency programs, and a service responsibility for utilizing its resources wherever feasible to influence and enhance the health care delivery system, and

WHEREAS, the parties hereto are committed to the principle that the Hospital, as a major provider of health care, must preserve its principal focus on community service while acting on its long range responsibility for producing qualified manpower resources for health care delivery by maintaining the school

of nursing and several training programs for other allied health personnel, and that the presence of medical education programs will further enhance the quality of patient services, and

WHEREAS, the governing boards of Southern Illinois University and Memorial Hospital of Springfield, recognizing the desirability of establishing a medical education program in the Springfield area, have declared their intent to enter into an agreement formalizing certain relationships between the two institutions essential to the development of the program,

NOW, THEREFORE, the parties hereto do mutually agree and covenant as follows:

I. The University shall exercise its prerogatives and fulfill its obligations herein generally through the School of Medicine, and unless the contrary be specifically stated or established by context, reference herein to the School of Medicine shall have the same contractual effect as reference to the University.

II. The Hospital Shall:

(1) Make its facilities available for use in clinical instruction of students admitted to the Southern Illinois University School of Medicine and for the education and training of residents and interns and agrees responsibility for the content and direction of medical education programs rests with the school of medicine.

(2) Recognize that the school of medicine must exercise strong positive influence on the clinical environment in which its students are trained. The nature of this guidance may include, but not be limited to: (a) establishment of standards of qualifications for clinical faculty appointments, (b) review and assessment of medical care working in concert with the hospital including its medical staff.

(3) Operate so that the Council on Medical Education of the American Medical Association acting for itself and the various specialty boards will approve the hospital for intern training, as well as resident training in those specialties for which the hospital and the medical school have jointly applied for such approval, and meet the standards for accreditation by the Joint Commission on Accreditation of Hospitals.

[illegible] delivery by maintaining [illegible] school

(4) Assist the dean of the school of medicine, as requested, in the recruitment of department chairmen for the medical school.

(5) Provide on site office space and some laboratory space for faculty members carrying on the medical instruction program at the hospital, it being understood that principal offices and laboratory facilities if necessary for this faculty will be located apart from the space now employed for hospital purposes.

(6) Process in a timely fashion applications for membership on the medical staff by any clinician member of the medical school faculty. Except for cogent reasons to the contrary, geographic full time faculty will be granted staff appointments at the hospital. During processing of such applications, as defined in the medical staff bylaws, the hospital will grant, in the regular manner, temporary privileges to such applicants.

(7) Be responsible for the total compensation of all agreed interns and residents assigned exclusively to the hospital and for a pro rata share of the compensation of interns and residents assigned for only a portion of their time to the hospital.

(8) Reimburse the school of medicine for that proportion of the total salaries of faculty members which represents payment for their involvement in the development and operation of internship, residency and other jointly developed programs, provided, however, that the school of medicine will reimburse the hospital on a similar reciprocal pro rata basis for the appropriate portions of the salaries of such faculty members as are primarily members of the hospital staff and receive their salaries from the hospital.

(9) Reimburse the school of medicine, or, if the parties agree on the desirability and feasibility thereof, pay directly to the individual concerned for the services of an assistant dean (director of medical education) who will be selected by the dean of the medical school with approval of the hospital. This faculty member will be responsible for on-site coordination of the medical education program and will also function as supervisor of post graduate and continuing education.

(10) Submit to the dean of the school of medicine for approval the names and files of proposed residents and interns.

(11) Notify the office of the dean of the school of medicine or the assistant dean (director of medical education) of any patient admitted to the hospital who is not to be available to the medical education program.

(12) Arrange for suitable facilities in which continuing education courses can be offered.

(13) Notify the office of the dean of the school of medicine as soon as possible of any intent to initiate changes and the status of such changes, in hospital policies, programs, services, personnel, financing, facilities or operations which may have significant implications for medical school programs, services and operation.

(14) Designate representatives of the key leadership of the hospital as members of a Joint Coordinating Committee. This committee will undertake to mediate any differences which may develop among the school of medicine, Memorial Hospital, and St. John's Hospital. One designee should be the president of the governing board.

(15) Appoint hospital division chiefs with the advice and consent of the dean of the school of medicine or designee, it being understood that such review shall be obtained prior to the submission of the recommended names to the governing board.

(16) Appoint future hospital based physicians involved in the medical education program only after the concurrence of the dean of the school of medicine, it being understood that such concurrence presupposes faculty appointment.

(17) Hold the university harmless for liability incurred as the result of the acts of hospital employees.

III. The School of Medicine shall:

(1) Accept responsibility for the content and direction of the total medical education program within the hospital including continuing education.

(2) Recognize that the hospital has an obligation to provide care for the patients of all physicians on the hospital medical staff regardless of

whether they hold a faculty appointment.

(3) Assist the hospital in attracting and be responsible for designating qualified interns and residents.

(4) Develop and coordinate the education and training program for interns and residents and attempt to provide experience for interns and residents at both Memorial and St. John's hospitals.

(5) Operate its programs to meet the approval requirements of the Council on Medical Education of the American Medical Association and the Association of American Medical Colleges.

(6) Accept in the medical education program such numbers of patients in the various departments as can be accommodated in keeping with program quality standards and staff size.

(7) Process in a timely fashion any application received from present or future members of the medical staff of the Hospital through service chiefs and departmental chairmen for possible membership on the clinical faculty of the school of medicine. It is understood that, when requested, any member of the clinical faculty will contribute at least one-half day of service per week without charge to the medical education program and will in addition undertake to fulfill committee assignments and requests to deliver special lectures and conduct teaching assignments as requested by the dean of the school of medicine.

(8) Include in its understanding with geographic full-time faculty members a limitation on the extent of private practice. This limitation may take the form of (a) type of practice, (b) time involvement, (c) percent of income above base salary, (d) dollar amounts or other forms.

(9) Provide, if necessary, primary offices and laboratory space for faculty members separate from facilities now employed for hospital purposes.

(10) Initiate as soon as practicable a continuing education program for physicians in the Springfield area. It is understood that the launching of the program will depend on available staff and funding.

(11) Notify the administration of the hospital as soon as possible of any intent to initiate changes, and the status of such changes, in school of

medicine policies, programs, services, personnel, facilities, financing or operations which may have significant implications for hospital programs, services and operations.

(12) Designate representatives of the key leadership of the university and the school of medicine as members of a Joint Coordinating Committee. This committee will undertake to mediate any differences which may develop among the school of medicine, Memorial Hospital and St. John's Hospital.

(13) Occupy the position of independent contractor, and as such, will hold the hospital harmless for liability incurred as the result of acts of its lawful agents.

IV. The Parties Hereto Do Further Mutually Agree To:

(1) Accept the principle that all hospital patients should be available for teaching, recognizing that specific exceptions may be necessary for individual situations.

(2) Establish a joint research committee responsible for reviewing proposals for research programs and projects which involve hospital space or personnel. Proposals will be forwarded to the committee after review by the appropriate medical school department chairman and hospital service chief. The committee in studying proposals will take into account: (a) availability of staff, space, and facilities; (b) overall balance within the research program; and (c) adequate funding and project management.

(3) Pursue jointly the development of internship, residency, postgraduate and continuing education programs as rapidly as adequate manpower and financial resources can be obtained.

(4) Assist each other as appropriate in preparing grant applications to government agencies, private foundations, corporations or other organizations for capital or operating funds.

(5) Terminate the agreement only upon four years' written notice by either party.

(6) Review the agreement annually at a meeting of representatives of the institutions to determine its operating effectiveness and to study how, if at all, the agreement might be improved to the satisfaction and mutual benefit of the parties.

V. It is understood and agreed by and between the parties hereto that this contract is the entire agreement between the parties and that no alterations, changes or additions therein or thereto shall be made except in writing approved by the parties hereto. The Hospital and the University, for themselves, their successors, and assigns hereby agree to the full performance of the covenants herein contained.

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

RECOMMENDED:

University Legal Counsel
Southern Illinois University

APPROVED:

SOUTHERN ILLINOIS UNIVERSITY

By _____

BOARD OF TRUSTEES
SOUTHERN ILLINOIS UNIVERSITY

By _____
Chairman of University Administrative Council

BOARD OF DIRECTORS
MEMORIAL HOSPITAL OF SPRINGFIELD

By _____
President

ATTEST:

By _____
Secretary.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership
in the
Council of Teaching Hospitals

(Please type)

Hospital: NEW YORK INFIRMARY
Name

New York
New York
City

321 East 15th Street
Street

10003
Zip Code
State

Principle Administrative Officer: Edward V. Grant
Name

Executive Director
Title

Date Hospital was Established 1853

Approved Internships:

Type	Date Of Initial Approval by CME of AMA*	Total Internships Offered	Total Internships Filled
Rotating	September 1965	15	15
Straight	July 1, 1974	13	13

Approved Residencies:

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total Residencies Filled
Medicine	July 1965	15	15
Surgery	January 1972	9	9
OB-Gyn	Obs-Gyn	6	6
Pediatrics	July 1965	8	8
Psychiatry			
Other			

Information Submitted By:

Edward V. Grant
Name

Executive Director
Title of Hospital Chief Executive

March 6, 1974
Date

Edward V. Grant
Signature of Hospital Chief Executive

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

PLEASE READ INSTRUCTIONS ON REVERSE SIDE

AFFILIATION AGREEMENT BETWEEN THE NEW YORK INFIRMARY AND NEW YORK UNIVERSITY

AGREEMENT made the 30th day of April 1969, by and between THE NEW YORK INFIRMARY, Stuyvesant Square and East 15th Street, New York City, New York, a Corporation organized under the laws of New York State (hereinafter called "The Infirmary"), and NEW YORK UNIVERSITY, a New York Corporation having its principal office at 40 Washington Square South, New York City, New York (hereinafter called "The University").

WITNESSETH

WHEREAS, the University is an educational corporation duly authorized to establish and operate medical and other schools and hospitals, and operates, as a separate administrative unit, the NEW YORK UNIVERSITY MEDICAL CENTER at 550 First Avenue, New York City, New York (hereinafter called "the Center") and

WHEREAS, the University, through the Center, and the Infirmary are mutually desirous of establishing closer collaboration and association, and

WHEREAS, the Infirmary desires to increase substantially its efforts in forward-looking medical education and service to the community which over a period of time, it is hoped, will have an important and beneficial effect upon the quality of health-care in the region, and

WHEREAS, the University, through the Center, is desirous of collaborating closely with the Infirmary to achieve the aforesaid purposes, NOW, THEREFORE, in consideration of the premises and of the agreements hereinafter set forth, the parties have agreed and hereby agree as follows:

1. The University and the Infirmary is each to continue its independent existence and control. Nothing in this agreement is to be construed to affect any function of either the University or the Infirmary not expressly covered by its terms.

2. A Joint Committee of the Medical Board of the Infirmary and the Executive Faculty Committee of the Center will be created to coordinate the joint educational effort of the Infirmary and the University on any matters pertaining to this relationship.

3. The Joint Committee shall consist of eleven members: four Directors of Service of the Infirmary, five Chairmen of Clinical Departments of the University, the Executive Medical Director of the Infirmary and the Dean of the School of Medicine. In the event that any member is unable to attend a meeting of the Joint Committee, he shall appoint a representative to attend in his place.

4. The Joint Committee shall elect a Chairman from among its members. The Committee shall designate one of its members as a Secretary, whose duty it shall be to record the minutes of the stated meetings and such other meetings as may be held from time to time.

5. The University, on the recommendation of the Joint Committee, may appoint to appropriate academic positions certain members of the professional staff of the Infirmary who are directly responsible for instructional programs in the Infirmary.

6. Any new Directors of Service of the Infirmary (Anesthesiology, Medicine, Medical Education, Obstetrics and Gynecology, Pathology, Pediatrics, Psychiatry, Radiology, and Surgery), to be appointed following the signing of this agreement must be approved by the

Joint Committee. The Directors of the clinical services at the Infirmary will appoint physicians-in-charge of the subspecialties, subject to the approval of the Joint Committee.

7. The Center will provide opportunities, at the discretion of the Chairmen of the Departments, for specialized instruction, clinical experience and research in established programs of medical education at the Center, for interns and residents on the staff of the Infirmary.

8. The Center may assign enrolled medical students to serve as clinical clerks or substitute interns at the Infirmary in such numbers as are approved by the Joint Committee.

9. The Center may assign to the Infirmary interns and residents in such numbers and for such periods as are approved by the Joint Committee.

10. The Infirmary shall provide reimbursement to the Center for the services of members of the faculty of the University who contribute to the desired educational and professional activities at the Infirmary. The agreement will otherwise place no financial obligations upon the University or the Infirmary.

11. The parties agree to review the terms and provisions of this agreement annually and negotiate in good faith as to any amendments requested by either. The agreement shall continue in full force and effect until terminated by either party and by mutual consent. Either party shall have the right to terminate the agreement with or without cause by giving written notice of termination of not less than twelve (12) months.

IN WITNESS WHEREOF the parties hereto have caused this agreement to be executed and their corporate seals to be hereunto affixed by their duly authorized officers the day and year first above written.

THE NEW YORK INFIRMARY

ATTEST:

Lois Best
Assistant Secretary

by Virginia W. Kress

NEW YORK UNIVERSITY

ATTEST:

E. Frederic Knauth
Assistant Secretary

by [illegible]

(corporate seal)

April 30, 1969

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership
in the
Council of Teaching Hospitals

(Please type)

Hospital: Wake County Hospital System, Inc.
Name

Raleigh — 3000 New Bern Avenue
City — Street

North Carolina — 27610
State — Zip Code

Principle Administrative Officer: William F. Andrews
Name

Executive Director
Title

Date Hospital was Established 1961

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
	Affiliation Agreement with the University of N. C. School of Medicine		
Medicine	1971	4	4
Surgery	1973	5	5 includes General, Orthopedics & Urolog
OB-Gyn	1964, 71	4	4
Pediatrics	1973	2	2
Psychiatry			
Other			

Information Submitted By:

Name — Executive Director
Title of Hospital Chief Executive

3/19/74
Date — William F. Andrews
Signature of Hospital Chief Executive

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

PLEASE READ INSTRUCTIONS ON REVERSE SIDE

ARTICLES OF AFFILIATION BETWEEN THE UNIVERSITY OF NORTH CAROLINA SCHOOL OF MEDICINE AND WAKE COUNTY HOSPITAL SYSTEM, INC.

This agreement is made this 28 day of September, 1971, by and between the University of North Carolina School of Medicine, hereinafter referred to as the Medical School, and Wake County Hospital System, Inc., hereinafter referred to as the Hospital.

W I T N E S S E T H:

THAT WHEREAS, Hospital operates the Memorial Hospital of Wake County, hereinafter referred to as Wake Memorial, which hospital has 386 beds (or more); and

WHEREAS, the Medical School operates a school of medicine for the purposes of medical education, medical research and medical service; and

WHEREAS, the Medical School recognizes the great need in our State to encourage physicians to practice medicine in all areas of the State, including rural areas; and

WHEREAS, the Medical School is dedicated to the concept of a statewide medical education system which strives to develop educational opportunities in medicine in North Carolina in order to place this State in the forefront of such education in this nation; and

WHEREAS, the Hospital desires to assist the Medical School in its efforts to further develop the educational opportunities in medicine in North Carolina so as to place this State among the first

in the nation in medical education and provision of medical care, and the Hospital and Medical School recognize that an opportunity is presented through affiliation to achieve these worthy ends; and

WHEREAS, Hospital and the Medical School find that it is mutually beneficial and advantageous to enter into this affiliation of educational programs to be operated at Wake Memorial.

NOW THEREFORE, the Medical School and the Hospital enter into an agreement for affiliation of education programs with the following objectives:

1. To provide additional educational experience for the enlarging student body at minimal cost by utilizing the physical facilities of the Hospital and by benefiting from the clinical experiences available at the Hospital.

2. To provide an educational opportunity for students to receive part of their training in community hospitals and see patients with primary care physicians.

3. To make available to students the knowledge and experience of physicians involved primarily in clinical medicine.

4. To extend the services of the Medical School to eastern North Carolina through faculty exchange and consultation.

5. To provide optimal continuing medical education by involvement of the practicing physician in the educational process.

6. To improve patient care through provision of continuing medical education for the practicing physician, and by increasing quality and quantity of house staff.

7. And to assist in meeting long-term needs for additional physicians in eastern North Carolina by developing a program which will attract new physicians to practice in the Hospital and area.

The Medical School and the Hospital shall remain separate legal entities. Each of them shall continue to conduct its own affairs under the control of its own respective governing bodies, and each of them shall remain solely responsible in all respects for the management of its own affairs.

The treatment and welfare of the patients at Wake Memorial shall continue to be the sole responsibility of and remain subject to the direction and control of the hospital.

The affiliations described herein will be coordinated by means of a medical education committee to be composed of the elected chairman of each department of the Medical Staff having specific affiliation hereunder, the chairman of the affiliated departments or their designee at the Medical School, a member of the Board of Trustees of the Hospital and the Administrator of the Hospital. The Medical Education Committee will (1) encourage cooperative effort, (2) interrelate the objectives of medical education and patient care, (3) evaluate the overall development of the affiliations, and (4) make appropriate recommendations to the Executive Committee of the Medical Staff, the Board of Trustees and Administration with reference to desired improvements in the medical education programs.

The nature of the affiliation as it relates to each department is described in the appendices. Faculty salary levels and fringe benefits will be determined by the Hospital in concurrence with the Medical School.

Initially, the Medical School will provide financial support as follows:

One-half of the salary for the Chief of the Wake Memorial Medical Teaching Service.

One-half of the salary for the Chief of the Wake Memorial Obstetrics-Gynecology Teaching Service.

One-half of the salary for the Chief of the Wake Memorial Surgical Teaching Service.

At the outset the Hospital will provide the remainder of the salaries from its own resources, philanthropic sources, governmental grants, and any other sources available. It should be pointed out, however, that the hospital cannot continue to impose the burden of the cost of medical education on its private patients, or on the taxpayers of Wake County; therefore, it shall be understood by both parties to this agreement that a concentrated effort must be made to derive a substantial proportion of the funds in the future from the State of North Carolina through its legislative budgetary process. Sharing of costs of fringe benefits is a matter for negotiation since these benefits may be subject to change from time to time. For fiscal purposes, the hospital will remit to the Medical School monthly its share of salaries and fringe benefits so that the chiefs of the various Wake Memorial Teaching Services at the Hospital may receive all compensation from a single source, the Medical School.

The Hospital will provide offices, secretarial services, and supplies. The Hospital will use its best efforts to provide laboratory space if requested.

The chiefs of the Wake Memorial Teaching Services will have full-time assignments and commitments to these programs and may not conduct private practices except that they may see private patients in consultation and treat

private patients resulting from emergency on-call duty. Any monies collected from these activities or for professional services rendered by faculty or residents in the course of the teaching process at the Hospital will be deposited to the account of the Foundation for Wake County Hospital System, Inc. Consistent with the "Rules, Regulations, and Policies (as revised February 1, 1969), Division of Health Affairs, University of North Carolina, Chapel Hill" and with the method of departmental allocation at the North Carolina Memorial Hospital, Chapel Hill, these funds will be spent on mutually agreeable aspects of the program described in this affiliation agreement. Honoraria and income from writing may be retained by the physician.

The Hospital will be responsible for meals and for laundry of uniforms of medical students while assigned to the Hospital. The Hospital will not be financially responsible for housing of medical students on assignment to Hospital. The Hospital will be responsible for salary, housing, and benefits of house staff on assignment to the Hospital. The department of the Medical School accepting a house officer from the Hospital will be responsible for arranging salary and benefits while such house staff is on assignment to the Medical School.

This affiliation is effective July 1, 1971, and extends until June 30, 1974, unless terminated before then by reasonable notice from one party to the other. Between the University of North Carolina School of Medicine and Wake County Hospital System, Inc., the effectiveness of the program in attaining its objectives will be evaluated by the Medical Education Committee with the addition of the Dean of the Medical School

or his representative (s). This committee will recommend to the two institutions by _____ whether the affiliation should be continued, discontinued, or altered after _____.

Believing it to be impracticable, even if it were possible, to provide for the conduct of the program in further detail now, and having the fullest confidence that when situations arise which are not provided for in this agreement mutually satisfactory conclusions can be reached by the two parties, the Medical School and the Hospital agree that provisions of these be changed at any time by mutual written consent of the Medical School and the Hospital.

Dean, School of Medicine
University of North Carolina

President, Board of Trustees
Wake Memorial Hospital

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership in the Council of Teaching Hospitals

(Please type)

Hospital: ST. JOHNS HOSPITAL
Name

SPRINGFIELD — 800 EAST CARPENTER STREET
City — Street

ILLINOIS — 62701
State — Zip Code

Principle Administrative Officer: Sister Ann Pitsenberger
Name

Administrator
Title

Date Hospital was Established 1875

Approved Internships:

Type	Date Of Initial Approval by CME of AMA*	Total Internships Offered	Total Internships Filled
Rotating	As such free standing internships have not been established; however, in selected specialties, the resident level I in reality is a first year internship type program.		
Straight			

Approved Residencies:

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total Residencies Filled
Medicine	10-27-72	18	8
Surgery	1-25-73	18	1
OB-Gyn	10-3-72	6	4
Pediatrics	1-5-73	8	0
Psychiatry	5-16-73	12	0
Other Family Practice	12-28-71	18	5
Pathology	11-2-73	4	0
Urology	12-17-73	3	0

Information Submitted By:

John M. Holland, M.D., Medical Director — Executive Vice President
Name — Title of Hospital Chief Executive

May 1, 1974 — Sister Jane Lyke
Date — Signature of Hospital Chief Executive

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

PLEASE READ INSTRUCTIONS ON REVERSE SIDE

AFFILIATION AGREEMENT

THIS AGREEMENT, made this 11TH day of DECEMBER, 1970, by and between ST. JOHN'S HOSPITAL OF THE HOSPITAL SISTERS OF THE THIRD ORDER OF ST. FRANCIS, a not-for-profit corporation of the State of Illinois, located at Springfield, Illinois, hereinafter termed the "Hospital", and the BOARD OF TRUSTEES OF SOUTHERN ILLINOIS UNIVERSITY, a body politic and corporate of the State of Illinois, located at Carbondale, Illinois, hereinafter termed the "University",

WITNESSETH:

WHEREAS, the policy of the State of Illinois includes expansion of its capacity for medical education through the existing university system and existing clinical facilities, and

WHEREAS, St. John's Hospital is a Catholic Hospital of which the apostolate in the Church is an extension of Christ's Mission of Mercy and is dedicated to serve as a community health center by providing a harmonious, efficient and well-administered institution with a coordinated effort of approved medical practice, high ethical standards and a Christ-like care of the sick in the hospital and with other community health agencies and to cooperate in the education of physicians, nurses and other hospital personnel, these ideals having been always the basis for the operation of St. John's Hospital over its ninety-three years of service to the people of Springfield and Central Illinois, and

WHEREAS, the governing body of the hospital and the medical community have clearly accepted the concept that development of strong medical education programs is an important and desirable element in assuring the availability of physician resources in the future as well as continuing improvement in the levels and quality of health care to the people of Springfield and Central Illinois, and

WHEREAS, there exists a community of understanding between the parties hereto that the purpose of the school of medicine recently established in the University is the education of

practicing physicians and that the responsibility of the university and its school of medicine continues substantially beyond granting degrees and on to the preparation of the physician for practice and even to his continuing education, and that the Southern Illinois University School of Medicine, as well as the Hospital, has a responsibility for exerting major leadership in the development of internship and residency programs, and a service responsibility for utilizing its resources wherever feasible to influence and enhance the health care delivery system, and

WHEREAS, the parties hereto are committed to the principle that the Hospital, as a major provider of health care, must preserve its principal focus on community service while acting on its longer range responsibility for producing qualified manpower resources for health care delivery by maintaining the school of nursing and several training programs for other allied health personnel, and that the presence of medical education programs will further enhance the quality of patient services, and

WHEREAS, representatives of St. John's Hospital have been appointed by the Board of Directors to conduct discussions for affiliation with Southern Illinois University and other educational institutions, either public or private, which may from time to time become party to the health care system for the people of Central and Southern Illinois, and

WHEREAS, the governing boards of Southern Illinois University and St. John's Hospital of Springfield, recognizing the desirability of establishing a medical education program in the Springfield area, have declared their intent to enter into an agreement formalizing certain relationships between the two institutions essential to the development of the program,

NOW, THEREFORE, the parties hereto do mutually agree and covenant as follows:

I. The University shall exercise its prerogatives and fulfill its obligations herein generally through the School of Medicine, and unless the contrary be specifically stated or

established by context, reference herein to the School of Medicine shall have the same contractual effect as reference to the University.

II. THE HOSPITAL SHALL:

(1) Make its facilities available for use in clinical instruction of students admitted to Southern Illinois University School of Medicine and agrees that the conduct and direction of students is the responsibility of the dean of the school of medicine.

(2) Delegate adequate authority to the dean of the school of medicine for the content and direction of mutually agreed programs for interns, residents and continuing education, with the understanding that delegation of such authority creates a pattern of shared responsibility.

(3) Recognize that the school of medicine will require avenues within the hospital and medical staff organization through which the medical school will be able properly to influence the clinical environment in which its students are trained. The nature of this guidance may include but not be limited to: (a) establishment of standards of qualifications for clinical faculty appointments, and (b) membership on appropriate committees of the medical staff which reviews and assesses medical care.

(4) Operate so that the Council on Medical Education of the American Medical Association acting for itself and the various specialty boards will approve the hospital for intern training, as well as resident training in those specialties for which the hospital and the medical school have jointly applied for such approval, and meet the standards

for accreditation by the Joint Commission on Accreditation of Hospitals.

(5) Cooperate with the school of medicine to every extent possible in the recruitment of department chairmen for the medical school.

(6) Process in a timely fashion applicatons for membership on the medical staff by any clinician member of the medical school faculty. Except for cogent reasons to the contrary, geographic full time faculty will be granted staff appointments at the hospital. All applications will be processed according to standard hospital operating procedure. Privileges, either temporary or permanent, will be granted on terms consistent with procedure and the licensing laws of the State of Illinois.

(7) Be responsible for the total compensation of all agreed interns and residents assigned exclusively to the hospital and for a pro rata share of the compensation of interns and residents assigned for only a portion of their time to the hospital. Such amounts, in any case, will not exceed budgets established by the hospital prior to the start of each hospital fiscal year.

(8) Reimburse the school of medicine for that proportion of the total salaries of faculty members which represents payment for their involvement in the development and operation of internship, residency and other jointly developed programs, provided however, that the school of medicine will reimburse the hospital on a similar reciprocal pro rata basis for the appropriate portions of the salaries of such faculty members as are primarily members of the hospital staff and receive their salaries from the hospital. Amounts payable by

the hospital, in any case, will not exceed budgets established by the hospital prior to the start of each hospital fiscal year.

(9) Submit to the dean of the school of medicine for approval the names and files of proposed residents and interns.

(10) Notify the office of the dean of the school of medicine or the assistant dean of any patient admitted to the hospital who is not to be available to the medical education program.

(11) Arrange for suitable facilities when available in which continuing education courses can be offered.

(12) Notify the office of the dean of the school of medicine as soon as possible of any intent to initiate changes and the status of such changes in hospital policies, programs, services, personnel, financing, facilities or operations which may have significant implications for medical school programs, services and operation.

(13) Designate representatives of the key leadership of the hospital to serve on appropriate committees charged with preservation and function of the St. John's Hospital -- Southern Illinois University affiliation.

(14) Guarantee that the dean of the school of medicine will be insured of his right to work through and with the members of the medical staff, committees, and officers in a manner that will result in the hospital governing board's appointment of acceptable competent chiefs of services.

(15) Consult with the dean prior to appointment of hospital based physicians who are to be involved in programs conducted by the school of medicine.

It is understood that the dean of the school of medicine has the exclusive right of making faculty appointments.

(16) Hold the university harmless for liability incurred as the result of the acts of hospital employees.

III. THE SCHOOL OF MEDICINE SHALL:

(1) Accept authority and shared responsibility for the content and direction of the mutually agreed programs for interns, residents and continuing education.

(2) Recognize that the hospital has an obligation to provide care for the patients of all physicians on the hospital medical staff regardless of whether they hold a faculty appointment.

(3) Cooperate with the hospital, to the extent possible, in attracting and evaluating qualified interns and residents.

(4) Coordinate the education and training programs for interns and residents and seek to provide experience for interns and residents as appropriate at both St. John's and Memorial Hospitals.

(5) Operate its programs to meet the approval requirements of the Council on Medical Education of the American Medical Association and the Association of American Medical Colleges.

(6) Insure that members of the faculty in the conduct of their professional activities at St. John's Hospital subscribe to the code of ethics as adopted and as may be amended by the Board of Directors of St. John's Hospital of the Hospital Sisters of the Third Order of St. Francis; it being understood that such code of ethics is based on concept and beliefs of the Catholic

Church as applied by the Bishop of the Diocese of Springfield.

(7) Accept in the medical education program such numbers of patients in the various departments as can be accommodated in keeping with program quality standards and staff size.

(8) Process in a timely fashion any application received from present or future members of the medical staff of St. John's Hospital through service chiefs and departmental chairmen for possible membership on the clinical faculty of the school of medicine. It is understood that when requested any member of the clinical faculty will contribute at least one half day of service per week without charge to the medical education program and will in addition undertake to fulfill committee assignments and requests to deliver special lectures and conduct teaching assignments as requested by the dean of the school of medicine.

(9) Include in its understanding with geographic full-time faculty members a limitation on the extent of private practice. This limitation may take the form of (a) type of practice, (b) time involvement, (c) percent of income above base salary, (d) dollar amounts or other forms.

(10) Provide primary offices and laboratory space for faculty members separate from facilities now employed for hospital purposes.

(11) Propose to the hospital, as soon as possible, a detailed program in continuing education for physicians in the Springfield area. It is understood that the launching of the program will depend on available staff and funding.

(12) Notify the administration of the hospital as soon as possible of any intent to initiate changes, and the status of such changes, in school of medicine policies, programs, services, personnel, facilities, financing or operations which may have significant implications for hospital programs, services and operations.

(13) Designate representatives of the key leadership of the university to serve on appropriate committees charged with preservation and function of the St. John's Hospital -- Southern Illinois University affiliation.

(14) Occupy the position of independent contractor and as such will hold the hospital harmless for liability incurred as the result of acts of its lawful agents.

(15) Conduct designated medical education programs within specified budgets established each fiscal year [July 1 - June 30]; such budgets to be compatible with standard hospital budgeting and accounting practices.

IV. THE PARTIES HERETO DO FURTHER MUTUALLY AGREE TO:

(1) a. Accept the principle that all hospital patients should be available for teaching, recognizing that specific exceptions may be necessary for individual situations.

b. Recognize that all services to the teaching or non-teaching patient are the responsibility of the attending physician. Therefore, the principle of informed consent rests with the attending physician.

(2) The following principles as governing the utilization of space at St. John's Hospital by the Southern Illinois University School of Medicine:

a. That there is the need by the school of medicine for on-site office space and some laboratory space in connection with the medical instruction programs at the hospital and that the parties will actively work together to provide space from existing facilities and acquire future space to that end.

b. That the hospital will allocate such hospital-owned space as it is able to provide for the use of the school of medicine and will be reimbursed on a negotiated lease basis for that fraction of such space exclusively devoted to the medical education program.

c. That space which results from federal, state or privately donated funds which become available clearly and primarily because of the hospital's affiliation with the school of medicine will be the subject of agreements separate from those to which reference is made in paragraph b, above.

(3) Establish a joint research committee responsible for reviewing proposals for research programs and projects which involve hospital space or personnel. Proposals will be forwarded to the committee after review by the appropriate medical school department chairman and hospital service chief. The committee in studying proposals will take into account: (a) availability of staff space and facilities; (b) overall balance within the research program, and (c) adequate funding and project management.

(4) Jointly pursue the development of internship, residency, post-graduate and continuing education programs as rapidly as adequate manpower and financial resources can be obtained.

(5) Assist each other as appropriate in preparing grant applications to government agencies, private foundations, corporations or other organizations for capital or operating funds.

(6) Terminate the agreement only upon four years written notice by either party.

(7) Review the agreement annually at a meeting of representatives of the institutions to determine its operating effectiveness and to study how, if at all, the agreement might be improved to the satisfaction and mutual benefit of the parties.

(8) Both the University and the Hospital shall be permitted to expand their medical education and training programs, independently of each other, by additional affiliation agreements with educational institutions or hospitals in whatever manner best accommodates the stated purpose of producing qualified manpower resources for health care delivery, but each shall consult with the other before instituting independent programs in the Springfield, Illinois area to explore the feasibility of joint programs and shall make every effort to coordinate all medical education and training programs in such a way as to encourage growth and development of existing working relationships under this affiliation agreement.

V. It is understood and agreed by and between the parties hereto that this contract is the entire agreement between the parties and that no alterations, changes or additions herein or hereto shall be made except in writing approved by the parties hereto. The Hospital and the University, for themselves, their successors, and assigns hereby agree to the full performance of the covenants herein contained.

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

RECOMMENDED:

University Legal Counsel
Southern Illinois University

APPROVED:

SOUTHERN ILLINOIS UNIVERSITY
By

BOARD OF TRUSTEES
SOUTHERN ILLINOIS UNIVERSITY

By
Chairman
Admissions Policy Committee

ST. JOHN'S HOSPITAL OF THE HOSPITAL SISTERS OF THE THIRD ORDER OF ST. FRANCIS

By Sister M. Clarella Arinto
President

ATTEST:

By Sister M Inez Stein
Secretary

Hospitals that have dropped membership to the Council of Teaching Hospitals

1. Scott and White Memorial Hospital
Temple, Texas 76501

2. The Reading Hospital
Reading, Pennsylvania

3. University of Tennessee Memorial Research Center & Hospital
Knoxville, Tennessee 37920

4. St. Vincent's Hospital
Jacksonville, Florida 32203

5. Brooke General Hospital
Fort Sam Houston, Texas 78234

6. Fitzsimons General Hospital
Denver, Colorado 80240

7. Lincoln Hospital
Bronx, New York 10454

8. St. Luke's Hospital
Bethlehem, Pennsylvania 18015

9. Harrisburg Polyclinic Hospital
Harrisburg, Pennsylvania 17105

10. Sisters of Charity Hospital
Buffalo, New York 14214

11. Mount Carmel Mercy Hospital
Detroit, Michigan 48235

12. University of Miami-School of Medicine, National Children's Cardiac Hospital
Miami, Florida 33136

13. Queens Hospital Center
Jamaica, New York 11432

14. Maimonides Medical Center
Brooklyn, New York 11219

15. The Buffalo General Hospital
Buffalo, New York 14203

16. U.S. Public Health Service Hospital
San Francisco, California 94118

17. Pontiac General Hospital
Pontiac, Michigan 48053

18. St. Mary's Hospital
Minneapolis, Minnesota 55406

19. Crouse-Irving Memorial Hospital
Syracuse, New York 13210

20. U.S. Public Health Service Hospital
New Orleans, Louisiana 70118

21. U.S. Public Health Service Hospital
Carville, Louisiana 70721

22. Jersey City Medical Center
Jersey City, New Jersey 07304

23. Milwaukee Children's Hospital
Milwaukee, Wisconsin 53233

24. St. Joseph Infirmary
Louisville, Kentucky 40217

25. University Hospital, State University of New York at Stony Brook
Stony Brook, New York 11790

26. Providence Hospital
Washington, D.C. 20017

27. The Jamaica Hospital
Jamaica, New York 11418

28. Carney Hospital
Boston, Massachusetts 02124

29. St. Agnes Hospital
Baltimore, Maryland 21229

30. Milwaukee Psychiatric Hospital
Wauwatosa, Wisconsin 53213

31. The Good Samaritan Hospital, Inc.
Baltimore, Maryland 21239

32. Bayfront Medical Center, Inc.
St. Petersburg, Florida 33701

33. Highland General Hospital
Oakland, California

34. David Grant USAF Hospital
Travis Air Force Base, California

35. Lafayette Charity Hospital
Lafayette, Louisiana

36. Children's Hospital of Birmingham
Birmingham, Alabama

37. Sinai Hospital of Detroit
Detroit, Michigan

38. Orthopaedic Hospital at Los Angeles
Los Angeles, California

39. Detroit Memorial Hospital
Detroit, Michigan

40. Methodist Hospital
Memphis, Tennessee

41. Baptist Hospital
Nashville, Tennessee

42. White Memorial Medical Center
Los Angeles, California

43. National Institutes of Mental Health
Lexington, Kentucky

44. William Beaumont General Hospital
El Paso, Texas 79920

45. St. Clare's Hospital & Health Center
New York, New York 10019

46. Fairview General Hospital
Cleveland, Ohio 44111

47. San Joaquin General Hospital
Stockton, California 95201

48. The Charles T. Miller Hospital
St. Paul, Minnesota 55102

HOSPITALS WHICH ARE ELIGIBLE FOR MEMBERSHIP IN COTH

	Name of Institution	Number of Beds	Residency Programs	Type of Affiliation	Total Residency Positions Offered	
1.	Carraway Methodist Medical Center P.E. Cox, Administrator Birmingham, Alabama	419	GS, IM,OBG, PTH, U	L-010	39[a]	(16)[b]
2.	Lloyd Noland Hospital John W. McLean, Jr., Administrator Fairfield, Alabama	307	AN,D,GS,IM, OBG,ORS,PD	L-010	32	(20)
3.	Pima County General Division Joseph C. Herrick, Administrator Tucson, Arizona	140	GS,IM,OBG,PD	M-100	--	
4.	Kern County General John Canning, Acting Administrator Bakersfield, California	182	GP,GS,IM,OBG, OPH,PTH	L-013	35	(17)
5.	David Grant USAF Medical Center Col. James E. Henry, Administrator Fairfield, California (Travis Air Force Base)	385	DR,GS,IM, OBG,PD,R	M-102	69	(50)
6.	Valley Medical Center of Fresno Manuel Perez, Administrator Fresno, California	583	FP,GS,IM, OBG,OPH,OTO, PD,PS	G-015, 016	61	(37)
7.	Kaiser Foundation James L. Rieder, Administrator Los Angeles, California	465	FP,GS,IM,N, OBG,PTH,PD,R, U	—	71	(50)
8.	White Memorial Medical Center Ronald L. Sackett, Administrator Los Angeles, California	307	AN,GS,IM,NS, OBG,OPH,ORS, OTO,PTH,PD,R, TS,U	M-012, L-014	86	(78)
9.	Highland General Lawrence Hoban, Administrator (Part of Alameda County Health Care Services Agency) Oakland, California	688	GS,IM,OBG, ORS,PTH,P,R, TS,U	G-016	62	(61)
10.	Kaiser Foundation Gordon R. Kirstein, Administrator Oakland, California	262	GS,IM,OBG, ORS,OTO,PD	L-016	47	(43)

[a]=Offered Positions as of July 1, 1974
[b]=Filled Positions as of September 1, 1972

11.	Naval Hospital Capt. E. B. Miller, MSC Administrator Oakland, California	775	AN,GS,IM,OBG, OPH,ORS,OTO, PTH,PD,P,R,U	--	113 (94)
12.	Huntington Memorial Robert S. Lund, Acting Administrator Pasadena, California	482	GS,IM,NS,PS	L-014	29 (21)
13.	San Bernardino County General C.M. Thayer, Administrator San Bernardino, California	306	FP,GS,IM,OBG, OPS,PTH	L-012, G-013	55 (35)
14.	Naval Hospital Capt. A.J. Schwab, MSC,USN Administrative Officer San Diego, California	1,700	AN,DR,D,GS, IM,OBG,OPH,ORS, OTO,PTH,PD,R,TS, TR,U	L-103	197 (155)
15.	Letterman General Brig. Gen. Robert W. Green, MC, Commander San Francisco, California	525	AN,CHP,DR,D,GS, IM,N,OBG,OPH, ORS,PTH,PD,PM,P, TS,U	L-016, 091	137 (138)
16.	St. Mary's Hospital & Medical Center Sister Mary Joanne RN, Administrator San Francisco, California	438	CHP,DR,GS,IM, ORS,PD,P,R,TR	L-016	63 (28)
17.	San Francisco General C. Charles Monedero, Administrator San Francisco, California	653	AN,DR,D,FP,GS, IM,NS,N,OBG,ORS, OTO,PTH,PD,PS,TR, U	M-016	20
18.	U.S. Public Health Service Karl F. Urbach, M.D. Director San Francisco, California	321	GS,IM,OPH,ORS	--	30 (10)
19.	Santa Clara Valley Medical Center Leo G. Smith, Administrator San Jose, California	457	AN,DR,GS,IM, NS,OBG,OPH,ORS, OTO,PTH,PD,PM,TR, U	M-015, G-016	40 (28)
20.	San Joaquin General William Mandel, M.D., Medical Director Stockton, California (French Camp)	462	FP,GS,IM,OBG, OPH,PD	L-102, G-016	44 (22)

21.	Fitzsimons General Maj. Gen. James A. Wier, M.D., Commanding Officer Denver, Colorado	850	D,GS,IM,OBG, OPH,ORS,OTO,PTH, PD,PDA,U	M-017, L-091	90	(89)
22.	St. Joseph Sister Mary Andrew, Administrator Denver, Colorado	554	GP,GS,IM,OBG, ORS,PTH,R	G-017	25	(22)
23.	District of Columbia Frank G. Bossong Administrator Washington, D.C.	816	GS,IM,NS,OBG,OPH, ORS,OTO,PTH,PD, PDA,R,TR,U	M-019, 020, 021	35	(31)
24.	Doctors Hospital Dudley P. Cook Administrator Washington, D.C.	284	GS,IM,PTH	L-019	23	(15)
25.	Walter Reed General Maj. Gen. William H. Moncrief, Jr., M.D. Administrator Washington, D.C.	943	AN,CHP,DR,D,GS, IM,NS,N,OBG,OPH, ORS,OTO,PTH,PD, PS,P,TS,U	M-019, L-021, G-020	201	(223)
26.	Orange Memorial J. Quinn & G. Walker Directors Orlando, Florida	787	GS,OBG,ORS,PTH, PS	--	44	(41)
27.	Tampa General Howard B. Lehwald, Administrator Tampa, Florida	583	CHP,DR,GS,IM,OBG, OPH,OTO,PTH,PD,P, R,U	M-115	27	(17)
28.	Georgia Baptist Edwin B. Peel Administrator Atlanta, Georgia	444	GS,IM,OBG,ORS	--	47	(33)
29.	University Hospital George B. Little, Jr., Administrator Augusta, Georgia	600	D,FP,GS,IM,NS,OBG, OPH,ORS,PTH,PD,TR	M-024	--	
30.	Medical Center of Central Georgia Damon D. King Administrator Macon, Georgia	484	FP,GS,OBG	L-024	31	(10)
31.	Memorial Medical Center R.J. Weinzettel, Executive Director Savannah, Georgia	433	DR,GS,IM,OBG,PTH, R,TS,U	L-024	33	(17)

32.	Tripler General Maj. Gen. C. Hughes, MC, Commanding General Honolulu, Hawaii	750	D,GS,IM,OBG,OPH, ORS,PTH,PD,U	M-105, G-016	91	(100)
33.	Columbus-Cuena Medical Center Joseph J. Rossi, Jr., Administrator Chicago, Illinois	---	GS,IM,OBG	L-027	28	(26)
34.	Louis A. Weiss Memorial Mortimer W. Zimmerman, Executive Director Chicago, Illinois	343	GP,GS,IM,ORS, PTH,R,U	M-030	42	(25)
35.	Naval Hospital Capt. William L. Long, MSC, Administrator Bethesda, Maryland	662	AN,D,GS,IM,N,OBG, OPH,ORS,OTO,PTH, PD,PS,P,R,TS,U	M-019, L-021, G-020	143	(109)
36.	Boston City Leon White, Ph.D., Commander Boston, Massachusetts	809	AN,DR,D,GS,IM,NS, N,OBG,OPH,ORS, OTO,PTH,PD,P,TS,U	M-040, 041, L-042	173	(149)
37.	Cambridge Hospital Leslie N.H. MacLeod, Director Cambridge, Massachusetts	187	AN,GS,IM,PTH,PS,P	M-041	40	(24)
38.	Naval Hospital Capt. S.G. Kramer, MC Commanding Officer Chelsea, Massachusetts	375	PS	M-040	2	(1)
39.	Mount Carmel Mercy Sister Mary Leila, Executive Director Detroit, Michigan	557	GS,IM,OBG,PTH,PD, PS,R	G-043	49	(27)
40.	Sinai Hospital of Detroit Julien Priver, M.D., Executive Vice President Detroit, Michigan	619	AN,DR,GS,IM,OBG, OPH,PTH,PD,PS,P, R,U	M-044	92	(74)
41.	St. Joseph Sister Agnes Breitenbeck, President Flint, Michigan	426	FP,GP,PTH,R	M-098	29	(8)
42.	William Beaumont Kenneth E, Meyers, Director Royal Oak, Michigan	700	DR,GS,IM,OBG,ORS, PTH,PD,PS,R,U	--	114	(101)

43.	Homer G. Phillips John P. Noble, Administrator St. Louis, Missouri	432	GS,OBG,OPH,OTO, PTH,R,U	L-049	70	(55)
44.	Hackensack Lawrence L. Smith, Executive Director Hackensack, New Jersey	471	AN,GS,PTH,P,R	L-053	25	(30)
45.	Jersey City Medical Center Ira C. Clark, Executive Director Jersey City, New Jersey	579	GS,IM,OPH,ORS, PTH,PD,PS,U	M-053	80	(69)
46.	St. Joseph's Sister Jane Frances Brady, Administrator Paterson, New Jersey	507	AN,GS,IN,OBG,ORS, PTH	L-053	59	(45)
47.	St. Peter's Sister Ellen Lawlor, Executive Director Albany, New York	423	GS,OBG,PTH,PD,PS, R	L-054	12	(10)
48.	Bellevue Hospital Center Bernard M. Weinstein, Director New York City, New York	1,572	CHP,DR,D,GS,IM,NS, N,OBG,OPH,ORS,OTO, PTH,PD,PDC,PM,PS,P, R,TR,TS,U	M-060		
49.	Coney Island Frank W. Hays, Executive Director Brooklyn, New York	600	AN,GS,IM,OBG,OPH, ORS,PTH,PD,U	--	46	(45)
50.	Flushing Hospital and Medical Center William F. Moore, Executive Director Flushing, New York	325	GS,IN,OBG,PTH,PD	--	32	(29)
51.	French and Polyclinic Medical School Irwin Shapiro, Executive Director New York City, New York	574	AN,GS,IN,OBG,OPH, ORS,PTH,PD,U	--	67	(59)
52.	Lincoln J. Cesar Galarce, Executive Director Bronx, New York	355	AN,GS,IM,OBG,ORS, OTO,PTH,PD,PDC,PM, PS,P,U	M-056	49	(85)
53.	Maimonides Medical Center Lee W. Schwenn, Executive Vice President Brooklyn, New York	613	AN,CHP,GS,IM,OBG, OPH,ORS,PTH,PD,P, U	M-061	44	(41)

54.	Metropolitan Hospital Center Unit 2 A. Constantine, Executive Director New York City, New York	925	AN,CHP,DR,D,GS, IM,N,OBG,OPH,ORS, OTO,PTH,PD,PDA,PM, P,U	M-059	--	
55.	New York Infirmary Edward Vincent Grant, Administrator New York City, New York	272	GS,OBG,PD	G-060	23	(21)
56.	Queens Hospital Center Robert A. Vitello, Executive Director Jamaica, New York	1,177	AN,CHP,GS,IM,OBG, OPH,ORS,PTH,PD, PDC,PM,P,R,TS,U	M-109	30	(28)
57.	St. Clare's Hospital & Health Center Sister John K, McNulty, Administrator New York City, New York	411	GS,IM,OBG,OPH, PTH,PD	--	64	(61)
58.	Wycoff Heights Allen Podell, Executive Director Brooklyn, New York	375	GS,IM,OBG,PTH,PD	--	56	(53)
59.	Crouse-Irving Memorial David M. Beers, Executive Vice President Syracuse, New York	466	AN,GS,IM,NS,N,OBG, OPH,ORS,OTO,PTH, PD,PDC,PS,TS,U	M-063	--	
60.	St. Joseph's Hospital Health Center Sister Patricia Ann, Executive Vice President Syracuse, New York	386	AN,FP,GS,OBG,ORS, PTH	M-063	13	(9)
61.	Good Samaritan David L. Ford, Administrator Dayton, Ohio	494	FP,GS,IM,OBG	--	36	(16)
62.	Good Samaritan Hospital & Medical Center Chester L. Stocks, Executive Vice President & Administrator Portland, Oregon	520	GS,IM,NS,N,OPH,PTH, PS	G-071	30	(26)
63.	Abington Memorial Morris F. George, President Abington, Pennsylvania	463	GP,GS,IM,OBG,ORS, PTH,R,U	M-074	43	(27)
64.	Lankenau Ralph F. Moriarty, President Philadelphia, Pennsylvania	425	GS,IM,OBG,OPH,ORS, PTH,PS	M-073, L-074	46	(37)

65.	Naval Hospital Capt. G. E. Cruft, Commanding Officer Philadelphia, Pennsylvania	1,000	AN,D,GS,IM,OBG, OPH,ORS,OTO,PD, P,R,U	M-073, L-072	110	(96)
66.	Reading James B. Gronseth, Administrator Reading, Pennsylvania	599	DR,FP,GS,IM,OBG, ORS,PTH,R	L-074, 075	55	(23)
67.	Mayaguez Medical Center Miguel A. Sepulveda, Administrator Mayaguez, Puerto Rico	400	GS,IM,OBG,PD	L-078	36	(31)
68.	Baroness Erlanger Harold L. Peterson, Administrator Chattanooga, Tennessee	652	GS,IM,OBG,OPH,ORS, PTH,PS,R	--	61	(45)
69.	University of Tennessee Memorial Research Center Hospital John H. King, Administrator Knoxville, Tennessee	473	AN,FP,GS,IM,OBG, ORS,PTH,PD,R	M-081	45	(33)
70.	Methodist Harry C. Mobley, Administrator Memphis, Tennessee	915	GS,IM,NS,OBG,OPH, ORS,OTO,PTH,R	G-081	43	(30)
71.	Children's Medical Center James J. Farnsworth, Administrator Dallas, Texas	122	DR,NS,N,OTO,PD,PDC, R,TR,TS	M-084	32	(26)
72.	St. Joseph Sister Mary Agnesita Brosman, Administrator Houston, Texas	768	AN,DR,GS,IM,OBG, OPH,ORS,PTH,PS,R	M-120, L-085	26	(24)
73.	Brooke General Brig. Gen. Edward H. Vogel, Jr., Administrator Fort Sam Houston, Texas	860	AN,DR,D,GS,IM,N, OBG,OPH,ORS,OTO, PTH,PD,PM,PS,TS,U	G-111	167	(141)
74.	Naval Hospital RADM Willard P. Arentzen, MC, Commanding Officer Portsmouth, Virginia	1,102	AN,GS,IM,OBG,ORS, PTH,PD,U	M-122	105	(76)
75.	Roanoke Memorial Hospital William H. Flannagan, Director Roanoke, Virginia	725	DR,FP,GS,ORS,PTH, R	M-089	46	(20)
76.	Virginia Mason Austin Ross, Administrator Seattle, Washington	286	AN,DR,GS,IM,OBG, PTH,R,TR,U	L-091	47	(37)
77.	Madigan General (Army) Tacoma, Washington	1,024	FP,GS,IM,OBG,OTO, PTH,PD,U	L-091	75	(57)

78.	Ohio Valley General Fred E. Blair, Executive Director Wheeling, West Virginia	438	GS,IM,OBG,PTH,R	L-092	30	(17)
79.	St. Joseph's Sister M. Jeanne Gengler, President Milwaukee, Wisconsin	580	DR,GS,OBG,PTH,R,TS	L-094	56	(18)

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ROBERT H. MYERS, JR.

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(1921-1932)
EDMUND B. QUIGGLE
(1921-1935)
PAUL FORREST MYERS
(1921-1965)

JAMES CRAIG PEACOCK
WILLIAM S. HYDE
COUNSEL

May 17, 1974

Dr. Richard M. Knapp, Director
Department of Teaching Hospitals
Association of American Medical Colleges
One Dupont Circle, N.W., Suite 200
Washington, D. C. 20036

Dear Dr. Knapp:

This concerns the proposed regulations to implement Section 223 of the Social Security Amendments of 1972 (P.L. 92-603) which appear in the March 19, 1974 Federal Register (20 C.F.R. Part 405) (Regulations No. 5). These proposed regulations, which relate to limitation on coverage of hospital costs under the health insurance program, were the subject of a letter of comment from the Association to the Social Security Administration dated April 18, 1974.

This letter of comment contained the Association's contentions that these proposed regulations reflect erroneous interpretations of congressional intent and conflict with the statute they are to ostensibly implement by not screening out only excess costs which flow from inefficiency in the delivery of health care services. On this latter point, the Association expressed its concern that incurred costs of teaching hospitals may be disallowed (i.e. deemed "unnecessary") notwithstanding the fact that such costs are, in every respect, reasonable, in contravention of the intent of Congress.

The comment period with respect to these proposed regulations closes on May 18, 1974, and we understand that they will be signed within seven to ten days thereafter, or toward the end of this month.

Consideration, then, is being given to the possibility of legal action by the Association to forestall the adoption of the proposed regulations in their present form. At the outset, however, it must be noted that there is no avenue of approach here that offers great certainty of success. Moreover, legal action would be premature pending the signing

of these regulations in final form, inasmuch as a court will review an agency's action only when "final" and once all administrative remedies have been exhausted.

The Association could, once the regulations become final, file an action in U.S. District Court, seeking to preliminarily enjoin the promulgation of the regulations and seeking a ruling that the proposed regulations are "arbitrary and capricious" on the ground that they exceed and conflict with the intent of Congress and perhaps that they are constitutionally deficient as well. In this regard, the court will look to see if the regulations have a rational basis in relation to the underlying legislation. (I should note that there does not appear to be any productive basis for attacking the pertinent statutory sections themselves.)

In testing these proposed regulations against the statute and its legislative history to see if they have a rational basis in relation to the statute and the intent of Congress in enacting it, and based upon the following observations, we conclude that the Association (and/or one or more of its member hospitals) has a case that the proposed regulations lack the requisite rational basis and thus should not be implemented (although it is not possible at this time to forecast with any specificity the likelihood of the outcome of such an action):

1. A valid contention can be made that the proposed regulations do not satisfactorily take into account the several factors that influence the variability of reasonable costs across hospitals and, in conflict with statutory requirements and congressional intent, omit certain essential factors.

2. The legislative history of Section 223 supports the view that Congress contemplated the utilization of variables of concern to the Association's membership in ascertaining reasonable costs.

3. A persuasive case can be made that these proposed regulations fail to meet and would in fact impede the ultimate goal of Section 223, which is to limit reimbursement for "unnecessary" costs of health care services. The Senate Finance Committee has stated that Section 223 was designed to initiate "reimbursement mechanisms that limit reimbursement to the costs that would be incurred by a reasonably prudent and cost-conscious management". However, it appears that, at least as applicable to teaching hospitals, the proposed regulations would screen out costs which are attributable to factors other than inefficiency, thereby contravening the expressed intent of Congress.

4. It seems clear that the proposed regulations exceed the scope of the statute they purport to implement, by requiring the intermediary to approve the charge of "excess charges" by the provider.

The question as to when such an action might be instituted depends in part, upon the following factors: (1) whether the comment period can be further extended, (2) when the regulations are signed into final form, and (3) the date the then-final regulations are to become effective.

Preferably, an action would be brought after the regulations become final but prior to the effective date, in an effort to stay the effectiveness of the regulations. The plaintiff in such an action would have to demonstrate, among other things, that such a stay would prevent "irreparable injury" and that requisite standing exists, i.e., that the plaintiff is an "aggreived" party or a party "suffering a legal wrong". As we have discussed, consideration should be given to the possibility of including as plaintiff one or more teaching hospitals, should a decision to file suit be reached.

Once effective, an action could be brought to invalidate the regulations. If for no more than strategic purposes, it would be preferable to initiate such a suit as soon after the effective date as is reasonably possible.

I know that you are thinking of the Association's Board meeting on June 20 in this connection. Assuming no extension of the comment period, these regulations will undoubtedly become final about three weeks in advance of that meeting. As discussed, a suit could be--and probably should be--filed as soon thereafter as possible, if a decision to sue is arrived at. If necessary, however, an action could be initiated in the context of the effective date, although in my opinion the impact on the court in terms of a request for immediate injunctive relief would be less than if the suit were brought right after the regulations became final.

I know the foregoing will prompt additional questions and I will be pleased to discuss them with you at your convenience.

Very truly yours,

Bruce R. Hopkins

cc: Dr. John A. D. Cooper

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

June 5, 1974

Stuart Altman, Ph.D.
Deputy Assistant Secretary for Planning,
Evaluation - Health
Department of Health, Education and Welfare
330 Independence Avenue
Washington, D.C. 20201

Dear Stu:

Yesterday afternoon in your conversation with John Cooper concerning the proposed regulations to implement Section 223 of the Social Security Amendments you indicated, among other things, that you had been informed that the Social Security Administration was less than satisfied with the advice and consultation it has received from a number of organizations including the AAMC on this issue. I have now heard this comment so many times and in so many different places that I feel compelled to document our efforts to deal with the Social Security Administration on this issue. In so doing I shall outline events which have taken place since March 16, 1973.

On March 16, 1973, Dr. Cooper wrote a letter to Irv Wolkstein stating the general concerns of the AAMC about Section 223, and formally requesting that at an appropriate time a small group of representatives of the Council of Teaching Hospitals be given the opportunity to discuss the implementation of this provision with SSA staff members. Four weeks elapsed and no reply had been received to this letter. I therefore called Mr. Wolkstein's office and asked about the status of the response to our letter; I was referred to the office of Mr. Robert O'Connor, then Director of the Division of Provider Reimbursement and Accounting Policy. I called Mr. O'Connor who indicated that although he had the letter, no response had been drafted. Mr. O'Connor stated that he felt that a meeting with COTH representatives would be inappropriate at that time. No other formal response to this letter was ever received.

In the ensuing months of May through October I spent a considerable amount of time with a number of people at the Bureau of Health Insurance dealing primarily with problems surrounding the implementation of Section 227, "Payment For Services of Supervisory Physicians In Teaching Hospitals." In the context of these working relationships, I frequently made inquiries

of various people concerning the status of Section 223 and my interest in it. At each request I was informed that the current status was such that it was not an appropriate time for review by individuals external to the Bureau of Health Insurance. This continued to be the case through December, 1973.

By letter of December 6, which arrived here on December 12, Mr. Wolkstein forwarded copies of the draft regulations implementing Section 223 and requested that comments be received in the office of Mr. Robert O'Connor no later than December 21. (Given the complexity of the regulation, six working days was an inordinately short period of time for review.) Nevertheless, I forwarded detailed comments to Mr. O'Connor on December 21. In doing so I specifically requested that we be provided with the data base utilized to construct the methodology in order to more adequately review these proposed regulations. No response was ever received to this letter in terms of the nature of our substantive comments or in response to my request for the data. Additionally, none of our suggestions were incorporated in the proposed regulations when published in the March 19 issue of the Federal Register.

On January 29, 1974, representatives of a group of health related organizations, including the AAMC, met with Mr. Wolkstein and other BHI staff members to discuss the status of these regulations and to inquire as to why no one had received a response to letters of comment submitted on December 21, 1973. The meeting was largely inconclusive, but again I reiterated our request for the data utilized to construct the methodology.

On February 25, Dennis Pointer, myself and Billy Simmons of the American Hospital Association met with John Jansak, Chief of the Provider Reimbursement Policy Branch, to again discuss these regulations and have the opportunity to review the data in his office. On February 26, I wrote to Mr. Jansak again requesting that we be provided the opportunity to independently review these data. On March 28 (fully nine days after the proposed regulations had already been released in the Federal Register), I received a letter from Mr. Wolkstein indicating that the arrays of hospital routine costs which we requested (excluding identification information) would be provided for the cost of reproduction. Two days later a check was forwarded to Mr. Wolkstein for $32.75, and approximately a week later the data arrived here in my office.

I have outlined in some detail the sequence of events above to document our sincere efforts to achieve a working relationship with members of the BHI staff which date back as far as March 16, 1973. Frankly, I believe the Association has just cause to be more than mildly dissatisfied with the deliberative process to draft these regulations, as opposed to any dissatisfaction which might be expressed by the staff of the Bureau of Health Insurance. Additionally, I reiterate this sequence of events in the hope

that over the next period of months we can initiate a working relationship with a group from your office which will allow a constructive approach to achieving the legislative intent of Section 223.

I appreciate your efforts in this area and look forward to a successful working relationship over the coming months.

Sincerely,

Dick

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

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

JOHN A. D. COOPER, M.D., PH.D.
PRESIDENT

WASHINGTON: 202: 466-5175

May 20, 1974

Mr. James B. Cardwell
Commissioner of Social Security
Department of Health, Education and Welfare
Fourth and Independence Avenue, S.E.
Washington, D.C. 20201

Dear Mr. Cardwell:

In a letter dated March 18, 1974, I set forth the formal comments of the Association of American Medical Colleges regarding proposed regulations seeking to implement Section 223 of P.L. 92-603. (Federal Register, Vol. 39, No. 54, pp. 10260-10262 and 10313-10315) The thirty day extension of the comment period has allowed the Association to undertake a comprehensive analysis of the hospital classification and per diem routine service cost methodologies contained in the proposed regulations. Attached is a paper entitled, "Classifying Short-Term Hospitals For Routine Service Cost Limitation Under Section 223 of P.L. 92-603: A Critical Analysis." I believe that this effort warrants your closest attention.

The study presents a series of analyses that seriously questions both the effectiveness and efficiency of the classification and cost limitation methodologies employed in the proposed regulations. Based upon this study the Association believes that if the regulations are implemented as proposed, costs will be arbitrarily denied which are in every way reasonable. The Association suggests that before the regulations are published the inadequacies of the methodology delineated in this paper should be addressed and subsequently refruted or corrected. In this regard, I respectfully request a response in writing to the substantive points presented in the attached study and in my letter of March 18, 1974.

Sincerely,

John A. D. Cooper

John A. D. Cooper, M.D.

Attachment:

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

MEMORANDUM #74-14 May 28, 1974

TO: AAMC ASSEMBLY

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

SUBJECT: AAMC Analysis of Section 223 Proposed Regulations

Attached is a paper entitled "Classifying Short-Term Hospitals For Routine Service Cost Limitation Under Section 223 of P.L. 92-603: A Critical Analysis." This is a well-executed analysis by our Department of Teaching Hospitals of a complex and significant set of federal regulations that will have a widespread impact upon the nation's health care industry.

Regulations seeking to implement Section 223 propose to subdivide all short-term hospitals into 70 groups based upon: (1) bed size; (2) metropolitan area designation (whether or not it is located in a SMSA), and (3) per capita income of the state in which the hospital is located. Within each group, a limit is placed upon allowable reimbursement for per diem routine service costs. Legislative wording is significantly broad to allow the extension of this mechanism to aggregate per diem costs in the future.

The regulations were published in their proposed form on March 19, 1974. The AAMC sought and was granted a 30-day extension of the formal comment period to May 20, 1974. Prior to being informed of the extension, the Association forwarded its substantive comments on the proposed regulations. (My letter of April 18, 1974 is included as Attachment III of this paper). During the extension period we received data employed by the SSA to construct the hospital groupings. These data form the foundation upon which the enclosed analysis is based.

The paper concludes that the proposed regulations seek to implement an overly simplistic and inadequate mechanism that has the capacity to deny reimbursement for incurred costs that are in every way reasonable. Empirical analysis demonstrates that the hospital groups established in the proposed regulations are no better than if hospitals had been randomly or arbitrarily assigned.

Attachment:

Classifying Short-term Hospitals for Routine Service Cost Limitation Under Section 223 of P.L. 92-603: A Critical Analysis*

Department of Teaching Hospitals
Association of American Medical Colleges

Washington, D.C.
May, 1974

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*This paper is the result of a collaborative effort by Dennis Pointer, Ph.D., Department of Teaching Hospitals, Association of American Medical Colleges and Joseph Phillip, Ph.D., Division of Research, American Hospital Association.

Background

Proposed regulations seeking to implement Section 223 of P.L. 92-603 were published in the Federal Register (Vol. 39, No. 54, pages 10260-10262 and 10313-10315) on May 19, 1974. The Association of American Medical Colleges (AAMC) in a letter to the Commissioner of the Social Security Administration (SSA) dated April 4, 1974 requested a 60-day extension to the comment period. The extension request was based upon the fact that the AAMC had not received data employed by SSA to designate the hospital groupings employed in the proposed regulations. (The Association had first requested this data in a letter to the SSA dated December 21, 1973). The AAMC forwarded its formal comments regarding the proposed regulations to the Commissioner of SSA (letter dated April 18, 1974--see Attachment III) prior to being informed that a 30-day extension of the comment period had been granted. This letter stated that the Association would supplement its formal comments with analysis of the empirical data employed to construct the hospital groupings delineated in the proposed regulations; such analysis is contained herein.

The analysis that follows is based on the following logic:

1. the criteria upon which hospitals should be grouped for cost limitation purposes under Section 223 of P.L. 92-603 are clearly specified in the Senate and House Committee reports;
2. such criteria were not fully employed by SSA in developing the hospital groupings delineated in the proposed regulations; and
3. since these criteria were not fully utilized, the methodology employed in the proposed regulations have the effect of denying reimbursement for routine service costs that are, in every way, reasonable and not associated with the provision of unnecessary services or the existance of inefficiencies.

Congressional Intent: Grouping Hospitals for Cost Limitation

Section 1861 (v)(i)(a) of the Social Security Act, as amended by Section 223 of P.L. 92-603, states that "... the reasonable cost of any service shall be the cost actually incurred, excluding therefrom any part of the incurred cost found to be unnecessary in the efficient delivery of needed health services..." The language of the law notes that costs defined as reasonable should be determined for "various types of classes of institutions." In elaborating the factors that influence the variation of costs between institutions that are reasonable and therefore not a result of the provision of unnecessary services or the existence of inefficiencies, the Senate Committee report notes that:

> "The Committee is mindful of the fact that costs can and do vary from one institution to another as a result of differences in size, in the nature and scope of the services provided, the type of patients treated, the location of the institution and various other factors affecting the efficient delivery of needed health services." (emphasis added)

The Committee report also observes:

> "to the extent that differences in provider costs can be expected to result from such factors as the size of the institutions, patient mix, scope of services offered or other economic factors, wide, but not unlimited recognition should be given to the variations in the costs accepted as reasonable." (emphasis added)

It is clear that Congress expected that the production characteristics of hospitals be given careful consideration when grouping such institutions for the purpose of limiting the reimbursement for cost incurred in the provision of services to Medicare beneficiaries. Different hospitals provide different configurations of facilities and services and treat patient populations having highly variable characteristics. The Congress realized that the costs incurred by a hospital offering a wide variety of sophisticated diagnostic and treatment modalities and treating patients with complex and compounded medical problems could not be compared to the costs of a hospital

providing only basic services and treating patients with routine diagnoses. To make controls meaningful, variations in hospital costs due to operational inefficiencies and the provision of unnecessary services must be separated from variations in costs due to differences in the type of care provided.

Methodology Employed in the Proposed Regulations

To develop the groupings limiting average routine service costs per diem, all short term general hospitals were initially cross-classified along the three dimensions noted below:

1. per capital income (five levels)
    a. State Group I (highest per capital income)
    b. State Group II
    c. State Group III
    d. State Group IV
    e. State Group V (lowest per capital income)
2. metropolitan area designation (two levels)
    a. located in a SMSA
    b. not located in a SMSA
3. pediatric and adult bed capacity (seven levels)
    a. <54
    b. 55-99
    c. 100-169
    d. 170-264
    e. 265-403
    f. 404-684
    g. >685

The classification system can be viewed as a 5 x 2 x 7 three dimensional matrix containing 70 cells; the nation's hospitals are distributed in the matrix according to their characteristics on the dimensions.

Routine service cost data was gathered on 6077 short term general hospitals as reflected by interim rates being paid by the intermediaries as of March 31, 1973. It is impossible for the AAMC to access the comparability and accuracy of these data. The data were arrayed in the matrix and two types of adjustments were made to the initial grouping methodology. First, due to the small number of hospitals in some groups, certain cells were combined. Second, due to wide variations of cost in group one states (highest per capita income category) this variable was divided into two sub-classes: 1. group I states excluding Alaska and Hawaii and; 2. group I states in total (i.e., not excluding Alaska and Hawaii). Given these modifications the classification scheme employed in the proposed regulations contained 66 hospital groups; a listing of these groups and their characteristics with respect to the classification dimensions can be found in Attachment I.

The per diem routine service cost limit in each group was established as the 90th percentile of the hospitals in the group plus 10 percent of the group median.[1,2] If the costs in each cell were distributed in a "bell shaped" fashion (which they are not, as later analyses will indicate) the limit would equate to approximately the 95th percentile.

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[1]Mathmatically this can be expressed as: LIMIT = $[1.64\ (S) + \overline{X}] + .10$ mdn; where S is the standard deviation of the costs in the cell, $\overline{X}$ is the mean cost and mdn is the median cost in the cell.

[2]Costs were adjusted upward 9/10th of one percent per month for the number of months occuring between the point at which the data was gathered and the time the proposed regulations were issued to adjust for inflation.

Thus, the methodology employed assumed: 1. that grouping hospitals on the basis of state per capita income, bed size and metropolitan area designation would aggregate facilities that are essentially "doing the same thing" so that extreme variations in cost would be due to the presence of inefficiencies and/or the provision of unnecessary services; and 2. costs in any one hospital group exceeding the 90th percentile plus 10 percent of the group's median cost would be "unreasonable" as defined by the Act.

Critique and Analysis of Grouping Methodology

It is the contention of the analyses presented here that the underlying structure of the hospital grouping methodology employed in the proposed regulations is overly simplistic and possesses severe limitations. Because of these limitations the methodology restrains the regulations from fulfilling the intent of Congress to prospectively deny reimbursement for costs resulting from operational inefficiencies and/or the provision of unnecessary services. This Section has two interrelated objectives. First, it will critique the conventional classification scheme employed in the proposed regulations to group hospitals. Second, it will analyse the efficiency of the grouping methodology utilizing data supplied by the Social Security Administration (such data was employed to establish the group per diem routine service cost limitations).

CRITIQUE OF THE GROUPING METHODOLOGY

A conventional cross-classification scheme has been employed by SSA in proposing regulations to implement Section 223 of P.L. 92-603. Hospitals are cross-classified along three dimensions: (1) per capita income on the basis of state groupings; (2) pediatric and adult bed capacity; and (3) metropolitan area designation (SMSA, non-SMSA). This type of conventional cross-classification methodology has been long recognized by taxonomists

(those specializing in the design of classification systems) as possessing severe limitations.

First, conventional cross-classification methodologies place severe restrictions on how detailed (refined) the classification can be. Every such scheme is associated with a radical proliferation of groups (and an equally radical reduction of the number of hospitals in each group) as the number of dimensions (and levels in the dimension) increase. For example, the initial classification employed by SSA generated 70 groups of which three were empty and seven contained less than ten hospitals; this necessitated collapsing groups (i.e., combining hospitals of highly different sizes). Any attempt to institute refinements to the classification scheme would result in many empty or low frequency groups. For example, the introduction of an additional dimension with only three levels (e.g., number of facilities and services offered - high, medium, low) to the SSA classification scheme would have generated 210 groups. Such a deficiency makes it impossible to introduce other needed dimensions into the classification scheme to correct the distortions discussed elsewhere in this paper.

Second, conventional cross-classification grouping schemes require that continuous ordinal characteristics (variables) be "compressed" into a few levels. For example, in the SSA cross-classification scheme contains a distribution of hospitals that range in size from 6 to over 3,000 beds that are compressed into seven levels (<54, 55-99, 100-169, 170-264, 265-403, 404-684, >685). All hospitals that fall within a given size class are placed in a single group. The assumption is made that size differences existing within the group are unimportant. Possibly more critical than the aforementioned problem is the fact that cut-off-points employed to establish the groups are arbitrary. The SSA method breaks all 50 states, the

District of Columbia and Puerto Rico into five per capita income groups by arbitrary subdividing a rank ordered list. The principle point is that the break points are arbitrary; one subdivision scheme is as good (or as bad) as any other.

Third, even if one could assume that the cut-off-points are optimal when each dimension is considered in isolation, there is no guarantee that they will remain optimal when all dimensions are employed together in a cross-classification scheme. This is due to the fact that when more than one dimension is employed in a cross-classification, interaction effects are introduced. (For a discussion of interaction effects see: E.F. Linquist, Design and Analysis of Experiments, Boston: Houghton Mifflin Company, 1953). Consequently, groupings different from the ones obtained from the cut-off-points of the isolated dimensions may be (and usually are) more valid and meaningful.

The points noted above are problems inherent in the utilization of any conventional cross-classification scheme such as that employed by the SSA in the proposed regulations. Equally, if not more important is the relationship between the design of the classification scheme and the purpose for which it is employed; design must match purpose. In enacting Section 223 of P.L. 92-603 it was the intent of Congress that a classification scheme be developed that would group similar hospitals so that extremely high per diem routine service costs within a group could be presumed to be due to inefficiencies and/or the provision of unnecessary services rather than to legitimate operating differences between hospitals. The classification scheme developed by SSA does not fully reflect this objective. A classification scheme based upon per capita income, metropolitan area designation and bed size does not adjust for real product differences between hospitals

or hospital groups. Variations in routine service costs related to differences in the nature of facilities and services and/or the types of patients treated are not accounted for in the proposed classification scheme. Thus, limitations based upon this classification have the potential to deny reimbursement for costs that are in every way reasonable. This is a fundamental and totally permeating criticism of the classification methodology employed in the proposed regulations. A more thorough development of this problem is provided in the Association's formal comments on the proposed regulations (see Attachment III).

The discussion presented above develops the arguments that the classification methodology employed in the proposed regulations: (1) has inherent inadequacies due to the nature of the classification scheme per se; and (2) because the design of the scheme does not match the purpose for which it is employed. As a result of these deficiencies one would expect that the SSA classification scheme would be both inefficient and ineffective. This is explored in the following section.

STATISTICAL ANALYSIS OF THE GROUPING METHODOLOGY

This section presents a statistical analysis of the distributions created by the classification methodology employed in the proposed regulations. The statistical properties of the classification provides an analysis of the necessary and not the sufficient conditions regarding the methodology's validity.

In order to evaluate the efficiency of the grouping methodology employed in the proposed regulations, the AAMC obtained from SSA the routine service costs of the 6077 hospitals used to determine the group limits. Data on the 6077 hospitals were coded and a series of descriptive statistics were calculated on each group. Attachment II provides the following routine

service cost data on each of the 68 hospital groupings:

1. group number and descriptive information regarding the classification dimensions (state code, metropolitan designation and bed size);
2. mean routine service cost;
3. standard deviation;
4. coefficient of variation;[3]
5. skewness;[4]
6. kurtosis;[5]
7. minimum;
8. maximum;
9. median;
10. estimated routine service cost limit;
11. number of hospitals in the cell that exceed the limit;
12. number of hospitals in the group; and
13. percentage of hospitals in the group that exceed the limit.

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[3]The coefficient of variation is a measure of the relative dispersion of a given distribution and is defined as $S/\bar{X}$; i.e., the standard deviation as a proportion of the mean.

[4]A distribution is considered to be skewed where there is a considerably larger number of extreme cases on one side of the distribution than on the other. The formula for skewness is:

$$\text{SKEWNESS} = \frac{\Sigma\,[(X_i - \bar{X})/S]^3}{N}$$

When the result is a positive number, the distribution is skewed to the right (i.e., extremely high scores are further away from the mean than extremely low scores); when the result is negative, the distribution is skewed to the left.

[5]Kurtosis is the measure of the general peakedness of the distribution. The formula for kurtosis is:

$$\text{KURTOSIS} = \frac{\Sigma\,[X_i - \bar{X}/S]^3 - 3}{N}$$

Positive values indicate leptokurtosis (i.e., more peaked in the middle than the normal distribution), and negative values indicate platykurtosis.

Data presented in Attachment II are unadjusted; that is, they differ from those reflected in the proposed regulations in that they were not "brought up to date" through an inflation correction (see footnote number 2 for an explanation of this method). This does not effect the validity of the analysis presented here as the inflation adjustment is a linear transformation (relationships between the data remain the same, only absolute values change).

At the very minimum, if the classification system employed in the proposed regulation is efficient (i.e., the necessary conditions are met), group statistics on per diem routine service costs should demonstrate the following two characteristics. First, the distributions should be symmetrical and fairly similar. Per diem routine service costs in the individual groups should not be "bunched" at either the high or low end of the scale. Second, the group distributions should be relatively homogenous and the variability of the individual groups should be less than the variability of the 6077 ungrouped hospitals.

Data presented in Table 1 indicate that the distribution of per diem routine service costs in the groups established by the SSA methodology are highly dissimilar and many groups are extremely unsymmetrical. Fully 45 of the 68 groups (66.2 percent) are positively skewed thus indicating that hospitals with high routine service costs per diem are further away from the mean than hospitals with low costs. Additionally, positive skewness indicates that the group median is less than the mean. In groups that are positively skewed (the majority of cases) the established cost limit is deflated due to the fact that 10 percent of the median (rather than the higher mean) is employed to establish the group limits.

Tables 2 and 3 present the SSA hospital groupings in terms of their standard deviations and kurtosis. As can be seen in Table 2, the standard

Table 1

Skewness	Number of Groups
over + 2.00	10
+ 1.51 to + 2.00	8
+ 1.10 to + 1.50	10
+ 0.51 to + 1.00	17
- 0.50 to + 0.50	19
- 0.51 to - 1.00	1
- 1.10 to - 1.50	1
- 1.51 to - 2.00	0
over - 2.00	0
Total	66

deviations (variation) of the groups are highly heterogenous; as indicated in Attachment II, they vary from a low of 6.70 to a high of 34.22. The standard deviation of the ungrouped per diem routine service costs for the 6077 hospitals is 15.47. If the classification scheme is efficient one would expect that the standard deviations of the individual hospital groups to be significantly less than this figure. As can be noted in the Table this is not the case. Fully 21 groups (32 percent of the total) have standard deviations that exceed the per diem routine service cost standard deviation of the ungrouped hospitals. Table 3 demonstrates that the SSA groupings are highly dissimilar with respect to the peakedness of the per diem routine service cost distributions. The groups range from being extremely peaked (a positive kurtosis value) to relatively flat (a negative kurtosis value). As can be seen in Attachment II the kurtosis of the groups range from a low of - 0.79 to a high of 88.95.

Table 2

Standard Deviation	Number of Groups
over 25.0	3
20.1 to 25.0	3
15.5 to 20.0	15
15.4 to 10.0	23
less than 10.0	22
Total	66

Table 3

Kurtosis	Number of Groups
over 20.0	6
15.1 to 20.0	2
10.1 to 15.0	2
5.1 to 10.0	6
0 to 5.0	37
less than 0	13
Total	66

As is noted by the discussion above: (1) the classification scheme fails to reduce the per diem routine service cost variability of the total group of 6077 hospitals; (2) the variability of the groups are highly heterogenous; (3) the skewnesses of the groups are extremely dissimilar; and (4) the peakedness of the groups vary considerably. The distributional properties of the individual hospital groups are so extremely diverse as

to lend credence to the hypothesis that the classification scheme employed in the proposed regulations is not any more efficient in grouping similar hospitals than a classification scheme based upon random and/or arbitrary assignments.

One final point deserves emphasis before concluding this critique of the classification and cost limitation methodology embodied in the proposed regulations. The adequacy of the data upon which the limitations are developed appears to be questionable. Even a hasty perusal of Attachment III leads one to question the data's accuracy. For example, in group A01, a 54 bed hospital is reported to have a per diem routine service cost of $343.96; a totally unbelievable figure. In the same group another hospital reports $25.93--thus, this group has a per diem service cost range of $318.03! This is not an isolated situation as other groups demonstrate equally radical ranges. It appears that the adequacy of the data upon which the group limits are based needs to be seriously reevaluated.

Conclusions

A sizeable body of health economic research has demonstrated that hospital costs are a function of a variety of factors including: (1) the scope of services offered;[6] (2) the nature of the services offered;[7] (3) the type and number of diagnostic and treatment facilities provided;[8] (4) characteristics of a hospital's output;[9] and (5) patient mix.[10]

[6]John Carr and Paul Feldstein, "The Relationship of Cost to Hospital Size," Inquiry (March, 1967), pp. 45-65.

[7]Edgar Francisco, "Analysis of Cost Variations Among Short Term General Hospitals," in Herbert Klarman (ed.), Empirical Studies in Health Economics (Baltimore; The Johns Hopkins University Press, 1970), pp. 321-332.

[8]Ralph E. Berry, Jr., "Returns to Scale in the Production of Hospital Services," Health Services Research (Summer, 1967), pp. 123-139.

[9]Harold Cohen, "Hospital Cost Curves with Emphasis on Measuring Patient Care Output," in Herbert Klarman (ed.), Empirical Studies in Health Economics (Baltimore; The Johns Hopkins University Press, 1970), pp. 279-293.

[10]Martin Feldstein, Econometric Analysis for Health Services Efficiency (Amsterdam, Holland: North-Holland Publishing Company, 1968).

While the aforementioned factors have been found to influence aggregate per diem hospital costs, a study by Ingbar and Taylor focused specifically on explaining the variation of routine service costs.[11] They found the following factors important: (1) the extent to which physician services are provided directly by the hospital; (2) occupancy rate of the facility; (3) radiological activity; (4) surgical activity; and (5) scale. The radiological and surgical activity variables are aggregations of many factors (obtained through factor analytic techniques), that are viewed as proxy measures for case mix complexion and complexity. The authors note that complexity proxy and utilization variables (as quantified by the occupancy rate) explain the greatest proportion of the variability in per diem routine service costs. Such costs vary directly with case complexity and inversely with occupancy rate, as would be expected. That is, hospitals providing a large volume of complex services and/or having a low occupancy rate would be expected to experience a higher per diem routine service cost than hospitals having a high occupancy rate and providing relatively few complex services.

The House and Senate Committee reports attached to Section 223 of P.L. 92-603 are cognizant of the fact that variation in routine service costs per diem are due to both legitimate (i.e., nature of the facilities provided and patient mix) and illigitimate (i.e., inefficiencies and the provision of unnecessary services) factors. The former factors must be accounted for if the latter factors are to be controlled. By not taking into account the product differences of hospitals in developing groups within which certain costs are limited,the proposed regulations have the capacity to deny reimbursement for incurred costs that are, in every way, reasonable.

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[11]Mary Ingbar and Lester Taylor, Hospital Costs in Massachusetts (Cambridge, Mass.: Harvard University Press, 1968).

Analyses presented here question the effectiveness and efficiency of the classification methodology employed in the proposed regulations. The design of the classification scheme per se was shown to have several inherent and significant deficiencies. Empirical analyses of statistical properties of the formulated groups demonstrated that their distributional properties were so diverse as to lend support to the assertion that the proposed classification scheme is no more efficient in grouping similar hospitals than random and/or arbitrary assignments. Additionally, evidence was forwarded that seriously questions the accuracy and adequacy of the per diem routine service cost data.

In proposing regulations to implement Section 223 of P.L. 92-603 the Social Security Administration has designed an overly simplistic mechanism frought with inherent inadequacies to address one of the most complex problems in the health services industry--the design of a taxonomy of hospitals. This paper has presented analyses that seriously question the effectiveness and efficiency of the proposed regulations. Based upon this paper the AAMC believes that if the regulations are implemented as proposed costs will be arbitrarily denied that are in every way reasonable. The Association suggests that before regulations are finally published the inadequacies of the methodology delineated in this paper should be addressed and subsequently refuted or corrected.

ATTACHMENT I

SPECIFICATION OF ROUTINE SERVICE COST REIMBURSEMENT GROUPINGS

Group Number	State Code	Metropolitan Designation	Bed Size
A01	I	SMSA	<54
A02	I	SMSA	55-99
A03	I	SMSA	100-169
A04	I	SMSA	170-264
A06	I	SMSA	404-684
A36	I	NSMSA	<54
A37	I	NSMSA	55-99
A38	I	NSMSA	100-169
A39	I	NSMSA	170-264
A40			265-403
A41	I	NSMSA	404-684
A42			>685
001	I	SMSA	<54
002	I	SMSA	55-99
003	I	SMSA	100-169
004	I	SMSA	170-264
005	I	SMSA	265-403
006	I	SMSA	404-684
007	I	SMSA	>685
008	II	SMSA	<54
009	II	SMSA	55-99
010	II	SMSA	100-169
011	II	SMSA	170-264
012	II	SMSA	265-403
013	II	SMSA	404-684
014	II	SMSA	>685
015	III	SMSA	<54
016	III	SMSA	55-99
017	III	SMSA	100-169
018	III	SMSA	170-264
019	III	SMSA	265-403
020	III	SMSA	404-684
021			>685
022	IV	SMSA	<54
023	IV	SMSA	55-99
024	IV	SMSA	100-169
025	IV	SMSA	170-264
026	IV	SMSA	264-403
027	IV	SMSA	404-684
028			>685
029	V	SMSA	<54
030	V	SMSA	55-99
031	V	SMSA	100-169

032	V	SMSA	170-264
033	V	SMSA	265-403
034	V	SMSA	404-684
035			>685
036	I	NSMSA	<54
037	I	NSMSA	55-99
038	I	NSMSA	100-169
039	I	NSMSA	170-264
040			265-403
041	I	NSMSA	404-684
042			>685
043	II	NSMSA	<54
044	II	NSMSA	55-99
045	II	NSMSA	100-169
046	II	NSMSA	170-264
047			265-403
048	II	NSMSA	404-684
049			>685
050	III	NSMSA	<54
051	III	NSMSA	55-99
052	III	NSMSA	100-169
053	III	NSMSA	170-264
054			265-403
055	III	NSMSA	404-684
056			>685
057	IV	NSMSA	<54
058	IV	NSMSA	55-99
059	IV	NSMSA	100-169
060	IV	NSMSA	170-264
061			265-403
062	IV	NSMSA	404-684
063			>685
064	V	NSMSA	<54
065	V	NSMSA	55-99
066	V	NSMSA	100-169
067	V	NSMSA	170-264
068			265-403
069	V	NSMSA	404-684
070			>685

ATTACHMENT II

SECTION 223, P.L. 92-603: CLASSIFICATION ANALYSIS

Group Number	State Code	Metro Desig	Bed Size	Mean	S.D.	C.V.	Skewness	Kurtosis	Min.	Max.	Median	Estimated Limit	# of Outlyers	# in Cell	% out of Limits
A01	I	SMSA	<54	72.05	34.22	0.47	4.97	34.51	25.93	343.96	66.03	121.88	5	115	4.34
A02	I	SMSA	55-99												
A03	I	SMSA	100-169	66.44	21.01	0.32	3.10	19.68	31.48	229.14	62.28	99.56	8	175	4.57
A04	I	SMSA	170-264	67.79	16.43	0.24	0.55	0.29	30.93	118.68	65.14	95.33	12	182	6.59
A06	I	SMSA	404-684	74.63	18.58	0.25	0.22	0.36	41.81	118.87	74.77	105.68	4	80	5.00
A36	I	NSMSA	<54	59.45	19.03	0.32	1.56	5.18	31.18	159.86	56.45	89.45	7	130	5.38
A37	I	NSMSA	55-99	54.00	15.12	0.28	0.52	0.40	28.41	97.70	50.43	78.39	6	106	5.66
A38	I	NSMSA	100-169	55.36	15.68	0.28	1.37	1.27	36.39	106.04	50.20	80.45	6	72	8.33
A39	I	NSMSA	170-264	52.22	9.78	0.19	0.47	0.29	34.75	73.74	52.11	69.94	4	39	10.25
A40, A41, A42	I	NSMSA	265-685+	53.99	7.88	0.15	0.40	0.82	41.98	69.00	52.15	69.28	0	15	0.00
01	I	SMSA	<54	71.96	34.10	0.47	4.93	34.40	25.93	343.96	66.03	122.21	4	117	3.41
02	I	SMSA	55-99												
03	I	SMSA	100-169	66.29	20.90	0.30	3.11	19.86	31.48	229.14	62.15	98.22	10	178	5.62
04	I	SMSA	170-264	67.64	16.40	0.24	0.57	0.04	30.93	118.68	64.97	95.12	12	184	6.52
05	I	SMSA	265-403	64.79	15.22	0.23	1.23	3.42	37.66	138.10	62.20	90.49	9	150	6.00
06	I	SMSA	404-684	74.48	18.51	0.24	0.24	-0.34	41.81	118.87	74.45	105.61	4	81	4.94
07	I	SMSA	>685	87.22	18.23	0.21	-0.61	-0.22	41.07	114.63	90.15	119.56	0	28	0.00
08	II	SMSA	<54	54.11	14.51	0.27	1.94	6.35	32.53	117.83	52.81	77.96	2	46	4.34
09	II	SMSA	55-99	56.22	17.24	0.31	1.46	5.20	21.75	139.54	53.90	83.67	5	82	6.09
10	II	SMSA	100-169	54.95	12.89	0.23	0.49	0.34	28.15	98.26	53.29	76.76	5	111	4.50
11	II	SMSA	170-264	58.88	13.07	0.22	0.52	0.56	33.90	104.11	58.61	81.41	10	156	6.41
12	II	SMSA	265-403	60.13	14.32	0.24	0.86	1.09	36.39	115.34	58.44	84.29	8	111	7.20
13	II	SMSA	404-684	62.31	16.28	0.26	1.45	2.47	40.24	122.66	58.96	89.03	5	74	6.75
14	II	SMSA	>685	74.35	19.67	0.27	0.19	-0.85	41.18	112.96	75.38	107.05	1	21	4.76
15	III	SMSA	<54	53.26	21.60	0.40	1.34	1.91	14.19	129.65	45.71	85.47	5	59	8.47
16	III	SMSA	55-99	52.12	11.35	0.22	0.90	0.57	36.34	81.45	49.15	71.55	5	55	9.01
17	III	SMSA	100-169	53.76	12.65	0.24	0.40	1.81	6.86	90.00	53.44	75.29	3	85	3.53
18	III	SMSA	170-264	56.66	18.70	0.33	3.67	21.72	31.57	183.00	53.98	85.98	5	89	5.61
19	III	SMSA	265-403	55.11	11.17	0.20	1.03	4.09	31.78	105.60	55.41	79.94	2	88	2.27
20, 21	III	SMSA	404-684+	54.84	13.58	0.25	0.52	0.72	18.38	98.28	52.90	77.51	4	80	5.00
22	IV	SMSA	<54	45.75	12.22	0.28	1.92	7.38	27.51	108.81	43.70	65.76	3	81	3.70
23	IV	SMSA	55-99	46.62	13.76	0.30	1.61	3.94	25.00	101.59	44.19	68.64	3	48	6.25
24	IV	SMSA	100-169	49.34	8.98	0.18	0.35	0.54	26.16	73.03	48.85	65.71	3	54	5.55
25	IV	SMSA	170-264	48.73	9.23	0.19	0.65	-0.34	34.63	70.91	46.57	65.19	4	54	7.40
26	IV	SMSA	265-403	48.13	9.34	0.19	0.28	-0.69	31.36	68.55	46.73	64.75	1	39	2.56
27, 28	IV	SMSA	404-685+	53.52	7.86	0.14	-0.37	-0.70	37.57	70.28	55.88	69.16	1	38	2.63
29	V	SMSA	<54	44.59	10.47	0.23	1.53	1.89	34.03	75.91	41.14	62.10	2	29	6.89
30	V	SMSA	55-99	44.66	8.89	0.19	0.99	0.56	32.36	67.62	42.95	60.33	2	25	8.00
31	V	SMSA	100-169	43.35	9.35	0.21	-0.06	0.14	23.12	65.84	42.28	59.53	1	32	3.12
32	V	SMSA	170-264	46.40	10.77	0.23	0.12	0.19	21.16	72.16	45.65	64.74	2	38	5.26
33	V	SMSA	265-403	46.63	8.47	0.18	0.65	-0.04	30.55	65.69	46.07	62.07	4	40	10.00
34, 35	V	SMSA	404-685+	48.10	9.14	0.19	0.90	1.23	32.02	76.81	47.37	64.52	1	34	2.94
36	I	NSMSA	<54	63.08	28.39	0.45	4.02	26.91	31.18	289.89	57.33	105.19	7	148	4.73
37	I	NSMSA	55-99	55.55	18.06	0.34	1.92	7.94	28.41	161.21	51.28	84.55	5	109	4.58
38	I	NSMSA	100-169	56.14	15.75	0.28	1.22	0.85	36.39	106.04	51.07	81.40	8	76	10.52
39	I	NSMSA	170-264	52.22	9.78	0.19	0.47	-0.29	34.75	73.74	52.17	69.40	4	39	10.25
40, 41, 42	I	NSMSA	265-685+	53.73	7.68	0.14	0.49	-0.69	41.98	69.00	51.50	68.71	1	16	6.25
43	II	NSMSA	<54	51.33	15.95	0.31	1.22	1.27	29.54	103.21	48.11	76.55	9	105	8.57
44	II	NSMSA	55-99	48.45	12.29	0.25	0.54	-0.17	23.53	81.66	45.85	68.76	10	116	8.62
45	II	NSMSA	100-169	50.14	11.20	0.22	0.29	-0.79	27.99	74.15	48.63	69.33	5	79	6.32
46	II	NSMSA	170-264	49.10	11.09	0.22	0.64	0.51	26.36	82.76	47.52	68.04	2	55	3.63

Group Number	State Code	Metro Desig	Bec Size	Mean	S.D.	C.V.	Skewness	Kurtosis	Min.	Max.	Median	Estimated Limit	# of Outlyers	# in Cell	% out of Limits
47, 48, 49	II	NSMSA	265-685+	43.02	8.38	0.19	-1.15	2.38	18.84	56.59	43.09	58.04	0	17	0.00
50	III	NSMSA	<54	42.51	12.57	0.29	3.94	33.50	18.60	171.95	40.22	62.61	23	540	4.26
51	III	NSMSA	55-99	42.53	14.88	0.35	7.27	88.95	11.91	231.90	41.00	65.67	5	291	1.71
52	III	NSMSA	100-169	44.91	8.98	0.20	0.05	0.51	19.35	69.62	45.09	60.90	7	134	5.22
53	III	NSMSA	170-264	46.25	10.02	0.21	1.50	4.75	29.25	87.75	46.36	63.70	2	50	4.00
54, 55, 56	III	NSMSA	265-685+	49.23	9.24	0.18	0.55	0.20	32.65	75.48	48.05	65.85	2	45	4.44
57	IV	NSMSA	<54	41.94	11.61	0.28	1.55	5.71	15.00	123.52	39.90	60.79	36	523	6.88
58	IV	NSMSA	55-99	42.09	7.95	0.19	0.11	-0.35	22.38	60.15	41.88	56.44	8	178	4.64
59	IV	NSMSA	100-169	43.87	9.05	0.20	0.91	0.40	27.76	70.69	41.65	59.61	10	124	8.06
60	IV	NSMSA	170-264	43.42	8.53	0.19	-0.17	-0.51	23.26	59.28	42.75	58.30	1	35	2.85
61, 62, 63	IV	NSMSA	265-685+	47.85	12.87	0.27	1.62	2.89	33.73	87.57	46.81	69.00	1	19	5.20
64	V	NSMSA	<54	38.55	11.14	0.29	2.15	8.87	19.20	111.85	37.26	56.52	18	354	5.08
65	V	NSMSA	55-99	37.38	8.47	0.23	0.85	1.55	17.99	65.96	36.60	51.88	13	217	5.99
66	V	NSMSA	100-169	38.34	7.19	0.18	0.21	0.61	19.52	58.55	37.86	51.32	7	111	6.31
67	V	NSMSA	170-264	41.72	9.04	0.22	1.49	2.11	29.48	68.75	38.80	57.17	3	42	7.14
68, 69, 70	V	NSMSA	265-685+	38.22	6.70	0.18	0.82	2.72	26.67	58.27	38.53	50.64	6	22	27.27

ATTACHMENT III

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

April 18, 1974

James B. Cardwell
Commissioner of Social Security
Department of Health, Education
and Welfare
Fourth and Independence Avenue
Washington, D.C. 20201

Dear Commissioner Cardwell:

On behalf of the nation's academic medical centers and particularly the 400 teaching facilities comprising the Council of Teaching Hospitals of the Association of American Medical Colleges, please find herein comments on proposed regulations seeking to implement Section 223 of P.L. 92-603. These proposed regulations were published in the Federal Register (Volume 39, Number 54, pp. 10260-10262 and 10313-10315) on March 19, 1974. The Association is concerned about the regulations as published from four interrelated perspectives: (1) the appropriateness of the methodology employed to group hospitals and the degree to which such a methodology reflects the intent of Congress in enacting the Section; (2) the comparability of the type of costs on which the regulations seek to limit across various groups of hospitals; (3) specific instances where the wording of the proposed regulations mandates actions not provided for in either the legislation itself or the legislative committee report; and (4) the lack of clarity of the exceptions review process.

Grouping Methodology

The Association is aware of Congressional desires to establish limitations on the coverage of costs under the Medicare program and its intent that such limitations should be established through the grouping of similar institutions. However, the Association believes that methodology employed by the proposed regulations to group hospitals does not fulfill the intent of the legislation, does not create groups of hospitals that are similar and thereby seeks to implement a mechanism that would deny incurred costs that are in every way reasonable. As such the proposed regulations are arbitrary; they are particularly onerous to teaching hospitals which provide services to patients with complex and often complicated conditions through a highly sophisticated production process.

Section 1861 (v)(i)(a) of the Social Security Act, as amended, states that "the reasonable cost of any services shall be the cost

actually incurred, excluding therefrom any part of the incurred cost found to be unnecessary in the efficient delivery of needed health services . . ." The language of the law notes that such reasonable costs should be determined for "various types or classes of institutions." In elaborating the factors that influence the variation in costs between types of institutions the Senate Finance Committee Report on H.R. 1 (P.L. 92-603) addressing "Limitations on the Coverage of Cost Under Medicare" observes that:

> "The Committee is mindful of the fact that costs can and do vary from one institution to another as a result of differences in size, in the nature and scope of the services provided, the type of patients treated, the location of the institution and various other factors affecting the efficient delivery of needed health services." (emphasis added)

The methodology employed in the proposed regulations neither encompass nor accounts for the "nature and scope of the services provided" or the "types of patients treated", that are known to influence the cost that the legislation seeks to limit. By not taking account of these factors the proposed regulations do not fairly meet the objective of the Section as delineated in the committee reports. As a result, incurred costs may be disallowed that are in every respect reasonable.

Both the House and Senate committee reports on Section 223 assume and, indeed, studies in health economics have confirmed that hospitals cannot be appropriately categorized by relying solely on the criteria of: (1) aggregated per capita income by state; (2) geographically related metropolitan designation (i.e., located in an SMSA, not located in an SMSA); and (3) scale of operation as quantified by adult and pediatric bed capacity. Mary Ingbar and Lester Taylor in their book entitled Hospital Costs in Massachusetts: An Econometric Study found that the following factors significantly influenced the variation in average daily routine service costs among short-term general hospitals in one state: (1) proxy variables that reflect the case complexity of the facility; (2) the extent to which physician services are provided directly by the hospital; (3) utilization as quantified by occupancy rate, and (4) scale. Other than for scale, the methodology employed in the proposed regulations for designating hospital groups in no way considers the impact of these variables upon costs.

Although the presently proposed regulations seek only to limit Medicare reimbursement with respect to routine service costs, the committee reports state that a developed grouping methodology and associated limits could be applied to overall cost per diem. Even if the proposed methodology was effective in grouping similar hospitals with regard to the manner in which they provide routine services (and

the Association contends that even this is not the case) the methodology would not of necessity be effective in equitably limiting broader aggregations of hospital costs. A host of health econometric research has demonstrated that aggregate costs per diem are influenced by such diverse factors as: (1) the scope of services offered; (2) the nature of services offered; (3) the type and number of diagnostic facilities provided; (4) characteristics of a hospital's output; and (5) patient mix.

Based on these considerations the Association contends that deviations from the cost limits established through the categorization methodology employed in the proposed regulations will be due more to product differences of hospitals than the extent of inefficiencies or the degree to which unnecessary or luxury services are provided. IT IS COSTS ASSOCIATED WITH THE LATTER FACTORS, NOT THE FORMER, THAT THE REGULATIONS SEEK TO CONTROL AND/OR ELIMINATE. The House and Senate committee reports state that ". . . the precision of the limits determined from these data will vary with the degree to which excessive costs can be distinguished from the provision of higher quality or intensity of care." This distinction is not made by the methodology for classifying hospitals incorporated in the proposed regulations. This is a serious and fundamental difficulty that will prove particularly onerous for those hospitals that provide sophisticated services and whose volume is comprised of a large proportion of patients having complex, multiple and/or compounded conditions.

Under separate cover at a later date the Association will forward an analysis of data employed to construct the hospital groupings from information supplied to the AAMC by the Social Security Administration. The Association requested data employed by the SSA to construct the groupings in letters to Robert O'Connor and John Jansak of the Bureau of Health Insurance, dated December 21, 1973 and February 26, 1974 respectively. Our request was approved in a letter dated March 28, and a check was forwarded to pay for reproduction costs on April 3. We have not, as yet, taken physical possession of the data thus preparation of the analysis has been delayed.

Routine Service Costs

The regulations proposing to implement Section 223 of P.L. 92-603 seek to establish limits on the per diem routine service costs of similar hospitals. However, the routine service costs of hospitals are not comparable as presented in the Medicare Cost Report. That is, routine service costs do not reflect comparable expenses across different hospitals because: (1) hospitals produce routine service products that vary in both nature and scope; this variation is related to reasonable differences in costs; and (2) hospitals vary in the accumulation of costs they experience in the production of routine services.

As an example of the first point one may note that some hospitals participate in providing educational experiences in health sciences (medicine, nursing, etc) while other hospitals provide no clinical training. There is great variability in the presence of special care facilities (neonatal, intensive and cardiac care units for example). The presence or absence of both educational programs and special care units are product differences of hospitals--such differences are related to legitimate differences in routine service costs. Second, hospitals accumulate costs to routine services differently. For example, hospitals are highly variable with regard to the amount of depreciation expense encountered, the volume of interest charges, and the number of full time physicians on the payroll. Given the way in which routine service costs are defined, the regulations seek to group and then limit units that are not comparable. Variations in the amount of routine service cost among "similar institutions" included in a particular grouping may not be due so much to the presence of inefficiencies and the provision of unnecessary services. But rather it may be due to legitimate variations in the types of costs which are incurred to produce the routine service product.

Exceeding Legislative Intent: Approval of Excess Charges

Section 405.461(a) of the proposed regulations state that a provider can charge for items of service that exceed the established limitations only if ". . . (1) the intermediary has approved such charges . . ." This provision has no foundation in the legislation as enacted or in the House Ways and Means and the Senate Finance Committees' reports. The Senate Report (p. 189, para. 4) notes that:

> "For other than emergency care, providers will be permitted to collect costs in excess of Medicare ceilings ... where these costs flow from items or services substantially in excess of or more expensive than those necessary for the effective delivery of needed services, provided all patients are so charged and the beneficiary is informed of his liability in advance." (emphasis added)

Nowhere is mention made of the constraint that the intermediary must approve such charges. The provision contained in Section 405.461(a)(1) goes beyond the intent of the legislation and should be struck from the regulations.

Exceptions Review Process

Section 405.460(f)(1)-(4) of the proposed regulations delineate reclassifications, exceptions, and exemptions to the established groupings and the specific cost limitations. With regard to this Section the Association has several specific concerns. First, the delineation of cri-

teria that will be employed to review exception requests are at best vague and at the worst non-existant. Second, individual providers seeking an exception under 405.460(f)(2) must be intimately familiar with the product and production process characteristics of other hospitals contained in its group in order to determine and document whether " ... items or services ... are atypical to the services generally provided by institutions similarly classified ..." The Social Security Administration has been unwilling to disclose the identity of hospitals in specific groups and has been able to characterize hospitals in such groups on only the crudest variables. The question becomes: how can the requirements of Section 405.460(f)(2) be met so that an exception could be obtained?

The proposed regulations at 405.460(4) delegate to the intermediary determinations of eligibility for exceptions. The Association objects to the provision on the grounds that the intermediary is not involved in making initial determinations of classifications, groupings or limits, and, thus would be in no position to grant exceptions to them. Additionally, since the hospitals in any given group are geographically dispersed (many, if not most, facilities would be located outside of the intermediaries' area) exception requests under Section 405.460(f)(2) would be difficult if not impossible to evaluate. It is essential that all appeals from the classifications as well as appeals for exemptions or exceptions be processed by the Bureau of Health Insurance which has the authority to effect the required changes and has, at least, the potential to coordinate inter-area comparisons of geographically dispersed hospitals included in the same group.

The Association has substantial reservations regarding the proposed regulations and the serious effects that they will have on the viability of the teaching-tertiary care hospitals which are unique and critical institutions in the health system of the nation. I hope that you will find our comments helpful in considering modifications to the regulations. The Association stands ready to discuss our views further if you desire.

Sincerely yours,

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

REPORT OF THE

AD HOC COMMITTEE TO REVIEW JCAH STANDARDS

June, 1974

Ad Hoc Committee to Review JCAH Manual

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I. INTRODUCTION

It is the purpose of this paper to review the accreditation standards and processes of the Joint Commission on the Accreditation of Hospitals in order to assess ways by which the Commission can contribute to increasing the effectiveness and efficiency of the teaching hospital. The Council of Teaching Hospitals has approached this study with the hope that it will be of assistance to both the membership and the Commission.

Too often in the past the teaching hospital has had a measured involvement in the Joint Commission's accreditation process. It is not the purpose of this document to categorize the reasons for this reserve. However, this may reflect the orientation of the teaching hospital toward education with the following set of assumptions: quality of delivery of service is fundamental to quality education in the health professions; if excellence is achieved in the education programs, then the delivery of care must also be satisfactory. No matter what the source of the reserve between JCAH and the teaching hospital, it is time for change.

A posture other than earnest compliance is not appropriate for the teaching hospital or any other institution in today's public climate. Stature as teaching hospitals should heighten the awareness of the processes of accountability that have multiplied with profusion in the last few years. Higher costs, longer lengths of stay, and the absence of documented quality of care assurance programs need to be explained and revised as appropriate. Insofar as no participant in the delivery of health care today is beyond scrutiny, the teaching hospital must scrupulously observe the procedures of public accountability not only to the letter, but with the fullest possible spirit of compliance.

Given this perspective, this paper seeks to identify accreditation-related problems shared by many teaching hospitals. Delineating such concerns for a group as broad and various as the nation's teaching hospitals is an exercise in approximation. As such, this is a subjective document, based on the judgements of committee members regarding shared problems. The committee reviewed the accreditation reports of six university-owned teaching hospitals, surveyed the membership of COTH for opinions regarding the revision of JCAH standards and searched the literature for what has been published already about the possibilities and limitations of the JCAH.

The response is intended, in part, to be an enunciation of the unique characteristics, special needs and particular problems faced by teaching hospitals with respect to the standards and procedures of the accreditation process. In another respect this report is a modest effort to present to the COTH constituency a statement of unfinished business before the nation's teaching hospitals.

II. EXISTING SITUATION

In an attempt to more rigorously delineate relational problems between the JCAH and teaching hospitals, the committee undertook the following analyses: (A) a review of the accreditation reports of six teaching hospitals surveyed in the last year; (b) a compilation of observations solicited from COTH members, and (C) a literature search. The results of these efforts are summarized below.

A. Accreditation Reports

Comparison of the JCAH survey reports of six university-owned teaching hospitals revealed several areas of common problems.* Despite the different styles of survey teams, clear patterns are present in their findings.

The problem most consistently encountered related to governance. In the reports where ranking is used as a tool by JCAH to indicate urgency or severity, governance related issues were rated as most important. Recommendations on governance emphasized the following:

- There must be bylaws on the governing body for teaching hospitals. The bylaws should be regularly reviewed, revised and dated.
- The governing body must delineate the responsibilities of the chief administrative officer, the medical staff and the governing body.
- The governing body must meet regularly and have representation from the community.
- The governing body must review the procedures of the medical staff for evaluating the quality of care and must have procedures for assuring due process in medical staff appointments and privileges.

* All surveys took place within the last year; five of the institutions were granted full two-year accreditation, one received conditional approval for twelve months.

Issues related to organization of the medical staff also dominate these particular accreditation reports. Comments focus upon procedures for organization of the medical staff and documentation of appropriate execution of its responsibilities. Among the more prevalent recommendations are these:

- Medical staff bylaws must provide due process protection for action on medical staff appointments and privileges.
- Medical staff must develop clinical criteria for use in medical care evaluation.
- Findings of medical care evaluation studies must be reflected in delineation of clinical privileges and in medical staff programs for continuing education.
- Minutes of clinical department meetings must document evaluation studies and related decisions for improvement of care.

Remaining sections of the survey reports deal with a variety of services that share a similar set of problems. The services most frequently mentioned include nursing services, emergency services and special care units. The problems most consistently identified appear to be two-fold:

- Absence of a written organizational plan for the service.
- Insufficient evidence of a program for evaluation of services with findings reflected in in-service education programs.

This brief summary of these particular JCAH accreditation reports is not exhaustive. It notes only those recommendations found consistently in the six survey reports. This pattern does not indicate whether problems lie with the standards of JCAH or with the organization or functional arrangements of teaching hospitals. However, such analysis does not suggest areas of common concern worthy of closer attention by both the Joint Commission and teaching hospitals.

B. COTH Survey of Membership

The Council of Teaching Hospitals distributed a general memorandum to its membership soliciting comments on the revised JCAH standards and the accreditation process. Many thoughtful replies were received. A summary of the points raised in this process appears as Appendix A of this report.

In general, respondents view with approval the shift in JCAH perspective from minimum basic standards to optimal achievable standards. "The movement from 'minimum essential' to 'optimal achievable" standards is commendable and essential for the accreditation program to maintain its position as the national benchmark," writes one administrator, expressing the consensus of teaching hospital response.

A number of themes are consistently identified by respondents as problems with the JCAH accreditation process. Prominent among these are the goverance and medical staff organization issues identified by comparison of the six university-owned teaching hospital survey reports. Other comments point to conflict between the specificity of JCAH requirements and the flexibility required by the teaching hospital to meet its obligations for innovation in the organization of health services and the training of health manpower. However, the overriding criticism expressed by teaching hospitals is concern for the survey process itself.

Governance

The governance structures of the teaching hospital often do not conform to the survey team's interpretation of the JCAH standards. The fact that teaching hospital governance structures differ from those encountered in community hospitals does not, in itself, indicate that the organizational

accountability arrangements of the teaching hospital are inadequate. More importantly, the accreditation process should address whether the essential process is being adequately executed remembering that there are many designs for doing so. One hospital executive perceives the problem as follows:

> The system of governance in university-owned hospitals is completely different from that of the community hospitals for which the standards were apparently designed... This may not be 'right,' and the JCAH may choose to try to change the way Boards of Regents govern their hospitals, but at least the standards should somehow recognize the peculiar systems of governance of university-owned and operated hospitals.

Medical Staff Organization

A number of points of divergence emerge between JCAH and the teaching hospitals related to the dual education and service roles of the teaching hospital medical staff. Comments from COTH members on a few of these differences follow:

1. Appointment of the medical staff and delineation of privileges:

   > Systems of appointemnts of members to the Medical Staff are totally different than procedures used in the community hospitals...most university-owned hospitals require faculty membership as a prerequisite...in most cases appointments are fairly automatic upon recommendation by the head of the clinical department...Somehow the JCAH should approve other methods of appointment and designation of privileges than those normally found in community hospitals.

2. Medical Audit

   > A tertiary-teaching medical center has an intensive, prospective patient care review system conducted in conjunction with its education programs...Should the hospital already doing this be required to develop the same medical auditing system as the non-teaching community hospital?

3. Service responsibilities of housestaff:

   In a teaching setting this delineation of privileges is particularly awkward since attending physicians are required to have privileges delineated, while those in training are not. Does this mean that the Joint Commission openly condones two standards of care -- one for teaching cases and another for non-teaching cases?

Innovation

Several respondents commented on the special needs of the teaching hospital for sufficient flexibility to initiate innovations in the utilization of health manpower and organization for delivery of health services. The teaching hospital has the obligation to pioneer new modes for delivery of health services and more effective, efficient utilization of manpower. Although the revised standards are less specific and, accordingly, permit greater flexibility than before, the obligation of the teaching hospital to innovate on these two important fronts conflicts at times with JCAH requirements.

One hospital director speaks to the changing roles of health professionals in comments on qualifications for medical staff membership: "in a time when allied health professionals are playing increasingly integrated roles in patient care, this question (clinical privileges) needs clarification." Additionally, comments addressed the obligation of the teaching hospital regarding the organization of health services beyond the institution's walls: "The standards (of JCAH) should attempt to reflect the current emphasis on inter and intra-institutional planning." Responsibility of the teaching hospital for health care is no longer confined to the acute care episode. Yet the standards of the Joint Commission do not recognize the needs for integration and coordination of the spectrum of health services.

Survey Process

The theme that occurrs with greatest frequency is disappointment with the visit of the survey team. The standards of the Joint Commission are only as strong as the members of the survey team evaluating whether they are met.

"Let me emphasize, " writes one administrator, "that our greatest concern is not the standards themselves but the quality of the survey process." Reservations about the survey process include such comments as the following:

- Teaching hospitals ought to be evaluated with more complete knowledge of the activities which take place within them.
- The fact remains that it is absolutely essential for the Joint Commission to select teaching hospital physicians to survey teaching hospitals.
- We have often found that the attitude of the physician visitor from the Joint Commission reflects his previous practice experience...If, on the other hand, he was previously a private practitioner not affiliated with a teaching hospital he does not seem to be as effective in attempting to evaluate the various programs in the teaching setting.
- The survey process is not seriously accepted by some institutional providers.
- What has given us some concern is the fact that during the survey the issues discussed at the summary session with the surveyors bore only a limited relationship to the written report of suggestions that were later mailed to our hospital.

C. Review of the Literature

The literature search was remarkable only in that it produced a paucity of published papers. The referenced articles appeared to fall into two groupings. (An annotated bibliography of literature reviewed is included in Appendix B.) Following the flurry of articles by Joint Commission staff in 1971, few articles appear until 1973. Of the several articles published

in the last year and one-half, most are authored by lawyers. They are concerned with recent court decisions using the standards of the Joint Commission in establishing the responsibility of the governing boards and the organized medical staff for the behavior of the individual physician. The unique features of the teaching hospital as related to the accreditation process received no attention in the literature, thus the search provided little assistance to the Committee.

III. FINDINGS AND RECOMMENDATIONS

The Committee's effort to learn more about the quality of the relationship between JCAH and the teaching hospital identified four significant problem areas: governance issues, medical staff organization issues, issues related to responsibility of the teaching hospital for innovation, and issues related to the quality of the survey process.

The following outline summarizes the findings and recommendations of the Committee within each problem area. These findings and recommendations are forwarded to: (1) propose some objectives for the teaching hospital; and (2) review and suggest ways in which the Joint Commission could assist in moving forward with this program.

A. Governance

Adequate fulfillment of governance/accountability functions are as important to the teaching hospital as to any other hospital. However, teaching hospitals, particularly those that are university-owned, have special problems conforming to JCAH governance standards.

- In many instances the teaching hospital governing board is a university-wide Board of Regents.
- The university Board of Regents often does not perform well the important roles of governing boards of hospitals. Boards of Regents have multiple responsibilities for the university as a whole that do not permit careful attention to the affairs of hospital governance. Among the necessary governance responsibilities that Boards of Regents are not adequately prepared to handle are issues of quality of care assurance, guaranteeing appropriate procedures for appointment to the medical staff and assignment of privileges.

Since 1971 both JCAH and the courts have focused on the necessity of hospital governing boards having a demonstrated capability for public

accountability. As with any corporate organization, the governing board of the hospital holds ultimate responsibility for the conduct of the institution. Charles Jacobs, attorney for the Joint Commission, outlined the compelling social, judicial and legislative mandates for trustee accountability in remarks presented to the Board of Regents, University of Minnesota, which is included as Appendix C. In the judgement of the Committee, adequate fulfillment of governance responsibilities for public accountability is as vital to the teaching hospital as to any other hospital.

For many teaching hospitals, particularly university-owned teaching hospitals, adequate fulfillment of the procedures of accountability will require change. In circumstances where the Board of Regents of the university serve a dual role as trustees of the teaching hospital, it may not be realistic to expect the governing board to perform the vital responsibilities demanded of governance today. In order that the processes of accountability are adequately carried out, alternative, clearly defined arrangements for governance will have to be explored.

The teaching hospital has responsibility to see that governance functions are adequately carried out either through the traditional governing board or through alternative arrangements.

In application of the JCAH standards for governance to the teaching hospital, the Joint Commission must recognize that often the teaching hospital will not conform to the customary governance design of the community hospital. The Committee recommends that the Joint Commission look beyond the governance format for evidence that the essential processes of governance are being adequately carried out; it is the adequacy of the process rather than its design that must be evaluated. This recommendation

does not take issue with the standards of the Joint Commission but with present practices for implementation.

B. Medical Staff Organization

The structure of the organized medical staff of the teaching hospital does not always conform to the standards of the Joint Commission in several respects. The differences relate to the dual education and service roles of the teaching hospital.

- There is inadequate distinction between medical staff and medical faculty qualifications in processes for appointment to the medical staff and assignment of privileges. Generally, appointment to the faculty automatically carries with it medical staff privileges.

- The present array of quality of care activities integral to the teaching process do not meet the requirements of the JCAH for a coordinated quality assurance program capable of generating patient profiles, physician profiles and disease specific profiles of care. Analysis of aggregate data, based on objective, specified criteria documenting patterns of care has been achieved by few, if any, teaching hospitals.

- The teaching hospital may not have the effective organizational structure essential to decision-making on important institution-wide delivery of care objectives. A functioning quality assurance program, the provision of responsive ambulatory services, and other pressing public policy issues in the delivery of health care often are not of high priority to the separate clinical departments and do not receive the attention they require.

- Housestaff hold significant service responsibilities that are not subject to the rules and regulations that govern the medical staff.

The findings of the Committee on issues of medical staff organization indicate ambiguity between the education and service responsibilities of the medical staff. As the teaching hospital is challenged to respond to important patient care objectives that do not necessarily correspond to medical school department priorities, It becomes increasingly necessary to distinguish between the roles of medical staff and medical faculty. This

is not to say that for the individual clinical teacher both roles are not superbly integrated; they are. But in order to meet the patient care objectives of the institution, the medical staff must have an organizational structure capable of addressing institution-wide health care delivery issues.

The Committee recommends that the teaching hospital seriously evaluate the role of the organized medical staff in making institutional patient care decisions. This necessitates asking the question: Is there a workable structure to meet the responsibilities of the organized medical staff? Procedures for appointment to the medical staff, delineation of privileges, and continuing education programs are significant indicators of an appropriately functioning organized medical staff.

Procedures for appointment to the medical staff,apart from appointment to the medical faculty, is one instance in which the separate responsibilities as faculty and staff requires clarification. The Committee recommends that qualifications for appointment to the medical staff be pursued as vigorously as the procedures for appointment to the faculty.

The ambience of the housestaff role within the teaching hospital requires attention. House officers have important roles as students, teachers and as providers of care. Likewise, the teaching hospital has responsibilities to its housestaff for the care provided and for the educational experience. Certification for housestaff programs through residency review committees for specialty training speaks to the education component of the housestaff role. The role of the housestaff in the provision of professional patient care has for too long escaped definition.

The Committee recommends that house officers have a clearly delineated role within the organized medical staff. While definition of this role will vary, the committee recommends that all teaching hospitals require

housestaff to participate in formal quality of care assurance programs. Analysis of aggregated patterns of care gives information which is an important supplement to individual case review, the primary mode of assessment currently practiced in the teaching hospital.

The central issue is not the individual quality of care provided in teaching hospitals. Certainly the quality of care activities integral to the teaching process -- rounds and clinical conferences, particularly death and complications conferences -- provide a continuing evaluation of clinical judgement. What is at stake is an obligation to the public to comply with the procedures of accountability and to students to equip them with the tools they will require as health professionals. Certainly the skills of audit are one such tool.

The Committee recommends that teaching hospitals assess their present audit capability and take the steps necessary to build a coordinated quality of care audit program for analysis of aggregated data, based on objectively specified criteria documenting patterns of care.

The Committee asks that the Joint Commission recognize the complex circumstances of the education and service mission of the teaching hospital. Again, this recommendation does not seek adjustment of JCAH standards, but of the process implementation.

C. Innovation

Teaching hospitals have responsibility for innovation in the organization of health services and the utilization of health manpower. There are two respects in which the Joint Commission can foster this important set of responsibilities: (1) by statement of the standards to allow the institution flexibility in compliance and (2) by developing standards as goals for

important new directions in the delivery of care.

- The statement of revised standards allows the flexibility required for initiative and innovation in the delivery of services. Implementation of standards does not always measure up to the spirit in which the revised standards are established.

- Insofar as the setting of standards by JCAH helps to clarify the objectives of the institution, the Joint Commission has a creative role it has not fully exercised.

- Programmatic focus of the teaching hospital is moving toward greater emphasis of ambulatory care. This shift is not recognized by the Joint Commission with standards for assessing the quality of care.

- Inter-institutional relationships to maximize the utilization of services, to integrate separate components of health care and to plan jointly to meet the future health care needs of an area are not addressed by the Joint Commission.

In its findings the Committee presented two ways in which the JCAH can assist the teaching hospital in meeting its responsibilities for innovation in the delivery of health care. The Committee recommends that the JCAH recognize and encourage innovation in teaching hospitals by: (1) stating standards in such a way that allows the institution flexibility in compliance; and (2) by developing standards as goals for important new directions in the delivery of care.

The Committee found that the revised standards are presented in a manner to allow initiative and innovation in compliance, but the survey process is not necessarily applied in this spirit. The Committee recommends that in implementation of the standards, the survey team conduct its inquiry consonant with the spirit of flexibility inherent in the revised standards.

In terms of establishing standards as goals for new directions in the delivery of care, the Committee recommends that JCAH consider the shift in emphasis that is taking place from the acute care component of health care

to coordination of the spectrum of services. Two aspects of ongoing changes that merit greater attention by the Joint Commission are the growing emphasis of ambulatory services and the growing need for inter-institutional coordination of health services and health planning.

D. Survey Process

Shortcomings of the survey process jeopardize the credibility of the Joint Commission and potential effectiveness of the survey process.

- Too often survey team members do not have necessary understanding of the teaching hospital. Surveyors who do not have teaching hospital background are not effective team members.
- Discrepancies which occur between the summary session of the site visit and the subsequent accreditation report challenge the integrity of the survey process.
- Multiple accreditation programs, of which JCAH is one, too often are duplicative and unnecessarily tax the limited resources of the teaching hospital.
- The potential of the Joint Commission as a shaping force in the delivery of health care today depends upon the quality of the process through which the standards are applied.

The current technique for review by the Joint Commission on Accreditation of Hospitals has substantial weaknesses for teaching hospitals. The problem is primarily one of credibility of the survey team in the minds of faculty and professional staffs. This relates to the frequent lack of prior teaching hospital exposure on behalf of survey team members. At the onset of teaching hospital surveys, a considerable amount of time is spent orienting the surveyors to the nature of the teaching hospital environment and its organizational structure. The usual interpretation and application of Joint Commission standards as applied to a community hospital is frequently difficult in the teaching setting. Although the standards are written in a

generally flexible way, the interpretation often fails to recognize the uniqueness of this milieu. Some of these problems can be corrected by changing the wording of the standards and interpretations as described earlier in this report. However, to adequately deal with the problem, it is the view of the committee that the survey technique must also be modified.

In suggesting a modification of survey technique, it should be pointed out that the intent of the Committee is to make the accreditation process more meaningful to the teaching hospital. The proposals suggested are intended to strengthen the review process by giving it more credibility in the teaching hospital. By doing so, it is the Committee's firm belief that the delivery of care in teaching hospitals will benefit since the recommendations that come forth from the survey process will have greater validity and impact.

Alternative A

This approach would maintain the current survey format, but change the membership of the survey team. In this instance, the survey team would be componsed of individuals who are currently working in or have considerable background in a teaching hospital environment. Individuals from teaching hospitals would be asked to serve as consultants to the Joint Commission, and as such, to give a certain number of days per year as a member of a survey team. The National Institutes of Health site visit approach has demonstrated that individuals are willing to serve in this capacity and that they can serve in an effective manner. This approach could be tested in a limited way to determine its efficiency.

The advantages of this approach are as follows:

1. It would provide surveyors of teaching hospitals with an understanding of that environment and hence have more likelihood of developing credibility with the staff being surveyed.
2. Because of increased credibility, the recommendations that come forth from the survey are more likely to have an impact on the organization and in improving the delivery of patient care.
3. This method would continue the present organizational format with the Joint Commission in sole control of the review process.
4. On the surface it would appear that the Joint Commission could hire consultants from teaching hospitals to perform this task at a cost that would not greatly exceed the current expenditure level.

The disadvantages to this approach are:

1. It would continue the present presumption that a limited number of individuals can survey an institution that is very complex. Although from a teaching environment, surveyors would necessarily come with a limited background, i.e., their own specialty and institutional arrangements. Hence, their ability to make in depth reviews of many different areas could be limited.
2. While surveyors would be well versed in the special considerations of the teaching hospital, they would not have comparable understanding of the purposes and standards of JCAH.

3. To continue the survey process in this manner maintains a duplication of institutional surveys by many different agencies and, hence, is a costly technique to the institutions.

Alternative B

This approach, in the view of the Committee, would do most to enhance the accreditation process. This approach would tie together the surveys of the AMA residency review committees for specialty training and the Joint Commission. Much of the data collected by the two agencies is already duplicative and thus resources could be saved by collecting the data once for both agencies. The Residency Review Survey is necessarily a more in-depth approach because it examines very closely the program in a given area. Therefore, the quality of the review by this technique should be considerably higher. It is recognized that some teaching institutions do not have residencies in every program area and would have to have some combination of survey by this program approach described in Alternative A. Because of the depth of this review process, it would not necessarily need to be done as often as the current Joint Commission survey. Annual interim reporting could be accomplished to both agencies. Given adequate criteria, this would signal any problems which occur between surveys. Ideally, it would be helpful if the data collection effort could be coordinated with all other agencies who survey teaching hospitals so that a common reporting format could be achieved.

The advantages of this approach are:

1. It provides an opportunity for in depth review of an institution by program area.

2. This technique will increase the credibility of the process and enhance the efficacy of the recommendations.
3. This approach will reduce the number of program reviews by coordinating them with other agencies.
4. Because the number of reviews will be reduced, the aggregate cost to all agencies and teaching hospitals should be less.
5. It will provide a common basis of reporting of an institution's performance and, hence, some consistency in the review process. The outcome of this should be a broad basis for common understanding and, hence, mutually supportable conclusions.
6. This approach could help coordinate the hospitals' and universities' respective roles in graduate training by pulling together the review porcess for specialty training and hospital accreditation.
7. This approach recognizes the relationships between patient care and education.

The disadvantages of this approach are:

1. As described, it will not completely cover institutions which have limited training programs. A dual approach will have to be defined for these organizations.
2. The shared nature of the review process will require organizations sharing it to be willing to give up some of their current prerogatives. In other words, a very strong commitment to this approach and a considerable degree of cooperation will be required to effect this kind of program.

3. This approach will inherently create dual standards of accreditation for the teaching and community hospitals.

Alternative C

Certain surveyors on the payroll of the Joint Commission should be assigned to survey only teaching hospitals. The advantage of this approach would be to combine understanding of the special circumstances of the teaching hospital with familiarity with the purposes and objectives of the JCAH. This alternative would keep surveyors salaried by the Joint Commission, avoiding possible criticism over speical interest groups having undue influence over the regulatory process. The question remains whether sufficiently experienced individuals could be retained by the Joint Commission on a full-time basis.

It is the Committee's view that improvement of the JCAH survey process is essential if the Joint Commission is to become an agent of change for the nation's teaching hospitals. The revised standards are a significant step forward. However, if the promise of progressive leadership offered by the revised standards is to be realized, the survey process itself must be reconsidered and restructured. While there may be several ways to build a meaningful survey protocol, the committee urges the Joint Commission to further explore at least the three alternatives presented here.

APPENDIX A

OBSERVATIONS ON THE JCAH STANDARDS

A Summary of Responses from COTH Members

Standard I - Interpretation - "...The governing body or advisory board should include a broad representation of the community served by the hospital..."

Comment: Unlike community hospitals who can delineate fairly easily the boundaries of the area they serve, teaching and tertiary care hospitals often draw patients from such a large geographic area that it is impossible to define "the community served by the hospital" which makes it difficult to ensure that this undefinable community has true representation.

Standard III - "...the delineation of medical staff privileges..."

Comment: A specialist who is Board Certified has already met the requirements of his peer group or he would not be certified. To ask the medical staff, many of whom are not certified in his specialty, to delineate privileges which have been already set by the Specialty Board seems redundant.

Suggested Alternatives: A Board Certified physician will automatically be granted clinical privileges in his own specialty. If he desires to practice outside his specialty, then these privileges must be delineated.

Standard I - Interpretation - "...Symbols and abbreviations may be used only when they have been approved by the medical staff..."

Comment: It is unrealistic to expect someone to review every word in a medical record to see that no abbreviations other than those approved have been used. It is agreed that extreme care must be taken in using abbreviations while writing drug orders and final diagnoses, but some leeway should be allowed in the body of the record. This is especially true in teaching hospitals with a constant rotation of large numbers of house staff.

Standard VI - Interpretation - "The respiratory care service shall be provided .... Pulmonary function studies and blood gas analysis."

Comment: This interpretation assumes that pulmonary function studies and blood gas analysis are the responsibility of the Respiratory Care Service. In some teaching hospitals these are separate areas and do not fall under the control of the Respiratory Care Service.

There needs to be a better definition of "social problems."

The patient's chart should include psycho-social diagnosis. (page 169 of the manual)

There needs to be more emphasis on dentistry; a representative of the American Dental Association should serve on the Board of Commissioners.

The standards are duly instructive and reasonable acceptable.

The hospital director reports to the Vice President not the Board of Directors. The composition of the Board meets university as well as hospital needs (faculty members are not looked upon as candidates).

No special standards should be set for teaching hospitals; present standards are reasonably acceptable.

The continuing medical education section should be strengthened. (page 46 of the manual)

The summary discussed with surveyors bore little relationship to final written report.

On page 111 medical records: International Classification of Disease is recommended; many hospitals still use the standard nomenclature of diseases and operations.

The team should review Residency Review Reports.

Privilege delineation for house officers should be required.

The team should review inspection reports from those organizations which specialize in inspecting laboratory and radiology services (CAP, AEC, st. department of P.H.)

The hospital/university affiliation arrangements should be reviewed.

There is a poor quality of surveyors.

The role of medical and dental students and house officers should be specified. Further, there should be a statement of qualifications, status, clinical duties and responsibilities of those members of the Allied Health Professions, such as doctoral scientists and others, whose patient care activities require that their appointment and authority for specific services be processed through the usual medical staff channels; non-physician practitioners and members of allied health professions shall be individually assigned to an appropriate clinical department and shall carry out their activities subject to departmental policies and procedures.

The standards are appropriate and realistic.

There should be required some justification of residency positions offered in terms of manpower needs.

The process could be upgraded if it took form of peer review including practicing physicians, nurses and administrators. More use should be made of other agency inspection reports.

The university-owned hospitals have a governing board and committee structure which is different. Medical staff appointment procedures are also handled differently. The role of the chief executive in these institutions varies according to organizational arrangements.

There needs to be a more specific definition of privilege delineation. Procedures for house officer privileges.

The standards are generally satisfactory.

The documentation of a long list of meetings, etc. is cumbersome. PSRO should substitute for medical audit requirements.

It is difficult for university-owned hospitals to meet hospital governing board requirements. Should teaching hospitals which engage in constant peer review be required to develop the same medical auditing system as the non-teaching hospital?

The standards are fine with one exception: the fact that consumers are entitled to review the findings and may request an audience with JCAH surveyors.

JCAH STANDARDS

Annotated Bibliography

1970

Carroll, Walter, "JCAH Standards: Opportunities for Medical Staff Leadership," Hospital Progress, Vol. 51, pp. 63-8, 100. October 1970.

Discussion of privileges and responsibilities of medical staff membership. Need for greater understanding of separate roles and responsibilities of hospital trinity-medical staff, administration, governing board. Reviews JCAH standards from perspective of opportunities for medical staff leadership. Suggests goals for organization of the medical staff.

1971

Stone, J. Martin, "JCAH Standards Emphasize Better Management, Physician Participation," Modern Hospital, Vol. 116, pp. 116, 108-10, February, 1971.

Critique of JCAH effort to assess hospital management through standards. Problems: (1) emphasis is on internal responsibilities of management, while good management must go beyond walls of institution; (2) standards are more minimal than optimal despite rhetoric; reasons; (3) assessment through specification of process may or may not work. Assumption is that if procedures are specified than good management will occur. Preferable to use evaluation through outcomes; (4) roof of hospital management problems is dichotomy between medical staff and the rest of the hospital. JCAH does not speak to this.

Porterfield, John, "JCAH Director Discusses New Standards", Hospitals, JAHA, Vol. 45, pp. 31-35, July 1, 1971, interview.

The need for change in the role of JCAH. Role of JCAH is not to guarantee quality of care but to address matrix within which care is delivered. New standards set "optimal achievable" goals.

McNulty, Elizabeth, "How Survey Mechanism Works," Hospitals, JAHA, Vol. 45, July 1, 1971, pp. 36-40.

Discussion of process of accreditation from computerized questionnaire, through visit of the interdisciplinary survey team, to appeals process.

Carroll, Walter, "Joint Commission Myth (and the Reality)", AORN Journal, Vol. 14, pp. 37-41, September 1971.

History of JCAH. Growth of responsibility with Medicare designation. Context for new approach, the shift from minimum standards to quality goals.

1971 (cont.)

Reinertsen, Jr., "Accreditation-the Administrator's View", AORN Journal, Vol. 14, pp. 47-48, September 1971.

New standards deal with function. Require written departmental organization plan with definition of roles for personnel within the specific service and relationship to other services. Emphasis is on delegation of authority or responsibility to each individual who controls or supervises a function.

Roberts, Bruce, "Accreditation and Legality," AORN Journal, Vol. 14 pp. 49-52, September 1971.

Changes in hospital liability law contributed to change in role for JCAH. Summary of changes: (1) loss of charitable immunity; (2) shift away from local standards to national standards of care; (3) extension of hospital responsibility into patient care arena. Standards reflect liability developments by "placing authority within the hospital organization where the law imposes the responsibility."

1973

Mackert, Mary Ellen, "JCAH Standards Generate Goals," Hospitals JAHA, Vol. 47, pp. 85-89, January,1973.

Implications of new JCAH outlook for central service department. Review of Standard III of environmental services section with requirements for qualified supervisory personnel, written procedures and inservice education.

Bernstein, Arthur, "Staff Privileges and the Hospital's Liability to Patients," Hospitals, JAHA, Vol. 47, pp. 156-170, March, 1973.

Review of recent decisions on hospital liability, Darling v. Charleston Community Memorial Hospital (1965). Nonprofit hospital found liable for error of licensed physician treating private patient in emergency room.

Hull v. North Valley Hospital (Montana, 1972). Found medical staff not an arm of the hospital administration so knowledge of a physician's inadequacy held by the medical staff cannot be attributed to hospital management. Rejected Darling.

Mitchell County Hospital Authority v. Joiner (Georgia, 1972). Found the medical staff is acting on behalf of governing board in assigning privileges. When medical staff knows of a physician's inadequacy and does not act to limit privileges, hospital is liable.

Purcell v. Zimbleman (Arizona, 1972). Found hospital is liable for failure to react to information of prior malpractice claims against a

Purcell v. Zimbleman (cont.)

physician when it has knowledge of them. The court noted JCAH accreditation standards which require governing board to extend privileges only to competent physicians and medical staff bylaws which require medical staff review of physician competence.

Hershey, Nathan, "Some Observations on the JCAH Guidelines," The Hospital Medical Staff, pp. 27-32, June, 1973.

Guidelines present a balance of physician rights and responsibility. The physician receives a grant of responsibility from the governing board and acquires guarantee of objective evaluation and right to due process. New guidelines force standards of medical performance beyond that which is prevalent in many institutions today.

Blaes, Stephen, "Why and How Should Bylaws be Revised," Hospitals, JAHA, Vol. 47 pp. 100-106, December, 1973.

Review of court decisions on hospital liability with attention to use of JCAH standards in Purcell. Recommends restraint in wording of medical staff bylaws so that physicians do not agree to do more than can be reasonably achieved.

APPENDIX C

Summary of Remarks to Health Sciences committee, August 10, 1973

University of Minnesota Board of Regents

Hospital Governance and Trustee Responsibility

Charles Jacobs, Attorney

Joint Commission on Hospital Accreditation*

*The Joint Commission on Accreditation of Hospitals is an independent accrediting agency financed by contributions from members and survey fees. The board of JCAH has representation from the American College of Surgeons, the American College of Physicians, the American Medical Association and the American Hospital Association.

Although accreditation by JCAH is voluntary, it has acquired added weight in recent years through cooperation of the public and private sectors. Accreditation is required for participation in internship or residency programs, eligibility for Hill-Burton funds, often third-party reimbursement, and reimbursement through Medicare and Medicaid.

The role of the hospital in the delivery of health care has changed dramatically in the postwar period. Prior to World War II, the prevailing notion of health care held that medicine was practiced out of the physician's black bag. During the war, physicians practiced within the hospital and subsequently brought home new regard for the hospital as the center or hub of the health care delivery system. Hospital development mushroomed.

It has taken awhile for the legal status of the hospital to catch up with the increasingly important presence of the hospital in the delivery of care. Only recently have the courts put to rest the doctrine of charitable immunity and mythology that only a person practices medicine. However tardy, the courts have now brought to the institution responsibility for patient care. Judicial decisions have determined that patients are patients of the hospital as well as the physician with the corresponding responsibility for liability.

Public regard for the role of expertise in our society has changed as well. Increasingly, expertise is being held accountable.

In the diffuse system for delivery of health care, what are the means to make expertise accountable? (1) Create a public utility. (2) Establish government regulatory machinery without total federal control. The Professional Standards Review Organization section of PL 92-603 is this kind of government regulation. (3) Reinforce accountability through the governing authority of the institution.

The Joint Commission has concluded that the future of a voluntary health system rests with option (3), establishing accountability through the governing authority of the institution. As with any corporate organization, the governing board of the hospital has ultimate responsibility for the conduct of the institution. The board represents the community if it is adequately discharging its responsibilities. In 1971, JCAH revised its standards for accreditation to require that the governing board have a demonstrated, viable capability for accountability.

What is the nature of the institution's responsibility? There is a social and judicial mandate to assure the quality of care and there is a legislative mandate for cost containment.

First let us look at responsibility for the quality of care. The institution is responsible for selection of medical staff and assignment of privileges commensurate with the physician's capabilities.

Traditionally it was left to the conscience of the physician to recognize the limits of his abilities. Caveat emptor or the buyer beware had continued to be the rule for the purchase of services long after warrantees protected the buyer in the purchase of goods. However, in an Arizona decision, Purcell v. Zimbelman (1972) the court held that the hospital shared responsibility for the misconduct of a member of its staff. The hospital had been named in previous malpractice suits related to the conduct of a specific member of its medical staff and accordingly shared responsibility for continued misconduct.

While the governing board may delegate to the medical staff the actual selection of medical staff and determination of privileges, the institution retains responsibility. For JCAH accrediation, the board must guarantee that duely constituted mechanisms are functioning to assure appropriate medical staff action.

Cost containment is the second area of the institutions public accountability. The Professional Standards Review Organization section of PL 92-603 is cost containment legislation and sets forward a challenge to the individual hospital. If the institution can implement cost containment procedures in the areas specified by the legislation and these internal procedures of the hospital are approved by the PSRO, then the institution will not be subject to external review by the PSRO. The PSRO will abide by the institution's own determinations.

PL 92-603 speaks to cost leakages attributable to physicians. There are some cost problems that relate to the misallocation of facilities, i.e., over building, but these are not the focus of PL 92-603. Physicians control admission to the hospital, discharge from the hospital and utilization of ancillary services. PL 92-603 mandates procedures to prevent admission of patients who do not require hospitalization, the hospitalization of patients longer than necessary and the overutilization of ancillary services. The law established physician dominated groups, external to the hospital, to monitor the allocation of physician-controlled hospital resources.

However if the hospital has its own mechanisms for evaluation of admissions, certification of length of stay and surveillance of utilization of ancillary services, then the PSRO can delegate to the institution responsibility for carrying out cost accountability. Again, the board must guarantee that appropriate mechanisms are appropriately functioning.

Are hospital boards prepared to meet the social, judicial and legislative challenge for public accountability? University hospitals have an especially difficult problem since the governing authority of the hospital also has responsibility for governing the university as a whole. It is important that the Board of Regents look closely at the job to be done, competing demands, and the extent of available resources. The demands for hospital governance are urgent.

While the responsibilities are urgent they are not overwhelming, nor are they highly technical. A governing board to be properly constituted must have a majority of lay people in order to guarantee its ability to serve as agent of the community. The board itself does not make technical judgments. Its responsiblity is to guarantee that the necessary machinery for accountability is established, operating and reviewed. The critical issues of hospital governance are not problems of expertise but compelling demands for accountability.

AGENDA

COD-COTH-CAS JOINT MEETING
NOVEMBER 13, 1974

AAMC ANNUAL MEETING
NOVEMBER 12-16,1974
CHICAGO, ILLINOIS

INSTITUTIONAL RESPONSIBILITY FOR GRADUATE MEDICAL EDUCATION:
ISSUES AND ANSWERS?

2:00 - 3:30 Policies for the allocation of medical center resources and facilities for graduate medical education: What is at stake?

- 2:00 - 2:15 The Hospital Administrator Speaks
- 2:15 - 2:30 The Dean Speaks
- 2:30 - 2:45 The Faculty Speaks
- 2:45 - 3:30 Discussion (Moderator and the three speakers lead discussion which is open to the floor.)

This section of the program is designed to lay out the organizational, educational and financing issues from the varying perspectives of those within the medical center who play key roles in graduate medical education and upon whom the success of any move toward institutional responsibility will depend. Questions to be addressed include: How will priorities be set and resources allocated? By whom? Through what organizational framework? Where will the resources be derived? And at what cost?

3:30 - 3:45 COFFEE BREAK

3:45 - 4:30 Qualitative and quantitative assessment: Who calls the shots?

- 3:45 - 4:05 Should the number of residents in each specialty be controlled and by whom?
- 4:05 - 4:25 Who is (or should be) responsible for standards of quality?
- 4:25 - 4:45 Student (Resident)selection- Problems and opportunities.
- 4:45 - 5:30 Discussion (Moderator and the three speakers lead discussion which is open to the floor.)

This section of the program will deal with supra-institutional issues, or those which may involve the operation of national bodies or national level cooperation among the institutions. Questions to be addressed include: Should there be a national system for allocating specialty training positions? If so, is this a governmental or a non-governmental function? What is the appropriate configuration for such a body? On what basis should such decisions be made? What is the role of external assessment procedures, accreditation, PSRO's? Who sets standards of quality and how? Is there any necessity for a national system for facilitating student (Resident) selection? How should it best be operated?