ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF TEACHING HOSPITALS
COTH Administrative Board Meeting
Dupont Plaza Hotel
Plaza Room
September 19, 1974
9:00 a.m. - 1:00 p.m.

AGENDA

I.	Call to Order	
II.	Approval of Minutes	TAB A
III.	Membership	
	A. Applications	TAB B
	1) New York Infirmary 2) Wake County Hospital System, Inc. 3) Mayaguez Hospital 4) McLean Hospital	
	B. Report of the COTH Ad Hoc Committee on COTH Membership Criteria	Executive Council Agenda - Page 40
	C. New COTH Membership Application	TAB C
IV.	Report of the COTH Ad Hoc Committee on JCAH Standards	Executive Council Agenda - Page 50
V.	CCME Report: Physician Manpower and Distribution	Separate Attachment
VI.	AAMC Policy Statement on New Research Institutes and Targeted Research Programs	Executive Council Agenda - Page 35
VII.	Student Representation on CCME, LCME	Executive Council Agenda - Page 38
VIII.	GME Resolution on NBME Rankings	Executive Council Agenda - Page 39
IX.	Discussion and Information Items	
	A. Association of Attending Physicians at Elmhurst Hospital	TAB D
	B. Annual Meeting Schedule and Next COTH Board Meeting	TAB E
	C. Publication of Aggregate Salary Data as DATAGRAM in JME	TAB F
	D. Teaching Hospital Utilization of Ancillary Services - A Grant Proposal	TAB G

IX. Discussion and Information Items

E. Examination of LCME Accreditation Process — Separate Attachment

F. COTH Board Input to Officers

G. Update on Section 223 Regualtions

X. New Business

XI. Adjournment

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COTH ADMINISTRATIVE BOARD MEETING
Dupont Plaza Hotel
Washington, D.C.
June 20, 1974

MINUTES

PRESENT

Robert A. Derzon, Chairman
Sidney Lewine, Chairman-Elect
David L. Everhart, Secretary
David A. Gee
S. David Pomrinse, M.D.
John M. Stagl
J. W. Pinkston, Jr.
Charles Womer
Arthur J. Klippen, M.D.
David D. Thompson, M.D.
Madison B. Brown, M.D., AHA Representative

GUEST

John H. Westerman

STAFF

John A. D. Cooper, M.D.
Dennis D. Pointer, Ph.D.
James I. Hudson, M.D.
Robert Carow
Steven Summer
Catharine Rivera

I. Call to Order:

Mr. Derzon called the meeting to order at 8:00 a.m. in the Dupont Room of the Dupont Plaza Hotel.

II. Consideration of Minutes:

The minutes of the Administrative Board meeting of March 21, 1974, were approved as corrected. (Section 233 should have read Section 223 in item X of the minutes.)

III. Forthcoming Board Meeting:

It was agreed that the next meeting of the Board will be held on September 19 to be preceded by a dinner meeting on the evening of September 18.

IV. Report of the Ad Hoc Membership Committee:

Mr. Womer reported on the membership committee meeting held June 7, 1974, to review the membership criteria of the Council of Teaching Hospitals. A final written report will be submitted at the September Board meeting. The draft report contains the following recommendations:

1. That the membership criteria established in November, 1972, as amended, continue to be applied uniformly to all new applicants for membership.

2. That the following considerations should be evaluated in determining the significance of a hospital's participation in medical education and the significance of its sponsorship or participation in approved, active residencies:

   a. Availability and activity of undergraduate clerkships.

   b. Presence of full-time chiefs of service or director. of medical education.

   c. Number of internship and residency positions in relation to size, the proportion (in full-time equivalents) which are filled, and the proportion which are filled by foreign medical graduates.

   d. The significance of the hospital's educational programs to the affiliated medical school and the degree of the medical school's involvement in them.

   e. The significance of the hospital's financial contribution to medical education.

3. That the COTH Administrative Board continue to be authorized to make exceptions to the membership criteria in the cases of specialty teaching hospitals (children's, rehabilitation, etc.) which fulfill the criteria except for their number of residency programs.

4. That the membership criteria adopted in November, 1972, as amended in recommendation number 2 above, be communicated to all present member hospitals and that they be advised that their eligibility for continued membership after November, 1977 will be determined on the basis of these criteria and considerations.

5. That family medicine residency programs be added to the list of major programs, of which an institution must participate in two of these programs to qualify for COTH membership.

Mr. Womer recommended that upon completion, the committee's final report be sent to the Executive Council and that an ad hoc committee be set up to review it.

ACTION #1

IT WAS MOVED, SECONDED AND CARRIED THAT THE STAFF MAKE EVERY EFFORT TO DETERMINE THE REASONS WHY HOSPITALS HAVE TERMINATED COTH MEMBERSHIP AND TO DETERMINE WHY HOSPITALS CURRENTLY ELIGIBLE FOR MEMBERSHIP HAVE NOT JOINED.

ADDITIONALLY, DR. COOPER WAS SPECIFICALLY REQUESTED TO INVITE MILITARY TEACHING HOSPITALS TO JOIN THE COUNCIL OF TEACHING HOSPITALS.

V. Membership Applications:

The Board was presented with five applications for membership in the Council. Upon consideration of the merits of each case, the following action was taken:

ACTION #2

IT WAS MOVED, SECONDED AND CARRIED THAT THE FOLLOWING APPLICATIONS FOR MEMBERSHIP BE ACCEPTED:

MEMORIAL MEDICAL CENTER
SPRINGFIELD, ILLINOIS

ST. JOHNS HOSPITAL
SPRINGFIELD, ILLINOIS

IT WAS MOVED, SECONDED AND CARRIED THAT THE FOLLOIWNG APPLICATIONS FOR MEMBERSHIP IN THE COUNCIL OF TEACHING HOSPITALS BE REJECTED UNTIL THERE IS GREATER EVIDENCE OF INVOLVEMENT IN MEDICAL EDUCATION:

NEW YORK INFIRMARY
NEW YORK, NEW YORK

WAKE COUNTY HOSPITAL SYSTEMS, INC.
RALEIGH, NORTH CAROLINA

IT WAS MOVED, SECONDED AND CARRIED THAT THE FOLLOWING HOSPITAL BE REJECTED WITHOUT PREJUDICE FROM MEMBERSHIP IN THE COUNCIL OF TEACHING HOSPITALS PENDING SIGNATURES OF BOTH PARTIES TO THE SERVICE AGREEMENT:

MAYAGUEZ MEDICAL CENTER
MAYAGUEZ, PUERTO RICO

VI. Report on JCAH Standards:

Mr. John Westerman, Chairman of the Committee on JCAH Standards, presented his committee's report. According to the committee report, the problem most frequently encountered in JCAH surveys related to governance.

ACTION #3

IT WAS MOVED, SECONDED AND CARRIED THAT THE BOARD ACCEPT THE REPORT OF THE AD HOC COMMITTEE. THE STAFF WAS DIRECTED TO CIRCULATE THE REPORT TO COTH MEMBERS FOR COMMENT; ADDITIONALLY, THE BOARD REQUESTED THAT THE REPORT BE PLACED ON THE AGENDA OF ALL THREE COUNCIL ADMINISTRATIVE BOARDS FOR REVIEW AND ACTION AT THEIR SEPTEMBER MEETINGS.

VII Regulations to Implement Section 223 of P.L. 92-603:

Bruce Hopkins, an attorney with the law firm of Williams, Myers and Quiggle, presented to the Board the options for legal action concerning the regulations to implement Section 223 of P.L. 92-603. The first option consisted of obtaining from the Court a temporary injunction to be followed by a permanent annulment of the regulation. The basis for this action would be the arbitrary and capricious nature of the regulations and their lack of congruity with the legislative intent of the statute. Irreparable harm to the plaintiffs will also have to be shown. Therefore, specific examples of financial harm to hospitals must be demonstrated. Mr. Hopkins suggested that two hospitals enter the suit along with the AAMC. The AAMC could then contend that it is damaged because its members are damaged.

A second option would involve working through the exceptions process. There ensued debate over whether suit by the AAMC would harm the Association's position in working with the SSA to alter the regulations.

ACTION #4

IT WAS MOVED, SECONDED AND CARRIED THAT THE ADMINISTRATIVE BOARD OF THE COUNCIL OF TEACHING HOSPITALS OBJECTS STRENUOUSLY TO THE FINAL REGULATIONS IMPLEMENTING SECTION 223 OF P.L. 92-603. THE BOARD BELIEVES THAT THESE REGULATIONS ARE UNSOUND CONCEPTUALLY AND, IN FACT, THREATEN THE FINANCIAL VIABILITY OF MANY OF OUR NATION'S LEADING PUBLIC AND PRIVATE TEACHING HOSPITALS. FOLLOWING EXTENSIVE DELIBERATION, THE BOARD RECOMMENDS TO THE EXECUTIVE COUNCIL THE FOLLOWING STATEMENT OF POSITION AND STRATEGY AS WE SEEK REMEDY AGAINST THESE INEQUITABLE RULINGS. THEREFORE, THE ADMINISTRATIVE BOARD:

ACTION #4

(1) REINFORCES ITS STRONG SUPPORT OF THE AAMC POSITION AS DETAILED IN THE LETTERS TO COMMISSIONER CARDWELL OF APRIL 18 AND MAY 20, 1974;

(2) REQUESTS AAMC STAFF TO PURSUE IMMEDIATELY DISCUSSIONS WITH HEW AND SSA THAT WILL DEVELOP AN EXCEPTIONS PROCESS FOR OVER-CEILING HOSPITALS WHICH IS EXPEDITIOUS AND IS BASED UPON CLEAR GUIDELINES CONSISTENT WITH THE ORIGINAL INTENT OF THE LAW:

(3) REQUESTS STAFF TO SEEK ASSURANCES THAT THE AAMC WILL HAVE A MAJOR ROLE IN THE REFORMULATION OF A CLASSIFICATION SYSTEM THAT WILL BE IMPLEMENTED FOR ACCOUNTING PERIODS BEGINNING ON OR AFTER JULY 1, 1975;

(4) REQUESTS STAFF TO SURVEY MEMBER AND CERTAIN NON-MEMBER TEACHING HOSPITALS TO ASCERTAIN THE ANTICIPATED IMPACT OF THESE RULES:

(5) RECOMMENDS THAT THE EXECUTIVE COUNCIL AUTHORIZE:

(1) LEGAL COUNSEL TO PREPARE NECESSARY LEGAL DOCUMENTS AT THIS TIME, AND (2) THAT THE EXECUTIVE COUNCIL CONTINUE THE AUTHORIZATION OF THE EXECTUIVE COMMITTEE TO COMMENCE SUIT IF THE ACTIONS IN PARAGRAPHS (2) AND (3) CANNOT BE ACCOMPLISHED IN A REASONABLE TIME PERIOD: AND LASTLY,

(6) SUGGESTS THAT THE TECHNICAL RESOURCES OF THE AAMC BE AVAILABLE TO MEMBER HOSPITALS WHO SEEK EXCEPTION OR INDEPENDENT LEGAL ACTION.

VIII. Moonlighting of House Staff:

Dr. David Thompson presented a report on moonlighting by house officers. Objection was raised to wording in the report. Consequently, alternative wording was suggested and adopted.

ACTION #5

IT WAS MOVED, SECONDED AND CARRIED THAT THE REPORT OF THE COMMITTEE BE ACCEPTED WITH THE FOLLOWING AMENDMENT:

THE AMENDMENT CHANGES THE WORDING OF THE REPORT OF ITEM 3 AS PRINTED ON PAGE 56 OF THE AGENDA FOR EXECUTIVE COUNCIL MEETING, JUNE 21, 1974, TO READ AS FOLLOWS:

3. MOONLIGHTING BY INCUMBENTS OF INTERNSHIPS AND RESIDENCIES APPROVED BY THE LIAISON COMMITTEE ON GRADUATE MEDICAL EDUCATION MAY BE PERMITTED ONLY IF THOSE ACTIVITIES ARE REVIEWED AND APPROVED BY THE PERSON(S) RESPONSIBLE FOR THE INDIVIDUAL'S GRADUATE TRAINING PROGRAM. HOUSE OFFICERS SHOULD BE INFORMED OF THE SUBSTANCE OF THIS PROVISION PRIOR TO APPOINTMENT.

IX. Report of the National Health Insurance Task Force:

It was noted in discussion that the written testimony of the AAMC failed to mention the significant contribution philanthropy has made to teaching hospitals and medical education. Fears were expressed that the enactment of national health insurance without provision for encouragement of philanthropy would jeopardize this important source of support. Consequently, an amendment was offered to the NHI Report recognizing the importance of philanthropy.

ACTION #6

IT WAS MOVED, SECONDED AND CARRIED THAT THE REPORT OF THE NATIONAL HEALTH INSURANCE TASK FORCE BE ACCEPTED AS AMENDED.

THE AMENDMENT WAS ACCEPTED AS FOLLOWS:

PHILANTHROPIC CONTRIBUTIONS HAVE PROVIDED NON-PROFIT HOSPITALS WITH URGENTLY NEEDED SUPPORT. TEACHING HOSPITALS, PARTICULARLY, HAVE RELIED UPON PHILANTHROPY FOR SUPPORT OF NEW CONSTRUCTION AND FOR INNOVATIVE PROGRAMS. THIS VITAL SUPPORT HAS STIMULATED RESEARCH AND DEVELOPMENT IN MEDICAL CARE ORGANIZATION.

ACTION #6

THE COUNCIL OF TEACHING HOSPITALS BELIEVES THAT STATEMENTS OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES CONCERNING NATIONAL HEALTH INSURANCE SHOULD RECOGNIZE AND ENCOURAGE THE CONTRIBUTION OF PHILANTHROPY TO THE HEALTH CARE SYSTEM. MORE SPECIFICALLY, THE TAX SYSTEM SHOULD CONTINUE TO PROVIDE DEDUCTIONS FROM CORPORATE AND INDIVIDUAL INCOME TAXES FOR CHARITABLE CONTRIBUTIONS. SECOND, HOSPITAL REIMBURSEMENT FORMULAS SHOULD SPECIFICALLY PROVIDE THAT UNRESTRICTED ENDOWMENT PRINCIPAL AND INCOME, DONATIONS, LEGACIES, BEQUESTS AND OTHER CHARITABLE CONTRIBUTIONS NOT BE INCLUDED IN FORMULAS ESTABLISHING PAYMENT RATES. FINALLY, EXPENDITURES OF FUNDS DERIVED FROM PHILANTHROPY SHOULD BE UNDER THE CONTROL OF THE BOARD OF TRUSTEES OF THE RESPECTIVE HOSPITAL SUBJECT ONLY TO THE CONTROL OF THE STATE PLANNING AGENCY.

THE COUNCIL OF TEACHING HOSPITALS REQUESTS THAT THIS AMENDMENT BE INCLUDED IN ALL AAMC POSITION STATEMENTS ON NATIONAL HEALTH INSURANCE.

X. Proposed AMA Guidelines for House Staff Contracts:

Several documents were presented to the board relating to proposed AMA guidelines for house staff contracts. The history of the guidelines was noted including an explanation of how the guidelines had "slipped through" the Board of the AMA. It was noted that the proposed guidelines did not consider the legitimate responsibilities and rights of the medical schools and teaching hospitals. Consequently the Board recommended a telegram be sent to Dr. Richard Palmer of the AMA expressing the AAMC's concerns with the proposed guidelines.

ACTION #7

IT WAS MOVED, SECONDED AND CARRIED TO RECOMMEND THAT THE EXECUTIVE COUNCIL OF THE AMA BOARD OF TRUSTEES EXPRESSING THE AAMC'S OBJECTIONS TO THE PROPOSED AMA GUIDELINES FOR MODEL CONTRACTS BETWEEN HOUSE OFFICERS AND HOSPITALS.

XI. Suggested Amendment to the AAMC Position on Foreign Medical Graduates:

It was recommended that the Board approve the amendment to the AAMC's position on Foreign Medical Graduates proposed by the Council of Deans with the following change: the phrase "could be employed for this purpose" appearing in lines 9 and 19 of the amendment (page 23 of the Agenda for Executive Council Meeting, June 21, 1974) should be changed to read, "should be required."

ACTION #8 — IT WAS MOVED, SECONDED AND CARRIED THAT THE AMENDMENT TO THE FOREIGN MEDICAL GRADUATE POLICY STATEMENT BE ACCEPTED.

XII. Issues, Policies and Programs of the AAMC:

A staff developed document entitled, "Issues, Policies and Programs of the Association of American Medical Colleges was reviewed. It included: (1) the major issues which the Association faces as the national representative of U.S. m edical schools and teaching hospitals; (2) the Association's current policy on steps to develop policy on each particular issue; and (3) AAMC activities undertaken in an effort to achieve the goals related to those policies.

ACTION #9 — IT WAS MOVED, SECONDED AND CARRIED THAT STAFF RECOMMENDATION TO PUBLISH THIS DOCUMENT BE APPROVED. IT WAS FURTHER RECOMMENDED THAT THE EXECUTIVE COUNCIL STIPULATE THAT THE DOCUMENT BE DISTRIBUTED TO THE CONSTITUENT MEMBERS OF THE ASSOCIATION WITH ADDITIONAL DISTRIBUTION LEFT TO THE DISCRETION OF THE AAMC PRESIDENT.

XIII. Statement on the Responsibilities of Institutions, Organizations and Agencies Offering Graduate Medical Education:

A statement authored by the Coordinating Council on Medical Education defining basic conditions which must be met by those organizations offering graduate medical education programs was presented to the Board.

ACTION #10 — IT WAS MOVED, SECONDED AND CARRIED THAT THE STATEMENT BE ACCEPTED.

XIV. Report of the Committee on Financing of Medical Education:

A report from the Sprague Committee on the Financing of Medical Education was presented. The report offered broad guidelines for the financing of medical education. There was some discussion over the failure of the report to recognize the costs of undergraduate medical education to the teaching hospitals.

ACTION #11

IT WAS MOVED, SECONDED AND CARRIED THAT THE REPORT OF THE COMMITTEE ON FINANCING OF MEDICAL EDUCATION BE APPROVED.

XV. COTH Relationship with the Association of Canadian Teaching Hospitals:

ACTION #12

IT WAS MOVED, SECONDED AND CARRIED THAT THE CURRENT FINANCIAL RELATIONSHIP WITH ACTH BE TERMINATED AND THAT ALL FUTURE RELATIONSHIPS BE ON A FRATERNAL BASIS WITH NO EXCHANGE OF DUES PAYMENT. THE BOARD FURTHER DIRECTED THAT THE STAFF MAKE EVERY EFFORT TO CONTINUE THE EXCELLENT COOPERATIVE RELATIONSHIPS THAT HAVE BEEN DEVELOPED BETWEEN THE TWO ORGANIZATIONS.

XVI. Adjournment:

There being no further business, Mr. Derzon adjourned the meeting at 12:30 p.m.

July 2, 1974

Mr. Edward V. Grant
Executive Director
New York Infirmary
321 East 15th Street
New York, New York 10003

Dear Mr. Grant:

At its meeting on June 20, 1974, the COTH Administrative Board, which also serves as the Membership Selection Committee, reviewed the New York Infirmary's application for membership in the Council of Teaching Hospitals. The review involved particular attention to the recently adopted criteria for membership in COTH which requires that the hospital have a documented, institutional affiliation agreement with a school of medicine for the purpose of significantly participating in medical education, and that the hospital sponsor or significantly participate in approved, active residencies in at least four recognized specialties including two of the following: Medicine, Surgery, Obstetrics-Gynecology, Pediatrics and Psychiatry.

As you know, your institution meets the technical criteria of participating in four residency programs, two of which are in the major five. However, because of the minimal involvement, the members of the Board consider that the membership could not be approved until such time as there is greater evidence of the educational involvement required.

We do appreciate your interest in the Council and in the activities of the Association,,and we would like to invite you to attend the COTH regional meetings. These regional meetings and the AAMC Annual Meeting in the Fall are open to all with an interest in medical education; there is no requirement that an institution be a member to attend these sessions.

Personal membership in the AAMC, which is available for $20.00 a year, entitles one to receive the Journal of Medical Education, ahd the AAMC Bulletin. I am enclosing a membership application for your use if you care to do so.

We will be pleased to furnish you with copies of the Council's monthly publication, the COTH REPORT, a sample of which is enclosed, and to keep you informed of the results of various surveys conducted by COTH such as those concerning House Staff Salary, and other studies we are exploring for our members. We are always pleased to respond to individual requests for information in a variety of areas. As your program progresses we shall be happy to review an updated application.

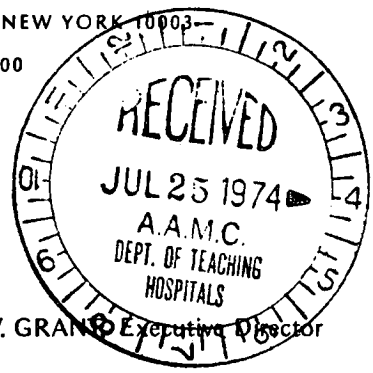
Sincerely,

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

RMK:car

Enclosure

STUYVESANT SQUARE EAST & 15TH STREET
NEW YORK, NEW YORK 10003
(212) 228-8000



new york infirmary FOUNDED 1853

EDWARD V. GRANT, Executive Director

July 22, 1974

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

Dear Dr. Knapp:

We are in receipt of your letter of July 2, 1974 advising us that the COTH Administrative Board were unable to grant approval to the New York Infirmary for Membership in the Council of Teaching Hospitals.

We fail to understand what the exact reasons are for the rejection. Some of the members of the Teaching Staff of the Infirmary read your letter and they too feel that the reasons for the rejection are vague.

It seemed to us that we met the requirements for membership not only by virtue of the fact that we have four approved training programs in Medicine, Surgery, Obstetrics and Gynecology and Pediatrics but also a formal Affiliation Agreement Contract with the New York University School of Medicine.

It would be appreciated if you would kindly explain to us exactly, and more clearly, why our application could not be approved. It is important that we hear from you as soon as possible.

Thank you.

Sincerely yours,

Edward V. Grant

Edward V. Grant
Executive Director

EVG:is

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

July 30, 1974

Edward V. Grant
Executive Director
New York Infirmary
Stuyvesant Square East & 15th Street
New York, New York 10003

Dear Mr. Grant:

As we discussed this afternoon, the application of the New York Infirmary for membership in the Council of Teaching Hospitals will once again be reviewed by the COTH Administrative Board at its meeting on Thursday, September 19.

In order to more effectively review the application, it would be most helpful if you would provide the following information:

1. the number of clerkships offered for each service, and the extent to which these clerkships are utilized by NYU medical students;

2. the number of medical staff members who hold NYU full-time faculty appointments;

3. the number of full-time, salaried chiefs of service, and in which departments they are serving;

4. the number of full-time equivalent residents in each of the four residency programs, and the number of these individuals who were trained in a foreign medical school.

If you have any further questions, please let me know. I shall look forward to hearing from you or one of your associates.

Sincerely,

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

RMK:car

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
State Zip Code

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

March 6, 1974
Date

Executive Director
Title of Hospital Chief Executive

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

Instructions:

Please complete all copies and return three copies to the Council of Teaching Hospitals, Association of American Medical Colleges, One Dupont Circle, N.W., Washington, D.C. 20036, retaining the Blue Copy for your files.

Membership in the Council of Teaching Hospitals:

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

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

a. those hospitals nominated by a medical school Institutional Member or Provisional Institutional Member of the AAMC from among the major Teaching Hospitals affiliated with the Members and elected by the Council of Teaching Hospitals, or

b. teaching hospitals which have approved internship programs and full, approved residencies in at least 4 recognized specialties including 2 of the following: Medicine, Surgery, Obstetrics-Gynecology, Pediatrics, and Psychiatry, and are elected by the Council of Teaching Hospitals

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

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

Name of School of Medicine NEW YORK UNIVERSITY SCHOOL OF MEDICINE

Name of Dean Dr. Jacobus L. Potter

Address of School of Medicine 550 First Avenue, New York, New York N.Y.

FOR COTH OFFICE USE ONLY

Date_____ Approved_____ Disapproved_____ Pending_____

Remarks_____

Invoiced_____ Remittance Received_____

June 24, 1974

William F. Andrews
Executive Director
Wake County Hospital System, Inc.
3000 New Bern Avenue
Raleigh, North Carolina 27610

Dear Mr. Andrews:

At its meeting on June 20, 1974, the COTH Administrative Board, which also serves as the Membership Selection Committee, reviewed the Wake County Hospital System, Inc. application for membership in the Council of Teaching Hospitals. The review involved particular attention to the recently adopted criteria for membership in COTH which required that the hospital have a documented, institutional affiliation agreement with a school of medicine for the purpose of significantly participating in medical education, and that the hospital sponsor or significantly participate in approved, active residencies in at least four recognized specialties including two of the following: Medicine, Surgery, Obstetrics-Gynecology, Pediatrics and Psychiatry.

As you know, your institution meets the technical criteria of participating in four residency programs two of which are in the major five. However, because of the minimal involvement; the members of the Board consider that the membership could not be approved until such time as there is greater evidence of the educational involvement required.

We do appreciate your interest in the Council and in the activities of the Association and we would like to invite you to attend the COTH regional meetings. These regional meetings and the AAMC Annual Meeting in the Fall are open to all with an interest in medical education; there is no requirement that an institution be a member to attend the sessions.

Personal membership in the AAMC, which is available for $20.00 a year, entitles one to receive the Journal of Medical Education, and the AAMC Bulletin. I am enclosing a membership applic ation for your use if you care to do so.

We will be pleased to furnish you with copies of the Council's monthly publication, the COTH REPORT, a sample of which is enclosed, and to keep you informed of the results of various surveys conducted by COTH such as those concerning House Staff Salary, and other studies we are exploring for our members. We are always pleased to respond to individual requests for information in a variety of areas. As your program progresses we shall be happy to review an updated application.

Sincerely,

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

RMK:car

Enclosure

WAKE COUNTY HOSPITAL SYSTEM, INC.

3000 NEW BERN AVENUE / RALEIGH, NORTH CAROLINA 27610

June 28, 1974

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

Dear Dr. Knapp:

I wish to respond to your letter of June 25, 1974, in which you have advised us that we cannot fulfill all of the requirements for membership in the Council of Teaching Hospitals.

You suggested this decision was made because of our minimal involvement in education. It has occurred to me that we may have failed to adequately list our participation in terms of numbers in our application. Please note the attached memorandum describing our activities for the past three years in connection with the grant request of The Duke Endowment. It is entirely possible that this memo will more adequately indicate the involvement which your committee says is minimal.

Any consideration that you may give to a review of our problem will be appreciated. In the meantime, we would like to be advised of the regional meetings and the annual meeting of the organization. At the present time I am unaware of the schedule of these sessions.

Sincerely yours,

William F. Andrews
Executive Director

WFA:ec
Enclosure

WAKE COUNTY HOSPITAL SYSTEM

RALEIGH, N. C.

INTER-OFFICE MEMORANDUM

TO: Mr. William F. Andrews
Executive Director

Date: June 25, 1974

FROM: Ron Butler
Administrative Assistant

File or Ref.

SUBJECT: Report of the Medical Education Affiliation with UNC
July, 1973 - June, 1974

This is the third year we have received an appropriation from the Duke Endowment to assist our Medical Education affiliation with UNC. This report is an explanation of how the funds from the Duke Endowment have been utilized during the past and how they will be utilized in the future.

To date, we have provided 375 third and fourth year student assignments and 125 residency assignments in medicine, pediatrics, urology, otolaryngology, surgery and OB-GYN:

Service	Student Assignments	Residency Assignments
Medicine	137	42
Pediatrics	61	22
Urology	0	3
Otolaryngology	0	5
Surgery	1	8
OB-GYN	176	45

The number of students and residents involved has been as follows:

Year	Third Year Students	Fourth Year Students	Residents
July 1, 1971-June 30, 1972	9	11	14
July 1, 1972-June 30, 1973	27	26	14
July 1, 1973-June 30, 1974	35	45	20
July 1, 1974-June 30, 1975 (Projected)	40	60	20

At any one time during the year the Teaching Service staff consists of:

Service	Faculty	Third Year Students	Fourth Year Students	Residents
Surgery	1	0	0	2
Medicine	1	4-6	4	4
Orthopedics		0	0	2
OB-GYN	1	4-5	1	4
EENT		0	0	4
Pediatrics	1	3	1	2

The third year students serve as clinical clerks and the fourth year students function as acting interns. From July, 1973 through February, 1974 the Teaching Services took an average of 48 percent of the admissions through the Emergency Room and the Night Clinic. During that period there were an average of three acting interns per month, with each intern being responsible for 16 percent of the admissions. It is proposed that the Teaching Service will base its future admissions on the number of acting interns present with each intern being responsible for 20% of such admissions.

The Teaching Service rarely has elective admissions and does occasionally receive patients in transfer from other services. The composition of the Medicine Teaching Service patients is approximately 90 to 95 percent service and 5 to 10 percent private unassigned. The number of patients seen in the Outpatient Department by the Medicine Teaching Service and the number of patients admitted to the Medicine Teaching Service during the past three years has been as follows:

Year	Patients Seen	Patients Admitted
July 1, 1971-June 30, 1972	376	369
July 1, 1972-June 30, 1973	1,546	427
July 1, 1973-June 30, 1974 (projected)	2,222	734

Beginning July 1, 1974 Dr. Gerald Blake will be on the full-time faculty at Wake Memorial Hospital and his major responsibility will be the operation of all the Medicine Teaching Service Clinics. There will be sufficient personnel to allow expansion of the Teaching Service Clinics when space is available.

Teaching rounds with the attending physicians are held Monday through Saturday for two hours each day. Grand rounds are made every Tuesday with participants from the Medicine Department at Wake Memorial and the faculty from the UNC School of Medicine. Lectures for the third year students and radiology conferences are held three times each week.

Dr. John C. Key was hired February 1 of this year to administer the AHEC program at Wake Memorial. The medical education affiliation is helping to promote the AHEC effort to provide more practical training for student doctors. It is hoped that the medical professionals will stay in the area where they receive their training.

The State has appropriated funds to provide office and classroom facilities on our site for the AHEC program. This lasting commitment on the part of the State will assure the continuation of the program beyond the five-year period.

The Medical Education Program has provided excellent care to the service patients of Wake County. We feel that the program has been a tremendous success. The continued support of the Duke Endowment has been most helpful and greatly appreciated.

THE UNIVERSITY OF NORTH CAROLINA
AT
CHAPEL HILL
27514

THE SCHOOL OF MEDICINE
OFFICE OF THE DEAN

July 3, 1974

Dr. Richard M. Knapp
Director, Department of Teaching Hospitals
Association of American Medical Colleges
1 DuPont Circle, N. W.
Washington, D. C. 20036

Dear Dick:

I am writing with respect to your letter of June 25, to Mr. William Andrews concerning the application of the Wake County Hospital System for membership in the Council of Teaching Hospitals. Perhaps we shall have a chance to discuss this shortly, but in case our discussion is delayed, I want to call a couple of things to your attention.

In the second paragraph of your letter, you indicate that the Wake County Hospitals meet the technical criteria of participating in four residency programs, two of which are in major specialties. In the next sentence you indicate that "because of the minimal involvement" the members of the board did not consider that membership was appropriate.

This means to me that we did not adequately express the degree of involvement of the Wake County Hospital in the teaching programs of the University of North Carolina School of Medicine. Perhaps the depth of the involvement can best be exemplified by the recent purchase of two buses for the purpose of transporting students and housestaff on a regular basis throughout the day, back and forth, between Chapel Hill and Raleigh. The Raleigh program has truly become a critical part of our clinical teaching orbit and a very high percentage of our total student body will spend some period of time in the Wake County Hospital during their experience as medical students. With that background, I would very much appreciate your letting me know how we might further document this involvement in a specific manner so that the Council of Teaching Hospitals administrative board could give further consideration to possible membership for the Wake County Hospital System, Incorporated. Your advice and counsel would be appreciated.

With best personal regards.

Yours truly,

Christopher C. Fordham, III, M.D.
Dean

CCF:fm

THE UNIVERSITY OF NORTH CAROLINA
AT
CHAPEL HILL
27514

THE SCHOOL OF MEDICINE
OFFICE OF THE DEAN

July 16, 1974

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

Dear Richard:

As a further elaboration of my recent letter concerning the Wake County Hospital's participation in the School of Medicine's teaching programs, I attach herewith specific information on student and house staff rotations at the the Wake County Memorial Hospital for 1973-74, and the anticipated student and house staff rotations for the year 1974-75. In addition to these rotations, we now have 9 part-time faculty, 6 full-time faculty, and 85 volunteer faculty working in the teaching program at the Wake County Hospital. Finally, there is substantial involvement of the Medical School faculty based in Chapel Hill, since the Raleigh hospital is but thirty miles to the east.

It is my conviction that all of this adds up to a major component of the clinical teaching programs of this Medical School, and I hope that this will provide the necessary information for you to review the application of the Wake County Memorial Hospital with the appropriate COTH committee.

Please let me know if you need anything further.

With best personal regards.

Yours truly,

Christopher C. Fordham, III, M.D.
Dean

CCF/lks
Attachment

P.S. - The distribution data on the number of visits to Raleigh program by Chapel Hill based faculty. This number, at the very least, would more than double.

1973-74 STUDENT AND HOUSE STAFF ROTATIONS AT THE WAKE AHEC

Medical Student Rotations

Medicine	92
Pediatrics	66
Ob-Gyn	51
ENT	2
TOTAL	211

House Staff Rotations

Medicine	28
Pediatrics	32
Ob-Gyn	27
General Surgery	8
Orthopedics	8
Urology	4
ENT	1
TOTAL	108

Other Student Rotations

Dentistry	74
Nursing: FNP	51
Undergraduate	84
Pharmacy	45
Public Health	26
Allied Health	89
TOTAL	369

July 16, 1974

PROJECTED 1974-75 STUDENT AND HOUSE STAFF ROTATIONS AT THE WAKE AHEC

Medical Student Rotations

Medicine	96
Pediatrics	84
Ob-Gyn	48
ENT	4
TOTAL	232

House Staff Rotations

Medicine	24
Pediatrics	45
Ob-Gyn	28
General Surgery	8
Orthopedics	8
Urology	4
ENT	1
TOTAL	118

Other Student Rotations

Dentistry	126
Nursing: FNP	40
Undergraduate	100
Graduate	4
Pharmacy	48
Public Health	67
Allied Health	56
TOTAL	441

July 16, 1974

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, Orth & Urology
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 — Signature of Hospital Chief Executive

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

PLEASE READ INSTRUCTIONS ON REVERSE SIDE

Instructions:

Please complete all copies and return three copies to the Council of Teaching Hospitals, Association of American Medical Colleges, One Dupont Circle, N.W., Washington, D.C. 20036, retaining the Blue Copy for your files.

Membership in the Council of Teaching Hospitals:

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

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

a. those hospitals nominated by a medical school Institutional Member or Provisional Institutional Member of the AAMC from among the major Teaching Hospitals affiliated with the Members and elected by the Council of Teaching Hospitals, or

b. teaching hospitals which have approved internship programs and full, approved residencies in at least 4 recognized specialties including 2 of the following: Medicine, Surgery, Obstetrics-Gynecology, Pediatrics, and Psychiatry, and are elected by the Council of Teaching Hospitals

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

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

Name of School of Medicine University of North Carolina

Name of Dean Christopher C. Fordham III, M.D.

Address of School of Medicine Chapel Hill, North Carolina

FOR COTH OFFICE USE ONLY

Date_____ Approved_____ Disapproved_____ Pending_____

Remarks_____

Invoiced_____ Remittance Received_____

June 27, 1974

Jose R. Gandara, M.D.
Hospital Director
Mayaguez Medical Center
P.O. Box 1868
Mayaguez, Puerto Rico 00708

Dear Dr. Gandara:

At its meeting on June 20, 1974, the COTH Administrative Board, which also serves as the Membership Selection Committee, reviewed the Mayaguez Medical Center's application for membership in the Council of Teaching Hospitals. The review involved particular attention to the recently adopted criteria for membership in COTH which requires that the hospital have a documented, institutional affiliation agreement with a school of medicine for the purpose of significantly participating in medical education, and that the hospital sponsor or significantly participate in approved, active residencies in at least four recognized specialties including two of the following: Medicine, Surgery, Obstetrics-Gynecology, Pediatrics and Psychiatry.

As you know, your institution meets the criteria of participating in four residency programs, two of which are in the major five. However, the members of the board consider that membership could not be fully evaluated until such time as the "Service Agreement" with the school of medicine has the signatures of both parties.

This being the case, I hope you will send me that agreement when it is signed so that I can once again place your application on the board agenda for its meeting on September 19. In the meantime, I have placed your name on our complimentary mailing list so that you will begin receiving our various publications and memoranda.

We do appreciate very much your interest in the Council of Teaching Hospitals.

Sincerely,

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

RMK:car

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership in the Council of Teaching Hospitals

(Please type)

Hospital: MAYAGUEZ MEDICAL CENTER
Name

Mayaguez — RD. #2 (P.O. Box 1868)
City — Street

Puerto Rico — 00708
State — Zip Code

Principle Administrative Officer: Miguel A. Sepúlveda
Name

Administrator
Title

Date Hospital was Established February 2, 1971

Approved Internships:

Type	Date Of Initial Approval by CME of AMA*	Total Internships Offered	Total Internships Filled
Rotating	July 1970	9	8
Straight	July 1971	11	9

Approved Residencies:

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total Residencies Filled
Medicine	July 1971	13	9
Surgery	July 1971	12	8
OB-Gyn	Feb. 1970	9	7
Pediatrics	July 1968	9	6
Psychiatry			
Other			

Information Submitted By:

José R. Gándara, M.D.
Name

Hospital Director
Title of Hospital Chief Executive

February 21, 1974
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

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Membership in the Council of Teaching Hospitals:

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

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

a. those hospitals nominated by a medical school Institutional Member or Provisional Institutional Member of the AAMC from among the major Teaching Hospitals affiliated with the Members and elected by the Council of Teaching Hospitals, or

b. teaching hospitals which have approved internship programs and full, approved residencies in at least 4 recognized specialties including 2 of the following: Medicine, Surgery, Obstetrics-Gynecology, Pediatrics, and Psychiatry, and are elected by the Council of Teaching Hospitals

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

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

Name of School of Medicine University of Puerto Rico-School of Medicine

Name of Dean Carlos E. Girold, M.D.

Address of School of Medicine G.P.O. Box 5067

San Juan, P. R. 00936

FOR COTH OFFICE USE ONLY

Date_____ Approved_____ Disapproved_____ Pending_____

Remarks_____

Invoiced_____ Remittance Received_____

CENTRO MEDICO DE MAYAGUEZ

DEPARTAMENTO DE SALUD

MAYAGUEZ, PUERTO RICO

APARTADO 1868
MAYAGUEZ, P. R. 00708
TELEFONO 832-8686

August 26, 1974

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

Dear doctor Knapp:

I make reference to your letter dated June 27, 1974, in reference to the membership of the Mayaguez Medical Center in the Council of Teaching Hospitals.

You will find enclosed the service agreement between the Secretary of Health, representing the Mayaguez Medical Center and the Cancellor of the University, representing the School of Medicine, the University of Puerto Rico.

This, I believe, fulfills the last requirement for our membership.

Sincerely Yours,

Ramón D. Acosta, M.D.
Medical Director

JRR/rlr

cc: Dr. José Ramírez Rivera
Director of Medical Education

Encl. 2

COMMONWEALTH OF PUERTO RICO
DEPARTMENT OF HEALTH
SANTURCE, PUERTO RICO

SERVICE AGREEMENT STATEMENT OF PURPOSE BETWEEN

PARTY OF THE FIRST PART: The School of Medical Sciences of the University of Puerto Rico, represented by its authorized chancellor, Dr. Adán Nigaglioni, of legal age, married, resident of Guaynabo, Puerto Rico, hereinafter refferred to as "University".

PARTY OF THE SECOND PART: The Health Department of the Commonwealth of Puerto Rico, represented by its Secretary, Honorable José A. Alvarez de Choudens, of legal age, married and resident of San Juan, Puerto Rico hereinafter referred to as "Second Part". This agreement is intended to benefit the medical education University, as well as that of the Department of Health. Its aim is to acquaint the medical students of Puerto Rico with the clinical facilities of the Department of Health as well as with those of the Puerto Rico Medical Center of Rio Piedras. It is sought, thereby, to provide motivation to medical students to serve in the various communities of the Island and ultimately to effect a better distribution of Doctors in Puerto Rico. This agreement is subject to the following:

CLAUSES & GENERAL CONDITIONS

SECTION I : The University recognizes the Mayaguez Medical Center, and specifically its hospital, as its clinical laboratory, accredited and affiliated to its Medical School.

SECTION II : The University will utilize the Mayaguez Medical Center for its training and educational programs as well as any other hospital or Medical facility of the Department of Health which receives joint approval.

SECTION III: The University in mutual accordance with the Secretary of Health will select from the Faculty Members of Mayaguez Medical Center the persons that will participate in the teaching programs and in the development of Medical Education.

SECTION IV: Both parties will grant joint appointments to the members of the Medical Faculty of Mayaguez Medical Center selected for the teaching and educational programs. The academic appointments of these persons will be initiated in the corresponding School Department and will be transacted in accordance with established University standards.

SECTION V: The Department of Health will contribute to the Medical School the maximum quantity of $64,000 during a period of twelve months to cover the additional expense of developing these programs including the payment of salaries to the participating faculty members in proportion to the time invested in them, traveling expenses, equipment and teaching materials.

The Department of Health will anticipate monies periodically to the University from funds which will be liquidated every three months on the basis of expenses accrued.

To this effect, the University will submit to the second part (the Depto. of Health) the plans and budget well in advance to the beginning of the training program. The monies will be paid from the Health and Welfare account 74-210-73-3-81 or from any other available funds.

SECTION VI: The Department of Health will provide the use of the facility designated "Housing Facility for Unmarried Physicians" located in the Mayaguez Medical Center. The necessary repairs and maintainance of this building so as to prepare it for the development of these programs will be carried out utilizing funds of both parties.

SECTION VII: The University and the Mayaguez Medical Center agree to interchange guidance and consultant services for the development of the medical education programs in Mayaguez, that will include those of continuing medical education and evaluation of all teaching programs.

SECTION VIII: The Department of Health agrees to provide the University within the maximium limits established in Section V with the funds necessary to cover all malpractice insurance premiums of personnel who has an appointment with the University and students in accordance with the proportion of time of their total practice which is dedicated to the activities appropiate to this contact.

This agreement shall be effective retroactive to August 2, 1974.

In San Juan, Puerto Rico, 8th of August 1974.

Adan Nigaglioni, MD
Chancellor

José A. Alvarez de Choudens, MD
Secretary of Health

CHARTERED 1811

McLEAN HOSPITAL

A division of the MASSACHUSETTS GENERAL HOSPITAL

FRANCIS DE MARNEFFE, M. D., DIRECTOR 855-2101
SHERVERT H. FRAZIER, M. D., PSYCHIATRIST IN CHIEF 855-2201
HENRY J. LANGEVIN, ADMINISTRATOR 855-2104

BELMONT · MASSACHUSETTS 02178
855-2000

June 14, 1974

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

Dear Dr. Knapp:

As a somewhat belated follow-up to the copy of your letter of April 17, 1974, to Dr. Ebert and our telephone conversation, at this time I would like to apply formally on behalf of the McLean Hospital for membership in the Council of Teaching Hospitals of the Association of American Medical Colleges.

McLean Hospital was incorporated as a di vision of the Massachusetts General Hospital in 1811. The Board of Trustees of the McLean Hospital is the same as the Board of the Massachusetts General Hospital, but below the level of the Board McLean Hospital has a separate administration, a separate budget, and a separate medical staff appointed by the Board of Trustees on the recommendation of the McLean Hospital Committee of the Trustees.

It has a long history in undergraduate and graduate teaching and is a teaching unit of the Harvard Medical School, as indicated in Dr. Ebert's letter to you. McLean Hospital has a basic residency training program in psychiatry accredited for three years. In addition we have had a special training program in adolescent psychiatry for the past several years, supported by the NIMH, and we have an internship program in clinical psychology, also so far supported by the NIMH. Since the opening of the Children's Center in 1973 there is a residency program in child psychiatry.

Although I don't believe that it would be of direct interest to the AAMC, you should also know that we train nurses, mental health workers and social workers.

Rather than describing in the body of my letter the different types of programs, I am enclosing in this letter material pertinent to the medical student program, the basic residency training program, the program in adolescent psychiatry, the Children's Center training program and the internship training program in clinical psychology.

If you require any further information, please let me know.

Yours sincerely,

Francis de Marneffe, M.D.
Director

FdeM/me
encl.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership
in the
Council of Teaching Hospitals

(Please type)

Hospital: McLean Hospital
Name

Belmont — 115 Mill Street
City — Street

Massachusetts — 02178
State — Zip Code

Principle Administrative Officer: Francis de Marneffe, M.D.
Name

Director
Title

Date Hospital was Established February 25, 1811

Approved Internships:

Type	Date Of Initial Approval by CME of AMA*	Total Internships Offered	Total Internships Filled
Rotating	NOT APPLICABLE		
Straight			

Approved Residencies:

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total Residencies Filled
Medicine			
Surgery			
OB-Gyn			
Pediatrics			
Psychiatry	July 28, 1965 *	6 - 8	8 (1974)
Child Psychiatry	January 26, 1973	6	6 (1974)
Other	Internship program in Clinical Psychology, training programs for nurses, mental health workers, social workers.		

* This is the date of approval of the McLean program as an independent program. Prior to that date, as far back as the 1930's, there was an exchange of residents for training purposes between the Massachusetts General Hospital and the McLean Hospital to provide broader training opportunities.

Information Submitted By:

Francis de Marneffe, M.D.
Name

June 14, 1974
Date

Director
Title of Hospital Chief Executive

Signature of Hospital Chief Executive

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

PLEASE READ INSTRUCTIONS ON REVERSE SIDE

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Membership in the Council of Teaching Hospitals:

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a. those hospitals nominated by a medical school Institutional Member or Provisional Institutional Member of the AAMC from among the major Teaching Hospitals affiliated with the Members and elected by the Council of Teaching Hospitals, or

b. teaching hospitals which have approved internship programs and full, approved residencies in at least 4 recognized specialties including 2 of the following: Medicine, Surgery, Obstetrics-Gynecology, Pediatrics, and Psychiatry, and are elected by the Council of Teaching Hospitals

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

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

Name of School of Medicine Harvard Medical School

Name of Dean Robert H. Ebert, M.D.

Address of School of Medicine 25 Shattuck Street, Boston, Massachusetts 02115

FOR COTH OFFICE USE ONLY

Date_____ Approved_____ Disapproved_____ Pending_____

Remarks_____

Invoiced_____ Remittance Received_____

Outline of the McLean Core Psychiatric Rotation for Medical Students

Currently, McLean Hospital offers, in conjunction with the Mount Auburn Hospital, an "elective" clinical clerkship for Harvard medical students which satisfies the pertinent distribution requirements imposed by the core clinical curriculum of the Harvard Medical School. The Mount Auburn component has supplemented the McLean training (described below) by providing experience in psychiatric consultation to medical and surgical patients in a general hospital. In addition, the McLean Children's Center supplements the McLean adult training program described below by providing experience in child psychiatry during which the medical student participates in a multi-disciplinary diagnostic team and in intensive exposure to outpatient diagnostics and therapeutics. A brief description of the chief elements of the training in the core adult psychiatric elective at McLean Hospital follows:

1. Administrative Information - McLean typically receives two to three and occasionally four Harvard medical students monthly for training in the core clerkship. The clerkship lasts, as do other conventional electives, for about one month. Students taking the HMS core clerkship spend three days at McLean and two days at the Beth Israel per week. A modification of this basic McLean clerkship is also offered to non-Harvard medical students who generally stay between four and six weeks and are trained entirely at this hospital. The medical student programs are coordinated by Dr. Harvey Shein, under the overall supervision of Dr. Shervert Frazier, Psychiatrist-in-Chief.

2. Inpatient Experience - The medical student is typically assigned to one of the psychiatrists in charge (PIC) as well as the resident assigned to his diagnostic team on the Admissions Unit where the student is expected to participate in the ongoing evaluative and therapeutic work of his team. The student conducts conjointly with the PIC, resident and other mental health professionals related to his team, the initial admissions interview. He then performs the physical examination and prepares an admission note as well as appropriate doctor's orders. These exercises are performed under the direct clinical supervision of the

psychiatric resident, who provides guidance particularly in the realm of the general workup, performance of the mental status examination, practical interviewing and treatment techniques, and the methodology of a careful anamnesis. Under supervision, the student continues to conduct his workup as it may involve contact with the patient's family and friends, and as it will continue after his team has reached tentative diagnostic conclusions which precede transfer of the patient to one of the longer term residential halls. The student follows his patient to his new treatment unit and shortly after transfer holds a brief planning conference with the unit's psychiatrist-in-charge and staff. The medical student initiates whatever speciality consultations the workup may entail, and under supervision prepares a four to six page anamnesis or case report. Subsequently, he presents his findings, in concert with other team members of the hall staff, to a senior psychiatric consultant during a formal teaching conference which concludes by formulation of diagnoses and treatment issues.

3. Outpatient Experience - The medical student is assigned to one of the outpatient multi-disciplinary diagnostic teams headed by a staff psychiatrist and including social workers, social work students, psychologist, psychology interns, other mental health professionals and volunteers. The team delegates to the medical student the evaluation of one or two outpatients whom he sees in diagnostic interview sessions customarily on a once weekly basis. At the end of the initial diagnostic session, the medical student prepares a brief note describing present illness, past history, etc., and the mental status examination. During his typical "outpatient day" the medical student participates with the members of his team in observing behind a one way mirror the "intake group" comprised of all those patients currently undergoing evaluation by team members for that month. Following the intake group which is led by mental health professionals from the team, there is an opportunity for discussion in which team members attempt to correlate patient behavior in the group and in the dyad with the help of

gaining greater diagnostic understanding. Subsequently, the medical student attends the general team conference in which members present and discuss their workups and, under supervision of the team psychiatrist, arrive at diagnosis and treatment plans. The medical student himself makes his presentation(s) to the team towards the end of his rotation.

4. Clinical Supervision - Clinical supervision of the medical students inpatient clinical work is undertaken in one hour weekly meetings with a psychiatrist in charge of the Admissions Center or one of the residential treatment units. This supervisory effort which focuses particularly on gathering relevent data for the case report, exploring relevent psychopathology diagnostic resolutions and both long and short term indicated therapeutic interventions. Outpatient work is supervised by psychiatrists directly affiliated with the clinic or attending physicians closely attuned to the hospital. A "teaching resident" is designated to meet with medical students three times weekly to provide a resident's perspective stimulated by the rotation which are chosen for discussion primarily by the students themselves.

5. Didactic Seminars - A basic seminar is held for an hour twice weekly by Dr. Shein to provide a formal intellectual structure for the clinical experience. Typically, the seminars begin with an exposition of human developmental psychology including consideration of the neurosciences, psychoanalytic thought, and the cognitive psychologies; subsequent sessions focus on symptom, character, and characterologic disturbance, neurosis, psychosis, and the full range of treatment modalities, ranging from the biologic to the psychoanalytically oriented psychotherapeutic. An attempt is made to cover main issues in descriptive and dynamic psychiatry as well as biological psychiatry.

Students are encouraged to complete the reading of at least one textbook in the field of general psychiatry. Other books or papers are suggested in the basic seminar and by other teachers and supervisors.

6. Additional Teaching and Clinical Experience - The above-noted clinical experiences, supervision and didactic teaching are supplemented by additional sessions with members of the McLean psychiatric staff who introduce the medical students to their area of particular psychiatric expertise. Dr. Ralph Ryback, Psychiatrist in Charge of the Alcoholism Unit, discusses the medical and psychiatric presentations of the alcoholic as well as relevant psychotherapeutic milieu and pharmacological treatment modalities. Physiologic research into alcoholism as well as its medical, legal interface may also be discussed in this session. The students meet also with Dr. Roger Meyer, head of the hospital's drug addiction unit for an introduction to psychopharmacology and drug addiction. Dr. Stephen Washburn, Director of the Partial Hospitalization Service, meets with the medical students to discuss the day care, night care and after care services and to ~~discuss~~ demonstrate the clinical interviewing of severely disturbed patients. The medical students meet with Dr. John Brandt, director of one of the two McLean halfway houses, to learn about the expanding role that such facilities are playing in psychiatric care.

Each medical student has the opportunity to present his inpatient case informally to Dr. Shervert Frazier, Psychiatrist in Chief, whose discussion serves to synthesize various questions posed by each case, as well as the many perspectives on the case to which the student has been exposed.

7. Evaluation of the Medical Student Rotation - Efforts to evaluate this psychiatric rotation are made through the use of verbal and written responses by the students to questions covering the major elements of the rotation.

RESIDENCY PROGRAM - McLEAN HOSPITAL

The residency training program at McLean has three parts, a basic three year training program for psychiatric residents, an adolescent training unit and a resident training program for the Hall-Mercer Hospital. This report will attempt to summarize the basic psychiatric residency program mainly. There is also a grant pending for continuing education which is aimed at the education of psychiatrists who will be presumably subject to relicensure examination in the future. This continuing education program, although only recently established, is expected to expand if a grant now pending materializes.

The goals of our training program are to produce academically oriented highly qualified psychiatrists who will set the standards in the field of psychiatry and become upcoming teachers in psychiatry, researchers or practitioners. There is no one type of expertise expected in an ideal resident or psychiatrist, but our goal is to insure that we accept and train the most qualified students that we can find to provide them with a comprehensive education which equips them to see the complex inter-relatedness of issues in mental health, and to become skilled in as many areas as they can given their own abilities and interests. The training program takes place in numerous hospitals of which the McLean inpatient service, Partial Hospitalization Program and Outpatient Clinic are the main facilities. McLean Hospital's residents are also affiliated with Cambridge City Hospital, Mt. Auburn Hospital, Metropolitan State Hospital, Massachusetts General Hospital, Boston Veterans Administration Hospital, Beth Israel Hospital, Mystic Valley Child Guidance Center, Emerson Hospital, New England Rehabilitation Hospital, Boston City Hospital, Children's Hospital, the Thom Clinic, and numerous other community placements such as school systems, and parts of the justice system too numerous to list. These affiliations are primarily used to increase the resident's exposure to neurology, child psychiatry, community psychiatry, and liaison psychiatry.

The inpatient service at McLean has approximately 250 beds for patients who require fairly prolonged inpatient care. These patients represent a range of people from the age of 12 to 78. The modal age of patients admitted is approximately 22. We have approximately 50 patients admitted a month; 40% are diagnosed with schizophrenic illness, 30% with borderline or a personality disorder diagnosis, 15% with affective disorders, 10% with adjustment reactions and 5% with drug or alcohol abuse. Most patients are admitted to the Admission Center, and they stay there for an average of 10 days. Approximately 20% of the patients are then discharged from the hospital, but a vast majority are transferred to another hall for more extensive treatment. Two thirds of the patients admitted to this inpatient facility come from the South Shore or North Shore, and the vast majority come from Massachusetts. The economic group represents mostly those who are covered by either insurance which is adequate for 30 to 90 days of hospitalization or those with major medical plans for over a year or two of coverage (this is approximately 60%-70% of the general population). Treatment programs in the inpatient services includes work both on the open and closed wards; patients can run to the most regressed and difficult to maintain. We are able to take addicts on a limited basis, and the maximum duration of treatment is without any limit.

The Partial Hospitalization Service has approximately over 150 patients on its rolls at any one time. This figure includes an After-Care Service (day care) which is run on the treatment wards where the patients have previously been hospitalized. Residents participate in both of these programs and get an opportunity to manage chronic long-term patients on an administrative and psychotherapeutic basis. It is through this experience that they get the best opportunity to study the natural history of the patients' illnesses, and the impact that treatment and management have on its course. Two half-way houses, one in Boston and one across Mill Street from the hospital provide services to discharged patients who need therapeutic residences in this area to continue their treatment and rehabilitation. Both of these homes are available for residency training. The Adolescent Day Service provides special learning opportunities as part of P.H.S. The Outpatient Clinic sees approximately 700 patients a year and provides first, second, and third year residents with an opportunity to treat ambulatory patients and to work within an interdisciplinary team doing diagnostic and treatment service. We see people in an age range from virtually the first few years of life up to the very eldest who are seen in our neuropsychiatric unit (Proctor House).

II. The Training Program

A list of residents who are in their residency training in the adult program is appended at the end of this report. It should be noted at this time that seminars which are described and appended in this section are open to social workers, nurses, mental health workers, medical students and other trainees who are in training at McLean.

In the beginning of the first year program there is an orientation period of approximately one week where the resident is given a review of psycho-active medication, is given an orientation to psychiatric emergencies, and is oriented by chiefs of the various services in the hospital to help expose them to the McLean environment. During this time the resident spends some time on their ward assignments so that they become acquainted with the service areas of patient care. They do not have new patients assigned to them for work-up in the first week and the sedond year take over that load for them during this orientation period.

Each new resident is assigned a preceptor with whom he meets his first year and this preceptor develops a close relationship to the resident to advise him and follow his progress. This preceptor also becomes his first psychotherapy supervisor. The preceptor should help the resident in career planning, discussion of theory, research and his progress with the residency program.

During the first year each resident is assigned to the admission unit which was described above for a period of four months. He admits, evaluates, and undertakes short-term treatment of acutely ill patients. This initial evaluation usually is done within 10 days, and he has individualized supervision during this time. During these initial workups the resident is oriented towards finding out how to do a good mental status examination, a clinic evaluation, and develops a capacity to write a reasonable history and make a meaningful initial formulation of the case. The supervision attempts to show the resident how to obtain a useful anemestic material while at the same time establishing a good working relationship with his patient. The resident

also learns how to initiate a workable treatment plan, or disposition to the community, or to arrange for a transfer to another hospital if McLean is inappropriate. The resident then spends one month in rotation at the Metropolitan State Hospital where he assists in running a ward and doing work-ups there. He gets an opportunity to see a somewhat different staffing pattern and to provide service to a large number of patients as he learns. Then in the first year the resident will spend another six months on one of the treatment wards where he will act as an assistant administrator to the physician in charge. Here he will get an opportunity to learn something about the milieu and the administration of sick patients, learning large and small group techniques, as well as how to integrate information coming from the ward staff.

During the first year the resident is also required to begin long-term intensive psychotherapy with at least two inpatients which he will see at least three times a week during the year. This training in prolonged individual psychotherapy remains a basic emphasis of the resident's experience throughout the three year program. The longitudinal structure of the hospital which permits residents to treat selected inpatients for the entire three years of training is clinically indicated, thereby allowing the residents to follow the vicissitudes of the therapeutic relationship and providing a working familiarity with transference issues that represent the basic training ground of the psychotherapist.

The resident then spends after September in the first year six hours in the Outpatient Clinic. There, he will participate in staff conferences and will both observe and lead the groups. He will do up to six evaluations during the year and is expected to take into treatment at least two outpatients during his first year. Supervision is provided for both group work and individual psychotherapy.

During this year each resident rotates through the electric shock therapy unit and there under the supervision of a staff member and a qualified anestheologist the resident learns to administer EST.

During this year the resident works up approximately one new case a month except for the time he is on the inpatient unit and does admission work-ups there. These workups are more prolonged when done on the treatment halls and residents are preferentially given cases to work up on the ward to which they are assigned. These more prolonged workups require anywhere from 10 to 20 hours of additional work and occasionally become the basis of a prolonged treatment relationship.

During the second year the resident has decreased responsibility for diagnostic evaluations as described above and does only one a month. He is assigned to the Partial Hospitalization Service for a four-month block, during which he works with a variety of patients both individually and in groups and receives supervision. This assignment provides the resident with a new kind of responsibility for making medical judgments about patients who are to remain at home outside the structure of a 24-hour psychiatric institution. The resident learns techniques in more detail of dealing with families and other social groups and gets some experience in studying the long-term problems which the patients' illness represent.

During the second year period each resident spends either one or two days in community settings. These include work in a court clinic or at a house of correction, one of several school systems, on the alcohol or drug units at McLean, in a multiservice center, or in the emergency room at the Cambridge City Hospital. Here the resident has an opportunity to begin to develop his skills in consultation, and he receives regular supervision from staff members at the facility to which he is assigned in order to learn these skills. This is one of the difficult assignments for a resident who has recently established his skills as a clinician to shift gears and to see himself in the role of consultant.

At the same time the resident is expanding his experience in other systems, he is expected to begin to see one family in treatment and at least one group. There are conferences on family therapy and seminars in group therapy as well as individual supervision for the clinical experience. During the second year the resident also continues to work in the Outpatient Clinic and is expected to see several more individual long-term treatment patients and usually picks up an outpatient group.

A rotation at the Massachusetts General Hospital in neurology is provided on a six-week basis during the second year. A child training program at the Hall-Mercer hospital for adult residents has not yet been arranged but is expected to be ready next year so that present second-year residents are not doing child work except on a consultation basis to the pediatric wards on an elective basis at Cambridge City Hospital.

The third-year resident continues his work in individual, group and family psychotherapy and is able to do elective work in many other areas. Residents are working in the Harvard Health Service, M.I.T. Health Service and Brandeis Psychological Service. Here they are given expert supervision in both short and long-term work with college students who are in a university setting. Residents also spend a form of rotation approximately eight hours a week at the Mt. Auburn Hospital where Dr. Don Lipsitt provides them with a course on medical psychology and consultation to the medical and surgical services in a general hospital. The residents during the third year at present are doing their training in child psychiatry one day a week in the affiliated hospitals which I mentioned above. The training and consultation to schools and courts can be continued on an elective basis during the second and third year and experience in the outpatient clinic on a more intensive basis especially in a teaching capacity can be provided for approximately half of the residents.

This review of the residency training program is necessarily sketchy and gives a summary of the teaching which is service oriented. A summary of the clinical seminars is provided in an appendix to this report and shows the breadth of the experience which is given the residents on a formal basis in all the areas which are deemed relevant in their development. The faculty who provide this experience is listed and appended to this report. Practically all attendings do some supervision of either group, individual or family therapy but these supervisors are not all listed in the training resource forms.

Goals

The service goals which the hospital would like to reach have to do with improving continuity of care and comprehensiveness of care. How this pertains to residency training particularly is in the area of the experience the resident will get in seeing how a health care delivery system works.

At the present time we cannot say that we have a community based or a fully operational, comprehensive system. It would seem that part of the integration of McLean's program on a training basis with other facilities would help provide this kind of comprehensiveness that we are seeking. The treatment resources which we need to include we are now including through an affiliation which is more or less informal as they were described above. In many ways the idea of the Consortium has been partially implemented through the affiliation of the residency training program with most of the hospitals which are meeting as part of the potential Consortium.

Although this report is not spelled out in any detail for training of social workers and psychology interns, we want to emphasize that they have been invited to all seminars which residents attend and do have a well developed and well thought out training program at McLean. Each of these programs has affiliated hospitals and clinics with which it works as well. It would appear that the major training lacks that McLean requires have to do with the area of community psychiatry, since we are not located within a community as for instance the Cambridge City Hospital is. It would seem that what we are capable of offering in the area of training is continuing long-term care of certain sick patients, but we have a more difficult time providing the in-depth experience with any community which contact could be useful to a psychiatrist's education.

Financing

Federal financing is being phased out by the NIMH over the next several years. The burden of the training program will then fall directly on the hospital financial resources. The federal cuts have already become a reality for the basic training grant. The adolescent grant has not been renewed and is ostensibly finished. New financial sources are a mystery at this moment and it would seem that this is an area where productive thinking has to take place.

McLean Hospital
115 Mill Street
Belmont, Massachusetts 02178

This is a two-year program in adolescent psychiatry open to physicians who have completed two years of accredited psychiatric training. The program provides the resident with a significant involvement with adolescents and their academic, social, familial, correctional, referral, and therapy environments. This is done in a suburban high school setting, a college health service, and a correctional justice system. In addition to the above, the residents have an opportunity to work with selected independent schools which include both elementary and secondary coeducational boarding schools. This enables them to see a broad spectrum of relatively healthy adolescents and to learn the importance of close collaboration with faculty and community.

All clinical and consulting work is closely supervised by highly experienced senior physicians, one of whom actually works at the schools alongside the resident and assists with liaison when needed.

Seminars in adolescent and developmental psychology, theory and practice of community psychiatry, and law and psychiatry supplement the practical field experience and supervision.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF TEACHING HOSPITALS

Application for Membership

INSTRUCTIONS: Type all copies, retain the Blue copy for your files and return three copies to the Association of American Medical Colleges, Council of Teaching Hospitals, One Dupont Circle, N.W., Washington, D.C. 20036. PLEASE ENCLOSE A COPY OF THE HOSPITAL'S AFFILIATION AGREEMENT WITH THE APPLICATION.

MEMBERSHIP CRITERIA:

Eligibility for membership in the Council of Teaching Hospitals is determined by the following criteria:

(a) The hospital has a documented institutional affiliation agreement with a school of medicine for the purpose of significantly participating in medical education;

AND

(b) The hospital sponsors or significantly participates in approved, active residencies in at least four recognized specialties including two of the following: Medicine, Surgery, Obstetrics-Gynecology, Pediatrics, Psychiatry, and Family Practice.

Membership in the Council is limited to not-for-profit (IRS-501C3) institutions, operated for educational, scientific or charitable purposes.

I. MEMBERSHIP INFORMATION

_____
HOSPITAL NAME

_____
STREET CITY

_____
STATE ZIP CODE TELEPHONE NUMBER

Chief Executive Officer: _____
NAME

_____
TITLE

Date Hospital was established _____

APPROVED INTERNSHIPS

TYPE	Date of Initial Approval by CME of AMA*	Total F.T.E.[1] Positions Offered	F.T.E.[1] Total Positions Filled by U.S. And Canadian Grads	F.T.E.[1] Total Positions Filled by FMG's
Rotating				
Straight				

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

1. F.T.E. positions at applicant institution only. If hospital participates in combined programs indicate only F.T.E. positions and individuals assigned to applicant institution.

APPROVED RESIDENCIES

TYPE	Date of Initial Approval by CME of AMA*	Total F.T.E. Positions Offered	F.T.E. Total Positions Filled by U.S. And Canadian Grads	F.T.E. Total Positions Filled by FMG's
Medicine				
Surgery				
Ob-Gyn				
Pediatrics				
Psychiatry				
Family Practice				
Other (List):				

II. PROGRAM DESCRIPTION

To supplement the information above and to assist the COTH Administrative Board in evaluating whether or not the institution fulfills the membership criteria, it is requested that you briefly and succinctly describe the extent of the hospital's participation in or sponsorship of educational activities with specific reference to the following questions.

A. Extent of activity for undergraduate medical education students (e.g., number of clerkships offered; number of students participating; proportion of medical staff time committed to medical students).

B. Presence of full-time salaried chiefs' of service and/or Director of Medical Education (e.g., departments which have salaried chiefs; hospital chiefs holding joint appointments at medical school).

C. Dimension of hospital's financial support of medical education costs and nature of financial agreement with medical school (e.g., dollars devoted to house staff salaries and fringe benefits; the percentage of the hospital's budget these dollars represent; hospital's contribution to cost of supervising faculty; portion of service chiefs' costs paid by the hospital).

D. Degree of affiliated medical school's involvement in and reliance upon hospital's education program (e.g., medical school faculty participation in hospital activities such as in-service education, conferences or medical staff committees).

The above are not meant to be minimum standards or requirements, but reflect the belief that COTH membership indicates a significant commitment and consideration of the items above. The hospital's organized medical education program should be described clearly with specific reference given to unique characteristics and to the institution's medical education objectives.

III. LETTER OF RECOMMENDATION

A letter of recommendation from the dean of the affiliated medical school should be included outlining the importance of the teaching hospital in the school's educational program.

Name and Address of Affiliated School of Medicine: _____

Name of Dean _____

Information Submitted By:

NAME _____ TITLE OF PERSON SUBMITTING DATA

DATE _____ SIGNATURE OF HOSPITAL CHIEF EXECUTIVE

THE MOUNT SINAI MEDICAL CENTER
Fifth Avenue and 100th Street • New York, N.Y. 10029 • 212/876-1000

THE MOUNT SINAI HOSPITAL · MOUNT SINAI SCHOOL OF MEDICINE OF THE CITY UNIVERSITY OF NEW YORK · THE MOUNT SINAI SCHOOL OF NURSING OF THE CITY COLLEGE · NEUSTADTER CONVALESCENT CENTER

Office of the Vice President
for Personnel

August 14, 1974

Dr. John Cooper, President
American Association of Medical Colleges
Suite 200
One Dupont Circle N. W.
Washington, D.C. 20036

Dear Dr. Cooper:

An Association of Attending Physicians at the Elmhurst Hospital Affiliation of the Mount Sinai School of Medicine has petitioned before the NLRB for certification as a bargaining agent. These physicians are in the main full-time practitioners who provide and are paid for by the Hospital for patient care services.

We intend to contest the appropriateness of such a unit on several grounds, i.e., they are managerial employees and are excluded from coverage under the NLRA and/or they are supervisory employees and are excluded from coverage. This is a case of first impression before the National Board.

Since the appropriateness of such a unit of attending physicians has not been passed upon by the Board to date, this is a most significant case in light of the recent extension of the NLRA to health care facilities. The law firm of Proskauer, Rose, Goetz & Mendelsohn will be representing this case for the Medical Center. Alan Jaffe, Esq. or Robert Jossen, Esq. of that firm will be contacting you shortly to discuss whether you wish to join as amicus curiae in this case. I am certain the import of this attempt to organize attending physicians does not escape you. I feel the urgency to impress the Board with the national implications inherent in their considerations. I trust that you will give serious consideration to cooperating with our legal advisers.

Very truly yours,

Norman Metzger
Vice President for Personnel

NM:mc

COUNCIL OF TEACHING HOSPITALS

COTH ACTIVITIES

Tuesday, November 12, 1974

12:00 p.m. COTH Annual Luncheon

1:30 p.m. COTH Annual Institutional Membership Meeting

Presiding: Robert A. Derzon
Chairman, COTH, 1973-1974

2:00-4:30 p.m. COTH GENERAL SESSION

Presiding: Sidney Lewine
Chairman, COTH, 1974-1975

NEW MANAGEMENT AND GOVERNANCE RESPONSIBILITIES FOR TEACHING HOSPITALS

Speaker: Robert M. Cunningham, Jr.
Chairman, Editorial Board
MODERN HEALTH CARE
Chicago, Illinois

Thursday, November 14, 1974

1:00-4:00 p.m. AAMC ASSEMBLY MEETING

Chairman's Report

President's Report

Presentation Abraham Flexner and Borden Awards

Election and Installation of AAMC Officers

6:00-7:30 p.m. AAMC General Reception

Opportunities in the PSRO Program for Teaching, Research and Service

(Tuesday Morning, November 12)

Presiding: Robert J. Weiss, M.D.

I. PSRO Implementation at the National Level
Ruth M. Covell, M.D.
Health Sciences Planning Officer
University of California, San Diego

II. DHEW Activities in Quality Assurance
Henry E. Simmons, M.D.
Director, Office of Professional Standards Review

III. Opportunities for Education in PSRO
Clement R. Brown, M.D.
Director, Professional Service
American Hospital Association

IV. Opportunities for Evaluation and Research
Sam Shapiro
Director, Health Service Research and Development Center
Johns Hopkins Medical Institutions

Paul M. Densen, Sc.D.
Director
Harvard Center for Community Health and Medical Care

V. Evaluation of National PSRO Program
Michael J. Goran, M.D.
Director, Bureau of Quality Assurance

Seminar on Foreign Medical Graduates

(Tuesday Evening, November 12)

I. FMG's in Specialties

II. The American Student Abroad

III. The AAMC Task Force Report

Educating the Public About Health

(Plenary Session, Wednesday Morning, November 13)

Presiding: Sherman M. Mellinkoff, M.D.
Dean, UCLA School of Medicine
AAMC Chairman-Elect

I. The Right to Know—Public Education in Health
Daniel C. Tosteson, M.D.
Chairman, Department of Physiology and Pharmacology
Duke University School of Medicine
AAMC Chairman

II. The Missing Link in Health Services
Walter J. McNerney
President
Blue Cross Association

III. The Role of the Federal Government
Caspar W. Weinberger
Secretary of Health, Education and Welfare

IV. The Role of the State Governments
Daniel J. Evans
Governor
State of Washington

Specialty Distribution of Physicians
(Wednesday Afternoon, November 13)

I. A Congressional Perception of the Problem

STEPHEN E. LAWTON
Counsel
Subcommittee on Public Health and Environment

II. Redistribution of Specialty Training Opportunities—Options for the Private Sector

ARNOLD S. RELMAN, M.D.
Chairman, Department of Medicine
University of Pennsylvania School of Medicine

III. Redistribution of Specialty Training Opportunities—Options for the Government

THEODORE COOPER, M.D.
Deputy Assistant Secretary for Health, HEW

IV. Panel Discussion

JULIUS R. KREVANS, M.D.
Dean
University of California
San Francisco School of Medicine

ROBERT A. CHASE, M.D.
Chairman, Department of Anatomy
Stanford University School of Medicine

CHARLES B. WOMER
Director
Yale-New Haven Hospital

Educating the Public About Health
(Plenary Session, Thursday Morning, November 14)

Presiding: DANIEL C. TOSTESON
AAMC Chairman

I. Mass Media and Health Education

H. J. BARNUN, JR.
President
J. Walter Thompson Affiliated Companies

II. The Role of Regulation in Public Education

ALEXANDER M. SCHMIDT
Commissioner
Food and Drug Administration

III. Encouraging American to Stay "Alive and Well"

WILLIAM H. KOBIN
Health Project Director
Children's Television Workshop

ALAN GREGG MEMORIAL LECTURE

The Role of Formal Education

TERRY SANFORD
President
Duke University

COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN
MEDICAL COLLEGES
One Dupont Circle
Washington, D. C.
(202) 466-5127

COUNCIL OF TEACHING HOSPITALS

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

ANNUAL MEETING PROGRAM

CONRAD HILTON HOTEL
CHICAGO, ILLINOIS

NOVEMBER 12, 1974
TO
NOVEMBER 15, 1974

Five Year Salary Trends of Teaching Hospital Chief Executives, Controllers and Directors of Nursing 1969-1973

by

Daniel Everitt
Summer Intern
Department of Teaching Hospitals

Robert Carow
Staff Associate
Department of Teaching Hospitals

The Department of Teaching Hospitals has surveyed executive remuneration in teaching hospitals since 1969. This information has provided the basis for yearly reports to teaching hospital executives on salaries and perquisites of other executives and teaching hospital personnel across the country.

Utilizing this information, it is now possible to analyze the short run trends in salaries for teaching hospital executive officers, controllers and the directors of nursing service. The analysis was confined to these groups due to comparability problems for other categories of hospital personnel. The study was based on data from 113 teaching hospitals for which complete data sets were available for the five year period. The 113 hospitals have the following characteristics: 45.1 percent were from the northeast; 18.6 percent from the south; 25.7 percent from the north; and 10.6 percent from the west. Based upon affiliation: 22.1 percent were university owned; 59.3 percent had a major affiliation; 17.7 percent had a limited affiliation; and .9 percent were not affiliated. Based upon ownership: 14.2 percent were state hospitals; .9 percent - city; 3.5 percent - church; 55.8 percent - other non-profit; 17.7 percent - V.A.; and 8 percent miscellaneous. Finally, 31.1 percent had

less than 355 beds; 17.7 percent had between 355 and 479 beds; 33.6 percent had between 480 and 659 beds; and 26.5 percent had more than 660 beds.

Average salary data for hospital chief executives, controllers and directors of nursing is presented in Table I.

TABLE I

Average Cash Salaries of Chief Executive, Controller and Director of Nursing, 1969-1973

	1969	1970	1971	1972	1973	Average Rate of Increase 1969-1973
Chief Executive	33,209	35,610	37,364	39,343	41,691	6.4%
Controller	18,493	20,442	22,421	23,097	23,699	7.0%
Director of Nursing	17,621	18,758	20,758	21,879	22,186	6.5%

Over this period, salary compensation of the chief executives increased $8,482 for an average yearly rate of increase of 6.4 percent. During this same period the consumer price index increased at an average yearly rate of 5.3 percent. Thus, regional variation notwithstanding, the real income of the chief executive increased over this period.

Salaries for controllers and directors of nursing increased at a somewhat faster rate. Controller's salaries increased from $18,493 to $23,699 for an average yearly increase of 7.0 percent. Salaries for the directors of nursing service increased at a more modest 6.5 percent.

Regional Salary Variations

The following three tables document regional variations in salaries of chief executives, controllers and directors of nursing service.

TABLE II

Average Cash Salaries of the Hospital Chief Executive
by Region 1969-1973

	1969	1970	1971	1972	1973	Average Rate of Increase 1969-1973
Northeast	35,931	38,805	40,792	42,984	45,764	6.8%
South	29,091	32,278	33,052	34,399	36,362	6.2%
Midwest	32,164	33,751	35,642	38,119	39,779	5.9%
West	30,978	32,935	35,493	35,332	39,275	6.7%

TABLE III

Average Cash Salaries of the Director of Nursing
by Region 1969-1973

	1969	1970	1971	1972	1973	Average Rate of Increase 1969-1973
Northeast	18,160	18,474	20,829	22,270	23,480	7.3%
South	16,659	17,866	22,355	22,737	20,895	6.3%
Midwest	16,929	17,450	19,183	20,658	21,133	6.2%
West	18,666	20,450	21,603	21,667	21,621	3.9%

TABLE IV

Average Cash Salaries of the Controller
by Region 1969-1973

	1969	1970	1971	1972	1973	Average Rate of Increase 1969-1973
Northeast	19,644	22,115	24,185	24,744	25,263	7.1%
South	16,630	17,626	21,362	20,175	20,846	6.3%
Midwest	17,865	20,236	20,686	22,655	23,685	8.1%
West	18,274	18,950	20,626	22,299	22,005	5.1%

These differentials reveal a regional salary variation pattern characteristic for many positions. Salary levels are highest in the northeast and lowest in the south. No distinct pattern emerged with regard to the average yearly rates of increase in salaries. Chief executive salaries rose most quickly in the northeast with an average yearly rate of increase of 6.8 percent. Directors of nursing also had the greatest rate of increase in the northeast with an average yearly rate of increase of 7.3 percent. However, controller's salaries grew most rapidly in the midwest where they demonstrated an average yearly rate of increase of 8.1 percent.

Average Salary By Hospital Size

The following three tables reveal the salary variability when hospitals are divided by size.

TABLE V

Average Cash Salaries of Chief Executives
by Hospital Bed Size 1969-1973

Beds	1969	1970	1971	1972	1973	Average Rate of Increase 1969-1973
LT. 335	31,180	33,714	36,093	36,714	40,578	7.5%
356-479	30,483	31,308	32,376	36,206	37,468	5.7%
480-659	33,768	35,889	37,830	39,375	41,938	6.0%
660 and up	36,272	39,976	42,055	44,224	46,232	6.9%

TABLE VI

Average Cash Salaries of Controllers
by Hospital Bed Size 1969-1973

Beds	1969	1970	1971	1972	1973	Average Rate of Increase 1969-1973
LT. 335	16,550	18,936	22,799	22,217	23,048	9.8%
356-479	18,014	19,248	19,364	20,397	23,299	7.3%
480-659	17,914	20,063	20,648	22,795	22,495	6.4%
660 and up	21,201	23,399	24,307	25,975	26,232	5.9%

TABLE VII

Average Cash Salaries of Chiefs of Nursing
by Hospital Bed Size 1969-1973

Beds	1969	1970	1971	1972	1973	Average Rate of Increase 1969-1973
LT. 355	16,152	16,665	18,950	19,239	21,178	7.8%
356-479	16,208	17,509	18,806	20,161	21,063	7.5%
480-659	17,542	18,373	20,158	21,405	21,868	6.2%
660 and up	19,850	20,560	22,165	23,804	24,188	5.5%

According to the data, salary levels increase with bedsize across the three salary categories; at least this is true for the three largest hospital groups. However, the smallest teaching hospitals, those with less than 355 beds, paid their chief executives, controllers, and directors of nursing, on average, more than those hospitals with 355 to 479 beds.

August, 1974

A Proposal

Differential Utilization of Ancillary Services in Three Groups of Hospitals Classified By Their Involvement In Medical Education

Dennis D. Pointer, Ph.D.
Department of Teaching Hospitals
Association of American Medical Colleges

July, 1974
Washington, D.C.

TABLE OF CONTENTS

I. Introduction

Since the mid 1960's, hospital costs have come under increased public, governmental and professional scrutiny. Only within the last several years, however, has there been a concerted nationwide effort to control both absolute costs and their rate of increase in the health care industry. The Economic Stabilization Program (particularly Phases III and IV) and selected provisions of the 1972 Amendments to the Social Security Act (especially Section 223) are testament to this effort.

Inseparably associated with efforts to control hospital costs are attempts to explain variations in costs across facilities; validity of the former activity is dependent upon success of the latter. A plethora of research (with varying methodologies, data, results and quality) has fairly conclusively demonstrated that hospital costs vary because hospitals are different;[1] they treat patients with different ailments of variable complexity, they provide different facilities and services, some facilities engage in massive teaching and research programs, others do not (or their involvement is marginal), they are subject to variable wage markets; the list is endless. Surely, hospitals also vary with respect to their degree of efficiency and the extent to which they provide unnecessary services --

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[1] For a review of selected research in this area see: Judith Mann and Donald Yett, "The Analysis of Hospital Costs: A Review Article", Journal of Business, Vol. (April, 1968), pp. 191-202; Judith B. Lave, "A Review of Methods Used to Study Hospital Costs", Inquiry, Vol. 3 (May, 1966), pp. 51-81; Thomas R. Hefty, "Returns to Scale in Hospitals, A Critical Review of Recent Research", Health Services Research, Vol. 4 (Winter, 1969), pp. 267-280; and Sylvester Berki, Hospital Economics, (Lexington, Massachusetts; D.C. Health and Company, 1972), see especially Chapter V.

such variability does effect costs. The primary question is, however, how does one separate "legitimate cost variation" due to differences in the product produced and the production process from cost variation attributable to other factors?

II. Background of the Problem

Previous research has suggested that hospitals engaged in teaching programs experience higher costs than hospitals who do not offer such programs. Analyses indicate that the cost differential is associated with the type of training programs provided and their size. Ingbar and Taylor found that cost per available bed day ran 20 to 25 percent higher in teaching hospitals than in facilities that provided no training programs.[2] Carr and Feldstein demonstrate that the marginal cost of each approved graduate medical training program is $55,347 and the marginal cost of each trainee is approximately $5,000.[3] Berry provides analyses indicating that the presence of a formal medical school affiliation agreement increases per diem hospital cost by seventy cents; the number of house staff (interns and residents) per occupied bed was also shown to be positively associated with average cost.[4] Schuman et al. found a significant relationship between

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[2]Mary Ingbar and Lester Taylor, Hospital Costs In Massachusetts: An Econometric Study, (Cambridge, Massachusetts: Harvard University Press, 1968).

[3]W. John Carr and Paul Fieldstein, "The Relationship of Cost to Hospital Size", Inquiry, Vol. 4 (June, 1967), pp. 45-65.

[4] Ralph Berry, Jr., "Product Heterogeneity and Hospital Cost Analysis", Inquiry, Vol. 7 (March, 1970), pp. 67-75. A more technical discussion of this work is provided in: Ralph Berry, Jr., "Efficiency in the Production of Hospital Services: A Progress Report", unpublished mimeo, Harvard University School of Public Health, (March, 1969).

a scaled measure of the degree of involvement in medical-health training and hospital total cost.[5] Taylor and Newhouse conclude, in their study of a single hospital clinic, that the impact of the presence of a graduate medical training program varies from service to service.[6] Additionally, Lave and Lave found that hospitals with "advanced teaching programs" averaged a 1.3 percent point per year higher rate of cost inflation than hospitals with no training programs.[7]

This rather prestigious volume of econometric research appears to coinside with widely held public, professional and governmental opinion that the costs of hospitalization are greater in teaching than in non-teaching settings. This presumption is difficult to pin down; indeed, it is somewhat like a "conventional notion".[8] Generally, the notion is vaguely specified. It appears difficult to identify just exactly what "causes" the care in teaching hospitals to be more costly than in nonteaching hospitals. (Note that the econometricians do not address the cause of the differential, they merely document its existance.)

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[5]Larry Schuman, Harvey Wolf and C. Patrick Hardwick, "predictive Hospital Reimbursement and Evaluation Modsl", Inquiry, Vol. 8, (June, 1972), pp. 17-33.

[6]V. Taylor and Joseph Newhouse, "Improving Budgetary Procedures and Outpatient Operations in Nonprofit Hospitals", Report RM-6057/1 (Santa Monica, California: RAND Corporation, 1970).

[7]Lester R. Lave and Judith B. Lave, "Hospital Cost Functions: Estimation of Cost Functions for Multi-Product Firms", American Economic Review, Vol. 60, (June, 1970), pp. 379-395.

[8]For several examples see: Walter E. O'Donald, "Who Needs a House Staff? Not Our Hospital", Medical Economics, (June 22, 1970), pp. 94-102. The following statement is typical: "National comparisons show that teaching hospitals, as compared with non-teaching hospitals of approximately the same size, have 35 percent higher per day costs:" See: Institute of Medicine, Costs of Education in the Health Professions, Interim Report, (Washington, D.C.: National Academy of Sciences, 1973), p. 94.

Some of the more common (neither mutually exclusive nor necessarily valid) reasons offered to explain the teaching-nonteaching cost differential are as follows:

1. Direct Cost - Teaching hospitals incur costs associated with intern and resident salaries and fringe benefits. Students (whether graduate or undergarduate) require space which construction and upkeep necessitate expenditures. Additionally, hospitals with training programs often hire directors of medical education.

2. Indirect Costs - Teaching and its support consumes resources at the margin. Staff time (physicians, nurses, medical record librarians, laboratory technicians, etc.) must be expended to conduct the teaching program.

3. Inefficiencies in the Provision of Patient Care - The involvement of students in the process of patient care slows it down; teaching patients stay in the hospital longer than nonteaching patients. Tests and examinations often have to be rescheduled and repeated.

4. Case Mix - Teaching hospitals, due to the tertiary care facilities and services available tend to draw patients having serious medical problems, multiple diagnoses, and complications.

5. Quality - Teaching hospitals provide higher quality medical care than nonteaching hospitals spanning from more highly trained personnel (at higher salaries) to better equipment (that costs more).

6. Utilization of Resources - Teaching requires diagnostic procedures to be repeated; often unnecessary tests are ordered. Repetition is due to both demonstration and the validation of tests conducted by trainees. Unnecessary tests are conducted because "more" is deemed better than "not enough".

III. Research Objective

This investigation chooses to focus upon the last "reason" for teaching-nonteaching hospital cost differences: differentials in the utilization of resources. This is not to say that this element has the most influence; indeed, it probably does not. Rather, each of the other influences has been investigated and/or discussed to some degree (although

both the quality and quantity of such material is highly variable).[9] While factors influencing the utilization of diagnostic services has been investigated;[10] no study, to date, has compared ancillary services utilization across different types of settings.

The participation of house staff and medical students in the process of patient care has been alleged to result in excessive requests for laboratory tests.[11] It is the objective of this study to provide foundational analyses in order to determine if this observation is, in fact, accurate. The research question underlying the design of this investigation is: Is there a differential utilization of ancillary services in three groups of hospitals classified as to their involvement in medical education?

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[9] *Direct and indirect costs see:* August J. Carroll, Program Cost Estimating in a Teaching Hospital: A Pilot Study (Washington, D.C.: Association of American Medical Colleges, 1969) and Hartford Hospital: Study of the Cost of Educational Programs (Hartford, Connecticut: Ernst and Ernst, Management Consultants, 1972); *Inefficiencies in the provision of patient care see:* S. J. Bosch and H. D. Banta, "Medical Education in Prepaid Group Practice", Journal of the American Medical Association, Vol. 212 (June 22, 1972), pp. 2101-2103, and Commission on Professional and Hospital Activities, "How Much Longer Do Patients Stay in Teaching Hospitals?", PAS Reporter, Vol. 6 (June 1969); *Case mix see:* Martin Fedstein, Economic Analysis for Health Services Efficiency, (Amsterdam: North-Holland Publishing Company, 1967), Judith Lave and Lester Lave, "The Extent of Role Differentiation in Hospitals", Health Services Research, Vol. 6 (Spring, 1971), and Maw Lee and Richard Wallace, "Case Mix and Hospital Costs", unpublished report (NCHSRD Grant No. HS 00442); *Quality see:* J.A.H. Lee et al., "Case-Fatality From Three Common Surgical Conditions in Teaching and Non-Teaching Hospitals", The Lancet, (October 19, 1957), pp. 785-791.

[10] See for example: Donald K. Freeborn, et al., "Determination of Medical Care Utilization: Physicians' Use of Laboratory Services", American Journal of Public Health, Vol. 62 (June, 1972), pp. 846-853.

[11] For an articulation of this perception see: Robert Slighton and Robert Bell, "The Total Costs of Medical Care in Teaching and Nonteaching Settings: A Preliminary Analysis", unpublished working paper (Santa Monica, California: the RAND Corporation, 1974).

IV. General Specification of Investigative Design

A generalized schematic of the research design is presented in Figure 1. The discussion provided in this section (and the associated schematic) is not meant to be exhaustive. Rather, the objective is to familiarize the reader with the overall flow of the research; the sample selection, methodological design and modes of statistical analyses will be described more comprehensively and rigorously in subsequent sections.

This research seeks to compare ancillary services utilization, given specifically defined discharge diagnoses, across three groups of hospitals comparable to each other except for their degree of involvement in medical education. The three groups of hospitals will have similar operating characteristics and will be comparable with respect to the type and extent of facilities and services provided. Hospitals selected for participation in the study will be subdivided into: those that provide both graduate and undergraduate training programs; those that offer only graduate training programs; and those that do not engage in any medical education activities.

Realizing that ancillary service utilization varies across different diagnosis, comparisons between the three hospital groupings will be across six specifically delineated diagnostic and treatment procedure categories (three medical diagnoses and three surgical procedures). Comparisons will be made across three sets of variables: (1) the nature and extent of ancillary services utilization; (2) general characteristics of the patients included in the analysis (e.g., sex, age, incidence rate of diagnoses or procedure); and (3) severity and complexity proxies.

A detailed specification of the research format briefly outlined above follows in the remaining sections of this proposal.

FIGURE 1

General Schematic of the Research Design

Group No. A (hospitals with graduate and undergraduate training programs)		Group No. B (hospitals with only graduate training programs)		Group No. C (hospitals with no involvement in medical education)	
diagnoses		diagnoses		diagnoses	
medical	surgical	medical	surgical	medical	surgical
M1 M2 M3	S1 S2 S3	M1 M2 M3	S1 S2 S3	M1 M2 M3	S1 S2 S3

CRITERION VARIABLES: diagnostic test utilization, severity proxies, general characteristics.

V. Sample Selection

Given the objective of this research and both the nature and volume of data required to achieve that objective, the Association turned to the Commission on Professional and Hospital Activities (CPHA) in Ann Arbor, Michigan for a listing of short-term general hospitals that participated in the Professional Activities Service (PAS). From the list of PAS subscribers (numbering approximately 1,700 facilities with over 14 million annual discharges) a judgmental sample of twenty-three hospitals was selected subdivided as follows:[12] 1). eight facilities conducting extensive undergraduate and graduate medical training programs; 2). seven facilities participating in significant graduate medical programs and having no involvement in undergraduate medical education; and 3). eight hospitals which were not involved in either undergraduate or graduate medical education.

The twenty-three hospitals were selected to insure their comparability with regard to: 1). the type and extent of facilities and services offered; and 2). operating characteristics. Information provided in Table 1 denotes the variables employed in and provides analyses regarding the efficiency of the matching procedure.[13]

The three groups of hospitals (A - graduate and undergraduate training programs; B - graduate programs only; and C - no participation in medical education) are first evaluated with respect to the number of facilities

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[12]A major constraint was that few hospitals providing extensive undergraduate and graduate training programs subscribed to PAS. Additionally, significant participation in graduate medical education usually appears simultaneously with extensive undergraduate training programs, thus limiting the population of hospitals with graduate training only.

[13]Data extracted from: The 1972 Guide to the Health Care Field (Chicago: The American Hospital Association, 1973).

Evaluation of Inter-group Matching Efficiency;
Three Sets of Hospitals Classified by Extent of Involvement in Medical Education

I.D. Number	Basic Facilities and Services	Quality Enhancing Facilities and Services	Complex Facilities and Services	Community Service	Beds	Discharges	Discharges Per Bed	Expense Per Discharge	Occupancy Rate
A1	5	5	8	3	509	16,700	32.83	1971.13	76.2
A2	5	5	8	6	560	20,200	36.12	1564.90	79.3
A3	5	5	9	4	398	11,500	28.88	1463.91	78.1
A4	5	5	9	4	914	33,600	36.74	-	74.8
A5	5	5	9	2	407	14,200	34.83	506.70	71.0
A6	5	5	7	3	473	19,200	40.59	976.56	82.4
A7	5	5	8	5	573	22,800	39.79	881.40	74.4
A8	5	5	8	5	297	9,600	32.32	1082.29	63.6
B1	5	5	7	3	619	21,600	34.89	712.36	76.5
B2	5	4	6	3	257	8,400	32.68	1608.09	58.8
B3	5	5	8	4	565	23,500	41.59	484.85	92.5
B4	5	5	8	2	586	24,500	41.80	766.69	92.4
B5	5	5	8	3	751	27,600	36.75	824.13	86.0
B6	5	5	9	4	1125	40,800	36.26	807.10	77.8
B7	5	5	7	2	626	30,600	48.88	504.34	89.4
C1	5	4	7	4	656	23,600	35.97	542.16	79.0
C2	5	4	6	3	565	23,500	41.59	484.85	92.5
C3	5	5	7	5	500	26,200	52.43	-	70.5
C4	5	5	8	3	292	12,500	42.82	587.20	79.8
C5	5	5	7	2	388	17,400	44.84	544.94	80.7
C6	5	4	8	3	254	10,300	40.55	616.50	73.0
C7	5	5	7	3	409	18,200	44.49	538.40	88.5
C8	5	5	8	3	501	14,800	29.54	491.35	64.4
Degrees of freedom		2,20	2,20	2,20	2,20	2,20	2,20	2,18	2,20
Mean square (within)		0.136	0.635	1.075	38,591	60.2×10^6	30.23	1.27×10^5	85.086
Mean square (between)		0.286	2.077	2.076	77,103	115.7×10^6	79.35	7.68×10^5	90.182
Calculated F		2.094	3.268	1.931	1.997	1.920	2.624	6.037	1.059

offered across three classifications: 1). basic, 2). quality enhancing, 3). complex, and 4). community service. This taxonomy was developed by Berry in his analysis of the patterns of facility and services occurance in 5902 short-term general hospitals.[14] As can be noted in Table 1, a one way analysis of variance demonstrates that the three groups of hospitals are not significantly different ($p \geq 0.01$) with respect to the mean number of facilities and services provided across the four facility and service classifications. That is, the institutions included in the analysis provide both a comparable number and mix of facilities and services; they have roughly similar production capabilities.

The efficiency of the inter-group hospital matching process is also evaluated across several operational characteristics, including: beds, discharges, discharges per bed, expenditures per discharge and occupancy rate. These variables were selected because they adequately characterize (given available data) the production processes of the hospital, to wit: 1). the number of adult and pediatric beds is a measure of production capacity; 2). the number of discharges is a quantification of the scale of an enterprise; 3). discharges per bed is a measure of the rate of production; 4). expenditures per discharge reflects resource intensity per unit of output; and 5). occupancy rate characterizes the extent to which existing production capacity is utilized. As can be noted in the table, statistical analyses demonstrates that the three groups of hospitals do not differ significantly ($p \geq 0.01$) on the five operational variables.

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[14] For a discussion of the methodology underlying and the rationale of the taxonomy see: Ralph Berry, "On Grouping Hospitals for Economic Analysis", Inquiry, Vol. 10 (December, 1973), pp. 5-12.

Each of the facilities included in Group A (graduate and undergraduate training) serves as the primary teaching hospital of and has a major affiliation with a university school of medicine.[15] All hospitals in this group provide medical student clerkships in at least four of the five major specialties (medicine, surgery, pediatrics, obstetrics-gynecology and psychiatry). The hospitals range in the number of house staff positions filled (in 1972) from a low of 31 to a high of 473.

Each of the facilities included in Group B (graduate training only) have limited affiliations with a university school of medicine; none of the hospitals participate in providing clerkships for undergraduate medical students. Each facility is an institutional member of the Council of Teaching Hospitals of the Association of American Medical Colleges.[16] The hospitals ranged from filling 18 to 98 house staff positions in 1972.

Each of the hospitals included in Group C (no teaching) do not have an affiliation agreement with a medical school. They do not participate in offering medical student clerkships nor do they offer internship or residency training programs. None of the facilities included in this group are listed in the Directory of Approved Internships and Residencies[17]

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[15]For a discussion of the different classifications of medical school-teaching hospital affiliation arrangements see: Directory of Approved Internships and Residencies, 1973-74 (Chicago: The American Medical Association, 1974).

[16]Membership in the Council signifies significant participation in graduate medical education. COTH Membership requires; 1) a formal written affiliation agreement with a school of medicine to significantly participate in medical education, and 2) the facility must offer residency training programs in at least four of the five major specialty areas (medicine, surgery, pediatrics, obstetrics-gynecology or psychiatry.

[17]See supra note number 15.

or the AAMC Directory of American Medical Education[18] (which denotes medical school affiliated hospitals engaged in undergraduate training programs).

Thus, a judgmental sample has been selected that subdivides twenty-three hospitals into three treatment groups. The groups have been demonstrated to be similar with respect to operating characteristics (production capacity, scale, rate of production, resource intensity per unit of output, and capacity utilization) and the nature and number of facilities and services provided (basic, quality enhancing, complex and community). The three treatment groups differ with respect to the nature of involvement in medical education (graduate and undergraduate, graduate only and no teaching).

Thus, to the extent possible in organizational-behavioral research, the sample selection procedure attempts to lay the foundation for a quasi-experimental design.[19] In the absolute, it is the intent of experimental designs to hold all factors having potential effect on the dependent variable (or variables) constant thus facilitating interpretation of the influence of the treatment variable (in this instance, nature of participation in medical education) on the dependent variable (the utilization of ancillary services). Such control is seldomly achievable except in the physical sciences. The design structured here (and elaborated upon in subsequent sections) does achieve reasonable control over a host of variables that would have the potential to confound any interpretation of the influence of the nature of participation in medical training programs on the utilization of ancillary services.

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[18] AAMC Directory of American Medical Education, 1973-74 (Washington, D.C.: Association of American Medical Colleges, 1973).

[19] See: Claire Selztiz, et al., Research Methods in Social Relations (New York: Holt, Rinehart and Winston, 1959); and Julian L. Simon, Basic Research Methods in Social Science: The Art of Empirical Investigation (New York: Random House, Inc., 1969).

VI. Delineation of Treatment Groups

As noted above, three primary treatment groupings comprising (in total) twenty-three hospitals have been established based upon the criterion "nature of participation in medical education". A measure of inter-group comparability has been achieved with regard to operational characteristics and the number and nature of facilities provided. Previous research has indicated that the utilization of ancillary services varies considerably according to diagnosis, case severity and/or type of theraputic procedure employed (e.g., medical versus surgical).[20] Thus, to contrast ancillary services utilization across the three treatment groups, control over variations in diagnostic complexity and treatment modality must be achieved.

Within each of the treatment groups, the patient (aggregated by hospital) serves as the foundational unit of analysis. The utilization of ancillary services by similar patients must be compared between groups. To achieve this control, individual patients included in the analyses will be partitioned into treatment subgroupings. The subgroupings are as follows:[21]

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[20]See for example: William B. Hope, "Clinical Laboratory Services in Physicians' Offices", unpublished doctoral thesis (School of Hygiene and Public Health, Johns Hopkins University, 1971); Michael Pozen, "Effects of Physician Education and Administrative Support on Hospital Ambulatory Care", unpublished doctoral thesis (Department of Medical Care and Hospitals, Johns Hopkins University, 1974); and Paul F. Griner and Benjamin Lepzin, "Use of the Laboratory in a Teaching Hospital", Annals of Internal Medicine, Vol. 75 (August, 1971), pp. 157-163.

[21]For specification of discharge diagnoses and operation designations employed here, see: Hospital Adoptation of ICDA: H-ICDA, Vol. 1 (Ann Arbor, Michigan: Commission on Professional and Hospital Activities, March, 1972).

M1 - primary discharge diagnosis of diabetes mellitus without complications (H-ICDA 250.0)

M2 - primary discharge diagnosis of acute myocardial infarction (H-ICDA 410)

M3 - primary discharge diagnosis of peptic ulcer, site unspecified without hemorrhage or perforation (H-ICDA 533.0)

S1 - primary discharge operation designation of cholecystectomy, resection of gallbladder (H-ICDA 53.5)

S2 - primary discharge operation designation of complete lobectomy (H-ICDA 162.1) with primary discharge diagnosis of malignant neoplasm of bronchus and lung (H-ICDA 162.1)

S3 - primary discharge operation designation of total abdominal hysterectomy (H-ICDA 71.1)

Thus comparisons of ancillary services utilization between the primary treatment groups will be made across similar partitions. For example the utilization of ancillary services by patients in partition M1 (diabetes mellitus without complications) will be compared across the three groups of hospitals. The partitions are representative of selected patient regimen differences: theraputic modality, case complexity, existance of complications, acuteness and prognosis.

VII. Criterion Variable Specification

Data on the following variables will be collected on each diagnosis/operation designation partition by hospital within treatment group:

(1) percentage of patients administered multi-channel chemistry

(2) variety index [22]

(3) percentage of patients administered EKG examinations

(4) percentage of patients administered repeat EKG examinations

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[22] The average number of different types of test administered to individual patients (aggregated across patients within a given hospital) out of a possible total of seventy.

(5) percentage of patients administered routine chest x-ray examinations

(6) percentage of patients administered diagnostic chest x-ray examinations

(7) percentage of patients administered skeletal x-ray examinations

(8) percentage of patients administered digestive tract x-ray examinations

(9) percentage of patients administered genitourinary tract examinations

(10) percentage of patients treated with antibiotics

(11) percentage of patients treated with parenteral fluids

(12) percentage of patients treated with test for electrolite balance

(13) percentage of patients administered repeat electrolite balance test

(14) number of patients discharged dead

(15) percentage of patients with white blood cell count exceeding 10,000 on admission

(16) percentage of patients with temperature exceeding 100° F on admission

(17) percentage of patients upon which operation performed

(18) percentage of patients receiving transfusion

(19) percentage of patients receiving treatment in intensive care and/or cardiac care units

(20) percentage of patients for whom minimum lab was not met[23]

(21) percentage of patients with emergency admission

(22) percentage of patients with urgent admission

(23) percentage of patients given consultation

(24) average length of stay

(25) number of patients

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[23]Minimum laboratory work up (urinalysis and hemoglobin or hematocrit) was not performed any time during hospitalization.

(26) rate per 1,000 discharges

(27) percentage of discharges, male

(28) percentages of discharges exceeding 65 years of age

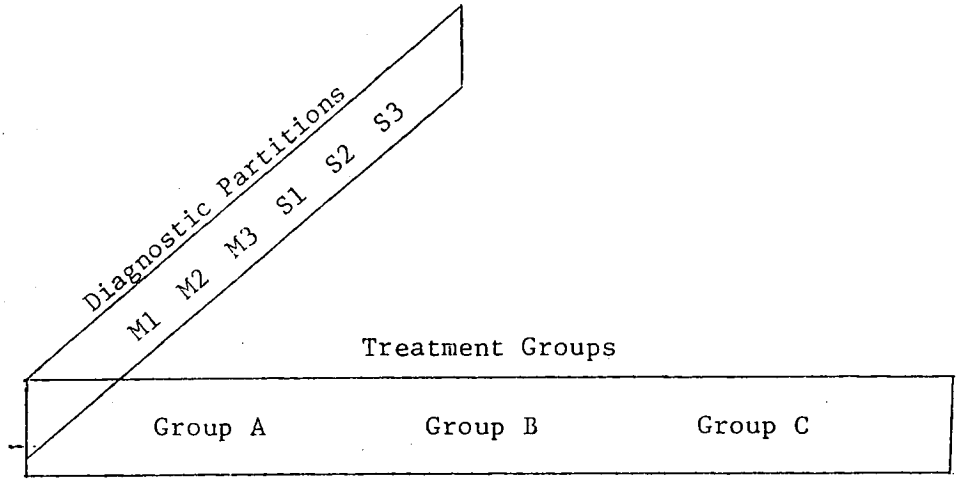
The criterion variables can be subdivided into three major sub-groupings: 1). ancillary services utilization variables (number 1 through 13); 2). case severity-complexity proxy variables (numbers 14 through 23); and 3). general patient characteristics variables (numbers 24 through 28). Data will be extracted from PAS case abstracts completed upon each discharge from hospitals in the study pool (a copy of the case abstract form can be found in Appendix A).

VIII. Analytical Design

The primary mode of analysis to be employed in this project will be the Kruskal-Wallis one-way analyses of varience by ranks. The analyses will entail employing each of the twenty-eight criterion variables in an analysis of each of six diagnostic partitions across the primary treatment groups. A total of eighty-four analytical "runs" will be executed. (A schematic of the analytical design is denoted in Figure 2.) For example in the first run, variable 1 (percentage of patients administered multi-channel chemistry) would be compared across each of the three primary treatment groups for diagnostic partition M1 (primary discharge diagnosis of diabetes mellitus without complications) -- the same analysis would then be undertaken for diagnostic partition M2, and replicated for each partition through S3. The second criterion variable (variety index) would then be employed and the same process as described above would be executed for each diagnostic partition (M1 through S3). The execution would be replicated for each of the twenty-eight criterion variables.

FIGURE 2

Schematic of Analytical Design



Due to the fact that the unit of analysis is the hospital (N=23, K=3) the statistical tool of choice is the Kruskal-Wallis analysis of varience by ranks. [24] This analytical procedure is ideally suited to small samples;[25] it assertains whether K independent samples could have been drawn from the same population. Compared with the most powerful parametric test (the F test), under conditions where the assumptions associated with the statistical model of the F test are met, the Kruskal-Wallis procedure has a asymtotic efficiency of $\frac{3}{\pi}$ = 95.5 percent. [26]

IX. Project Execution

Figure III depicts the time sequence of the total research project. As can be noted, the project is a collaborative effort between the Association of American Medical Colleges and the Commission on Professional and Hospital Activities (Ann Arbor, Michigan). CPHA will be working under a subcontract from the AAMC to prepare the raw data for the analysis. Data will be abstracted from the ongoing Professional Activities Surveys conducted at the twenty-three study hospitals. CPHA will search the 468,600 discharge abstracts accumulated by the hospitals for the year 1972 and compile relevant variables (detailed in Section VII of this proposal) into a working tape. CPHA will also execute the analytical runs specified in Section VIII. The AAMC is responsible

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[24] For a general discussion of the Kruskal-Wallis test see: Sidney Siegel, Nonparametric Statistics for the Behavioral Sciences (New York: McGraw-Hill Book Company, 1956), pp. 184-194.

[25] W. H. Kruskal, "A Non Parametric Test for the Several Sample Problem", Annals of Mathematical Statistics, Vol. 23 (May, 1952), pp. 525-540; and W. H. Kruskal and W. A. Wallis, "Use of Ranks in One-Criterion Varience Analysis", Journal of the American Statistical Association, Vol. 47 (March, 1952), pp. 583-621.

[26] F. C. Andrews, "Asymptotic Behavior of Same Rank Test for Analyses of Varience", Annals of Mathematic Statistic, Vol. 25, (April, 1954), pp. 724-736.

FIGURE 3

Estimated Time Frame For Project Execution

TASKS		Elapsed Time (in months)
AAMC	CPHA	
		0
design		1
		2
		3
	feasibility review	4
project review		5
analyses specification	cost estimate preparation	6
	program layout	7
execution, supervision and coordination		8
	working tape generation	9
	analytical runs	10
data analysis		11
		12
write up		13
		14
		15
finish		16

for the overall design, execution, analysis and final write-up of the project.

The project has now advanced to the feasibility-project review stage (i.e., month number 4 in the estimated time frame). Given the execution schedule it is estimated that the project can be completed in approximately twelve months (± two months).

Staff directly involved in the execution of the project are as follows, (resumes can be found in Appendix B):

Project Supervisor:	Richard M. Knapp, Ph.D. Director Department of Teaching Hospitals Association of American Medical Colleges
Primary Investigator:	Dennis D. Pointer, Ph.D. Assistant Director Department of Teaching Hospitals Association of American Medical Colleges
Investigator:	Robert J. Carow Staff Associate Department of Teaching Hospitals Association of American Medical Colleges
Consultant:	Michael F. Ball, M.D. Associate Director Department of Academic Affairs Association of American Medical Colleges
Research Assistant:	Gail A. Mather Department of Teaching Hospitals Association of American Medical Colleges

X. Project Budget

The proposed budget for execution of the reserach project can be found in Appendix C. As can be noted from the attachment, of a total project cost of $18,815.00, the Association is seeking outside support in the amount of $11,025.00.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
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August 27, 1974

MEMORANDUM

TO: The Administrative Boards of the COD, CAS and COTH

FROM: Joseph A. Keyes, Director, Division of Institutional Studies

SUBJECT: Background Material for Administrative Board Examination of LCME Accreditation Process

The purpose of this paper is to assist the Administrative Boards in their examination of the process of undergraduate medical education accreditation. It provides a brief description of the LCME and its role in accreditation; it then reviews three facets of accreditation--the standards, the evaluators, and the procedures for evaluation. Finally, it summarizes the results of the process for the year 1973-74, and lists the actions of the LCME for the past three academic years.

Since 1942, accreditation of educational programs of medical education leading to the M.D. degree has been conducted through the agency of the Liaison Committee on Medical Education (LCME). This committee was formed to facilitate the cooperation of the AMA and the AAMC in accomplishing their common goal of enhancing and maintaining the quality of medical education. Prior to that date, the activities of the two associations were conducted independantly. The AMA's Council on Medical Education, one of four standing committees of the House of Delegates, was organized in 1904, began inspecting medical schools in 1906, and assisted in the Carnegie Foundation study of 1909 which resulted in the "Flexner Report." The AAMC, first organized in 1876 and reorganized in 1890, set standards for membership as a means of upgrading the quality of medical education and has published its list of member schools since 1896.

The LCME is currently a 15-member committee constituted as follows: 6 are appointed by the AAMC Executive Council; 6 are members of the AMA Council on Medical Education; 2 are "public representatives" selected by the committee itself; 1 is a "federal representative" designated by the Secretary of Health Education and Welfare on the invitation of the Liaison Committee. Thus the process of accreditation involves the community of practicing physicians, the academic community and the public.

Accreditation, originally a kind of voluntary peer review signifying that an approved program had received public recognition as meeting certain minimal standards of quality, has become an

integral part of the process of two governmental activities, licensure and funding of programs. Graduation from an approved program is a condition of eligibility for professional licensure in many states. Approval by an agency recognized by the Commissioner of Education is a statutory prerequisite of eligibility for an institution's receipt of federal funds under many programs. The states vary in their licensure provisions, some specify the approving agency in the medical practice act, some leave this to the board of medical examiners; some specify the AMA, some the AAMC, and some the LCME. The current practice of both the AMA and the AAMC has been to meet these various requirements by delegating authority for making the accreditation decisions to the LCME subject to a somewhat pro forma ratification by the sponsoring agencies. This approach, combined with the specific review and recorded opinion of each survey report by each member of the cognizant body of both sponsoring agencies (the Executive Council of the AAMC and the Council on Medical Education of the AMC) serves to preserve the early and immediate involvement of the practicing community, the academic community and the public in an administratively manageable fashion.

The committee receives staff support from both the AMA and the AAMC, the secretariate alternating between the two associations annually. The professional staff of the two associations serve as secretaries on site visit teams. The expenses of the committee are borne equally by the two parent associations.

1. Standards. The Functions and Structure of a Medical School, developed by the LCME and adopted in 1972 by the AAMC Assembly and in 1973 by the AMA House of Delegates, is the basic policy document of the LCME.

The objectives of the document are set out in the introduction as follows:

> "It is intended that this material be used to assist in attainment of standards of education that can provide assurance to society and to the medical profession that graduates are competent to meet society's expectations; to students that they will receive a useful and valid educational experience; and to institutions that their efforts and expenditures are suitably allocated.
>
> The concepts expressed here will serve as general but not specific criteria in the medical school accreditation process. However, it is urged that this document not be interpreted as an obstacle to soundly conceived experimentation in medical education."

Thus, this document avoids setting out detailed requirements such as student-faculty ratios, number of books in the library, or number of beds per student. Its purpose is to set out some basic guidelines within which a high degree of professional judgment can be exercised.

In order to assist site visitors in their evaluation, a check-list derived from this document has been developed. (Attachment I) This check-list, which is given to each survey team member, sets out a series of discrete statements expressing the explicit expectations of the LCME contained in Functions and Structure. With respect to each, the question is asked, "Does the school conform?"

The LCME is presently considering these procedures with a view to answering the following questions. Are these standards adequate and appropriate? If not, in what respect are they deficient? Are they in the proper form? Are they understood by the academic community, by the evaluators, by the public?

Do these standards meet the criteria set forth in the "Criteria for Recognition of Accrediting Agencies and Associations of the Office of Education?" (Attachment II)

Do these standards require further elaboration after the manner of the Southern Association of Colleges and Schools? (Attachment III, excerpt of the research standard from that Association's 27-page brochure.)

2. The Evaluators. Each institution surveyed is evaluated through a process involving multiple levels of review. After review by the institution itself, the first and key review is done by the survey team which visits the school.

Each team is made up of four persons, two selected to represent the AMA and two, the AAMC. The team chairman represents one association, the team secretary is a staff member of the other. The teams are selected on a preliminary basis at a conference held prior to the academic year of the survey between the staffs of the AMA and the AAMC responsible for the operation of the LCME. Every effort is made to select a team with a balance of experience and expertise best suited to evaluate each institution. Where particular problem areas are known to exist, the team is constituted with an eye to the problems, and evaluators with skills viewed as particularly relevant to an understanding of such problems are requested to serve on the team.

Characteristically, the AMA selects a practicing clinician and an administrator as its representatives, frequently choosing from among the members of the CME and its Advisory Committee. The AAMC, having access to basic scientists and hospital administrators, frequently selects such persons to represent it, but relies heavily on deans and clinical faculty members as well. The final composition of the teams is, of course, dependent upon the availability of the prospective team members on the survey dates and their willingness to serve. It is also subject to their acceptability to the institution, though this has never proved to be a significant problem. The chief problem in composing the teams is acquiring the agreement to serve on the team from those identified as appropriate evaluators.

Attachment IV is a listing of those who have served as site visitors over the past three years, along with a somewhat simplified identification of their roles.

The following questions are posed. Have appropriate visitors been selected? Are there additional qualified people who should be asked to serve? How should the pool of visitors be identified? Should any of the visitors be disqualified? Is the process of selecting the team appropriate? If not, how should it be modified?

3. The Procedures. Each institution to be accredited is contacted several months in advance of the anticipated visit and an acceptable date is agreed upon. An extensive presurvey questionnaire is forwarded to the school with a request that it be completed in time for the site visit team to review approximately a month in advance of the visit. The team secretary, after consultation with the team chairman, negotiates an appropriate schedule of interviews with a designated representative of the school. Attachment V is a sample schedule. After the visit, the survey report is prepared by the team secretary, reviewed and revised by the team members, sent to the dean of the institution visited for correction of factual errors, and then distributed to the 54 members of the LCME, the AAMC Executive Council, the AMA Council on Medical Education (CME) and the CME Advisory Committee on Undergraduate Medical Education. A ballot accompanies the report and each of the reviewers is requested to provide his recommendation to the LCME on two matters: a) whether to accept the report, and b) whether to approve the team's recommendations. A composite vote sheet is prepared for the LCME agenda book which displays each reviewer's vote, recommendations and comments. (See Attachment VI) This material is taken into account as the LCME deliberates on the final action to be taken. Frequently, especially where the decision is a difficult one, a member of the team is present to respond to questions about the report or the institution.

The following tables summarize the results of this process for the 22 reports on which there has been final LCME action during the past year:

# of Reports	Votes not to Accept
9	0
8	1
1	2
2	3
1	4
1	8 (of 30)
22	

Thus, out of 54 possible votes on each report, and an average of about 35 actual votes, 17 of 22 reports received either unanimous acceptance or one dissenting vote; only one received over 10% negative votes of the total panel; two received over 10% negative votes of those actually voting. If there is widespread dissatisfaction over the quality of the reports, these vote sheets do not reflect it.

The second question on the advisory ballot, whether to approve the team recommendation, produces a greater level of disagreement as displayed in the following table:

# of Reports	Dissenting Votes
6	0
4	1
2	2
1	3
1	4
3	5
2	6
1	8
1	9
1	22
22	

Thus about half of the reports had two or fewer votes dissenting from the team recommendation. A more complete display of the relationships between the team recommendations, the ballot responses and the final LCME action appears as Attachment VII.

4. The Results. A review of the final LCME decisions, with respect to these 22 schools, discloses the following:

A. Regular Accreditation Actions. In 17 cases the LCME action was the same as the team recommendation. In one case an additional requirement of a progress report was imposed. One school received a four-year approval and was required to submit a progress report in contrast to the team's recommended seven-year approval. In one case the team's recommendation was accepted with an increase in the maximum number of students permitted to be matriculated, in another this number was decreased by the LCME from that recommended by its survey team. One decision was deferred.

B. New VA-Medical Schools (P.L. 92-541 subchapter I). The LCME acted upon the request of four schools for a letter of reasonable assurance of accreditation (LRA) to provide eligibility for funding under the new VA-Medical School program with the following results:

# of Schools	Team Recommendation	LCME Action
1	Yes	Yes
1	Yes	No
2	No	No

C. VA-Assistance to Existing Schools, VA (P.L. 92-541 subchapter II). Twenty-four schools requested LRA's to meet the eligibility requirement for the subchapter II VA assistance.

These were reviewed by a Task Force of the LCME prior to LCME action. Sixteen were recommended for approval and eight for disapproval. The LCME accepted all of these recommendations.

D. Summary of LCME Activities and Actions.

i. 1971-72 LCME Activities and Actions

32 Medical schools surveyed
10 Full accreditation for a period of seven years
7 " " " " " five "
4 " " " " " three "
5 " " " " " two "
6 Provisional accreditation
2 Letters of reasonable assurance granted
9 Schools requested and received staff consultation visits

ii. 1972-73 LCME Activities and Actions

34 Medical Schools surveyed
9 Full accreditation for a period of seven years
8 " " " " " five "
5 " " " " " three "
7 " " " " " two "
5 Provisional accreditation
7 Proposals to establish medical schools brought to the attention of LCME
2 Letters of Reasonable Assurance granted
1 School placed on "open probation"
19 Schools submitted progress reports for LCME consideration
6 Schools requested and received staff consultation visits

iii. 1973-74 LCME Activities and Actions

*39 Medical Schools surveyed
10 Full accreditation for a period of seven years
1 " " " " " four years
1 " " " " " three "
6 " " " " " two "
2 " " " " " one year
4 Provisional accreditation
4 Proposals to establish medical schools brought attention of LCME
1 Letter of Reasonable Assurance issued VA P.L. 92-541 subchapter I

*Not all the surveys conducted during 1973-74 have been acted upon by LCME.

1973-74 LCME Activities and Actions (continued)

3 Letters of Reasonable Assurance denied VA P.L. 92-541 subchapter I
9 Schools submitted progress reports for LCME consideration
5 Schools requested and received staff consultation visits
16 Letters of Reasonable Assurance issued VA P.L. 92-541 subchapter II
8 Letters of Reasonable Assurance denied VA P.L. 92-541 subchapter II

LIAISON COMMITTEE ON MEDICAL EDUCATION

Check List - For use by members of Medical School Survey Teams.

Statements are derived from Functions and Structure of a Medical School (1973). Does the school conform to the statement?

	Yes	No
DEFINITION AND MISSION		
1. A medical school IS an aggregation of resources that have been organized as a definable academic unit to provide the full spectrum of education in the art and science of medicine in not less than 32 months, culminating with the award of the M.D. degree.	___	___
2. The educational program MUST be sponsored by an academic institution that is appropriately charged within the public trust to offer the M.D. degree.	___	___
3. The principal responsibility of the medical school IS to provide its students with the opportunity to acquire a sound basic education in medicine and also to foster the development of life-long habits of scholarship and service.	___	___
4. A medical school IS responsible for the advancement of knowledge through research.	___	___
5. Each school IS responsible for development of graduate education to produce practitioners, teachers, and investigators, both through clinical residency programs and advanced degree programs in the basic medical sciences.	___	___
6. Another IMPORTANT role for the medical school is participation in continuing education aimed at maintaining and improving the competence of those professionals engaged in caring for patients.	___	___
7. As a central intellectual force within the center, the medical school SHOULD identify those needs that it might appropriately meet and create programs consistent with its educational objectives and resources to meet them.	___	___
8. A medical school SHOULD develop a clear definition of its total objectives, appropriate to the needs of the community or geographic area it is designed to serve and the resources at its disposal.	___	___
9. When objectives are clearly defined, they SHOULD be made familiar to faculty and students alike.	___	___
10. Schools SHOULD be cautious about overextending themselves in the field of research or service to the detriment of their primary educational mission.	___	___

APPROVED BY THE LIAISON COMMITTEE ON MEDICAL EDUCATION ON MARCH 28, 1973.

EDUCATIONAL PROGRAM	Yes	No
1. Each student SHOULD acquire a foundation of knowledge in the basic sciences that will permit the pursuit of any of the several careers that medicine offers.	___	___
2. The student SHOULD be comfortably familiar with the methods and skills utilized in the practice of clinical medicine.	___	___
3. Instruction SHOULD be sufficiently comprehensive so as to include the study of both mental and physical disease in patients who are hospitalized as well as ambulatory.	___	___
4. (Instruction) SHOULD foster and encourage the development of the specific and unique interests of each student by tailoring the program in accordance with the student's preparation, competence, and interests by providing elective time whenever it can be included in the curriculum for this purpose.	___	___
5. Attention SHOULD also be given to preventive medicine and public health, and to the social and economic aspects of the systems for delivering medical services.	___	___
6. Instruction SHOULD stress the physician's concern with the total health and circumstances of patients and not just their diseases.	___	___
7. Throughout, the student SHOULD be encouraged to develop those basic intellectual attitudes, ethical and moral principles that are essential if the physician is to gain and maintain the trust of patients and colleagues, and the support of the community in which the physician lives.	___	___
ADMINISTRATION AND GOVERNANCE		
1. A medical school SHOULD be incorporated as a nonprofit institution.	___	___
2. Whenever possible it SHOULD be a part of a university . . .	___	___
3. If not a component of a university, a medical school SHOULD have a Board of Trustees composed of public spirited men and women having no financial interest in the operation of the school or its associated hospitals.	___	___
4. Trustees SHOULD serve for sufficiently long and overlapping terms to permit them to gain an adequate understanding of the programs of the institution and to function in the development of policy in the interest of the institution and the public with continuity and as free of personal and political predilections as possible.	___	___

Administration and Governance (continued)	Yes	No
5. Officers and members of the medical school faculty SHOULD be appointed by, or on the authority of, the Board of Trustees of the medical school or its parent university.	___	___
6. The chief official of the medical school, who is ordinarily the Dean, SHOULD have ready access to the University President and such other University officials as are pertinent to the responsibilities of his office.	___	___
7. He SHOULD have the assistance of a capable business officer and such associate or assistant deans as may be necessary for such areas as student affairs, academic affairs, graduate education, continuing education, hospital matters and research affairs.	___	___
8. The medical school SHOULD be organized so as to facilitate its ability to accomplish its objectives.	___	___
9. Names and functions of the committees established SHOULD be subject to local determination and needs.	___	___
10. Consideration of student representation on all committees IS both DESIRABLE and USEFUL.	___	___
11. The manner in which the institution is organized, including the responsibilities and privileges of administrative officers, faculty and students, SHOULD be clearly set out in either medical school or university bylaws.	___	___
FACULTY		
1. The faculty MUST consist of a sufficient number of identifiable representatives from the biological, behavorial and clinical sciences to implement the objectives that each medical school adopts for itself.	___	___
2. ..the faculty SHOULD have professional competence as well as an interest in research and teaching in the fields in which instruction is to be provided.	___	___
3. Inasmuch as individual faculty members will vary in the degree of competence and interest they bring to the primary functions of the medical school, assignment of responsibility SHOULD be made with regard to these variations.	___	___
4. The advantage to the student of instruction by such physicians (who are practicing in the community), as well as by those in full-time academic service, SHOULD be kept in mind.	___	___

Faculty (continued)	Yes	No
5. Nominations for faculty appointment ORDINARILY involve participation of both the faculty and the Dean, the role of each customarily varying somewhat with the rank of the appointee and the degree to which administrative responsibilities may be involved.	___	___
6. Reasonable security and possibility for advancement in salary and rank SHOULD be provided (to the faculty).	___	___
7. A small committee of the faculty SHOULD work with the Dean in setting medical school policy.	___	___
8. (The committee) MAY be organized in any way that would bring reasonable and appropriate faculty and student influence into the governance of the school.	___	___
9. The faculty SHOULD meet often enough to provide an opportunity for all to discuss, establish, or otherwise become acquainted with medical school policies and practices.	___	___
STUDENTS		
1. The number of students that can be supported by the education program of the medical school and its resources, as well as the determination of the qualifications that a student should have to study medicine, ARE proper responsibilities of the institution.	___	___
2. ...it is DESIRABLE for the student body to reflect a wide spectrum of social and economic backgrounds.	___	___
3. Decisions regarding admission to medical school SHOULD be based not only on satisfactory prior accomplishments but also on such factors as personal and emotional characteristics, motivation, industry, resourcefulness, and personal health.	___	___
4. Information about these factors CAN BE developed through personal interviews, college records of academic and non-academic activities, admission tests and letters of recommendation.	___	___
5. There SHOULD be no discrimination on the basis of sex, creed, race, or national origin.	___	___
6. ORDINARILY, at least three years of undergraduate education are required for entrance into medical school although a number of medical schools have developed programs in which the time spent in college prior to entering medical school has been reduced even further.	___	___
7. The medical school SHOULD restrict its specified premedical course requirements to courses that are considered essential to enable the student to cope with the medical school curriculum.	___	___

	Yes	No
Students (continued)		
8. A student preparing for the study of medicine SHOULD have the opportunity to acquire either a broad, liberal education, or if he chooses, study a specific field in depth, according to his personal interest and ability.	___	___
9. Advanced standing MAY be granted to students for work done prior to admission.	___	___
10. REQUIRE that transfers between medical school be individually considered so that both school and student will be assured that the course previously pursued by the student is compatible with the program he will enter.	___	___
11. There SHOULD be a system for keeping student records that summarizes admissions, credentials, grades, and other records for performance in medical school.	___	___
12. These records SHOULD reflect accurately each student's work and qualifications by including a qualitative evaluation of each student by his instructors.	___	___
13. It IS very IMPORTANT that there be available an adequate system of student counselling.	___	___
14. Academic programs allowing students to progress at their own pace are DESIRABLE.	___	___
15. There SHOULD be a program for student health-care that provides for periodic medical examination and adequate clinical care for students.	___	___
FINANCES		
1. The school of medicine SHOULD seek its operating support from diverse sources.	___	___
2. The support SHOULD be sufficient for the school to conduct its programs in a satisfactory manner.	___	___
3. (The support) SHOULD reflect, as accurately as possible, the educational, research, and service efforts of the faculty.	___	___
FACILITIES		
1. A medical school SHOULD have, or enjoy the assured use of, buildings and equipment that are quantitatively and qualitatively adequate to provide an environment that will be conducive to maximum productivity of faculty and students in fulfilling the objectives of the school.	___	___
2. Geographic proximity between the preclinical and clinical facilities is DESIRABLE, whenever possible.	___	___

Facilities (continued)	Yes	No
3. The facilities SHOULD include		
faculty offices and research laboratories	___	___
student classrooms and laboratories	___	___
a hospital of sufficient capacity for the educational programs	___	___
ambulatory care facilities	___	___
a library	___	___
4. The relationship of the medical school to its primary or affiliated hospitals SHOULD be such that the medical school has the unquestioned right to appoint, as faculty, that portion of the hospital's attending staff that will participate in the school's teaching program	___	___
5. All affiliation agreements SHOULD define clearly the rights of both the medical school and the hospital in the appointment of the attending staff.	___	___
6. Hospitals with which the school's association is less intimate MAY be utilized in the teaching program in a subsidiary way but all arrangements should insure that instruction is conducted under the supervision of the medical school faculty.	___	___
7. A well maintained and catalogued library, sufficient in size and breadth to support the educational programs that are operated by the institution, IS ESSENTIAL to a medical school.	___	___
8. The library SHOULD receive the leading medical periodicals, the current numbers of which should be readily accessible.	___	___
9. The library or other learning resource SHOULD also be equipped to allow students to gain experience with newer methods of receiving information as well as with self-instructional devices.	___	___
10. A professional library staff SHOULD supervise the development and operation of the library	___	___

Standards

The recently published criteria for Recognition of Accrediting Agencies and Associations of the Office of Education, DHEW, include the following references to standards:

> "149.2 Accrediting means the process whereby an agency or association grants public recognition to a school, institute, college, university or specialized program of study which meets certain established qualifications and educational standards, as determined through initial and periodic evaluation...
>
> 149.6 (b) Responsibility. Its (the agency) responsibility will be demonstrated by the way in which --
>
> ... (2) (ii) The agency or association publishes or otherwise makes publicly available:
>
> (A) The Standards by which institutions or programs are evaluated.
>
> ... (5) It maintains a program of evaluation of its educational standards designed to assess their validity and reliability.
>
> ... (8) It accredits only those institutions or programs which meet its published standards and demonstrates that its standards, policies and procedures are fairly applied and that its evaluations are conducted and decisions rendered under conditions that assure an impartial and objective judgment."

STANDARD ELEVEN*

Research

As long as colleges and universities have been established, members of their faculties have made significant contributions through the discovery of new knowledge. The zest for discovery of truths as well as for the communication of knowledge is an essential characteristic of an atmosphere conducive to the development of scholarship.

For adequate support of his individual research program, the teacher-investigator must frequently seek funds from outside sources. In recent years ever-increasing financial support for research has been made available through private and governmental agencies. Such contractual or sponsored research has become an integral part of the activities of colleges and universities today.

Policies relative to research should insure conformity of this activity to the stated purposes of the institution, provide an appropriate balance between research and instruction, and guarantee control of administration of the research by the institution. The investigator's freedom in research, including direction and communication of results, should be preserved.

In using funds from contracts, grants, and contributions in support of research, the institution should not become dependent upon that portion allowed for indirect or overhead cost in support of its regular operating budget.

Illustrations and Interpretations

1. *Administration*

Although many advantages accrue to institutions from research support possibilities through private and governmental agencies, problems often arise through research contract and grant procedures and administration. As a means of dealing with these problems, the administration of research should provide for conformity of research activities to the stated purposes of the institution.

Responsibility for contractual research should be related to departmental administration. If departmental administration fails to provide leadership, lack of morale and lack of coordination of activities can result.

The institution should have a clear policy relative to the division of responsibility between research and other activities. Certainly each institution may set up its own policy,

* The Southern Association of Colleges and Schools, Standards of the College Delegate Assembly, December 13, 1972, Atlanta, Georgia, Southern Association of Colleges and Schools, 1972, pp. 26-27.

4. *Faculty Morale*

Care should be exercised that support from outside agencies in some areas within the college or university does not affect adversely morale in other areas through development of jealousies. If teaching loads are reduced so that obligations to outside agencies may be satisfied, resentment on the part of persons in other areas, or even in the same area, can be significant basis for low morale. The administrative officers of the institution should provide research support and time for those who are not in a position to seek grants.

5. *Expenditure of Research Funds*

An institution has the prerogative of developing its own policy of purchasing procedures and, in general, purchases with contract funds should conform to the established procedural policy. Most granting agencies state clearly that purchasing procedures using grant funds must conform to the institution's policies; however, it is not essential that policies governing expenditures of research funds be the same as those governing expenditures of general funds.

6. *Freedom of Investigation*

The elements inherent in undertaking "classified" research should not tend to destroy the principles of freedom of investigation and of reporting results. This freedom has always been a sacred prerogative of faculties of educational institutions of higher learning, whether privately or publicly supported.

AMA REPRESENTATIVES FOR SURVEY VISITS

Evaluator	1973-1974	1972-1973	1971-1972	GENERAL FIELD			
				Dean/ Administrator	Hospital Administrator	Basic Scientist	Clir
Allan Bass		1	1			X	
Steven Beering	1			X			
E. N. Boettcher		1			X		
Warren Bostick	1	1	1	X			
James Campbell	1			X			
Bland Cannon	2	2	1				
H. Meade Cavert	1			X			
Earle Chapman		1	1				
Jack W. Cole		1					
F. Coleman			1				
J. Conger			1	X			
Patrick J.V. Corcoran	1	1					
Perry Culver		1			X		
James Dennis		1	1	X			
R. C. Derbyshire	1	1	1				
John Dixon	1	1		X			
F. Eagle		1					
Richard Ebert	1	1					
Harlan English			1				
Russell Fisher	1						
Ed Flink			1				
Eva Fox	1	1					
John G. Freymann	1				X		
Allwyn Gatlin	1					X	
Sam Harbison			1				
James Haviland	1	1	1				
William Holden	1	1	1				
Charles Hudson	1	1					
John E. Ives		1			X		
William Kellow	1		1	X			
Gerald A. Kerrigan	1			X			
Charles Kidd			1	X			
William Knisely	1		1			X	

AMA REPRESENTATIVES FOR SURVEY VISITS

Evaluator	1973-1974	1972-1973	1971-1972	GENERAL FIELD			
				Dean/ Administrator	Hospital Administrator	Basic Scientist	Clinici
Francis Land	1	1	1				X
George Leroy	1			X			X
Morton Levitt		1					
William Maloney		1		X			X
Richard Manegold	1	1				X	
Horace Marvin	1	1	1				
R. Magraw			1	X			X
William Meacham	1			X			
Thomas Mou	1						X
Merle Mussleman	1					X	
H. Nicholson		1					X
John Nunemaker	1	1					
Stanley Olson			1	X			X
Claude Organ	1						X
F. Paustian		1					
Warren Pearse			1	X			
Edward Pelegrino	1	1	1	X			
Ken Penrod	1	1		X			
Chase Peterson	1			X			
Gilles Pigeon		1		X			X
Bernard Pisani	1	1	1				
Warren Point	1			X			X
Bryce Robinson	1	2	1				X
W. Rial			1				X
Edward Rosenow	1	1	1				
William Ruhe		1	1	X			
John Sheehan			1	X			
T. Sherrod		1				X	
F. Simeone		1					X
William A. Sodeman	1	1	1	X			
John Stapleton			1	X			
Robert Stone			1	X			
M. Watts		1		X			

AMA REPRESENTATIVES FOR SURVEY VISITS

Evaluator	1973-1974	1972-1973	1971-1972	GENERAL FIELD			
				Dean/ Administrator	Hospital Administrator	Basic Scientist	Clinic
William Wartman	1					X	
Joseph White	1	1	1	X			
H. Wiggers			1	X			
J. Jerome Wildgen	1						X
William Willard	1	1	1	X			
David Wilson	1	1	1		X		
Michael Wilson			1			X	X
Vernon Wilson		1		X			
SECRETARIES							
David Babbott			1				
Warren Ball	1						
John Ballin	1	1					
. Barclay			1				
Anne Crowley	1						
Richard Egan	6	4	2				
J. Fauser		1					
Leonard Fenninger	1						
Asher Finkel	1	1	1				
H. Glass	1		1				
Norman Hoover			1				
Rut Howard			1				
Ralph Kuhli			1				
D. Lehmkuhl		1					
Glen R. Leymaster	3	2	1				
Clark Mangum	1						
H. Nicholson			4				
Edward Petersen	4	4					
Philip White		1	1				
T. Zimmerman			1				

AAMC REPRESENTATIVES FOR SURVEY VISITS

Evaluator	1973-1974	1972-1973	1971-1972	GENERAL FIELD			
				Dean/ Administrator	Hospital Administrator	Basic Scientist	Clinici
George Aagard			1	X			
Bobby R. Alford	1						X
J. E. Anderson	1					X	
Len H. Andrus	1						X
Sam Asper			1				X
Truman Blocker	2		1	X			
Daniel Bloomfield	1			X			
Edward Bresnick	1					X	
John Brobeck	1					X	
Robert Bucher	1			X			
Ralph Cazort	1	1		X			
G. Cartmill			1		X		
Carleton Chapman			1	X			
John Chapman	1	1	1	X			
A. L. Chute		1					
Samuel L. Clarke, Jr.	1		2			X	
Jack M. Colwill	1						X
William G. Cooper		1					
Kenneth Crispell	3	2	1	X			
Joyce Davis	1	1				X	
John Dietrick	1			X			
William Drucker	1	1		X			
Dick Ebert			1				X
James Eckenhoff		1	1	X			
L. Elam		1					
Paul Elliott	1			X			
R. Estabrook		1				X	
J. Feffer		1		X			
Pat Fitzgerald			1				
Christopher Fordham	1	1		X			
Shervert Frazier	1	1					X
Neal Gault	1	1		X			

AAMC REPRESENTATIVES FOR SURVEY VISITS

Evaluator	1973-1974	1972-1973	1971-1972	GENERAL FIELD			
				Dean/ Administrator	Hospital Administrator	Basic Scientist	Clinician
Clifford Grulee	1	1	1	X			
T. Stewart Hamilton	1		1		X		
R. Hardin		1			X		
R. Heyssel							X
Doris Howell		1	1			X	
Clyde G. Huggins	1						
Andrew Hunt	1	1	1	X			
G. Irwin			1	X			
Paul C. Johnson	1					X	
Thomas D. Kinney	1	1	1	X			
Ernst Knobil	1	1	1			X	
Jack Kostyo			1			X	
Lucian Leape			1				X
Morton Levitt	1					X	
Robert A. Liebelt	1	1	1				
Marion Mann	1	1		X			
Robert Q. Marston	1			X			
R. G. McAuley		1					
Frank McKee		1					
Manson Meads		1		X			
Max Michael			1				X
Howard Morgan	1	1				X	
R. Hugh Morgan		1					
J. Myers			1				X
Stanley Olson	1	1		X			
Robert Page	1			X			
Carter Pannill	1	1		X			
Emanuel Papper		1		X			
John Parks			1	X			
Lsyle Peterson	1					X	

AAMC REPRESENTATIVES FOR SURVEY VISITS

Evaluator	1973-1974	1972-1973	1971-1972	GENERAL FIELD			
				Dean/ Administrator	Hospital Administrator	Basic Scientist	Clinici
Walter Rice	1		1	X		X	
William Rieke			1			X	
G. Gordon Robertson	1	1					
R. Saunders		1				X	
Roy Schwarz	1	1		X			
D. Scarpelli		1		X			
J. R. Schofield					X		
Stuart Sessoms	1		1	X		X	
W. Shorey							
Parker Small	1			X			
Donn Smith	1		1	X			
Cheves Smythe	1	1		X			
Robert D. Sparks		1		X			
Charles Sprague	1	1			X		
John Stagle			1				
Robert Stone		1		X			
M. Suter				X			
Isaac Taylor	1					X	
Dan Tosteson			1				
C. John Tupper	1	1	1	X			X
Carlos Vallbona	1						X
Douglas Walker	1	1					X
William B. Weil, Jr.	1		1			X	
Alfred Wilhelmi			1				
George Wolf			1	X			
SECRETARIES							
David Babbott		1					
Michael Ball	1						
Thompson Bowles		1	1				
William Cooper	1						
James Erdmann	1	1					
Doris Howell	2						

AAMC REPRESENTATIVES FOR SURVEY VISITS

	1973-1974	1972-1973	1971-1972	GENERAL FIELD			
				Dean/ Administrator	Hospital Administrator	Basic Scientist	Clinic
SECRETARIES (cont'd)							
Roy Jarecky	1	1	1				
Davis Johnson	1	1	1				
Richard Knapp	1	1	2				
Carter Pannill		1					
Walter Rice		1	1				
J. R. Schofield	3	4	3				
Frank Stritter	1		1				
Emanuel Suter	2	1					
August Swanson		1	1				
Marjorie Wilson	1	2	1				

Schedule for Survey Visit, June 12 - 15

Monday, June 12

:30 ~~9:00 a.m.~~ a.m. Dr. J. Robert Buchanan, Dean and Dr. Fletcher H. McDowell, Associate Dean

9:25 Meet other Associate Deans

	Team A	Team B
9:45	Dr. Fritz F. Fuchs, Professor of Obs-Gyn	Dr. Fred Plum, Professor of Neurology
10:45	Mr. M. James Peters, Fiscal Officer	
11:30	Dr. Charles A. Santos-Buch, Associate Dean - Student Affairs	
12:15 p.m.	Lunch with students	
1:15	Dr. Arthur H. Hayes, Jr., Associate Dean - Academic Programs	
2:00	Dr. Thomas H. Meikle, Jr., Associate Dean (Basic Sciences), Chairman, Admissions and Dean, Graduate School of Medical Sciences	
2:45	Members of Basic and Clinical Science Faculty Councils	

	Team A	Team B
3:30	Dr. James L. Curtis, Associate Dean - Minority Groups	Mr. Erich Meyerhoff, Director of the Library

Tuesday, June 13

9:00 a.m. Dr. J. Robert Buchanan, Dean

9:30 Dr. E. Hugh Luckey, President, The New York Hospital-Cornell Medical Center

	Team A	Team B
10:30	Dr. John A. Evans, Professor of Radiology	Dr. Paul A. Ebert, Professor of Surgery
11:30	Dr. John T. Ellis, Professor of Pathology	Dr. William T. Lhamon, Professor of Psychiatr

12:30 p.m. Lunch with house staff (and young faculty)

	Team A	Team B
1:30	Dr. W. P. Laird Myers, Chief of Medicine, Memorial Hospital	Dr. Alton Meister, Professor of Biochemistry
2:30	Dr. Alexander G. Beam, Professor of Medicine	Dr. Michael A. Alderman, Assistant Professor of Public Health (substituting for Dr. Walsh McDermott, Professor)
3:30	Dr. Robert F. Pitts, Professor of Physiology	Dr. George G. Reader, Professor of Public Health-elect

Wednesday, June 14

9:00 a.m.	Dr. Roy C. Swan, Professor of Anatomy	Dr. William F. Scherer, Professor of Microbiology

10:00 Dr. David D. Thompson, Director, The New York Hospital

	Team A	Team B
11:00	Dr. Wallace W. McCrory, Professor of Pediatrics	Dr. Walter F. Riker, Professor of Pharmacology

12:00 Noon Lunch Faculty - younger group

1:00 p.m. Dr. Bruce H. Ewald, Director, Laboratory Animal Medicine

2:00 Dr. Charles L. Christian, Chief of Medicine, Hospital for Special Surgery

3:30 President

Thursday, June 15

9:00 a.m. - Dr. Buchanan

10:30 a.m.- President or Provost

FROM: Glen R. Leymaster, M.D.

RE: Survey of

BY: Kenneth E. Penrod, Ph.D.(Chairman); Robert G. Page, M.D.
Douglas Waugh, M.D.; Michael F. Ball, M.D.; James B. Erdmann, Ph.D. (Secretary)

RECOMMENDATIONS: That be granted full accreditation for seven years as of the final date of this survey,

The survey team also recommends to the Executive Council of the Association of American Medical Colleges that be granted full Institutional Membership.

This recommendation for approval should be interpreted to apply to the currently requested increases of class size for the first year from 93 to 108 and for the third year from 32 to 56. Approval for these class sizes is contingent upon presenting satisfactory evidence to the LCME that:

(a) a mechanism is established for orderly planning and development of expansion activities.

(b) additional clinical faculty are acquired in areas of need as identified in the report.

The team does not endorse expansion beyond these levels for either of the above classes without the specific review of the LCME.

The Dean should submit a letter to the LCME Secretary early in 1975 detailing progress in achieving these contingencies.

Name	Accept	Approve	Comment
COUNCIL ON MEDICAL EDUCATION, AMA			
ostick	X		Approval for a term limited to 5 years. (7 years is too long). They have too much to do. I believe their class (freshman) increase should be delayed at least 1 year.
Burgher	X	X	
Cannon	X	X	Approval with contingencies.
Fisher	X	X	Concur with limitations on increasing student body.
Haviland	X	X	The 7 year approval hedged by the tight restrictions would appear to call for more progress reports than the single item for 1975.
Pisani	X	X	Recommendations and suggestions regarding clinical department are very important and call for early implementation.
Sodeman	X		Approval for a term limited to 4 years. The current status of clinical facilities, lack of 3 permanent departmental chairmen, lack of development of institutional and departmental objectives, and lack of final basic science coordination, I believe warrant less than full approval.
White	X		Approval for a term limited to 3 years. I cannot vote approval for seven years for a school unable to accommodate its full entering class at the clinical level. This needs discussion.

Name	Accept	Approve	Comment
Wildgen	X		Pathology appears weak. Autopsy Rate & Volume not recorded. Excellent approach in Family Medicine but no mention of student contact before 4th year. I suggest earlier involvement.
V. Wilson	X	X	In 2 1/2 years a great deal has happened. The areas of criticism should be remedied if the present trend is maintained.
PUBLIC MEMBERS, LCME			
Inskeep	X	X	Approval for 7 years, with stipulations.
Stark	X	X	Approval for 7 years.
FEDERAL REPRESENTATIVE, LCME			
Stone	X	X	Approval for 7 years
ASSOCIATION OF AMERICAN MEDICAL COLLEGES			
Buchanan	X	X	
Cazort	X	X	
Clarke-Pearson	X	X	Excellent Report.
Cole	X	X	
Crispell	X	X	Amazing improvement, a long way to go.
Cronkhite	X	X	
Derzon	X	X	Approval as noted.
Estabrook	X	X	Approval only as long as class size is 108. I strongly vote that class size should not increase above 108 per entering class until another survey is completed and adequate facilities are demonstrated.
Grulee	X	X	
Hamilton		X	Despite (or because of) the length of this report, I had difficulty getting a mental picture of the school. I missed specific comments such as ratios of applicants to places, average scores, etc. Among the problems (for me) was the statement that the school needs a new hospital without comment as to whether the area needs the beds, how it will be constructed or financed. This is 1974, not 1964.
Kinney	X	X	The matter of class size should be carefully considered at meeting of LCME
Knobil			Report Not Acceptable - Approval for a term limited to 5 years. Contents of report are O.K., but as an official document of AMA and AAMC it is excessively sloppy in appearance and replete with spelling and typographical errors. Such shoddiness should be unacceptable. Seven years is a lot too long a period of accreditation for this institution.
Krevans	X		Approval for a term limited to 4 years. It seems to me that there are enough critical unresolved issues that another look is justified before 7 years.
Lewine	X	X	Findings seem to indicate borderline decision between full accreditation and more limited approval.

Name	Accept	Approve	Comment
Mellinkoff	X	X	Caveats Noted.
Papper	X	X	There are some serious problem areas at ; especially in the area of clinical faculty recruitment and expansion of some teaching facilities. However, one must be impressed by the Visiting Team's impression of the progress made since the last site visit. Certainly the credits far outweigh the deficits and the School deserves full recognition with the stipulated qualifications.
Petersdorf	X	X	
Tosteson	X	X	
Tupper	X		Approval for a term limited to 3 years. In spite of commendable progress, the continuing problems are so real that more than a 3 year approval seems incomprehensible.
Van Citters	X		Approval for a term limited to 2 years. The recommendations for 7 years accreditation & full institutional membership are not consistent with citation of 16 "Serious Weaknesses"--"require immediate action" (See Pages 66-69) I think this operation has a Hell of a way to go before it can be looked on as a first line going concern.
ADVISORY COMMITTEE, AMA			
Brown	X	X	Should be definite that approval entends only to entering class size of 108.
Bucher	X	X	
Derbyshire	X		In view of the many deficiencies I think the decision of the team was most generous.
Fox		X	
Magraw	X	X	Approval for regular term with conditions--The issues associated with the imposition of foreign trained students onto a new curriculum, and newly formed faculty and the apparently successful resolution of problems and successful completion of studies merit a survey report all to themselves. Where is the money for a tertiary care hospital going to come from? What is the population the hospital will serve?
O'Neal	X	X	Excellent report - good details for insight.
ADDENDUM			
Culver	X	X	Many helpful recommendations in this report made by the Survey Team. I am increasingly of the persuasion that a Flexnerian basic science curriculum along departmental lines & with repetition is the preferable approach to medical education.

September, 1973 - June, 1974

SCHOOL	TEAM RECOMMENDATION	ACCEPT REPORT	APPROVE RECOMMENDATION	FINAL LCME ACTION
Albany Medical College	Continued full approval for seven years as of 9/23/73 and continued membership in the AAMC.	YES 39 NO 0	YES 39 NO 0	Same as team recommendation
University of Texas Medical Sc School at Houston	Full accreditation for two years as of 9/27/73 and membership in the AAMC. Recommended entering class not be increased above present 48 until present building program completed.	YES 41 NO 0	YES 40 + 1 ? NO 0	Same as team recommendation
University of Chicago Pritzker School of Medicine	Continued full approval for seven years as of 10/3/73 and continued membership in the AAMC.	YES 39 NO 0	YES 39 NO 0	Same as team recommendation
Mayo Medical School	Continued provisional approval pending resurvey before graduation of first class. Number of entering students should continue to be 40. Facilities are more than adequate for the admission of up to ten more students into the second year, a total of 50 students, through the prospective contract with North Dakota, or by other means.	YES 37 NO 0	YES 37 NO 0	Same as team recommendation
University of North Dakota School of Medicine	Continued full approval as a School of Basic Medical Science and continued membership in the AAMC. Provisional approval as an M.D. degree-granting School which will implement a third-year curriculum for 40 students by contract in 1974 and a fourth year curriculum for 40 students in 1975.	YES 36 NO 1	YES 27 NO 9	Same as team recommendation with additional statement: SINCE THE CURRENT SITUATION IS DIRECTED TO THE DEVELOPMENT OF AN M.D. DEGREE GRANTING INSTITUTION, THE SCHOOL WILL BE SURVEYED IN APPROXIMATELY TWO YEARS DURING THE ACADEMIC 1975-76 YEAR IF DEVELOPMENT PROCEEDS AS PLANNED.

SCHOOL	TEAM RECOMMENDATION	ACCEPT REPORT	APPROVE RECOMMENDATION	FINAL LCME ACTION
The University of Nebraska	Full accreditation for a period of two years with a progress report submitted in one year to LCME, and continued membership in the AAMC.	YES 31 NO 1	YES 27 NO 5	Same as team recommendation wit additional statement: PROGRESS REPORT IS REQUESTED BY NOVEMBER 1, 1974, WHICH RESPONDS TO THE NUMBEROUS CONCERNS EXPRESSED BY THE TEAM UNDER THE SUMMARY AND CONCLUSIONS OF THE REPORT.
Hahnemann Medical College and Hospital	Full accreditation for a period of one year and continued membership in the AAMC. Postponement of authorization for increasing by 50 students the size of the entering class (entering class in 1973 was 154).	YES 38 NO 1	YES 33 6	Same as team recommendation
College of Medicine & Dentistry of New Jersey -- Rutgers Medical School	Full accreditation for a period of seven years and continued membership in the AAMC. Approval applies to currently requested increases of class size for the first year from 93 to 108 and for the third year from 32 to 56. Approval for these class sizes is contingent upon presenting satisfactory evidence to LCME that: a) a mechanism is established for orderly planning and development of expansion activities and b) additional clinical faculty are acquired in areas of need as identified in the report. The Dean should submit a letter to the LCME Secretary early in 1975 detailing progress in achieving these contingencies.	YES 29 NO 3	YES 26 6	FULL ACCREDITATION FOR A PERIOD OF FOUR YEARS WITH PROGRESS REPORT DUE NO LATER THAN OCTOBER 1, 1974 PROVIDING DETAILS OF ADDITIONAL FACULTY RESOURCES PROVIDED TO MEET THE OBLIGATION TO THE INCREASED NUMBER OF STUDENTS. Otherwise same as team recommendation.
University of Massachusetts	Full accreditation for a period of two years with membership in the AAMC. Progress report in one year concerning staffing of the Departments of Pharmacology, Obstetrics and Gynecology, Pediatrics and Psychiatry. Although the class size planned, namely 64 in 1974 and 100 in 1975, is appropriate, it is suggested that the faculty give consideration to the admission of 100 students in 1974.	YES 35 NO 1	YES 34 NO 2	Same as team recommendation

SCHOOL	TEAM RECOMMENDATION	ACCEPT REPORT	APPROVE RECOMMENDATION	FINAL LCME ACTION
Texas Tech University School of Medicine	Full accreditation for a period of one year and full membership in the AAMC. Recommended that the entering class not be increased beyond 40 students until the present building program is completed, an event now expected to occur in mid-1975.	YES 31 NO 3	YES 29 NO 5	Same as team recommendation
Medical University of South Carolina	Full accreditation for a period of seven years and continued membership in the AAMC.	YES 36 NO 0	YES 31 NO 5	Full accreditation for a period of four years with a Progress Report due by January 1, 1976 concerning finances. Full membership in the AAMC.
University of Missouri--Kansas City School of Medicine	1.Full accreditation for a period of two years. Because of the unusual difficulties involved in understanding this innovative and complex program, the next survey team should include 1 or two members of an earlier team. 2. Approval for enrollment of 72 students in the third year for 1974-75. 3. Approval for enrollment of 80 first year students in 1974 and 90 in 1975. This plan is in accord with the School's own projected rate of growth. 4. Recommends admission of up to 12 additional students (in advance standing) into years 3, 4, or 5 in accord with the conditions outlined by Dr. Dimond, which includes the intent to offer these opportunities to nurses, oral surgeons, and and Ph.D.'s in the life sciences, with no student to be awarded the M.D. degree after less than 24 mos. in residence in the Medical School. 5. Full membership in the AAMC.	YES 22 NO 8	#1 #2 #3 #4 #5 YES 27 27 22 9 27 NO 4 4 9 22 4	1. Full accreditation for two years. 2. Enrollment of 72 year 3 students in 1974-75. 3. Enrollment of 72 year 1 students in 1974-75 and 72 students in 1975-76. 4. Approval of admission of up to three additional students in to years 3, 4, &5 in 1974. Total number of students admitted to advanced standing should not total more than ten by the 1975-76 year.

SCHOOL	TEAM RECOMMENDATION	ACCEPT REPORT	APPROVE RECOMMENDATION	FINAL LCME ACTION
University of Southern California	Full accreditation for a period of seven years and continued membership in the AAMC.			Same as team recommendation
UCLA School of Medicine	Full accreditation for a period of seven years and continued membership in the AAMC.	YES 36 NO 1	YES 36 NO 1	Same as team recommendation
Boston University School of Medicine	Full accreditation for a period of seven years and continued membership in the AAMC. Entering class of up to 133 students in 1975-76.	YES 21 NO 0	YES 20 NO 1	Same as team recommendation
SUNY-Stony Brook Medical School	Full approval for a period of two years and the number of first-year students be limited to 48 for the year 1974-75, and to 60 for the year 1975-76. Membership in the AAMC.	YES 30 NO 2	YES 29 NO 3	Same as team recommendation
Medical College of Ohio at Toledo	Full approval for a period of three years and continued membership in the AAMC. Progress report request early in 1976 describing progress in the developmentof the Basic Science Graduate Program, the Clinical Graduate Program, and the faculty of the clinical departments in the affiliated hospitals. Faculty and facilities are considered adeqaute for the entering classes namely 80 in 1974 and 96 in 1975. Should an entering class larger than 100 for 1976 be contemplated, the 1976 report should be expanded to include progress in the completion of basic science facilities and staffing of basic science departments.	YES 18 NO 1	YES 19 NO 0	Same as team recommendation

SCHOOL	TEAM RECOMMENDATION	ACCEPT REPORT	APPROVE RECOMMENDATION	FINAL LCME ACTION
University of Arkansas School of Medicine	Full accreditation for a period of seven years and continued membership in the AAMC.	YES 18 NO 1	YES 18 NO 1	SAme as team recommendation
University of Hawaii School of Medicine	Continued provisional accreditation for an entering class of 66 students and continued membership in the AAMC.	YES 19 NO 0	YES 17 NO 2 LRS Prov. Ac.	Same as team recommendation
Texas A & M University/Baylor College of Medicine	-Recommends against issuing letter of reasonable assurance and against provisional accreditation at this time.	YES 19 NO	YES NO	Same as team recommendation
Southern Illinois University School of Medicine	Continued Provisional Accredition and continued provisional membership in the AAMC. No further acceptances to the first-year class entering June 1974 shall be offered after March 12, 1974; Acceptances offered prior to March 12 for places in the June 1974 places shall be honored; If students who have been previously accepted places in the class withdraw, they shall not be replaced unless the number of students accepted for admission shall be 48 or less; in this circumstance additional acceptances may be offered in order to enroll 48 students; No students shall be accepted for advanced standing after March 12, 1974; SChool to be resurveyed in January or early February, 1975. Until completion of this survey and action by the LCME, acceptances for the entering class in June 1975 shall be limited to 48 students.	YES 24 NO 4	YES 28 NO 0	Same as team recommendation with the number of students being 60 instead of 48 - this was based on the fact that the LCME had earlier on accepted the school's planned expansion which included 60 students for 1974-75. 48 students were specifically indicated for 1973-7
University of Connecticut School of Medicine	Full accreditation for a period of four years with continued membership in the AAMC. Progress report by January 1, 1976 with detailed information on the specified items.	YES 34 NO 0	YES 30 NO 4	Same as team recommendation

SCHOOL	TEAM RECOMMENDATION	ACCEPT REPORT	APPROVE RECOMMENDATION	FINAL LCME ACTION
University of Nevada School of Medicine	Full accreditation for a period of two years and continued membership in the AAMC. Entering class should not be increased beyond the present size of 48, and a Letter of Reasonable Assurance for expansion beyond this size is not issued. Progress Report in June, 1975 concerning the state budget for the years 1975-76.			Same as team recommendation
Loma Linda University School of Medicine	Continued full accreditation for a period of seven years and continued membership in the AAMC. Progress Report due as of October 1, 1974 and a limited resurvey during the 1974-75 academic year.	YES 35 NO 1	YES 28 NO 8	Action deferred to next LCME meeting.