

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

COTH ADMINISTRATIVE BOARD MEETING

November 12, 1974

7:30 a.m. - 9:00 a.m.

Parlor #412

Conrad-Hilton Hotel

Chicago, Illinois

AGENDA

- | | |
|--|------------|
| I. Call to Order | |
| II. Approval of Minutes | TAB A |
| III. Membership Application | |
| A. Crozer-Chester Medical Center
Upland-Chester, Pennsylvania | TAB B |
| IV. Report of AAMC Task Force on the Goals and Priorities
Committee Report of the National Board of Medical Examiners | TAB C |
| V. Report of the COTH Ad Hoc Committee on Membership Criteria | TAB D |
| VI. Report of the COTH Nominating Committee | Mr. Wilmot |
| VII. COTH Distinguished Members | TAB E |
| VIII. AAMC Health Manpower Policy Reconsideration | TAB F |
| IX. AAMC Officers Retreat - COTH Input | |
| X. Information Item: | |
| A. OSR Resolutions | TAB G |

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

COTH ADMINISTRATIVE BOARD MEETING

Dupont Plaza Hotel
Washington, D.C.
September 19, 1974

MINUTES

PRESENT:

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

STAFF:

Richard M. Knapp, Ph.D.
James I. Hudson, M.D.
Dennis D. Pointer, Ph.D.
Steven J. Summer
Catharine A. Rivera

I. Call to Order:

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

II. Approval of Minutes:

The minutes of the June 20, 1974 Administrative Board meeting were approved as circulated.

III. Membership Applications:

The Board reviewed five applications for membership and after a brief discussion took the following action:

ACTION #1

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

WAKE COUNTY HOSPITAL SYSTEM, INC.
RALEIGH, NORTH CAROLINA

MAYAGUEZ MEDICAL CENTER
MAUAGUEZ, PUERTO RICO

IT WAS MOVED, SECONDED AND CARRIED THAT THE FOLLOWING APPLICATION BE APPROVED SUBJECT TO VERIFICATION OF A DOCUMENTED AFFILIATION AGREEMENT WITH HARVARD MEDICAL SCHOOL:

McLEAN HOSPITAL
BELMONT, MASSACHUSETTS

IT WAS MOVED, SECONDED AND CARRIED THAT THE FOLLOWING HOSPITAL BE REJECTED WITHOUT PREJUDICE FROM MEMBERSHIP IN THE COUNCIL OF TEACHING HOSPITALS AND THEY BE ENCOURAGED TO REAPPLY, UPON APPROVAL OF THEIR RESIDENCY PROGRAMS:

FRANKLIN DELANO ROOSEVELT
VETERANS ADMINISTRATION HOSPITAL
MONTROSE, NEW YORK

In addition, Dr. Knapp reported that the New York Infirmary had not responded to his request for further documentation of that institution's involvement in medical education. Therefore, the application was not considered.

IV. Report of the COTH Ad Hoc Committee on COTH Membership Criteria:

The Administrative Board reviewed the Committee's report in conjunction with its placement in the Executive Council's agenda for September 20, 1974. One question raised by the Board was in regard to those particular institutions which potentially may be dropped from COTH membership commencing with the new guidelines to be in effect in 1977. Dr. Knapp stated that at the most, 15 to 20 institutions would probably be involved, and Mr. Womer, Chairman,

of the Committee, stated that the guidelines would serve to provide a framework for evaluating the scope and depth of a hospital's participation in medical education rather than serving as new criteria. Institutional members would be individually reviewed by the COTH Administrative Board in 1977 to determine if they fulfill the membership criteria. During extended discussion of the recommendations, other points were raised regarding the need for such COTH guidelines and the requirement for more specificity in membership requirements.

ACTION #2

IT WAS MOVED, SECONDED AND CARRIED THAT THE BOARD APPROVE THE REPORT OF THE AD HOC COMMITTEE, AND THAT IT BE BROUGHT BEFORE THE MEMBERSHIP AT THE COTH MEMBERSHIP MEETING IN NOVEMBER.

The Administrative Board also favorably reviewed a proposed revision in the application for membership which incorporates the recommendations of the Ad Hoc Committee report.

V. Report on JCAH Standards:

Dr. Knapp summarized the replies received from the membership on the report and noted that in general, those responding were essentially supportive of the tone of the Committee's remarks as well as the focus of findings and recommendations. The Administrative Board agreed that a copy of the report should be sent to the Joint Commission on Accreditation of Hospitals following action by the AAMC Executive Council.

VI. CCME Report: Physician Manpower and Distribution:

Dr. Thompson, a member of the Committee which drafted the report, presented it to the Administrative Board for review and approval. The report had been approved by the CCME for distribution to the five parent organizations for action. The three AAMC Administrative Boards were requested to review and comment prior to Executive Council action.

The COTH Administrative Board expressed concern for certain sections of the report pertaining to financial support and suggested that the increased emphasis of primary care and family practice may require a suggested redirection of resources.

ACTION #3

IT WAS MOVED, SECONDED AND CARRIED THAT THE REPORT AND ITS OBJECTIVES BE ENDORSED AND ACCEPTED BY THE COTH ADMINISTRATIVE BOARD WITH THE FOLLOWING AMENDMENTS:

CCME REPORT . . .

1. ON PAGE 12, PARAGRAPH 3, LINE 3, THE WORD "UNIT" FOLLOWING THE TERMS "FAMILY PRACTICE" SHOULD BE REPLACED BY THE WORD "PROGRAM."
2. THE LAST SENTENCE ON PAGE 13, RECOMMENDATION C, SHOULD READ: "FINANCIAL SUPPORT FOR THIS DEVELOPMENT SHOULD BE PROVIDED AND SOME REALLOCATION OF RESOURCES MAY BE ESSENTIAL TO FOSTER FAMILY PRACTICE RESIDENCIES."

VII. Report of the Health Services Advisory Committee:

Dr. Hudson presented the recommendations for action relating to physician manpower distribution from the September 11, 1974 Health Services Advisory Committee meeting. The report contained two recommendations: 1) the need for specific action in dealing with physician manpower needs; and 2) AAMC support for the establishment of a national health professions data base.

ACTION #4

IT WAS MOVED, SECONDED AND CARRIED BY THE COFH ADMINISTRATIVE BOARD THAT THE REPORT OF THE HEALTH SERVICES ADVISORY COMMITTEE AND THE RECOMMENDATIONS THEREIN BE APPROVED WITH THE AMENDMENT TO RECOMMENDATION 1 TO READ THAT:

- (A) STAFF DEVELOP A CATALOGUE LISTING OF INSTITUTIONS SUCCESSFULLY ADDRESSING THE PROBLEM OF GEOGRAPHIC AND SPECIALTY MALDISTRIBUTION AND A SUMMARY OF EACH PROGRAM:
- (B) THAT STAFF DETAIL A TECHNICAL ASSISTANCE PROGRAM WHICH WILL BE AVAILABLE TO INTERESTED INSTITUTIONS. CATEGORIES OF TECHNICAL ASSISTANCE WOULD INCLUDE, BUT NOT BE LIMITED TO, ACTIVITIES IN LIAISON WITH STUDY GROUPS SUCH AS THE INSTITUTE OF MEDICINE AND ACTIVITIES THAT EASE THE INSTITUTIONAL TRANSITIONS TOWARD PROVIDING MORE EFFECTIVE PRIMARY CARE.

VIII. AMA Guidelines for House Staff Contracts:

The AAMC had been asked by the AMA to appear before the AMA Board of Trustees meeting in October and to comment on these guidelines. In order for the Executive Council to instruct its representatives, each board was requested to discuss and react to the document. Following a lengthy and intensive discussion, the following position was taken:

ACTION #5

IT WAS MOVED, SECONDED AND CARRIED THAT THE AMA GUIDELINES FOR HOUSE STAFF CONTRACTS BE REJECTED AND THE FOLLOWING RESOLUTION BE SENT TO THE AAMC EXECUTIVE COUNCIL WITH RECOMMENDATION THAT IT BE FORWARDED TO THE AMA.

"THE COUNCIL OF TEACHING HOSPITALS, ASSOCIATION OF AMERICAN MEDICAL COLLEGES, EXPRESSES ITS DISSATISFACTION WITH BOTH THE INTENT AND STRUCTURE OF THE AMERICAN MEDICAL ASSOCIATION'S 'GUIDELINES FOR HOUSE STAFF CONTRACTS,' AS REVISED AUGUST 10, 1974. THE COUNCIL OF TEACHING HOSPITALS HOLDS THAT INDIVIDUAL AGREEMENTS WITH HOUSE OFFICERS DIRECTED TOWARD CLARIFYING AND EMPHASIZING THE EDUCATIONAL CONTENT AND PROCESS OF THE POST GRADUATE TRAINING EXPERIENCE ARE BENEFICIAL. PRIMARY RESPONSIBILITY FOR CONDUCT OF THE GRADUATE TRAINING PROGRAM MUST REST WITH THE PROGRAM DIRECTOR AND FACULTY/MEDICAL STAFF. THE COUNCIL BELIEVES THAT THE INTERVENTION OF THIRD PARTIES, SUCH AS HOUSE OFFICER COLLECTIVE BARGINING AGENTS, ERODES THE TRAINEE-FACULTY RELATIONSHIP AND THE CONTENT, FORM AND PROCESS OF GRADUATE TRAINING PROGRAMS ARE ADEQUATELY DELINEATED BY THE ESSENTIALS OF APPROVED RESIDENCIES AND THE AMERICAN HOSPITAL ASSOCIATION'S STATEMENT ON THE TERMS AND CONDITIONS OF HOSPITAL-HOUSE OFFICER AGREEMENTS AS APPROVED BY THE AMERICAN HOSPITAL ASSOCIATION'S COUNCIL ON MANPOWER AND EDUCATION ON MARCH 11, 1970."

IX. AAMC Policy Statement on New Research Institutes and Targeted Research Programs:

Following a review of the revised policy statement, the Administrative Board took the following action:

ACTION #6

IT WAS MOVED, SECONDED AND CARRIED THAT THE COH ADMINISTRATIVE BOARD APPROVE THE REQUEST THAT THE POLICY STATEMENT BE ENDORSED BY THE AAMC EXECUTIVE COUNCIL.

X. Student Representation on CCME, LCME:

The OSR Administrative Board requested the AAMC Executive Council and each board to approve a statement supporting the concept of medical student participation and representation in the CCME and LCME. It was the sense of the COH Administrative Board that this issue might best be left to the discretion of the Council of Academic Societies and the Council of Deans because of their more direct involvement in the process of medical education accreditation.

ACTION #7

IT WAS MOVED, SECONDED AND CARRIED THAT THE COTH ADMINISTRATIVE BOARD TAKE NO POSITION ON THIS MATTER.

XI. GME Resolution on NBME Ranking:

Dr. Knapp explained the basis for this resolution which recommends that the AAMC request the National Board of Medical Examiners to cease publishing, confidentially or otherwise, information regarding medical school ranking of student performance on parts I and II of the National Board Examination. Although the COTH Administrative Board concluded that the nature of this request does not fall within their province, their sentiments were not in agreement with the resolution but in favor of the current procedure of publication.

ACTION #8

IT WAS MOVED, SECONDED AND CARRIED THAT THE COTH ADMINISTRATIVE BOARD TAKE NO POSITION ON THE GME RESOLUTION ON NBME RANKING.

XII. AAMC Annual Meeting:

Dr. Knapp noted the Annual Meeting schedule of events and stated that the next COTH Administrative Board meeting will be held during the Annual Meeting in Chicago at 7:30 a.m. on Tuesday, November 12, 1974. The place of the meeting will be announced at a later date.

XIII. Publication of Aggregate Salary Data as a DATAGRAM in JME:

The Administrative Board discussed the potential distribution of an analysis of aggregate salary information, and agreed that the COTH staff be advised not to publish the information.

XIV. Teaching Hospital Utilization of Ancillary Services- A Grant Proposal:

Dr. Pointer reviewed briefly the proposal and discussed the intentions of COTH to obtain funding for the project which will study differential utilization of ancillary services in three groups of hospitals, classified by their involvement in medical education. There was consensus regarding the excellence of the proposal, and the staff was encouraged to move ahead with the project.

XV. COTH Awards:

The Administrative Board was informed that four research applications were received for the COTH Research Awards, and recommended that none of them be approved.

ACTION #9

IT WAS MOVED, SECONDED AND CARRIED THAT THE COTH ADMINISTRATIVE BOARD REJECT ALL RESEARCH PROPOSALS AND THAT THOSE HAVING SUBMITTED PROPOSALS BE SO NOTIFIED.

The Board also requested that they receive a progress report on the two COTH Research Award projects which were approved last year.

XVI. Association of Attending Physicians at Elmhurst Hospital:

Dr. Pomrinse gave the Board an update on the status of the petition from the Association of Attending Physicians at the Elmhurst Hospital Affiliation of the Mount Sinai School of Medicine. One-hundred and fifty attending physicians are seeking recognition as a collective bargaining unit under the recently amended National Labor Relations Act. The physicians are full and regular part-time salaried employees, stated Dr. Pomrinse, and work at Elmhurst Hospital through a professional service affiliation agreement with the New York City Health and Hospitals Corporation. At issue is whether salaried attendings can be considered as supervisors and/or managers; both categories of personnel are excluded from coverage of the Act. The election is scheduled for October 22 and 23.

XVII. Status of Section 223 Regulations:

Dr. Pointer discussed recent developments regarding attempts to restructure the hospital classification and cost limitation methodologies recently implemented under Section 223 of P.L. 92-603. Operational control of the redevelopment effort has been assigned to the Office of Research and Statistics, SSA, under the direction of Dr. Clifton Gauss. A technical task force has been appointed to assist OSR in its activities; the Association will be represented by Dr. Dennis Pointer.

Several informal meetings have taken place with Dr. Gauss and his staff. It appears that there is impetus to move from limiting routine service costs to controlling aggregate cost either on a per diem or per admission basis. A host of variables will be examined in order to facilitate the grouping of hospitals into isoproduct categories (i.e., combining hospitals that produce essentially the same product.) Emphasis will be placed upon case mix complexion and the nature and scope of facilities and services offered.

Dr. Pointer stated that a sample of approximately 1,200 hospitals will be selected to serve as the base for modeling and testing alternative classification and cost limitation schemes. Existing data on the 1,200 hospitals will be consolidated from industry and government sources; no new data will be collected on the facilities. No decisions have been made regarding the format of the analytical scheme. Dr. Pointer expressed confidence in the objectivity and technical ability of the study staff.

XVIII. COTH Board Input to AAMC Officers Retreat:

This year's annual AAMC Officers Retreat will be held on December 11-13, 1974. Mr. Derzon requested that members of the Administrative Board review the AAMC paper on Issues, Policies and Programs prior to the November Board meeting. The staff was requested to mail a copy of the updated policy document.

to Board members for this purpose. Additionally, the staff was requested to provide a list of current COTH Distinguished Members and solicit nominations for membership in this category.

XIX. Examination of LCME Accreditation Process:

This document was prepared by Joseph Keyes, Director, Division of Institutional Studies for the purpose of assisting the Administrative Boards in their examination of the process of undergraduate medical education accreditation. It describes the CCME and its role in the accreditation process - the standards, evaluators, and the procedures for evaluation.

There was not enough time for the Board to discuss this Report.

XX. Adjournment:

There being no further business, the meeting adjourned at 1:00 p.m.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership
in the
Council of Teaching Hospitals

(Please type)

Hospital: Crozer-Chester Medical Center
Name
Chester 15th Street & Upland Avenue
City Street
Pa. 19013
State Zip Code

Principle Administrative Officer: James H. Loucks, M.D.
Name
President
Title

Date Hospital was Established 11/29/63 (Merger) two hospitals incorporated

Approved Internships:

Type	Date Of Initial Approval by CME of AMA*	Total Internships Offered	Total Internships Filled
Rotating	<u>August 31, 1964</u>	<u>8</u>	<u>8</u>
Straight	<u>August 31, 1964</u>	<u>4</u>	<u>4</u>

Approved Residencies: (By affiliation with Hahnemann Med. College & Hosp. of Phila.)

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total Residencies Filled
Medicine	<u>August 31, 1964</u>	<u>10</u>	<u>10</u>
Surgery	<u>August 31, 1964</u>	<u>6</u>	<u>6</u>
OB-Gyn	<u>August 31, 1964</u>	<u>6</u>	<u>6</u>
Pediatrics	<u>August 31, 1964</u>	<u>2</u>	<u>2</u>
Psychiatry	<u></u>	<u></u>	<u></u>
Other	<u></u>	<u></u>	<u></u>

Information Submitted By:

James J. Catania, Vice President
Name
September 13, 1974
Date

President
Title of Hospital Chief Executive
James H. Loucks, MD
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.

AFFILIATION AGREEMENT
BETWEEN

THE HAHNEMANN MEDICAL COLLEGE AND
HOSPITAL OF PHILADELPHIA

AND

CROZER-CHESTER MEDICAL CENTER

THIS AGREEMENT, made this first day of July, 1969, by and between THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL OF PHILADELPHIA, a nonprofit corporation of the Commonwealth of Pennsylvania (which is hereinafter referred to as Hahnemann), and CROZER-CHESTER MEDICAL CENTER, a nonprofit corporation of the Commonwealth of Pennsylvania (which is hereinafter referred to as Crozer-Chester), the parties hereto,

WITNESSETH THAT

WHEREAS, CROZER-CHESTER operates a general hospital at Upland, Pennsylvania and wishes to ensure continued excellence of medical services at the hospital through its efforts in postgraduate education and training of residents, and believes that this can best be done by developing a well-organized program of medical education, including affiliation with a Pennsylvania medical school; and

WHEREAS, HAHNEMANN operates a medical college and general hospital in Philadelphia, Pennsylvania and, for research and teaching purposes, wishes to develop and promote postgraduate and resident education and to secure for its medical students access to the teaching and research facilities in the clinical departments of CROZER-CHESTER after the academic facilities have been adequately developed,

NOW, THEREFORE, the parties hereto, each intending to be legally bound hereby, mutually covenant and agree as follows:

FIRST: Commencing July 1, 1969, Crozer-Chester and Hahnemann shall cooperate, as hereinafter provided, in the establishment and conduct at Crozer-Chester of an academic program of medical education, training and research (which is hereinafter sometimes referred to as the "program").

The program shall be conducted initially in the clinical departments of medicine, surgery, obstetrics/gynecology and pediatrics (which are referred to herein as the "four departments"), and secondarily in the supporting professional departments such as laboratory and radiology. The officials and members of the staffs of Crozer-Chester shall collaborate in the development of this program.

SECOND: (a) Crozer-Chester and Hahnemann shall remain separate corporations.

Each of the parties shall continue to conduct its own business and affairs under the control of its own officers and Board of Directors or Trustees, and each of them shall remain solely responsible in all respects for the management of its own corporate affairs.

(b) Treatment and welfare of the patients in the departments at Crozer-Chester shall continue to be the sole responsibility, and remain subject to the direction and control, of Crozer-Chester and the members of its hospital staff on duty in those departments. As many beds as are necessary shall be made available for teaching to fulfill the academic needs of the program.

THIRD: Hahnemann, without charge to Crozer-Chester, shall contribute to the establishment and conduct of the program as follows:

(a) Hahnemann shall collaborate with the directors of the program at Crozer-Chester in providing guidance and academic supervision for the development and operation of the program.

(b) Hahnemann shall include the appropriate departmental representatives from Crozer-Chester in the

Advisory Committees of each of the four clinical departments so that they can participate in planning the programs of the departments in accordance with the By-Laws of the Hahnemann Medical College, Article III, Section 4, and the policies of the College Council of Hahnemann.

(c) Hahnemann shall encourage postgraduate programs for practicing physicians to be conducted regularly by Crozer-Chester, and such programs shall be approved and supervised by Hahnemann through the appropriate Departmental Liaison Committee. Hahnemann shall make available members of its faculty for participation in such programs as arranged through these Departmental Liaison Committees.

(d) Hahnemann shall assist Crozer-Chester in obtaining grants from governmental and private agencies in pursuance of the program.

Research: Crozer-Chester shall continue to maintain its research program under the auspices of the members of its medical staff. There may be joint participation in grants received by either institution whenever there is a facility or personnel existing in one institution which could be used to implement a grant being proposed at the other institution or to assist in its implementation. Physical facilities in both institutions are to be available to both research programs.

Both parties agree to abide by the established policies and procedures of granting agencies. All research grants shall be subject to review by the appropriate Departmental Research Committee of Hahnemann. The chairman of each Departmental Research Committee of Crozer-Chester shall be a member of the corresponding Departmental Research Committee at Hahnemann.

(e) Recognizing the variations among clinical departments as to requirements for residency and fellowship programs, and acknowledging that a well-organized, smoothly functioning house staff program is of great importance with regard to patient service and postgraduate education in a hospital, whenever possible Hahnemann will develop inter-institutional (integrated) residency and fellowship

programs when mutually agreeable to both parties. The interinstitutional program for residents and fellows in each department shall be under the primary direction of the chairman of that clinical department at Hahnemann. This agreement to develop and support interinstitutional programs shall not preclude the development by Crozer-Chester of independent training programs in one or more departments. Such a development shall automatically be associated with the termination of the specific departmental inter-institutional resident program, so that there will not be within any department at Crozer-Chester coincident independent and interinstitutional programs for resident training.

(f) Upon the development of the inter-institutional residency training program at Crozer-Chester, and after approval of adequacy of the academic facilities and personnel in each clinical department by the Departmental Crozer-Chester-Hahnemann Liaison Committees, the Departmental Advisory Committees, and the chairman of each clinical department at Hahnemann, Hahnemann shall assign medical students to participate in the program at Crozer-Chester. Students shall be assigned to each department in such numbers and for such periods of time as the chairman of the corresponding department of Hahnemann shall determine (in conformity with the policies of Hahnemann) after consultation with the Coordinator of the program at Crozer-Chester and the Hahnemann-Crozer-Chester Departmental Liaison Committee, on which shall sit the Chiefs of the services to which the students are assigned at Crozer-Chester. Hahnemann shall provide Crozer-Chester with adequate notice of the number, names and sex of medical students who are to be assigned to Crozer-Chester in advance of their arrival.

Failure on the part of any department at Crozer-Chester to meet the requirements of the program will first be reviewed by the appropriate Departmental Liaison Committee, with Crozer-Chester participating. Along with the recommendation of this committee and the recommendations of the Chairman of the respective department at Hahnemann, the matter will be referred to the Interinstitutional Planning Committee, consisting of the four departmental chairmen from Hahnemann, the four clinical department chiefs from Crozer-Chester, the Dean at Hahnemann and the Coordinator of the program at Crozer-Chester.

FOURTH: Crozer-Chester shall contribute to the establishment and conduct of the program by providing the following minimum personnel and facilities:

(a) An over-all Coordinator of the program at Crozer-Chester, who shall be appointed on a full-time or geographical full-time basis, as described in Dean's Memo No. 8 of the Hahnemann Medical College.

(b) A Chief of Service on a full-time or geographical full-time basis (as noted above) in each of the four primary clinical departments, as well as such assistants to each Chief as he, the Coordinator and the Chairman of the corresponding department at Hahnemann may decide are needed to conduct the program properly in his particular department, after consultation with the administration of Crozer-Chester.

It is understood that the present Chiefs of Surgery, Obstetrics/Gynecology, and Pediatrics may continue to serve in this capacity on a voluntary basis. As an interim measure, a full-time or geographical full-time Director of Education will be obtained by Crozer-Chester in each of these clinical departments.

(c) Equipment, physical facilities and space in all four departments which are satisfactory for conducting a program similar to the academic programs conducted in the corresponding departments at Hahnemann.

(d) A general medical library of the size and quality that it now maintains, which shall be operated and administered by Crozer-Chester and which shall afford access to resident physicians and all additional personnel assigned to the program by Hahnemann.

(e) In addition to the discharge of the obligations set forth above with respect to the conduct of the program, Crozer-Chester shall remain responsible, administratively and financially, in each of the four primary clinical departments for

- (1) Patient welfare and treatment;
- (2) Supplying food, maintenance of medical records, and the conduct of all other usual administrative functions; and
- (3) Supplying all necessary hospital personnel, services, equipment and physical facilities.

FIFTH: (a) The program in each of the four departments shall be formulated and supervised by the Chief or Interim Director of Education for that department. Each such Chief or Interim Director of Education shall have such duties with respect to the program in his department as shall be determined jointly by him as Chief of the Department and the Chairman of the corresponding Department of Hahnemann.

Crozer-Chester may also assign to the Chiefs or Directors of Education any additional duties which do not conflict or are not incompatible with the duties described in the preceding paragraph.

(b) The Chief or Interim Director of Education in each of the four departments shall be adequately qualified and shall be appointed by Crozer-Chester only after prior consultation with and approval by the corresponding Departmental Chairman at Hahnemann. The Departmental Liaison Committee made up of members appointed from each institution shall review the qualifications of candidates and make appropriate recommendations to the Departmental Chairman at Hahnemann. Such appointments must be mutually acceptable to Crozer-Chester and Hahnemann.

SIXTH: (a) Hahnemann shall appoint to its medical college faculty, during the term of this Agreement, the Chiefs or Interim Directors of Education of the four departments at Crozer-Chester who hold such positions at the time of execution of this Agreement, and acceptance of the appointment is required of the Chiefs or Interim Directors of Education. These Chiefs or Interim Directors of Education shall also be appointed to their respective Departmental Advisory Committees, which committees are provided for in the By-Laws of the Hahnemann Medical College.

Hahnemann shall, at the time of execution of this Agreement, appoint to its medical faculty all members of the active medical staff (exclusive of the Section of General Practice in the Department of Medicine) of Crozer-Chester who are then assigned to any one of the four departments and approved by the Chairman of their particular department at Crozer-Chester and who participate in the Crozer-Chester academic program. Those members participating in the academic program and having faculty appointments at Hahnemann shall be considered as being members of the academic staff. Crozer-Chester will encourage their active staff to accept their faculty appointments, and failure to accept such appointments shall exclude said staff members from participation in the program (student, intern, and resident teaching program). Failure to perform assigned academic duties by anyone holding a Hahnemann faculty appointment shall result in removal of the physician from the faculty appointment at Hahnemann. Such action shall be implemented following review by the appropriate Departmental Liaison Committee and their recommendations made to the Departmental Chairman at Hahnemann. Failure to perform these assigned academic duties adequately as determined by the Chairman of the Department at Hahnemann shall result in transfer of the physician from the academic staff to the nonacademic staff of Crozer-Chester by action of its Board of Trustees and withdrawal of the faculty appointment by Hahnemann. This action will automatically preclude house staff coverage of the patients being attended by this staff man.

Those on the medical staff who are appointed to the Hahnemann faculty shall automatically become members of the allied medical staff of Hahnemann Hospital, with the rights and privileges pertaining thereto.

The Crozer-Chester medical staff shall continue to have a courtesy staff.

The Department of Medicine shall include a Section of General Practice, which section shall include those members of the active staff with no specialized professional interest, and their professional activities may cross departmental lines. The Section of General Practice shall be under the administrative direction of the Chief of the Department of Medicine at Crozer-Chester as a component section of that department but with specific appointments to this section only. Appointment to the Section of General Practice will not carry with it the possibility of transfer to General Internal Medicine of the Department of Medicine without going through the procedures as indicated herein for new appointments to the staff at Crozer-Chester.

Such physicians as may be determined by the Chief of the Department of Medicine at Crozer-Chester and any member of the active staff not limiting his practice to services within one department may be assigned to the Section of General Practice of the Department of Medicine after approval by its Chairman. Whenever this physician participates in practices that regularly belong to other departments, the Chief of that Department or Departments at Crozer-Chester affected must first approve and define this participation.

The Education Program of the Section of General Practice of the Department of Medicine will be developed along the lines of the Family Medicine and Community Medicine Tracks of Hahnemann. This will include medical student preceptorships.

Physicians in the Section of General Practice will be appointed either to the active academic staff or to the active nonacademic staff. As noted above for appointment procedures, appointment to the academic staff requires the approval of the Departmental Chairman at Hahnemann and should also include the recommendations of the Head of the Section of Family Medicine. Appointment to the nonacademic staff precludes participation in the residency and student training programs.

(b) After the date of execution of this Agreement, Crozer-Chester will not appoint any individual chief of any of the four departments unless the person to be appointed previously

- (1) Has been approved by Hahnemann for appointment to the Hahnemann medical faculty; and
- (2) Has agreed to accept an appointment to the faculty of Hahnemann.

(c) After the date of execution of this Agreement, Crozer-Chester will not appoint any individual to its active staff with the sole exception of the nonacademic staff of the Section of General Practice of the Department of Medicine or the Emergency Medical Associates, unless the person to be appointed previously

- (1) Has been approved by Hahnemann for appointment to the Hahnemann medical faculty; and
- (2) Has agreed to accept an appointment to the faculty of Hahnemann.

However, in considering persons for appointment to its faculty under this subparagraph (c), Hahnemann shall limit its inquiry to determination of their willingness to accept the responsibilities of faculty appointment, as well as their medical and academic qualifications; if the appointee proposed by Crozer-Chester satisfies these requirements, Crozer-Chester shall then have the sole right to make or reject the appointment. Crozer-Chester shall, with the exception of the Section of General Practice of the Department of Medicine and the Emergency Medical Associates, add no physicians to the active staff unless they are either board-certified or board-eligible in their particular specialty and have indicated in writing their willingness to participate in the academic program and have been approved by the appropriate Departmental Liaison Committee.

SEVENTH: During the term of this Agreement, Hahnemann will appoint to the Executive Faculty of its medical college the Chief of each of the four clinical departments and at least one additional person from each of the four departments of Crozer-Chester who has accepted appointment to the faculty of Hahnemann.

The persons so appointed shall have the same authority, rights and privileges as all other members of the Executive Faculty.

EIGHTH: During the term of this Agreement, Crozer-Chester shall not, without written approval of Hahnemann, affiliate with any other hospital or medical college in the operation of the clinical departments or in the conduct of an academic program in those departments; Crozer-Chester must also have approval from Hahnemann to discuss any proposals to establish an affiliation for the conduct of an academic program in any of the units of its hospital other than the clinical departments. As is the case at Hahnemann, students from other schools may serve elective assignments at Crozer-Chester when they are approved by the Chief of the service at Crozer-Chester and the Coordinator of the Corresponding department at Hahnemann.

NINTH: An interinstitutional Planning Committee shall be appointed, consisting of the four Department Chairmen from Hahnemann, the four Chiefs of the clinical departments from Crozer-Chester, the Dean at Hahnemann, and the Coordinator of the program at Crozer-Chester.

Believing it to be impracticable, even if it were possible, to provide for the conduct of the program in further detail at the present time, and having the fullest confidence that when situations arise which are not provided for in this Agreement mutually satisfactory conclusions can then be reached by the parties, Hahnemann and Crozer-Chester agree in each such case to refer the matter to the Interinstitutional Planning Committee of ten members.

The written recommendations of a majority of members of the Interinstitutional Planning Committee with respect to the matters so referred to shall not be final until approved by the Boards of Trustees of both parties.

TENTH: (a) The initial term of this Agreement shall commence July 1, 1969, and terminate June 30, 1974.

(b) After 1970, this Agreement shall be automatically renewed for five years from year to year, unless by the first day of September of the fifth year preceding that in which the original or any subsequent renewed term of this Agreement is to expire, either party shall give the other written notice of its intention to terminate the Agreement on the thirtieth day of June four years and nine months from the date of such notice.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed by their duly authorized representatives the day and year first above written;

(CORPORATE SEAL)

CROZER-CHESTER MEDICAL CENTER

Attest: [Signature]
Secretary

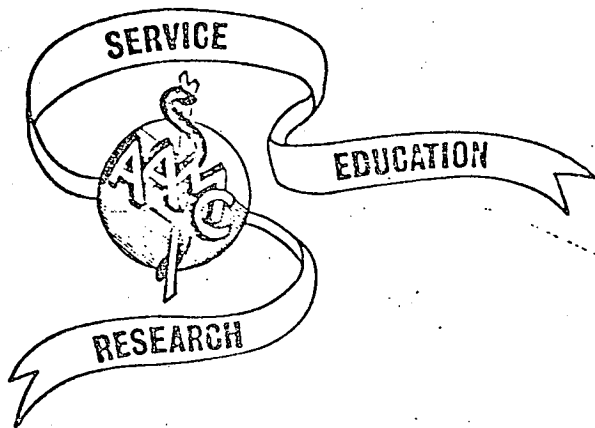
By: [Signature]
President, Board of Trustees

(CORPORATE SEAL)

THE HAHNEMANN MEDICAL COLLEGE
AND HOSPITAL OF PHILADELPHIA

Attest: [Signature]
Secretary

By: [Signature]
Dean



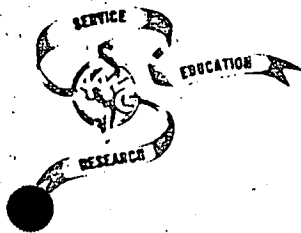
REPORT OF THE
AAMC TASK FORCE
ON THE
GOALS AND PRIORITIES COMMITTEE
REPORT
OF THE
NATIONAL BOARD OF MEDICAL EXAMINERS

This report is distributed for discussion and comment. The report is not an official policy statement of the AAMC.

Comments Should be Directed to:

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

October 25, 1974



ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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

REPORT OF THE AAMC TASK FORCE ON
 THE GOALS AND PRIORITIES COMMITTEE REPORT OF
 THE NATIONAL BOARD OF MEDICAL EXAMINERS

The AAMC has long been engaged with furthering the improvement of medical education in the United States. Through direct services to its constituents, interactions with other organizations and agencies concerned with medical education, national and regional meetings and participation in the accreditation of medical schools, the Association has exercised its responsibilities to the schools, teaching hospitals and to the public which is served by its medical education constituency. From time to time, the Association has analyzed and responded to reports bearing on medical education emanating from other organizations and agencies. This Task Force Report on the National Board of Medical Examiners' Goals and Priorities Committee Report is such a response.

Members of the Task Force:

Neal L. Gault, Jr., M.D., Chairman
 H. Robert Cathcart
 A. Jay Bollet, M.D.
 Carmine D. Clemente, Ph.D.
 Robert L. Tuttle, M.D.
 Ronald P. Kaufman, M.D.
 John H. Moxley, III, M.D.
 Ms. S. Shackleton (Student)
 Mark Cannon (Student)

The Task Force was particularly assisted in its deliberations by the working papers developed from the studies of a committee of the Group on Medical Education chaired by Mitchell Schorow. This committee met with faculty and administrators of schools in all four regions of the country. Many views and comments were also received from academic societies, individuals, schools and from regional groups of the Organization of Student Representatives. The Task Force is profoundly grateful for the assistance which these inputs provided in its deliberations.

THE GOALS AND PRIORITIES COMMITTEE OF THE NATIONAL BOARD OF MEDICAL
 EXAMINERS

In the Spring of 1971, the National Board of Medical Examiners appointed an eleven person committee called the Goals and Priorities (GAP) Committee, which was charged by the Board to examine American

Task Force Report on GAP Committee Report of NBME

medical education and make recommendations regarding the role the National Board should play in providing evaluation services during the next decade.

The GAP Report is a thorough treatment of a new role for the National Board of Medical Examiners in providing services for evaluating the developing competence of undergraduate and graduate medical students and the continuing competence of physicians. The NBME has, for nearly sixty years, served as an independent agency for evaluating medical students and newly graduated physicians for certification for licensure. For the past twenty years the NBME has increasingly become involved with research and development in medical student testing, and during the past decade the Board has become engaged in the research and development of testing methodologies for graduate students as well as undergraduate students.

Summary of Major Recommendations of the GAP Report

The GAP Committee Report recommends that the NBME reorder its examination system. It advises that the Board should abandon its traditional 3 part exam for certification of newly graduated physicians who have completed one year of training beyond the M.D. degree. Instead, the Board is advised to develop a single exam to be given at the interface between undergraduate and graduate education. The GAP Committee calls this exam 'Qualifying A', and suggests that it evaluate general medical competence and certify graduating medical students for limited licensure to practice in a supervised setting. The Committee further recommends that the NBME should expand its role in the evaluation of students during their graduate education by providing more research and development and testing services to specialty boards and graduate medical education faculties. Finally, the GAP Committee recommends that full certification for licensure as an independent practitioner be based upon an exam designated as Qualifying B. This exam would be the certifying exam for a specialty. In addition, the GAP Report recommends that the NBME: 1) assist individual medical schools in improving their capabilities for intramural assessment of their students; 2) develop methods for evaluating continuing competence of practicing physicians; and 3) develop evaluation procedures to assess the competence of "new health practitioners."

GENERAL OBSERVATIONS BY THE TASK FORCE

Throughout the GAP Report there is an effort to separate clearly the role of the NBME as a testing agency responsible for certifying that physicians have the necessary qualifications for licensure and the NBME's role in the evaluation of the educational achievement of students. The Task Force believes that this is a very important separation. This report of the Task Force is predicated on the fundamental concept that the faculties of duly accredited medical schools are solely responsible for the evaluation of their students' educa-

Task Force Report on GAP Committee Report of NBME

tional achievement, their promotion and their being granted the M.D. degree. State licensing boards are solely responsible for establishing criteria for licensure and for the evaluation of a physician's qualifications to practice medicine within their jurisdictions.

The delegation of the responsibility for evaluation, either by faculties or by licensing boards to another agency, must be done only with full and complete knowledge and understanding of the characteristics and limitations of the evaluation instruments which are used. The Task Force further believes that evaluation instruments designed to qualify physicians for certification for licensure (either limited or full) are not appropriate for measuring the educational achievement of individual students as they progress through a school's curriculum.

UNDERGRADUATE EVALUATION AND ABANDONMENT OF PARTS I AND II OF THE NATIONAL BOARD OF MEDICAL EXAMINERS EXAMINATIONS.

The GAP Committee proposes that the National Board cease utilizing its 3 part exam system (Parts I and II in the undergraduate period and Part III at the end of the first graduate year) to certify physicians as qualified for full licensure. This proposal is tempered by the recommendation that the NBME, on request from an educational institution, should provide services for evaluating the educational achievement of individual students and the educational programs themselves. The Task Force supports this recommendation, and proposes that nationally normed exams similar to the present Parts I and II should be made available as a part of the services for evaluation of curricula.

Abandonment of Part I

The abandonment of the certifying function of the Part I exam is viewed by many as yet another inroad into the emphasis upon basic science education in our medical schools. Indeed, this would be true if the NBME, through the Part I exam, were the sole agency responsible for ensuring the scientific integrity of medical education in the United States. However, as emphasized above, the faculties of our duly accredited schools are responsible. This responsibility means that faculties must develop evaluation methods to determine whether their students are achieving their educational objectives in the basic medical sciences; and the LCME, through its accreditation process, must determine whether the educational objectives established by each faculty are adequate and whether the school has evaluation methods which will determine that students have met these objectives. The continued availability of nationally normed exams in the basic sciences will provide an opportunity to evaluate a school's educational programs against a national standard, if the faculty deems such an evaluation necessary or desirable.

Task Force Report on GAP Committee Report of NBME

The Task Force recommends that the LCME should place greater emphasis, as a factor in the accreditation process, on assessing the effectiveness of medical schools' internal evaluation of their educational programs and of their students' achievement in the basic sciences. The Task Force also recommends that the AAMC, working with the NBME, academic societies, the National Library of Medicine, and other agencies, develop the capability to assist faculties in the development of evaluation instruments and methods which can be flexibly adapted to each school's particular curricular emphasis.

In order for the LCME to place a greater emphasis upon the assessment of the adequacy of each school's evaluation system, the Task Force recommends that accreditation site visit teams include individuals capable of investigating and judging testing methodologies. The Task Force further recommends that individuals capable of assessing the content and quality of basic science course work be included on all site visit teams.

Abandonment of Part II

The comments and recommendations relative to eliminating the certification function of Part I also apply to Part II. Faculties are solely responsible for the evaluation of their students' achievements in their clinical courses and clerkships. Evaluation methodologies must provide for assessment of students' accomplishments in relationship to the educational objectives established by the faculty. Generally, evaluation during the clinical years relies in part upon faculty members' descriptive impressions of a student's attitudes, skills, and accomplishments and in part on an assessment of the knowledge acquired by the student. In recent years testing methodologies to evaluate a student's problem-solving skills have been introduced and are a valuable adjunct to faculty descriptions and knowledge acquisition assessments. The Task Force recommends that the AAMC, in cooperation with the above-mentioned agencies, develop the resources to assist faculties in improving all facets of their student evaluation methods during the clinical years.

The Task Force also recommends that, as in the case of the basic sciences, the LCME place greater emphasis in the accreditation process on the effectiveness of the medical schools' internal evaluation of their students achievements in the clinical sciences.

Nationally normed exams, which permit comparative evaluation of a school's instructional program against a national standard, from time to time will continue to be necessary. The Task Force recommends that the NBME continue to make available the Part II exam, or its improved equivalent, to faculties desiring to assess the adequacy and scope of their curricula through this instrument.

Task Force Report on GAP Committee Report of NBME

QUALIFYING A

The GAP Committee recommends that the NBME develop an examination to be taken by students at the time of their transition from undergraduate to graduate status. The agencies for whom this exam will be pertinent will be state licensing boards, who are responsible to their jurisdictional constituencies for assuring that individuals providing physician services are competent, and graduate education institutions and programs, who are responsible for the welfare of the patients within their clinical teaching facilities. The examination is not deemed pertinent to undergraduate medical educators for, as emphasized above, the decision to grant the M.D. degree by the faculty of any school must be based upon internal evaluation methods developed by the school. The Task Force concurs with the establishment of such an examination and makes the following comments and recommendations.

The exam would provide for a single standard for the evaluation of all students entering graduate medical education in the United States. Because of the varied curricula in our domestic medical schools and the wide range of quality of foreign students seeking entrance to U.S. graduate programs, it is essential that a single standard be established which will assure that each student who enters a graduate program is ready, as regards both knowledge and clinical skills, to assume patient care responsibility.

The examination should provide a balanced assessment of the student's basic science and clinical knowledge and an assessment of the student's logic and problem-solving abilities. The assessment of basic science knowledge and skills in utilizing fundamental scientific concepts should be sufficiently rigorous so that students passing the exam can be considered to have had a sound education in the basic science disciplines.

If at all possible, the exam should be criterion-based rather than norm-referenced and the results should be reported as either "passed" or "failed".

The results should be reported only to the student, to the graduate institution or program for which the student has been selected, and the licensing agency with jurisdiction over the student and the graduate program. The exam should not be reported to graduate programs as part of the student's application information. The purpose of the exam is to assure readiness for clinical responsibility; it should not be used in the selection of graduate medical students or to predict future success in any clinical discipline.

Task Force Report on GAP Committee Report of NBME

Students from domestic schools should not be permitted to sit for the exam before the beginning of the last half of their final undergraduate year. The examination schedule should be so arranged that students will have a second opportunity to take the exam and receive the results before the usual date of beginning of the first graduate year. Graduates of foreign schools should be permitted to sit for the exam at any time, but should not be permitted to begin their graduate education until a report that they have "passed" has been received by the above-mentioned agencies.

The Task Force believes that passing the exam should be the responsibility of the student. Students who fail must assume individual responsibility to obtain needed additional education and study. Schools which have granted the M.D. degree to students who fail the exam should have no obligation to provide remedial assistance, although in practice the Task Force believes most students will seek additional education from their own school. This should not be denied if the student is willing to pay the required tuition and fees.

Limited Licensure

The Task Force could not reach unanimous agreement on the GAP Committee recommendation that licensure be limited to providing care in a supervised graduate education setting. Objection by the student members of the Task Force and doubts regarding the willingness of all fifty-five jurisdictions in the United States and its territories to provide such a limited licensure at this stage was the cause of this impasse. It is the Task Force's view that the impetus for implementation of this examination will derive from the Liaison Committee on Graduate Medical Education. The Liaison Committee can insist that only students who have passed the qualifying exam be admitted to accredited graduate programs.

EVALUATION DURING GRADUATE MEDICAL EDUCATION

The GAP Committee recommends that the evaluation of students during their graduate education be vastly improved. The Task Force concurs with this recommendation and makes the following comments and recommendations.

The faculties responsible for graduate clinical education should assume sole responsibility for the evaluation of their students as they progress through their education. Evaluation methodologies should be developed and applied which will assess whether residents are achieving the requisite knowledge and skills expected by the faculty and the specialty boards. The Liaison Committee on Graduate Medical Education should place a strong emphasis on requiring effective in-

Task Force Report on GAP Committee Report of NBME

ternal student evaluation methods in its accreditation requirements for graduate programs. The specialty boards should require that program directors, when certifying their finishing residents as ready for board examinations, provide evidence of sound internal assessment of each resident's abilities and qualifications.

QUALIFYING B

The GAP Committee recommends that licensure for the unlimited independent practice of medicine be based upon a candidate's passing the Qualifying B examination which would be one of the specialty board examinations. The Task Force recommends that medical licensure should not necessarily be linked to specialty certification. Physicians should be eligible for full medical licensure after the satisfactory completion of the core portion of a graduate medical educational program, this core portion to be delineated individually by each specialty board. Specialty board certification should continue to be a mechanism by which individual physicians may demonstrate outstanding accomplishment in a given field. Such certification may be used by individual physicians as an alternative method of gaining medical licensure, but it should not be required.

RECERTIFICATION AND RELICENSURE

The Task Force concurs with the GAP Committee's recommendation that the National Board of Medical Examiners should be prepared to provide assistance to those agencies which may in the future be responsible for providing periodic examinations for the recertification or relicensure of physicians.

REORGANIZATION OF THE NATIONAL BOARD OF MEDICAL EXAMINERS

The Task Force concurs with the reorganization as proposed by the GAP Committee. The Task Force urges student representation on the National Board of Medical Examiners.

Task Force Report on GAP Committee Report of NBME

SUMMARY OF TASK FORCE RESPONSES TO THE GAP COMMITTEE'S MAJOR RECOMMENDATIONS

1. The NBME should abandon its 3 part system of examination for certification for licensure.

The Task Force concurs.

2. The NBME should continue to make available norm-referenced exams in the disciplines of medicine now covered in Parts I and II of the National Board.

The Task Force concurs and recommends that faculties use these exams to evaluate their curricula and instructional programs only and not to evaluate individual student achievement.

3. The AAMC, NBME and other interested agencies should assist the schools to develop more effective student evaluation methodologies.

The Task Force concurs and recommends that the LCME place a specific emphasis on investigating schools' student evaluation methods in its accreditation surveys.

4. The NBME should develop an exam to be taken by students at their transition from undergraduate to graduate education for the purpose of determining students' readiness to assume responsibility for patient care in a supervised setting.

The Task Force concurs and makes the following recommendations.

- a. *The exam should be sufficiently rigorous so that the basic science knowledge and concepts of students are assessed.*
- b. *The exam should place an emphasis on evaluating students' ability to solve clinical problems as well as assessing students' level of knowledge in clinical areas.*
- c. *The exam should be criterion-referenced rather than norm-referenced.*
- d. *The exam should be reported as "passed" or "failed" to the students, to the graduate programs they are entering, and to the licensing boards that require certification for graduate students.*

Task Force Report on GAP Committee Report of NBME

- e. *The exam results should not be reported to medical schools.*
- f. *Students failing the exam should be responsible for seeking additional education and study.*
- g. *Graduates of both domestic and foreign schools should be required to pass the exam as a prerequisite for entrance into accredited programs of graduate medical education in the U.S.*

5. The Federation of State Medical Boards and their members should establish a category of licensure limited to caring for patients in a supervised graduate medical education setting.

The Task Force doubts that all jurisdictions will establish such a category and believes that the LCGME should require that all students entering accredited graduate medical education pass the exam.

6. The NBME and other agencies should assist graduate faculties to develop sound methods for evaluating the achievements of their residents.

The Task Force concurs and recommends that graduate faculties assume responsibility for periodic evaluations of their residents and that the specialty boards require evidence that the program directors have employed sound evaluation methods to determine that their residents are really to be candidates for board exams.

7. Certification for licensure for independent practice should be based on certification by a specialty board.

The Task Force recommends that specialty certification be only one mechanism by which individual physicians may gain licensure; it should not be the prime or sole mechanism. The Task Force recommends that physicians should be eligible for full licensure after the satisfactory completion of the core portion of a graduate medical educational program.

MINORITY REPORT BY CARMINE CLEMENTE, Ph.D.
MEMBER OF THE TASK FORCE

As the only practicing basic scientist on the Task Force, I do not agree with two of the summary recommendations. I believe the Report does not represent the broad views of the membership of the AAMC, especially those of the basic scientists. In fact, several basic science societies have expressed the view that the elimination of Part I will irreparably reduce the emphasis on basic sciences in the curriculum of the first two years of medical school.

Therefore, I recommend that in the Summary of Task Force Responses, Item 1 read as follows:

1. The NBME should abandon its 3 part system of examination for certification for licensure.

The Task Force believes that the 3 part system should not be abandoned until a suitable examination has been developed to take its place and has been assessed for its usefulness in examining medical school graduates in both the scientific and clinical aspects of medical education.

The issue here is not "licensure", for that function of the National Board has already been supplanted through the use of the FLEX exam. My concern is for the term "abandonment". Once the Task Force concurs with abandonment of the 3 part examination, it will imply a downgrading of the importance of the basic sciences in the education of physicians by eliminating a nationally referenced instrument now available through Part I.

I also recommend a substitute for Item 2 of the Summary. It would read:

2. The NBME should continue to make available norm-referenced exams in the disciplines of medicine now covered in Parts I and II of the National Board.

The Task Force recommends that at least Part I of the National Boards continue to be utilized through the foreseeable future in the current manner, so that faculties at schools of medicine might retain the advantage of evaluating their curricula and instructional programs of the first two years against a national norm. Individual schools could continue to determine, on an ad hominem basis, the manner in which each school wishes to use Part I. Part I and the qualifying exam could then fulfill different functions.

REPORT OF THE COTH AD HOC COMMITTEE ON COTH MEMBERSHIP CRITERIA

The first meeting of the Ad Hoc Committee on COTH Membership Criteria was held on June 7, 1974, at the AAMC headquarters in Washington, D.C.

The Chairman, Charles Womer, presided, and with one exception all members of the Committee were present. The Committee was established by action of the COTH Administrative Board at its meeting on March 21, 1974.

Committee membership is as follows:

Allan C. Anderson
Executive Director
Strong Memorial Hospital of the
University of Rochester
Rochester, New York

Don L. Arnwine
President
Charleston Area Medical Center
Charleston, West Virginia

Clyde G. Cox
Director
Veterans Administration Hospital
Birmingham, Alabama

Andrew D. Hunt, Jr., M.D.
Dean
College of Human Medicine
Michigan State University
East Lansing, Michigan

Although the Committee was charged to generally review the membership criteria, it was specifically requested to address situations in which medical schools are affiliating with hospitals not participating significantly in graduate medical education.

The non-university owned and/or formerly non-university affiliated (community based) teaching hospitals are becoming involved in providing clinical settings for undergraduate medical education. This appears to be

the result of two somewhat parallel developments. First, newly developing medical schools are choosing to use presently existing clinical facilities to accomplish specific educational objectives, and/or they are finding it increasingly difficult to secure the necessary funding to build and subsequently operate university-owned hospital facilities. Second, established medical schools are increasingly looking toward community based hospital facilities to provide clinical settings to permit increases in class size and/or to provide a broader clinical exposure to physicians in training.

When the Section on Teaching Hospitals was established within the AAMC in 1958, each medical school dean was entitled to appoint the chief executive of one of its primary teaching hospitals to membership in the Section. This situation prevailed until the Council of Teaching Hospitals was established in 1967. Initially, eligibility for membership in the Council was determined on the basis of one of the following two criteria:

- (1) teaching hospitals which have approved internship programs and full approved residencies in at least four recognized specialties including three of the following: medicine, surgery, obstetrics-gynecology, pediatrics and psychiatry;

OR

- (2) those hospitals nominated by an AAMC medical school institutional member or provisional institutional member from among the major teaching hospitals affiliated with the member.

These criteria were utilized until November of 1972 when the following criteria were approved by the membership:

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

AND

- (2) 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 and psychiatry.

This revision developed from the belief that since the Association of American Medical Colleges represents the nation's medical schools, each teaching hospital should reflect the orientation of the Association by having a documented affiliation agreement with a school of medicine. Additionally, those institutions which participate should not be characterized only by the presence of undergraduate medical education, but must make a significant commitment to graduate medical education.

Perceived problems regarding present membership criteria can be examined from two interrelated perspectives. First, institutions which do not presently meet the existing criteria have sought membership in the Council. Second, new organizational forms and arrangements are being developed which are not defined as "hospitals," but which are being utilized to achieve medical education objectives; such organizations seek representation to further their medical education objectives.

The membership criteria were established to provide a basis from which hospitals could effectively organize to promote the hospital as an educational institution. Additionally, a primary objective of COTH is to more clearly and adequately represent those institutions which are characterized by a number of unique features consonant with their

significant commitments to medical education. A previous examination of COTH membership* criteria delineated a number of dimensions which characterize the unique nature of teaching hospitals. They are:

- (1) the size and scope of the intern and resident staff;
- (2) the number of fellowship positions;
- (3) the extent to which the full range of clerkships is offered to undergraduate medical students;
- (4) the number and scope of allied health education programs sponsored by the hospital or in which the hospital participates;
- (5) the volume of research undertaken;
- (6) the extent to which the medical faculty is integrated with the hospital medical staff in terms of faculty appointments;
- (7) the nature and substance of the medical school affiliation arrangement;
- (8) the appointment of full-time salaried chiefs of service;
- (9) the number of full-time salaried physicians;
- (10) the number of special service programs offered, e.g., neonatal care units, pediatric evaluation centers, or renal dialysis units;
- (11) the level of complexity demonstrated by the diagnostic mix of patients;
- (12) the staffing pattern and ratios resulting from the distinctive patient mix;
- (13) the scope and intensity of laboratory and x-ray services;
- (14) the financial arrangements and volume of service rendered in out-patient clinics.

*COTH Ad Hoc Membership Committee Report, approved at November 1972 COTH institutional membership meeting.

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It is these, as well as other unique features of the teaching hospital which characterize those institutions that require special representation. Given these dimensions, the question becomes one of whether membership criteria of the Council of Teaching Hospitals should be changed to include the newer organizational and other arrangements which have been developed to achieve given educational objectives or whether the Council of Teaching Hospitals as a component of the AAMC should continue to represent and concentrate its efforts on those institutions that have special needs as a result of their unique characteristics as set forth above. The Committee recommends the latter course.

Based on the foregoing the Committee recommends:

1. That the membership criteria established in November 1972 as amended later in this report 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 support for 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.

With respect to recommendation number 2 above, the Committee emphasizes that items a. through e. are items which should be considered in evaluating whether or not an applicant fulfills the membership criteria. They are not intended to be requirements, nor should fixed minimum numerical standards be developed in regard to them.

The Committee reviewed the question of member hospitals which do not meet the membership criteria and determined that the interests of the Association and its members are best fulfilled if all member hospitals are required to meet the current membership criteria within a reasonable period of time. Therefore, the Committee recommends:

4. That the membership criteria adopted in November 1972, as amended by this report, together with the considerations listed 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.

In reviewing the criteria for membership (particularly the criterion that an applicant offer four approved residency programs, two of which must be the major specialties) the Committee discussed the increasing development of family medicine residency programs in teaching hospitals and the major commitments that a number of institutions are making to such programs. In view of these developments, and to demonstrate the commitment of the Council of Teaching Hospitals and the Association of American Medical Colleges to programs in primary care and family medicine, the Committee recommends:

5. That family medicine be added to the residency programs itemized in the existing criteria, of which an institution must participate in two to qualify for membership.

The remainder of the meeting was devoted to a discussion of the new organizational forms and arrangements which are being developed to achieve medical education objectives. Basically, these arrangements, as discussed by the Committee, may be classified into three specific types, none of which are currently defined as "hospitals."

Dr. Andrew Hunt, Dean of the Michigan State University College of Human Medicine, provided an example of one type of this corporate form which has developed in Michigan. While this example served to make the point of the discussion, it is recognized that similar corporate forms have been developed in Florida, Illinois, Hawaii and other states. In Grand Rapids, Michigan, the Grand Rapids Area Medical Education Center (GRAMEC) has been developed and incorporated to provide an organizational

framework within which the resources of a variety of institution can be brought together in order to achieve medical education objectives. This nonprofit corporation is an effective instrument in achieving these objectives. At the present time, the organization is devoted to undergraduate medical education, but has the potential to serve as the locus for the development and coordination of graduate medical education programs. Such an organization is not a hospital, and therefore, by definition, is not eligible for membership in the Council of Teaching Hospitals.

Two other forms of organizational developments have been taking place which are closely akin to this concept. One of these is the establishment of area health education centers, and the other is regionalization programs of the Veterans Administration insofar as it affects medical education and the integration of specialized resources to provide a broader organizational framework for coordination and effective utilization of resources.

It was agreed that these developments do represent significant changes in the medical education community. There was full discussion of the role of the Council of Teaching Hospitals in defining the relationship with these organizations as well as the possibility that the issue requires further examination within the broader framework of the organization of the Association of American Medical Colleges. The Committee recommends:

6. That the problem of reflecting these changes and meeting the needs of these particular organizations is broader than the

question of COTH criteria for membership, and if consideration is to be given to them by the AAMC, such consideration would be best undertaken by an ad hoc committee of the AAMC Executive Committee.

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

<u>TYPE</u>	<u>Date of Initial Approval by CME of AMA*</u>	<u>Total F.T.E.¹ Positions Offered</u>	<u>F.T.E. ¹ Total Positions Filled by U.S. And Canadian Grads</u>	<u>F.T.E. ¹ Total Positions Filled by FMG's</u>
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.

TYPE	Date of Initial Approval by CME of AMA*	Total F.T.E. Positions Offered	F.T.E.	F.T.E.
			Total Positions Filled by U.S. And Canadian Grads	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 _____

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DISTINGUISHED SERVICE MEMBERS

Distinguished Service Members are defined on the attached page of the AAMC Bylaws as persons who have been actively involved in the affairs of the Association and who no longer serve as Association representatives of any members described under Section 1.

Section 1 outlines the various classes of institutional membership including the Council of Teaching Hospitals. Therefore, the chief executive officer of any COTH member hospital is not eligible to become a Distinguished Service Member.

COTH Nominations for Distinguished Service Members were approved last December by the Executive Council and will be ratified at the November 1974 AAMC Assembly meeting. They are as follows:

Donald J. Caseley, M.D.
John H. Knowles, M.D.
Russell A. Nelson, M.D.
Matthew F. McNulty, Jr., Sc.D.
Albert W. Snoke, M.D.

New COTH Nominations can be made at any time. Each board member is encouraged to suggest nominations for consideration at the November 12, 1974 Board meeting.

Section 2. There shall also be the following classes of honorary members who shall meet the criteria therefore established by the Executive Council:

- A. Emeritus Members - Emeritus Members shall be those retired individuals who have been active in the affairs of the Association prior to retirement.
- B. Distinguished Service Members - Distinguished Service Members shall be persons who have been actively involved in the affairs of the Association and who no longer serve as AAMC representatives of any members described under Section 1.
- C. Individual Members - Individual Members shall be persons who have demonstrated a serious interest in medical education.
- D. Sustaining and Contributing Members - Sustaining and Contributing Members shall be persons or corporations who have demonstrated over a period of years a serious interest in medical education.

Section 3. Election to membership:

- A. All classes of members shall be elected by the Assembly by a majority vote on recommendation of the Executive Council.
- B. All institutional members will be recommended by the Council of Deans to the Executive Council.
- C. Academic society members will be recommended by the Council of Academic Societies to the Executive Council.
- D. Teaching hospital members will be recommended by the Council of Teaching Hospitals to the Executive Council.
- E. Distinguished service members will be recommended to the Executive Council by either the Council of Deans, Council of Academic Societies or Council of Teaching Hospitals.

Section 4. Revocation of Membership - A member with any class of membership may have his membership revoked by a two-thirds affirmative vote of the Assembly on recommendation with justification by the Executive Council; provided that the Executive Council shall have given the members written notice of the proposed revocation prior to the Assembly at which such a vote is taken.

Section 5. Resignation - A member with any class of membership may resign upon notice given in writing to the Executive Council. However, any such resignation shall not be effective until the end of the fiscal year in which it is given.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Memorandum #74-37

To: The Assembly

October 21, 1974

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

Subject: AAMC health manpower policy reconsideration

This memorandum provides background for the reconsideration of current Association policy on federal legislation for health professions education assistance. Adoption of an alternative health manpower policy would represent a major change in Association position. Accordingly, the issue is to be placed before the Assembly during its November 14, 1974, meeting in Chicago.

This memorandum briefly reviews the Association's present health manpower policy and the current legislative situation, and presents a series of possible alternatives for the future guidance of the Association.

Present AAMC policy

Association health manpower policy is based on two reports prepared by the Committee on the Financing of Medical Education. The Executive Council has approved the two reports prepared by the Committee. The first report, in October 1973, Undergraduate Medical Education: Elements, Objectives, Costs, identified the costs of the undergraduate medical education program. The second report, in June 1974, Financing Undergraduate Medical Education, presented recommendations on how undergraduate medical education should be financed.

Specific policy on health manpower legislation is based on the recommendations of the Committee on Health Manpower, which were approved by the Executive Council on November 14, 1973. Among other recommendations, the AAMC policy calls for institutional support through capitation grants at a level slightly higher than the present level, with no preconditions. Capitation bonuses are to be available for increasing undergraduate enrollment, or for programs in primary care, or for programs in underserved areas. At the heart of the Association's present policy is the preservation of capitation grants to provide substantial and continuing support for the federal share of the teaching activities of the medical schools that are essential to undergraduate medical education. Other than routine financial accountability, no preconditions are to be attached.

The Committee considered and rejected "last dollar" financing which would involve federal support, individualized for each school, for that portion of the operating budget not covered by income from other sources. It also considered and rejected the approach advocated by Congressman Roy which would provide only indirect support to medical schools by expanding federal student financial aid programs permitting an increase in tuition to more closely meet the costs of medical education at each institution.

Additionally, the AAMC Task Force on Foreign Medical Graduates recommended in a report adopted by the Executive Council on March 22, 1974, that U.S. medical schools should be the major source of physicians practicing in the United States, that first-year graduate training positions should be reduced

gradually so as to exceed only slightly the number of graduates from U.S. medical schools, and that new health personnel should be trained to meet hospital staff needs created by the reduced training of Foreign Medical Graduates in the face of continuing patient responsibilities.

Current legislative situation

As the health manpower bills have evolved this year, the capitation-grant mechanism has become distorted. Both the House and the Senate have seized on the mechanism as a means of forcing federal initiatives on the schools, and this threatens serious government intrusion into the process of medical education. Capitation conditions of this nature, as of this date, are presented below:

Senate:

Secure national service agreements from at least 25 percent of students, with each such student entitled to a national health service or a shortage area scholarship, provided that the HEW Secretary may agree with a school to increase the requirement to 50 percent and increase the capitation payments by 10 percent.

One-time medical student enrollment increase of 5% or 10 students.

Lowering ceilings on FMGs in affiliated graduate training programs of 40-35-25 percent over three years.

Establish department or program in Family Medicine or comparable primary care. Administer a residency program in Family Medicine of not less than 10-15-20 percent (over three years) of all affiliated graduate training positions or in comparable primary care of not less than 35-40-45 percent (over three years) of all affiliated graduate training positions.

House:

Secure agreements with students to repay capitation payments unless they serve in the National Health Service Corps.

One-time medical student enrollment increase of 5% or 10 students, or offer training as a physician assistant.

Approved plan for remote-site training, to be supported by at least 25% of capitation payment.

The cumulative effect of these conditions for eligibility is to convert capitation from institutional support for basic program maintenance to restrictive support for federal initiatives, distributed on a per capita basis. The changing nature of capitation intent requires a search for alternate mechanisms for providing federal support to the schools for both basic program maintenance, and for responding to national needs identified both in the public and private sectors. The remainder of this memorandum sets forth a series of such alternatives.

Health Manpower Policy Alternatives

This section briefly reviews current public concerns, describes assumptions upon which policy alternatives should be considered and provides a selection of possible policy choices.

Current concerns

Following are brief descriptions -- as seen from the federal perspective -- of major public concerns with medical education and health care personnel.

Basic program: Current Association policy holds that the federal government's share of basic operating expenses should be provided through capitation grants without any preconditions except routine financial accountability. Both Congress and the Administration reject the Association's position. Congress appears willing to continue capitation provided that certain requirements are met by the schools. The Administration wants to drop capitation altogether. Without substantial evidence, both Congress and the Administration believe that without capitation funds no school will be seriously affected, because other funding sources will be found or schools will accommodate by spending less and restricting their programs.

Innovation, quality improvement: These are the traditional special project categories of curriculum development. While special projects show a federal concern for quality, the major emphasis is on numbers of students graduated.

Enrollment increase: There is disagreement within the federal government on the need for additional physicians. Congress generally believes that a further increase in the education and training of new physicians is needed. The Administration does not advocate an increase in the number of medical school graduates beyond those now planned.

Specialty distribution: Both the Administration and Congress believe that there is an imbalance in specialty distribution, and that more primary care physicians are required. There appears to be a willingness to support the efforts of the private sector in bringing about a redistribution of specialists through control of training opportunities over the next two to three years. Control of licensure to prohibit practice in oversupplied specialties has also been discussed.

Geographic distribution: Both the Administration and Congress believe that ways must be found to get physicians into underserved urban and rural areas. There is a widely held view that this can best be accomplished either by requiring medical schools to obtain agreements from students to practice in underserved areas, or by increasing student aid programs which encourage or require service commitments as a condition of receiving the aid. There is little interest in a physician draft to redistribute physicians.

Foreign medical graduates: This concern differs somewhat from the others because the method for dealing with it involves developing exclusionary devices rather than facilitating programs. The implications of certain reactions to this concern appear in both the concern with undergraduate enrollment and the concern with specialty distribution. Congress and the Administration disagree on the issue. The Administration officially supports major reliance on FMGs in meeting domestic American health personnel needs. Congress objects to the rising number of FMGs, and is seeking ways of checking the flow by setting ceilings on the total number of graduate positions and on the percentage of these positions that can be filled by FMGs.

Fiscal and economic situation: This concern, again, is slightly different from the others. Congress and the Administration agree, despite some superficial quarreling, that present federal budgets are excessively large, and that their magnitude requires stringent efforts to hold down future controllable spending. In addition, the overall economic situation is one of persistent inflation at an unacceptably high rate. This leads to rising costs across the whole economy, with particular attention focusing on large cost increases such as those in the health care field generally. Congress and the

Administration agree, again despite some superficial quarreling, that steps must be taken to control rising costs, and that the strongest controls must be leveled at the sharpest cost increases.

Assumptions

Following are a set of assumptions which should be used in considering new Association policies on the federal role in professional health manpower education, in light of current public concerns.

1. Responsiveness toward current public concerns is essential, if the schools are to maintain their position as public institutions worthy of support from any source.
2. There will always be disagreements on the nature of the appropriate mechanisms to respond to federally perceived needs.
3. Public funding of some nature is required to help finance the high cost of quality medical education.
4. Variations among institutions will result in differing abilities to respond to federal requirements.
5. Qualifying requirements can be expected, regardless of the source or mechanism of support, and often these will intrude on traditional institutional prerogatives.
6. Current methods of meeting federal concerns are unstable and can be expected to shift over relatively short periods of time, two to three years for example. Additional concerns are likely to be identified from time to time.
7. Long-term federal assistance for basic program support is being challenged because of shifting public demands for priority use of a relatively limited amount of funds. Short-term developmental aid for specific initiatives is less subject to challenge.
8. Appropriated levels of assistance will almost always be lower than authorized levels of appropriations. (Appropriations are provided through a Congressional process completely independent of the process used in the development of authorized appropriations.)

Policy choices

Following are a set of policy choices for selecting sources of funding for the basic operating programs associated with undergraduate medical education.

Federal support

Funding source

Advantages

Disadvantages

Capitation

If it complies with the original concept of federal support for basic on-going operating budgets, it provides stable support on the basis of the number of students.

It has been distorted to direct changes in educational programs. It is unlikely to be provided without conditions. It fails to

Federal support

Funding source

Advantages

Disadvantages

Capitation
(con't.)

differentiate among varying degrees of financial need.

Tuition subsidy
to students

If it is sufficiently high, it would allow schools to adjust tuition income to meet basic operating needs.

State schools are not able to adjust tuition without approval by multiple higher authorities. Tuition income does not go directly to many state schools. Tuition subsidy may be used to coerce students to fulfill federally perceived needs. Schools may have to fulfill imposed requirements in order for their students to receive federal financial aid. Tuition subsidy authorization or appropriation, or both, are likely to be inadequate.

Last-dollar

It will prevent failure of schools. It will distribute scarce resources to schools with the greatest need.

Determination of eligibility and of the amount provided will require federal inspection and audit of a school's programs and operations. Eligibility requirements can be used to coerce schools toward federal concepts of form and organization of medical schools.

No federal aid

This would free schools of the constraints associated with federal dollars.

This would force increased reliance on non-federal sources, and thus make a school more vulnerable to coercion from those sources. This is likely to be viewed as an abdication by the schools of their social responsibility, with almost certain adverse results. There is a danger of inadequate support from non-federal sources.

Non-federal support

Funding source

Advantages

Disadvantages

Increased state support:

state schools

The state has a traditional obligation to maintain the basic program of the school. Negotiations for support provide more opportunities for taking advantage of the local and state interests. Many states currently have revenue surpluses.

The appropriation process in some states would make transition from federal to state sources difficult. State school budgets must be cleared through the university in many cases, and opportunities for advancing the school's interests may be curtailed. State concerns for manpower are similar to federal concerns, and thus direction by the state legislature is a real possibility.

private schools

Provides a portion of basic support, thus augmenting endowment and tuition income.

The appropriation process in some states would make transition from federal to state sources difficult. State-imposed requirements may restrict a school's options: taking increased numbers of state residents, for example. State support may be last-dollar in nature, with all the attendant coercion, and eligibility and reporting requirements.

Tuition increase:

state schools

Increased payment by students may improve negotiations with university and legislative budget committees for a greater basic operating budget.

Many states are unwilling to increase tuition for residents significantly, or the decision-making authority for tuition rates is well removed from the medical school, or both. Tuition income may not be directly available to the schools.

private schools

Tuition adjustment ability is flexible, and tuition can be adjusted to meet needs.

For both state and private schools, increasing tuition to meet basic operating expenses will mean that fewer of lower-income students can attend medical school since it would be difficult to develop the required student financial aid programs.

Non-federal support

Funding source

Advantages

Disadvantages

Medical service
income:

state schools

Increased patient demand for and entitlement to medical services provides a growing source of income. Permits the development of stronger clinical programs.

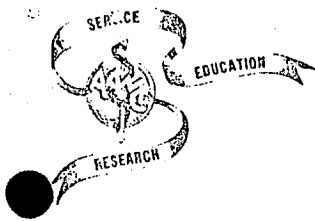
There is a real potential that an overcommitment to medical service will dominate the other missions of the medical schools. Future constraints and regulations on reimbursement are likely and unpredictable in nature. This income may be viewed by legislatures as an offset, rather than a supplement, to other state support.

private schools

Increased patient demand for and entitlement to medical services provides a growing source of income. Permits the development of stronger clinical programs.

There is a real potential that an overcommitment to medical service will dominate the other missions of the medical schools. Future constraints and regulations on reimbursement are likely and unpredictable in nature.

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

October 21, 1974

MEMORANDUM

TO: Selected AAMC Staff
FROM: Diane Mathews
SUBJECT: OSR Resolutions

The following resolutions, approved by the OSR Administrative Board at their September 14 meeting, were referred to various AAMC councils, groups, divisions, and committees for appropriate action. Many of these resolutions are referred for inclusion on specific agenda; others are referred simply for information purposes. Please contact me should any of the resolutions require further clarification or explanatory background information.

Referred to CAS Administrative Board:

1. "No person outside the Dean's office may review the student's records without that student's permission."
- *2. "Athletic facilities should be made available by each medical school for male and female student use, open at times convenient for student use, adequate to accommodate the numbers of students desiring them, and should be included within future planning, adjacent to or within proposed structures."
- *3. "Childcare facilities and/or services should be incorporated into future planned medical school constructions and where possible should be available in existing institutions."
4. "The AAMC should consider developing a program for providing information about the characteristics of individual programs in graduate medical education and the criteria for selection of participants in these programs."
5. "The AAMC should consider with other concerned groups the feasibility of a uniform application form for programs in graduate medical education."

*Referred for inclusion on the CAS Administrative Board Agenda as an information item.

Referred to the COD Administrative Board:

- 1. "No person outside the Dean's office may review the student's records without that student's permission."
- *2. "Athletic facilities should be made available by each medical school for male and female student use, open at times convenient for student use, adequate to accommodate the numbers of students desiring them, and should be included within future planning, adjacent to or within proposed structures."
- *3. "Childcare facilities and/or services should be incorporated into future planned medical school constructions and where possible should be available in existing institutions."

*Referred for inclusion on the COD Administrative Board Agenda as an information item.

Referred to the COTH Administrative Board:

- *1. "Athletic facilities should be made available by each medical school for male and female student use, open at times convenient for student use, adequate to accommodate the numbers of students desiring them, and should be included within future planning, adjacent to or within proposed structures."
- *2. "Childcare facilities and/or services should be incorporated into future planned medical school constructions and where possible should be available in existing institutions."

*Referred for inclusion on the COTH Administrative Board Agenda as an information item.

Referred to the AAMC Division of Accreditation:

- 1. "Since only an hour is usually devoted to meeting with students in on-site visits by members of the LCME Accreditation Team, the OSR requests that (1) at least one month advance notice be given to Student Council or student body representatives through the Dean's office prior to Accreditation Team visits to allow for development of student input to the Accreditation Team; (2) students be permitted to submit materials prior to on-site visits for preliminary consideration by the Accreditation Team; (3) student(s) be included on Accreditation Teams."

Referred to the AAMC Division of Student Programs:

1. "At the present time, the Public Health Service does not permit participation in its programs as recipients of Public Health Professional Scholarships by individuals who seek classification I-O from the Selective Service System, whereas persons classified as I-A-O are eligible for participation. The OSR requests the AAMC to use its influence in order to have the Public Health Service correct this policy."

Referred to the Executive Council:

1. "Objectives and expectations of the faculty for student performance should be clearly stated at the onset of a course or clerkship with ongoing feedback throughout the course or clerkship."
2. "The AAMC should consider developing a program for providing information about the characteristics of individual programs in graduate medical education and the criteria for selection of participants in these programs."
3. "The AAMC should consider with other concerned groups the feasibility of a uniform application form for programs in graduate medical education."

Referred to the Group on Medical Education:

1. "No person outside the Dean's office may review the student's records without that student's permission."
- *2. "Athletic facilities should be made available by each medical school for male and female student use, open at times convenient for student use, adequate to accommodate the numbers of students desiring them, and should be included within future planning, adjacent to or within proposed structures."
- *3. "Childcare facilities and/or services should be incorporated into future planned medical school constructions and where possible should be available in existing institutions."

*Referred to the Group on Medical Education as an information item.

Referred to the Group on Student Affairs:

1. "Objectives and expectations of the faculty for student performance should be clearly stated at the onset of a course or clerkship with ongoing feedback throughout the course or clerkship."

2. "No person outside the Dean's office may review the student's records without that student's permission."
- *3. "Athletic facilities should be made available by each medical school for male and female student use, open at times convenient for student use, adequate to accommodate the numbers of students desiring them, and should be included within future planning, adjacent to or within proposed structures."
- *4. "Childcare facilities and/or services should be incorporated into future planned medical school constructions and where possible should be available in existing institutions."

*Referred to the Group on Student Affairs as an information item.

Referred to the Health Services Advisory Committee:

1. "Since it is the concern of medical students that health care in prisons is often inadequate, it is recommended that information be gathered regarding the quality of care in prisons and the possible role of medical schools and teaching centers in providing care."

*Referred to the Health Services Advisory Committee as a request for information on the status of the work of that committee.

cc: Drs. Erdmann, Hudson, Knap[✓], Schofield, and Swanson; Messrs, Boerner, Clarke-Pearson, Keyes, and Waldman

AAMC
COUNCIL OF TEACHING HOSPITALS

ANNUAL INSTITUTIONAL MEMBERSHIP MEETING

1:30 PM

Tuesday, November 12, 1974
Conrad Hilton Hotel
Chicago, Illinois

I. Call to Order - Introductions - Robert A. Derzon, Chairman	1
II. Issues in the Health Manpower Legislation, John A. D. Cooper, M.D., President AAMC	2
III. Report of COTH Staff -- James I. Hudson, M.D.	21
-- Richard M. Knapp, Ph.D.	29
-- Dennis D. Pointer, Ph.D.	34
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V. Report of the Nominating Committee and Election of Officers -- Irvin G. Wilmot, Chairman Nominating Committee	39
VI. Report of Chairman -- Robert A. Derzon	44
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IX. New Business	
X. Adjournment	55

COUNCIL OF TEACHING HOSPITALS

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

ANNUAL MEETING
NOVEMBER 12-15, 1974

Conrad Hilton Hotel
Chicago, Illinois

Tuesday, November 12, 1974
1:30 PM

Grand Ballroom
Conrad Hilton Hotel

COTH ANNUAL INSTITUTIONAL MEMBERSHIP MEETING

The Annual Institutional Membership Meeting of the Council of Teaching Hospitals of the Association of American Medical Colleges was convened on Tuesday, November 12, 1974, at the hour of 1:30 o'clock PM, Mr. ROBERT A. DERZON, Chairman, COTH, 1973-1974, presiding.

CHAIRMAN DERZON: I would like to call to order the Membership Meeting, the Annual 1974 Membership Meeting of the Council on Teaching Hospitals, and to start off this afternoon's program we have asked Dr. John Cooper, President of the American Association of Medical Colleges, to bring us wise words from Washington.

He had originally intended to limit his comments to the health manpower field and various

problems surrounding it, but in recent days he decided to expand his horizons and talk with us about that issue and a number of other current issues affecting the Association. John.

DR. COOPER: Thank you very much, Bob.

I thought I would sort of give you my interpretation of the view from Washington. As everybody knows, on August 9 Gerald R. Ford became the Thirty-Eighth President. What had been the Nixon Administration suddenly became the Ford Administration. I think it's important for us to look at what has happened, or what hasn't happened, as a result of that change. First, I would like to talk about what has happened.

There certainly seems to be considerable relaxation of White House control over the executive departments and agencies. The opening up of the administration really began before Ford became President, and had followed President Nixon's intense preoccupation with his own self defense and, I think, the departure of Erlichman and Haldeman from the central administration. It does appear that the President is open, seems open and relaxed, and the new freedom and independence that the various departments are enjoying may, in fact, continue as something of a more conscious presidential

policy. One implication of that is that the federal policy makers will be much more accessible to private sector organizations and more interested in listening to their ideas.

On the other hand, I think recently there has been some suggestion that maybe some of the openness is beginning to disappear and that the loneliness of the presidency is beginning to fall around Mr. Ford's activities.

I think that there is a very pervasive presidential concern with the national economy, and this is going to result in renewed efforts to hold down federal spending, even though competent economists hold that it will have very little effect on inflation. In trying to lower the inflationary pressure of federal spending, President Ford has announced his intention to hold down total spending below \$300 billion for '75, and he has urged Congress to exercise restraint in its actions, and has specifically cited the fiscal 1975 Labor-HEW Appropriations Bill for exceeding budget requests. He has called the bill irresponsible and inflationary in its nature. As a result, Congress has been listening and may even outdo the President in reducing the federal budget. The Appropriations Bill has been

... tied up in conference since mid-September as members, both in the House and Senate, have worked at trying to produce a presidentially acceptable bill. Congress has listened so much so carefully to President Ford that, for I think the first time in recent history, the Senate Appropriations Committee actually reversed its normal course and reduced the House-passed Labor-HEW appropriations. This came very late in consideration of the bill, when it was brought before the full Committee and the concerns about spending became widespread in the Congress. So we do have a considerable problem already in the Labor-HEW appropriations. Not only will the appropriations probably be down, but there is already planning in the Department for restrictions on spending on even what is now available through a continued resolution and to cut back on the outlays of funds means that there are going to be very serious effects on the health budget in HEW, and particularly in the areas of the National Institutes of Health, capitation, and other programs of direct interest to our institutions.

The reason for this is that this forms the largest part of the controlled budget in the Department, and although health spending may go up now or in

the future, it will largely be in the uncontrollable aspects of Medicare and Medicaid. So we may actually return to some of the tough times that the institutions had in the 1968-69 period, with very severe cutbacks which will now be instituted when we are already six months into the budget, fiscal '75 budget, which means that cuts are going to have to be twice as deep during the last half of the budget period as they would have been if they had been spread throughout the fiscal year.

In a closely related area, there is a new law on the books which sets up a revised Congressional budget review process and which strengthens Congressional efforts to restrict presidential impoundment of appropriated funds. The clear intent of the budget review provisions is to enable Congress to take a comprehensive look at budget requests and appropriations actions, and it will occur through the newly established House and Senate budget committees, rather than to continue what has been Congress' tradition of piecemeal consideration of funding through the various appropriations subcommittees, which have operated with virtual autonomy. There has been no overlook in the past, but now, if the new process works as it is supposed to, it gives an opportunity for

the Congressmen to look at all of their spending before they really release money in the appropriation process. And this means that the health budget, for example, will get much tougher scrutiny, and from Congressmen and Senators who are on the budget committees and may have no special interest in health. This is going to mean that we are going to have a much harder time, probably, in getting adequate appropriations in the health area.

The anti-impoundment measures that the bill provides for do give some hope that at least if the money is appropriated by the Congress we will not have to go to the courts in order to get it released if the executive branch tries to hold it back, because the President must get approval, or at least must not be disapproved by the Congress in holding back any funds.

Thinking a little bit on what has happened, as you all know I am sure there has been a great deal of presidential interest in national health insurance. In his initial speech to Congress, President Ford cited national health insurance as a major domestic priority and asked early enactment of the administration's current proposal. There was a momentary degree of re-

awakening of Congressional interest, but no agreement was reached immediately, and Congress I think resumed its previous drowsy attitude with regard to health insurance. Most importantly, I think, Congress found that there was no real administration follow-up to implement the President's words. There were some discussions between the Secretary and members of the Ways and Means and Senate Finance Committees, but really there was no big program put into effect which would really push national health insurance. So nothing followed up President Ford's words that he gave in his speech before the Congress.

However, it does appear that we will have a return of interest in national health insurance, -- I will talk about that a little later -- in the new Congress.

There is also a growing disenchantment with the emerging shape of current health manpower legislation. What used to be a fairly evenly balanced package for support of medical schools consisting of construction assistance, capitation support, student assistance and special project grants, is slowly turning into a two-part program of national service related

student aid and specifically targeted project support distributed to schools on a per capita basis. In other words, the original concept of capitation which would provide for the support of ongoing medical school programs has now largely been forgotten, and as Mr. Roger says the schools are actually required now in many cases to undertake programs which are more expensive than the money that one would receive for capitation that you have to engage in in order to get the money.

It reminds me of the story some of you may have heard about the fellows who decided they would make some money, so they decided to go out and buy vegetables from the farmers and bring them in town and sell them to the housewives. So they bought a truck, went out and bought potatoes at ten cents a pound, brought them into the city and sold them at ten cents a pound. At the end of the year they came up short and were trying to figure out what went wrong. One of the fellows said, "I think I know what happened." He said, "We didn't get a large enough truck." (Laughter)

And in essence what is happening here, I think they are claiming that we haven't got a large enough truck.

The confusion this year in the development of health manpower legislation has been the greatest that

I have ever seen in my short period in Washington. The bills are not professionally written. They change hour by hour. There seems to be no real over-all substantial guidance in developing a rational legislative package. And we are in trouble, because the current bill which supports medical schools ran out last June 30. Fortunately, through advanced funding that that bill provided, we do have funds for this year's academic year. But unless something happens between now and June 30 we will not have the money next year, and given the seven months' lead time between the enactment of legislation and the development of the regulations and all of the bureaucracy that has to take place before money can actually be sent out to the schools, it seems very unlikely, unless we can get a simple one year extension of the current bill, that money will flow to medical schools before the end of the fiscal year.

There have been some important personnel changes in the presidential office of management and budget which I think are of interest to this group. Deputy Director Fred Malek, who was sort of a hatchet man in the administration and the Number Two person at OMB, has been replaced by Paul O'Neill, who was formerly in charge of health human resources programs, including

DHEW's health manpower and biomedical research programs. The change is important because it removes Malek, a political appointee who had gained an unshakable reputation for toughness and aggressiveness. As I said, Paul O'Neill has been a very capable apolitical designer of complex departmental programs, and the implications of this change are, I think, that OMB will become an even tougher watchdog over federal programs and their budgets, because I think they will require much more rational support for department positions than we have had in the past. Although the full implications of the O'Neill for Malek, Malek to O'Neill shift must await President Ford's decision on the tenure of Roy Ash, a Nixon administration holdover as OMB Director, I think we will find considerable tightening up of OMB control over many of the programs that we have that we are interested in.

Now, these are then the things that have happened: relaxed White House control, concern with inflation, indications of presidential interest in national health insurance, trouble with health manpower legislation, a familiar face moving to an important new position at OMB. A lot of things have happened, to be sure, and these are at least some of the important ones.

Now to turn briefly to what has not happened.

There has not been any important substantive change in health policy thus far under President Ford. Nixon policies on health manpower, health planning and categorical health programs, although largely ignored in the legislative process, have not been redrafted by the new administration. Similarly, nothing has happened to the trends previously under way in federal health policies. Emphasis continues, for example, on converting the federal role away from provider of long term operating support to provider of short-term, time limited developmental assistance. Emphasis also continues on increasing the role of state governments, hopefully so that they can take over these programs after the federal funding, which is short term, expires. There has also been a continuation of the decentralization program of the administration. There has been more consolidation of health programs under the Assistant Secretary for Health. There has also been an increasing interest, I think, largely through the influence of the office of planning and evaluation in the Department, on cost benefit analysis of everything in the areas of interest to us.

There have been no cabinet level personnel changes yet affecting health programs. There are rumors all around Washington that President Ford will keep most

present cabinet officers in their posts through the lame duck session of the present Congress, but will expect many to have found new jobs by January. He may be disappointed if he finds that they have returned after the end of the present session of Congress. Jim Cavanaugh in the White House remains as the principal designated presidential advisor on health.

The role of the Domestic Council, which has never been as clear cut and strong as its counterpart in foreign affairs, the National Security Council, still remains inscrutable and obscure. The new President really has not done much to reorganize the staff operation of the White House or of the top levels of the executive departments. Instead, his overriding priority seems to be getting himself known to the American people, and at that he works tirelessly.

There appears to be no change in the adversarial and sometimes siegeliike relationship between the White House and the Congress. As nondevelopments go, this one is stunning, because President Ford is a Congressional creature, far more so, for instance, than Lyndon Johnson ever was, and that in theory would make for better relations between the executive and Congressional branches. This adversary situation, while inherently present, grew

noticeably in the later years of the Johnson presidency and spread weedlike during the Nixon years. In a constitutional system that is based on trust and cooperation among the various branches of government, this development of acute adversarial positions has produced we think some serious results. Congress continually enacts new limits on executive powers, and the executive devises new methods of bypassing the Congressional intent, and the operation of the government is more and more turned over to the courts as interpreters of the law. As the Judge said when he ruled on our suit, which we were successful with, he said he didn't like the ruling he had to make because he said that the American government was becoming more and more an oligarchy of the judicial branch, in which more and more actions were occurring in courts instead of some sort of a relationship between the executive and legislative branches.

So I think what has not happened is important, too. No major policy changes, no cabinet level personnel changes, and strangely, considering the new openness in the executive branch, no letting up in the struggle between the White House and the Congress. This may even become greater during the next Congress, since the Democrats have a very large majority in both

Houses, the monkey is now on their back with regard to inflation, unemployment, and so on. There is going to be a lot of jockeying to try and transfer that monkey back and forth between the executive and legislative branches, because who has the monkey on its back in '76, it will be very important who ends up with the monkey on his back in '76 with regard to the outcome of those elections.

Where is all this likely to take us? The President's economic troubles are almost certainly going to increase. There is a clearly deteriorating economy in the United States. Output is going down. Unemployment is going up. The rate of inflation is into double digits for the first time in this country's history and promises to continue at this level for at least several years. Some claim that no country can continue with a constitutional government with this kind of inflation.

In other countries the picture is even worse. Italy is bankrupt. If it had been a company, it would have been in receivership some time ago. England is not far behind. There are other countries that are moving in the same direction. And these, of course, all interact and affect what is happening in this country. And looming over the economies of all nations is the newly discovered and runaway economic jingoism of the

Middle Eastern oil producing countries, and what they have done has been picked up and adopted by other countries to control scarce natural resources. This means that we are probably going to have more pressures on us, with price increases in other areas. This is going to leave the President very little time for anything but economic affairs, and make him even more interested in making stronger efforts at holding down federal spending and in careful hording of normal revenue increases to underwrite what will probably be necessary public employment programs as the unemployment increases. So it is going to be probably very hard for us to get the President's attention for health affairs, and it is going to be a real challenge to get money in any substantial amount for health programs.

Some presidential decisions on health policy will have to be made. They will turn up in the State of the Union Message, the budget when it is released in January, and perhaps in a special health message. The issues which will be brought to the President for decisions are national health insurance and the funding of health programs.

There is a possibility -- and there is already an indication -- that the President is taking a

direct interest in the health manpower legislation because of the situation in which it finds itself in the Congress.

National health insurance will probably be the toughest policy problem. The reason is that it generates so many conflicting arguments, even within the executive branch. An example: HEW says we need it now. Its whole health strategy is based on the assumption that national health insurance will be a reality before the end of this decade. Various economists say we can't afford it, it will push national health spending out of sight, aggravate inflationary pressures and outstrip the profession's ability to provide services. Other economists, such as Federal Reserve Board Chairman Arthur Burns, agree with HEW that we need it, but go on to assert that just now is not the right time to switch over to it. There are conflicting political arguments as well, on all sides. The pro-insurance thinking in President Ford's coterie thinks that if he is going to run in 1976 he will need a major presidential accomplishment to run on, and he certainly has more opportunities -- and less competition with his predecessor -- in the domestic rather than the international sphere to make a name for himself, and thus should make a major personal

commitment to enactment of national health insurance. If this is the case, then we certainly would end up with something.

The anti-insurance thinking says the economy is really going to take a dive; that unemployment is going to soar; that vastly expanded public employment programs will become essential; and that normal revenue increases should be conserved for those programs, rather than earmarked for even a relatively low cost catastrophic national health insurance plan.

Federal health funding, by comparison, is a somewhat easier policy problem. It probably will be cut back. If it goes up, it will be only because elements of it which are relatively uncontrollable pushed the total upward. No one is against federal spending on health. It just happens that in the over-all federal budget, health spending -- excluding Medicare and Medicaid -- is one of the very few areas that is relatively controllable. Much of the rest of the budget is tied to contractual agreements, such as veterans' pensions, or to personnel costs, such as military pay and allowances. Unfortunately, from our perspective, nearly all the controllable health spending is in programs that affect our constituents: biomedical research, health manpower, and so forth.

From this prospect, we are going to have a very tough time.

Health manpower policy is less clear.

It may not be resolved in the present Congress. It probably will be taken up in -- very early in the next Congress. And, as I said, the President is apparently going to take an active interest in getting something through as soon as the Congressmen agree on some sort of consensus.

There are some new policies that are going to come up, and these are all going to revolve around some of the changes that are occurring in what I have already characterized as non-changes.

One, interesting views of the future can be gotten from looking at the Department of Health, Education and Welfare's five year plan, the Forward Plan for Health. This is a very interesting document. It has no official standing. It is not departmental policy, and it surely is not a blueprint for anything. It does come from the Assistant Secretary for Health, and it is interesting because it does represent some of the current thinking of at least the health part of HEW.

The Forward Plan is organized around five themes: (1) Prevention, the feeling that not enough money has been put in prevention of disease, that we

ought to shift in that direction, rather than curing of disease, which is of some interest to this group.

(2) They also think that we ought to prepare more for national health insurance, including more capabilities for primary care, for health planning and for regulation, such as cost restraints. They are very strong about methods that they think should be invoked to stop the spiraling costs of health care.

(3) They are concerned about quality assurance in the five year Forward Plan.

(4) The fourth area of interest is tracking health status and the health industry. In other words, having programs that can keep better monitoring of what is going on in the industry.

(5) And finally, knowledge development, which is related to the interests of the Department in biomedical and other kinds of research.

Each one of the Association's key interests is discussed in the Forward Plan. One of the interesting ones is a Commission on Biomedical Research, which is a basic part of the plan, which really calls for a widespread, very detailed re-examination of the role of federal government in biomedical research, and how National Institutes of Health are carrying on their role

and function.

Where we may be going then is into a period of worsening economic conditions, some real presidential decision making on major health policies, such as national health insurance, federal health spending, and perhaps health manpower, some cabinet and White House staff changes, and some newly coordinated thinking within the DHEW on how it is going to solve some of the health problems and how its health programs should operate. I think we are in for a period of great uncertainty and instability, and this is going to present increasing challenges for outside groups. What answers there are we won't know until January when we have a new State of the Union message and a new budget, and obviously not all of the problems are going to have answers.

By nature I am an optimist, and I don't like to play the role of gloomy Gus, so I still think that some place in all that gloom there is a gleam.

(Applause)

CHAIRMAN DERZON: John, I don't know whether I ought to thank you or not, but I think we appreciate your insight for what is happening in Washington and are very grateful to you for sharing your thoughts with us this afternoon.

I have asked three members of the staff to give us brief reports on progress and accomplishments of the AAMC staff this year, and, in order, Dr. Jim Hudson, the Director of the Department of Health Services, Dick Knapp and Dennis Pointer, Director and Assistant Director, respectively, of the Department of Teaching Hospitals, will give us brief statements.

Jim.

DR. HUDSON: Thank you, Bob.

All of you who are COTH members understand the high priority given to issues relating to education of health professionals for primary care by the Association during this past year. The key issues were highlighted during the Institute on Primary Care held here in Chicago last month. Some 450 attendees included Deans, Chairmen of Departments of Medicine, Pediatrics, Family Medicine, Ob-Gyn, Psychiatry and selected federal and foundation officers. As a planned follow-up to the Institute, workshops have been scheduled in Boston, Baltimore, Miami, Chicago, Albuquerque and San Francisco from January through April next year. These sessions, scheduled as two-day programs and involving approximately 120 participants each, constituting an average of six individuals from each academic medical center, will

address for the most part the same topics as those centered upon during the course of the Institute. Of all the issues so far discussed, the roles and functions of Departments of Pediatrics, Medicine and Departments of Family Medicine in physician education for primary care appears to be scheduled for the most vigorous discussion on a region by region basis. The question seems forced from a variety of directions. If, for instance, pressures continue to mount for a national ceiling of postgraduate medical education positions, and if we can view as possible, if not quite likely, a mandate to allocate fifty per cent of these positions to primary care related specialties, then the distribution of these positions within the primary care designation will become a matter of heated adversary debate.

Already questions are being asked as to the degree of control being exercised by our individual constituent members with respect to residency position distribution, the implication being that the degree of self regulation that is already evident with consideration of local and national needs may have some salutary effect on eventual legislative intervention in this area. As a staff activity we are therefore planning a survey of our membership with respect to the current status of voluntary

corporate management regulation of residency training programs, and hope to have this completed during the current year. On a similar vein, we have reason to believe that it is important that we gain more complete information on initiatives being taken by our institutional members in addressing the physician geographic maldistribution problem, and will undertake surveys of the medical schools and community hospital affiliations with this in mind this year.-- ~~affiliations~~ with community hospitals and community practice arrangements to introduce training programs in health care networks geographically removed from the mother campus. To accurately document these activities we believe would result in some strengthening of the argument for voluntary initiative in attempts to answer what is generally accepted as a national problem. Therefore, the Department of Health Services and Teaching Hospitals in concert with the staffs of the Departments of Academic Affairs and Institutional Development will shortly name a small advisory committee from the constituency to develop a comprehensive survey of these institutions having such programs. We expect the results to be of value for reports to outside agencies as well as for disseminating information within our constituency. An analysis of the objectives of these

programs, plus the development of evaluation instruments to measure their effectiveness in meeting these objectives will constitute the major portion of this survey.

The desire to explore and evaluate new models of health care delivery, along with the actual need to find additional spaces for student experience in ambulatory settings, have been but two of the strong motivating forces behind the academic medical center's interest in HMO's during the past three to four years. We have just recently concluded a program of technical assistance and consultation to five prototype academic medical center affiliated HMO's in various levels of organizational development. Throughout this effort our Department was assisted by advice and counsel from the Health Services Advisory Committee, chaired initially by Bob Heyssel and later by Chris Fordham. A formal report of this program is now printed and available to any of you who may wish a copy. Additionally, a list of individuals who worked with us as primary consultants to each of the HMO programs is likewise available. Each has indicated a willingness to serve as consultant to any future programs desiring advice on HMO affiliation and HMO development.

Of all those medical schools which have

so far developed affiliations with operational HMO's, few have yet been able to implement significant educational programs for physician training, especially at the undergraduate level. This seems ironic considering the main function of the medical school. It is, however, not a surprising fact considering the many organizational difficulties and economic hazards inherent in introducing students into a newly developing program whose lifeline on the open market is directly linked with operational efficiency. This is, by the way, in sharp contrast to some more traditional university based outpatient departments. The problem becomes more critical from the point of view of those who would promote the prepaid group health model, that is, the HMO model, as a major alternative to the traditional fee for service system, and by those who would consider that one of the limiting factors in the eventual nationwide growth of HMO's is the number of physicians whose education has exposed them to some experience within the HMO setting, this exposure being sufficient to allow them to consider HMO practice as a possible future career choice. Thus, if the growth of HMO's is dependent upon the degree of educational and training experience for physicians in HMO's, and if these same organizations present a uniquely difficult

situation in which to introduce students, one ends up with a dilemma of Catch 22 dimensions. The situation, as ironic and difficult as it may be, can nevertheless be overcome, we believe, by careful operational analysis and application of new educational methodologies and a clear delineation of educational objectives. This is a basis of a program in which we are now involved with six selected institutions. This program will aim to produce curriculum for physician training within the HMO setting maximizing educational experiences while at the same time minimizing service disruption. The six institutions participating are: Harvard, with the Harvard Community Health Plan, Cambridge Hospital, Boston; Brown University School of Medicine with Rhode Island Group Health Association; University of Pennsylvania, the Graduate Hospital, with the Penn Urban Health Service Center, a component of South Philadelphia Health Action; Georgetown University with Georgetown University Community Health Plan; the University of Rochester with the Genesee Valley Group Health Association; and the University of Washington with the Group Health Cooperative of Puget Sound. This entire effort should be completed by December 1975. Here we are aided by an advisory group chaired by Sam Bosch of Mt. Sinai School of Medicine in

New York.

I will not take further time to report in detail additional departmental programs, except just to mention quickly one further activity related to the issue of PSRO's and quality assurance. During this past year we conducted a detailed survey of medical schools and teaching hospitals with respect to PSRO involvement and with regard to formal educational programs which would relate medical students directly to quality of care assessment and methodologies. The analysis revealed that forty-five per cent of medical schools and twenty-eight per cent of teaching hospitals had, at the time of the survey in March 1974, involvement with locally designated PSRO's. Eleven per cent of medical schools indicated a concentrated program for medical students in quality assurance methodology. However, on a closer scrutiny of these programs, only a handful were found to have a bona fide formal educational program of real substance. During this coming year we hope to plan a demonstration project involving one or more of these formal programs as prototypes in undergraduate education and thereby provide for them some opportunities for expansion and improvement of their more salient features and to provide a means to

transmit information relevant to these programs to other interested institutions. The Health Services Subcommittee on Quality of Care chaired by Bob Weiss has provided us with a mixture of encouragement and advice on these matters. Lily Engstrom from our Department, who is here today, will work primarily in this area. In addition, she keeps regular contact with the National PSRO Council and will be responsible for most of our staff activities within the quality of care area this year. I would like to report also that during the past year we added two additional staff members: Mr. Marcel Infeld, formerly management specialist and program analyst in the Office of Health Affairs, OEO, who came to us as a former consultant for Messer Associates and who serves as our project coordinator for the physician training program in HMO's, and Mr. Joe Giacalone, formerly research assistant in the National Academy of Sciences, who came to us from the Department of Planning and Evaluation of Project HOPE.

As always, it has been a real pleasure to work closely with Dick Knapp and his staff. During this past year I have particularly enjoyed my association with Bob Derzon and with the entire COTH Administrative Board. Finally, it's my pleasure again to bring to you,

the institutional membership, my department report for this year. Thank you for your attention.

(Applause)

DR. KNAPP: In order to follow the Chairman's request that I be brief, I have prepared a summary of the Department's activities during the past year which is available at the entrance to this meeting. As you review this summary -- and I hope you will -- please keep in mind that I am always interested in any reaction that you may have to what we are doing or what we ought to be doing.

During the past two years, I have been fortunate in bringing together a highly talented staff. What success we have achieved is in no small measure due to their energy and skills. The staff is stable in terms of size and is comprised of an excellent group of individuals possessing a wide range of skills, experiences and perspectives.

Bob Carow joined us as an economist fourteen months ago. He has acted as interim editor of the COTH Report and has been instrumental in designing and executing analysis and research activities which Dennis will describe to you in a moment. Presently, Bob is preparing a paper which discusses the impact of educational programs, case

mix and the nature and scope of hospital costs.

Armand Checker, who has served in a variety of positions on the AAMC staff over the last five years, is responsible for all our survey and data collection efforts. These include the house staff and executive salary surveys, compiling information on state support of graduate medical education, and other issues. Both Bob and Armand are back in Washington minding the store.

Steve Summer who had been with the Maryland Hospital Association joined the staff in July of this year, and I think you probably have already seen the result of his efforts in the change of both substance and format of the COTH Report, our monthly publication. He also has been staffing John Westerman's Committee on JCAH model medical staff bylaws and is beginning to take on more responsibilities in the areas of legislative liaison, quality assurance activities, hospital-medical school affiliation arrangements.

Steve, would you stand for a minute, so we can see who you are?

I think you all know Dennis Pointer and have become familiar with his excellent performance. You will hear from him in a moment.

Due to the Department's relative

staff stability, I think we have managed to cultivate the necessary working relationships with governmental agencies and legislative committees to be sure we are fully informed, and to be sure that the viewpoint of the teaching hospital community is adequately represented. I have in mind such agencies as the Bureau of Health Insurance and Office of Research and Statistics of the Social Security Administration, the Veterans Administration, the Office of the Assistant Secretary for Health as well as Planning, the Health Resources Administration, the Bureau of Quality Assurance, the Ways and Means and Finance Committees in Congress, and I could go on with a list which would sound like alphabet soup. We have also been active, and have good working relationships, with the American Hospital Association, American Medical Association, and organizations such as the Institute of Medicine.

Based on telephone calls, letters and conversation with the membership, it would appear to me there are substantive areas where we need to further strengthen our activities to be more responsive to the membership. I will mention just a few:

Organization, financing and other issues in ambulatory care or outpatient departments;

Salary information for hospital based or full time physicians;

VA hospital relationships with schools of medicine;

More precise information and possibly a small exploratory conference on teaching hospital-medical school affiliation arrangements;

And the matter of medical center governance which Bob Cunningham will address later this afternoon.

We will be reviewing these issues and based upon guidance from the COTH Administrative Board will move forward with some of them. On the other hand, I sometimes find it difficult to know where we will be spending our major efforts next year. Reviewing what I might say today caused me to think back to where we were a year ago. At that time, proposed Phase IV regulations were released, we were in the middle of the debate over Section 227, and we knew routine hospital cost ceilings were being developed for the Medicare program. All this was unpleasant but I had the feeling that at least we knew rather specifically what we were dealing with. At this point, I think the situation is quite different. The nature and substance of the planning legislation is indefinite at best. The outlook for the manpower legisla-

tion is uncertain. Construction and modernization financing sources are unstable. Some feel wage and price controls are necessary right now in the health industry, although I haven't heard a great deal of discussion of the form such controls should take. Others believe these controls should only appear within the framework of a national health insurance program. The debate over national health insurance during the past year has been largely indeterminate; we will have to wait and see what the recent election has brought forth. In any case, it is reasonably clear that governmental efforts to regulate and/or control various aspects of the health services industry will continue. However, I believe that our efforts as described in our summary of activities will help us better explain the complexities of the teaching hospital environment as the forthcoming issues are better defined.

I wish to say again that we perceive our mission as one of doing our best to serve you, and I hope you will give us your thoughts on what we are doing or what we ought to be doing.

In closing, it's been a pleasure again to work with Jim Hudson as well as the Chairman, Bob Derzon, and the other members of the administrative board, and I would like to thank all of you for your help and support

during the past year.

Well, now I would like to call on Dennis Pointer for a few remarks.

(Applause)

DR. POINTER: Thanks, Dick.

Last year, during his preliminary address, then Chairman of the COTH Administrative Board, Dr. Leonard Cronkhite, observed that with regard to the application of regulatory and control mechanisms, the health industry is beginning to display the characteristics of a public utility. Dr. Cronkhite suggested that the industry could serve itself well to model its response to this development after other sectors of the economy that have come under increasing federal control -- aviation, banking, insurance are several examples. Len felt that hospitals must begin to assume the role of a friendly adversary to government. He stressed that critical to the effective assumption of this role is a development, by associations, of an in depth analytical capability that would serve to underpin both lobbying and legal activities.

The developments of the last several years, as exemplified by Dr. Cooper's remarks and by Jim Hudson's and Dick Knapp's, I think have proven Dr.

Cronkhite's description and prescription fundamentally correct. I would like to take a few moments today to describe to you analytical-research activities that have been undertaken within the Department. Such activities, for the purpose of discussion, can be grouped as follows: (1) targeted regulatory analysis; (2) basic research; and (3) membership analytical support.

Targeted regulatory analyses are investigative efforts framed to serve as a response to legislative-regulatory initiatives on the part of the federal government. Examples of such activities undertaken with considerable success by the Department and efforts related to the proposed implementation of Sections 227 and 223 of the 1972 Social Security Amendments; payment of teaching physicians and cost limitation of hospitals. With regard to the former, Section 227, the staff of the Department conducted case studies in six academic health centers to assess the fiscal, organizational and programmatic impact of moving from customary charge to cost base reimbursement systems. As you know, this hundred-page study was instrumental in causing Congress to pull back the regulations and to commission the Institute of Medicine to study the problem and make recommendations prior to March, 1976. In response to Section 223

regulations, hospital grouping and per diem cost limitation, the Department secured Social Security Administration data and subjected it to a series of empirical analyses to assess the efficiency of proposed hospital classifications. The analyses demonstrated that the groupings were no better than if done randomly or arbitrarily. The final report of this research stimulated Secretary Weinberger to charge the Social Security Administration with redeveloping the regulations for implementation next year. The Department is represented on the technical advisory group assisting in this effort.

The Department's basic research program is focused upon describing and analyzing the unique characteristics of teaching-tertiary hospitals; such activities form the foundation for preparing targeted responses to public policy initiatives and assist the constituency in better explaining their mission and mode of operation to their various publics. The Department is completing an extensive annotated bibliography on hospital cost studies and will soon publish a monograph on that subject focused on analyzing the effect of teaching programs on hospital costs. Initial findings of this effort indicate that the cost differential between teaching and nonteaching hospitals are not so much due to the presence of teaching

programs, but rather result from differences in case mix complexion and the nature and scope of facilities and services offered. A grant proposal has recently been prepared seeking support to study the differential utilization of ancillary services in teaching and nonteaching hospitals. Results of several pilot studies in this area conducted by the Department suggest that when controlled for the nature and severity of diagnoses, teaching hospitals do not employ a significantly greater number of diagnostic and therapeutic procedures than nonteaching facilities. We are attempting to build a computer base data system on teaching hospitals that will serve as a general research resource and will assist us in preparing special studies requested by member hospitals.

The Department continues to expand and refine its membership support services. Periodic studies are conducted regarding house staff policy and stipends, executive salaries, and university owned hospital income and expenses. This year, standard report formats were supplemented with special studies examining trends in each of these areas. In addition to periodic studies, the Department has begun to engage in one time analytical efforts regarding problems of particular importance. For example, a study is now under way to describe and evaluate

the structure and functioning in teaching hospital computer service capability. Other special studies have been conducted on the taxability of house staff stipends, and the distribution of foreign medical graduates and minorities in teaching hospitals.

The Department has made a concerted attempt to engage in action research, research conducted not for the sake of research alone, but rather research designed to contribute directly to the mission of both the Department and the Association in better serving you our constituency. We solicit your continued participation in identifying, designing and evaluating research activities of the Department.

Thank you very much. (Applause)

CHAIRMAN DERZON: Thank you very much.

The next item of business at the Membership Meeting is approval of the COTH Administrative Board's actions and activities over the course of the year. These actions and activities of the Administrative Board have been reported to you periodically through the various news pieces that come from the staff of the Association and the various periodicals. So I would now entertain a motion from the floor to accept and approve the acts and actions of the Administrative Board.

A VOICE: So move.

CHAIRMAN DERZON: Is there a second?

A VOICE: Second.

CHAIRMAN DERZON: Any discussion?

If not, those in favor signify by saying aye; opposed.

So carried.

Now I would like to call on Mr. Irvin Wilmot to make a Report of the Nominating Committee for new officers for the incoming year. Irv.

MR. WILMOT: Thank you, Bob.

The Nominating Committee this year consists of the Chairman, the current Chairman of the COTH Administrative Board and one member-at-large. So your Committee was made up of myself, Irvin Wilmot, Robert A. Derzon and Herluf V. Olsen, President of the Medical Center Hospital of Vermont.

I have several groups of nominations, and I think I will run through the slate in its entirety, if you don't mind, and let the Chairman take it from there.

In accordance with the change last year in the AAMC Bylaws, COTH representation on the AAMC Assembly has been increased from 35 to 57. Therefore, we have

nineteen nominations for the AAMC Assembly for a three-year term expiring 1977:

Mr. Reuben Cohen, Veterans Administration, East Orange, New Jersey

Mr. Clyde G. Cox, Veterans Administration, Birmingham

Dr. Leonard Cronkhite, Children's Hospital Medical Center, Boston

Mr. Al Gavazzi, Veterans Administration, Washington, D.C.

Dr. Robert Heyssel, Johns Hopkins Hospital, Baltimore

Dr. Baldwin Lamson, University of California, Los Angeles

Mr. Sidney Lewine, Mount Sinai Hospital of Cleveland

Mr. Henry Manning, Cuyahoga County Hospital, Cleveland

Mr. Stuart Marylander, Cedars-Sinai Medical Center, Los Angeles

Brigadier General Paul Myers, Wilford Hall U.S. Air Force Medical Center

Mr. C. L. Nordstrom, Veterans Administration, Allen Park

Mr. C. J. Price, Dallas County Hospital District

Mr. Malcolm Randall, Veterans Administration, Gainesville

Mr. Vernon Schaeffer, Temple University Hospital

AAMC Assembly for three-year term:

Sister Evelyn M. Schneider, St. Vincent's Hospital and Medical Center of New York

Mr. Robert Sigmond, Albert Einstein Medical Center, Philadelphia

Mr. Donald Shropshire, Tucson Medical Center

Mr. Robert Toomey, Greenville Hospital System

The next group is also for the AAMC Assembly, for a two-year term expiring in 1976. There are nineteen slots in this class, with seven vacancies, and we will present the following for those seven:

Mr. Irwin Goldberg, Montefiore Hospital, Pittsburgh

Mr. James Harding, Wilmington Medical Center

Dr. Robert Mack, Hutzel Hospital, Detroit

Mr. Mikael Peterson, Kaiser Foundation Hospital of the Kaiser Permanente Medical Center

Mr. P. N. Schmoll, Veterans Administration, Albuquerque

Mr. Willis Underwood, Veterans Administration, West Haven

Mr. Irwin Wilmot, New York University Medical Center

Now the next group is for the AAMC Assembly also, for a one-year term expiring in 1975. Here again we have nineteen slots, with seven current vacancies:

Mr. Allan Anderson, Strong Memorial Hospital of the University of Rochester

Mr. Robert Derzon, University of California, San Francisco

Dr. William McLees, Medical University Hospital, Medical University of South Carolina

Mr. Joseph Paris, Veterans Administration, Buffalo

Mr. Felix Pilla, Monmouth Medical Center

Mr. Alton Pruitt, Veterans Administration West Side,
Chicago

Mr. David Reed, Lenox Hill Hospital, New York City

That completes the slate for the AAMC Assembly. We have nominations now for the Council of Teaching Hospitals Administrative Board for three-year terms expiring in 1977:

Mr. John Colloton, University of Iowa

Dr. Baldwin Lamson, University of California, Los Angeles

Mr. Malcom Randall, Veterans Administration Hospital, Gainesville, Florida

For a one-year term on the Council of Teaching Hospitals Administrative Board:

Mr. Robert Toomey, Greenville Hospital System.

The Bylaws of the AAMC were changed this year, and accordingly we have picked up one additional representative to the Executive Council of the AAMC. We were previously represented by three people, who were generally our President, President Elect and Immediate Past President; so that for the additional fourth representative to the Executive Council of the AAMC we would nominate:

Dr. David Thompson, New York Hospital, New York.

In addition to these appointments, we have the Immediate Past Chairman, which is automatic, Robert, you will be happy to know:

Mr. Robert Derzon

The Chairmanship, likewise, is automatic, since you acted on it last year:

Mr. Sidney Lewine

And for your Chairman Elect, we would recommend:

Mr. Charles Womer, Yale-New Haven Hospital

Mr. Chairman, I would move these nominations.

CHAIRMAN DERZON: Thank you very much.

Are there further nominations from the floor?

If not, I would accept a motion by acclamation that the nominees presented by Irv Wilmot be elected.

A VOICE: So move.

A VOICE: Second.

CHAIRMAN DERZON: I think congratulations are in order. Is Chuck Womer here?

(Mr. Womer rose.)

(Applause)

CHAIRMAN DERZON: I would like to remind you members who are here that have just been nominated and elected to the Assembly that the meeting of the Assembly

will be held on Thursday afternoon. You can now exercise your franchise, and we would suggest you be present at one-thirty P.M. in the Williford Room of this hotel, and to those of you who will be here, we would commend to you your attendance at the Assembly Meeting.

I would now like to cover with you just a few of the highlights of this past year in a Chairman's Report. In view of the staff reports which have already been presented, I will not discuss all of the activities of the Council during the past year, but rather will highlight those matters which I believe to have been of the greatest significance to this body over the course of this year.

You may recall that Leonard in his report to you last year characterized the year as one of aggressive confrontation, and cited the lawsuits brought by the Association in seeking release of impounded funds. Our aggressive posture has not changed, but I think the events of the past year might best be described in terms of a process of active involvement, intervention and mediation, in matters of pressing importance to our Association, and teaching hospitals in particular.

The most outstanding example of this process is the result of our efforts to deal with the

issue of physician reimbursement in the teaching setting, Section 227 of the 1972 Social Security Amendments. It was during this Annual Meeting last year that the AAMC officers met with Senator Constantine of the staff of the Senate Finance Committee and discussed the possibility that Section 227 be deferred for a period during which the issue would be re-examined more carefully. There was no mention of the Institute of Medicine at the time, but by the time this proposal made its way through both committees of Congress and became law, the IOM was charged with the responsibility for the study, the scope of which went considerably beyond prior discussion and included such matters as physician distribution by specialty and geography, foreign medical graduates and financing of house staff training programs.

Many of you had the opportunity last night to hear Ruth Hanft, who is directing this study at the Institute of Medicine. And Ruth is here with us this afternoon, the lady in red with red hair. Stand up, Ruth. And we are delighted you are here, and I would hope that all of you have an opportunity before she leaves to return to Washington to meet her and talk with her a little bit about the work of this study.

As a member of the steering committee

overseeing the study, I urge each of you to give your utmost cooperation to the Institute's data gathering efforts which are going to commence very shortly and the in-depth site visits that are going to take place in some six of our major teaching hospitals in the United States, because I believe it is in our best interest to be sure that the data and information necessary for the study are accurate, and that the study is carried out in a spirit of constructive cooperation by all of you who will be involved in it.

A second illustration of this mediation by a third party is the "Cost of Education in the Health Professions" also completed by the Institute of Medicine and published in January of this year.

In a different framework, a similar process is under way with regard to the routine service cost limitations set forth under Section 223 of the 1972 Medicare Amendments. The Office of Research and Statistics of the Social Security Administration is re-examining the methodology for determining these cost limitations. Dennis Pointer touched on that earlier. And the Council of Teaching Hospitals is represented on the Technical Advisory Committee constituted to assist in this effort.

I think the staff has been diligent in

making every effort to be sure we are represented, in one way or another, on all advisory bodies in the whole variety of areas that are of pressing concern to us.

In another important area, a significant contribution this year has been made by an ad hoc committee appointed last January under the Chairmanship of John Westerman, Director, University of Minnesota Hospitals. This committee was formed in response to an invitation from the Joint Commission on Accreditation of Hospitals. The Committee's task was to review the accreditation standards and process in order to assess ways by which the Commission can contribute to increasing the effectiveness and efficiency of the teaching hospital. This report, which I am sure most of you have received by now, was distributed in June. It addresses such issues as: governance; the role of the organized medical staff; qualifications for medical staff appointments; and institutional requirements for auditing patient care. We recognize that teaching hospitals have special problems with respect to the Joint Commission.

I want to thank those of you, and there were many of you, who took time out to respond to our invitation to make comments for the Westerman Committee Report, and most of those comments were incorporated in

the final document.

Since John's Committee did such a splendid job with their first project, we decided to assign them another one, and this came about when COTH was asked to join in a review of the 1971 Guidelines for the Formulation of Medical Staff Bylaws, Rules and Regulations of the JCAH. It is anticipated that this effort will help to assure that the JCAH Guidelines reflect the requirements unique to teaching hospitals. The draft report on the medical staff guidelines is now being reviewed by the Committee and the draft documents will then be submitted to the membership early next spring.

COTH representatives continue to be involved in all AAMC committees and program activities. In this regard, I think it is important to note, as evidenced by Irv Wilmot's comments a few minutes ago, that a fourth COTH member has been added to the AAMC Executive Council, which is the governing executive committee for the Association, and COTH representation in the AAMC Assembly has been increased from 35 to 57 members.

An effort has also been made in this year's annual meeting program to provide for combined sessions, other than the plenary sessions, where hospital directors, deans and the faculty can come together for discussion of

issues which are germane and important to all of us. The "Quality Assurance and PSRO" session this morning and "Specialty Distribution" program tomorrow afternoon are examples of our desire to work more closely as an organization with the constituent bodies in this Association. I would urge all of you to attend tomorrow afternoon's meeting on "Specialty Distribution" and to participate actively in those deliberations. They are critical, if not totally vital, to the future of our teaching hospitals.

I think it is also important to identify Association efforts to highlight the issues surrounding "primary care" programs. These issues received intense scrutiny at the AAMC Institute on Primary Care held here in Chicago last month, which I hope that many of you have had the opportunity to attend.

To me it's clear that we are moving into an era of shifting program emphasis where primary care training efforts will be substantially enlarged and where present patient care programs as a result in many of our teaching hospitals will undergo important reassessments. We have a large stake in the shifting that is likely to take place in the balance of residency training programs.

Jim Hudson mentioned that there would be six primary care workshops around the country commencing in January, and I hope that many of you will have a chance to be on hand at one of the regional meetings.

Jim covered many of the items concerning the activities of the Department of Health Services, and I would not reiterate them.

I have thought as I looked back over the course of this year that we have been extremely fortunate to have the staff that we have in AAMC. They handled themselves not only well in this room, but they handled themselves extremely well where it counts even more, which is in the halls of Congress and HEW and in the external relationships that are so vital to this Council. We have a very small, very effective and very talented staff, and I have found them to be alert and productive this year, and I think they deserve the praise of this group.

Before concluding these brief remarks, I want to call your attention to one final matter. You are all familiar, I believe, with the current criteria for membership in the Council of Teaching Hospitals. These criteria, to my knowledge, have always been and continue to be the subject of considerable debate, not

only on the Administrative Board but within the membership itself. There are those who believe the membership criteria should be made more liberal to include the participation of newly involved community hospitals, and to reflect the changes taking place as we extend the boundaries of American medical education. There are others who believe that the Council of Teaching Hospitals should continue to represent and concentrate its efforts on those institutions that have special needs and unique characteristics and contributions to make as a result of their significant commitment to medical education and research. Chuck Womer has chaired a committee which I appointed last spring to review the membership criteria. That report is presently being debated by the COTH Administrative Board, and was discussed again at considerable length this morning. It's also been discussed in preliminary form by the Executive Council of the AAMC. It's my feeling that this Council of Teaching Hospitals is a creature of the membership, and as this particular issue becomes more publicly displayed, as it will, we hope that you will communicate your views on this issue to the officers, incoming officers, and to the staff. Next year at this meeting you will have the opportunity to debate and vote on any

changes in membership criteria for the Council of Teaching Hospitals which might be proposed.

Suffice it to say that your leadership takes seriously its responsibility to concentrate the COTH program in those areas where we feel it can be most responsive to our constituents. This has not been an easy task, particularly as this body grows larger and larger each year, and as it grows larger and becomes more diversified in its interests. The adhesive of the Teaching Hospital Council is its common commitment to quality medical education. And yet the make-up of our Council of Teaching Hospitals at the present time is extremely heterogeneous, and its ties to the medical schools quite variable in their affiliation and Association relationships.

It has been a pleasure for me to serve as Chairman this past year. I want to thank the staff as well as all of you for your support. I would also like to express my thanks personally, and on behalf of the membership, to the thirteen members of the Administrative Board for the time and effort they have expended during the past years in providing advice and guidance to the Council. They have been an active group, very stimulating, very exciting, very argumentative, and I think that they have brought to the Council of Teaching Hospitals effective

and able leadership.

There are two members of the Administrative Board who retired this year, and I would now at this time ask them to come forward so we can express our gratitude for their contribution during the past years. David Hitt and Arthur Klippen, Will you come up, Dave? Thank you. (Presenting gift.) (Applause)

Will you come up, Arthur. (Presenting gift.) (Applause)

It's now my pleasure to thank you for your cooperation throughout my one year term as your Chairman and turn the meeting over to your new Chairman, Sidney Lewine. In a spirit of tradition and fellowship, Sid, I think you and the group here will be pleased to know that there is more unfinished business than finished business, so you will have plenty to do next year.

Sid is well known to most of you as Director of the Mount Sinai Hospital in Cleveland, a position he has held since 1952, which is at least one kind of a record, Sid. I don't think we have had a Chairman who has held his job as long as you have. In addition to having served as President of the Ohio Hospital Association and the Greater Cleveland Hospital Association, Sid has served on a variety of committees and councils of the

American Hospital Association and is currently a member of the AHA House of Delegates. Sid has also served us nobly this year as Chairman of the Committee which guided our response to the Phase Four regulations and to Section 223 of the Social Security Amendments, and the results of that work are well known and have been reported to you. So Sid, come forward. A fresh set of headaches and a grand opportunity.

(Applause)

DR. LEWINE: Thank you, Bob. And now it is our turn to express gratitude to you for your able leadership over the past year in directing the Council's program. In addition to his commanding grasp of the role of Chairman and administrator of the Board, Bob has been an articulate and forthright spokesman for our teaching hospitals in the Executive Council and the Executive Committee of the AAMC.

Bob, I would like to present you with this gavel inscribed with the dates of your term of office, and with thanks from all of us.

(Applause)

Now I would like to adjourn this member-

ship meeting before we proceed to our general session. Before doing so, the floor is open for any new business.

Hearing none, I will accept a motion to adjourn the membership meeting.

A VOICE: So move.

DR. LEWINE: I gather there is no opposition to that motion. I will declare it passed.

My first important piece of business is to declare a five minute stretch before we open our general session.
