

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

COTH ADMINISTRATIVE BOARD MEETING

January 15, 1975

Gallery Room

Dupont Plaza Hotel

Washington, D.C.

9:00 a.m. - 4:00 p.m.

AGENDA

- I. Call to Order
- II. Approval of Minutes TAB A
- III. Report of the Ad Hoc Committee to Review the JCAH EXECUTIVE COUNCIL AGENDA  
1971 Guidelines for the Formulation of Medical Staff Page 71  
Bylaws, Rules and Regulations
- A. Letter from Dr. Robert Heyssel and Revised JCAH Provisions TAB B
- IV. Committee Appointments
- V. Membership
- A. Crozer-Chester Medical Center TAB C
- VI. Summary of Health Manpower Questionnaire Survey TAB D
- VII. 1975 Constituent Meetings
- A. Annual Meeting TAB E  
B. COTH Regional Meetings  
C. Special Conference on House Staff Collective Bargaining TAB F
- VIII. CCME Actions EXECUTIVE COUNCIL AGENDA  
Page 29
- IX. CCME Report: The Primary Care Physician EXECUTIVE COUNCIL AGENDA  
Page 30
- X. CCME Report: The Role of the Foreign Medical Graduate EXECUTIVE COUNCIL AGENDA  
Page 31 & TAB G
- XI. The NIRMP: CAS Action, GSA Recommendations,  
LCGME Subcommittee Report EXECUTIVE COUNCIL AGENDA  
Page 65
- XII. Report of the Task Force on Groups EXECUTIVE COUNCIL AGENDA  
Page 84

XIII. OSR Actions

XIV. Report of the AAMC Officers Retreat

TAB H

XV. New Business

XVI. Adjournment

ASSOCIATION OF AMERICAN MEDICAL COLLEGES  
COTH ADMINISTRATIVE BOARD MEETING  
Conrad Hilton Hotel  
Chicago, Illinois  
November 12, 1974

MINUTES

PRESENT:

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

GUESTS:

Neal L. Gault, Jr., M.D.  
Robert L. Van Citters, M.D.  
Irvin G. Wilmot

STAFF:

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

I. Call to Order:

Mr. Derzon called the meeting to order at 7:30 a.m. in Parlor 412 of the Conrad Hilton Hotel.

II. Consideration of Minutes:

The minutes of the September 19, 1974 Administrative Board meeting were approved as circulated.

III. Membership Applications:

The Board reviewed two applications for membership and took the following action:

ACTION #1

IT WAS MOVED, SECONDED AND CARRIED THAT THE AUDIE L. MURPHY MEMORIAL VETERANS ADMINISTRATION HOSPITAL IN SAN ANTONIO, TEXAS BE APPROVED FOR MEMBERSHIP IN THE COUNCIL OF TEACHING HOSPITALS.

ACTION ON THE CROZER-CHESTER MEDICAL CENTER IN CHESTER, PENNSYLVANIA WAS DEFERRED UNTIL JANUARY, AND THE STAFF WAS REQUESTED TO SEEK FURTHER INFORMATION ON THE DETAILS OF THE APPLICATION.

IV. Report of the AAMC Task Force on the Goals and Priorities Committee Report of the National Board of Medical Examiners:

Neal L. Gault, Jr., M.D., Dean of the University of Minnesota Medical School and Chairman of the AAMC Task Force discussed the report of the NBME Goals and Priorities Committee. Dr. Gault went on to highlight the potential changes which could result from adoption of the NBME Report, and briefly discussed the background issues as they related to the observations and recommendations as set forth by the Task Force.

In the discussion which followed, the COTH Administrative Board voiced concern with the implications for teaching hospitals. Specific areas mentioned by the Administrative Board included the need to examine the timing of the various examinations with implications for the NIRMP and the status of individuals who are admitted to a graduate program who subsequently fail the examination.

The Administrative Board recommended that COTH staff relay the Board's comments regarding the report to Dr. Cooper and members of the AAMC Task Force.

V. New COTH Membership Criteria:

Mr. Derzon explained the actions of the AAMC Executive Council at the September meeting at which time the newly proposed COTH membership criteria were reviewed. The Executive Council referred the report back to the COTH Administrative Board, specifically asking that the Board reconsider the implications of the Ad Hoc Committee Report.

Robert L. Van Citters, M.D., Dean of the University of Washington School of Medicine and a member of the Council of Deans, presented the issues from the perspective of the Council of Deans. He pointed to an apparent inconsistency

between the changing emphasis toward family medicine and the inability of newly affiliated teaching hospitals for this purpose (family medicine or primary care) to be admitted to membership in COTH. Members of the Board were not in agreement but understood the problem. Recognizing that the teaching hospitals participating in medical education and in COTH must be evaluated in light of a total commitment, the Board reiterated this position as basic to the mission and purpose of COTH.

Following further discussion including discussion of a revised new application form (Appendix A to these minutes), the Board took the following action:

ACTION #2

IT WAS MOVED, SECONDED AND CARRIED THAT THE PRESENT COMMITTEE REPORT ON COTH MEMBERSHIP CRITERIA BE TABLED AND THAT THE INCOMING COTH CHAIRMAN APPOINT A NEW AD HOC COMMITTEE OF THE BOARD TO REVIEW THE COMMITTEE REPORT, SPECIFICALLY THE ISSUE OF MEMBERSHIP CATEGORIZATION, IN LIGHT OF THE RECENT CONCERN EXPRESSED BY THE COUNCIL OF DEANS IN THE AAMC EXECUTIVE COUNCIL. THE BOARD ALSO ENDORSED ADOPTION OF A REVISED APPLICATION FORM TO ASSIST THE BOARD IN EVALUATING POTENTIAL MEMBERS.

VI. Report of the COTH Nominating Committee:

Irvin Wilmot, Chairman of the COTH Nominating Committee, indicated that the following individuals would be proposed for nomination at the COTH Institutional Membership meeting and the AAMC Assembly.

COTH ADMINISTRATIVE BOARD

|  |   |
|--|---|
| CHAIRMAN                                       | Sidney Lewine   |
| CHAIRMAN-ELECT                                 | Charles B. Womer  |
| THREE-YEAR TERM                                | John W. Colloton<br>Baldwin G. Lamson, M.D.<br>Malcom Randall |
| ONE-YEAR TERM                                  | Robert E. Toomey  |
| REPRESENTATIVE<br>TO AAMC EXECUTIVE<br>COUNCIL | David D. Thompson, M.D.                                       |

COTH Representatives to the AAMC Assembly are attached as Appendix B.

VII. AAMC Distinguished Service Membership:

The following COTH Nominations for Distinguished Service Members, approved last December by the Executive Council, were recommended for presentation to the 1974 AAMC Assembly:

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

Dr. Knapp noted that new COTH nominations can be made at any time and each Board member was encouraged to suggest nominations for consideration.

VIII. AMA Guidelines for House Staff Contracts:

Dr. Knapp distributed the latest revision for the house staff guidelines as recently passed by the AMA Board of Trustees. The COTH Administrative Board agreed that except for some minor changes, such as a reduction in the inflammatory rhetoric and a statement that "contracts or agreements may be formed between individuals, groups or institutions," it would appear that the substance of the document remains unaltered. Therefore, the following action was taken:

ACTION #3

IT WAS MOVED, SECONDED AND CARRIED BY THE COTH ADMINISTRATIVE BOARD THAT THE SENSE OF THE RESOLUTION AS ADOPTED ON SEPTEMBER 19, 1974, BY THE COTH ADMINISTRATIVE BOARD AND THE AAMC EXECUTIVE COUNCIL BE REAFFIRMED. THE BOARD WENT ON TO FURTHER NOTE THAT MANY OF THE ELEMENTS OF THE GUIDELINES MAY BE ADEQUATELY DELINEATED BY THE PRESENCE OF THE ESSENTIALS OF APPROVED RESIDENCIES.

IX. Health Planning Legislation - H.R. 16204 and S. 2994:

Dr. Knapp distributed copies of an analysis of the bills prepared by COTH staff which included a number of important elements which may require an AAMC response. The issues are as follows: 1) five year review of services and facilities; 2) state rate review option; 3) inadequate Hill-Burton authority; 4) excessive federal role in planning issues; 5) accreditation and licensing of radiologic technicians. The Board suggested that staff draft a letter to the House and Senate Committee Chairmen, expressing AAMC concerns and endorsing the AHA position against these specific sections of the Senate bill.

The Administrative Board also requested that staff prepare an analysis of the bills for distribution to COTH membership when they are reported out.

X. Adjournment:

There being no further business the meeting was adjourned at 11:00 a.m.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES  
COUNCIL OF TEACHING HOSPITALS

Application for Membership

INSTRUCTIONS: Type all copies, retain the Pink copy for your files and return two 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 and Psychiatry.

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

I. MEMBERSHIP INFORMATION

\_\_\_\_\_ HOSPITAL NAME \_\_\_\_\_

\_\_\_\_\_ STREET \_\_\_\_\_ CITY \_\_\_\_\_

\_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_ TELEPHONE NUMBER \_\_\_\_\_

Chief Executive Officer \_\_\_\_\_ NAME \_\_\_\_\_

\_\_\_\_\_ TITLE \_\_\_\_\_

Date hospital was established: \_\_\_\_\_

APPROVED FIRST POST-GRADUATE YEAR

| <u>TYPE</u> <sup>2</sup> | <u>Date of Initial Approval by CME of AMA</u> <sup>**</sup> | <u>Total F.T.E.<sup>1</sup> Positions Offered</u> | <u>F.T.E.<sup>1</sup></u>                                | <u>F.T.E.<sup>1</sup></u>              |
|--------------------------|---|---|--|--|
|                          |   |   | <u>Total Positions Filled by U.S. And Canadian Grads</u> | <u>Total Positions Filled by FMG's</u> |
| Flexible                 | _____   | _____   | _____  | _____                                  |
| Categorical              | _____   | _____   | _____  | _____                                  |
| Categorical*             | _____   | _____   | _____  | _____                                  |

<sup>\*\*</sup> Council on Medical Education of the American Medical Association and/or with appropriate AMA Internship and Residency Review Commission.

1. Full-time equivalent positions at applicant institution only. If hospital participates in combined programs indicate only F.T.E. positions and individuals assigned to applicant institution.
2. Type as defined by the AMA Directory of Approved Internships and Residencies. (Flexible-graduate program acceptable to two or more hospital program directors; Categorical-graduate program predominately under supervision of single program director; Categorical\*-graduate program under supervision of single program director but content is flexible.)

ASSOCIATION OF AMERICAN MEDICAL COLLEGES  
COUNCIL OF TEACHING HOSPITALS

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AND

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

**I. MEMBERSHIP INFORMATION**

|                         |          |                  |  |
|-------------------------|----------|------------------|--|
| HOSPITAL NAME           |          |                  |  |
| STREET                  | CITY     |                  |  |
| STATE                   | ZIP CODE | TELEPHONE NUMBER |  |
| Chief Executive Officer | NAME     |                  |  |
|                         | TITLE    |                  |  |

Date hospital was established: \_\_\_\_\_

**APPROVED FIRST POST-GRADUATE YEAR**

| <u>TYPE<sup>2</sup></u> | <u>Date of Initial Approval by CME of AMA**</u> | <u>Total F.T.E.<sup>1</sup> Positions Offered</u> | <u>F.T.E.<sup>1</sup> Total Positions Filled by U.S. And Canadian Grads</u> | <u>F.T.E.<sup>1</sup> Total Positions Filled by FMG's</u> |
|-------------------------|---|---|---|---|
| Flexible                | _____   | _____   | _____   | _____   |
| Categorical             | _____   | _____   | _____   | _____   |
| Categorical*            | _____   | _____   | _____   | _____   |

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

- Full-time equivalent positions at applicant institution only. If hospital participates in combined programs indicate only F.T.E. positions and individuals assigned to applicant institution.
- Type as defined by the AMA Directory of Approved Internships and Residencies. (Flexible-graduate program acceptable to two or more hospital program directors; Categorical-graduate program predominately under supervision of single program director; Categorical\*-graduate program under supervision of single program director but content is flexible.)



## COUNCIL OF TEACHING HOSPITALS

COTH REPRESENTATIVES TO  
AAMC ASSEMBLY  
1974-1975

THREE YEAR TERM  
EXPIRING 1977

Reuben Cohen  
Hospital Director  
Veterans Administration Hospital  
East Orange, New Jersey 07019

Clyde G. Cox  
Director  
Veterans Administration Hospital  
700 South 19th Street  
Birmingham, Alabama 35233

Leonard W. Cronkhite, Jr., M.D.  
President  
Children's Hospital Medical Center  
300 Longwood Avenue  
Boston, Massachusetts 02114

A. A. Gavazzi  
Hospital Director  
Veterans Administration Hospital  
50 Irving Street  
Washington, D.C. 20422

Robert M. Heyssel, M.D.  
Executive Vice President  
and Director  
The Johns Hopkins Hospital  
601 North Broadway  
Baltimore, Maryland 21235

Baldwin G. Lamson, M.D.  
Director of Hospital and Clinics  
U.C.L.A. Hospital  
10833 Le Conte Avenue  
Los Angeles, California 90025

Sidney Lewine  
Director  
The Mount Sinai Hospital of Cleveland  
University Circle  
Cleveland, Ohio 44106

THREE YEAR TERM

Henry E. Manning  
President  
Cuyahoga County Hospital  
Cleveland Metropolitan General Hospital  
2295 Scranton Road  
Cleveland, Ohio 44109

Stuart Marylander  
Executive Director  
Cedars-Sinai Medical Center  
4833 Fountain Avenue  
Los Angeles, California 90029

Brigadier General Paul Myers  
Commander  
Wilford Hall U.S. Air Force Medical Center  
Lackland Air Force Base  
San Antonio, Texas 78236

C. L. Nordstrom  
Hospital Director  
Veterans Administration Hospital  
Southfield at Outer Drive  
Allen Park, Michigan 48101

C. J. Price  
Administrator  
Dallas County Hospital District  
5201 Harry Hines Boulevard  
Dallas, Texas 75235

Malcom Randall  
Hospital Director  
Veterans Administration Hospital  
Archer Road  
Gainesville, Florida 32601

Vernon Schaeffer  
Administrator  
Temple University Hospital  
3401 N. Broad Street  
Philadelphia, Pennsylvania 19104

Sister Evelyn M. Schneider  
Executive Director  
St. Vincent's Hospital and Medical Center  
of New York  
153 W. 11 Street  
New York, New York 10011

THREE YEAR TERM

Robert M. Sigmond  
Executive Vice President  
Albert Einstein Medical Center  
York and Tabor Roads  
Philadelphia, Pennsylvania 19141

Donald G. Shropshire  
Administrator  
Tucson Medical Center  
5301 E. Grant Road  
Tucson, Arizona 85716

Robert E. Toomey  
General Director  
Greenville Hospital System  
Greenville General Hospital  
Box 2760  
Greenville, South Carolina 29601

Robert W. White  
Administrator  
Orange County Medical Center  
101 City Drive South  
Orange, California 92668

TWO YEAR TERM  
EXPIRING 1976

Daniel W. Capps  
Administrator  
University Hospital  
Arizona Medical Center  
1501 N. Campbell Avenue  
Tucson, Arizona 85725

H. Joseph Curl  
Administrator  
Georgetown University Hospital  
3800 Reservoir Road, N.W.  
Washington, D.C. 20007

David L. Everhart  
Executive Director  
New England Medical Center Hospitals  
171 Harrison Avenue  
Boston, Massachusetts 02111

David A. Gee  
President  
The Jewish Hospital of St. Louis  
216 South Kingshighway  
St. Louis, Missouri 63110

TWO YEAR TERM

Irwin Goldberg  
Executive Director  
Montefiore Hospital  
3459 5th Avenue  
Pittsburgh, Pennsylvania 15213

James G. Harding  
President  
Wilmington Medical Center  
510 West Fourteenth Street  
Wilmington, Delaware 19889

Wayne H. Herhold  
Director  
Shands Teaching Hospital and Clinics  
J. Hillis Miller Health Center  
University of Florida  
Gainesville, Florida 32601

Sister Irene Kraus  
Executive Director  
St. Thomas Hospital  
2000 Hayes Street  
Nashville, Tennessee 37203

Robert E. Mack, M.D.  
President  
Hutzel Hospital  
432 East Hancock Avenue  
Detroit, Michigan 48201

Mikael Peterson  
Administrator  
Kaiser Foundation Hospital of the  
Kaiser-Permanente Medical Center  
2425 Geary Boulevard  
San Francisco, California 94112

S. David Pomrinse, M.D.  
Director  
The Mount Sinai Hospital  
100th Street and Fifth Avenue  
New York, New York 10021

Charles A. Sanders, M.D.  
General Director  
Massachusetts General Hospital  
Fruit Street  
Boston, Massachusetts 02114

TWO YEAR TERM

P. N. Schmoll  
Hospital Director  
Veterans Administration Hospital  
2110 Ridgecrest Drive, S.E.  
Albuquerque, New Mexico 87108

David D. Thompson, M.D.  
Administrator  
New York Hospital  
525 East 68th Street  
New York, New York 10021

Willis O. Underwood  
Hospital Director  
Veterans Administration Hospital  
West Spring Street  
West Haven, Connecticut 06516

John H. Westerman  
Director  
University of Minnesota Hospitals  
412 Union Street, S.E.  
Minneapolis, Minnesota 55455

Irvin G. Wilmot  
Executive Vice President  
New York University Medical Center  
560 First Avenue  
New York, New York 10016

David B. Wirthlin  
Administrator  
Latter-day Saints Hospital  
325 8th Avenue  
Salt Lake City, Utah 84103

Jay O. Yedvab  
Executive Director  
Mount Zion Hospital and Medical Center  
P.O. Box 7921  
San Francisco, California 94120

ONE YEAR TERM  
EXPIRING 1975

Allan C. Anderson  
Executive Director  
Strong Memorial Hospital  
of the University of Rochester  
260 Crittenden Boulevard  
Rochester, New York 14642

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

Robert A. Derzon  
Director  
Hospitals and Clinics  
University of California  
Third and Parnassus  
San Francisco, California 94122

David H. Hitt  
Associate Executive Director  
Baylor University Medical Center  
3500 Gaston Avenue  
Dallas, Texas 75246

John F. Imirie, Jr.  
Vice President  
Medical College of Virginia Hospitals  
Virginia Commonwealth University  
1200 E. Broad Street  
Richmond, Virginia 23219

Bernard J. Lachner  
President  
Evanston Hospital  
2650 Ridge Avenue  
Evanston, Illinois 60201

William A. McLees, Ph.D.  
Hospital Director  
Medical University Hospital  
Medical University of South Carolina  
80 Barre Street  
Charleston, South Carolina 29401

Stanley R. Nelson  
Executive Director  
Henry Ford Hospital  
2799 West Grand Boulevard  
Detroit, Michigan 48202

Marvin F. Neeley, Jr.  
Hospital Administrator  
Milwaukee County General Hospital  
1700 West Wisconsin Avenue  
Milwaukee, Wisconsin 53226

ONE YEAR TERM

Joseph Paris  
Hospital Director  
Veterans Administration Hospital  
3495 Bailey Avenue  
Buffalo, New York 14215

Felix Pilla  
Administrator  
Monmouth Medical Center  
Long Branch, New Jersey 07740

J. W. Pinkston, Jr.  
Executive Director  
Grady Memorial Hospital  
80 Butler Street, S.E.  
Atlanta, Georgia 30303

Alton L. Pruitt  
Hospital Director  
Veterans Administration  
West Side Hospital  
820 South Damen Avenue  
Chicago, Illinois 60612

Mitchell T. Rabkin, M.D.  
General Director  
Beth Israel Hospital  
330 Brookline Avenue  
Boston, Massachusetts 02115

David A. Reed  
President  
Lenox Hill Hospital  
100 East 77th Street  
New York, New York 10021

John Reinertsen  
Administrator  
University of Utah Hospital  
50 N. Medical Drive  
Salt Lake City, Utah 84112

John V. Sheehan  
Hospital Director  
Veterans Administration Hospital  
150 S. Huntington Avenue  
Boston, Massachusetts 02130

John M. Stagl  
President  
Northwestern Memorial Hospital  
Superior Street and Fairbanks Court  
Chicago, Illinois 60611

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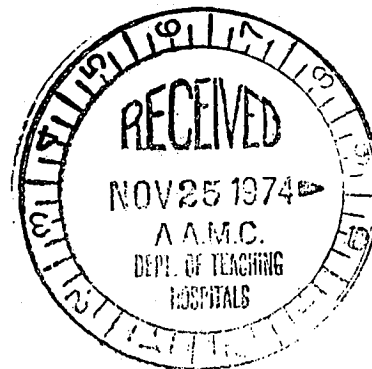
ONE YEAR TERM

Charles B. Womer  
Director  
Yale-New Haven Hospital  
789 Howard Avenue  
New Haven, Connecticut 06511

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The Johns Hopkins Hospital



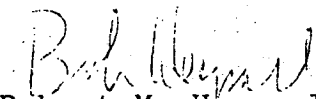
November 19, 1974

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

Dear Dick:

I want to go on record as being strongly opposed to including as a part of Hospital Medical Staff Bylaws - "due process" provision for physicians in hospitals acting in an administrative capacity as is being proposed by the JCAH. I strongly endorse the protection of physician staff from arbitrary or capricious loss of staff privileges through formal mechanisms defined by the medical staff and approved by the Boards of Trustees of hospitals. Physicians acting for the hospitals in managerial roles (i.e., Chiefs of Services, Directors of Emergency Rooms, Directors of ICU's etc.) should be subject to removal from those managerial responsibilities on the same basis as any lay managerial level employee of the hospital. The question of staff privileges or academic appointment in a university are quite separate issues and are matters which the medical staff has a proper concern. Any attempt, however, to treat physicians as a different group with regard to responsibility for the consequences of inadequate managerial performance is wrong both as a matter of equity and as a matter of proper management of our institutions.

Sincerely,

  
Robert M. Heyssel, M.D.

DRAFT 1

GUIDELINES FOR MEDICAL STAFF BYLAWS

December 11, 1974  
Joint Commission on  
Accreditation of Hospitals

3.2-4 Nondiscrimination

Medical staff membership shall not be denied on the basis of sex, race, creed, color or national origin or on the basis of any other criterion lacking professional justification.

3.2-5 Administrative and Medico-Administrative Practitioners

A practitioner employed by the hospital in a purely administrative capacity with no clinical duties is subject to the regular personnel policies of the hospital and to the terms of his contract or other conditions of employment, and need not be a member of the medical staff. A medico-administrative officer must be a member of the medical staff, achieving this status by the procedure provided in Article V. His clinical privileges should be delineated in accordance with Article VI. The medical staff membership and clinical privileges of any medico-administrative officer shall (not) be contingent on his continued occupation of that position.

3.3 DURATION AND INCIDENTS OF APPOINTMENT

3.3-1 Duration

Initial appointments shall be for a period extending to the end of the current medical staff year. Reappointments shall be made for a period of not more than (two) medical staff year(s).

*Comment*

The two-year reappointment cycle eliminates the necessity for annual reappointment of each staff member, thus easing the workload and making periodic reappraisal the comprehensive and meaningful activity it must be. Some hospitals may, however, still prefer to have reappointments on an annual basis and, in some instances, may be required to do so by state law.

A hospital may find it desirable to provide for more frequent evaluation of the older practitioner. If so, the nature and circumstances of this review should be specifically stated in the bylaws.

hearing by a committee appointed by the board. If such hearing does not result in a favorable recommendation, he shall then be entitled, upon request, to an appellate review by the board before a final decision is rendered.

8.2-3 Procedure and Process

All hearings and appellate reviews shall be in accordance with the safeguards set forth in the Due Process Plan appended to these bylaws.

8.2-4 Exceptions

Neither the issuance of a warning, a letter of admonition, or a letter of reprimand, nor the denial, termination or reduction of temporary privileges shall give rise to any right to a hearing or appeal.

8.3 DISMISSAL OF MEDICO-ADMINISTRATIVE OFFICERS

Dismissal of a medico-administrative officer shall be subject to review and, if requested, a Section 8.1 interview by a joint conference of \_\_\_\_\_ board representatives and \_\_\_\_\_ representatives selected by the members of the medical staff (*specify the manner of selection agreeable to the staff*). The joint conference shall determine the nature of the reason for the action and whether both his administrative position and medical staff membership and privileges or either shall be affected. When the reason for the action is determined to involve the individual's clinical competence, the procedures provided in Article VII and Section 8.2 shall operate. When the reason for the action is determined to be purely administrative in nature and does not involve the individual's clinical competence, the board's usual personnel policies, or the terms of the individual's contract, if there is one, shall apply.

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<br>by CME of AMA* | Total Internships<br>Offered | Total Internships<br>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<br>by CME of AMA* | Total Residencies<br>Offered | Total Residencies<br>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.

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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

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CROZER-CHESTER MEDICAL CENTER



UPLAND, CHESTER, PENNSYLVANIA 19013 - (215) 874-9611

December 16, 1974



Richard M. Knapp, Ph.D.  
Director  
Department of Teaching Hospitals  
Association of American Medical Colleges  
Suite 200  
1 DuPont Circle, N.W.  
Washington, D.C. 20036

Dear Dr. Knapp:

I am in receipt of your letter of December 4, 1974 requesting more information with respect to our application for membership to COM.


I shall be happy to answer the four items of information listed in your letter:

- A. The number of medical students in our Medical Education Program ranges from 40 to 50 in any given period. These are mostly students from Hahnemann Medical College in Philadelphia. But we have elective students here almost constantly from other medical schools including Jefferson, Temple, University of Pennsylvania, Medical College of Pennsylvania, Philadelphia College of Osteopathy, University of Louisville, University of Virginia at Charlotte, and others. In the Department of Medicine there are twelve teaching services with one or two students assigned to each service. The entire Department of Internal Medicine has faculty appointments at Hahnemann Medical College and we presently have twenty-two geographical full time physicians in the Department of Medicine. The Department of Surgery has one geographical full time salaried physician and twenty-four voluntary attending staff surgeons who are committed to teaching medical students. In the OB/GYN Department we have three geographical full time salaried physicians and ten voluntary attending staff, all of which are committed to the teaching program. In the Pediatrics Department, we have three part time salaried physicians and six voluntary attending staff physicians all committed to the teaching program.

- B. All of the chiefs of service are geographical full time salaried physicians. The one exception is in the Department of Pediatrics where the duty is divided between three pediatricians. All of the Department Chairmen and Division Heads of Crozer-Chester Medical Center hold joint appointments at Hahnemann Medical College. Our Chief of Psychiatry is full time and holds a joint appointment at the Hospital of the University of Pennsylvania. In addition to the full time chiefs, the hospital director is a physician who was our full time Director of Medical Education. We have a full time physician who is Vice President for Medical Affairs. This Vice President is closely involved with all of our teaching programs.
- C. The hospital's financial support of medical education costs is 100%. Our agreement with the medical school is that we assume all expenses while medical students are participating in our program. We also assume all of the expenses of any affiliating intern or resident. The dollars devoted to house staff and the fringe benefits of the house staff for fiscal 1974-75 is about \$900,000. These dollars represent about 5% of the hospital's budget. We pay the entire salary of the geographical full time faculty (26 full time and 3 part time). The entire portion of the service chiefs cost is paid by the hospital.
- D. The percentage of foreign medical graduates of the 36 intern and residency positions is 25% (27 American graduates and 9 foreign graduates). I might add that we also have two American dental interns and five American fellows in the Department of Medicine (Community Medicine, Special Hematology, Pulmonology, Neurology and Radiology).

I hope I have been able to give you in detail the further information you required. If there is anything else you need from us, please contact me.

Sincerely yours,

  
James J. Catania  
Vice President

JJC:jrm

RESULTS OF THE HEALTH MANPOWER QUESTIONNAIRE

|  | COH- (171) |               | CAS - (129) |               | OSR- (56) |               | COD- (106)    |          |              |
|--|------------|---------------|-------------|---------------|-----------|---------------|---------------|----------|--------------|
|  | Yes        | No            | Yes         | No            | Yes       | No            | Yes           | No       |              |
| 1. There was considerable discussion in meetings of the various Councils and of the Assembly about conditions established by the House or Senate for the receipt of capitation support. Should the Association position be to -- |            |               |             |               |           |               |               |          |              |
| a) favor pure capitation   | 35.7%      | 51.5%         | 52%         | 38%           | 46.4%     | 50.0%         | 26.4%         | 57.5%    |              |
| b) accept conditional capitation   | 63.7%      | 18.1%         | 50%         | 34%           | 60.7%     | 33.9%         | 76.4%         | 16.0%    |              |
| 2. Capitation conditions:  | Should do  | Should not do | Should do   | Should not do | Should do | Should not do | Already doing | Would do | Would not do |
| a) One-time medical student enrollment increase of 5% or 10 students, whichever is greater   | 61.4%      | 32.7%         | 47%         | 52%           | 53.6%     | 44.6%         | 40.6%         | 34.9%    | 23.6%        |
| b) Offering or increasing a program for the training of physicians' assistants   | 50.9%      | 43.9%         | 51%         | 46%           | 89.3%     | 10.7%         | 47.2%         | 29.2%    | 22.6%        |
| c) Secure national service agreements from all entering students, with selection of graduates required to serve through a lottery  | 19.9%      | 74.9%         | 27%         | 72%           | 30.4%     | 67.9%         | /////         | 36.8%    | 57.5%        |
| d) Secure national service agreements from 25% of entering students  | 25.7%      | 70.2%         | 17%         | 81%           | 8.9%      | 89.3%         | /////         | 44.3%    | 49.1%        |
| e) Secure national service agreements from 25% of entering students, with each such student entitled to federal support for tuition costs and living expenses  | 49.1%      | 45.6%         | 38%         | 60%           | 25.0%     | 71.4%         | /////         | 65.1%    | 29.2%        |
| f) Secure agreements from students to repay the school for federal capitation payments in connection with the student's enrollment   | 24.6%      | 69.6%         | 18%         | 76%           | 14.3%     | 83.9%         | ////          | 31.1%    | 63.2%        |
| g) Secure agreements from students to repay the government for capitation payments in connection with the student's enrollment, unless the student serves in the National Health Service Corps                                   | 55.6%      | 39.2%         | 45%         | 51%           | 37.5%     | 57.1%         | ////          | 44.3     | 50.0%        |
| h) Prepare a federally approved plan for training all students for at least six weeks at a site away from the medical center, supported by an amount equivalent to at least 25% of the school's capitation grant                 | 30.4%      | 63.7%         | 16%         | 82%           | 71.4%     | 26.8%         | 20.8%         | 40.6%    | 34.9%        |
| i) Establish a specified academic unit for primary care training whose faculty size and curriculum duration also would be specified  | 55.6%      | 37.4%         | 37%         | 61%           | 85.7%     | 12.5%         | 44.3%         | 29.2%    | 22.6%        |
| j) Establish residencies in family medicine or comparable primary care field, with program size specified  | 79.5%      | 15.2%         | 68%         | 30%           | 91.1%     | 8.9%          | 62.3%         | 29.2%    | 5.7%         |
| k) Reduce the percentage of foreign medical graduates in affiliated graduate training programs to specified levels   | 76.0%      | 20.5%         | 78%         | 21%           | 66.1%     | 28.6%         | 20.8%         | 69.8%    | 5.7%         |

|   | COTH         |              | OSR        |            | OSR          |              | COD          |              |
|---|--------------|--------------|------------|------------|--------------|--------------|--------------|--------------|
|   | Yes          | No           | Yes        | No         | Yes          | No           | Yes          | No           |
| 3. Would you favor direct subsidy to students?  | <u>49.7%</u> | <u>47.4%</u> | <u>54%</u> | <u>44%</u> | <u>39.3%</u> | <u>60.7%</u> | <u>27.4%</u> | <u>68.9%</u> |
| 4. If your answer to question 3 was "yes", would you still prefer direct student subsidy if conditions were attached to it similar to existing conditions associated with capitation?   | <u>31.0%</u> | <u>24.0%</u> | <u>25%</u> | <u>34%</u> | <u>28.6%</u> | <u>21.4%</u> | <u>9.4%</u>  | <u>24.5%</u> |
| 5) Would you favor last-dollar support compared to --   |              |              |            |            |              |              |              |              |
| a) capitation without conditions  | <u>37.4%</u> | <u>49.1%</u> | <u>39%</u> | <u>54%</u> | <u>50.0%</u> | <u>44.6%</u> | <u>24.5%</u> | <u>69.8%</u> |
| b) capitation with conditions   | <u>40.9%</u> | <u>45.0%</u> | <u>38%</u> | <u>47%</u> | <u>33.9%</u> | <u>57.1%</u> | <u>30.2%</u> | <u>58.5%</u> |
| c) direct student subsidy without conditions  | <u>31.0%</u> | <u>55.6%</u> | <u>31%</u> | <u>57%</u> | <u>37.5%</u> | <u>53.6%</u> | <u>18.9%</u> | <u>69.8%</u> |
| d) direct student subsidy with conditions   | <u>39.8%</u> | <u>44.4%</u> | <u>39%</u> | <u>46%</u> | <u>28.6%</u> | <u>60.7%</u> | <u>26.4%</u> | <u>62.3%</u> |
| 6) Do you believe there should be a reduction in the number of residency training slots to 125 percent of U.S. medical school graduates, with no change in the distribution of slots among specialties, in order to reduce the number of FMGs?  | <u>40.9%</u> | <u>54.4%</u> | <u>52%</u> | <u>46%</u> | <u>32.1%</u> | <u>66.1%</u> | <u>37.7%</u> | <u>59.4%</u> |
| 7) Do you believe there should be control over the distribution of residency training slots among the various specialties (particularly to increase the proportion devoted to preparation of primary care physicians) and over the number of slots (limiting them to 125 percent of U.S. medical school graduates in order to reduce the number of FMGs)? | <u>69.0%</u> | <u>27.5%</u> | <u>57%</u> | <u>42%</u> | <u>37.5%</u> | <u>58.9%</u> | <u>73.6%</u> | <u>25.5%</u> |
| 8) If the answer to question 6 or 7 was "yes", would you prefer that the control be exercised by --   |              |              |            |            |              |              |              |              |
| a) a federal commission   | <u>5.8%</u>  | <u>64.9%</u> | <u>6%</u>  | <u>58%</u> | <u>14.3%</u> | <u>33.9%</u> | <u>6.6%</u>  | <u>62.3%</u> |
| b) the private sector   | <u>76.6%</u> | <u>5.8%</u>  | <u>69%</u> | <u>6%</u>  | <u>35.7%</u> | <u>14.3%</u> | <u>76.4%</u> | <u>5.7%</u>  |

1975 ANNUAL MEETING

FORMAT

The schedule outlined below is proposed by the staff as the basic format for the 1975 Annual Meeting. It has been developed to take into account the suggestions and comments of members about previous meetings and the logistic requirements of a meeting of 3,000 people and 200 separate functions.

Washington Hilton Hotel  
Washington, D.C.  
November 2-6, 1975

|      | SUN.                                  | MON                                      | TUES                          | WED   | THURS                    |
|------|---------------------------------------|--|-------------------------------|---|--------------------------|
| A.M. | OSR<br>Misc. Societies<br>Other Misc. | Council Meetings<br>Busi/Prog.<br>Groups | PLENARY SESSION<br>(thematic) | GENERAL SESSION<br>(political)                            | Misc. Meetings<br>Groups |
| P.M. | OSR<br>Misc. Societies<br>Other Misc. | Council Meetings<br>Busi/Prog.<br>Groups | ASSEMBLY                      | GENERAL SESSIONS<br>COD/CAS/COTH<br>other specific topics | Misc. Meetings<br>Groups |

THEME

Recommendations of a theme will be presented to the Retreat for discussion. The Executive Committee traditionally serves as the "Annual Meeting Program Committee" in selecting speakers.

### Tentative Schedule

COTH WORKSHOP - Housestaff Collective Bargaining  
Organization: Approaches to Meeting the Challenge

(Note: names of speakers serve as examples, they have not been contacted regarding their willingness or ability to participate in the workshop.)

- 8:30 AM - 9:00 AM      Registration, coffee
- 9:00 AM - 9:15 AM      Introduction - Welcome  
(Mr. Sidney Lewine, Director, Mount Sinai Hospital of Cleveland, Chairman COTH Administrative Board)
- a. objectives of the workshop
  - b. format scheduling
  - c. personal reflections
- 9:15 AM - 9:45 AM      The Taft-Hartley Act: An Overview (Mr. Robert Moss, Counsel, House Special Labor Subcommittee)
- a. objectives of the Act
  - b. structure
  - c. health facility provisions
- 9:45 AM - 10:15 AM    The Status of House Officers Under Federal Labor Law (a representative of the National Labor Relations Board, Washington, D.C.)
- 10:15 AM - 11:15 AM    The Recognition Process (Carl Wm. Vogt, Fulbright and Jaworski Attorneys at Law, Washington, D.C.)
- a. recognition petition
  - b. regional and NLRB hearings
  - c. bargaining unit certification
  - d. election procedures
- 11:15 AM - 11:45 AM    Panel discussion and questions: house staff labor law status and recognition
- 12:00 Noon - 1:15 PM    Lunch (included in workshop fee)
- 1:15 PM - 2:15 PM      House Staff Organization: One Hospital's Experiences (Mr. Stuart Marylander, Executive Director, Cedars-Sinai Medical Center; and Mr. Harry Keaton, Mitchell, Silberberg and Knupp, Los Angeles)

2:15 PM - 2:45 PM

Organized and Unorganized Hospitals: What's the Difference (Philadelphia Constituent)

2:45 PM - 3:15 PM

Dispute Resolution Under the NLRA (Dennis Pointer, AAMC)

- a. contract termination
- b. strike notice
- c. medication
- d. emergency disputes

3:15 PM - 4:00 PM

Unfair Labor Practices (Mr. William Abelow, League of Voluntary Hospitals and Homes, New York City)

- a. union
- b. management
- c. hearings
- d. relief

4:00 PM - 4:30 PM

Panel discussion and questions



# ST JOHN'S *Episcopal* HOSPITAL

A SERVICE OF THE CHURCH CHARITY FOUNDATION OF LONG ISLAND

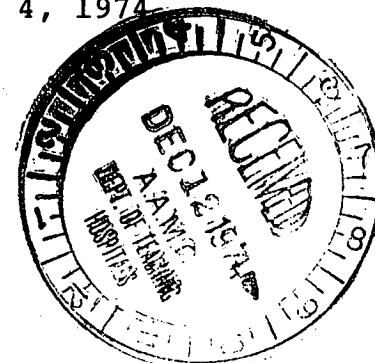
480 HERKIMER STREET • BROOKLYN, N.Y. 11213

EDWARD J. WALSH, *Administrator*

(212) 467-7000

December 4, 1974

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



Dear Dr. Knapp:

We have carefully reviewed your report dated November 5, 1974, re: Role of the Foreign Medical Graduate and submit the following as opposing your viewpoint.

We are a 350 bed voluntary hospital located in the Bedford-Stuyvesant area of Brooklyn, a predominantly low-income Black population. We have an Affiliation with the Downstate School of Medicine. Our residency programs in Medicine, Surgery, Obstetrics - Gynecology, Pediatrics and Pathology has been fully approved by the Specialty Boards. We have full-time instructors of service in each of the departments and a full-time Director of Medical Education. All of our directors of clinical services hold rank of at least Associate Professor at the Downstate Medical School. Our teaching program is very active and complete in all respects.

Our House-Staff is composed of foreign medical graduates, predominantly from the Philippine Islands; language is no problem. As part of their training, our residents spend time at Downstate where they act as residents. All reports indicate that our residents hold their own with the American resident. This is also borne out by the fact that 90% of our residents pass the State licensing examination on the first attempt and our percentage on the Specialty Boards is not much different from the American graduate.





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480 HERKIMER STREET • BROOKLYN, N.Y. 11213

EDWARD J. WALSH, *Administrator*

(212) 467-7000

Dr. Richard Knapp - COTH

- 2 -

December 4, 1974

We maintain a large active Family Medical Outpatient Department and Emergency Room averaging 100,000 visits per year. In addition, we maintain two very active satellite medical clinics as well as two methadone clinics each with 200 patients. Ninety per cent of the physicians serving these clinics are on a full-time basis and are residents we have trained. These young physicians are living in the area and providing high grade quality medicine to a population group that never had this type of care before.

Some of our graduates have also gone on to practice in small communities in the mid and far west away from large suburban areas. Enclosed is a partial list of our graduates who have gone to areas desparately in need of physicians.

We are opposed to your proposition that only accredited U.S. medical schools sponsor foreign medical graduates. We do not believe they are in any superior position to understand nor adjust to the problem of the foreign medical graduate. Since our residency training programs have to meet the same standards as the University residencies to achieve approval, we fail to see where they can offer more. Indeed, over the years, most University hospitals have accepted relatively few foreign medical graduates and years of experience in understanding and solving the problems of the foreign medical graduate have given us a decided edge.

We are opposed to limiting the graduate training program to two years. We feel the foreign medical graduate should have a graduate training program that will qualify him in the same manner as our American graduate. This would require at least three years of residency training.

We cannot see the need for yet another certifying body such as L.C.G.M.E. We are at present reviewed endlessly by the Specialty Boards, the A.M.A., Federal, State and City agencies. This seems like more bureaucracy.



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EDWARD J. WALSH, *Administrator*

(212) 467-7000

Dr. Richard Knapp - COTH

- 3 -

December 4, 1974

We think your approach is unrealistic. On the one hand, you speak of this new program taking place July, 1976. This would remove 70% of the interns and residents in our area (Brooklyn). On the other hand, you indicate it will take approximately a decade for our medical schools to double the number of graduates. What do we do in the interim?

We also believe you give too little credit to hospitals like ours who are turning out the kind of physicians you are aiming to develop. You are implying that most residencies staffed by foreign medical graduates are not doing a good job. We take issue with that. We do not believe we should all be penalized for the sins of others.

We recognize a problem exists. The problem is that there are not enough American trained graduates to fill all the residencies offered. We believe your approach would eliminate a great many residency programs that are vital, stimulating, educational and providing the foreign medical graduate with the ability to enter the mainstream of American medicine if he so wishes.

Very truly yours,

Felix Taubman, M.D.  
President, Medical Staff

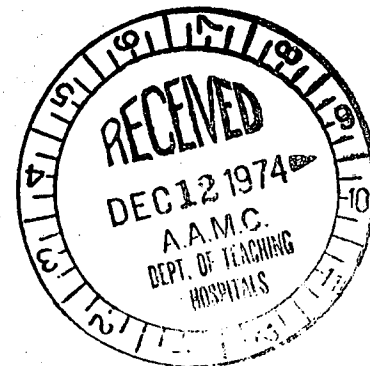
Enclosure



HEALTH AND HOSPITALS CORPORATION  
BRONX MUNICIPAL HOSPITAL CENTER

AFFILIATED WITH  
ALBERT EINSTEIN COLLEGE OF MEDICINE  
PELHAM PARKWAY SOUTH AND EASTCHESTER ROAD  
BRONX, NEW YORK 10461

OFFICE OF THE  
EXECUTIVE DIRECTOR



December 9, 1974

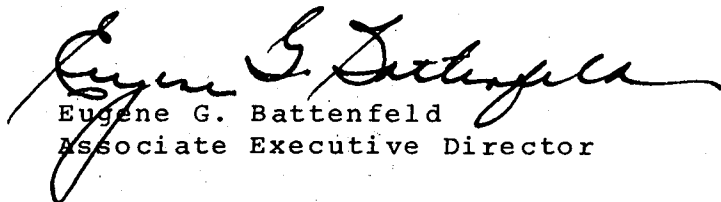
Richard M. Knapp, Ph.D., Director  
Department of Teaching Hospitals  
COTH - Association of American Medical Colleges  
One DuPont Circle, N.W.  
Washington, D.C. 20036

Re: COTH General Membership Memorandum  
No. 74-15G  
CCME Report: Role of the Foreign Medical  
Graduate

Gentlemen:

We are enclosing for your consideration a memorandum of comments set forth by Dr. John Stein, President, Medical Board, Bronx Municipal Hospital Center/Albert Einstein College of Medicine as regards the above subject matter.

Sincerely,

  
Eugene G. Battenfeld  
Associate Executive Director


EGB:bs

Encl.

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION  
Internal Memorandum

To: Mr. E. Battenfeld

Date: 11/22/74

From: John M. Stein, M.D. 

Subject: CCME Report: Role of the  
Foreign Medical Graduate  
Re: Your Log No. 194

---

Thank you for sending me a copy of the recommendations made by the Coordinating Council on Medical Education concerning foreign medical graduates. My opinions concerning this document remain very much the same as they were some time during the past summer when the original draft of this document was forwarded to me for comment.

In essence this document, 1) discriminates against the immigration of physicians to the United States if they wish to come; 2) will rapidly make it impossible for many hospitals, including the Bronx Municipal, to obtain house staff; 3) will decrease markedly the number of practicing physicians available to our community.

It is evident that the production of physicians by United States and Canadian medical schools cannot possibly keep up with the demand for physicians and therefore the foreign medical graduate forms an important pool. I do agree that accepting foreign trained physicians deprives the donating country of their services. I also agree that those physicians who are inadequately trained should be given excellent training in the United States so that the caliber of medical care will remain high.

As long as the situation outlined in Table 6 on the last page of this document persists, whereby only 38% of American applicants to American medical schools are able to gain entry to American medical schools, the training of American nationals will go on in medical schools outside of this country. This is a national shame and no major proposals in the document deal with this aspect in any significant way.

At a time when the need for physicians in the United States is increasing it would seem to me that the major thrust of the suggestions offered by this group should address the problem of increasing domestic production of physicians rather than deporting foreign graduates.

JMS: lab



SAINT LOUIS UNIVERSITY  
SCHOOL OF MEDICINE

1402 South Grand Boulevard  
Saint Louis, Missouri 63104  
664-9800

December 9, 1974

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

Dear Dr. Knapp:

I have reviewed the recent CCME Report: Role of the Foreign Medical Graduate and I should like to make the following comments.

1. I agree that the system of examinations for foreign medical graduates should be reevaluated. I think that the system should be equally as comprehensive as that given to American medical graduates, namely parts I, parts II and III of the National Board of Medical Examiners. At our school we require the passage of parts I and II of the National Board of Examiners as a requirement for graduation.
2. I very much agree with the statement that no one really knows exactly the quality of training that goes on in foreign medical schools, and I am particularly referring to those in India, Southeast Asia, and the Philippines. Whether the graduates are nationals from these countries or are Americans in these schools one has no accurate way to assess the quality of education that they are receiving. Having had some firsthand acquaintance with graduates from the Autonomous University of Guadalajara I am anything but impressed with the quality of product coming out of that school, and I am specifically thinking about the United States citizens who are students in that school.
3. I agree with the statement that the exchange visitor program for foreign physicians has been counter productive. My experience at Saint Louis University as Assistant Dean for Postgraduate Training, has been the same as been noted in the report, namely these individuals come to the United States, receive a very sophisticated level of training-usually not applicable to the clinical problems in their homeland- but then remain here. I think a great deal of the fault lies with the country of origin in that these individuals come to the United States with no plan for their utilization

upon the completion of their training. While Medicine in the United States continues to be a very attractive profession, both from the standpoint of the ability of the individual to select his specialty in which he desires to practice and from the monetary point of view, some thought must be given to trying to make these individuals return to their native land to upgrade the quality of Medicine in that area. I concur that it will probably take changes in the Immigration laws before the trend can be reversed significantly.

4. I am not too sure that if we continue with the "universal declaration of human rights adopted by the UN General Assembly in 1948 assuring for every individual the right to leave any country, including his own, and return to his country" that we will not wind up with the same problem. The problem is partly economic and is also partly based upon the fact that most of these foreign medical graduates have very little to which they can return to upon the completion of their training.
5. As regards orientation in educational experience is concerned, I think this would be a rather costly undertaking for many institutions and I am not too convinced that the School of Medicine at Saint Louis University would be interested in expending any significant amount of funds to carry on such a program. As I am sure you are well aware, most of this orientation and educational experience for foreign medical graduates is usually in a community hospital with no expense to the major teaching institutions as these individuals will not come into our programs until after a year, or more, in the United States. By this time their command of the language and acquaintances with U.S. culture is adequate.
6. I agree with the CCME when it recommends that the admission of foreign medical graduates to the United States as exchange visitors be limited to the defined purposes and the limited period of time authorized by the Department of State regulations.
7. If the sponsorship of foreign medical graduates coming into the United States for graduate medical education is limited only to accredited U.S. medical schools or other accredited schools of the health professions this would certainly have the effect of cutting down on the flow of foreign medical graduates into the teaching programs.
8. It was my impression, from meetings that I have attended over the last few years, that the U.S. has already entered into agreements with various countries that would insure the foreign medical graduate returning at the end of postgraduate training, depending upon the specialty in which he had trained. I would certainly be in favor of the United States government, through the State Department, entering into agreements with governments of other countries wherein the United States would agree to provide specific types of graduate medical education for individual physicians who have been designated to fill key educational governments, or other posts in that country. As I noted earlier, I think this is one of the main reasons for failure of the exchange visitor program. Certainly, if this were adhered to it would take care of the length of time these individuals would be in training

in the United States.

9. I think your recommendation that "in order to qualify for a third or sixth preference immigration visa an applicant physician should be required to demonstrate to the Department of Labor that he possesses an unrestricted license to practice Medicine in a state or other licensing jurisdiction of the United States or has reasonable prospect of qualifying for such a licensure" is unrealistic. I would imagine that the failure rate for these individuals, were they taking a FLEX exam without having been to the United States would be extremely high and would have the same affect as a change in the Immigration laws.
10. As far as the Labor Department basing its determination on the premise of an insufficient supply as compared to the physician-population ratios, I feel it is unrealistic to think that these individuals would not see through this rather rapidly. I cannot envision that the courts would allow any foreign medical graduate to be bound to any agreement to practice in a certain area or in a certain specialty for any length of time once they had achieved permanent citizenship. In the state of Missouri, the courts have already struck down the requirement of permanent residency, or citizenship, as a requirement for licensure. This proposal would seem to me to be either inherently unconstitutional or impossible to enforce.
11. As far as state legislatures and medical licensure boards adopting eligibility requirements and qualifying procedures for licensure that are uniform, in the state of Missouri I think this is the case. As I noted above, the courts have struck down the requirements of permanent residency or citizenship as a requirement for licensure. The foreign medical graduate takes the same examination as the graduate of an American school.
12. I would presume that when you discuss the LCGME establishing eligibility requirements for graduate medical education at the hospital residency level you would mean the FMG would have to take some sort of qualifying examination. In my opinion, the examination they should have to take should be an examination equal to that required by the sponsoring school of its own undergraduates as a requirement for graduation, and in the case of Saint Louis University this would be passage of Parts I and II of the National Board of Medical Examiners. Certainly it would not seem feasible if every school, or approved program, gave its own examination. We would again wind up with no uniform way of assessing the quality of individuals entering into the various programs.
13. If the director of approved internships and residencies is to list the graduate medical education programs approved by the LCGME which are available to immigrant physicians it would seem that they would have to start putting this directory at some sort of an earlier date rather than the usual late date at which it is now received. At the time this directory is received in mid, or late December of each year, it is too late for even our senior students to use it effectively in the NIRMP and we have tried to have as much of the administrative work on residency contracts

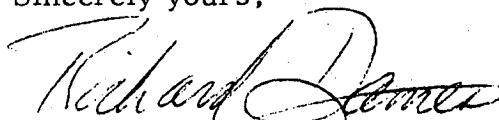
out of the way before the last half of December.

14. As regards to organizing, on an interim basis, a special program under the sponsorship of accredited medical schools for immigrant physicians who have failed to qualify for approved residencies and who have immigrated to this country prior to January 1, 1976 I would be opposed to this unless some sort of funding was available. I would imagine that most private medical schools do not have the financial resources, in these times, to underwrite such a program.
15. I would think that a definite policy regarding United States citizens who are either in, or completing, medical training in foreign medical schools should be set forth. I see no way in which U.S. citizens in foreign medical schools could, or should, transfer into an American school without some objective assessment of their level of training, and by this I am again referring to the passage of Part I of the National Board of Medical Examiners. We have had a few isolated instances in the School of Medicine at Saint Louis University where individuals have passed Part I of the National Board of Medical Examiners and then transferred into our junior class. These individuals have completed the course but I do not consider them to be the usual run-of-the-mill student from a foreign medical school - i.e., Autonomous University of Guadalajara in this case.

In summary, I agree with the basic premise that there should be some objective way of assessing the competence and capability of foreign medical graduate, be he a U.S. citizen or a foreign national who is immigrating to the United States. Quite possibly the problem might, with the conscientious neglect which you have mentioned in your report, tend to solve itself as a number of American medical school graduates increases and the number of residency training positions, outside of the primary care disciplines, is not allowed to expand indefinitely as has been the case in the past. I am not against the immigration of the foreign medical graduate but I am appalled at the way in which they have been allowed to wander in and out of our system, making career changes as desired, and not returning to their native country as was the original intent of the exchange visitor program.

I do wish you well in your work on this extremely difficult and vexing problem and I regret being late with my comments.

Sincerely yours,



Richard J. Dames, M.D.  
Assistant Dean

RJD/mw





UNIVERSITY of CINCINNATI • MEDICAL CENTER

# CINCINNATI GENERAL HOSPITAL

234 Goodman Street • Cincinnati, Ohio 45229  
67

December 4, 1974

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

Re: CCME Report: Role of the Foreign Medical Graduate

Dear Dr. Knapp:

On page 17 of your report, Section II, Specific Recommendations, (B) Recommendations on Foreign National Physicians Seeking Permanent Residence, paragraph 6, it states:

That eligibility requirements for medical licensure in every State, applicable to both FMG's and USMG's, include two or more years of supervised graduate medical education at the hospital residency level in a program approved for such training by the Liaison Committee on Graduate Medical Education;

The above paragraph dramatically changes the requirements for licensure in every state and would require in the future, instead of one year of postgraduate training post-medical-school, two years. Is this the intent?

Currently there are some physicians graduating from either three or four years of medical school who take a one-year postgraduate training program and enter family practice. Under this new recommendation, all trainees would be required to take two years of post-medical-school training.

I do not know the number of individuals who take one year of post-graduate training and enter practice, but I would assume that there are a relatively significant number. Could you give me this figure, and also let me know whether the Council on Medical Education is advocating two years of training post-medical-school instead of one.

Sincerely,

Joseph Lindner, Jr., M.D.

Associate Dean

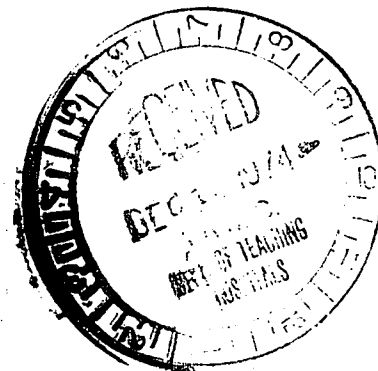
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cc: Robert S. Daniels, M.D., Interim Dean  
Stanley B. Troup, M.D., Vice President of the University of Cincinnati and Director of the Medical Center

ROBERT K. MATCH, M.D.  
Executive Vice President and Director

December 9, 1974

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



Dear Dr. Knapp:

This is in reply to COTH General Membership Memorandum No. 74-15G:  
CCME Report: Role of the Foreign Medical Graduate.

While we are in general agreement with the major thrust of the report, we have the following three specific comments on the document.

First, we believe that recommendations #3 and #4 on temporary visitor physicians (pages 11;12) should be altered to read as follows (alterations underlined):

3. That commencing July 1, 1976, the sponsorship of FMG's coming to the U.S. for graduate medical education as exchange visitor physicians be limited only to accredited U.S. medical schools or hospitals with approved programs in graduate medical education.
4. That such medical schools or hospitals with approved programs in graduate medical education specifically approved by the LCGME to sponsor exchange visitor physicians, etc.....

Second, recommendation #5 on foreign national physicians seeking permanent residence (page 17), while doubtless desirable, is probably unrealistic, impractical, and unworkable.

Finally, we believe that the AAMC should attempt to distinguish U.S. F.M.G.'s from F.F.M.G.'s, and incorporate this distinction into its considerations, especially with respect to graduate medical education. Although U.S.F.M.G.'s



Dr. Richard M. Knapp

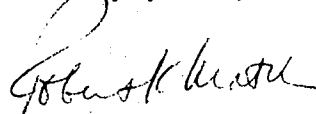
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December 9, 1974

might suffer from most of the educational deficits of attending medical school in countries other than the United States, nonetheless U.S.F.M.G.'s usually do not have the language and socio-cultural barriers to competent functioning as medical house officers as do F.F.M.G.'s.

We appreciate the opportunity of expressing our opinions on these issues. If you have any questions or comments on these views, I would be pleased to discuss them further with you.

Sincerely yours,



Robert K. Match, M.D.  
Executive Vice President  
and Director

RKM/cf

cc: Dr. James Mulvihill  
Mr. Harold Light

## REPORT OF THE AAMC OFFICERS' RETREAT

December 11-13, 1974

### Officers Present:

Dr. Sherman M. Mellinkoff (Chairman)  
Dr. John A.D. Cooper (President)  
Dr. John F. Sherman (Vice-President)  
Dr. Ivan L. Bennett, Jr. (Chairman, COD)  
Dr. John A. Gronvall (Chairman-Elect, COD)  
Dr. Jack W. Cole (Chairman, CAS)  
Dr. Rolla B. Hill (Chairman-Elect, CAS)  
Mr. Sidney Lewine (Chairman, COTH)  
Mr. Charles B. Womer (Chairman-Elect, COTH)  
Mr. Mark Cannon (Chairperson, OSR)  
Dr. Cynthia B. Johnson (Vice-Chairperson, OSR)  
Dr. Kenneth R. Crispell (Distinguished Service Member)

### Staff Present:

Mr. Charles Fentress  
Dr. H. Paul Jolly  
Dr. Richard Knapp  
Dr. Emanuel Suter  
Dr. August Swanson  
Mr. J. Trevor Thomas  
Mr. Bart Waldman  
Dr. Marjorie Wilson

The retreat of the Association's officers was held December 11-13 at the Belmont Conference Center, Elkridge, Maryland. Individuals invited to attend included the Chairman and Chairman-Elect of the Association and of each Council, the OSR Chairperson and Vice Chairperson, the "coordinator" of the Distinguished Service Members, and the Executive Staff.

The discussion and recommendations of the retreat participants are presented below in the outline format in which each issue was considered.

## I. AAMC Organization and Governance

### A. COTH Membership Criteria

Membership criteria proposed by a COTH task force had been presented to the Executive Council and referred back to the COTH Administrative Board to provide for the inclusion of affiliated community hospitals having only a family practice residency. COTH representatives felt that a strong commitment to medical education must be shown by a hospital in order to qualify for COTH membership. The view was expressed that the nomination of an affiliated hospital by a dean might be considered to be sufficient evidence of this commitment. The issue of COTH size was also considered, since it was agreed that COTH should never try to include the over 1500 hospitals having graduate training programs and since some deans had previously expressed the view that COTH had grown too large. It was agreed that hospitals having a significant commitment to medical education should not be excluded and that a new task force which would include deans should be appointed to review the mechanics of accomplishing this.

### B. Housestaff Representation

The question of including housestaff representation in the Association was discussed by the retreat participants. The OSR had suggested this item, expressing the belief that house officers should have a voice in Association affairs. A number of alternate methods by which house officers could be included in the Association, either as a governing organization such as the OSR, or in a less formal status, were presented.

Since no formal request had been presented to the Association by any group representing house officers and since a representative of the Physicians National Housestaff Association had expressed some opposition to the idea, the retreat participants felt that no action should be taken at this time. They specifically indicated that the AAMC should avoid, at all costs, giving recognition to any group which might function as a union. In discussing further alternatives, it was emphasized that if residents were to be included, the Association should seek only to represent them as teachers and students. Employee interests of house officers should never be served through the AAMC.

Doctor Bennett expressed the strong feeling that the Association should observe the housestaff situation, waiting until employee issues, which dominate the house officers' interests, calm down. He also felt that the AMA/housestaff relations should be observed for a period of time.

The retreat participants agreed that formal housestaff representation should be postponed, but that the Association should seek qualified housestaff input to appropriate committees and explore the possibility of having the deans or program directors invite house officers to the annual meeting.

C. Report of the Task Force on Groups

A task force of the Executive Council had been appointed to consider the appropriate role of the five existing groups within the AAMC, the most desirable relationship of the groups to the staff and to the Councils, and the appropriate level of staff and financial resources which should be devoted to supporting groups. The task force's report supported the existing organizational structure and allocation of resources. It went on to recommend a formal mechanism by which groups could recommend items to be considered by the Executive Council and the constituent Councils.

The retreat participants expressed their full support for the recommendations of the task force and agreed that the task force report should be circulated immediately to the group chairmen with invitations to the January meeting of the Executive Council.

D. Distinguished Service Members

Doctors Mellinkoff and Crispell discussed the first meeting of the Association's Distinguished Service Members which had been held at the annual meeting in November. The minutes of this meeting were distributed for information.

The retreat participants felt that the role which had been identified by the Distinguished Service Members was appropriate and should be pursued with enthusiasm. It was also agreed that some limit on the size of this group be sought in discussions with the Councils which recommend their election. It was also felt that editorials for the Journal of Medical Education should be sought from members of this group.

II. Relationships with Other Organizations

A. CCME, LCME and LCGME

The retreat participants discussed the general structure and function of these three bodies and then addressed specific issues raised in the retreat agenda. It was agreed that Dr. Cooper should be appointed as an AAMC representative to the CCME. It was also felt that expansion of the LCME membership, beyond the current AMA-AAMC composition, should be addressed on the merits of participation by other organizations and should not be handled as a political question. Strong feelings were expressed that at least one, and maybe all of the additional groups being proposed, should not be added on the merits of their contributions to the accreditation of undergraduate medical education.

The question of staffing the CCME was discussed but it was felt to be an issue which should not be confronted until some problem arose regarding the staffing by the AMA. It was also felt that the question of which policies should be forwarded to the CCME and which policies should be considered independently by the AAMC should be addressed on an individual issue-by-issue basis.

B. Association for Academic Health Centers and Federation of Associations of Schools of the Health Professions

Relationships with groups representing schools of other health professions were reviewed. It was agreed that the Association's close liaison with the AAHC should be continued as in the past. Special relationships with groups representing dentistry, nursing and public health were strongly supported. It was felt that the Federation should only serve as a forum for discussion and should not be used to advance positions on national legislation.

III. Staff Activities

A. Resource Allocation

Doctor Sherman reviewed in detail the process by which the staff was attempting to identify component activities and assign dollar allocations on an actual time and dollars spent basis. He outlined the methodology for this process which included the establishment of a Program and Budget Review Committee and would eventually include a system of evaluation of each of the component staff activities. The retreat participants were presented with an array of 148 distinct activities, along with a description of each and the number of person years devoted to each. Doctor Sherman also presented the dollar allocations devoted to four of the aggregate categories of activities, as well as an array of the percentage of Association manpower being assigned to each general classification.

The retreat participants supported the concept of the program budgeting and expressed the view that this activity would be more useful as an internal educational tool than for any other purpose. It was stressed that the figures would never be accurate and should not be relied on too heavily. Mr. Lewine indicated that if the figures were within ten percent of the actual numbers, the Association would be doing well. He also expressed a strong feeling that any attempt to determine priorities through a mechanism of program assessment would be futile.

The mechanics of the study were reviewed and the feeling expressed that the personnel figures presented needed to reflect dollar expenditures and not simply person years. The treatment of Federal Liaison activities by including them in the substantive areas was supported.

Doctor Bennett reminded the retreat that priorities must also be looked at in terms of which activity, when reduced, will save the most dollars. This meant that a decision to cut back an activity would be meaningless unless the number of people and/or the travel funds could be reduced.

It was agreed that the January Executive Council meeting would be presented with the process being undertaken. Representatives of each Council would be asked to assess the expectations of the Council members regarding this display and its ultimate effect on the setting of priorities. The retreat participants also discussed inconclusively the concept of asking a management consultant to work with the Association on this activity.

#### B. Space Requirements

Doctor Cooper and Mr. Thomas discussed the activities of the Building Committee, the expanded space requirements of the Association, and the Washington, D.C. real estate market. The Building Committee had recommended that the staff actively seek either the outright purchase of an existing facility or the leasing, with option to buy, of office space where the staff activities could be consolidated. Mr. Thomas indicated that market conditions in the Washington area were extremely unfavorable to this type of action. It was recommended that the AAMC continue to lease space at One Dupont Circle and elsewhere as needed. More favorable market conditions are anticipated within two to three years.

The retreat participants concurred in this recommendation, adding that it would be psychologically disadvantageous to purchase office space at a time when general economic conditions affecting the constituency were so restricting.

### IV. Physician Production and Distribution

#### A. Federal Support of Medical Education

The retreat participants reviewed the steps which had been taken since the meeting of the Assembly to reconsider the Association's position on health manpower legislation. They agreed with the appointment of a Task Force on Health Manpower, chaired by Dr. Daniel Tosteson, and reviewed the questionnaire which had been sent to the full AAMC membership. It was felt that the substantive consideration of health manpower policies should be left to the task force with recommendations to come before the Executive Council.



In anticipation of the task force report, it was recommended that meetings be arranged with potentially influential individuals. The discussion then turned to suggestions of people who would be appropriate contacts with House and Senate leaders. It was also suggested that deans and hospital directors be encouraged to visit nearby, underserved areas to establish the basis for future outreach programs.

#### B. Output and Adequacy

The question of expanding and improving staff activities in the area of assessing the output and adequacy of physician supply was discussed. The retreat participants felt that the two issues should be separated--that output measures and predictors be improved, but that any attempts to measure adequacy be dropped. It was recommended that staff stay aware of studies of needs conducted by others and to also be familiar with the methodologies used. The maintaining of a bibliography of such studies was recommended.

It was also recommended that the schools be encouraged to analyze their local areas and work within these regions to alleviate identifiable shortages. It was felt, however, that any Association statement relating to physician needs of the Nation would fail to convince Congressional leaders that shortages do not exist and that more physicians are not the solution.

#### C. Specialty Distribution

The retreat discussed various proposals which had been advanced to regulate and reallocate residency training positions. In particular, they reviewed the proposal contained in the House health manpower legislation which would designate the CCME as the body to regulate both the numbers of residency programs and their distribution by specialty.

It was generally felt that by enforcing stricter accreditation criteria, the number of residencies could be reduced to an acceptable amount. In addition, the introduction of a uniform qualifying examination would limit the demand for marginal residency programs. It was felt that these qualitative controls should be attempted before any absolute limits were placed.

On the issue of supporting the particular provisions of the House bill, the retreat did not reach a consensus. It was generally agreed that the development of an Association policy on this should be the work of the Task Force on Health Manpower. The political expectations of both Mr. Rogers and Senator Kennedy in this area were discussed. It was agreed that any discussions with them should emphasize the overall approach of changing the income differences of primary care physicians and specialists through a national health insurance mechanism.

#### D. Geographic Distribution

The retreat participants briefly considered an appropriate position on geographic distribution and again felt that specifics of this issue relating to legislation should be reviewed by the Task Force on Health Manpower. They reiterated their support for voluntary programs by which the schools and hospitals would work within their regions to alleviate manpower problems. In addition, support was expressed for a tracking program by which the Association would assist the schools to develop a data base tracing ultimate career and residence choices of their students.

#### V. Replacement of NIH Director

It was reported that the Washington Post had just published a story saying that NIH Director, Dr. Robert Stone, had been asked to resign. A general discussion of the process by which the NIH director would be selected ensued and strong feelings were expressed that this not be a political appointment. It was agreed that the Association would ask that a career NIH'er be appointed as the director and would specifically request that the new director be someone with scientific qualification who could provide continuity of leadership.

#### VI. Consideration of the House Health Manpower Bill

During the course of the retreat, Dr. Cooper was informed that Mr. Rogers' health manpower bill had passed the House under a suspension of the rules by an overwhelming margin. The specific provisions of this bill were reviewed with the retreat participants and it was felt that if Mr. Rogers would agree to modifying several provisions of his bill in conference, the Association would support his bill and ask the Senate to go to conference. Provisions singled out for modification were mandatory service, enrollment increase waivers, and the requirement that 25 percent of capitation money be spent in remote educational sites.

#### VII. Study of Medical Practice Plans

Doctors Cooper, Sherman and Jolly reviewed a proposed study of practice plans in effect in all U.S. medical schools. The sensitivity and viability of the study were reviewed by the retreat. Although the retreat participants agreed that this information would be useful to the Association in establishing credibility on matters of medical school financing, it was strongly felt that this would be information which the schools and the faculty members would be reluctant to divulge. In some cases, individual salary information was not even available to the institutions.

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It was agreed that a qualitative study of the practice plans themselves would be acceptable, but a quantitative study of how much medical practice income is involved would be impractical.

#### VIII. Multimedia Learning Materials Project

Doctor Swanson reviewed the Association's collaborative activities with the National Library of Medicine in the area of cataloging and evaluating multimedia learning materials. One component of this project was to identify areas in which improved multimedia educational materials are needed. As a follow-up to this activity, the Association conducted a feasibility study of establishing a Multimedia Learning Advancement Program as a mechanism for the Association to develop the capability of influencing the production and distribution of these materials.

Support for this project would be sought from foundations and the Federal agencies. Approximately \$500,000 per year would be needed to support the Association's core activities exclusive of any project support. Doctor Swanson described the feedback loop which would enable the program to become self-supporting once distribution of the materials began.

The retreat participants agreed that this was a worthwhile project and that the Association should proceed to explore the possibility of generating outside funding. Caution was recommended over accepting a large portion of the funding from any agency which provides support for other Association activities. It was felt that these other activities should not be jeopardized in order to develop the substantial support required by this program.

#### IX. 1975 Annual Meeting

Doctor Mellinkoff suggested that the theme of the 1975 annual meeting be "Quality in Medical Education and Care." The retreat participants agreed but felt that it should be modified to cover only "Quality in Medical Education." By narrowing the theme in this way, the "continuum of medical education in the post-Flexnerian era" could be considered.

A format by which one plenary session would be devoted to this theme and one plenary session devoted to political speakers and issues was accepted. It was also agreed that the Assembly meeting should come earlier in the week and that the joint Council program should follow the final plenary session.

X. National Health Insurance and Its Effect on Medical Education

Doctor Mellinkoff proposed that the Association might wish to appoint a task force to look specifically at the educational component of national health insurance and to recommend provisions which might optimize the effect that national health insurance would have on medical education. It was suggested that each council might wish to have a task force to consider these broad questions with some provision made for coordination. The retreat participants agreed that further consideration of this would take place at the January meeting of the Executive Council.