

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

MEETING SCHEDULE  
COUNCIL OF TEACHING HOSPITALS  
ADMINISTRATIVE BOARD

June 23-24, 1976  
Washington Hilton Hotel  
Washington, D.C.

Wednesday, June 23

6:30 P.M.

Joint COTH/COD/CAS/OSR  
Administrative Board Dinner  
(Dr. Theodore Cooper)

Monroe Room

Thursday, June 24

8:00 A.M.

COTH Administrative Board  
Business Meeting  
(Coffee and Danish)

Grant Room

1:00 P.M.

Joint COTH/COD/CAS/OSR  
Administrative Board Luncheon

Hemisphere Room

Executive Council  
Business Meeting

4:00 P.M.

Adjournment

AGENDA  
COUNCIL OF TEACHING HOSPITALS  
ADMINISTRATIVE BOARD

June 24, 1976

- I. Call to Order
- II. Update on House Staff Unionization Issues Page 1 - Carl Vogt
- III. Consideration of Minutes Page 3
- IV. Membership
- A. New Application Page 11
- St. Margaret's Hospital for Women  
        Dorchester, Massachusetts
- B. Terminations
- Baptist Medical Center Page 21  
        Oklahoma City, Oklahoma
- St. Francis Hospital Page 22  
        Evanston, Illinois
- V. Distinguished Service Members Page 23
- VI. Follow-Up Items to March Board Meeting
- A. Malpractice Activities of Other Associations Page 25
- B. Member Experience Under Section 223 Regulations Page 37
- C. Survey of Hospital Ambulatory Service Deficits Page 52
- VII. COTH Nominating Committee Policy Page 53
- VIII. AAMC Response to the IOM Social Security Studies Executive Council  
Page 82
- IX. Draft Testimony on Talmadge Bill Page 57
- X. Report of the President's Biomedical Research Panel Executive Council  
Page 65
- XI. Approval of Subscribers Executive Council  
Page 21
- XII. AAMC Membership in the Federations of Associations Executive Council  
of Schools of the Health Professions Page 23

- XIII. AAMC Membership in the Biology Alliance for  
Public Affairs Executive Council  
Page 24
- XIV. Report of Joint CCME/LCGME Committee on Financing  
Graduate Medical Education Executive Council  
Page 33
- XV. Report of Joint CCME/LCGME/LCSB Committee to Consider  
the Standard Order of Procedure for Approval of  
New Specialties Executive Council  
Page 35
- XVI. Report of the Committee on Governance and Structure Executive Council  
Page 37
- XVII. LCME Guidelines to Functions and Structure of a  
Medical School Executive Council  
Page 43
- XVIII. Supplemental Guidelines for Medical Schools with  
Branch or Multiple Campuses Executive Council  
Page 61
- XIX. Report of the Department of Health Services Dr. James Hudson
- XX. Information Items
- A. Annual Meeting Program Page 84
  - B. "Graduate Medical Education Viewed from the National  
Intern and Resident Matching Program" Page 85
  - C. Supplemental Report of the Department of  
Health Services Separate Enclosure
- XXI. New Business
- XXII. Adjournment

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CARL WM. VOGT

PARTNER

June 4, 1976

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

Dear Dick:

This letter will confirm our telephone conversation last week regarding the house staff issues pending in New York.

Pursuant to your request I attended the meeting in New York on May 17, 1976 of hospital attorneys and representatives called by Bill Abelow on behalf of the League of Voluntary Hospitals. It was the consensus of the group that in the Misericordia case, no court action should be taken pending a decision by the New York State Labor Commission on the issue of state jurisdiction. Some of the hospitals and New York associations will file amicus briefs with the Commission in support of Misericordia's position that the interns and residents issue has been preempted by the National Labor Relations Board. If the Commission asserts jurisdiction, then an appeal may be taken to a New York state court. Ultimately, an action may be filed in a federal district court to enjoin the Commission from taking jurisdiction over the case.

I believe that at this time, the interests of AAMC and the hospitals would not be best served by AAMC participation in an amicus capacity before the New York Labor Commission. It is at least uncertain whether the Commission would give any particular favorable weight to the participation of a national association in a state proceeding. Some knowledgeable New York attorneys feel that there might be an adverse effect. The greatest potential impact which the AAMC can have will be in the federal courts. That impact will be enhanced if AAMC enters the case anew rather than as another unsuccessful litigant at the state level. Of course, if the issue is favorably resolved at the state level, AAMC participation will not be necessary at all.

Richard Knapp, PhD.  
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Subsequent to the New York meeting I spoke again with Ken Harfenist, counsel to Misericordia, and he is in accord with the AAMC position which I have outlined above.

As I mentioned on the telephone, Jerry Bodner of the Einstein Medical Center called to say that the CIR had filed an unfair labor practice charge with the New York Labor Commission protesting Einstein's refusal to bargain regarding fellows. The issues are essentially the same as in the Misericordia case and I believe that the AAMC would be well advised to follow a parallel course of action.

I will remain in touch with both Harfenist and Bodner and will keep you posted on any new developments. In the meantime, if you have any questions please do not hesitate to call.

Very truly yours,



Carl Wm. Vogt

CWV/kal

Association of American Medical Colleges  
COTH Administrative Board Meeting

Washington Hilton Hotel  
Washington, D.C.  
March 25, 1976

MINUTES

PRESENT:

Charles B. Womer, Chairman  
David D. Thompson, M.D., Chairman-Elect  
Sidney Lewine, Immediate Past Chairman  
David L. Everhart, Secretary  
John W. Colloton  
Leonard W. Cronkhite, Jr., M.D.  
David A. Gee  
Baldwin G. Lamson, M.D.  
S. David Pomrinse, M.D.  
John Reinertsen  
William T. Robinson, AHA Representative  
John M. Stagl

ABSENT:

Robert Heyssel, M.D.  
Stanley R. Nelson  
Malcom Randall  
Robert E. Toomey

STAFF:

James D. Bentley, Ph.D.  
Robert Carow  
Armand Checker  
James I. Hudson, M.D.  
Richard M. Knapp, Ph.D.  
Steven J. Summer  
Catharine A. Rivera

I. Call to Order:

Mr. Womer called the meeting to order at 9:00 a.m. in the Independence Room of the Washington Hilton Hotel.

II. Consideration of Minutes:

The minutes of the January 14, 1976, Administrative Board Meeting were approved as circulated.

III. Membership:

## A. Termination Letter of Church Hospital Corporation

Mr. Womer noted that the Association has been notified that the Church Hospital Corporation of Baltimore, Maryland no longer qualified for membership in COTH and consequently indicated that it will no longer retain its membership.

The Administrative Board accepted with regret Church Hospital Corporation's decision to not renew its membership in the Council.

## B. Criteria for Corresponding Membership

The COTH Administrative Board reviewed the criteria for Corresponding Membership as stated in the Executive Council agenda book. It was agreed that in addition to meeting the criteria set forth in the AAMC Bylaws, Corresponding Members should also have: (1) a documented institutional affiliation with a school of medicine for the purpose of participating in medical education; and (2) the written endorsement of the dean of the affiliated school of medicine as part of its application for Corresponding Membership.

ACTION: IT WAS MOVED, SECONDED AND CARRIED THAT THE COTH ADMINISTRATIVE BOARD APPROVE THE CORRESPONDING MEMBERSHIP CRITERIA AS SET FORTH IN THE EXECUTIVE COUNCIL AGENDA BOOK.

## C. New Application for Corresponding Member

The Board reviewed one application for Corresponding Membership and took the following action.

ACTION: IT WAS MOVED, SECONDED AND CARRIED THAT THE FOLLOWING APPLICATION FOR CORRESPONDING MEMBER IN THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES BE RECOMMENDED FOR APPROVAL TO THE EXECUTIVE COUNCIL:

THE METHODIST MEDICAL CENTER OF ILLINOIS

IV. Follow-up Items to January Board Meeting:

## A. January 30, 1976, letter to Mr. Jay Constantine

The COTH Administrative Board reviewed the letter submitted to Mr. Jay Constantine of the Senate Finance Committee staff in which the views of the Administrative Board regarding the proposed Talmadge Medicare Amendments were outlined. Dr. Knapp discussed the current status of that legislation and noted that it is now scheduled to be introduced in early April. Following the Board's discussion of the proposal, the following action was taken.

ACTION: IT WAS MOVED, SECONDED AND CARRIED THAT THE COTH ADMINISTRATIVE BOARD COMMEND THE STAFF OF THE DEPARTMENT OF TEACHING HOSPITALS ON THEIR EFFORTS IN EXPRESSING AND SUMMARIZING THE VIEWS OF THE ADMINISTRATIVE BOARD TO MR. JAY CONSTANTINE ON THE "TALMADGE" BILL.

#### B. Survey of Hospital Ambulatory Service Deficits

The Board analyzed a proposed questionnaire developed by Mr. Summer at the request of the Board. In his review of the various problems concerning development of the questionnaire, Mr. Summer noted the inconsistencies and confusion related to the comments that have been received in response to his request to the Board that they review and comment on the draft instrument. The Board recommended that staff convene a small task force to examine the questionnaire and the problems related to it in more depth, and that individuals on this task force be representative of the various viewpoints expressed by the Board members. The following specific points were also discussed:

- (1) physician services should not be included in the totals, but if possible, should be identified somewhere on the questionnaire;
- (2) to the extent possible, the instrument should utilize the Medicare cost report;
- (3) "bad debts" should be the amount reserved for bad debts rather than the actual write-off dollars; and,
- (4) respondents should be allowed to comment and elaborate on their responses.

#### C. Hospital Fiscal Indicators

Dr. Knapp called the Board's attention to his letter of February 2, 1976, to Mr. Robert E. Linde of the American Hospital Association.

#### V. AMA Request for Data:

The COTH Administrative Board reviewed the correspondence dated February 10, 1976, from the American Medical Association requesting information on the Department's Survey of House Staff Collective Negotiations. In addition, the Board discussed Dr. Knapp's response to Mr. Burrows dated February 26, 1976, and noted their agreement with the contents and thrust of Dr. Knapp's letter. The Board reiterated its policy of not permitting release of information submitted by individual COTH members and reaffirmed the fact that this information should not be distributed without the prior approval and knowledge of the membership.



VI. Review of IOM Social Security Studies:

Dr. Knapp introduced the Report on "Medicare Medicaid Reimbursement Policies" as recently completed by the Institute of Medicine. The Association, he noted, has formed an ad hoc committee to review the report and in addition, each Administrative Board has been requested to offer comments. It was pointed out that the Association's recommendations will be forwarded to the Senate Finance Committee and the House Ways and Means Committee for consideration. Because of the delays in processing these comments and with the time needed to introduce an amendment, it is expected that Section 227 will be postponed for at least three months.

Mr. Colloton presented the preliminary thoughts of the ad hoc committee's deliberations for the Board's consideration. Subsequent to this discussion, the Board reviewed each recommendation as contained in the IOM Report and offered the following comments:

I. Cost Based Reimbursement

The Board members expressed some concern over what is to be included in the definition of "costs" and stated that costs should reflect the true reasonable costs which the institution incurs. Additionally, there were some questions raised as to how payment for volunteer services is to be handled and what the impact of segregated settings would be. It was suggested that with proper clarification of the above points, the Board would not object to a cost-based reimbursement as an alternative method of payment.

II. Unified Reimbursement Method

The Board raised some questions about this recommendation in that it infers that medical education is not an institutional cost, and that it may cause conflict between house staff and teaching physicians. However, the Board, in stating their reservations, did not object to the method for use in those circumstances where it does not detract from or reduce the educational focus of graduate medical education programs.

III. Fee Based Payment

This particular section of the report received the most intensive discussion. The recommendation in question reads as follows:

Guidelines for a fee-based method of payment should include:

Phasing out cost-reimbursement for supervisory and teaching services in teaching hospitals where fees are paid, over a two-year period at the rate of 50 percent per year. At the close of the two-year period, no cost-reimbursement would be allowed for:

- Supervision or teaching of house officers, except the director of medical education as noted below;
- Regular or routine teaching physician service on general care nursing units; and,

- Administrative services of teaching physicians, except where there is a written agreement defining the specific services to be performed; for example, director of medical education, administration of a pulmonary function laboratory, or the like.

While there was some disagreement over the interpretation of this recommendation there was consensus that the thrust of the position is to:

- (1) disallow payment for specific teaching time devoted to residents, except in very limited circumstances;
- (2) disallow reimbursement for supervision of house officers if patients were being billed a fee by a supervising physician;
- (3) requiring written agreement before administrative services of teaching physicians would be reimbursed.

The extent to which institutions represented at the Board meeting rely on reimbursements which could be disallowed if this recommendation were adopted was variable. Some hospitals receive no reimbursement for these services while others rely heavily on dollars generated for these services. The Board did not come to any firm position on this issue, and the Chairman agreed to present both sides of the issue at the Executive Council meeting.

A second issue which received thorough discussion concerning this recommendation is expressed by the following statement in the report: "Mixed and geographic settings for different payment methods within a hospital would not be recognized." It is clear that the objective of this recommendation is to achieve a single standard of care and single reimbursement method at least within each teaching hospital. There was no disagreement with this objective; however, there was concern expressed about the ability of some institutions to meet this objective in the immediate future.

IV. The COTH Administrative Board did not disagree with the IOM's recommendation to initiate demonstration and experimentation programs on variations of the proposed payment methods.

V. The COTH Administrative Board supported the IOM recommendation postponing implementation of Section 227 of P.L. 92-603.

VI. The Board supported the IOM recommendation that there be more uniform treatment of payment for teaching physicians by state Medicaid programs and other third party payors.

The Board noted that while there was need for additional clarification, on the whole the report does reflect the situation as it exists in teaching hospitals. Because of the multitude of situations throughout the country,

the Board agreed that is difficult to evaluate the true dollar impact of the recommendations. It was suggested that the AAMC consider convening regional meetings to better explain the Report to the constituency.

Dr. Lamson briefly reported on the four chapters devoted to the problems of geographic and specialty distribution. He stated that these chapters are well done and worth reading. While he felt that the chapters did not seem to support some of the manpower recommendations, he did not believe that the AAMC should quarrel over this. As a final point he quoted the following sentence as one about which there ought to be concern: ". . . there is not a direct relationship between the services generated by the health care system and the health status of the population it serves."

ACTION: IT WAS MOVED, SECONDED AND CARRIED THAT THE BOARD'S COMMENTS ON THE INSTITUTE OF MEDICINE STUDY BE BROUGHT TO THE EXECUTIVE COUNCIL FOR CONSIDERATION AND THAT THE BOARD MEMBERS BE GIVEN AN OPPORTUNITY TO REVIEW THE FINAL DOCUMENT BEFORE IT IS SUBMITTED TO THE TWO CONGRESSIONAL COMMITTEES.

VII. Correspondence with the Wyatt Company on Malpractice Exposure of Faculty Physicians:

Dr. Knapp explained the genesis of the Association's communications with the Wyatt Company and noted that the information gathered from such a survey might prove useful to the membership. Two specific points must be addressed, he stated: (1) what is the Board's reaction to the preliminary data; and (2) does the Board wish to consider a recommendation expanding these efforts. Additionally, if the Association sees value in the study, it may want to recommend that the members participate in such an expanded survey, regardless of whether the Association is involved.

The Administrative Board noted such problems as inconsistent definitions and the fact that some states have differing situations depending upon their state malpractice statutes. However, the Board agreed that such information, while useful, may already be available elsewhere. Mr. Robinson, AHA representative to the Board, mentioned AHA efforts to study the problem. Mr. Stagl suggested that the Association focus on the specific problems and characteristics of teaching hospitals and that the Association not duplicate the work of others in this area.

ACTION: IT WAS MOVED, SECONDED AND CARRIED THAT THE DEPARTMENT OF TEACHING HOSPITALS STAFF INVESTIGATE THE EXTENT TO WHICH OTHER ORGANIZATIONS SUCH AS THE AMERICAN HOSPITAL ASSOCIATION AND THE AMERICAN MEDICAL ASSOCIATION HAVE UNDERTAKEN OR IDENTIFIED STUDIES OF THE PRESENT PROBLEM WITH RESPECT TO MALPRACTICE AND LIABILITY INSURANCE AS IT PERTAINS TO THE TEACHING HOSPITAL. THE BOARD REQUESTED THE STAFF TO REPORT AT THE JUNE MEETING AS TO PROGRESS IN THE AREA.

There was no objection to the AAMC encouraging medical schools to participate in the current Wyatt Company survey.

Minutes/7

VIII. LCME Guidelines for Functions and Structures of a Medical School:

The COTH Administrative Board reviewed the Liaison Committee on Medical Education guidelines as enclosed in the Executive Council agenda. While not disagreeing with the general nature of the guidelines, the Board did suggest that some of the wording may be altered. For example, the Board suggested that on page 2 of paragraph 2, the statement regarding "faculty's primary responsibility to the medical school," could be re-phrased. It was recommended to the staff that the guidelines be closely examined so as to remove any similar objectionable phrases.

IX. Criteria for Subscribers:

The COTH Administrative Board reviewed the recommended criteria for Subscriber Membership in the AAMC and took the following action.

ACTION: IT WAS MOVED, SECONDED AND CARRIED THAT THE COTH ADMINISTRATIVE BOARD RECOMMEND APPROVAL TO THE EXECUTIVE COUNCIL OF THE CRITERIA FOR SUBSCRIBERS.

X. Approval of Subscriber Member:

The COTH Administrative Board reviewed the two applications for Subscriber status which the Association has received. Since both applications appear to meet the criteria for Subscribers, the COTH Administrative Board took the following action.

ACTION: IT WAS MOVED, SECONDED AND CARRIED THAT THE COTH ADMINISTRATIVE BOARD RECOMMEND APPROVAL OF SUBSCRIBER STATUS FOR EAST CAROLINA UNIVERSITY SCHOOL OF MEDICINE AND TEXAS A & M BAYLOR COLLEGE OF MEDICINE.

XI. Admission of Women to Medical School:

The Board reviewed the Association's revised policy statement on admission of women to medical school and took the following action.

ACTION: IT WAS MOVED, SECONDED AND CARRIED THAT THE COTH ADMINISTRATIVE BOARD VOTE TO APPROVE THE AAMC REVISED STATEMENT ON ADMISSION OF WOMEN TO MEDICAL SCHOOL.

XII. Report of the Task Force on Continuing Medical Education:

Dr. Emanuel Suter, Director of the AAMC Division of International Medical Education, reviewed for the Board a report of the Task Force on Continuing Medical Education. He emphasized the importance of these efforts for the Association and elaborated on various mechanisms which the Task Force has recommended by which the Association could respond to the issue of continuing medical education.

Recognizing that there is a need for a forum for discussion of continuing medical education, the Board suggested that the AAMC Committee on Governance may be the most appropriate mechanism for considering this issue. Since the AAMC Committee on Governance was developed for the purpose of looking at AAMC structure, the Administrative Board recommended that the Association defer the decision concerning creation of a group on continuing medical education, pending the committee's evaluation. Following further discussion of the Task Force on Continuing Medical Education Report, the Board took the following action.

ACTION: IT WAS MOVED, SECONDED AND CARRIED TO RECOMMEND THAT THE EXECUTIVE COUNCIL DEFER CREATION OF A GROUP ON CONTINUING MEDICAL EDUCATION AND THAT THE RECOMMENDATION OF SUCH A GROUP BE SUBMITTED TO THE AAMC COMMITTEE ON GOVERNANCE. THE BOARD FURTHER RECOMMENDS THAT THE EXECUTIVE COUNCIL APPOINT AN AD HOC COMMITTEE ON CONTINUING MEDICAL EDUCATION TO RECOMMEND TO THE EXECUTIVE COUNCIL POLICIES FOR PROMULGATION AT THE NATIONAL LEVEL AND THAT ASSIGNMENT OF STAFF RESOURCES TO CONTINUING MEDICAL EDUCATION PROGRAMS BE APPROVED.

XIII. Governmental Cognizance of the Institutional Well-Being of Academic Medical Centers:

Dr. Knapp reviewed the background of the statement contained in the Executive Council agenda book concerning the Federal Government's responsibility or lack thereof, for institutional well-being of academic medical centers. He also noted that in recent times due to the increasing extent of Federal regulations, that the situation has become much more difficult.

The COTH Administrative Board suggested that instead of the term institutional "well-being" that the term "integrity" be substituted. The Board also suggested that this would be an appropriate topic for the Citizens Advisory Group to discuss and that the Association's letter to Dr. Ted Cooper concerning the DHEW Forward Plan for Health FY 1977-81, also concerns this subject.

XIV. Adjournment:

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

St. Margaret's Hospital For Women

HOSPITAL NAME

90 Cushing Avenue

STREET

Dorchester

CITY

Massachusetts

STATE

02125

ZIP CODE

617-436-8600

TELEPHONE NUMBER

Chief Executive Officer

Sister Mary Bernadette Doyle

NAME

Administrator

TITLE

Date hospital was established: Incorporated--October, 1874

APPROVED FIRST POSTGRADUATE YEAR

TYPE <sup>2</sup>	Date of Initial Approval by CME of AMA**	Total F.T.E. <sup>1</sup> Positions Offered	F.T.E. <sup>1</sup>	F.T.E. <sup>1</sup>
			Total Positions Filled by U.S. And Canadian Grads	Total Positions Filled by F.T.E.'s
Flexible				
Categorical				
Categorical*	<u>1975</u>	<u>18</u>	<u>13</u>	<u>5</u>

\*\* 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.)

Specialty	Date of Initial Approval by CMA of CMA**	Total F.F.E. Positions Offered	Total Positions Filled by U.S. And Canadian Grads	Total Positions Filled by U.S. Grads
Internal Medicine				
Surgery				
Ob-Gyn	12/55	19	13	5
Pediatrics				
Psychiatry				
Family Practice				
Other (List):				

\*Pediatric residency from Floating Hospital & Tufts University rotating through St. Margaret's

II. PROGRAM DESCRIPTION

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

- Extent of activity for undergraduate medical education students (e.g., number of clerkships offered; number of students participating; proportion of medical staff time committed to medical students).
- Presence of full-time salaried chiefs of service and/or Director of Medical Education (e.g., departments which have salaried chiefs; hospital chiefs holding joint appointments at medical school).
- Dimension of hospital's financial support of medical education costs and nature of financial agreement with medical school (e.g., dollars devoted to house staff salaries and fringe benefits; the percentage of the hospital's budget these dollars represent; hospital's contribution to cost of supervising faculty; portion of service chiefs' costs paid by the hospital).
- Degree of affiliated medical school's involvement in and reliance upon hospital's education program (e.g., medical school faculty participation in hospital activities such as in-service education, conferences or medical staff committees).

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

III. LETTER OF RECOMMENDATION

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

enclosed

Name and Address of Affiliated School of Medicine: Tufts University School of Medicine

136 Harrison Avenue, Boston, MA 02111

Name of Dean: Lauro F. Cavazos, Ph.D.

Information Submitted by:

Sister Mary Bernadette Doyle Administrator

NAME

TITLE OF PERSON SUBMITTING DATA

4/12/76

DATE

SIGNATURE OF HOSPITAL CHIEF EXECUTIVE

*Sister Mary Bernadette Doyle*

ASSOCIATION OF AMERICAN MEDICAL COLLEGES - COUNCIL OF TEACHING HOSPITALS

Application for Membership

II. PROGRAM DESCRIPTION

A. We have four Ob-Gyn medical students on clerkships each month (48 per year) plus we offer one elective per month (12 per year). Staff time committed to teaching of students amounts to approximately six hours weekly per staff doctor.

B. Presence of full-time salaried chiefs' of service and/or Director of Medical Education.

Edward C. Kelley, Jr., M.D. -- Director of Medical Education and Chief of Ob/Gyn-non-salaried chief.

Joseph L. Kennedy, Jr., M.D. Chief of Neonatology, Director of Nurseries, Neonatologist--responsible for teaching: full-time salaried.

Marguerite Herschel, M.D. Assistant Director of Neonatology, full-time salaried

Curtis L. Cetrulo, M.D. Director of Maternal Fetal Medicine, full-time salaried

Robert Driscoll, M.D. Chief Pediatrics, non-salaried

All the above have joint appointments at Medical School.

C. Dimension of hospital's financial support of medical education costs and nature of financial agreement with medical school.

\$185,000. House staff salaries and fringe benefits;

1.64% Percentage of the hospital's budget above represents

\$ 75,000. Portion of service chiefs' costs paid by the hospital

D. 50% of Tufts Medical School's third year class is dependent upon St. Margaret's Hospital for educating the students. We have a full-time Assistant Professor of Obstetrics and Gynecology, Curtis L. Cetrulo, M.D. who spends at least four (4) hours weekly teaching the students. They have assignments on obstetrics and gynecology in both the inpatient and outpatient areas, Monday through Friday during their education programs of the attending medical staff as well as meetings of the house officers.

In order to give you an idea of the medical education program here at St. Margaret's Hospital we have enclosed a monthly calendar of our educational program.



NOTE:

St. Margaret's Hospital is responsible for providing neonatal intensive care experience for house staff from Tufts New England Medical Center at the PL-1 and PL-3 levels. Their entire experience is a learning one.

The PL-1 students are also taught normal newborn management in nurseries and out-patient department.

A PL-2 and PL-3 resident from St. Elizabeth's Hospital Pediatric Residency Program receives both intensive care and normal newborn experience.

Two neonatal fellowships (clinical) are offered at the PL-4 and PL-5 level.

Anesthesia residents requiring obstetrical experience as part of their learning process, receive experience at St. Margaret's.

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
			8:15 Disc. House Pts. Resident Case Pre. 11:30 High Risk Clinic 3:00 Resident's Conf.	8:15 Disc. House Pts. 11:00 Ob Stat Mtng. 2:00 Pathology Conf. CARNEY	9:00  Diagnosis and Treatment of retal Distress includ- ing Scalp Sampling  Dr. Curtis L. Cetrulo SM
8:15 Disc. House Pts. 3:00 Resident's Conf.  *Dr. Duncan	8:15 Disc. House Pts. 11:00 Pathology Conf. SMH 3:00 Resident's Conf.	8:15 Disc. House Pts. 9:00 Ped., Path., Obs. Mtng. 11:00 *Dr. McMahon's Conf. 12:00 Research Dept. Mtng. 1:00 Tumor Clinic NECH	8:15 Disc. House Pts. Resident Case Pre. 11:30 High Risk Clinic 3:00 Resident's Conf.	8:15 Disc. House Pts. 11:00 GYN Mtng. then Ob Stat Mtng.	9:00  Stress and Continece  Dr. Douglas Marchant NECH
8:15 Disc. House Pts. 3:00 Resident's Conf.  *Dr. Fallon	8:15 Disc. House Pts. 11:00 Child. Advoc. Group OPD 3:00 Resident's Conf.	8:15 Disc. House Pts. 11:00 *Dr. McMahon's Conf. 12:00 Research Dept. Mtng. 1:00 Tumor Clinic CARNEY	8:15 Disc. House Pts. Resident Case Pre. 11:30 High Risk Clinic 3:00 Resident's Conf.	8:15 Disc. House Pts. 11:00 Ob Stat Mtng. 2:00 Pathology Conf. CARNEY	No Conference
8:15 Disc. House Pts. 11:00 Pathology Conf. SMH 3:00 Resident's Conf.  *Dr. Fanous	8:15 Disc. House Pts. 11:00 Pathology Conf. SMH 3:00 Resident's Conf.	8:15 Disc. House Pts. 9:00 Pediatric Speaker Conf. 11:00 *Dr. McMahon's Conf. 12:00 Research Dept. Mtng. 1:00 Tumor Clinic NECH	8:15 Disc. House Pts. Resident Case Pre. 11:30 High Risk Clinic 3:00 Resident's Conf.	8:15 Disc. House Pts. 11:00 Ob Stat Mtng.	9:00  Diagnosis and Management of Cardiac Arrythmias  Dr. Philip Doherty CARNEY
8:15 Disc. House Pts. 3:00 Resident's Conf.  *Dr. Farid	8:15 Disc. House Pts. Executive Comm. Mtng. 3:00 Resident's Conf.	8:15 Disc. House Pts. 11:00 *Dr. McMahon's Conf. 12:00 Research Dept. Mtng. 1:00 Tumor Clinic CARNEY	8:15 Disc. House Pts. Resident Case Pre. 11:30 High Risk Clinic 3:00 Resident's Conf.	8:15 Disc. House Pts. 11:00 Ob Stat Mtng. 2:00 Pathology Conf. CARNEY	

\*Denotes Mat. or Service  
 Please note the following: Dr. McMahon's Conf. and High Risk Clinic are held in the Clinic Conf. Room.  
 Ob Stat Mtngs. are held in the McSweeney Lecture Hall - Research Dept. Mtngs. and Tues. Morning Path. Conf. are held in  
 the Pathology Conf. Room. All others are held in the McSweeney Lecture Hall, unless otherwise stated.  
 PLEASE NOTE: THE PLOON CONFERENCE ROOM IS NO LONGER USED FOR MEETINGS.

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OFFICE OF THE DEAN

TUFTS UNIVERSITY  
SCHOOL OF MEDICINE

136 HARRISON AVENUE  
BOSTON, MASSACHUSETTS 02111

April 8, 1976

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

Dear Dr. Cooper:

I am writing to support the application of St. Margaret's Hospital for Women, Boston, Mass. for membership in the Council of Teaching Hospitals. St. Margaret's Hospital is our parent associated hospital for the teaching of obstetrics and gynecology and the care of newborn infants to medical students. At the present time, there are approximately 40 students at St. Margaret's per year. Additionally, the attending staff of St. Margaret's are members of the faculty of Tufts University School of Medicine.

In addition to the education of Tufts medical students, this hospital serves to educate residents. Residents from the Boston Floating Hospital, (the pediatric hospital of the New England Medical Center Hospital) rotate through this hospital under the direction of a full-time neonatologist. Additionally, there are active research programs involving Tufts faculty investigating the immunology of pregnancy.

St. Margaret's Hospital for Women has played an important role in the development of the educational program at Tufts. We strongly support their application as members of the Council of Teaching Hospitals of the Association of American Medical Colleges.

Sincerely yours,

Lauro F. Cavazos, Ph.D.  
Dean

LFC:et

AGREEMENT FOR AFFILIATION

THIS AGREEMENT made effective as of the date of signing  
by and among the following parties:

- a. Trustees of Tufts College, Medford, Massachusetts,  
hereinafter referred to as the "University," acting  
primarily with reference to and on behalf of its  
School of Medicine, Boston, hereinafter referred to  
as the "School"
- b. St. Margaret's Hospital, Dorchester
- c. Carney Hospital, Dorchester-Department of Gynecology
- d. New England Medical Center Hospitals, Boston-  
Department of Gynecology

WHEREAS, all of these institutions are voluntary non-profit  
institutions organized and existing under the laws of the  
Commonwealth of Massachusetts, and

WHEREAS, the University operates a Medical School for the  
purpose of providing medical, and related education and medical  
care and conducting research and other activities incident to  
the proper operation of a high quality school of medicine, all  
as provided by charter from the Commonwealth of Massachusetts;  
and

WHEREAS, St. Margaret's Hospital, Carney Hospital and the New  
England Medical Center Hospitals are organized and established  
to provide responsible health care services for those seeking  
these services within the institutions and their related  
communities, as well as providing an atmosphere for continuing  
education and the pursuit of research activities, and

WHEREAS, each of the parties to this agreement recognized a common purpose in establishing a residency program in Obstetrics and Gynecology in these hospitals for training and education in these branches of medicine and desire to affiliate and associate themselves for the attainment of this common purpose,

WHEREFORE, all parties to this agreement hereby covenant and agree to and with each other as follows:

FIRST: The title of the residency program shall be Tufts University School of Medicine Affiliated Residency in Obstetrics and Gynecology.

SECOND: In the conduct of the residency program in Obstetrics and Gynecology, St. Margaret's Hospital will be the parent hospital. Decisions pertaining to the residency program shall not be made unilaterally, but joint action of a committee which shall be comprised of the individuals holding the following positions:

1. Director of the subject program, who shall be the chairman of the Department of Obstetrics and Gynecology at the School.
2. Assistant Director of the subject program in each participating hospital.

The position of Assistant Director of the subject program in each hospital shall be filled by a salaried full or part time physician or by the Chief of Service.

THIRD: For matters pertaining to general administration and/or fiscal operation of the subject program which may be of common concern to the parties hereto, authorized representatives of the parties hereto will join in making decisions relative to such matters.

FOURTH: The autonomy of each hospital will be safeguarded. The internal management of each institution will continue according to its own philosophy and policies, providing, however, that such philosophy and policies are consistent with the maintenance of a proper medical education environment.

FIFTH: Each hospital will continue to appoint its staff in accordance with its own by-laws. However, appointments to the teaching staff of each hospital's Department of Obstetrics and Gynecology must be initiated and approved by the University.

SIXTH: All residents will rotate through the three institutions according to a pre-determined and educationally sound plan which must be consistent with the maintenance of a proper medical education environment.

SEVENTH: The School shall have representation on any ad hoc committee charged with recommending a candidate for a full time clinical teaching position in, or as Assistant Director of, the subject program in the Department of Obstetrics and Gynecology of a participating hospital.

EIGHTH: The recommendation of any ad hoc committee regarding a candidate for a full time clinical teaching position in, or as Assistant Director of, the subject program in the Department of Obstetrics and Gynecology of a participating hospital shall be final and not subject to change by any party nor a member of such ad hoc committee. However, if the designated candidate does not receive the approval of the board of trustees of the participating hospital and of the University, the ad hoc committee shall reconsider its selection, and either present further justification for its selection or present another candidate. Nothing in this paragraph shall be considered to be a limitation or modification of the right of the University to initiate and approve appointments to the teaching staff of each hospital's Department of Obstetrics

and Gynecology, as provided for in paragraph fifth.

NINTH: If in the future additional clinical facilities of these or other institutions become available, consideration may be given to their inclusion in the program.

TENTH: This agreement shall continue in effect indefinitely respect to the parties signatory hereto, except that any party may withdraw on July 1 of any year by giving no less than twelve months prior notice of its intention to do so in writing to each of the other parties.

IN WITNESSESS WHEREOF, the parties have set their hands this

February 3 day of 1957

Trustees of Tufts College

By Robert C. Hascove  
(President)

Tufts University School of Medicine

By William M. ...  
(Dean)

St. Margaret's Hospital

By Sister Beatrice Peck, Abbot

Carney Hospital

By Sister ...

New England Medical Center Hospitals

By John Foster

BAPTIST MEDICAL CENTER • 3300 NORTHWEST EXPRESSWAY • OKLAHOMA CITY, OKLAHOMA 73112

May 5, 1976

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

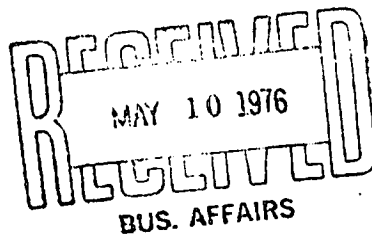
Gentlemen:

Enclosed please find your invoice to Baptist Medical Center for membership dues in your organization for the year July 1, 1976 through June 30, 1977. We have decided to discontinue membership in the Association for the present time. Please consider this to be formal notice of such cancellation.

Sincerely yours,

*James L. Henry*  
James L. Henry  
President

jh



AREA CODE (405) 946-6414



TELEPHONE  
(202) 466-4657

INVOICE

PLEASE REFER TO  
THIS NUMBER IN  
ALL CORRESPONDENCE  
ABOUT ORDER

No. 82094

# ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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

BILL  
TO

St. Francis Hospital  
Sister M. Alfreda, President  
355 Ridge Avenue  
Evanston, IL 60202

SHIP  
TO

(Same as BILL TO unless indicated)

DATE  
5-3-76

PURCHASE ORDER NO.

RE:

QUANTITY	DESCRIPTION	AMOUNT	
		Unit	Total
	Teaching Hospital Membership Dues for the period July 1, 1976 through June 30, 1977		\$1,000.00

755 7919 205

*Please Cancel  
Membership*

*Sister M. Alfreda  
Pres.*

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ASSOCIATION OF AMERICAN MEDICAL COLLEGES

BYLAWS

I. MEMBERSHIP

Section 1. There shall be the following classes of members, each of which that has the right to vote shall be (a) an organization described in Section 501 (c) (3) of the Internal Revenue Code of 1954 (or the corresponding provision of any subsequent Federal tax laws), and (b) an organization described in Section 509 (a) (1) or (2) of the Internal Revenue Code of 1954 (or the corresponding provisions of any subsequent Federal tax laws), and each of which shall also meet (c) the qualifications set forth in the Articles of Incorporation and these Bylaws, and (d) other criteria established by the Executive Council for each class of membership:

- A. Institutional Members - Institutional Members shall be medical schools and colleges of the United States.
- B. Affiliate Institutional Members - Affiliate Institutional Members shall be medical schools and colleges of Canada and other countries.
- C. Graduate Affiliate Institutional Members - Graduate Affiliate Institutional Members shall be those graduate schools in the United States and Canada closely related to one or more medical schools which are institutional members.
- D. Provisional Institutional Members - Provisional Institutional Members shall be newly developing medical schools and colleges of the United States.
- E. Provisional Affiliate Institutional Members - Provisional Affiliate Institutional Members shall be newly developing medical schools and colleges in Canada and other countries.
- F. Provisional Graduate Affiliate Institutional Members - Provisional Graduate Affiliate Institutional Members shall be newly developing graduate schools in the United States and Canada that are closely related to an accredited university that has a medical school.
- G. Academic Society Members - Academic Society Members shall be organizations active in the United States in the professional field of medicine and biomedical sciences.
- H. Teaching Hospital Members - Teaching Hospital Members shall be teaching hospitals in the United States.

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

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

Section 3. Election to membership:

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

RECOMMENDATION:

It is recommended that the following individuals be nominated as Distinguished Service Members by the Council of Teaching Hospitals:

Stanley Ferguson

T. Stewart Hamilton, M.D.

## Malpractice Activities of Other Associations

At its March, 1976 meeting, the COTH Administrative Board directed the staff of the Department of Teaching Hospitals to investigate the extent to which other organizations have undertaken studies of professional liability insurance, particularly studies pertaining to teaching hospitals. This report summarizes discussions with representatives of the American Hospital Association, the American Medical Association, Marsh and McLennan risk management consultants, the American Bar Association, and the National Association of Insurance Commissioners. The report includes a proposed questionnaire on malpractice insurance coverage and costs for university-owned hospitals, and it concludes with a discussion of specific teaching hospital issues.

### American Hospital Association

The AHA initially expanded its interest and activity in malpractice insurance and risk management when major insurance carriers, including Argonaut and St. Paul Fire and Marine, indicated they intended to stop underwriting professional liability insurance for hospitals. Faced with the situation of insurance unavailability, the original focus of AHA activities was to prepare for and establish a captive corporation capable of underwriting malpractice insurance. Working with Marsh and McLennan risk management consultants, the AHA has established a shell corporation, the Health Providers Insurance Company (HPIC). Actuarial, legal, and organizational work required to incorporate and operate HPIC has been completed. Two separate seminars involving a total of 54 hospitals have been held in cooperation with Marsh and McLennan to develop and refine a questionnaire for HPIC to use in determining premiums for individual hospitals. Because hospital malpractice insurance remains generally available through casualty insurers or state hospital association captives, and because the AHA has no evidence that HPIC could underwrite malpractice coverage at rates significantly below those presently available to hospitals, the AHA Board of Trustees has not activated HPIC. It is the Board of Trustees' present policy that HPIC will not be activated until the following conditions are met: (1) two or more state hospital associations report that hospital malpractice insurance in their states is either unavailable or available only at exorbitant rates; (2) at least one-hundred hospitals are involved; (3) the hospitals involved have a total of at least 10,000 beds; and (4) the hospitals involved have a potential initial total premium of at least \$5 million.

Having placed HPIC on hold, the AHA's malpractice activities are presently directed at five additional topics. First, with some assistance from Marsh and McLennan, the AHA is presently examining the actuarial, legal and organizational issues of establishing a captive re-insurance company. This company would not underwrite hospitals as primary insurers. Rather, the company would re-insure other primary insurers such as state hospital association

captives. Action on this proposed re-insurance company is limited because the AHA does not want to reduce presently available excess and re-insurance by seeking a separate underwriting commitment in the London market.

Secondly, the AHA, especially its Washington Office, is actively seeking BHI approval of changes in Medicare's treatment of self-insurance reserves. This effort to have BHI recognize payments to self-insurance reserves as hospital costs has already taken eighteen months. To date, Baylor University Medical Center and Humana, Inc. have obtained private "approval" from BHI for self-insurance programs; however, in each case, corporate attorneys have found BHI's letter so vague and uncertain that self-insurance has not been undertaken. AHA staff understands Mr. Tierney has the changes in BHI policy on his desk, and they are actively encouraging him to approve and publish the changes as soon as possible.

Third, the AHA has developed -- with the assistance of specially retained legal counsel, Mr. James Ludlam -- model laws and administrative procedures for use in revising and amending state statutes concerning professional liability. This manual, which is regularly revised and updated, has had significant impact in states where hospital associations and medical societies jointly and cooperatively support recommended changes.

Fourth, the AHA is initiating a series of regional conferences on safety and risk management in hospitals. The major objective of these conferences is to inform hospital administrators and their staffs of actions they can take to minimize and actively manage hospital risks, including professional liability. The initial eight conferences will be held from June through August of this year. The AHA, in seeking to expand this education and training approach to risk management, is presently discussing future conference ideas with the American Medical Association and the American College of Surgeons.

Lastly, as more fully discussed below, the AHA is actively working with the National Association of Insurance Commissioners to establish an accurate and complete data base on closed malpractice claims against physicians and hospitals.

In summary, while the AHA staff is actively pursuing several aspects of the malpractice problem, its focus is industry-wide. They have collected some very limited data on teaching hospitals in conducting their activities; however, their consultant believes such data is based on too small a sample to be statistically stable or reliable for comparative studies.

#### American Medical Association

Professional liability insurance for medical practitioners reached a critical state approximately one-year before severe hospital problems were encountered. In addition to substantially increased premiums, physicians in several states and communities were confronted by carriers withdrawing from the malpractice market. Unlike the hospital market,

where most states retained at least one carrier, physicians in some areas were left with no carrier. The AMA response to these developments was to encourage the development of Joint Underwriting Associations (JUAs) and to seek changes in each state's tort liability system. The AMA hoped JUAs, in which each casualty carrier licensed to sell insurance in the state shares a portion of the malpractice risk, would solve the problem of insurance availability. To date, the AMA and constituent societies have had several bad experiences with JUAs. It's difficult to positively determine who is responsible in a specific situation for a claim; it's hard to identify which carrier to work with, and most of the JUA legislation expires at the end of two years.

Given the undesirable JUA experience and given the present existence of at least fifteen physician-owned companies writing professional liability insurance, the AMA Board of Trustees voted unanimously on May 14th to authorize the Association's Executive Vice President to apply for a Certificate of Authorization from the Illinois Insurance Department as the first step in going operational with a captive re-insurance company. The new company, called American Medical Assurance Company, is to be capitalized with \$2 million of existing AMA funds. It is proposed that physician-sponsored companies seeking re-insurance from AMACo will initially pay a one-third extra premium as a secondary debenture to provide the company with surplus funds. The Certificate of Authorization which the AMA is seeking would establish AMACo with a multi-line charter permitting it to write primary coverage in addition to re-insurance. The company is currently being operationalized, and the AMA is seeking a management company to operate AMACo under contract.

AMA efforts to modify state tort statutes have had mixed success. While several states have revised tort statutes, some of the changes have been rejected by the courts. The AMA is working with the AHA to establish a single model statute for state society use.

Lastly, the AMA Center for Research and Development has been authorized by the Association's Board of Trustees, to serve as a clearinghouse on malpractice surveys and studies. Because this effort is just beginning, the AMA does not have general or teaching institution data to share at present. They have, however, promised to keep the Department of Teaching Hospitals informed as data collection proceeds and to share appropriate data with the AAMC.

#### Marsh and McLennan

Under the direction of Mr. Thomas Tucker, Marsh and McLennan is a risk management and actuarial consultant to the AHA, the AMA and several state societies and associations. In discussing presently available malpractice claims and premium data, Mr. Tucker was reluctant to describe any of it as very good. In his professional judgment, he finds most studies include

too few hospitals to be statistically meaningful. While stating the AHA and Pennsylvania Hospital Association studies of 54 and 140 hospitals, respectively, are useful for designing and refining rating questionnaires, he argued against using either to develop claims or premium data for teaching hospitals. He was, however, enthusiastic about long-run prospects for data from the National Association of Insurance Commissioners.

#### American Bar Association

Under the direction of Lyman M. Tondel, Jr., of New York City, the ABA has established a multidisciplinary Commission on Medical Professional Liability. The Commission -- funded by the ABA, Chicago Community Trust, Commonwealth Fund, and DHEW -- includes only one hospital "spokesman," James Ludlam, counsel for the California Hospital Association and consultant to the AHA.

"The Commission's primary objective is to identify the underlying problems that have caused the medical malpractice insurance crisis and to recommend means for meeting them.

The Commission initially gave priority to proposed changes in the tort system because they were actively being considered by the various States as possible means of easing the situation. While some such changes would appear to be improvements in court procedure, and a few might prove significant after some years, it is in the Commission's tentative view that for the foreseeable future, changes in the tort law system are not likely to meet the underlying problems or bring about reduced insurance premiums. This is because most such proposed changes, even if beneficial, would not have significant impact on malpractice claim statistics, and the extent of the impact of those few that might be significant will not be known for some years.

Accordingly, the Commission is now stressing other measures, including efforts to find insurance mechanisms to reduce premiums. All such efforts are greatly handicapped by the lack of adequate data as to past experience. Current statistical data is now being collected on a more detailed basis but such data will not be very useful until it reflects a significant period of time."  
(Information Report, ABA, January 5, 1976)

The Commission expects to present another progress report in August and will include the AAMC in its distribution.

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### National Association of Insurance Commissioners

In reviewing and regulating malpractice insurers, state insurance commissioners have been handicapped by the lack of appropriate data on malpractice claims. To correct this situation the commissioners, with the assistance of their association, are requiring malpractice carriers to provide NAIC with detailed information on professional liability claims closed after July 1, 1975. The AHA, AMA and Marsh and McLellan expect this NAIC data base will provide definitive information that is statistically stable at the end of about three years. While the data base was initially designed to collect closed claims data on physicians, it has been expanded to include key hospital data. The AHA is actively encouraging NAIC to expand its collection of data on hospitals.

Hospital participation in medical education is not presently being reported on closed claim data to NAIC, and the AHA is not proposing adding this variable to the NAIC data. While March and McLennan believes that COTH might be successful in adding this variable, Mr. Tucker does caution that once included it will stay. Thus, if teaching hospital experience is comparatively favorable, the Insurance Services Office (ISO) which calculates rates can be expected to provide teaching hospitals with a favorable credibility factor. On the other hand, if the NAIC shows teaching hospital claims are more frequent or higher or both, ISO will include an unfavorable factor until several studies show otherwise.

### University-Owned Malpractice Questionnaire

University-owned hospitals frequently include a substantial number of clinical faculty as named insureds in their professional liability policies. This significantly increases malpractice premiums above those for the hospital industry generally. To provide university hospital directors with more information for use in negotiating policy coverage and costs, Mr. Charles O'Brien, Administrator at Georgetown University Hospital, has proposed that the Department of Teaching Hospitals conduct a study of malpractice insurance in university-owned hospitals. Department staff have designed and pretested a questionnaire (see Appendix A) at four university-owned hospitals. All institutions completed the questionnaire and were willing to share aggregate data with other hospitals.

### Teaching Hospital Issues

In discussing the malpractice problem with those working in this area, six specific teaching hospital issues have been identified:

1. Higher premiums. Teaching hospitals do have consistently higher premiums; however, it is Marsh and McLennan's finding that this is appropriate. Most non-teaching hospitals have only a few, if any, physicians included as named insureds in the hospital's policy. Therefore, under the ISO rate schedule, the hospital characteristics dominate in determining



the rate. In teaching hospitals where housestaff and some full-time clinical faculty are often included as named insureds in the hospital's policy, physician exposure dominates. Premiums are significantly higher because the insurers' risk is comparatively higher.

2. Comparative Claims. All sources agreed there presently is no good data on comparative malpractice claims in teaching hospitals. If COTH seeks such data, all sources encouraged working with NAIC to include the teaching status variable in their closed claims data.

3. Inadequate Aggregate Coverage. If teaching hospitals include housestaff and faculty as named insureds, exposure to risk under the policy increases more rapidly than total aggregate coverage (including excess coverage) increases. This is a truism which cannot be "solved." In a general community, if an insurer writes more physicians, the risk is pooled but exposure is independent. In a teaching hospital, adding housestaff and faculty as named insureds pools the risk and includes some common exposure. Consequently, maintaining a constant relationship between aggregate coverage and named insureds becomes prohibitively expensive for the institution.

4. Coverage for Residents in Affiliated Programs. Residents training in multi-hospital programs are beginning to encounter coverage problems. In some cases, the insurer covering the "base" hospital will not cover the resident during periods of assignment to other hospitals. The argument is that the resident is beyond the procedures and controls of the "base" hospital. On the other hand, some insurers have agreed that the "non-base" hospital should not cover the resident because he is part of the "base" hospital's program. The solution to this problem appears to be a negotiated agreement between the several hospitals and insurers involved in each specific situation.

5. Premium Allocation. Substantial increases in malpractice premium rates have led several hospital directors to question existing policies where the hospital includes full-time faculty and housestaff in its policy and pays the entire premium. Some directors are seeking specific rate information by class of insured to use in negotiating shared premiums with medical schools (where appropriate) and faculty practice plans. To date, these directors have had difficulty obtaining "split" versus all-inclusive premium quotations. While some insurers and brokers have told hospital directors such data does not exist, Marsh and McLennan know of no carrier which does not have such information. While it may be difficult to obtain, Marsh and McLennan claim it exists.

6. Endowments as a Restraint on Self-Insurance. One of the barriers to undertaking self-insurance for professional liability is the possibility of exposing endowment funds to claims under malpractice settlements. In some jurisdictions this presents no problem because endowments cannot be attached for malpractice claims. In other jurisdictions, they can be attached. Because this problem depends on local and state laws governing endowments and because it depends, in part, on restrictions placed on endowments, this is an institution-by-institution problem with no model solution.

Issue

Should COTH encourage the National Association of Insurance Commissioners to include a teaching hospital classification in their closed claims data base?

Recommendations

1. It is recommended that the COTH Administrative Board approve the establishment of a survey of malpractice coverage, premiums, and claims in university-owned hospitals.

2. In light of the AHA, AMA, ABA and NAIC actions and given the specific character of malpractice issues for teaching hospitals, it is recommended that the COTH Administrative Board not initiate a separate AAMC malpractice program beyond the university-owned survey but encourage staff to maintain liaison with other organizations, particularly the NAIC.

Survey on Professional Liability Insurance  
in University Hospitals

Association of American Medical Colleges  
Council of Teaching Hospitals  
One Dupont Circle, N.W.  
Washington, D.C. 20036

Hospital Name: \_\_\_\_\_

Hospital Address: \_\_\_\_\_

Person completing questionnaire:

Name: \_\_\_\_\_

Position: \_\_\_\_\_

Telephone: \_\_\_\_\_

NOTE: In completing this questionnaire, the following definitions are used for physicians.

Strict Full-Time Physicians: physicians who receive their total professional income as a fixed annual amount from one or more of the following sources: medical school, parent institution, and/or owned or affiliated hospital.

Geographic Full-Time Physicians: physicians who receive a fixed salary from a medical school and/or hospital and fee earnings.

Part-Time Salaried Physicians: physicians who receive a partial salary from a medical school and/or hospital for a given proportion of their professional time.

Independent/Voluntary Attending Physicians: physicians with admitting privileges at the hospital who receive no salary from the medical school and/or hospital.

1. Please indicate the number of personnel your hospital has in the following categories:

	<u>Number of Personnel</u>
Strict Full-Time Physicians	_____
Geographic Full-Time Physicians	_____
Part-Time Salaried Physicians	_____
Independent/Voluntary Attending Physicians	_____
House Staff (including Fellows)	_____
All Others	_____

2. Please indicate the source of professional liability insurance coverage for each of the following types of personnel:

	Source of Professional Liability Coverage (circle as appropriate)				
	<u>Medical School Policy</u>	<u>Hospital Policy</u>	<u>Practice Plan Policy</u>	<u>Individual/ Personal Policy</u>	<u>Other (specify)</u>
Strict Full-Time Physicians	School	Hospital	Plan	Personal	_____
Geographic Full-Time Physicians	School	Hospital	Plan	Personal	_____
Part-Time Salaried Physicians	School	Hospital	Plan	Personal	_____
Independent/Voluntary Attending Physicians	School	Hospital	Plan	Personal	_____
House Staff (including Fellows)	School	Hospital	Plan	Personal	_____
Clinical Clerks	School	Hospital	Plan	Personal	_____
All Others	School	Hospital	Plan	Personal	_____

3. Please indicate the source of premiums for professional liability insurance for each types of personnel:

	Source of Professional Liability Premium (circle as appropriate)				
	<u>Medical School</u>	<u>Hospital</u>	<u>Practice Plan</u>	<u>Individual</u>	<u>Other (specify)</u>
Strict-Full Time Physicians	School	Hospital	Plan	Individual	_____
Geographic Full-Time Physicians	School	Hospital	Plan	Individual	_____
Part-Time Salaried Physicians	School	Hospital	Plan	Individual	_____
Independent/Voluntary Attending Physicians	School	Hospital	Plan	Individual	_____
House Staff (including Fellows)	School	Hospital	Plan	Individual	_____
Clinical Clerks	School	Hospital	Plan	Individual	_____
Others	School	Hospital	Plan	Individual	_____

4. For physicians insured under the hospital's professional liability coverage, please indicate the additional premium required to include them in the policy.

	<u>Additional premium (amount)</u>
Strict Full-Time Physicians	\$ _____
Geographic Full-Time Physicians	\$ _____
Part-Time Salaried Physicians	\$ _____
Independent/Voluntary Attending Physicians	\$ _____
House Staff (including Fellows)	\$ _____

5. If your hospital has decided to self insure for professional liability, please provide the following information. (If you do not self insure, go to question #6.)

a. Date self insurance began: \_\_\_\_\_

b. Self insurance reserves: 1975 \$ \_\_\_\_\_ 1976 goal \$ \_\_\_\_\_

c. Self insurance reserves 1975 \$ \_\_\_\_\_ 1976 goal \$ \_\_\_\_\_  
per patient day

d. Self insurance reserves 1975 \$ \_\_\_\_\_ 1976 goal \$ \_\_\_\_\_  
per bed

e. Do you have umbrella coverage in addition to self insurance?  
Yes, limits are \$ \_\_\_\_\_ / \_\_\_\_\_ No \_\_\_\_\_

f. The primary reason your hospital began self insurance was (please check)

- \_\_\_\_\_ a. commercial insurance unavailable
- \_\_\_\_\_ b. available commercial insurance had coverage limits which were too low
- \_\_\_\_\_ c. available commercial insurance was too expensive
- \_\_\_\_\_ d. Other (specify) \_\_\_\_\_

g. Your hospital's self insurance program includes coverage for:

	<u>Coverage Includes (circle)</u>	
Strict Full-Time Physicians	Yes	No
Geographic Full-Time Physicians	Yes	No
Part-Time Salaried Physicians	Yes	No
Independent/Voluntary Attending Physicians	Yes	No
House Staff (including Fellows)	Yes	No
Clinical Clerks	Yes	No

6. If your hospital purchased professional liability insurance in 1974, 1975, or 1976, please provide the following information. (NOTE: If year is different from the calendar year, please provide the dates for insurance coverage year.)

Fiscal Year 1974: from \_\_\_\_\_ to \_\_\_\_\_  
 Fiscal Year 1975: from \_\_\_\_\_ to \_\_\_\_\_  
 Fiscal Year 1976: from \_\_\_\_\_ to \_\_\_\_\_

	<u>1974</u>	<u>1975</u>	<u>1976</u>
a. Primary coverage limits (in 000's)	\$ _____ / _____	\$ _____ / _____	\$ _____ / _____
b. Excess coverage (in 000's)	\$ _____	\$ _____	\$ _____
c. Primary coverage premium (in 000's)	\$ _____	\$ _____	\$ _____
d. Excess coverage premium (in 000's)	\$ _____	\$ _____	\$ _____
e. Deductible or retained amount (in 000's)	\$ _____	\$ _____	\$ _____
f. <u>Cost per patient day</u> for professional liability insurance	\$ _____	\$ _____	\$ _____
g. <u>Cost per bed per year</u> for professional liability insurance	\$ _____	\$ _____	\$ _____
h. Percentage of total cost per patient day for professional liability insurance	_____ %	_____ %	_____ %
i. Insurance carrier for primary coverage	(Name) _____	(Name) _____	(Name) _____
j. Carrier for excess coverage	(Name) _____	(Name) _____	(Name) _____

7. Are the professional liability insurance limits shown for 1976 (or 1975 if 1976 is unavailable) the full limits you wish to carry?

- a. primary coverage: Yes \_\_\_\_\_ No, prefer \$ \_\_\_\_\_ / \_\_\_\_\_  
 b. excess coverage: Yes \_\_\_\_\_ No, prefer \$ \_\_\_\_\_

8. Please provide the following information on your hospital's professional liability experience since 1970:

Year	Total Premiums	Open Claims		Closed Claims		Total Claims	
		#	\$	#	\$	#	\$
1970	_____	_____	_____	_____	_____	_____	_____
1971	_____	_____	_____	_____	_____	_____	_____
1972	_____	_____	_____	_____	_____	_____	_____
1973	_____	_____	_____	_____	_____	_____	_____
1974	_____	_____	_____	_____	_____	_____	_____
1975	_____	_____	_____	_____	_____	_____	_____

9. 1. Is the sharing of individual data with other university hospitals participating in the survey acceptable to you?

Yes \_\_\_\_\_ No \_\_\_\_\_

2. Is a descriptive publication of the results of this survey with institutional confidentiality preserved acceptable to you?

Yes \_\_\_\_\_ No \_\_\_\_\_

10. Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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## Member Experience Under Section 223 Regulations

To develop quantitative support for the Association's appeal of Federal regulations regarding per diem routine service cost limitations under the Medicare program, a postcard survey of non-Federal COTH members was conducted from March 22, 1976 to May 24, 1976. The survey requested member hospitals to indicate the following:

1. the inclusive date of the hospital's cost reporting periods for the current and immediate past years;
2. the Medicare cost ceiling for routine service costs for the past and current year as well as the past year's actual and current year's projected costs for routine service costs;
3. whether the hospital is in a standard metropolitan statistical area, a standard consolidated statistical area, or neither type of statistical area; and,
4. the name and telephone number of the person completing the postcard.

(Appendix A includes a copy of the General Membership Memorandum and survey postcard.)

### Initial Findings

By May 24th, completed postcards were received from 274 of the 329 hospitals surveyed. This constitutes an 83% response rate and provides a statistically meaningful and stable source of data for examining member experience under Section 223.

Table 1 shows the section 223 status of the responding hospitals. Last year, 74% of the responding hospitals did not exceed the ceiling for routine service costs. For the current year, 69% of the responding hospitals predict costs will not exceed the ceiling. For the past and current year, 20% and 24% of responding hospitals, respectively, exceeded the routine service cost ceiling. For the past year, 6% of the responding hospitals were unable to report either their cost ceilings or their actual costs. For the current year, 7% of the hospitals do not know either their Medicare ceiling or their projected annual costs.

Table 2 shows a frequency distribution of the number and percent of responding hospitals which exceeded the Medicare routine service cost ceiling for the past and current years. For the current year, 66 hospitals expect to exceed the ceiling while only 56 exceeded the ceiling last year. Moreover, hospitals exceeding the ceiling for the current year are generally over the ceiling by a larger amount than were those hospitals which actually



exceeded the ceiling last year. For example, last year 43% of the hospitals exceeding the ceiling did so by \$10 or more per patient day; this year, 60.5% of the hospitals exceeding the ceiling expect to do so by \$10 or more per patient day. Thus, the number of responding hospitals exceeding the ceiling has increased and the amount by which the ceiling is exceeded has increased.

To determine whether or not there were any systematic patterns descriptive of COTH hospitals exceeding the Medicare ceiling, responding hospitals were compared by geographic region, affiliation status, bed size, type of hospital control, and housestaff salaries per adjusted patient day. Table 3 shows the characteristics of those hospitals which disproportionately exceeded the ceiling when compared with all responding COTH hospitals. It shows the finding for all hospitals over the ceiling and for those exceeding the ceiling by \$10 or more. The characteristics of COTH hospitals exceeding the Medicare ceiling are quite stable (1) from the past year to the current year and (2) from all hospitals exceeding the ceiling to those exceeding it by \$10 or more. For both years, COTH hospitals disproportionately over the Medicare ceiling tend to be university-owned, under 410 beds, controlled by a state or county, and spending over \$7.75 per adjusted patient day for housestaff salaries. For the current year, a disproportionate number of hospitals in the Western Region are over the Medicare ceiling.

If the Medicare classification system and cost limitations measured only inefficiency, there would be no reason to expect any particular group of COTH members to exceed the ceilings. The disproportional impact shown in Table 3 indicates that the present scheme includes systematic biases. This conclusion is more fully supported by Table 4 which shows the Section 223 status of responding hospitals by housestaff salaries per adjusted patient day. As housestaff salaries per adjusted patient day increase, the percentage of responding hospitals exceeding the Medicare ceiling increases. The present classification scheme and its resulting cost limitations are working to the disadvantage of COTH members with relatively high housestaff salary expenditures.

#### Future Actions

Department of Teaching Hospital staff are presently contacting all responding hospitals with actual or projected costs over the routine service cost limitation. Using the questionnaire presented in Appendix B, staff are attempting to determine the extent to which COTH hospitals exceeding the ceiling (1) have undertaken studies to document causes for exceeding the ceiling and (2) have sought exceptions for atypical costs.

In addition, on May 17th, Dr. Knapp wrote Mr. Michael Maher of BHI requesting a comprehensive list of hospitals which have been granted exception on routine service costs, a list of the reasons for which exceptions have been granted, and a statement of the number of hospitals which have

submitted exception requests. (Appendix C is a copy of the letter to Maher.) A response from BHI was received on June 7th (see Appendix D). Department staff are presently contacting COTH members who have received exceptions in order to obtain complete documentation of exception requests and responses. As appropriate, information obtained on required exception documentations and grounds for approved exceptions will be sent to COTH members in a General Membership Memorandum.

Table 1

Section 223 Status of COTH Members

<u>Status</u>	<u>Past Year</u>		<u>Current Year</u>	
	<u>Number</u>	<u>%</u>	<u>Number</u>	<u>%</u>
Ceiling exceeds Cost	202	74%	190	69%
Cost exceeds Ceiling	56	20	66	24
Don't Know	<u>16</u>	<u>6</u>	<u>18</u>	<u>7</u>
TOTAL	274	100%	274	100%

Table 2

Frequency Distribution of Section 223 Status in  
Responding Hospitals where Costs Exceed Medicare Ceiling

<u>Amount by which Costs exceeds Ceiling</u>	<u>Past Year</u>		<u>Current Year</u>	
	<u>Number</u>	<u>%</u>	<u>Number</u>	<u>%</u>
\$ 0.0. to 4.99	21	37.5%	13	19.7%
5.00 to 9.99	11	19.6	13	19.7
10.00 to 14.99	7	12.5	10	15.2
15.00 to 19.99	6	10.7	8	12.1
20.00 to 24.99	3	5.4	7	10.6
25.00 to 29.99	2	3.6	4	6.1
30.00 to 34.99	3	5.4	2	3.0
35.00 to 39.99	0	0.0	3	4.5
40.00 to 44.99	2	3.6	2	3.0
45.00 to 49.99	0	0.0	2	3.0
50.00 to 54.99	0	0.0	0	0.0
55.00 to 59.99	0	0.0	0	0.0
60.00 to 64.99	1	1.8	0	0.0
65.00 to 69.99	<u>0</u>	<u>0.0</u>	<u>2</u>	<u>3.0</u>
TOTAL	56	100.1%	66	99.9%

Table 3

Characteristics of COTH Hospitals Which Disproportionately<sup>1</sup>  
Exceed Medicare Routine Service Cost Limitations

<u>Past Year</u>	<u>Disproportionate Percentage of Hospitals</u>	
	<u>Costs Exceed Ceiling by Any Amount</u>	<u>Costs Exceeded Ceiling by \$10.00 or more</u>
Region <sup>2</sup>	None	None
Affiliation <sup>3</sup>	University-owned	University-owned
Bed Size <sup>4</sup>	410 beds or less	410 beds or less
Control <sup>5</sup>	State, County, Church	State, County, Church
Housestaff Salaries <sup>6</sup>	\$7.75 or more	\$7.75 or more
<u>Current Year</u>		
Region <sup>2</sup>	West	West
Affiliation <sup>3</sup>	University-owned	University-owned
Bed Size <sup>4</sup>	410 beds or less	410 beds or less
Control <sup>5</sup>	State, County	State, County
Housestaff Salaries <sup>6</sup>	\$7.75 or more	\$7.75 or more

<sup>1</sup> Categories in which the percentage of hospitals exceeding the ceiling is 1.5 times the percentage of all COTH hospitals exceeding the ceiling.

<sup>2</sup> Categories were Northeast, South, Midwest, West

<sup>3</sup> Categories were university-owned, major affiliation, limited affiliation, unaffiliated.

<sup>4</sup> Categories were 410 beds or less, 411 to 520 beds, 521-745 beds, and 746 or more beds. This classification divides COTH members into quartiles.

<sup>5</sup> Categories were state, county, city, church, other, nonprofit and hospital district control

<sup>6</sup> Categories were less than \$3.24, \$3.25 to \$5.09, \$5.10 to \$7.74, and \$7.75 and more per adjusted patient day. This classification divides COTH members into quartiles.

Table 4

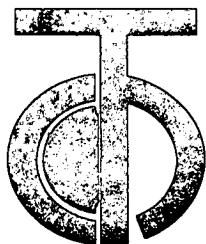
Section 223 Status by Housestaff Salaries per Adjusted Patient Day

Past Year

<u>Housestaff Salaries per Adjusted Patient Day</u>	<u>Cost &gt; Ceiling</u>		<u>Total Responses</u>
	<u>Number</u>	<u>%</u>	
\$3.24 or less	3	5%	61
3.25 - 5.09	10	18	55
5.10 - 7.74	11	17	63
7.75 or more	27	36	76
Unknown	<u>5</u>	<u>28</u>	<u>18</u>
TOTAL	56	20%	274

Current Year

<u>Housestaff Salaries per Adjusted Patient Day</u>	<u>Cost &gt; Ceiling</u>		<u>Total Responses</u>
	<u>Number</u>	<u>%</u>	
\$3.24 or less	3	5%	61
3.25 - 5.09	11	20	55
5.10 - 7.74	18	29	63
7.75 or more	29	38	76
Unknown	<u>15</u>	<u>28</u>	<u>18</u>
TOTAL	66	24%	274



APPENDIX A

COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES  
ONE DUPONT CIRCLE, N. W. • WASHINGTON, D. C. 20036 • (202) 466-5127

COTH General Membership Memorandum  
No. 76-5G  
March 22, 1976  
Subject: Update on Member Experience  
Under Section 223 Regulations,  
Routine Cost Limitations in  
Hospitals

Federal regulations regarding per diem routine service cost limitations in hospitals became effective for accounting periods beginning after June 30, 1974. As you will recall, COTH/AAMC filed suit in the U.S. District Court for the District of Columbia seeking relief from the regulation by arguing that the regulations were arbitrary and capricious and that they would cause irreparable harm to teaching hospitals. While the initial decision was against the AAMC position, the Association is presently awaiting a court date for the appeal to the U.S. Court of Appeals for the District of Columbia Circuit.

To assist in developing quantitative support for the appeal, I would appreciate your completing the enclosed postcard at the earliest possible date. Please indicate on the card:

1. the inclusive dates of your hospital's cost reporting periods for the current and past year;
2. the Medicare cost ceilings for routine service costs for the past and current year as well as your past year actual and projected costs for routine service costs;
3. whether your hospital is in a standard metropolitan statistical area (SMSA), a standard consolidated statistical area (SCSA), or neither type of statistical area. (See Intermediary Letter 75-69 if you have a question on SCSAs); and,
4. the name and telephone number of the person completing the postcard.

Your assistance in completing this survey will ensure timely and relevant support of our case.

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

Section 223 Postcard Survey

1. Inclusive dates of cost reporting periods beginning after June 30, 1974:

Past Year: from \_\_\_\_\_ to \_\_\_\_\_  
Current Year: from \_\_\_\_\_ to \_\_\_\_\_

2. Routine service cost per day: Past Year Current Year  
Medicare cost ceiling: \$ \_\_\_\_\_ \$ \_\_\_\_\_  
Actual & Projected Cost \$ \_\_\_\_\_ \$ \_\_\_\_\_

3. Your hospital is located in:  
\_\_\_\_ a standard metropolitan statistical area (SMSA)  
\_\_\_\_ a standard consolidated statistical area (SCSA)  
(See I.L. 75-69)  
\_\_\_\_ neither an SMSA nor an SCSA

Completed by: \_\_\_\_\_

Telephone: \_\_\_\_\_  
(area code)(number)(extension)

DEPARTMENT OF TEACHING HOSPITALS

Telephone Questionnaire on Hospitals Over Section 223 Ceiling

Person making the call: \_\_\_\_\_

Hospital called: \_\_\_\_\_

Person contacted: \_\_\_\_\_ Position: \_\_\_\_\_

Was the person contacted the same individual identified on the 223 postcard?

\_\_\_\_\_ Yes

\_\_\_\_\_ No, Why not? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Interview:

Several weeks ago, the Council of Teaching Hospitals mailed a postcard to member hospitals requesting information on routine service costs and routine service cost ceilings. Because this information will be used to provide statistical support for the COTH/Association of American Medical Colleges appeal for relief from Section 223 regulations, we are making this telephone survey to selected hospitals to verify some data and to obtain additional important information.

1. According to our records:

a. your hospital's routine service costs for the past year

were \$ \_\_\_\_\_. Is this correct?

\_\_\_\_\_ Yes

\_\_\_\_\_ No State hospital's routine service costs \$ \_\_\_\_\_

b. your hospital's Medicare cost ceiling for routine service

costs for the past year was \$ \_\_\_\_\_.

Is this correct?

\_\_\_\_\_ Yes

\_\_\_\_\_ No State hospital's cost ceiling \$ \_\_\_\_\_



2. Has your hospital undertaken any studies to identify and investigate any costs which might be used to seek an exception from the cost ceiling?

\_\_\_\_\_ Yes

\_\_\_\_\_ No

\_\_\_\_\_ Don't know. Who should be contacted?

\_\_\_\_\_ Name

\_\_\_\_\_ Telephone

If yes, in which cost areas:

- \_\_\_\_\_ capital amortization
- \_\_\_\_\_ intern and resident costs
- \_\_\_\_\_ malpractice insurance
- \_\_\_\_\_ nursing education costs
- \_\_\_\_\_ patient mix
- \_\_\_\_\_ security costs
- \_\_\_\_\_ scope of services provided
- \_\_\_\_\_ utility expenses
- \_\_\_\_\_ wage levels

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. Has your hospital filed for, or is it planning to file for, an exception to the past year's Medicare cost ceiling on routine service costs?

\_\_\_\_\_ Yes

\_\_\_\_\_ No

\_\_\_\_\_ Don't know Who should be contacted?

\_\_\_\_\_ Name

\_\_\_\_\_ Telephone

a. If yes, in which areas and what per diem dollar amounts (or percentage) are requested over your ceiling?

___ capital amortization	\$ _____	_____ %
___ intern & resident costs	\$ _____	_____ %
___ malpractice insurance	\$ _____	_____ %
___ nursing education	\$ _____	_____ %
___ patient mix	\$ _____	_____ %
___ security costs	\$ _____	_____ %
___ scope of services	\$ _____	_____ %
___ utility expenses	\$ _____	_____ %
___ wage scales	\$ _____	_____ %
___ _____	\$ _____	_____ %
___ _____	\$ _____	_____ %
___ _____	\$ _____	_____ %

b. If your hospital has filed for an exception, please

- (1) what was the total amount requested? \$ \_\_\_\_\_
- (2) what was the total amount granted? \$ \_\_\_\_\_

Please send one copy of all correspondence between your hospital and Medicare program authorities to:

James D. Bentley, Ph.D.  
Assistant Director  
Department of Teaching Hospitals  
Association of American Medical Colleges  
One Dupont Circle, N.W.  
Washington, D.C. 20036

May 17, 1976

Michael Maher  
Social Security Administration  
Bureau of Health Insurance  
DPRAP  
Room 401, East High Rise  
Baltimore, Maryland 21235

Dear Mr. Maher:

The Association of American Medical Colleges wishes to request the following information under the Freedom of Information Act:

- 1) A listing which indicates each institution that has been granted an exception (or adjustment) to the limitations on Medicare routine service costs under Section 223 of P.L. 92-603;
- 2) A listing of the respective reasons for or basis on which the above noted exceptions have been granted; and,
- 3) The number of institutions which have submitted exception and/or adjustment requested by category of exception.

Your timely response on this matter would be appreciated.

Sincerely,

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

RMK:car



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

REFER TO:  
IHI-324

JUN 2 1976

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

Dear Dr. Knapp:

In your letter of May 17, 1976, you requested a listing of all institutions which have been granted exceptions to the hospital cost limits, a listing of the reasons for which exceptions have been granted and the number of institutions which have submitted requests for each category of exception. The enclosed lists which represent actions taken and requests received through May 21, 1976, should supply you with the necessary information.

Sincerely yours,

  
Mike Maher

Assistant Bureau Director  
Division of Provider Reimbursement  
and Accounting Policy  
Bureau of Health Insurance

Enclosures 2

Exceptions Granted

1. Peter Bent Brigham
2. Mount Auburn
3. New England Medical Center
4. Boston City Hospital
5. University Hospital
6. Beth Israel Hospital
7. Memorial Hospital for Cancer and Allied Diseases
8. Calvary Hospital
9. Crouse-Irving Memorial Hospital
10. Mount Sinai Hospital\*
11. Long Island College Hospital
12. West Virginia University Hospital
13. Cleveland Metropolitan General Hospital
14. Kirksville Osteopathic Hospital
15. University of Arizona Medical Center
16. Stanford University Hospital
17. St. Luke's Hospital

\* Approval of this exception is conditional upon satisfactory resolution of certain questions concerning reported costs.

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Reasons for Granting Exceptions and Number Requested

<u>Reason</u>	<u>Number Requested*</u>
Intern and Resident	23
Nursing Education	5
Malpractice Premium	20
Utility	22
Atypical Nursing Service	17
Security Costs	1
Professional Staff	2

\* Most requests received cite more than one basis for exception.

## Survey of Hospital Ambulatory Service Deficits

At the March 24th COTH Administrative Board Meeting, the Hospital Ambulatory Service Deficit questionnaire was reviewed and discussed. In addition to agreeing on several substantive issues as noted in the minutes, the Board recommended Department Staff meet with hospital representatives to revise the questionnaire.

On May 5th, Steven Summer met with Marvin Rushkoff (Mount Sinai Hospital) and Peter Szekrenyi (UCLA Hospitals and Clinics). A revised questionnaire was developed and sent for review to Rushkoff, Szekrenyi and Kenneth Yerrington (University of Iowa Hospitals and Clinics). Upon review Peter Szekrenyi noted several substantial deficiencies in the references to the Medicare Cost Reports.

With Steven Summer's pending departure, the draft questionnaire and Peter Szekrenyi's comments were assigned to James Bentley for final questionnaire design and survey implementation. At present, the new questionnaire is being pretested in eight hospitals. The pretest is designed to ensure that instructions and definitions are clearly stated, that questionnaire items include all significant data elements, and that questionnaire responses are comparable.

If the pretest indicates the present questionnaire produces valid and reliable data which can be compared, it is anticipated that the survey will be mailed in early August.

# VANDERBILT UNIVERSITY HOSPITAL



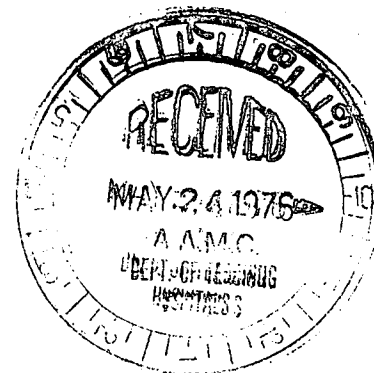
NASHVILLE, TENNESSEE 37232

TELEPHONE (615) 322-7311

Office of the Director • Direct phone 322-2351

May 17, 1976

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



Dear Dick:

As in the past several years, the Appalachian Council of Hospital Administrators would like to arrange a fall meeting at the time of the annual AAMC meeting. I am advised by John Harlan that arrangements can be made through the AAMC and would appreciate your assistance if this is correct.

In November, 1975, we met on Sunday preceeding the AAMC meeting. About 20 members attended and I expect this number would be repeated this year.

I would appreciate your assistance in making whatever arrangements are appropriate; through AAMC or directly with the hotel. I will be guided by your recommendations.

At the annual meeting of the Appalachian Council last month, an item of discussion was that of COTH representation. The group recommended that a member from the Appalachian Council be appointed to the Administrator's group of COTH to provide continuity and communications between the Appalachian Council and AAMC. For this reason, I am enclosing a membership roster of the Appalachian Council with the recommendation from the Council that one of its members be appointed or elected as appropriate through the Administrators' organization.

Sincerely,

William F. Towle  
Executive Director

WFT/ts

Enclosures



DRAFT

Proposed Talmadge Bill Testimony

The Association of American Colleges is pleased to have this opportunity to testify on the "Medicare-Medicaid Administrative and Reimbursement Reform Act" (S. 3205) of 1976. The Association represents 400 of the nation's major teaching hospitals, all of the nation's medical schools, and 60 academic societies. Thus, the Medicare and Medicaid amendments proposed in S. 3205--concerning administrative, provider reimbursement and practitioner reimbursement reforms--are of a direct interest and concern to the Association's members.

For several months, the Health Subcommittee staff of the Senate Finance Committee has been most generous in discussing general concepts and tentative provisions of S. 3205 with Association representatives. These meetings were informative and, we believe, of mutual benefit. For this dialogue and for the staff's concern in developing amendments to strengthen the Medicare and Medicaid programs, the Association expresses its appreciation to the Subcommittee and its staff.

The Association is well aware of the fact that spending for health care -- as a result of general economic inflation, increased service availability, improvements in service quality, growth and changes in population, and increased per capita utilization -- has increased more rapidly in the past two decades than have most other segments of the economy. This fact has focused consumer, industrial, governmental, and

DRAFT

**DRAFT**

provider attention on the nation's health care expenditures. In recent legislation -- such as P.L. 92-603 and P.L. 93-641 -- the Congress has attempted to establish programs and policies which will help stimulate a more efficient and effective health industry. The Association hopes that present legislative efforts will attempt to further that objective of stimulating a more efficient and effective health industry.

Of equal concern to this Association is the objective of continually ensuring that quality patient care is not sacrificed as a result of program economy measures. Members of the Senate Finance Committee have demonstrated their interest in guaranteeing quality patient care to Medicare beneficiaries by establishing the Professional Standards Review Organization and Utilization Review procedures. In past Congressional testimony, the AAMC has spoken out against proposals which would be detrimental to the Medicare recipient. We will continue to do so and urge that the Subcommittee not lose sight of this important objective.

We assume the purpose of S. 3205 is to stimulate efficient and effective programs while ensuring high quality patient care. Critical comments made in this testimony support those purposes and are submitted with the intention of strengthening the legislation. We also realize that some of the problems inherent in the proposal are not due to a lack of will by the Subcommittee staff but reflect the infant "state of the art" in several areas.

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# DRAFT

The Association wishes to address one fundamental consideration concerning this legislation's principal philosophical and systematic approach. Underlying the proposed provider reimbursement reforms is an approach that recognizes the need for management flexibility. Retaining the freedom to organize and finance individual services within expenditure or cost limits is required for the hospital to continue to meet the needs of the population it supports. Reimbursement methods in S. 3205 for determining the hospital's routine operating cost essentially retain management's operational authority and flexibility. Other sections of the proposed bill -- overhead cost controls and contract approvals, for example -- eliminate the manager's prerogative. As elaborated upon later in this testimony, the AAMC would encourage the Subcommittee to avoid implementation of a system so restrictive that its administrative burden possibly outweighs its value.

## Administrative Reforms

### Establishment of Health Care Financing Administration

This Section proposes a centralization of the Federal health care financing function and a unification of administrative entities presently known as the Bureau of Health Insurance, Medical Services Administration, Bureau of Quality Assurance, Office of Nursing Home Affairs, and related research and statistical units. The Association supports efforts toward centralization and unification of Federal health care financing. Costs of hospitals which result from diffuse and conflicting administrative and reporting requirements and which add overhead

DRAFT

to the provision of direct patient services should be somewhat moderated by the policy of unification and administrative standardization which should accompany this reorganization.

The present bill provides for an Assistant Secretary of Health Care Financing to direct the Health Care Financing Administration. The Assistant Secretary would report directly to the Secretary of Health, Education and Welfare. Establishing the position of Assistant Secretary for Health Care Financing seems to contradict the present bill's emphasis on centralization and consolidation, for the new Assistant Secretary for Health Care Financing would be at the same organizational level as the Assistant Secretary for Health. At a minimum, the presence of two Assistant Secretaries will require lengthened bureaucratic procedures for mutual coordination. And, in all likelihood, the presence of two Assistant Secretaries with major health care responsibilities will result in problems of coordination and conflict which could reduce the benefits of centralization. To further the goal of a unified and coordinated Federal health care policy, the Association recommends that the Health Care Financing Administration be under the direction of a Deputy Assistant Secretary of Health for Health Care Financing who reports to the Assistant Secretary for Health. The Assistant Secretary for Health would then be the Department's central individual for all health matters.

Consolidation of Federal health care financing responsibilities will contribute to reducing administrative confusion presently

# DRAFT

faced by health care providers. If a Deputy Assistant Secretary for Health Care Financing is established to direct the unified agencies, gains of economy and efficiency will be preserved. While these would be valuable reforms, the Association believes the benefits of these reforms are limited by continuing the subordination of the health function within the Department of Health, Education and Welfare. A Cabinet-level Department of Health is needed to serve as the single point of responsibility for the nation's critically important health policies and programs. The Association hopes that the proposed consolidation is the first step in the movement toward the creation of such a Cabinet-level Department of Health.

### State Medicaid Administration

The reform of state Medicaid administration to provide more rapid payment of health care providers is strongly endorsed by the Association. Because of delays in Medicaid payments to hospitals, health care providers in many states have had to borrow funds at substantial interest rates to provide adequate cash flow. These additional interest costs add to the nation's health care expenses without contributing to the direct provision of personal health services. Decreasing the time required for Medicaid payments should contribute, in at least a small way, to moderating the nation's health expenditures as well as to reducing the tension between hospitals and state governments.

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Regulations of the Secretary

The Association understands and shares the general Congressional concern with present procedures for proposing, evaluating, and publishing Federal regulations. The provisions of Section 7, which would establish a 60 day comment period for regulations, are a much needed reform in this area. Sixty days will allow time for a more thorough evaluation and review. Moreover, it will enable individuals and groups to collect appropriate data to illustrate and substantiate their comments and to offer constructive suggestions. To help ensure that the Subcommittee's intentions are complied with, the Association recommends that some clarification or definition be provided in the Committee Report for the term "urgent" as it applies to the regulations. The Association would also like to emphasize that this reform should not be limited to Medicare and Medicaid programs alone. This Committee and others in both the House and the Senate are urged to consider the need for this reform and others in the area of administrative procedures for the publication of rules and regulations.

Provider Reimbursement Reforms

Uniform Accounts, Cost Reporting and Allocation Procedures

The most important prerequisite for proper evaluation and measurement of "routine operating costs" is the development of a system of uniform cost reporting. A mechanism for assuring the comparability of financial data must be developed prior to

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full implementation of the program. Experiences in such states as California and Maryland, where uniform financial reporting systems are being developed and implemented, demonstrate that, with the present state-of-the-art in this area, enormous efforts are required to attain the goal. Similarly, Federal efforts to develop uniform accounting and reporting programs, which are being developed as specified in Section 1533(d) of PL 93-641, provide evidence of the difficulties in this area. Therefore, the Association urges the Subcommittee to provide an adequate and phased-in period of implementation for uniform cost reporting subsequent to final passage of the legislation.

#### Classification of Hospitals

A fundamental concern of the Association is that the designation of specific hospital groups is fixed in the legislation. This eliminates much needed flexibility. Alterations based on experience will be most difficult to make on a timely basis. Recognizing that there is a lack of data available for analyzing the impact of this system, a more prudent approach would be to permit the agencies some flexibility with which to construct the system. It is important, however, that the Committee provide the Department with some specific guidelines and direction in which to proceed. Therefore, the Association recommends that S. 3205 state that hospitals "be classified by type and size" with some guidance in the Committee report, rather than stipulate the specific bed categories. It is further recommended

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that a "National Technical Advisory Board" be appointed to recommend and evaluate alternative classification systems of size and type, review progress, monitor implementation, examine problems encountered and make recommendations regarding appropriate solutions. The advisory board to be established should include representation from the Legislative and Executive Branches of Government, as well as knowledgeable individuals from the private sector.

In the past, the Association has not specifically advocated a separate classification of teaching hospitals. Rather, if a cross-classification approach is to be used, the Association has recommended the exclusion of specific components of routine operating costs which will help ensure that variations in the remaining costs are not due to the nature of the product produced or to characteristics of the production process. Therefore, the Association believes that the exclusion of such costs from routine operating costs in S. 3205 is a step in the proper direction.

The legislation does provide for the creation of a separate group of hospitals which are the "primary affiliates of accredited medical schools." It is difficult to evaluate the implications of creating such a group because of the absence of data. Efforts to gain data and experience with a separate group are hampered by the inability of the current Medicare reporting process to identify and extract the elements to be



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excluded from the present scheme. Thus, there is uncertainty as to the relative merits of a separate group for teaching hospitals.

More importantly, the present legislation would restrict the "primary affiliates of accredited medical schools" to a single hospital per medical school. This is a gross injustice to many teaching hospitals. Limiting each medical school to one and only one "primary affiliate" is arbitrary and does not recognize the complexity or the reality of medical education in this nation. Therefore, the Association opposes the establishment of a specific classification for "primary affiliates of accredited medical schools" as proposed in S. 3205.

In the absence of adequate data and operational experience to evaluate the proposed classification scheme and to avoid arbitrarily limiting the "primary affiliates of accredited medical schools" to one hospital per school, the Association is of the opinion that the combination of a flexible classification system and an adequate phase-in period are essential elements of the program's chances for success. Thus, the Association strongly recommends that the Secretary of the Department of Health, Education and Welfare be directed to examine the implications for reimbursement of alternative definitions of the term "teaching/tertiary care hospitals." Instead of prescribing a pre-defined grouping for teaching hospitals, it is proposed that the Secretary be required to determine, in

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consultation with the appropriate knowledgeable health organizations, a definition which most accurately reflects the teaching hospital's role as a referral center for tertiary patient care services and as an educational institution. This is a good example of an issue which would be brought before the above proposed Technical Advisory Board.

Determining Routine Operating Costs

The Association recommends that two additional components of routine operating costs be excluded. S. 3205 does propose removing "energy costs associated with heating or cooling the hospital plant." This is appropriate and desirable; however, it ignores the energy costs associated with lighting the hospital facility. Energy costs for lighting, like those for heating and cooling, are beyond the hospital's control. Therefore, the Association requests that energy costs for lighting also be excluded from routine operating costs. Secondly, since there is wide regional and institutional variation in malpractice premium rates, and because these rates are largely beyond the control of the hospital, malpractice insurance premiums should be added to the list of exclusions from routine operating costs which are contained in the proposal. It has been our understanding that there was every intention of excluding malpractice premiums, although the proposed statute has omitted it. The exclusion of energy costs for lighting and malpractice insurance premiums will help to ensure the remaining costs are comparable between facilities.

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In determining routine operating cost, the proposed legislation includes a provision allowing for initial consideration of hospital wage levels, if available, for the local or state area where they are higher than the general wage levels in the area. Following this initial first year adjustment, future hospital increases would be controlled by increases for all wages in the area in which the hospital is located. An approach similar to this has been supported by the Association and would serve to address one of its major concerns.

A further consideration in the wage level methodology, however, relates to the particular nature of the tertiary care/teaching hospital staffing patterns. The type and array of skilled personnel utilized in academic medical centers is frequently drawn from a national labor pool. For example, the University of Virginia Medical Center in Charlottesville is located in a rural area of the state and outside of an SMSA. It must, however, compete with medical centers in Richmond, Virginia, Washington, D.C., and Baltimore, Maryland for skilled personnel. Because many medical centers must recruit personnel outside of the immediate area and across state lines, the Association recommends that the legislation include a provision which recognizes the skilled labor requirements of large academic medical centers.

Section 223 of PL 93-603 permitted a provider, with appropriate public notice as determined by the Secretary to charge the patient for "...services which are more expensive than the items or services determined to be necessary in the efficient delivery

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of needed health services..." S. 3205 in replacing Section 223 does not contain this or a similar provision. Providing that consumers and medical practitioners are appropriately appraised of additional charges prior to the use of services, the Association recommends that hospitals be permitted to charge the patient above the established cost ceiling (1) for medically necessary services which are more expensive than the items or services determined to be necessary in the efficient delivery of services and (2) for more expensive services directly requested or authorized by the patient.

S. 3205 will allow those institutions with routine operating costs below the ceiling for their group to share in the "surplus". One concern we must raise is the manner in which hospitals will be required to handle this "surplus". Although the Association believes it may very well be inappropriate to stipulate in legislation the specific ways this must be utilized, Congress is encouraged to provide some guidance while assuring that the institutions have flexibility in determining institutional priorities.

The Association strongly supports the case mix provision provided in S. 3205. Tertiary care/referral hospitals serve the more severely ill patients and referral of such patients from other hospitals tends to increase in times of adverse economic conditions. Recognition of these facts in the legislation should help to ensure the economic integrity of tertiary/referral centers.

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Experience gained since the development and initial operation of Section 223 of the 1972 Medicare amendments has demonstrated the urgent need for a viable and timely exception and appeal process. Such an effective and equitable process has not functioned under the present Section 223 cost limitations. Therefore, the Association recommends this legislation include provisions for an exception and appeals process which provides (1) that information describing the specific methodology and data utilized to derive exceptions be made available to all institutions; (2) that the identity of "comparable" hospitals located in each group be made available; (3) that the basis on which exceptions are granted be publicly disclosed in each circumstance, widely disseminated and easily accessible to all interested parties; and (4) that the exceptions process permit the use of "per-admission cost" determinations recognizing that compressing the length of stay often results in an increase in the hospital's routine per diem operating costs but no change or reduction in the per-admission costs.

Section 10(e) provides that "nothing in this section shall be construed as otherwise limiting the authority of the Secretary to continue otherwise authorized efforts toward development of improved systems of reimbursement..." The Association recommends that this subsection be modified to strongly and positively encourage the Secretary to continue and, where appropriate, expand efforts to develop improved systems of reimbursement.

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Assuring Medicare beneficiaries needed health care services and encouraging efficiency in the provision of health care should be the guiding principals of any reimbursement system. The compatibility of the goals can be maintained under a system which accounts for the many legitimate service and case-mix differences found between hospitals. When this is done, illegitimate costs arising from inefficiency or extravagance can be isolated. However, if care is not taken to identify the costs of inefficiency, legitimate reimbursement may be threatened and consequently the hospitals' ability to provide needed health services will be reduced.

In this regard, one has to be impressed with the thought and effort that went into the provider reimbursement portion of this proposal. One is also impressed with the real complexity of implementing the proposal on a national scale. While the Association finds the proposal, with suggested amendments, worthy of support, the Association recommends that we move forward cautiously and under the review and supervision of the above recommended Technical Advisory Board.

#### Practitioner Reimbursement Reforms

The apparent purpose of Section 22(c) is to eliminate Medicare and Medicaid recognition of remuneration arrangements between physicians and hospitals in which the physician's fee-based income rate in his service practice is used as a basis for computing his compensation for Part A reimbursable services. In place of such arrangements, the subsection proposes recognition of "... an amount equal to the salary which would have reasonably been paid for such services..."

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While this objective seems clear in principle, it is clouded with ambiguities in practical application. The bill includes no indication of the basis on which "...an amount equal to the salary which would have reasonably been paid..." is to be determined. Certainly the Association realizes and appreciates the desire of the Congress to permit those developing regulations to have some flexibility in implementing this amendment; however, in recruiting and negotiating with the medical staff, the hospital chief executive officer and/or medical school dean must be able to determine the amount of compensation that Medicare and Medicaid will recognize. Therefore, the Association requests that Congress either modify the proposed amendment to incorporate some specific guidelines for regulations or so specify its intent in hearings and Congressional Reports that those preparing the regulations have a clear and consistent direction for determining a reasonable salary for physicians in employment situations.

Miscellaneous Reforms

Percentage Contracts

Section 40, as the Association understands it, is designed, in part, to eliminate as reasonable charges Medicare and Medicaid recognition of expenses for services or facilities which are determined as a percentage of health service revenues. However, our discussions with many groups of individuals have indicated that there are varying interpretations for this subsection. Therefore, the Association requests that the Subcommittee clearly state the objective of this subsection in its report on this legislation.

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Overhead Cost Controls

Section 40 will require the Secretary to establish regulations for determining the reasonable cost or charges of direct and indirect overhead expenses. This approach of regulating individual line-item expense components is one means of controlling costs; however, it seems to be in direct conflict with the philosophy and purpose underlying the cost ceilings imposed in Section 10. The direct and indirect overhead expense controls specified in this subsection are based on a system of itemizing and controlling individual, rather than aggregate, expenses. The Association believes that simultaneous controls on individual overhead expenses and aggregate cost ceilings places management in an untenable position. To provide efficient and effective services within the cost ceilings, the hospital director needs the administrative flexibility which the overhead controls would diminish. In its consideration of changes, the Association strongly recommends that the Subcommittee adopt exclusively a cost control philosophy of cost ceilings rather than a philosophy of both ceiling and line-item controls.

Contract Approval

This provision directs the Secretary to establish a program for review and advance approval of "consulting, management, and service contracts" with an annual cost of \$10,000 or more. The Association strongly recommends that this subsection either be eliminated or significantly modified by the Committee. First, as with the overhead controls program, this contract approval amendment is an individual service control rather than an aggregate

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ceiling control. Once again, the hospital director must try to live within a ceiling at the same time his operational flexibility to do so is reduced. Second, by requiring advance approval of virtually all types of hospital contracts, this amendment shifts operational management authority from the hospital director to the HEW staff. The hospital director and governing board could propose and implement but not decide on courses of action. In effect, DHEW will be managing by contract review significant aspects of the nation's hospitals. Third, by requiring all contracts with an annual payment of \$10,000 or more to be approved, the amendment guarantees that DHEW will have to undertake a significant bureaucratic expansion. This \$10,000 threshold is so low that the number of contracts requiring approval will be significant. Bureaucracy will mushroom and the resultant costs will be an additional burden on the nation's health expenditures. Fourth, the legislation requires a procedure to determine if the services may appropriately be furnished by contract. Even if government authorities could judge the reasonableness of a contract price and could evaluate the contractor's likely ability to perform the services, the governing board of the institution should retain the right to determine whether it wants a function performed by "in-house" or contract personnel.

The Association understands that this segment of the proposed Section 40 is intended to ensure that Medicare and Medicaid do not subsidize contracts of questionable value or contracts undertaken

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with nearly fraudulent intentions. These objectives are commendable. The provisions do not discriminate, however, between those contracts likely to be undersirable and those which are characteristic of routine hospital operations. It is an attempt to control the small percentage of irregularities by controlling everything. The Association recommends that this section be completely re-written to direct the Secretary to control only those irregular, nearly fraudulent and self-dealing contracts which may be sources of abuse.

Conclusion

In conclusion, the Association expresses its appreciation to the Committee for this opportunity to testify on S. 3205. The Association shares the Committee's objective of improving the Medicare and Medicaid programs, and the Association has offered this testimony on the legislation as a sincere effort to refine and improve the proposed amendments.

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

January 30, 1976

Mr. Jay Constantine  
Professional Staff Member  
Senate Finance Committee  
2227 Dirkson Senate Office Building  
Washington, D.C. 20510

Dear Jay:

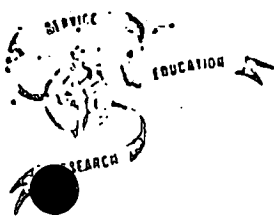
In response to your request, I am writing to provide you with the Association's tentative observations and comments on the hospital reimbursement section of the proposed Medicare Amendments ("Talmadge Bill"). These are based on the attached summary paper which outlined our current understanding of the proposal at the time as it was discussed at the recent Council of Teaching Hospitals (COH) Administrative Board meeting on January 14, and at earlier meetings in your office. From our subsequent discussions on January 27, I realize that tentative decisions have been reached concerning some of our suggestions and reservations. However, the intent of this letter is to set forth the Board members' views based upon their knowledge of the proposal as of January 14.

It is clear to us that the Senate Finance Committee staff has made a sincere effort to take into consideration and to accommodate to many of the characteristics which make hospitals different from one another and consequently extremely difficult to classify. We appreciate very much the opportunity you have afforded us to offer constructive comments during the process of developing the proposal as well as the invitation to set forth our serious concerns with some portions of the proposal.

Recognizing that the new proposal represents a series of steps directed toward improving and moving forward from Section 223 of the 1972 Medicare Amendments and other aspects of retrospective cost determination, the COH Administrative Board spent a considerable amount of time deliberating over the potential impact of the proposal. The Board identified a number of problem areas which it requested that I bring to your attention.

Uniform Accounting And Cost Allocation

The most important prerequisite for proper evaluation and measurement of "routine operating costs" is the development of a system of uniform accounting and cost allocation. A mechanism for assuring the comparability of financial data should be developed prior to full implementation of the program. Experiences in California and Maryland, where uniform financial reporting systems



Since the following letter to Jay Constantine served as the basis for the draft testimony, it is provided as a reference for discussion.

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January 30, 1976  
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have been developed, demonstrate that enormous time and effort are required to achieve this goal. The Board believes that a period of two years subsequent to final passage of the bill is necessary.

### Classification Of Hospitals

In the past the Association has not specifically proposed a separate classification of teaching hospitals, but rather has proposed the exclusion of specific components of "routine operating costs" so that variations in the remaining costs to be measured and compared are not due to the nature of the product produced or to characteristics of the production process that cannot reasonably be altered in short periods of time. Therefore, we believe that the proposed exclusion of capital, education and utility costs are steps in the right direction.

The proposal provides for the creation of a separate group of "primary medical center hospitals." It is difficult to evaluate the implications of creating such a group because of the absence of data. As you know, efforts to gain data and experience with this separate group are hampered by the inability of the current Medicare reporting process to identify and extract the elements to be excluded from the present scheme. Thus, there is uncertainty as to the relative merits of a separate group for "primary medical center hospitals." On balance, however, it was the Board's best judgment that a separate group or groups would be desirable, but that the appropriate definition and composition of this group(s) is a very serious matter which it could not specifically address without considerably more data, experience and thorough examination.

### Definition And Composition: Teaching Hospital Group

A serious effort has been made to define the type of hospital which includes those characteristics which we assume you imply with the term "primary medical center hospitals." Even teaching hospitals differ greatly in the scope, breadth and depth of their commitment to educational purposes, the characteristics of patients they serve, and the nature and scope of services they provide. The Association's governing body adopted the following policy statement in November of 1972.

"At least three major factors must be considered when attempting to characterize or classify hospitals:

- The nature and scope of the hospital's educational objectives and the degree of institutional commitment to meet the incremental costs of providing the environment for undergraduate and graduate medical education;

- The severity of illness, complexity of diagnosis, and socioeconomic characteristics of the patients served by the hospital;
- The comprehensiveness and intensiveness of services provided by the hospital.

There is a great variation in the extent to which each teaching hospital meets these dimensions. Any attempt to characterize or classify teaching hospitals must recognize the limitations of grouping all teaching hospitals . . . . "

Since there is not a commonly accepted definition of a "teaching hospital" for the purpose intended, the Board strongly recommends that, instead of a specific definition, language should be incorporated into the Bill which would require the Secretary to examine the implications for reimbursement of various definitions of the terms "teaching/tertiary care hospitals" to determine which definitions most accurately reflect the teaching hospital's role as a referral center for tertiary patient care services, and as an educational institution.

#### Specific Statutory Requirements

A fundamental concern of the Board relates to the fact that the design of the hospital groups (and other matters) in the proposal is specifically defined in the Bill, thus making alterations based on experience most difficult to make on a timely basis. Realizing, however, that there are equally pertinent concerns with the extent to which Congressional intent is reflected in Executive branch implementation, the Board recommends that the Bill provide that hospitals shall be classified by size and type, and that it further provide for the establishment of an "advisory body" to evaluate alternative classifications of size and type, to review progress and monitor implementation, and to examine problems encountered and make recommendations regarding solutions.

The question of the most appropriate definition and classification of teaching/tertiary care hospitals is a good example of an issue which would be brought before this advisory group. There undoubtedly would be many other issues in light of the fact that the "state-of-the-art" in classifying hospitals for cost control is in its infancy, that the risks of initial inequities are high, and that the "phase-in" period for the program requires a careful, step-by-step review.

An advisory group should be established, and members of this group should include representation from the Legislative and Executive branches of the government as well as knowledgeable individuals from the private sector.

### Establishment Of Payment Rate

The Bill proposes that the ceiling for each group be determined by calculating the average adjusted cost and adding ten percent to that average. In the absence of precise data, it is difficult to know the percentile rank which will be set as a group ceiling. With the uncertainty concerning the proposal, the average plus ten percent could well result in too many hospitals being over the ceiling and therefore in danger of fiscal instability and making an exceptions process unmanageable. The Board strongly recommends that the initial ceiling should be higher.

### Wage Rate Indices

The wage rate index should include consideration of hospital wage levels, if available, for the local or state area where they are higher than general wage levels. In such instances an initial adjustment should be made for the higher level with future increases controlled by increases in community wage levels. This approach addresses the concern you expressed about the intensity of collective bargaining if a complete hospital wage level adjustment were allowed.

### Malpractice Insurance Premiums

Since there is wide regional and institutional variation in premium rates, and because these rates are largely beyond the control of the hospital, the Board strongly recommends that malpractice insurance premiums be added to the list of exclusions from routine operating cost which are contained in the proposal.

### Exception And Appeal Procedures

Experience gained since the development and operation of Section 223 of the 1972 Medicare Amendments has demonstrated the urgent need for an effective and timely exceptions and appeals process. An effective and equitable exception and appeal process has not been functioning under the present Section 223 limitations. For example, information describing the specific methodology and data utilized to derive exceptions should be made available to all institutions, as well as the identity of "comparable" hospitals located in each group. The basis on which exceptions are granted should be publicly disclosed in each circumstance and easily accessible to all interested parties. Further, substantive response to appeal and exception requests should be required to be made in a reasonably short time period.

The Board was of the opinion that because many hospitals are reducing their patient lengths of stay, controls based on per diem routine operating costs may not in all circumstances be appropriate or equitable. This is due

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January 30, 1976  
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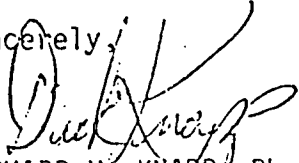
to the fact that compressing the length of stay often results in an increase in the hospital's routine per diem operating costs but no change or even a reduction in the per admission costs. Therefore, the exceptions process should recognize this phenomenon and allow hospitals to demonstrate reasonable costs through the use of a "per-admission cost."

A hospital should also be permitted to establish through the exceptions process that it has an abnormal case mix and/or intensity of service which affects routine operating costs. In light of the fact that the tertiary care/referral hospital serves the more severely ill patients and that referrals of such patients from other hospitals tend to increase in times of adverse economic conditions, this type of patient mix and intensity (or scope) of service factor therefore should be recognized in the exceptions process.

In conclusion we wish to express again our appreciation for the opportunity to set forth our views on the Committee staff's proposal. I should emphasize that we have offered our observations on the proposal as a sincere and thoughtful effort to refine and improve Section 223 of the 1972 Medicare Amendments and other aspects of retrospective cost determination without addressing the advantages and disadvantages of a centrally administered national scheme. Nor have we evaluated the relative merits of this approach in contrast to others which do not use the "cost of a routine day of care" as the unit of analysis or control.

While we do have reservations as stated above, we believe the course of direction which has been charted may be fruitful and is appropriate to bring before the Senate Finance Committee for consideration.

Sincerely,



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

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Enclosure



CONTROL OF HOSPITAL ROUTINE SERVICE COSTS

Hospital Reimbursement Proposal (Senate Finance Committee)

The determination of routine service costs of hospitals will conform to a uniform accounting and cost allocation system (to be established by the Secretary) and shall exclude:

- a) capital costs, such as interest expense on loans to purchase capital assets, and depreciation expense;
- b) costs of hospital education and training programs;
- c) costs of interns, residents, and salaried medical staff; and,
- d) energy costs associated with heating and cooling of the hospital plant. Such costs are excluded because:
  - 1) they are an uncontrollable factor of non-wage costs in national cells which may vary substantially; and,
  - 2) because of the unusual and unstable economic conditions currently involved in the purchase of energy.

Hospitals shall be classified according to:

- a) number of beds
  - 1) less than 25 beds (will be excluded from this proposal)
  - 2) 26-99 beds
  - 3) 100-249 beds
  - 4) 250-500 beds
  - 5) more than 500 beds
- b) type of hospital, including short-term general hospitals, primary hospital of a medical center (to be defined) and specialty hospitals including psychiatric, pediatrics, geriatric, maternity, or other specialty hospitals to the extent that such differences in type of hospital affect routine operating costs as determined under this proposal.
- c) urban hospitals whose patient mix is essentially derived from a low income population shall be considered separately and shall constitute one or more cells of the classification system, if the Secretary determines that location in such cases does affect routine service costs as determined under this proposal.

In the second quarter of each fiscal year (beginning with the January - March quarter of 1977), the average per diem routine service cost shall be determined within each cell of the classification system, and adjusted for variations in wages in the areas in which the hospitals in the cell are located, according to the following methodology.

- a) routine service costs shall be determined for each hospital, and divided into two components, a personnel cost component and other component. The personnel cost component shall be adjusted for variations in wages as follows:

- 1) a wage index shall be prepared for the cell based on general wage levels in the areas in which the hospitals are located, with the lowest wage area assigned a value of 1.000 and all other areas indexed to reflect their relations to the wage rates in effect in the lowest area;
  - 2) the personnel cost component of routine, operating cost shall be adjusted downward by the wage index described above by dividing the personnel costs by each hospital's wage index.
- b) The total of the "other" routine service costs and the adjusted personnel cost component shall be calculated for all hospitals in the cell. Such totals shall be divided by the total number of days of routine care provided by the hospitals to determine the adjusted average per diem routine service cost.

The adjusted average per diem routine service cost for each cell shall constitute the basic payment rate for routine services in the next fiscal year (beginning with the fiscal year starting October 1, 1977). In determining the adjusted average per diem within any cell, the Secretary shall exclude any hospitals which have significant understaffing problems, or other significant cost differentials resulting from failure to fully meet the statutory and regulatory conditions of participation as determined by JCAH, State agency certification procedures, or other information available to the Secretary. Such hospitals shall be reimbursed on the basis of their actual costs, not to exceed the rate which would be paid to them under this part.

Hospitals shall be reimbursed for their actual costs if their routine service costs exceed the average adjusted payment rate for their cell by no more than 10 percent. Hospitals with routine operating costs in excess of this amount shall receive no more than the average adjusted payment rate plus 10 percent.

An exception shall be provided in the first year of operation under this proposal so that hospitals can be reimbursed for their actual costs if they agree to narrow the gap between their actual costs and the adjusted payment rate ceiling by more than 50 percent.

Hospitals with costs less than the average adjusted payment rate shall be reimbursed their actual costs plus some added amount (method to be determined) as a reward for efficiency.

For cost increases occurring after determination of a hospital's adjusted rate payment, the adjusted rate of payment shall be adjusted on a quarterly basis by the lesser of:

- a) the hospital's estimate of the percentage increase in its costs, or
- b) the increase in prices estimated by the Social Security Administration for the mix of goods and services, including personnel and non-personnel costs, which comprise routine operating costs as determined under this part.

At the end of the fiscal year, a retrospective adjustment shall be made to the amounts reimbursed for such cost increases to the lesser of:

- a) the actual cost increases incurred by the hospital, or
- b) the actual increase in prices which the Social Security Administration determines has occurred for the mix of goods and services, including personnel and non-personnel, which comprise routine operating costs as determined under this part.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES  
Annual Meeting  
San Francisco, California

Friday, November 12, 1976

7:30 - 9:00 AM COTH ADMINISTRATIVE BOARD BREAKFAST

9:30 - 11:30 AM COD/COTH JOINT PROGRAM

The Commission on Public-General Hospitals

"Activities of the Commission"

Russell A. Nelson, M.D., Chairman

"Issues for State University-Owned Hospitals"

John R. Hogness, M.D.

President, University of Washington

"Issues for Big City Public Teaching Hospitals"

Joseph V. Terrenzio

President, United Hospital Fund  
of New York

12:00 - 5:00 PM COTH LUNCHEON, INSTITUTIONAL MEMBERSHIP MEETING  
AND GENERAL SESSION

(Dr. Clifton Gaus)

Saturday, November 13, 1976

9:00 - Noon PLENARY SESSION

Noon - 1:30 PM COTH PAST CHAIRMAN'S LUNCHEON

1:30 - 4:00 PM AAMC ASSEMBLY

Sunday, November 14, 1976

9:00 - Noon PLENARY SESSION

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GRADUATE MEDICAL EDUCATION  
VIEWED FROM  
THE NATIONAL INTERN AND RESIDENT MATCHING PROGRAM

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GME VIEWED FROM THE NIRMP-GRAETTINGER

John S. Graettinger, M.D.

Executive Vice President  
National Intern and Resident Matching Program

Dean of Faculty Affairs, Rush University  
Director, Graduate and Continuing Medical Education  
Rush Presbyterian-St. Luke's Medical Center

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Chicago, Illinois 60612

ABSTRACT

The total number of applicants for first year programs in graduate medical education in the NIRMP exceeded the number of positions offered for the second consecutive year in 1976. The number of positions available for the anticipated number of the applicants who will be graduates of U.S. Medical Schools in 1976 was approximately 1.22. Based on student preferences for their GME-1 programs, deficits exist in the openings offered in the primary care specialties and surfeits in medical and surgical subspecialties, pathology, psychiatry and radiology.

In the first 25 years of its operation, what is currently the National Intern and Resident Matching Program (NIRMP) has served over 90% of graduating students from U.S. Medical Schools and the hospitals offering them internships and residencies by matching students and hospital choices each year. For the first 20 years, the interface between undergraduate and graduate medical education changed slowly and reasonably predictably. In the years since 1970, however, major changes have been occurring at the UG-GME interface because of a confluence of several factors. These changes are described in the following data, which have been harvested from yearly statistical reports\* of NIRMP. The data also highlight certain problems in graduate medical education (GME).

#### Positions Offered and Applicants

The number of GME-1 positions offered compared with the number of graduates from U.S. Medical Schools are plotted in figure 1 for the years 1952 through 1976. The marked changes since 1970 are obvious. In table 1, the data from the number of GME-1 openings and the number of applicants for the seven years beginning with 1970 are shown. Several trends are clear. First the number of positions offered increased by approximately a thousand a year until 1973, and then decreased

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\*For many years the matching process and the accumulation of data were carried out manually. Descriptions and data have been published. (1)

Beginning in the 1974-75 academic year, a system devised for NIRMP by Centner-Peranson Associates of Toronto, has provided data for detailed studies of the program.

in 1974 and 1975. The number of positions offered for 1976 was between those offered in 1970 and 1971. Second, the number of applicants has more than doubled and the composition of the pool of applicants has altered markedly. The proportion of applicants who are graduating from U.S. Medical Schools has decreased from 92.5% represented by the 8327 students in 1970, to only 67.9% represented by the 13,223 applicants for 1976. This change has occurred because of several factors. In 1970, the 8536 "North American Graduates" (NAG's) included, in addition to U.S. graduating medical students (USGS), 120 graduating students from Canadian schools, 70 osteopathic graduating students and 19 graduates of U.S. schools who were "physician candidates", i.e., had not entered graduate medical education via NIRMP in the year of their graduation, for a total of 209 other U.S. - Canadian graduates. This category increased to 620 for 1976 primarily because of the applications of 5th pathway students who first appeared in 1973 and numbered 297 for 1976, and also because of an increase of "physician candidates" to 139. The major reason for the decreased proportion of USGS is, however, the increase in the number of applicants who are graduates of foreign medical schools outside of North America (FMG's). In 1970, there were 470 such applicants, representing about 5% of applicants as they had for many years. By 1975, 3968 FMG's constituted 24% of applicants, and for 1976, the 5953 made up 30% of the applicant pool. These changes have contributed to decreasing the ratio of the number of openings per applicant from 1970 to 1976 by over half, to 0.8. For all NAG's and, for current USGS, the number of openings has decreased from 1.9 to 1.2 positions per student.



### Results in the Matching Programs

The over-all results of the matching for these positions are shown in tables 2 and 3. Each year the number of applicants who are actually in the matching process is less than the original number of applicants because of those who "x" all choices, resign from the program, or simply do not return a list. This number may be calculated by subtracting the data in the first panel of table 2 from the "Applicants" in table 1. From 1970 to 1976, it has increased from 6 to 15% for all applicants. The withdrawal rate for FMG's has ranged from 20 to 40%. For USGS, the percent of applicants who withdraw has increased from 5 to 11%.

For the total applicants in the match, the percent matching to positions has decreased over these seven years from 97% to 73%. A decrease of about 6% matched of NAG's and of USGS has occurred in the same period. Thus the decrease in matching by the total applicant pool has been primarily in the group of FMG's.

The relationship of matched applicants to positions offered is shown in table 3. In 1970, when the matching success of all categories of applicants was 86 to 97%, only 52% of positions were filled. 95% of them were filled by USGS and only 5% by others. In 1976, only 73% of all applicants were successfully matched, yet 76% of the positions filled. Only 88% of the filled positions were occupied by USGS and 12% by others.

The data of the three tables are displayed in the bar graphs of figure 2. Inspection of the figure reveals that almost all USGS apply

to NIRMP. An increasing number of graduates who withdraw is evident and requires further study. The percent of non U.S. graduates who withdraw is much greater than that of USGS. The number and percent of unmatched USGS has also increased and will be examined below. The FMG data indicate that, despite a marked increase in the number of applicants since 1972, the actual number matched has remained relatively constant in the past 4 years with the result of a marked drop in the percent of those successful in the match from 1974 to 1976.

#### Types of Programs

The number of programs of various types offered and their filling by all applicants and by USGS are shown in tables 4 and 5.

The abolition of the rotating internship and its replacement by Flexible GME-1 residency positions in 1975 resulted in a decrease of 3626 non disciplinary GME-1 offerings, but a decrease of only 1712 in the total number of GME-1 openings. This was because of an increase of 1914 in the number of positions in disciplinary programs, 1114 of which were increased positions in the primary care programs. In 1976, the number of flexible positions decreased further by 282 and positions in disciplinary programs increased by 503 for a net increase of 221 positions.

The percent of positions offered was greater than the percent of those matching in them in 1974, 1975 and 1976 for rotating/flexible programs, general practice, pathology, psychiatry, radiology and both medical and surgical specialties, while the percent of those matching in them was higher than the percent of offerings in family practice,

internal medicine and pediatrics (table 4). Ob/Gyn and general surgery offerings were essentially the same as the percents of those matching. In 1974, the primary care specialties, which constituted only 43% of the positions offered, attracted 53% of those matching. In 1975, these specialties accounted for 54% of the positions offered and 64% of those matching. In 1976, they totaled 56% of the positions and 65% of those matching. The 61% filling of all of the positions offered in 1974, the 72% in 1975, and the 76% in 1976 represent the highest rates of filling in the history of the matching program. For the same years, 76%, 84% and 87% of the available positions in the primary care specialties were filled.

In table 5, the data are displayed for 1974, 1975 and 1976 for the USGS only. Their preferences for family practice, internal medicine and pediatrics above the numbers offered is clear, as shown in the percents of those matching. In 1974, 56% of those matched were in the primary care fields, in 1975, 65% of those matched, and in 1976, 66% of those matched despite the fact that the percents of positions offered in them were only 43%, 54% and 56% respectively in these last three years.

In table 6 are shown the data for those three years for all other matched students, i.e., the 247 NAG's plus 1151 FMG's in 1974, the 225 NAG's plus 1056 FMG's in 1975, and the 331 NAG's plus 1101 FMG's in 1976. In these years they filled 8-9% of the positions offered and constituted approximately 12% of those matching. Their successes in matching were greatest in rotating/flexible programs, surgery, pediatrics and pathology.

Although both the total number and percent of non-U.S. graduating students changed little from 1974 to 1976, their number in primary care specialties increased by 272 and their percent of the total matched in them from 9% to 10%. The major reason was the steady increase in pediatrics, up to 16% of those matched. A major increase in non-U.S. graduating students, from 178 to 342, also occurred in surgery and the surgical specialties, which was an increase from 11% to 28% of those matching.

#### Unmatched Students

In table 7 are shown the programs applied for by the 636 (6.5%) USGS who were unmatched in 1974, the 803 (7.4%) who were unmatched in 1975, and the 952 (8.1%) who were unmatched in 1976. (table 2)\* The first choices of two-thirds of the unmatched students in 1974 were for internal medicine and family practice programs of which 73% were filled by USGS plus another 7% filled by others. The first choices of nearly three-quarters of our unmatched graduates in 1975 and 1976 were for these two fields which were 80% and 82% filled by USGS plus another 7% filled by others. Regionally there were differences with only 6% of students unmatched in the northeast and midwest, but 9% unmatched in the west and 10% in the south. Approximately 15% of the unmatched students in 1974, 1975 and 1976 listed only one or two choices. This may be of significance in that nearly a third of the students who did match did so with their 3rd or lower choice or program.

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\*The totals in table 7 are slightly less because of ambiguity in hospital codes used by 5 students in 1974, 1 in 1975, and 5 in 1976.

### Discussion

The major phenomena occurring at the interface between the undergraduate and graduate phases of medical education have been described in these data, as seen from the vantage point of the matching program. Extrapolation of these NIRMP data to describe the distribution of all programs in GME-1 and the behavior of all aspirants to the first year of graduate medical education is hazardous. Not all hospitals offering such positions participate in the matching program. Unfortunately, the numbers of approved positions for the past three years, which are the necessary denominators to measure participation, are not yet available. Since over 98% of USGS participate in the program, however, an analysis of their choices and of the filling of the kinds of programs offered would seem to give considerable insight into the beginning of the final, formal phase of medical education.

The ratio of positions available to all NIRMP applicants decreased from 1.73 in 1970 to 0.87 in 1976, and for USGS, from 1.87 to 1.22. Concurrently the percent of all participants successfully matched decreased from 97% to 73% and from 97% to 92% of USGS. The filling of positions offered has increased from 52% in 1970 to 76% in 1976. The major reasons for these changes seem evident in the data on the supply of and demand for GME-1 positions.

The number of GME-1 positions dropped abruptly in 1974 and 1975 accompanying the abolition of the free-standing rotating internships and the numbers of both USGS and independent applicants for them increased. This latter group has been of considerable concern and is

clearly separable into three subgroups as was shown in table 3. The first consists of graduates of Canadian medical schools, of osteopathic schools and physicians who previously graduated from U.S. medical schools. They have had less success in matching in recent years and will occupy only 0.8% of filled positions in 1976. The second subgroup is represented by the 5th pathway students who first appeared in 1973, and have matched almost as well as USGS and will occupy 2% of filled positions in 1976. Their numbers will probably increase. The third subgroup consists of the graduates of non-North American medical schools (FMG's). Although their applications increased from 5% to 30% of the total from 1970 to 1976 and their participation in the matching from 3% to 27% of the total candidates, their success in matching decreased from 86% to 24%. The net result has been that they occupied 3% of the total filled positions in 1970, 10.8% in 1974, but 9.4% in 1975 and will have 9.0% of matched positions in 1976. Preliminary analyses of matched applicants by hospitals suggest that their distribution is not homogenous, i.e., that they fill considerably greater than 9% of positions in some hospitals and considerable fewer in others.

The filling of various kinds of programs has varied markedly. The numbers of GME-1 positions offered in the primary care specialties of family practice, internal medicine, pediatrics and obstetrics/gynecology have been increasing. Their rate of increase has, however, been less than the increasing numbers of applicants for them. Students graduating from U.S. Medical Schools (USGS) have not only been increasing in numbers, with graduates in 1976 estimated to be at least 60% greater than

in 1970, but also their choices for types of program in the GME-1 year has changed markedly. 56% of those matched were in the primary care specialties in 1974 and 66% in 1976. In addition to these quantitative and qualitative changes of USGS, the percent of non-USGS in the primary care specialties increased from 37% in 1974 to 55% in 1976. The combination of these factors led to an 87% filling of available positions in the primary care programs in 1976, ranging from the 91% in internal medicine to 79% in obstetrics/gynecology.

In addition, a record number, 952 USGS, 8% of those in the matching, were unmatched. An analysis of those who were unmatched revealed that over 80% applied in primary care specialties in the last two years. Less than 30% of the unfilled positions have been in these programs in the last three years. The applicants for GME-1 positions, particularly USGS, by their applications and by their choices for matching, have indicated their major preference for entering GME-1 in these programs. These data suggest that a considerable maldistribution exists in the kinds of positions offered to all applicants, particularly USGS. The most serious deficit is in internal medicine where 458 unfilled positions were fewer than the 527 unmatched students whose first choices were for a program in internal medicine in 1976. In family practice, the 241 unfilled positions only slightly exceeded the 160 unmatched students whose first choices were for those programs.

Obviously increased numbers of positions in the sought-after programs will have to be established if the preferences of applicants are to be met. The existence of approximately 10% unfilled positions in

these two fields, however, needs further study before national actions can be taken. One explanation for the unfilled positions would be the geographic dimensions of the country, coupled with the regional proclivities of graduates and, perhaps, even program directors and their hospitals. Although communication, such as the "hot line" used by the Academy of Family Practice might help, this explanation would suggest that the minimum number of positions offered nationally should definitely be greater than 1.0 per graduate.

Another explanation for the unfilled positions would be, however, that they are in programs which are regarded as unacceptably inferior by applicants. Some insight into the relative importance of these two factors can be gained by studying applications of students to hospitals. The cost of establishing and maintaining GME positions make approaches which will provide a close congruence of student choices and hospital openings highly desirable.

Positions in flexible residencies decreased from 33% to 11% of the openings offered from 1974 to 1976 and attracted a smaller proportion of both USGS (23% to 9%) and non USGS (48% to 15%) applicants who matched. The increase in filling them (50% to 68%) was only a reflection of the overall decrease in number of positions per applicant. 18% of the positions were filled by non USGS. With the exception of General Practice, which attracted only non-USGS, this was the highest percent filling of any type of program by non-USGS. Flexible residencies, therefore, have not proven to be highly acceptable GME-1 programs for most USGS.



The problems presented by the GME-1 programs in disciplines other than the primary care specialties is complex. Those offered in the NIRMP were approximately 60% filled in 1976. 70% of the unfilled positions were in such programs. In the current environment, with the emphasis of both the general public (including their legislators) and medical students on producing physicians for the primary care areas, the crucial importance of producing smaller but appropriate numbers of each type of specialist and sub-specialist must not be ignored. A considerable number of unfilled GME-1 positions in a specialty is, however, difficult to justify in the presence of deficits of positions in others.

The data reported make obvious that not all positions and programs in the specialties of pathology, psychiatry, radiology and the medical and surgical subspecialties participate in NIRMP, and that those which do are not vigorously sought after as GME-1 experiences by USGS. The recruitment and selection of trainees in these fields, therefore, pose at least three major problems. The first is what kinds and how many positions should be offered at what levels of GME and with what prerequisites. In the very rapid response of the smaller specialties and their program directors to the Millis report,<sup>(2)</sup> the internship requirement was abolished by many Boards with the consequence that the number of different programs in disciplines offered to graduating students increased greatly. In the NIRMP, 38 different program types in 20 disciplines were available for 1976. Currently several Boards are reconsidering their requirements for a broader clinical experience.

Evidence that local or national interdisciplinary discussions have influenced these decisions and offerings in any significant manner is lacking. The second problem is the laissez-faire selection process which exists for programs not offered in the NIRMP. The consequence is forcing the student to make decisions regarding specialty selections and specific programs inappropriately early in the medical school experience, i.e., the phenomenon which led to the formation of the National Interassociation Committee on Internships, the parent of the NIRMP, in 1951.<sup>(3)</sup> The third problem occurs when such a program is offered via NIRMP, namely, the temptation of students and program directors concerned with smaller specialties with a small number of applicants to make early commitments in violation of the NIRMP contract.<sup>(4)</sup> The temptation may be anticipated to be particularly great when only some of the programs in a specialty or subspecialty are offered through the matching program and the program director of such a participating program must compete with the directors of programs not bound by a NIRMP agreement.

Questions of "cheating" and "sham matching" have occurred with increasing frequency in the past few years. An unusually high incidence of first choice matching for a particular program type, particularly when combined with an unusually high incidence of only a single choice on students' rank order lists, suggest more than a casual discussion of mutual interest between student and program director. This unusual confluence has occurred in several of the smaller, non-primary care, less popular specialties in recent years and is clearly unfair to the student and subversive to the NIRMP. That the student who lists only

a single choice is put in jeopardy is evident in the fact that 11% of those who did so last year went unmatched.

The NIRMP now functions at the interface between two phases of the sequence of formal medical education, not at the end as it did prior to the rapid and diversified expansion of programs in graduate medical education from internships. The problems facing students, program directors, and the NIRMP at this interface arise mainly from the diversity and relative anarchy which currently characterize the initial portions of graduate medical education. A promising approach to the establishment of an orderly UG-GME sequence is the development of corporate responsibility for GME as well as UGME by the Medical Centers and their developing networks of hospitals, <sup>(5,6)</sup> which was an integral part of the recommendations of the Millis Commission. <sup>(2)</sup> The vast majority of programs offered to USGS and other applicants are in hospitals with current affiliations with Medical Centers. The movement of USGS into quality GME programs is thus of mutual concern to hospitals and Medical Schools and their Deans. The assumption of corporate responsibility means intra- Medical Center Committees, consisting of members from various disciplines and hospitals, for planning, admissions, curricula and evaluation for the several years of each of the various specialty programs. Included can be the development of sequential programs, from the GME-1 year to the final year, leading to Board eligibility in each of the various specialties and subspecialties. Closer study and planning based on action patterns of graduates and their regional preferences will make possible a better fit of numbers and kinds of offerings to

graduates with a smaller number of openings. If Medical Centers in each region will offer and vigorously attempt to fill a number of GME-1 positions approximately equal to the number of their graduates, with a distribution among specialties reflecting both student aspirations and the medical needs of the region, a better match of the UGME portion to the GME portion of the education-training of finished physicians can be anticipated.

The NIRMP has served well for a quarter of a century and, with the current diversity and complexity of GME, is even more important than when it was founded, in order that students and hospitals may make deliberate, thoughtful choices. These data from the Program make obvious, however, that problems exist which are quite unrelated to matching and which require qualitative and quantitative changes in the processes of GME. Corporate planning and conduct of GME, carried out within and among the Medical Centers of the various and differing regions of the country, rather than by autonomous, discipline-based or national planning, would seem essential for the production of appropriate kinds and numbers of practicing physicians. The Matching Program will continue to serve to facilitate the transition from the undergraduate to the first, to several or to all years of graduate medical education, and to provide descriptive data of the process.

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Figure 1: Comparison of the number of GME-1 positions offered with the number of graduates of U.S. Medical Schools for the years 1952 through 1976.

Figure 2: Participation and results in the NIRMP for the years 1970 through 1976. The left column for each year represents U.S. graduating students and the right column of each pair represents the total applicants, i.e., USGS plus NAG's plus FMG's. In the lower portion of each right column, the FMG's alone are shown. The total height of each column represents the number of applicants, the clear portion the number who withdrew, the diagonal-lined portion the number unmatched and the stippled portion the number matched. Above each pair of columns a dash defines the number of positions offered that year, and over the left column (USGS) a dot indicates the total number of graduates in the U.S. for that year.

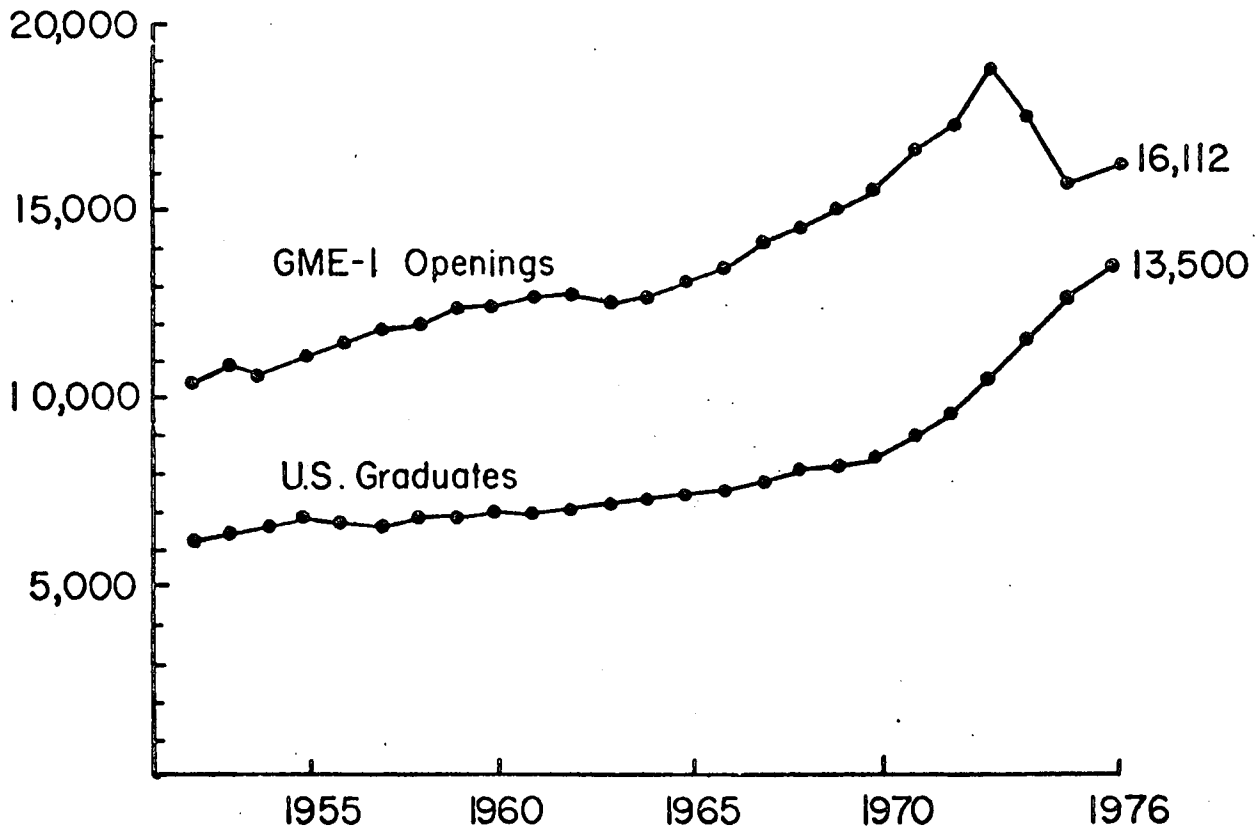


FIGURE 1

### NIRMP PARTICIPATION AND RESULTS

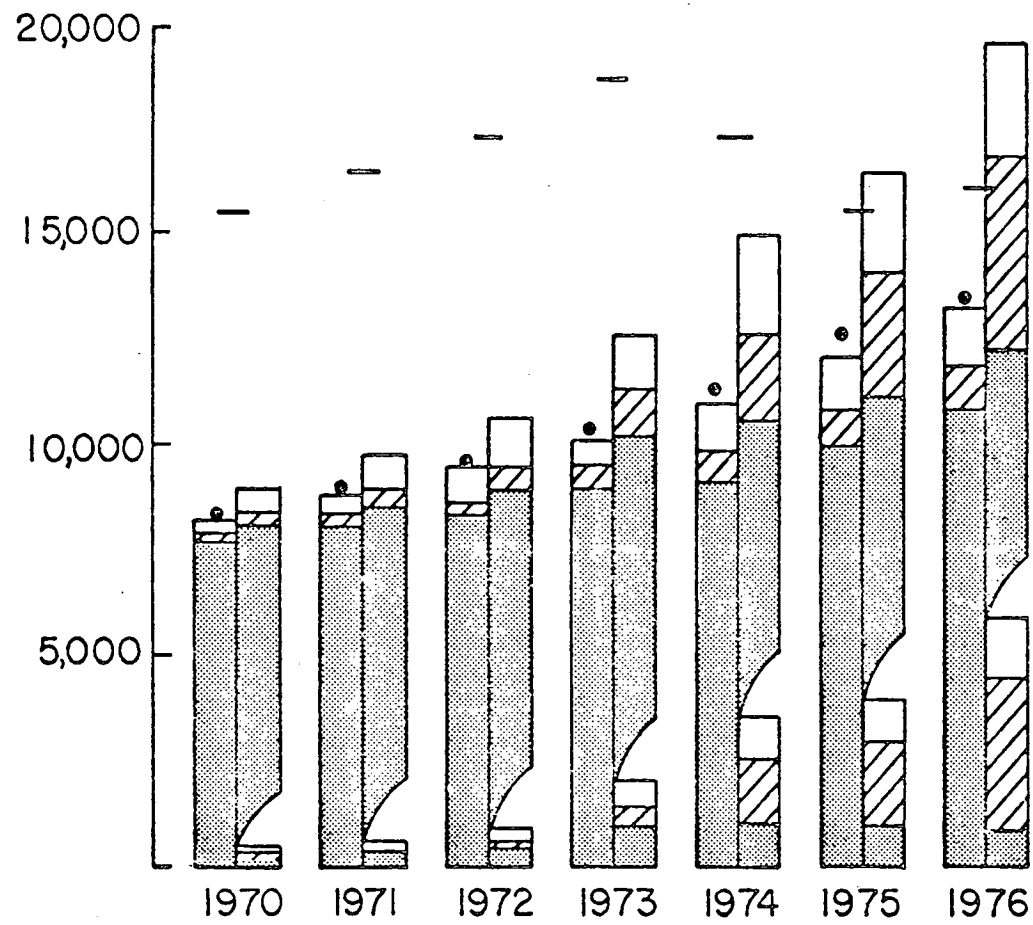


FIGURE 2



TABLE 1. THE RELATIONSHIP BETWEEN THE NUMBER OF GME-1 OPENINGS AND APPLICANTS, 1970-1976

	1970	1971	1972	1973	1974	1975	1976
Total Openings	15,567	16,615	17,283	18,728	17,403	15,691	16,112
Total Applicants	9006	9846	10,765	12,640	15,041	16,536	19,796
North Amer. Grads	8536	9222	9818	10,549	11,438	12,568	13,843
U.S. Students	8327	8858	9494	10,125	11,003	12,166	13,223
<u>Openings per:</u>							
Total Applicants	1.73	1.69	1.61	1.48	1.16	0.95	0.81
North Amer. Grad	1.82	1.80	1.76	1.78	1.52	1.25	1.16
U.S. Students	1.87	1.88	1.82	1.85	1.58	1.29	1.22

TABLE 2. SUCCESS OF APPLICANTS IN THE NIRMP 1970-1976

	1970	1971	1972	1973	1974	1975	1976
Number in match	8387	9004	9542	11,286	12,798	14,153	16,728
North Amer. Grads	8104	8643	8958	9822	10,162	11,079	12,151
U. S. students	7950	8417	8758	9525	9860	10,802	11,735
Total Matched	8113	8599	9044	10,217	10,622	11,280	12,215
North Amer. Grads	7869	8297	8554	9213	9471	10,224	11,114
U. S. students	7732	8107	8389	8969	9224	9999	10,783
Total % Matched	96.7	95.5	94.8	90.5	83.0	79.7	73.0
North Amer. Grads	97.1	96.0	95.5	93.8	93.2	92.3	91.5
U. S. students	97.3	96.3	95.8	94.2	93.5	92.6	91.9
Total Unmatched	274	405	498	1069	2176	2873	4513
North Amer. Grads	235	346	404	609	691	855	1037
U. S. students	218	310	369	556	636	803	952
Total % Unmatched	3.3	4.5	5.2	9.5	17.0	20.3	27.0
North Amer. Grads	2.9	4.0	4.5	6.2	6.8	7.7	8.5
U.S. students	2.7	3.7	4.2	5.8	6.5	7.4	8.1

TABLE 3. RELATIONSHIP OF MATCHED APPLICANTS TO POSITIONS

	1970				1976			
	Matched #	%	% Positions Filled	% Filled Positions	Matched #	%	% Positions Filled	% Filled Positions
U S STUDENTS	7732	97.3	49.7	95.3	10,783	91.9	66.9	88.3
Other (1)	137	89.0	0.9	1.7	104	63.4	0.6	0.8
5th Pathway	----	----	----	----	227	90.1	1.4	1.9
FMG	244	86.2	1.6	3.0	1101	24.1	6.8	9.0
Total	8113	96.7	52.1	100.0	12,115	73.0	75.8	100.0

(1) Canadian and Osteopath Graduates and Independent U.S. Physicians

TABLE 4. TYPES OF PROGRAMS OFFERED AND FILLED BY ALL APPLICANTS

Type of Program	1974			1975			1976				
	Openings		Total Matched	Openings		Total Matched	Openings		Total Matched	Openings Filled	
	#	%	#	#	%	#	%	#	%	%	
Rotating/Flexible	5655	( 33)	2826	( 27)	50	2039	( 13)	60	1219	( 11)	63
General Practice	67	( -)	0	( -)	0	58	( -)	9	62	( -)	13
Family Practice	1016	( 6)	821	( 8)	81	1352	( 9)	85	1163	( 10)	85
Internal Medicine	4347	( 25)	3452	( 33)	80	4845	( 31)	88	4250	( 38)	88
Med. Specialties (1)	96	( 1)	7	( -)	7	125	( 1)	41	51	( -)	41
Ob/Gyne	595	( 3)	307	( 3)	52	804	( 5)	71	571	( 5)	71
Pathology	635	( 4)	206	( 2)	32	641	( 4)	36	233	( 2)	36
Pediatrics	1380	( 8)	1044	( 10)	76	1450	( 9)	82	1169	( 11)	82
Psychiatry	489	( 3)	248	( 2)	51	744	( 5)	45	336	( 3)	45
Radiology (2)	289	( 2)	59	( 1)	20	405	( 3)	31	124	( 1)	31
Surgery	2452	( 14)	1553	( 15)	64	2497	( 16)	72	1802	( 15)	72
Surg. Specialties (3)	372	( 2)	79	( 1)	21	721	( 5)	45	327	( 3)	45
Totals	17,403	(100)	10,522	(100)	61	15,891	(101)	72	11,280	(100)	72
Primary Care (4)	7405	( 43)	5634	( 53)	76	8519	( 54)	84	7183	( 64)	84
									9060	( 56)	84
									7881	( 55)	87

(1) Dermatology, Neurology, Physical Medicine and Rehabilitation

(2) General, Diagnostic and Therapeutic Radiology

(3) Anesthesiology, Neurosurgery, Ophthalmology, Orthopedics, Otolaryngology, Urology

(4) General and Family Practice, Internal Medicine, Obstetrics and Gynecology and Pediatrics

TABLE 5. TYPES OF PROGRAMS OFFERED AND FILLED BY U.S. GRADUATING STUDENTS

Type of Program	1974			1975			1976								
	Openings		Total Matched	Openings		Total Matched	Openings		Total Matched	% Openings Filled					
	#	%	#	%	#	%	#	%							
Rotating/Flexible	5665	( 33)	2153	( 23)	38	2039	( 13)	986	( 10)	48	1757	( 11)	988	( 9)	56
*General Practice	67	( -)	0	( -)	0	58	( -)	1	( -)	2	68	( -)	0	( -)	0
*Family Practice	1016	( 6)	801	( 9)	79	1362	( 9)	1133	( 11)	83	1637	( 10)	1346	( 13)	82
*Internal Medicine	4347	( 25)	3122	( 34)	72	4845	( 31)	3829	( 38)	79	4971	( 31)	4071	( 38)	82
Med. Specialties	96	( 1)	6	( -)	6	125	( 1)	46	( 1)	37	145	( 1)	60	( -)	41
*Ob/Gyne	595	( 3)	291	( 3)	49	804	( 5)	528	( 5)	66	808	( 5)	575	( 5)	71
Pathology	635	( 4)	163	( 2)	29	641	( 4)	204	( 2)	32	601	( 4)	235	( 2)	39
*Pediatrics	1380	( 8)	910	( 10)	66	1450	( 9)	1028	( 10)	71	1576	( 10)	1107	( 10)	70
Psychiatry	489	( 3)	238	( 3)	49	744	( 5)	321	( 3)	43	897	( 6)	362	( 4)	43
Radiology	289	( 2)	56	( 1)	19	405	( 3)	115	( 1)	29	483	( 3)	205	( 2)	42
Surgery	2452	( 14)	1366	( 15)	57	2497	( 16)	1504	( 15)	60	2417	( 15)	1486	( 14)	52
Surg. Specialties	372	( 2)	78	( 1)	21	721	( 5)	304	( 3)	42	752	( 5)	328	( 3)	44
Totals	17,403	(100)	9224	(100)	53	15,691	(100)	9999	(100)	64	16,112	(100)	10,783	(100)	67
*Primary Care	7405	( 43)	5124	( 56)	69	8519	( 54)	6519	( 55)	76	9060	( 56)	7099	( 56)	78

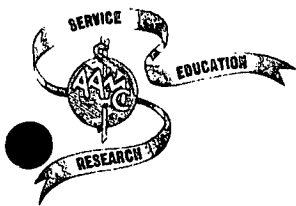
TABLE 6. PARTICIPATION AND RESULTS OF NON U.S. STUDENTS

Type of Program	1974				1975				1976			
	Matched		Openings Matched(1)		Matched		Openings Matched(1)		Matched		Openings Matched(1)	
	#	%	%	%	#	%	%	%	#	%	%	%
Rotating/Flexible	673	( 48)	12	24	233	( 18)	12	19	213	( 15)	12	18
General Practice	0	( -)	--	--	4	( -)	7	80	9	( 1)	13	100
Family Practice	20	( 1)	2	2	30	( 2)	2	3	50	( 4)	3	4
Internal Medicine	340	( 24)	8	10	431	( 34)	10	10	442	( 31)	9	10
Med. Specialties	1	( -)	--	--	5	( -)	4	10	6	( -)	5	9
Ob/Gyne	16	( 1)	3	5	43	( 3)	5	8	65	( 5)	8	10
Pathology	23	( 2)	3	11	29	( 2)	4	12	39	( 3)	7	14 <sup>1</sup>
Pediatrics	134	( 10)	10	13	161	( 13)	11	14	216	( 15)	14	16 <sup>1</sup>
Psychiatry	10	( 1)	2	4	15	( 1)	2	5	38	( 3)	4	9
Radiology	3	( -)	1	5	9	( 1)	2	7	12	( 1)	3	6
Surgery	177	( 13)	7	11	298	( 23)	12	17	301	( 21)	12	17
Surg. Specialties	1	( -)	--	--	23	( 2)	3	--	41	( 3)	5	11
Totals	1398	(100)	8	13	1281	(100)	8	11	1432	(100)	9	12
Primary Care	510	( 37)	7	9	669	( 52)	8	9	782	( 55)	8	10

(1) The first column is the percent of total positions offered which were filled by these applicants, i.e., difference between the percent of openings filled by all applicants shown in Table 3 and percent filled by USGS shown in Table 4. The second is the percent their number matched represents of the total number matched in each program.

TABLE 7. CHOICES OF UNMATCHED U.S. GRADUATING STUDENTS

Type of Program	1974				1975				1976			
	First Choice		All Choices		First Choice		All Choices		First Choice		All Choices	
	#	%	#	%	#	%	#	%	#	%	#	%
Rotating/Flex	115	( 18)	851	( 20)	54	( 7)	284	( 6)	75	( 8)	534	( 7)
*General Practice	0	( -)	0	( -)	0	( -)	0	( -)	0	( -)	0	( -)
*Family Practice	134	( 21)	780	( 19)	180	( 22)	875	( 19)	160	( 17)	1108	( 14)
*Internal Medicine	263	( 42)	1970	( 47)	409	( 51)	2833	( 61)	527	( 56)	5016	( 65)
Med. Specialties	2	( -)	2	( -)	0	( -)	0	( -)	3	( -)	6	( -)
*Ob/Gyne	14	( 2)	90	( 2)	41	( 5)	169	( 4)	66	( 7)	406	( 5)
Pathology	2	( -)	12	( -)	4	( -)	7	( -)	5	( -)	29	( -)
*Pediatrics	28	( 4)	202	( 5)	45	( 6)	232	( 5)	37	( 4)	302	( 4)
Psychiatry	16	( 3)	44	( 1)	8	( 1)	23	( 1)	14	( 2)	47	( 1)
Radiology	1	( -)	2	( -)	3	( -)	9	( -)	5	( -)	34	( -)
Surgery	52	( 8)	226	( 5)	44	( 6)	170	( 4)	39	( 4)	192	( 3)
Surg. Specs.	4	( 1)	10	( -)	14	( 2)	53	( 1)	16	( 2)	58	( 1)
Totals	631	(100)	4189	(100)	802	(100)	4676	(100)	947	(100)	7732	(100)
Primary Care	439	( 70)	3042	( 73)	675	( 84)	4110	( 88)	790	( 83)	6832	( 88)



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

June 9, 1976

MEMORANDUM

TO: COTH Administrative Board  
FROM: James I. Hudson, M.D.  
SUBJECT: Preliminary Reports

Attached are two documents which may be of interest to you:

(a.) Excerpts from the Preliminary Draft of the Executive Summary:

Project to Develop Curriculum for Physician Training  
in HMOs; Contract No. N01-MB-44009

(b.) Excerpts from the Third Quarterly Progress Report:

Project for the Development of Models for the Provision  
of "One Class" Ambulatory Care Services in University-  
Affiliated Teaching Hospitals; Contract No. 230-75-0188

Final reports on these projects will be completed by mid-July.  
Contact me if you wish copies.

JIH/jg



DRAFT FINAL REPORT

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(CHAPTERS 2-7 OF EXECUTIVE SUMMARY)  
(MINUS APPENDICES)

PROJECT FOR THE DEVELOPMENT OF CURRICULUM

FOR PHYSICIAN TRAINING IN HMOs

CONTRACT NO. N01-MB-44009

CHART VIII

AAMC Sponsored -- HRA/BHM/DHEW Funded  
 Program to Develop Curricula for Undergraduate  
 And Graduate Medical Education in HMO's (6)

Institution	Student Involvement	Project Emphasis
Harvard Community Health Plan Harvard University	Residents Internal Medicine Psychiatry	Curriculum for residents, cost analysis, resident training
Rhode Island R.I. Group Health Assn. Brown University	Medical Students (Pre Med & Medicine)*	Curriculum for Medical Students
Genessee Valley G.V. Group Health Rochester Univeristy	Medical Students	Curriculum Evaluation
Penn-Urb S. Philadelphia H.P. U. of Pennsylvania	Medical Students, Residents, Internal Medicine & Pediatrics	Curriculum Evaluation
Georgetown HMO Georgetown University	Medical Students	Curriculum for Medical Students
Puget Sound Group Health Corp of PS U. of Washington	Medical Students, Residents, Family Medicine	Cost Analysis for Medical Students, Residents

(6) See Final Report on Contract No. N01-MB-44009, available Summer 1976.

\* Brown University has a 7 year medical school system (years 1-3 comparable to traditional Pre-Med)

Chapter 2

GEORGETOWN UNIVERSITY

and

GEORGETOWN UNIVERSITY COMMUNITY HEALTH PLAN (GUCHP)

Washington, D.C.

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The Curriculum Planning Process

The HMO Guide

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2. Patient Interview Form
3. A Medical Student's Guide to HMO's

## Chapter 2

### GEORGETOWN UNIVERSITY

and

### GEORGETOWN UNIVERSITY COMMUNITY HEALTH PLAN (GUCHP)

Georgetown's major achievements were the development of a unique curriculum planning process, the preparation of a 50-page HMO guide for medical students, and designing and implementing a physician-preceptor training program. The study was conducted by the medical school's Department of Community Health and International Medicine with the assistance of the GUCHP medical staff and three sophomore medical students.

#### BACKGROUND

Georgetown University's medical school is part of a larger Health Sciences Center which includes a teaching hospital, a dental school, and a school of nursing. In 1971 it implemented a major curriculum revision and thereafter rapidly increased the size of the entering class to 205 students. The severe stress placed upon teaching resources, particularly in ambulatory care, by the rapid rise of the medical student population motivated the medical school to establish a health maintenance organization, the Georgetown University Community Health Plan (GUCHP). GUCHP was initiated through the efforts of the Department of Community Medicine and International Health (DCMIH) and was authorized by the medical school with the understanding that the HMO would provide a resource for primary care education and research as well as a source of referral for the University Hospital Speciality Clinics.

GUCHP is a pre-paid group practice type HMO which opened for services in November 1972. Although it is legally an independent corporate entity, most of the members of the board of directors are appointed by the university president. Moreover, the Chancellor of the Medical Center serves as Chairman of the Board, while the Dean of the Medical School serves as Vice-Chairman. GUCHP currently serves over 10,000 "pre-paid" enrollees and an additional 6,000 active "fee-for-service" patients in three primary care facilities in the Washington metropolitan area. One Center is located in Reston, Virginia and serves a predominantly white upper middle class population; the second center, located in Edgewood Terrace Housing Complex in Northeast Washington, serves a predominantly black, low and moderate income population; and the third center in Kensington, Maryland, is a relatively stable suburban middle class community in the greater Washington area. Each center utilizes a local community hospital for general inpatient care and Georgetown University Hospital for tertiary care.

GUCHP was heavily involved in education even prior to the initiation of this project. Educational experiences at GUCHP included a 6-month field training for two physician assistant students from Northeastern University (both were later hired by GUCHP); a summer training program for pre-medical and first year medical students participating in a special ("AMOS"-type) physician assistant program; a six-week elective clerkship in primary care; and rotation of senior psychiatric residents under the supervision of the faculty of the Department of Psychiatry. However, these educational experiences were offered haphazardly, no overall curriculum plan had been developed, and the results were not being evaluated. Hence,

Georgetown's initial objective was not so much the construction of a curriculum, but rather the development of a rational curriculum planning process:

"If you think you're confused, consider poor Columbus. He didn't know where he was going! When he got there, he didn't know where he was. And when he got back, he didn't know where he'd been."

Anonymous

In many ways, the task of curriculum building for physician training in health maintenance organizations is similar to the experience of Columbus. There are groups of doubters, there is a dearth of funds, and the waters are uncharted. A major outcome of our project has been a mapping of where we are going. As a result, when we get there we will know where we are and with the use of evaluation, know where we have been. In essence, the major accomplishment of our project has been to establish a curriculum planning process, rather than a finalized, polished, discrete set of courses.<sup>1</sup>

An important outcome of the curriculum planning process was the identification of a need for an HMO student guide and the development of the preceptor's teachings skills.

#### THE CURRICULUM PLANNING PROCESS

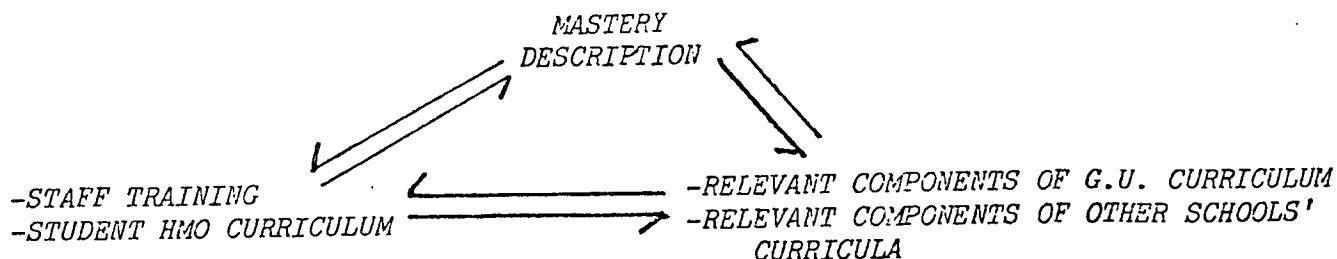
The curriculum planning process is based on an analysis of the skills, knowledge and attitudes required by competent practitioners in the HMO setting. Since a comprehensive, functional analysis of physician performance in HMO's is beyond the scope of this study, an abbreviated approach, represented in the schematic diagram below, was implemented. The ultimate result of such an approach is a list of professional responsibilities which the competent practitioner has "mastered", or should have mastered.

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<sup>1</sup>Final Report to the AAMC on the Project to Develop Curriculum for Physician Training in HMO's. Department of Community Medicine and International Health, G.U. School of Medicine, December 1975.

This list, or "Mastery description", is then converted to a list of educational objectives which the student must master or gain competence in. The process consists of five major components.

SCHEMATIC REPRESENTATION OF DYNAMIC CURRICULUM PLANNING PROCESS



*DOUBLE ARROWS:* indicates a one-to-one relationship

*MASTERY DESCRIPTION:* a list of professional tasks or responsibilities that a competent primary care practitioner must master

*STAFF TRAINING:* the identification of such tasks or responsibilities currently missing from our HMO primary care practitioners and training of staff in these areas

*HMO CURRICULUM:* the educational objectives and instructional activities derived from the mastery description as modified by

*G.U. CURRICULUM:* what is relevant and already learned somewhere else in the Georgetown curriculum complemented with

*OTHER CURRICULA:* successful and relevant educational opportunities implemented by other schools



a. Mastery Description - The object is to obtain a list of professional tasks or responsibilities unique to primary care practice in the HMO, and involve in the process all parties concerned: the practitioners of primary care (physicians and nurses); the recipients of primary care (patients); and the students of primary care (medical and nursing students).

Three medical and three nursing students were hired for the summer to conduct interviews with GUCHP physicians, nurses<sup>1</sup> and patients. A team of one medical and one nursing student was assigned to each of the three GUCHP centers. After an intensive literature search, the students first prepared their own list of physician and nurse professional competencies and then developed questionnaires, for interviewing physicians, nurses and patients (see Appendices 1 and 2). Initial analysis of the data indicates a need not only for a student guide and a preceptor training program but also for teaching experiences in telephone medicine, developing a good "chairside" manner, primary care team elective and a primary care team clerkship.

b. Relevant Components of Medical School Curriculum - The four-year G.U. medical curriculum was examined for primary care-ambulatory care experiences presently offered so as to avoid duplication.

c. Relevant Curricula from Other Medical Schools - This involved a review of published literature from other schools, including Alpert and Charney's The Education of Physicians for Primary Care, and continual communication with the other institutions participating in this study.

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<sup>1</sup>The nursing component relates to another project (funded by another agency) concerned with the multi-disciplinary training of medical and nursing students in primary care teams.

- d. Curriculum Development - In the Spring of 1975 the Department of CMIH offered preclinical students an experimental course entitled, A Practical Introduction to HMOs, to examine the potential advantages/disadvantages, strengths/weaknesses of alternative forms of teaching as well as the instructional roles of GUCHP physicians. The course included introductory seminars by guest speakers on the development and operation of HMO's; field visits to two local HMO's; and the initiation, with GUCHP physicians serving as preceptors, of field studies of mutual interest to the student and GUCHP.
- e. Staff Training - This involved discussing with the medical staff the timing of opportunities for training students, physician interest in planning the curriculum and teaching and the need for developing in the competent clinician a repertoire of teaching skills.

#### THE HMO GUIDE

Another major achievement of this project was the preparation of A Medical Student's Guide to HMO's, presented in its entirety as Appendix 3. The guide was designed for medical students by medical students to provide them with a broad background in HMO issues. It is primarily a learning aid, and includes study questions for self-assessment and discussion questions appropriate for group discussion. It is already being used by several of the participating institutions.

#### THE PHYSICIAN-PRECEPTOR TRAINING PROGRAM

The HMO course and the physician interviews identified a need to train physicians to be competent educators/preceptors. This need was based on the assumptions that:

1. HMO physicians are usually recruited and hired for their clinical competencies, not their teaching abilities.
2. Teaching skills are not necessarily innate, but rather can be learned.
3. HMO physicians who act as instructors must be oriented to the overall goals and approach of the educational program.
4. Approaches for student learning in the HMO (based on the requirement of provider productivity and consumer voice in management) will require methods of instruction unfamiliar to the traditionally trained physician.
5. There are a variety of teaching roles and responsibilities HMO preceptors can and must fulfill if a well-planned curriculum is to be successfully implemented.

As a result the Georgetown group is presently developing and implementing a program to train HMO physicians as competent educators. Since this program was not originally intended to be part of the one year project, the AAMC and HEW agreed to extend Georgetown's project for six months, to June 30, 1976. A report of the results is being prepared in the form of a guide for preceptor preparation.

Chapter 3

UNIVERSITY OF ROCHESTER

and

GENESEE VALLEY GROUP HEALTH ASSOCIATION (GVGHA)

Rochester, N.Y.

Background

The Curriculum

Evaluation

Costs

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2. The Seminars
3. Student Interviews with GVGHA Department Chiefs
4. Recommended Readings
5. Evaluation Instruments
6. Issues and Methods in Curriculum Evaluation

## Chapter 3

UNIVERSITY OF ROCHESTER SCHOOL OF MEDICINE AND DENTISTRY

and

THE GENESEE VALLEY GROUP HEALTH ASSOCIATION (GVGHA)

### BACKGROUND

In recent years the University of Rochester medical school has placed increasing emphasis on primary care in its curriculum. An ambulatory care experience, either at the University's Strong Memorial Hospital or in other extramural ambulatory care settings, is now required of all fourth year students. The Division of Family Medicine now offers three electives for pre-clinical students; and the Department of Preventive Medicine and Community Health offers a wide-ranging first-year elective, Introduction to Preventive Medicine and Community Medicine, in which students are placed in community health facilities. One of these facilities is the Joseph E. Wilson Center of Genesee Valley Group Health Association (GVGHA).

GVGHA is an independent, community-based pre-paid group practice plan sponsored by Rochester Blue Cross. The center opened in August 1973, in a new 52,000 square foot facility. It presently serves 20,300 enrolled members with an additional 2,000 individuals served on a fee-for-service basis. Rochester's major accomplishment was the development, implementation, evaluation, and cost analysis of an HMO-based curriculum for first-year medical students participating in a community medicine course. Much of the effort was focused on evaluation. The evaluation was based not only on pre-post tests but also on a comparison with students participating in the

same course but placed in other ambulatory settings. A second course for fourth year students was implemented too late in the year to be included in Rochester's final report. The project was directed by the associate dean for medical education who also serves as chairman of the school's Curriculum Committee. The course content was prepared primarily by the HMO's medical director and the evaluation methodology was designed by a specialist in educational communications.

Its leadership has been committed to education since GVGHA's inception. In the Spring of 1974, the HMO was host to 15 medical and nursing students participating in a medical school course entitled "Physician/Patient in Society", and a small number of fourth year medical students have taken an ambulatory care elective there. The AAMC program was an opportunity for both institutions to construct a rational, objective-oriented curriculum and to evaluate its results.

The study was divided into two phases. The first phase involved the development, field testing and evaluation of a curriculum for first-year medical students participating in the community medicine elective mentioned above. The second phase, which began in October 1975, involved an ambulatory care clinical clerkship for fourth-year students. Since evaluation of the latter will not take place until the spring of 1976, it is not reported here.

## THE CURRICULUM

The stated goals of the introductory course in preventive and community medicine were that students learn about the role and responsibilities of primary care physicians in prevention; the relationship between availability, accessibility, cost, and quality of care; the incidence, magnitude and severity of a health problem; and the psychological, political, economic and social relationship to illness and the delivery of health services. Each student was assigned to a health or social service institution for one-half day per week for fourteen weeks. Participating institutions included the Association for Retarded Children, an inter-city health center, Planned Parenthood, a venereal disease clinic, a family court, and GVGHA. Students met for a series of seven lecture-seminars and combined exercises called "Recall" sessions. A total of twelve students chose to be placed at GVGHA during the spring semester of 1975. It is for these students that a curriculum was constructed, field tested and evaluated.

The major objectives of the GVGHA section was to teach students about HMO concepts and to try to change their attitudes concerning primary care and HMO practice. A list of the cognitive and affective objectives is presented in Appendix 1.

The students met at the Wilson Center one-half day per week for fourteen weeks. Each session was divided into three parts. The first 45 minutes were devoted to one-to-one interviews between the student and

a department head. By the end of the semester, each student had personally interviewed the chiefs of the departments of medicine, pediatrics, ob/gyn, eye services, urgent visit clinic/surgery, X-ray, laboratory, business office, pharmacy, and medical records/communications center.

Following the interviews, the students convened for a one hour seminar to discuss an HMO-related issue or to discuss the case history of the students' patients. Most of the seminars were led by the medical director, although occasionally a guest lecturer was invited. A detailed description of the content of the seminars is presented in Appendix 2.

The third part of the session consisted of an observation period with a physician preceptor. Three students were assigned to each of the four preceptors. The student was assigned to a patient, whom he visited at least once during the course of the semester, and was responsible for presenting his/her case history. Descriptions of the case histories are also presented in Appendix 2.

#### EVALUATION

The evaluation design was developed with three major goals in mind: (1) to identify changes in knowledge and attitude; (2) to analyze correlations between demographic/personal characteristics and outcome measures so as to identify possible predictors of cognitive and affective achievements; and (3) to compare the results with control groups.



For comparison purposes, three groups of students, all of which participated in the community medicine course, were selected. Group 1 consisted of the twelve students based at GVGHA; Group 2, called related, consisted of ten students assigned to other primary care organizations; and Group 3, called non-related, was made up of students assigned to community agencies, not involved in primary care.

Knowledge and attitudes were tested with two pre-post tests, presented as Parts A and B of Appendix 5, and through semi-structured interviews with an evaluator. The personal characteristics assessed for correlation included sex, hometown size, physician parentage, undergraduate major, Medical College Admission Test (MCAT) score and the Edwards Personal Preference Schedule which measures fifteen normal personality characteristics. At the completion of the course, all 33 students completed an activity summary and a course evaluation form, presented in Appendix 5. To complement and validate the sources of evaluation information, the evaluator attended all seminars, conducted interviews, and observed student/patient interactions. A more detailed description of the evaluation methodology is presented as Appendix 6, "Issues and Methods in Curriculum Evaluation", published in the December 1975 issue of the Journal of Medical Education.

Using a variety of sophisticated statistical techniques, the evaluator found that there were few significant differences between pre and post test scores within a group or among the three groups. As anticipated, the GVGHA-based students made considerable progress in their knowledge of

and attitude towards HMO's; but the experience did not produce any great shift in individual career plans. The career choice results showed an overall general trend among all groups towards varying forms of primary care. An analysis of the student activity forms indicated that the GVGHA group had more patient and provider contact than the control groups.

#### COSTS

A consultant to GVGHA conducted a cost analysis and determined that the course costs GVGHA a total of \$1,880, or approximately \$157 per student per semester. The costs include the extra staff time needed for student teaching, but excludes overhead costs and space costs. Space costs were not included because the conference room used for the seminars is not used to capacity.

To determine the extra staff time needed for teaching, sample studies were conducted in the Pediatrics Department and the Urgent Visit Clinic. Preliminary data indicated that students caused little disruption in patient care. For example, in the Urgent Visit Clinic it took 140 minutes to see 9 patients without students present and 144 minutes with students present; in the Pediatrics Department it took 43 minutes to see 5 patients without students and 51 minutes to see a comparable set of patients with students present.

UNIVERSITY OF ROCHESTER

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2. The Seminars
3. Student Interviews with GVGHA Department Chiefs
4. Recommended Readings
5. Evaluation Instruments
6. Issues and Methods in Curriculum Evaluation

Chapter 4

UNIVERSITY OF PENNSYLVANIA

and

PENN URBAN HEALTH MAINTENANCE PROGRAM (PENN URB)

Background

Accomplishments

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2. The Curriculum Modules: Rationale, Objectives, Methods and Prerequisites
3. Report of Efforts to Develop a Standardized Test of Knowledge and Attitudes Relevant to the HMO Setting

## Chapter 4

UNIVERSITY OF PENNSYLVANIA

and

PENN URBAN HEALTH MAINTENANCE ORGANIZATION (PENN URB)

The major accomplishments of this project are described in detail in the appended pages. They include the development of a unique iterative curriculum planning process involving educators, clinicians, and other professionals; the preparation of curriculum modules; the design of an evaluation methodology and related instruments; and field-testing of the curriculum and evaluation instruments. Since these accomplishments are aptly described in the accompanying papers, this chapter is brief.

### BACKGROUND

Penn Urb is a multi-disciplinary primary care center sponsored and supported by the University of Pennsylvania, although it is a separate legal entity. It opened for services in 1974, a small (5,500 square feet) renovated facility and presently provides 18,000 patient visits per year, both on a pre-paid capitation and fee-for-service basis.

The project was managed by Penn Urb under the direction of its medical director and with the active participation of the entire professional staff. Day-to-day activities were coordinated by a medical educator.

### ACCOMPLISHMENTS

The curriculum construction process began with the delineation of

objectives in six conceptual areas relevant to the HMO setting. These areas were:

- primary and comprehensive care
- the health care team
- consumer participation
- quality of care
- economics of HMOs
- change and innovation

The entire professional staff at Penn Urb participated in this effort. A task force consisting of at least one educator and one provider was established for each area with responsibility for defining behavioral objectives, recommending methods of instruction, developing a bibliography and identifying prerequisites. The process is described in greater detail in the accompanying paper, "Designing a Curriculum in a Clinical Setting: An Iterative Process", presented as Appendix I. The entire curriculum itself is presented as Appendix II.

Sections of resulting curriculum were offered in an inter-session course entitled Introduction to Comprehensive Health Care Systems. The course is an intensive one-week, 35 contact-hour experience offered to medical, nursing, allied health professions, health care administration, and social work students twice a year during inter-sessions. Sections of the curriculum were also field-tested with one medical student who clerked at Penn Urb one session per day for four weeks.

To assess the effectiveness of the curriculum, a series of evaluation instruments were designed and field tested in the inter-session course. As

indicated in the "Report of Efforts to Develop a Standardized Test of Knowledge and Attitudes Relevant to the HMO Setting", presented as Appendix III, the evaluation methodology and related tools were designed for applicability in other HMO settings. Although the effort was organized by the Penn Urb staff, all participating institutions contributed to its development.

UNIVERSITY OF PENNSYLVANIA

APPENDICES

1. Designing a Curriculum in a Clinical Setting: An Iterative Process
2. The Curriculum Modules: Rationale, Objectives, Methods and Prerequisites
3. Report of Efforts to Develop a Standardized Test of Knowledge and Attitudes Relevant to the HMO Setting



Chapter 5

THE UNIVERSITY OF WASHINGTON  
and  
GROUP HEALTH COOPERATIVE OF PUGET SOUND  
Seattle, Washington

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3. Proposed Evaluation Instruments
4. The Cost Study
5. AAMC Comments on the Cost Study

## Chapter 5

### THE UNIVERSITY OF WASHINGTON

and

### GROUP HEALTH COOPERATIVE OF PUGET SOUND

A unique feature of Group Health Has been its involvement in student education almost since its inception 30 years ago. Training programs for medical students and residents have been operating at Group Health several years prior to the initiation of this project. Hence, one of the first tasks was to review and assess these programs, and more importantly, to attempt to determine their costs. The major accomplishment of this project included a survey of existing medical student courses; the development of a third-year curriculum with related evaluation instruments; and the initiation of a cost study.

#### BACKGROUND

In the past ten years the University of Washington has been increasingly focusing its attention on the maldistribution of medical care and the training of primary care physicians. A major curriculum revision took place in 1968 and the Department of Family Medicine was established in 1971. More recently the University became a regional center in medical education by establishing the WAMI program - academic sites in the states of Washington, Alaska, Montana, and Idaho, devoted to primary care service and training.

The ourcome of these efforts has been that more than half of the graduating medical students are entering primary care training programs, and the entering class has been increased from 85 to 175 students. As a result,

the medical school has found itself in need of additional clinical training sites in primary care. Group Health Cooperative of Puget Sound, with its strong orientation towards primary care, represents an important clinical teaching resource.

Group Health is a nonprofit, consumer-owned cooperative established in 1947 and presently serving approximately 200,000 members. It owns and operates nine outpatient facilities and a 300-bed general hospital for a total staff of 2,700, including 200 physicians.

Group Health has been involved in student education almost since its inception. Over the years, educational programs have expanded to such a degree that one of the first activities of this project was to identify their extent and scope. Medical students have been training at Group Health for over 12 years although the bulk of courses were not initiated until 3 years ago. The first family practice residency training program was initiated in 1973 with the signing of a Memorandum of Understanding between the University's Department of Family Medicine and Group Health. The Memorandum, presented as Appendix 1, provides for the exchange and training of each other's family practice residents and for medical student preceptorships at Group Health.

The AAMC-sponsored project was welcomed by the University and Group Health as an opportunity to examine the HMO's role in the education of medical students and to develop, if possible, an integrated, cost effective curriculum for medical students. Specifically, the major objectives of the study were:

- To conduct a survey and evaluate existing medical student courses at Group Health;
- If necessary, to develop a comprehensive curriculum that could be applicable to other HMO settings;
- To develop appropriate evaluation instruments to assess the curriculum's effectiveness; and,
- To examine the costs of medical student teaching at Group Health so that future programs could be designed in a cost-effective manner.

The study was conducted jointly by both institutions, with the medical school's Assistant Dean for Curriculum and Group Health's Director of Medical Education at Group Health serving as project co-directors. A major role was assigned to educators from the Office of Research in Medical Education, who provided consultation in research design, curriculum development and evaluation, and teaching methodology. Two physicians, one from each institution, collaborated in the cost study.

#### SURVEY AND EVALUATION OF EXISTING COURSES

A survey of existing courses at Group Health revealed that in 1975-76 over 570 students, including students in nursing, public health, medical technology, pharmacy and medical students from 11 institutions were training at Group Health facilities. Of these, 180 are medical students enrolled in seven different courses, as shown in the table on the following page. The first four of these courses were selected for careful study and evaluation.

UNIVERSITY OF WASHINGTON  
MEDICAL STUDENT TEACHING AT GROUP HEALTH

Course	Med student year	GHC Department	Length of Association (years)	Number of students per session	Time involved for each student	Total number of students in past year	# days/yr students at Group Health x # of students
Family Med 401* <sup>3</sup>	1	Outpt - FP	3	0-6/quarter	1/2 day/wk/quarter	12	66
Family Med 420* <sup>3</sup> 421 422	2	Outpt - FP	1	3-4/year	1/2 day/wk/e qtrs.	4* <sup>1</sup>	60
Radiology 493* <sup>4</sup>	3	Radiology	4	0-4/month	1 day every 2 wks for 4-6 weeks	16	32
HuBio 413* <sup>3</sup> 422 435	1	Hospital	2	124/quarter	2-3 1/2 days/quarter for 3 quarters	124	372
Ob-Gyn 465* <sup>5</sup>	3-4	Ob-Gyn	1	3/4 weeks	4 weeks - 8 sessions/quarter	18	360
Peds 401* <sup>3</sup> 465* <sup>5</sup> 493* <sup>4</sup>	3-4	Peds	12	0-2	varies: 1/2 day/wk - 1 quarter 5 days/wk - 4 weeks 5 days/wk - 1 week	5	25
Health Services 531* <sup>3</sup>	1-4	HS 531	3	0-2 years	variable amount of time at Group Health	2	---

- NOTE: \*<sup>1</sup> 1 student only present for 2 quarters.  
\*<sup>2</sup> This is a crude attempt to measure quantitative impact (i.e., 1000 = 10 students present for 100 days or 100 students present for ten days).  
\*<sup>3</sup> See Appendix B - 401 - Introductory  
\*<sup>4</sup> 493 denotes 4th year electives in clinical or lab medicine  
\*<sup>5</sup> 465 denoted basic clerkship in ob-gyn, med, etc. (3rd - 4th year).

Source: Presented as Appendix C-2 in Final Report: Project to develop curriculum for physician training in HMO's, U. of Washington School of Medicine, December 31, 1975

Since there was insufficient time to evaluate all seven courses, only those with major impact in terms of time commitment, numbers of students, or those offering a unique experience to medical students were chosen for investigation.

Prior to the initiation of this study, the University already had a well established evaluation system for many courses in the medical school and at Group Health. Such an evaluation system typically included three components:

- (1) Evaluation of the course - by students, faculty and a course committee.
- (2) Evaluation of faculty - by students, course committee and faculty self-ratings.
- (3) Evaluation of student performance - by the preceptors, patients and student self-ratings.

As part of this study, the evaluation systems of the four courses were also investigated to determine their effectiveness and to identify possible problems or flaws.

The reassessment indicated that the courses provided students with a useful primary care experience and that students and faculty alike were pleased with the experience. It should be pointed out that the courses were not designed to teach the unique features of HMO practice, but rather to provide a primary care experience. Since the courses have been offered for some time and will be continued in the future, they are described below in some detail.

1. Introduction to Clinical Medicine (Human Biology 413, 422, and 435).

These three sequential courses, each one quarter long, are required of all first year students and are conducted largely at Group Health Hospital. They provide the students with their first exposure to patients and are designed to introduce basic skills in interviewing, history taking and physical examinations. The courses involve didactic, demonstration and experimental techniques, and a series of patient interviews.

Instructional strategies include an extensive syllabus of printed material covering all aspects of the medical interview; conventional didactic presentations; small group discussions with the preceptors; and an intensive orientation week with lectures, demonstrations, small group discussions, interviews with paid actors, and audio/video tapes for performance evaluation and lecture demonstrations.

The evaluation system features student-designed and administered questionnaires and extensive student-faculty coordination. During the previous two years, evaluation focused on the adequacy of the course objectives, instructors, and learning resources, and self-ratings of skill and satisfaction. On the whole, the students were highly satisfied with the courses and felt that they were some of the most valuable components of the first year curriculum. Faculty evaluation was also highly favorable and no changes were proposed.

2. Family Medicine Preceptorship (Family Medicine 401).

This is a one quarter elective for first year students, in which the student observes a practicing physician one-half day per week and is introduced to concepts of family practice. Approximately 15-25 students elect the course each quarter. During the 1975 winter quarter, six of 25 preceptors were Group Health physicians and eight students were assigned to Group Health facilities. The other preceptors were solo practitioners or physicians practicing in other settings.

The evaluation procedure for this course consists of a brief, open-ended questionnaire in which students evaluate their preceptors, identify positive and negative features of their preceptorship, and provide suggestions for improvement. This provided an opportunity for comparing the results and performance of students at Group Health with those in other settings. An analysis of the student questionnaires, however, indicates that there was little difference in the responses of the two groups.

3. Family Medicine Continuity Clerkship (Family Medicine 420,421, and 422).

This new course, offered for the first time in 1974-75, is designed for second year students, most of whom take it for three consecutive quarters. Students meet with a practicing physician one-half day per week and are given the opportunity to work up and follow selected patients. Site experience is supplemented with weekly university-based lecture-discussions on various aspects of family practice. Of the 24 students taking the



course last year, four were assigned to Group Health preceptors. Course objectives include exposing the student to the concept of continuity of care and simple office procedures. Preceptors generally try to guide the student toward clinical practice so that by the end of the course the student functions in this capacity about 50% of the time.

A comprehensive evaluation system was developed for this course utilizing input from students, faculty and patients. The system consists of six components:

- (a) Daily activity logs completed by students;
- (b) Site visits by preceptors;
- (c) An open-ended evaluation questionnaire completed by students;
- (d) A student evaluation form completed by the patient;
- (e) A productivity impact questionnaire completed by the preceptor for identifying productivity loss and teaching preparation time;
- (f) A student performance form completed by the preceptor in which the student is rated on dependability, initiative and interest, ability to communicate with patients, relationships with patients and staff, and competence in eliciting and synthesizing information from patients.

The resulting evaluation data was analyzed to examine differences between the HMO and other settings. It was found that the only significant difference was in productivity loss. Group Health preceptors showed a productivity loss of 62% or 6.2 patients per 3 hour session,

while all preceptors (including Group Health preceptors) averaged a productivity loss of 25% or 4 patients per session. Preparation time was also greater with Group Health preceptors who reported an average of 50 minutes per week of preparation, while all preceptors reported an average of 30 minutes. An analysis of the student activity logs revealed that Group Health students saw fewer patients, but tended to receive more intensive exposure and were allowed somewhat greater levels of responsibility.

4. Independent Field Study (Public Health and Community Medicine, PH-CM 531).

This is an independent study elective which relies heavily on one-on-one discussions between student and preceptor. The student and faculty advisor arrange for special projects at community health agencies such as Group Health.

#### THE PROPOSED CURRICULUM

The University and Group Health held a series of joint workshops to consider the results of the survey, to discuss the University's training needs, and to construct a curriculum best suited to the needs of both institutions. It was decided to develop curriculum for an intermediate clinical clerkship designed for third year students who would spend approximately six weeks full time in the HMO. In addition, it was decided that the major thrust of the curriculum would be on the development of clinical skills and knowledge which could be most effectively and efficiently taught in the HMO but which

are not necessarily unique to it. A complete and detailed outline of the course including goals and objectives, instructional methods, and evaluation methods, are presented as Appendix 2. While this curriculum was designed primarily for third year clerkships, sections of the curriculum might be used in other existing courses.

Group Health is examining the possibility of offering other clinical courses. A list of approximately 90 courses presently offered by the medical school in other clinical settings has been circulated to Group Health preceptors to identify those courses which can be effectively taught at Group Health.

#### PROPOSED EVALUATION INSTRUMENTS

In conjunction with the proposed curriculum, a series of evaluation instruments, designed to evaluate the performance of both students and preceptors, were developed and are presented as Appendix 3. The author's description of these instruments is presented on the following page.

#### SUMMARY OF COST STUDY

The proliferation of educational programs and courses at Group Health was a primary motivating factor for undertaking the cost study. In fact, the university had originally proposed to do only a cost study, and to do it for medical students only. However, at the urging of the Project Advisory Committee, the university agreed to expand the project and also include a

## DESCRIPTION OF PROPOSED EVALUATION INSTRUMENTS

### 1) Completed by the Student.

#### Exhibit 1: Student Log Recording Form and Computer Summary Report.

Students will be asked to log patient problems and procedures encountered in the clerkship experience and to submit the logs on a weekly schedule. At the end of the clerkship, the students and preceptors will receive computer-generated summaries of the student's individual experience. A summary report analyzing all student-patient encounter experiences will also be produced. These reports are to be used by the various course committees to assist them in their evaluation of both the course and faculty. They are to be used by the faculty for the purpose of self-evaluation and by the student as a record of accomplishments.

#### Exhibit 2: Student Progress Report.

Approximately midway through the quarter students will be asked to complete this brief form to help the course committee and preceptors evaluate the course from the students' point of view.

#### Exhibit 3: Student Course Evaluation.

This form is to be completed by students at the end of the course to evaluate the course's strengths and weaknesses.

#### Exhibit 4: Student Assessment of Preceptor and Training Site.

This form will also be completed by the student toward the end of the course and is to be used for evaluating the preceptor and training site.

### 2) Completed by the Preceptor

#### Exhibit 5: Preceptor Progress Report.

This brief report is to be filled out periodically as an informal method for the course committee to keep abreast of the course from the preceptor's point of view.

#### Exhibit 6: Course Achievement/Grade Report.

This will be used by the preceptors to rate student performance on each instructional objective and on selected professional attributes. It should serve as the principle medium for documenting student achievement.

### 3) Completed by the Patient

#### Exhibit 7: Patient Feedback to Students.

This form provides the means for patients to record their impressions of students and for students to evaluate their own strengths and weaknesses. This form should be used sporadically or in some way mutually determined by preceptors and students. After a few weeks in the office, students in other settings have appreciated the reassurance that has come from patients' positive remarks on these forms.

### 4) Completed by the Course Committee.

#### Exhibit 8: Site Visit Report

This form outlines the procedures involved in a site visit by the course administrators to a preceptor's office. Since time may not permit a site visit to each office, they will probably be conducted on a random basis or in response to reported or suspected problems. The visits and reports thereof, are used to facilitate evaluations of the course and the preceptors.

cost analysis of its family practice residency training program. The study is presented in its entirety in Appendix 4 and specific AAMC comments are presented in Appendix 5.

The study presents data on the various costs for the medical student courses described above and for the family practice program. Costs that are easily measured, such as salaries, space, equipment, and supplies, and costs and benefits not so easily measured, such as job satisfaction and impacts on quality of care and enrollment, are reviewed. Data was collected by a variety of methods including structured interviews of preceptors, students, administrators and consumers; questionnaires; clinic records; daily activity logs; and a time-motion study. A summary of the data for the medical student is presented in the table on the following page. Data for the family practice residency training program is presented in Table V-6, Appendix 4. The annual costs of training one resident was found to be approximately \$15,000. However, this does not appear to include the value of the resident's services performed in the "coverage" setting. As the authors themselves indicate, this study is preliminary in nature and both the conceptual framework and data need additional refinement.

Cost of Medical Student Teaching

Course	Student Level	Student Activity	Number of Students in Course	Cost per Student-day	No. of Student Training Days in Course	Cost of Course
Human Biology 413	1st year	interviews	175 students	0		0
Family Medicine 401	1st year	observation	8	\$4.30	50 days	\$225
Family Medicine 420	2nd year	interviews, patient exams	4	79.80	59	4,708
Family Medicine (unnumbered)	3rd year	advanced patient exams	1	53.20	40	2,123
Community Medicine 531		research	1	(\$10.00) net benefit		

Source: Compiled from tabulated data presented in the University of Washington Final Report

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## Chapter 6

### BROWN UNIVERSITY

and

### RHODE ISLAND GROUP HEALTH ASSOCIATION

Brown's major achievement was the development and field-testing of a curriculum for the RIGHA segment of a mandatory course in community medicine. RIGHA is the only one among the participating HMO's where the student's participation is mandatory. Plans are also in progress for initiating innovative elective courses at RIGHA. The project was managed primarily by the Section on Community Health and the RIGHA staff.

#### BACKGROUND

A two-year Master's Program in Medicine initiated in 1963, became a 4-year medical school ten years later and graduated its first M.D. class in 1975. The medical school is unique in several respects. First, it offers a medical curriculum conducted as a program rather than an independent school or faculty. Second, the program admits most of its students to a 7-year curriculum. Finally, it was planned from the beginning to rely on community-based teaching facilities. Having no teaching facilities of its own, the University has entered into affiliation with local community hospitals and other health care institutions. One such institution is the Rhode Island Group Health Association (RIGHA).

RIGHA is a labor-sponsored, community-based prepaid group practice plan which opened in May, 1971. It is located on the grounds of a local



community hospital (Our Lady of Fatima Hospital) in a 13,000 square foot converted laundry facility. Additional office space is located in the hospital. As of December, 1975 it had an enrollment of 15,000 members and served an additional 2,000 persons on a fee-for-service basis. RIGHA is partly supported by loans and grants from HEW and the Prudential Life Insurance Company. In 1973, facing severe financial difficulties, RIGHA entered into a management service contract with Prudential. Prudential now operates the HMO and is represented on its Board of Directors together with representatives of organized labor and the public sector. In November, 1975, RIGHA became one of the first HMO's to be certified under the HMO Act of 1973.

RIGHA's interest in education dates back to 1973 when it signed a Memorandum of Association with the University (see Appendix 1). It views teaching as a learning experience for the preceptor as well as the student and believes it is a positive factor in recruiting top quality medical staff. The first educational experience at RIGHA occurred in early 1974 when several clinical students spend a week there on an experimental basis. However, no program had been prepared for this purpose. The AAMC program was viewed as an opportunity to design a well-planned and rational curriculum for teaching medical students in the HMO setting.

## THE RIGHA ROTATION IN THE COMMUNITY HEALTH CLERKSHIP

In the initial planning of the clinical curriculum, no specific provision was made for the teaching of primary care. The clinical curriculum consists of 48 weeks of required core clerkships (internal medicine, 12 weeks; surgery, 12 weeks; pediatrics, obstetrics, psychiatry and community health, 6 weeks each), 10 weeks of "selected" clerkships, and 24 weeks of open electives. When it became apparent that the major clinical disciplines were planning to use their core clerkships for the teaching of in-patient aspects of medicine, the section on community health resolved to make the teaching of primary care one of its major objectives.

The clinical student's major experiences in primary care are embodied in the Core Clerkship in Community Health. This course consists of four major parts: (1) patient work-ups at the Rhode Island Hospital Ambulatory Patient Center; (2) a seminar series on current issues in community health; (3) an assigned Health Planning Problem in which students work in groups on issues such as Planning for Obstetrical Care in Rhode Island, Meeting the Needs of Mentally Disturbed Children in Rhode Island, the Control of Hypertension Among the Disadvantaged, the Problem of Malpractice, the Rehabilitation of Stroke Patients in Rhode Island, and the Problem of Meeting the Needs of the Terminally Ill; and (4) a set of options, 1 to 2 weeks long, such as a preceptorship, a tutorial assignment, or a research project. The 6 week course is mandatory for all clinical students and has as a prerequisite the 12 week clerkship in internal medicine.

The community health clerkship is offered continuously throughout the year so that only 8 students are enrolled at any one time.

During the course of the year, a total of 64 third and fourth year students participating in the clerkship were rotated through RIGHA. After experimenting with various formats, it was decided to restrict patient-student contact so as to avoid charges of patient exploitation. The current RIGHA rotation consists of a mandatory one day seminar and an optional one or two-week research assignment on a topic of particular interest to the student and the medical staff.

The seminar focuses on three topics: (1) Structure and Organization of Group Practice and Philosophy of HMO's; (2) The History and Development of RIGHA; and (3) Basic HMO Concepts as they Relate to the Operation of RIGHA. An outline of the seminar is presented in Appendix 2. To supplement the seminar, a series of resource materials were prepared, including an HMO Reader consisting of 8 selected articles (see Appendix 3) and an HMO Library containing over 250 articles and monographs. The Library is maintained in the Section on Community Health.

#### PROPOSED ELECTIVES

Brown and RIGHA also developed a series of electives for students who wish to expand upon their RIGHA experience. The first elective, entitled, Primary Care in the HMO Setting, is a 4-6 week course in which the student spends half his time in clinical practice under the supervision

of a physician-preceptor, and the other half of the time on a special research project. The student may rotate through several clinical departments or stay in the same department throughout. A maximum of 2 students will be accepted at any one time. The course was approved by the curriculum committee in August, 1975, and was offered for the first time in the 1976 spring semester. A similar elective is being developed in ambulatory pediatrics and will be submitted soon to the curriculum committee for approval. Finally, a third elective entitled, Medical Management : The Role of the Medical Director in the HMO, will be offered next year to students interested in administrative medicine. Further descriptions of these electives are presented in Appendix 4.

Chapter 7

HARVARD UNIVERSITY

and

HARVARD COMMUNITY HEALTH PLAN - CAMBRIDGE CENTER (HCHP-CC)

Cambridge, MA

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Chapter 7  
HARVARD MEDICAL SCHOOL

and

HARVARD COMMUNITY HEALTH PLAN - CAMBRIDGE CENTER

The Harvard curriculum is the only one in this report dealing with residents and the only one focused on clinical skills. The Harvard group developed an objective-oriented clinical curriculum and field-tested it at the Harvard Community Health Plan - Cambridge Center on internal medicine residents participating in the Harvard Primary Care Program. The curriculum focused on areas other than internal medicine, with a special emphasis on psychiatry. A preliminary cost analysis of the HMO-based residency training was also prepared. The project was performed by staff physicians from the Cambridge Center and its affiliated community hospitals. A group of three internists was responsible for curriculum development in all areas except psychiatry and a group of three psychiatrists (known as the Behavioral Sciences Subcommittee) was responsible for the psychiatric component and for planning for a psychiatric residency training program.

BACKGROUND

The Harvard Medical School and its affiliated hospitals have been engaged in primary care education since the mid-sixties when a Family Health Program was initiated at Children's Hospital Medical Center. In the late sixties an occasional resident in medicine or pediatrics elected rotations in neighborhood health centers or other ambulatory facilities. Other primary care education efforts involved the Harvard Community Health Plan (HCHP), as indicated below.

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The Harvard Community Health Plan - Cambridge Center (HCHP-CC) is the Cambridge satellite of the Harvard Community Health Plan, the major center of which is located at Kenmore. The Cambridge Center has been in operation since 1973 and presently serves over 15,000 enrollees in a new 44,000 square foot facility. The Kenmore Center, which has been in operation since 1969, has already reached capacity at over 35,000 enrollees.

Residency training at Kenmore dates back to 1970-1971 when three residents in Internal Medicine and one in Psychiatry spent one afternoon per week under the supervision of a staff physician. Educational opportunities were also offered to medical students. A one month elective provided several clinical students an opportunity to study in depth a problem in primary health care, and a course entitled The Delivery of Medical Care in the 1970's: Issues and Examples, was offered to first year students.

Residency training was an explicit goal of the Cambridge Center even prior to its inception. A Robert Wood Johnson Foundation award to the Cambridge Center in December 1972 was contingent upon the development of a residency training program. In July 1975 four residents in Internal Medicine participating in the Harvard Primary Care Program began their training at the Cambridge Center. The Harvard Primary Care Program, also supported by the Robert Wood Johnson Foundation, supports primary care training at various ambulatory care sites in the Boston area for 25 Internal Medicine residents.

#### THE CURRICULUM DEVELOPMENT PROCESS

The major objective of the project was to prepare a curriculum for the new residents based on task analysis and definition of behavioral objectives and focused on areas other than internal medicine (AOTIM). Traditionally, clinical teaching has been haphazard. Learning objectives are rarely specified and when they are, they are too vague to benefit either the preceptor or resident. Moreover, the skills that the resident acquires in his training do not always reflect the requirements of private practice and primary care. This approach was designed to avoid these pitfalls.

Drawing upon their own experience in the AOTIM specialty under consideration, the internists prepared a preliminary list of tasks most often encountered in primary care practice. On the basis of these tasks, the group delineated and progressively refined a set of behavioral objectives, expressed in terms that can be measured and evaluated. The objective list was then submitted to a consultant who was asked to consider: (1) what were the most common referrals from primary care physicians; and (2) which of these could be treated by the referring physician? Generally, for each specialty, objectives were grouped as follows:

1. Statements of history-taking and physical examination skills.
2. Statements of psycho-motor skills.
3. Inductive (symptom oriented) considerations.



4. Deductive (disease oriented) considerations.
5. Conditions and diseases that the resident must recognize and refer for treatment.
6. Statements of important therapeutic principles.

The rationale for this structure was based on convictions about the general substance of post graduate training programs, best expressed in the authors' own words:<sup>1</sup>

1. Skills in history taking and physical examination are emphasized as crucial areas. Too often organized formal training in physical diagnosis stops after the medical student level. Areas such as the pelvic or neurologic examinations may not be well developed in the houseofficer who then tends to ignore these important areas. Alternately, the physician in training may have mislearned whole parts of the physical examination. We seek to emphasize fundamental competence in the primary care physician both in general medicine as well as in AOTIM (area other than internal medicine).
2. Within each area described below, we have identified key skills that belong in the primary physician's repertoire. Some of these abilities should be part of any doctors' capabilities, as e.g. skills in first aid or cardiopulmonary resuscitation. However, in this report we have focused on those skills in the AOTIM that would be commonly used by the physician. The items listed have been cross-checked with consultants in each area as being in the primary care realm and within the scope of primary physicians' practice.
3. From the very beginning of our curriculum deliberation, we grappled with the question of using an inductive versus deductive approach. Most textbooks of medicine utilize the latter perspective and are written -- as MacBryde put it -- ". . .as though every sick person carried his presumptive diagnosis labeled on his chest".<sup>2</sup>

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<sup>1</sup>Matthew A. Budd et. al., Training Adult Primary Care Residents in an HMO: In Fulfillment of a Grant from the AAMC. December 1975.

<sup>2</sup>Cyril MacBryde, ed., Signs and Symptoms, 4th edition, J.P. Lippincott Co., Philadelphia, c. 1964.

On the other hand, a symptom oriented emphasis more nearly reflects the manner in which patients present. There is a practical limit however to the amount of useful information that can be subsumed under any given symptom or sign. Nevertheless, the formula which says, e.g., "Given a patient with a chief complaint of dizziness, proceed in the following way: . . ." offers a clinically useful guide. It gives form to what otherwise may be disjointed facts not easily used in patient care. Within each AOTIM objectives are contained the major symptoms (or signs) that the primary care physician can expect to encounter in practice. The objectives are intended to reflect subsequent approaches attendant upon the given symptom or sign.

4. There comes a point in the diagnostic process where inductive reasoning generates a tentative diagnosis. Thus, a knowledge of specific disease states is a very important part of the physicians' cognitive skills. The AOTIM curriculum objectives have listed the common entities with which the physician must be conversant. With the help of our AOTIM consultants, we have defined these common diseases and have classified them generally into two groups: (1) those which the primary care physician should be able to recognize and treat, and (2) those which the primary care physician should recognize and refer.
5. Of the AOTIM diseases, we have chosen to segregate those illnesses which though uncommon must be recognized or suspected even if treatment of the illness falls outside the primary care physicians' capabilities. The common denominator is the treatability of these conditions, which if missed generally have serious to catastrophic consequences. This characteristic justifies the incorporation of these problems into a separate set of objectives. Some examples of these conditions would be ectopic pregnancy, acute epiglottitis, angioneurotic edema, acute disc herniation with sphincter compromise, and acute glaucoma.
6. Treatment issues are a fairly obvious part of any clinically oriented curriculum. These objectives span the range of specific motor skills (e.g. using a cock up splint) to items dealing with medication (cost/effective objectives; generic/brand issues, etc.).

The result of this process was the preparation of a set of preliminary lists of objectives in eight areas: urology, ENT, ophthalmology, orthopaedics, general surgery, nutrition, dermatology and Ob/Gyn. They are presented in their entirety in Appendix 1.

#### THE RESIDENCY TRAINING PROGRAM

The program was predicated on several assumptions. First, the primary care physician should be able to handle the majority of problems brought by his panel of patients. Since these are often in areas other than internal medicine, the residents' training must be broadened accordingly. Second, the curriculum must reflect the fact that a high proportion of patient visits concern psychological problems. Third, continuity of care must be an integral part of the curriculum. Finally, the curriculum itself is a dynamic product, constantly changing as results are evaluated and conditions change.

Curriculum implementation began in July 1975 with the introduction to the Cambridge center of four internal medicine residents -- two junior residents from Mount Auburn Hospital and two senior residents from Cambridge Hospital -- who are participating in a two year residency program in adult primary care. The program consists of eight alternating three-month blocks, half of which are spent in the ambulatory care setting, and half at the backup hospital. Residents are paired to facilitate coverage of each other's patients. The content of the hospital rotation is similar to hospital training received by other hospital-based residents in straight internal medicine, except that during the hospital rotation, one afternoon per week is spent at the Cambridge center.

During his/her stay at the Cambridge center, the resident is assigned four one-half days per week to a team consisting of an internist-preceptor and a nurse practitioner.

The resident spends an equal amount of time per week with various consultants, mostly in surgery and surgical subspecialties. Both the consultants and the resident are provided with the appropriate list of objectives. It helps the specialist know what to teach and the resident what is expected of him. The program includes a didactic lecture once a week in which consultants discuss a topic drawn from the behavioral objectives. In addition, all internists and residents attend once a week an "LMD Journal Club" in which participants select a topic of interest based on commonly occurring problems.

#### THE BEHAVIORAL SCIENCE COMPONENT

The behavioral science group was assigned the responsibility to design the psychiatric component of the curriculum for the internal medicine residency program and prepare initial plans for a psychiatric residency. Utilizing the procedures of their colleagues in internal medicine, the psychiatrists tried but soon abandoned efforts to derive detailed objectives from corresponding task lists. There were several reasons for this. First, the data base in psychiatry is much softer than in the medical disciplines. Secondly, techniques in psychiatry are more related to process than tasks. Finally, evaluation of change is much more subjective in this field. Instead, the group developed a set of three overall objectives as a general framework for the psychiatric content of the primary care curriculum. These overall objectives are:

- (1) Sensitivity skills - learn to be more sensitive to patients and their needs for treatment and understanding.
- (2) Therapeutic skills - learn how to counsel various kinds of patients with problems complicating, causing, or resulting from their medical (and social-psychological) conditions.
- (3) Referral skills - learn to recognize serious psychiatric disorders and develop skills of referral, utilizing appropriate resources.

A further elaboration of these objectives is presented in Table 1 on the following page.

A variety of instructional methods were developed for implementing this curriculum (see Table 2). These included a one-hour didactic seminar per week (see Table 3); a supervisory experience where the resident sees one case per week; one hour per week of consultation where the resident observes the psychiatrist with his patients; video tapes; group experience with peers and faculty for a one and one-half hour session per week; and electives as available. To evaluate the efficacy of the curriculum, the group developed a set of evaluation instruments, are presented as Appendices 2 and 3.

#### PLANS FOR A PSYCHIATRIC RESIDENCY

The development of a primary care residency with significant behavioral science content, provides a vehicle for the training of psychiatry residents at the interface of medicine and psychiatry. A preliminary set of objectives

of such an experience are presented as Table 4 on the following page. A proposal for a psychiatric residency program is presently being negotiated with McLean and Cambridge Hospitals.

#### COST ANALYSIS

One of the internists, Robert Lawrence, M.D., who is also director of the Harvard Primary Care Program, prepared a cost analysis of the internal medicine residency training program at the Cambridge Center. He found that the average resident produces 7.1 patient visits per four-hour session compared to 13.0 patient visits for the average internist. However, the resident doesn't quite pay his way. While his stipend averages \$12,000 per year, the replacement value of his production is about \$9,900 per year for a net cost of about \$2,100. Moreover, this figure does not include the loss of productivity by the internist preceptor as a result of time devoted to teaching.

The cost analysis is presented in Appendix 4 following this chapter. Both the methodology and the figures are preliminary in nature and need further refinement, especially with regard to staff productivity loss.

TABLE  
Behavioral Science Component  
Objectives and Methods

CATEGORY OF SKILLS	OVERALL OBJECTIVES	SUB-OBJECTIVES	METHODS
SENSITIVITY SKILLS	To educate primary care physicians to be more sensitive to patients and their needs for treatment and understanding.	<p>Understand the process of normal development through life cycle.</p> <p>Be aware of own reactions and effect of treatment process.</p> <p>Understand economic, class and environmental influences on illness.</p> <p>Learn to use knowledge of psychosocial factors and community resources for treatment.</p>	<p>Didactic, Supervision, Consultation.</p> <p>Group, Consultation, Supervision.</p> <p>Didactic, Consultation</p> <p>Didactic, Consultation</p>
THERAPEUTIC SKILLS	Learn how to counsel various kinds of patients with problems complicating, causing or resulting from their medical (and psychosocial conditions.)	<p>Understand the "psychosomatic approach" in its broadest sense.</p> <p>Be experienced in rudiments of history taking, interviewing skills, and minor psychotherapeutic techniques.</p> <p>Be able to recognize and deal with the acute (though often low level) anxiety and depression often related to illness.</p>	<p>Didactic, Consultation</p> <p>Didactic, Supervision, Consultation, Videotape</p> <p>Didactic, Supervision, Consultation</p>
REFERRAL SKILLS	Learn to <u>recognize</u> serious psychiatric disorders and develop skills of referral process, utilizing appropriate resources.	<p>Develop diagnostic skill for major psychiatric disorders.</p> <p>Be able to elicit data relevant to suicidal or homicidal potential.</p> <p>Know how to arrange for hospitalization when needed.</p> <p>Know how to work with psychiatrists in providing proper treatment.</p> <p>Understand various types of psychiatric treatment, other types of therapists, and ways in specialized services are presented.</p>	<p>Didactic, Consultation</p> <p>Didactic, Consultation Videotape.</p> <p>Didactic</p> <p>Didactic, Group, Supervisor</p> <p>Didactic, Supervision</p>

TABLE 2  
BEHAVIORAL SCIENCE COMPONENT  
TEACHING METHODS

Didactic Seminars (D/S)

A series of one-hour presentations interspersed throughout the year with other medical topics. Designed to provide practical and applicable psychosocial information relevant to the physician's daily clinical case load.

Supervisory Experience (S)

Specifically designed to offer the resident closely monitored experience in dealing with the emotional problems of medical practice. Residents will see patients in brief psychotherapy to learn how to deal with appropriate cases in individual or couples therapy. Each resident will see one case per week.

Consultation (C)

Each resident should learn how to utilize the services of a psychiatric consultant in the management of his usual medical case load. Psychiatrists can observe the resident's interviewing and history-taking technique, how he establishes a doctor-patient relationship (alliance), and how he attends to cues in his decision-making process. Regularly scheduled medical patients will be seen by the psychiatrist and resident. One hour each week.

Videotape (V)

Useful for observing how experienced interviewers talk to patients as well as for observing oneself critically in the process of learning and using new skills.

Group Experience (G)

Designed to foster interaction of peers and faculty in one-and-one-half hour sessions each week throughout the two year program. Case-oriented discussions are co-led by a psychiatrist and primary care preceptor and will include comments on and criticism of the resident's understanding and skill. Part of the experience will have as its objective to learn about oneself--reactions to patients, prejudices, strengths and weaknesses, the interaction of physician's personality with that of the patient. The emphasis is upon the experiential (rather than substantive) side of becoming a doctor and engaging in doctoring.

Electives (E)

Residents with special interests will have opportunities in the second year to pursue these (e.g. applications of hypnosis to medical care; behavioral techniques, etc.).

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TABLE 3

BEHAVIORAL SCIENCE COMPONENT

DIDACTIC SESSIONS

For the primary care physician to be able to care for his patients as a whole, he/she must be able to acquire the knowledge and experience which will permit him/her to compose diagnoses and treatment plans in physical, psychological and social terms. A series of seminars, interspersed with other medical topics throughout the year is intended to complement other learning experiences with attention to practical application to office practice.

1. The Emotional Aspects of Common Problems Presenting to a Doctor: A Survey of Medical Practice.  
Why do patients come to the doctor? What do they want? Tuning your ear to the chief complaint.
2. The "Psychosomatic " Approach: Illness as a Unified Whole.  
The fallacy of mind-body, organic-functional dualism.
3. The Experience of Illness: What It Means to be Sick.  
Determinants of pain: cultural and social aspects.
4. Hypochondriasis: Isn't All Pain Real?
5. The Life Cycle and the Family: A Developmental Approach to the Individual Problems Related to Phases of Growth, Adolescence, Mid-life, Old Age, Death and Dying.
6. Eliciting the Sexual History: An Approach to Individual and Marital Sexual Development.
7. "Bad Feelings": Recognizing and Managing Depression and Anxiety.
8. Suicide: How to Assess the Risk and What to Do.
9. Habit Patterns and How to Modify Them:  
Uses of Hypnosis, TM, Group Therapy, Biofeedback  
The Health Hazards of Smoking, Obesity, Drug Abuse  
Alcoholism and its Medical Treatment
10. Psychopharmacology: What Drugs for What Problems?
11. Practical Tips on Interviewing, Taking a Mental Status, and Making Personality Diagnoses.
12. The Physician as Psychotherapist: Brief Techniques.
13. Referral to a Psychiatrist: When, Why, and How?
14. Community Resources and Other Therapies.

TABLE 4

PSYCHIATRIC RESIDENCY OBJECTIVES

A residency track in psychiatry and primary medical care should address itself to the following objectives:

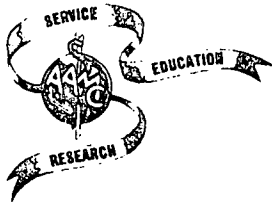
1. Acquaint the resident with the body of knowledge which comprises psychosomatic medicine as a scientific discipline.
2. Teach the resident the skills necessary to apply a psychosomatic approach to all of medicine.
3. Provide an experience which includes close working relationships with non-psychiatrists as well as paraprofessionals in what will be an interdisciplinary approach.
4. Obtain experience in a general hospital or ambulatory setting, to familiarize oneself with the spectrum of patients who are treated for acute illness by the medical profession.
5. Work closely with a primary care physician in a typical (or simulated) office practice for maximum exchange of viewpoints, styles, and skills.
6. Obtain special training in behavioral modification techniques, hypnosis and other modalities which rely to some extent upon an appreciation of psychological understanding in their application to general medical complaints (e.g. obesity, smoking, accident proneness, generalized anxiety, and so on.)
7. Devise and carry out a circumscribed clinical/research project which demonstrates the use of the psychosomatic approach and its applicability (by the primary care physician) to general medicine.
8. Learn and appreciate the nature of primary medical practice, including the pressures, orientation, skills, styles, rhythm, and so on of the primary physician.
9. Learn how to translate psychodynamic principles into comprehensible language with practical application to the common problems of medical practice.
10. Learn how to alter the psychiatric stance and interviewing style of the psychiatric intake process to the more medically-oriented model of the practicing physician.
11. Learn to recognize and deal with one's own discomforts about "returning" to the medical scene, often experienced as a regression in the psychiatrist's identity as a psychotherapist and specialty consultant.
12. Learn how to be supportive and not critical of the physician who is trying to learn how to cope with his own anxieties, especially around the aspect of converting from an active to a more passive listening approach. The psychiatrist must refrain from "psycho-analysing" his primary care colleague.

EXCERPTS

THIRD QUARTERLY PROGRESS REPORT

PROJECT FOR THE DEVELOPMENT OF MODELS  
FOR THE PROVISION OF "ONE CLASS" AMBULATORY CARE SERVICES  
IN UNIVERSITY-AFFILIATED TEACHING HOSPITALS

CONTRACT NO. 230-75-0188



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

Ambulatory Care Project - Contract No. HRA 230-75-0188

THIRD QUARTERLY PROGRESS REPORT FOR THE PERIOD  
January 1 - March 31, 1976  
PREPARED FOR SUBMISSION TO THE OFFICE OF  
PLANNING, EVALUATION AND LEGISLATION, HRA, DHEW

This quarter was a significant one in that it included two workshops for the selected participants. The successful and effective completion of these workshops was possible because of the work done during the preceding quarters by the AAMC staff, the faculty and the members of the Project Advisory Committee. At each step cognizance has been taken of the recorded experiences in "Selected Innovative Hospital Programs in Ambulatory Care" (DHEW Publication No. (HRA) 75-610).

A. Work Completed in Quarter

1. Faculty. Early evidence suggested a need for a faculty which included skills in the operational aspects of ambulatory care and skills in organizational psychology, group process and organization development. This balance was achieved for the second workshop and that experience indicated the correctness of this decision. The Faculty who participated in Workshops I and II are shown in Appendices I-A and II-A.

The faculty group at the time of the first workshop was minimal in number; however, because of commitment and hard work it was possible to meet the objectives of the participants. In contrast, because of additional efforts in identifying and recruiting faculty with skills in both areas, a more satisfactory faculty grouping was attained for Workshop II. The effectiveness, at the second workshop, was evident in better preparation of didactic presentations on selected topics and, more especially, in improved work process with the individual institutional teams. This was achieved through building on the experience of Workshop I, by additional recruitment, by the help of a faculty planning session held in Washington on February 11-12, 1976 (See Appendix III), and by additional faculty preparatory sessions at the time of the second workshop.

2. Curriculum or Workshop Format. The major impact of the workshop results from the work done by the individual team members in concert with their faculty. Both workshops have indicated the additive effect of a lesser

component devoted to formal presentations, with group discussion, by the faculty. The schedules for Workshops I and II are enclosed (Appendices I-B and II-B). Our current experience suggests that the schedule for Workshop II represents a reasonable mix of didactic and individual team efforts and an optimal time sequence. For example, in Workshop I an excessive amount of time was scheduled for both elements. This resulted in fatigue for participants and faculty.

3. The Participants. The workshops were predicated and institutions selected on the concept of participation by key decision makers from a given institution. The insistence upon this requisite required considerable staff effort which was rewarded by the the attendance of desired participants. The lists of participants for Workshops I and II are enclosed in Appendices I-C and II-C.

Institutional commitment to change was evident from the composition of the teams. Out of a total of 36 individuals from five institutions who participated in the second workshop (5 to 9 individuals per institution), 23 held key positions affecting ambulatory care in their institutions. They included: 7 clinical department chairmen (3 chairmen of Departments of Internal Medicine, 2 in Pediatrics and 1 each in Family Medicine and Surgery), 4 hospital directors, 4 directors of ambulatory services, 4 directors of nursing services, 2 deans and 2 chief fiscal officers. Both the hospital and medical school were well represented among participants in each team although officially the participating institutions were: 2 hospitals, 2 medical schools and 1 health sciences center composed of the medical school and hospital. In fact, of the participants, roughly one-third hold positions at the hospital, another one-third at the medical school and one-third hold positions at both institutions.

To illustrate, one can cite the University of Indiana, a participant at Workshop II. The members from this institution included the Dean, the Assistant to the Dean, the Chairmen of the Departments of Medicine and Pediatrics, a representative from Gynecology and the following key representatives from the County Hospital (the site where the major question concerning ambulatory care exists): Chief of Medicine, Hospital Administrator and Assistant Chief of Nursing.

In every instance, the representatives from a selected institution were those committed to and capable of the necessary analysis and work on ambulatory care at their institution. The experiences with both workshops support the view that participation by key decision makers should be a requirement for the program.

4. The Workshops.

- a. The Site. The requirements considered for the site included: appropriate isolation, an environment conducive to intensive work,

facilities for total group meetings and especially for the institutional team sessions, and competitive cost acceptable to the participants. (Bellevue Biltmore, for example, had a single rate of \$42, including meals.) These requirements were met in January by the Bellevue Biltmore Hotel in Clearwater, Florida (a site used previously by the AAMC for group meetings similar to that in this project), and by the Gene Autry Hotel in Palm Springs, California, the site of the March workshop. A major determinant, more optimally met at Workshop II, is the requirement for appropriate meeting rooms for the individual team sessions, since most of the work time is devoted to this activity. We encountered problems in meeting this requirement during the first workshop.

- b. The Workshop. The sequence in Workshop II (See Appendix II-B) represents the current opinion as to a reasonable combination of didactic presentations and formal time allocations for team meetings. The topics which were presented by the faculty included: organizational structure for ambulatory care, planning for change, financing of ambulatory care, one-class ambulatory care program characteristics, how to design a work plan, education in the ambulatory setting and management strategies for implementing change.

The second workshop in March had a number of identifiable strong points and few deficiencies. The faculty group was adequate in number and balance, with a clear commitment, and this produced a high level of interfaculty satisfaction. The evolved curriculum included, for the individual teams, a time-related identification of problems with priority determinations, a clear statement of objectives and, by the end, a definite work plan with task responsibility assignments by individuals and by dates. The accomplishment of the latter was facilitated by the sequence of didactic presentations. For example, certain of the process faculty reviewed different techniques which could be utilized for problem identification and for the work plan. An additional strength was the fact that the five institutions were represented by strong team members. The time allotted for the entire workshop and for the didactic and team efforts was again tested and shown to be both reasonable and acceptable. There is a minority view which holds that workshops could be shortened. The site met virtually all of the characteristics stated above. Finally, the added experience and planning by the faculty was associated with a clearer understanding and more effective commitment to the work in progress. A mechanism for on-site consultation follow-up by faculty was in operation.

A relative weakness was the timing (too long) and mode (too diffuse) of certain formal presentations. Furthermore, two suggestions were made for improved workshop facilitation: (a) a site visit by

faculty prior to the workshop and (b) a recommended reading list to be distributed to institutional members prior to the workshop.

In contrast, the first workshop in January indicated areas in need of improvement. At that time, the effort was effective in terms of helping institutional members to identify problems and to devise a work plan, and it met with a high degree of participant satisfaction. At the same time, the experience at Workshop I indicated that the faculty was too few in number and relatively less clear as to the work to be done, both in the didactic and in the team sessions; the results were manifest by creative tension and by fatigue engendered from the excessive work span attempted. Facilities at the Belleview Biltmore were satisfactory, though less than optimal, especially because of the limitations on the rooms for the team efforts and the requirement to utilize a number of locations for the total group meetings. A mechanism had not been evolved for follow-up consultations. All of these problems had been corrected satisfactorily by the conclusion of the second workshop.

B. Current Work and Unresolved Questions.

1. Follow-up consultations. Collective experience, operative by the time of the second workshop, suggests the need for at least one consultation follow-up by a faculty member to be carried out during the period prior to June 1, combined with a report to the AAMC (See Appendix IV). The purpose of this is to assist the institution in the implementation or revision of the work plan and, at the same time, to provide information to the AAMC on this particular programmatic approach.
2. Evaluation of Effectiveness. This topic has been reviewed continuously by the AAMC staff, the Project Advisory Committee, the faculty and participants. It is recognized that this is a complex issue, especially as it is influenced by the termination date of the current contract which is June 30, 1976. This program has met with a high degree of interest as evidenced by the 59 applicants and by additional inquiries in excess of 50. Furthermore, key decision makers from the selected institutions came and worked intensively for the entire span of the workshop. A questionnaire, evolved and used for Workshop II, indicated an overall high evaluation of the workshop itself. (The workshop was rated excellent by 75% and good by 25% of respondents.)

More importantly, it is projected that a more objective evaluation will rest upon the specific review of the work plan during consultation visits to the participating institutions by faculty and AAMC staff. Optimally, an element of time beyond that afforded by this contract period will be needed to fully evaluate this effort. However, our information from at least one on-site visit to each institution prior to June 1 can provide useful data on this point.

3. A report on this experience to help others. This, along with the evaluation, has had extensive consideration by the AAMC staff, by the faculty and by the team coordinators at Workshop II. We have a keen interest in sharing useful information with other interested institutions. At this time, based on the collective input, we have considered the following options:
  - a. A self-help guide as stipulated in the contract;
  - b. A monograph on ambulatory care by the faculty, which might include selected reprints or original position papers;
  - c. A single author (Project Director) critical review on issues or perspectives in ambulatory care; or
  - d. Defer a formal publication pending additional experience.

In considering these options, the faculty and Workshop II team coordinators have indicated serious reservations about the feasibility of developing a meaningful self-help guide. An explanation for this lies in the fact that each of the 11 institutions which have participated have decidedly different problems affecting ambulatory care. Furthermore, the value attached to the program lies largely in the individual team problem solving activities, an approach which does not lend itself to a guide or outline. Additional experience, from a continuation of the program, may identify general or common characteristics which could be presented in this manner.

Each of the faculty members is extremely busy and we have been fortunate to have them allocate the necessary time to the workshops and to the consultation follow-ups. The faculty, during a review of this subject at the second workshop, indicated that they were disinclined to participate in the development of a monograph on ambulatory care at this time. It was suggested, moreover, that the experience to date could be the basis for a single-authored critical review on perspectives on ambulatory care; such an approach could be attempted by the Project Director, with input by the faculty.

4. Continuation of the Project. The expressed interest by institutions (initial applicants of 59) and continuing inquiries (over 50) would suggest the desirability of continuing this programmatic approach. It is of note in this regard that the participants to date have attached a priority to this as evidenced by their work and their willingness to pay their direct expenses (travel, lodging and food) incidental to the workshops.

A continuation of the program for two more years, strongly encouraged by the AAMC, would provide 3 to 4 more workshops per year thereby accommodating the specific ambulatory service restructuring of some 41 to 51 institutions over a three year period. It would permit the longitudinal on-site consultation by faculty, further facilitating the necessary change processes in participating institutions and significantly enhancing the collective body of knowledge on this important issue.



AAMC AMBULATORY CARE WORKSHOP

Clearwater, Florida  
January 19-23, 1976

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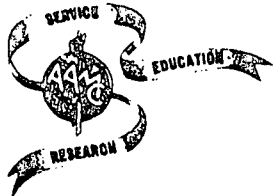
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AAMC Ambulatory Care Workshop

January 19-23, 1976  
Clearwater, Florida

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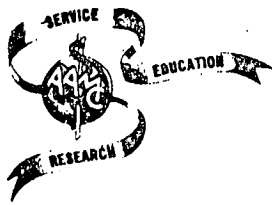
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ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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AAMC Ambulatory Care Workshop  
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