Gus
Fred Robbins is very positive on Michener

welcome Ensign Mayfield Rabkin Dolegal

Pinkston appointment

House Std's Reg. effort

Talmadge Comm.

MAP program repeat in June - 7-12

aamc **association of american medical colleges**

MEETING SCHEDULE
COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD

January 12-13, 1977
Washington Hilton Hotel
Washington, D.C.

Wednesday, January 12

6:00 P.M.	COTH Administrative Board Meeting	Edison Room
7:00 P.M.	Cocktails	Farragut Room
7:30 P.M.	Dinner	Edison Room

Thursday, January 13

9:00 A.M.	COTH Administrative Board Business Meeting (Coffee and Danish)	Adams Room
1:00 P.M.	Joint COTH/COD/CAS/OSR Administrative Board Luncheon	Caucus Room
	Executive Council Business Meeting	
4:00 P.M.	Adjournment	

annual mtg

ask Dave to announce what we're thinking about

Council of Teaching Hospitals
Administrative Board

January 13, 1977
Washington Hilton Hotel
Edison Room
9:00 a.m. - 1:00 p.m.

Bill Pinkston's appointment

AGENDA

DISCUSSION ITEMS

XIV.	Uniform Application Process for Graduate Medical Education	Executive Council Agenda Page 114
XV.	Student Representatives on the LCME	Executive Council Agenda Page 116

INFORMATION ITEM

XVI.	COTH Response to BHI Proposed Self-insurance Reimbursement Policies	Page 31
XVII.	New Business	
XVIII.	Adjournment	

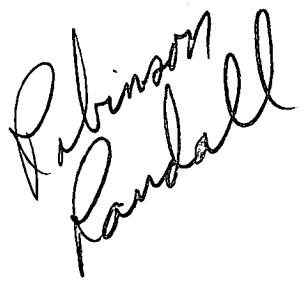
Association of American Medical Colleges
COTH Administrative Board Meeting

San Francisco Hilton Hotel
San Francisco, California
November 12, 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
David A. Gee
Robert M. Heyssel, M.D.
Baldwin G. Lamson, M.D.
Stanley R. Nelson
S. David Pomrinse, M.D.
John Reinertsen



ABSENT:

John M. Stagl
Robert E. Toomey

STAFF:

James D. Bentley, Ph.D.
James I. Hudson, M.D.
Joseph C. Isaacs
Richard M. Knapp, Ph.D.
Catharine A. Rivera

I. Call to Order:

Mr. Womer called the meeting to order at 8:00 a.m. in the Whitney Room of the San Francisco Hilton Hotel.

II. Consideration of Minutes:

The minutes of the September 16, 1976 COTH Administrative Board meeting were approved as circulated.

III. Membership:

The Board reviewed two applications for membership, including the application of Mount Sinai Hospital in Hartford, Connecticut which was tabled at the September Board meeting. Dr. Knapp stated that he had discussed the Mount Sinai application with Robert B. Bruner, Mount Sinai's Executive Director, who stated that the affiliation agreement with the University of Connecticut was misdated and actually expired in 1976. Mr. Bruner also stated that Mount Sinai had integrated residencies with the University as follows: three positions in Surgery, six positions in Pediatrics, one in Pathology, and one in Nuclear Medicine. On the basis of this additional information and having reviewed the applications submitted, the Board took the following action:

ACTION: IT WAS MOVED, SECONDED AND CARRIED THAT THE FOLLOWING APPLICATIONS FOR COTH MEMBERSHIP BE RECOMMENDED FOR APPROVAL TO THE EXECUTIVE COUNCIL:

MOUNT SINAI HOSPITAL
HARTFORD, CONNECTICUT

HACKENSACK HOSPITAL ASSOCIATION
HACKENSACK, NEW JERSEY

IV. COTH Nominating Committee:

The COTH Nominating Committee was composed of the Immediate Past Chairman, the current Chairman of COTH and one member-at-large, Mr. Roy Rambeck. As Chairman of the Committee, Mr. Lewine read the nominations which would be submitted to the COTH Annual Business Meeting for consideration. (See Attachment A.)

V. AAMC Officers' Retreat:

Noting that the new COTH Chairman, Chairman-Elect, and Dr. Knapp would be attending the annual AAMC Officers' Retreat in December, Mr. Womer read the list of tentative agenda items (Attachment B) and asked the Board for any additional items. While no further items were suggested, it was noted that several of the agenda items are of particular significance to COTH members.

VI. Liaison Committee on Graduate Medical Education:

As one of the AAMC representatives to the LCGME, Dr. Heyssel discussed the present activities of and problems facing the Committee. He reported that the Committee is still trying to define its role and authority, has inadequate manpower to review the accreditation reports of the RRC's, and has found itself in conflict with some RRC's over essentials and guidelines and over RRC funding. An additional problem was identified as the role of the LCGME and CCME in the approval process for new specialty boards. The

AMA and ABMS have taken one position on CCME's role and the AAMC and the AHA have taken another. Since a "No" vote by any parent organization leads to inaction, the LCGME reflects the policies of its component organizations rather than the policies of its individual representatives. While Dr. Heyssel said that he believed that the LCGME was becoming more effective, he identified four future problems for the Committee: the conflicts between the policies of the parent organizations could lead to LCGME paralysis; strong challenges from the RRC's and individual boards, which are voluntary participation, could lead to their withdrawing participation; committee staffing and funding which are heavily dependent upon AMA resources, and conflicts over accreditation decisions that are likely to result when specialty training numbers have importance for federal funds such as medical school capitation.

Members of the Board expressed interest in Dr. Heyssel's report, and requested that they continue to be informed about LCGME activities.

VII. House Staff Labor Relations:

Dr. Knapp reviewed the status of house staff labor relations at Misericordia Hospital Medical Center. On October 14th, the New York State Supreme Court for New York County ruled that the State Labor Relations Board has jurisdiction over house staff despite the provisions of the National Labor Relations Act and the related NLRB decisions.

As a result of the New York deicsion Dr. Knapp reported the AAMC Executive Committee has three alternatives for potential participation in future court action: (1) the AAMC could seek to be an amicus in a Misericordia appeal of the state court decision; (2) the AAMC could seek to be an amicus if the NLRB files suit against New York State alleging federal pre-emption of house staff issues; and, (3) the AAMC could seek to be an amicus is PNHA files a suit against the NLRB alleging that the Board violated Congressional intent in making the Cedars-Sinai decision.

Dr. Knapp also informed the Board that Representative Frank Thompson, (D.-NJ), Chairman of the House Subcommittee on Labor-Management Relations, introduced a bill which would specifically define house staff as employees under the National Labor Relations Act. It is anticipated that the current bill, or some version of it, would be re-introduced in the Congress in 1977.

VIII. Section 223 Court Suit:

Dr. Knapp informed the Board that no decision had been made by the U.S. Court of Appeals on the AAMC's appeal of the Section 223 regulations establishing Medicare's routine service cost limitations. It is hoped that a decision will be returned in December or January.

XI. AHA Activities:

Mr. Robinson reviewed recent policy developments under consideration by the American Hospital Association. In revising the Policy Statement on Health Services, consideration is being given to replacing the positions that health care is a right and that access to care is a right with the position that efforts should be made to provide the best possible access to health care. In addition, the phrase "national health insurance" is being replaced by the term "universal health insurance." In a separate policy issue,the AHA's position on cost control is to support local cost control programs organized under federal guidelines specifying organizational and operating characteristics. In the Statement of Financial Requirements for Hospitals, the AHA is asking its Regional Advisory Boards to study a position advocating a formula for determining an adequate operating margin for hospitals participating in prospective reimbursement schemes. The COTH Board briefly discussed each of these possible changes and requested that Mr. Robinson furnish more complete information on the appropriate policy statement prios to the AAMC Officers' Retreat.

X. Recognition of Member Service:

On behalf of the COTH Administrative Board, Mr. Lewine expressed appreciation to Mr. Womer for his service as COTH Chairman. Mr. Womer then thanked Messrs. Lewine, Gee, Stagl and Dr. Pomrinse -- all of whom were concluding service on the Board -- for their support and participation in Board deliberations and COTH activities.

XI. Adjournment:

There being no further business the meeting adjourned at 9:25 a.m.

COTH NOMINATING COMMITTEE REPORT

Sidney Lewine, Chairman

November 12, 1976

By tradition, the Nominating Committee is composed of the Immediate Past Chairman of the COTH Administrative Board who serves as the Chairman, the current Chairman of COTH, and one member-at-large. Thus, your Committee includes: myself as Chairman, Charles Womer and Roy Rambeck, Executive Director, University of Washington Hospitals.

I have several groups of nominations, and I will present the entire slate and let the Chairman take it from there.

In accordance with the AAMC Bylaws, COTH is entitled to 57 representatives on the AAMC Assembly. Therefore, we have:

19 Nominations for the AAMC Assembly for a Three-Year Term Expiring 1979:

J. E. Birmingham	Veterans Administration Hospital Albuquerque, New Mexico
Philip S. Birnbaum	George Washington University Hospital Washington, D.C.
J. L. Buckingham	Touro Infirmary New Orleans, Louisiana
Mario Cancelosi	Bernalillo County Medical Center Albuquerque, New Mexico
James B. Ensign	Omaha Regional Health Care Corporation Omaha, Nebraska
David L. Everhart	Northwestern Memorial Hospital Chicago, Illinois
Alvin Goldberg	Mount Sinai Medical Center of Greater Miami, Inc. Miami, Florida
Irwin Goldberg	Montefiore Hospital Association of Western Pennsylvania Pittsburgh, Pennsylvania

Lawrence Hill	New England Medical Center Hospital Boston, Massachsuetts
H. Jaffrey	Veterans Administration Hospital Cleveland, Ohio
Merlin Olson	University of Colorado Medical Center Denver, Colorado
Vincent J. Parrish	Veterans Administration Hospital Little Rock, Arkansas
Vito F. Rallo	Cincinnati General Hospital Cincinnati, Ohio
Mitchell T. Rabkin, M.D.	Beth Israel Hospital Boston, Massachusetts
John K. Springer	Hartford Hospital Hartford, Connecticut
Lavand M. Syverson	Saint Paul-Ramsey Hospital & Medical Center Saint Paul, Minnesota
David D. Thompson, M.D.	New York Hospital New York, New York
William F. Towle	Vanderbilt University Hospital Nashville, Tennessee
James Varnum	University Hospital Seattle, Washington

To replace representatives on the Assembly who are no longer associated with COTH member institutions, we have:

Three Nominations for a Two-Year Term Expiring 1978:

David A. Barrett	Memorial Hospital Worcester, Massachusetts
Gordon M. Derzon	University of Wisconsin Hospitals Madison, Wisconsin
Gary Gambuti	St. Luke's Hospital Center New York City

Two Nominations for a One-Year Term Expiring 1977

Carl I. Bergkvist	The Bryn Maw Hospital Bryn Maw, Pennsylvania
Doyle R. Liles	Veterans Administration Hospital Birmingham, Alabama

For the COTH Administrative Board, the Following Nominations:

For a Three-Year Term:

Jerome R. Dolezal	Veterans Administration Hospital Seattle, Washington
James B. Ensign	Omaha Regional Health Care Corporation
Mitchell T. Rabkin, M.D.	Beth Israel Hospital Boston, Massachusetts

For a Two-Year Term:

Stuart Marylander	Cedars Sinai Medical Center Los Angeles, California

Secretary (Three-Year Term):

John Reinertsen	University of Utah Medical Center

Representative to the AAMC Executive Council. A Two-Year Term to replace John Stagl, who has resigned.

Robert M. Heyssel, M.D.	The Johns Hopkins Hospital

In addition to these appointments, we have the Immediate Past Chairman which is automatic - Mr. Charles Womer.

The Chairmanship, which likewise is automatic since you exercised your franchise last year - Dr. David Thompson and,

Chairman-Elect: David L. Everhart Northwestern Memorial Hospital

Mr. Chairman, I move the nominations.

COTH INSTITUTIONAL MEMBERSHIP MEETING
Friday, November 12, 1976
Imperial Ballroom
San Francisco Hilton Hotel
San Francisco, California
1:00 -.m. - 2:00 p.m.

AGENDA

I.	Call to Order - Introductions	Charles B. Womer, COTH Chairman President, University Hospitals of Cleveland
II.	Report of COTH Staff	James I. Hudson, M.D. Director, Department of Health Services Richard M. Knapp, Ph.D. Director Department of Teaching Hospitals
III.	Report of the COTH Chairman	
IV.	Report of the COTH Nominating Committee and Election of Officers	Sidney Lewine, Chairman COTH Nominating Committee
V.	Presentation of Awards	
VI.	Installation of Incoming Chairman	
VII.	New Business	
VIII.	Adjournment	

COTH GENERAL SESSION
2:00 p.m. - 5:00 p.m.

CLINICAL CASE MIX DETERMINANTS OF HOSPITAL COSTS

Moderator: David D. Thompson, M.D.
Director, New York Hospital

Speaker: Clifton R. Gaus. Sc.D.
Director, Division of Health Insurance Studies
Social Security Administration

Panel: John D. Thompson
Chief, Division of Health Services Administration
Yale University School of Medicine

Charles T. Wood
Director, Massachusetts Eye and Ear Infirmary

Baldwin G. Lamson, M.D.
Director, UCLA Hospital and Clinics

TENTATIVE AGENDA

AAMC OFFICERS' RETREAT

December 15-17, 1976

I. AAMC Organizational Concerns

a. Regionalization and Fractionalization of the Association's Membership

b. Representation of Vice Presidents in the AAMC

c. Housestaff Representation in the AAMC

II. Graduate Medical Education

a. AAMC Conference on Graduate Medical Education

b. Housestaff Collective Bargaining Rights

III. Federal Concerns

a. Implementation of the Health Manpower Bill

b. Preparing for Health Manpower Renewal

c. National Health Insurance

d. Legislative Outlook in the Coming Year

e. Getting Good People Into Federal Agencies

f. Update on FTC Activities

IV. Miscellaneous Topics

a. Process of Developing CCME Policy

b. Staffing of the CCME & Liaison Committees

c. 1977 Annual Meeting

For Information and Review: Presentation of AAMC Activities by Department and Division

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Corresponding Membership

INSTRUCTIONS: Type all copies, retain the pink copy for your files and return two copies to the Association of American Medical Colleges, Department 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 Corresponding Membership 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 participates in approved, active residencies.

Membership is limited to not-for-profit (IRS-501C3) institutions, operated for educational, scientific or charitable purposes and publically-owned institutions. Teaching hospitals which are eligible for full participating membership in the Council of Teaching Hospitals are not eligible for Corresponding Membership.

1. MEMBERSHIP INFORMATION

Greater Southeast Community Hospital
HOSPITAL NAME

1310 Southern Avenue, S.E.
STREET CITY

Washington, D. C. 20032 574-6000
STATE ZIP CODE TELEPHONE NUMBER

Chief Executive Officer: Mr. George Caldwell (Name)

President, Greater Southeast Community Hospital Foundation, Inc. (Title)

APPROVED FIRST POST-GRADUATE YEAR

TYPE[2]	Date of Initial Approval by CME of AMA**	Total F.T.E.[1] Positions Offered	F.T.E.[1] Total Positions Filled by U.S. And Canadian Schools	F.T.E.[1] Total Positions Filled by FMG's
Flexible	N			
Categorical	O N			
Categorical*	E			

** 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 for 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.)

APPROVED RESIDENCIES

TYPE	Date of Initial Approval by CME of AMA**	Total F.T.E.[1] Positions Offered	F.T.E.[1] Total Positions Filled by U.S. And Canadian Grads	F.T.E.[1] Total Positions Filled by FMG's
Medicine		0	0	
Surgery		3	3	
Ob-Gyn		4	4	
Pediatrics		3	3	
Psychiatry		0	0	
Family Practice		7	7	
Other (List):				
Orthopedic Surgery		3	3	

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 specifici reference to the following questions.

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

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

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

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

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

III. LETTER OF RECOMMENDATION

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

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

Name of Dean: Marion Mann, M.D.

Information Submitted by:

Raymon A. Noble, M.D.
NAME

Director of Medical Education
TITLE OF PERSON SUBMITTING DATA

12/14/76
DATE

SIGNATURE OF HOSPITAL CHIEF EXECUTIVE

HOWARD UNIVERSITY HOSPITAL
2041 GEORGIA AVENUE, N.W.
WASHINGTON, D. C. 20060

OFFICE OF THE
MEDICAL DIRECTOR

September 7, 1976

Raymond Noble, M.D.
Director of Residency Training Program
Greater Southeast Community Hospital
1310 Southern Avenue, S.E.
Washington, D.C. 20032

Dear Doctor Noble:

As you know, the Howard University has had affiliations with your hospital for several years. Specifically, the first agreement was in the Orthopedics Residency Program and was signed in July 1971. Others were signed in General Surgery, Family Practice and Obstetrics-Gynecology in July 1972.

Our affiliations in these programs continue to provide valuable educational experiences for our house officers. More recently, our Chairman of Pediatrics, Professor Melvin E. Jenkins, and his staff concluded disucssions with your Department of Pediatrics, and I am pleased that they, too, were able to begin their affiliation agreement July 1, 1976.

Further, our Faculty and the Residents have found that the combination of experiences of these two hospitals is providing a better mix of economic and social problems and of disease entities than would have existed in one hospital alone. We are pleased to have joined with Greater Southeast Community Hospital in what is now one of our major clinical affiliations.

Yours truly,

V. J. Roux, M.D.
Medical Director

Marion Mann, M.D.
Dean, College of Medicine

VJR:ml

SUPPLEMENT TO COTH APPLICATION

A. Greater Southeast Community Hospital does not participate in a formalized program for undergraduate medical education. There are, however, two members of our medical staff who utilize the hospital resources in the teaching of a Physical Diagnosis course to medical students from Georgetown University School of Medicine.

B. Greater Southeast Community Hospital has the following full-time salaried personnel:

1. Dr. Jay R. Shapiro - Director of Medical Education Affairs.
2. Dr. Raymon A. Noble - Director of Medical Education. He is an Instructor in Family Practice at Howard University College of Medicine.
3. Dr. Richard Levin - Co-Chairman, Department of Pathology.
4. Dr. Michael Dolan - Co-Chairman, Department of Pathology.
5. Dr. Solomon Albert - Chairman, Department of Anesthesiology.
6. Dr. Meechai Sriprasert - Chairman, Department of Pediatrics. He is a Clinical Assistant Professor of Pediatrics at Howard University College of Medicine.
7. Dr. Paul Domson - Educational Program Director, Department of Pediatrics. He is a Clinical Instructor in Pediatrics at Howard University College of Medicine.
8. Dr. Barry Pearson - Clinical Pathologist.
9. Dr. David Reagen - Clinical Pathologist.
10. Dr. Carmen Enecio - Pediatrician.
11. Dr. Bai Singh - Cardiologist.

Each of the above individuals contributes directly to graduate and postgraduate medical education in this hospital.

C. Financial support for graduate medical education is reflected in direct cost allocations in the attached "Resident Service Budget Report." Costs for supervising faculty as well as indirect costs have not been identified. Of particular note is that none of the supervisory faculty in either part-time or full-time position are paid by Greater Southeast Community Hospital for their educational activities.

The total operating budget for Greater Southeast Community Hospital for fiscal year 1976 is $35,310,285, while direct costs for resident education is $354,450.

D. The degree of involvement of Howard University Hospital in the overall education programs (graduate and continuing medical education) of Greater Southeast Community Hospital is as delineated by departments below:

1. Orthopedic Surgery - Attending Staff at Greater Southeast Community Hospital and the teaching faculty at Howard University Hospital are interchangeable in both resident and post-graduate educational conferences and seminars. This exchange is best observed in Orthopedic Surgery Grand Rounds and daily ward rounds.

2. Obstetrics/Gynecology - Members of Howard University Hospital's faculty frequently participate in monthly C.M.E. programs at Greater Southeast Community Hospital.

3. General Surgery - Select members of Howard University Hospital's faculty participate in ward rounds for general surgery residents.

4. Pediatrics - Howard University Hospital faculty conduct twice weekly teaching rounds with residents and periodic C.M.E. programs at Greater Southeast Community Hospital.

5. Family Practice - There is no Howard University Hospital faculty involvement in resident education or C.M.E. except that provided periodically by the Director of Medical Education of Greater Southeast Community Hospital.

From the above brief descriptions, it is obvious that inter-institution education resource sharing is in the developmental stages. Anticipated is further growth in this area because this has been adopted as an institutional goal of Greater Southeast Community Hospital, because it is cost-effective to share limited educational resources and because more intense sharing strengthens both programs.

RESIDENT SERVICE BUDGET REPORT

July 1, 1976

SALARIES		
1st year position	$ 13,649	
2nd year position	14,604	
3rd year position	15,559	
4th year position	16,515	
5th year position	17,470	
SERVICES		
Family Practice		
2 - 1st year	27,298	
5 - 2nd year	73,020	
Pediatrics		
1 - 3rd year	15,559	
2 - 2nd year	29,208	
Obstetrics/Gynecology		
2 - 4th year	33,030	
2 - 3rd year	31,118	
Orthopedics		
1 - 4th year	16,515	
2 - 2nd year	29,208	
General Surgery		
1 - 3rd year	15,559	
2 - 2nd year	29,208	
20 Positions	$299,723	
12.12% - Fringe Benefits	35,967	
	$335,690	
MEALS		
$60/Mo./Position		
20 Positions	$ 14,400	
EDUCATIONAL TRAVEL BENEFITS		
$200/Position/Year	4,000	
UNIFORM ALLOWANCE BENEFITS		
$18/Position/Year		
20 Positions	360	
TOTAL EXPENDITURES	$354,450	$354,450
Anticipated Expenditures		
Emergency Medicine Resident		
(Georgetown) - $14,100/Year	$ 11,750	
October 1, 1976-June 30, 1977		
12.12% Fringe Benefits	1,424	
TOTAL ANTICIPATED EXPENDITURES	$ 13,174	13,174
GRAND TOTAL		$367,624

Submitted By: Raymon A. Noble, M.D., Director of Residency Training

AFFILIATION AGREEMENT

THIS AGREEMENT made as of the 1 day of July, 1976 by and between HOWARD UNIVERSITY HOSPITAL (hereinafter referred to as "University") and GREATER SOUTHEAST COMMUNITY HOSPITAL (hereinafter referred to as "Hospital").

WITNESSETH:

WHEREAS, University is engaged in providing medical instruction and training to resident physicians in many medical fields, among which are Surgery, Family Practice, Obstetrics and Gynecology, Pediatrics and Orthopedics; and

WHEREAS, Hospital is equipped with modern facilities, equipment and laboratories, providing medical care to patients in many medical fields among which are Surgery, Family Practice, Obstetrics and Gynecology, Pediatrics and Orthopedics, and

WHEREAS, University and Hospital wish to continue and formalize their affiliation program which has the following goals:

1. To provide superior health care to all patients in the aforementioned medical fields at the Hospital.

2. To provide high level teaching the aforementioned medical fields and learning experiences through delivery of superior patient care to all patients in the aforementioned medical fields.

3. To provide opportunities for clinical research as approved by both parties.

NOW, THEREFORE, in consideration of the mutual covenants herein set forth, the parties agree as follows:

1. The parties agree to affiliate during the term of this Agreement for the purpose of providing clinical instruction and experience to University's resident physicians in the medical fields of Surgery, Family Practice, Obstetrics and Gynecology, Pediatrics and Orthopedics. This Agreement may be amended, from time to time, to include such additional medical fields as may be mutually agreed upon by the parties in a written document signed by both parties hereto.

2. University shall whenever possible for the purposes of this Agreement assign to the Hospital, at all times, residents at the educational level and in the numbers, medical fields and rotational basis set forth as follows:

Levels (years)	Medical Field	Number of Residents	Rotational Basis
Second and Third	Surgery	three (3)	3 - 6 months
Second and Third	Family Practice	three (3)	3 - 6 months
First and Second	Family Practice (Pediatrics)	three (3)	3 - 6 months
Second and Third	Obstetrics and Gynecology	four (4)	3 - 6 months
Second and Third	Pediatrics	three (3)	2 - 3 months
Second and Third	Orthopedics	three (3)	3 - 6 months

3. The Director of Residency Training at the Hospital is the Program coordinator of the affiliation program.

4. Each resident, while assigned to the Hospital under this Agreement, shall be under the supervision of the Program Coordinator and shall abide by the Rules and Regulations of the Hospital.

5. Faculty appointments at University will be offered to qualified physicians of the Hospital practicing in the medical fields to which residents are assigned hereunder as may be required by mutual agreement of the parties hereto.

6. All staff appointments and promotions on the medical staff of the Hospital will be continued in accordance with past practice of the Hospital.

7. An Affiliation Committee will be created by the parties upon the commencement of the term hereof and will consist of educational representatives from the University and Hospital, specifically, the respective Medical Directors or designees, the respective Directors of Residency and/or Housestaff Training and the respective Administrators or his designee plus the respective Departmental or Divisional Chairmen of the medical fields involved. The Committee shall meet no less frequently than every three months. The Committee will be charged with the overall responsibility for the educational program that interfaces with each institution.

8. In the event of a dispute between a resident and a member of the medical staff at the Hospital which cannot be resolved through the efforts of the Hospital, the Affiliation Committee will serve to arbitrate said dispute.

9. Hospital will, during the period each resident is assigned to it, provide each such resident the following:

(a) A stipend paid every two weeks in an amount equal to the stipend paid by the University subject to notification by University to Hospital of the maximum amount of such stipends prior to November 1 of each year immediately preceding commencement of each renewal year hereunder.

(b) Laundry service for uniforms. Hospital shall reimburse University for one third of the actual cost of suppying uniform to residents for each full time equivalent resident furnished hereunder (i.e., 19 as provided in paragraph 2 hereof).

(c) Meal allowance of $60.00 per month in the Hospital cafeteria, plus free lunches at selected conferences.

(d) Suitable on-call facilities.

(e) Insurance coverage for malpractice arising out of duties as a resident physician.

(f) Hospitalization coverage as provided in Hospital program.

(g) Social Security and Workmans Compensation in accordance with the policy of the Hospital.

(h) Parking and sick leave will be furnished to residents in accordance with Hospital policy.

10. Residents will not be scheduled for night call more frequently than every third night except under emergency or unusual circumstances.

11. Residents will be entitled to one (1) week's vacation for every four (4) months served at the Hospital. Scheduled vacations must be approved in advance by the Program Director of the Hospital.

12. The Pediatric residency affiliation program has as a goal of that program to provide the opportunity for tertiary pediatric subspecialty back up at University for patients with difficult and complicated health problems.

13. Selected University faculty members will make inpatient rounds on a rotational basis at least two half days per week in the Department of Pediatrics and on the Medical Service of Hospital.

14. Hospital will provide University a written evaluation of each resident physician's performance every two (2) months. The evaluation will include specific information as to any deficiencies.

15. The term of this Agreement shall be for a period of one (1) year, beginning July 1, 1976. Thereafter this Agreement shall automatically renew itself

from year to year unless one of the parties has given written notice of termination at least seven (7) months prior to the end of the original term or any renewal thereof. Changes in or termination of the Agreement may be made by mutual agreement in writing signed by both parties at any time.

16. Nothing contained herein will in any way preclude the Hospital's right to enter into agreements similar to this one with other medical schools.

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

HOWARD UNIVERSITY HOSPITAL

By _____
Augustus L. Palmer, Financial Director

By _____
Charles Ireland, M.D., Hospital Director

By _____
Casper L. Harris, Jr., Vice President for Business and Financial Affairs/Treasurer

GREATER SOUTHEAST COMMUNITY HOSPITAL

By _____
George B. Caldwell, President

By _____
Jay R. Shapiro, M.D., Director of Medical and Educational Affairs

By _____
Dunlop Ecker, Administrator

By _____
Raymon Noble, M.D., Director of Residency Training

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

Sidney Farber Cancer Institute
HOSPITAL NAME

44 Binney Street — STREET
Boston — CITY

Massachusetts — STATE
02115 — ZIP CODE
617-732-3450 — TELEPHONE NUMBER

Chief Executive Officer: Emil Frei III, M.D. — NAME
Director and Physician-in-chief — TITLE

Date hospital was established: July, 1975

APPROVED FIRST POST-GRADUATE YEAR

TYPE[2]	Date of Initial Approval by CME of AMA**	Total F.T.E.[1] Positions Offered	F.T.E.[1] Total Positions Filled by U.S. And Canadian Grads	F.T.E.[1] Total Positions Filled by FMG's
Flexible				
Categorical	May, 1949*	3	3	0
Categorical*				

** 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 directpr; Categorical*-graduate program under supervision of single program director but content is flexible.)

*Peter Bent Brigham Hospital

APPROVED RESIDENCIES

TYPE	Date of Initial Approval by CME of AMA**	Total F.T.E. Positions Offered	F.T.E. Total Positions Filled by U.S. And Canadian Grads	F.T.E. Total Positions Filled by FMG's
Medicine	Feb., 1927*	3	3	0
Surgery				
Ob-Gyn				
Pediatrics				
Psychiatry				
Family Practice				
Other (List):				

*Peter Bent Brigham Hospital

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 specifici reference to the following questions.

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

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

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

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

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

III. LETTER OF RECOMMENDATION

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

Name and Address of Affiliated School of Medicine: Harvard Medical School, 25 Shattuck Street, Boston, MA. 02115

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

Information Submitted by:

Gerald S. Goldberg
NAME

Administraton
TITLE OF PERSON SUBMITTING DATA

December 21, 1976
DATE

SIGNATURE OF HOSPITAL CHIEF EXECUTIVE

ADDENDUM TO APPLICATION FOR MEMBERSHIP

COUNCIL OF TEACHING HOSPITALS

II. Program Description

A. No clerkships are currently being offered, although discussions are underway to initiate them in the near future. It is difficult to quantify the proportion of medical staff time committed to educational activities. All members of the medical staff are required by Institute By-Laws to have an appointment at the Harvard Medical School. The amount of time spent in teaching activities varies from physician to physician. I would estimate that it averages out to between 5-10% of the time put in by our staff.

B. All our clinical Departments have full-time salaried chiefs paid directly by the Institute or shared with a neighboring facility. These include Medical Oncology, Pediatric Oncology, Surgical Oncology, Gynecologic Oncology, Radiology, Pathology, Blood Products, Microbiology, Radiotherapy, and Immunology. All Department chiefs have appointments at the Harvard Medical School.

C. The Farber Institute pays the full cost of the salaries and fringe benefits of its full-time staff including all Department chiefs. In those instances where professional clinical services of our staff are shared significantly with another of the Harvard teaching hospitals, sources of salaries are split proportionately between the sharing hospitals. Our total costs for medical staff salaries and fringes is budgeted at $1,630,000 for the current fiscal year. Assuming that 5-10% of our total staff time is spent in teaching activities, the Institute's salary support of medical education including $100,200 for house staff salaries and fringes for the current year is $222,450, or 6% of our total salary budget.

D. In addition to the interns and residents from the Peter Bent Brigham and Beth Israel Hospitals rotating through the Institute to receive medical oncology training, residents in a variety of sub-specialties including dermatology, neurology, general surgery, radiology, nuclear medicine, and radiotherapy are using our patients as a teaching source. The Harvard Medical School appointment required of all our staff members commits them to teaching responsibilities outside the Institute including pre-clinical courses and general hospital rounds at other Harvard affiliated hospitals. Additionally, there is active interdigitation of other members of the Harvard Medical School faculty with the Institute staff on patient care, teaching, and research.

HARVARD MEDICAL SCHOOL
25 SHATTUCK STREET
BOSTON, MASSACHUSETTS 02115
~~REGENT 4-3300~~
617-732-1501

OFFICE OF THE DEAN

December 6, 1976

Richard M. Knapp, Ph.D.
Director
Department of Teaching Hospitals
Council of Teaching Hospitals
1 Dupont Circle, N. W.
Washington, D. C. 20036

Dear Dr. Knapp:

I am happy to support the application of the Sidney Farber Cancer Center for membership in the AAMC Council of Teaching Hospitals. The Sidney Farber Cancer Center has the same affiliation agreement with Harvard as do our other major teaching hospitals, including the MGH, the Children's Hospital Medical Center and the Peter Bent Brigham Hospital, to name a few.

All of the members of the staff of the Sidney Farber Cancer Center are members of the Harvard faculty and the heads of departments are chosen by search committees appointed by the President. The Sidney Farber Cancer Center has a heavy involvement in teaching, both at the medical student level and at the graduate level. Interns and residents rotate through the Farber Institute from the Peter Bent Brigham Hospital and the Beth Israel on a formal basis and the institution offers courses for medical students doing optional work in research and clinical areas. There are at present 28 pre- and post-doctoral students as well as 20 fellows mainly in medical and pediatric oncology doing work at the Sidney Farber Cancer Center.

On the basis of this close working relationship I hope that you will be willing to make the Sidney Farber Cancer Center a member of the AAMC Council of Teaching Hospitals.

Sincerely,

Robert H. Ebert, M. D.
Dean

RHE:so

At the September 16, 1976 Board meeting John Westerman (a JCAH Commissioner) presented and discussed a JCAH generated document entitled, "Guidelines for the Application of Hospital Accreditation Program Standards in Surveying University Hospitals." Mr. Westerman pointed out that the document is intended for use and guidance by JCAH surveyors.

A lengthy discussion ensued, and the staff was directed to incorporate the discussion into a revised draft which would be forwarded to the JCAH. There was question of whether the document needed to be reviewed by the AAMC Executive. Since the document is intended to be used as a JCAH internal set of guidelines, this was not felt to be necessary.

The following represents the document as it has been amended based on discussion at the September meeting. A number of Board members and the staff are not yet satisfied that the document is ready to be sent to the JCAH. Your suggestions are invited.

SUBJECT: Guidelines for the Application of Hospital Accreditation Program Standards in Surveying University Hospitals

That there are unique characteristics, special needs and particular problems posed by university hospitals with respect to the standards and procedures of the JCAH accreditation process must be acknowledged. This involves recognition of the university hospitals' dual mission -- education and service. University hospitals also often serve as the research and development arm of the health care delivery system. There is also the hospitals' real concern that the very rigid application of specific standards requirements by JCAH will conflict with the need for a more flexible approach perceived by the university hospitals as necessary to meet their additional responsibility and obligation for innovation in the organization of health services and the training for new health manpower roles.

Since the surveyor must be concerned with the "hospital" rather than the "university" apsect of the relationship, and with the "quality of patient care" rather than the "teaching program" per se, it is prudent to examine the hospital service/university academic relationships. In assessing the teaching hospitals' responsibility to respond to patient care objectives, one must face the reality that these objectives may differ from medical school departmental objectives. Thus, it becomes increasingly necessary to distinguish between the roles of the physician acting as a member of the medical staff and his role as a member of the medical faculty.

Governance - The adequate fulfillment of governance/accountability functions are as important to the university hospital as to any other hospital. Its stature as an academic support unit should serve to

heighten the awareness of the process of accountability. In the frequent circumstances where the governing body is a University Board of Regents, often geographically remote from the hospital, it happens that the multiple responsibilities of the university as a whole do not permit careful attention to the affairs of hospital governance. This is particularly a problem in the board's responsibility for quality of care assurance, guaranteeing appropriate procedures for appointment to the medical staff, and assignment/approval of privileges. The existence of an identifiable, accountable governance function is as important for the university hospital as the community hospital. Where there is no evidence of the university board fulfilling a trusteeship function, either directly or through clear delegation, a problem may exist.

This problem is best resolved through a process by which the Board of Regents delegates in writing the authority for another body to act for them in critical areas such as those denoted above. It is inappropriate for the Board of Regents to attempt to delegate trusteeship functions to a single individual or small internal group.

The JCAH requirement for community representation on the governing body must be approached realistically. The "community" is hard to define where the hospital is a research and referral facility. The test of appropriate representation should be the ability to act objectively in conducting governance accountability. Basically, the accreditation process should address whether the essential process of governance is being adequately executed within JCAH requirements, regardless of the mechanism for accomplishing it.

Medical Staff - The medical staff must have an organizational structure capable of addressing institution-wide health care delivery issues plus being able to meet the responsibilities incumbent upon any organized medical staff. As required of any hospital, the organization of the medical staff is reflected in its bylaws, rules and regulations which must address procedures for appointment and reappointment to the medical staff, the delineation of privileges, periodic reappraisal of the staff, and continuing medical education programs.

Most university hospitals require medical school faculty membership as a prerequisite for medical staff appointment. This usually includes all departmental faculty, both full-time and those appointed to the teaching staff who serve on a part-time basis. In most cases, appointments are fairly automatic upon recommendation by the head of the clinical department/ service. However, the hospital credentialing function cannot be omitted, although duplication of effort performed during the faculty appointment is not required, provided the information is made available to the hosptial for its files. Consideration must be given to the fact that a physician's excellent credentials in the research/teaching field does not necessarily ensure excellence in patient care. Medical staff reappraisal information required for faculty status, if made available for "hospital" use and retention, can obviate the need to duplicate the effort of obtaining this information for required periodic reappraisal of the medical staff of the hospital. The university faculty reappraisal is usually performed on an annual basis and thus also satisfies the JCAH requirement for the regular reporting by departmental chairmen on the professional performance of medical staff members. The requirement for "provisional" appointment of

new staff members does not ordinarily apply to department/service chairmen. Also, the tenure system must be understood in relation to reappointment requirements for academic activities only.

The organization of the medical staff in the university hospital does not always follow the usual staff categories. This is particularly true when the entire staff is not engaged in full-time teaching and there is a "teaching staff" category in addition to the "active," etc., categories. The university may use the "division" category, reserving the use of the term "department" for what may be called a "clinical service" in the non-teaching hospital.

Thus, in some university or university-affiliated large teaching hospitals there are teaching physicians, community physicians and house staff physicians. It is in this type of setting that particular care must be taken to ensure there is not more than one standard of care permitted.

To varying degrees, house staff members have roles of students, teachers, and providers of care. If they do not have a clearly defined role within the organized medical staff, they may hold significant service responsibilities that are not subject to the rules and regulations that govern the medical staff. Thus, the mechanism of supervision of house staff members must be defined and their participation in quality of care assurance and other departmental activities ensured.

There must be privilege delineation for all members of the medical staff. There is usually an inadequate distinction between medical staff and medical faculty qualifications in processes of appointment to the medical staff and assignment of privileges. In the university hospital there tends to be a natural resistance to privilege delineation which is

felt to be satisfied by peer certification. Actually, the delineation of privileges is usually very well established within the department/service structure; the task is to get the privilege delineation reduced to writing.

It is required that there be an adequate review of the quality of care rendered in the facility. The university hospital has an intensive, prospective patient care review system conducted in conjunction with its educational programs. This is usually reflected in a heavy concentration of individual case review, often as the primary mode of assessment of quality of care. To provide a continuing evaluation of clinical judgment, a strong relationship of the quality of care activities to the teaching process is maintained. However, there is still a requirement for the university hospital to participate in retrospective outcome audits as a measure of the quality of care rendered. It is important to demonstrate to the medical staff that the audit of large numbers of cases for retrospective outcome can serve a function not met by individual case review. When retrospective audit is performed, care must be taken to ensure that the criteria used are equally applied to all patients in the hospital and not only to patients on the "teaching " service(s). Otherwise there may develop more than one standard of care in the same hospital.

In evaluating either an area of care provided or a continuous monitoring function of the medical staff, it may not be possible to obtain all required information from one individual as usually occurs in a small community hospital. For example, in evaluating respiratory care services in a large teaching hospital, it may be necessary for the surveyor to interview the director of pulmonary medicine, the director of a specific

intensive care unit, the director of the pulmonary function laboratory, the individual who provides blood gas analyses, the chief respiratory therapist, etc. Similarly, in evaluating the infection control program, it may be required to consult with the chairman of the infection control program, the hospital epidemiologist, the chairman of a department of infectious diseases, the director of the microbiology or bacteriology laboratory section, surveillance nurses, etc. Where possible, a group interview of these individuals provides maximum information and clarifies the interrelationship fo roles.

The survey team should be very careful before making a recommendation relative to the lack of medical staff continuing education programs or its documentation. This normally abounds at all levels in all divisions (department/service/section) of the university hospital, and indeed the hospital is itself the provider of the continuing education not only for its own staff but for many other physicians. There is a recognized but unwritten self-educational effort inherent in the teaching of others and in the publishing of professional papers.

aamc association of american medical colleges

December 10, 1976

Mr. Hugh McConville, Chief
Provider Accounting Policy Branch
Division of Provider Reimbursement and
Accounting Policy
Program Policy, BHI
Room 412 East Building
6401 Security Boulevard
Baltimore, Maryland 21235

Dear Mr. McConville:

The Association (AAMC) sincerely appreciates this opportunity to comment on the November 15th draft revision of the Provider Reimbursement Manual proposing alternatives to commercial insurance for malpractice and comprehensive general patient liability insurance. The AAMC represents all of the nation's medical schools, 60 academic societies and over 400 of the nation's major teaching hospitals. Thus, the draft revisions of the Provider Reimbursement Manual are of direct and significant interest to the Association's members. Without prejudicing the opportunity of individual Association members to comment on the draft revision, the AAMC submits the following comments on the November 15th draft.

At the outset, the Association commends the Bureau of Health Insurance for its efforts in developing the November 15th draft revision. It is a substantial improvement over the first draft and evidence of diligent efforts by the BHI staff. In commenting on the draft, the Association would like it clearly understood that critical observations are submitted solely with the intention of assisting the Bureau in developing a more practical and viable Manual revision.

The Association's comments on the second draft are focused on six issues: (1) inclusion of physicians as named insureds within the hospital's malpractice policy or program, (2) the designation of an independent trust agent, (3) the inclusion of risk management expenses in self insurance programs, (4) the limitation of settlements exceeding coverage, (5) the comparison of premiums and coverages, and (6) the relationship of malpractice and general liability insurance.

Inclusion of Physicians

The final sentence on page 1 of the draft revision states, "costs incurred by providers for a physician's personal risk for direct medical care services rendered to patients are not allowable." This proposed provision is overly restrictive and is contrary, in some instances, to established tradition. The AAMC agrees that the Manual revision should not enable the hospital to include community-based, voluntary attending physicians within the hospital's professional liability coverage. Such a policy would be contrary to tradition, and, in effect, it would use Part A trust funds to pay traditionally Part B costs. On the other hand, house staff

phsycians (i.e., interns, residents, and fellows), hospital-based physicians (e.g., radiologists and pathologists), and salaried physicians have traditionally been included in the hospital's policy and in hospital costs as long as they are performing tasks within the scope of their hospital duties. Therefore, the Association strongly recommends that that draft be revised to permit the hospital to include as an allowable cost those costs incurred to include house staff, hospital-based and salaried physicians as named insureds in the hospital's malpractice and general liability insurance program.

Designation of Trust Agent

In specifying the conditions for self-insurance programs, the draft states that the provider must establish the "...fund with a recognized independent agent such as a bank trust company." While the Association supports the intent of this provision, it is requested that the draft be revised to clearly enable governmental providers (e.g., state university hospitals, municipal hospitals, etc.) to establish their trust fund with the treasurer of the governmental unit as their trust agent. Many state and local governments require trust funds of governmental agencies to be under the control of the government's financial agent. Adding language to permit state and municipal treasurers to serve as trust agents would be consistent with the Federal Government's objectives and would clearly enable governmental providers to establish designated self-insurance programs.

Risk Management Expenses

When a provider obtains commercial malpractice insurance, the provider may include within the policy contract insurer expenses for administering a risk management program. As presently drafted, the BHI proposal would not permit risk management expenses as allowable costs for a self-insurance fund. Because these costs have been included in premiums in some areas and because excess insurers are likely to require the fund for primary coverage to establish and support a risk management program, the AAMC strongly recommends that allowable costs for self-insurance funds be defined to include expenses for administering risk management programs.

Settlement Expenses and Coverage

Section 2160.2, as proposed, states, "this section no longer permits providers to include the costs of losses in excess of insurance coverage in allowable costs." This proposed revision is highly undesirable as stated. While BHI should not encourage under-insurance with its attendant threat to the provider's stable financial future, the Bureau should not encourage over-insurance which would add significant costs and only minimum benefits. Therefore, the AAMC strongly recommends that this, and similar provisions in the November 15th draft (§.2162.6), be revised to deny losses exceeding coverage as allowable costs only in instances where the hospital's coverage was not representative of prudent business practices.

Premium Expenses and Coverage

In comparing the premium for commercial coverage, if available, with the face value of the coverage and expenses of alternative forms of coverage, the Bureau is encouraged to include more flexible language than that included in the draft. Within broad limitations, commercial malpractice coverage is a contract agreement between independent parties. Variations in coverage and supporting services (e.g., defense costs, risk management costs, etc.) are available. There is no uniform policy. Therefore, in establishing the elements to be considered in comparing premium costs with coverage limits and in comparing commercial premiums with costs of alternative forms of coverage, BHI is encouraged to establish a general policy requiring the provider to make the comparison using comparable services. Furthermore, BHI is encouraged to include specific services in Section 2162 only as illustrative, not exhaustive, service comparisons.

Malpractice and General Liability Insurance

In the draft, the term general patient liability coverage is used. Historically, general patient liability coverage and general non-patient liability coverage have not been available as separate coverages. General liability coverage has been indivisible. To preclude the development of overlapping coverages and "grey area" suits, the Association strongly recommends that the phrase "general liability" be used throughout the draft wherever the term "general patient liability" presently appears.

In conclusion, the Bureau is clearly moving ahead in its development of revisions to the Provider Reimbursement Manual which reflect the developments in professional liability insurance. The Association is pleased with BHI's intent and encourages BHI staff to expedite their evaluation of these and other comments so that the new reimbursement policies are announced and in effect at the earliest possible date.

Sincerely,

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

RMK:mk