



association of american
medical colleges

MEETING SCHEDULE
COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD

September 21-22, 1983
Washington Hilton Hotel

WEDNESDAY, September 21, 1983

6:30pm	COTH ADMINISTRATIVE BOARD MEETING Grant Room
8:00pm	COTH ADMINISTRATIVE BOARD DINNER Farragut Room

THURSDAY, September 22, 1983

9:00am	COTH ADMINISTRATIVE BOARD MEETING Jackson Room
1:00pm	JOINT ADMINISTRATIVE BOARD LUNCHEON Lincoln West
2:30pm	EXECUTIVE COUNCIL BUSINESS MEETING Monroe East

A G E N D A

COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD MEETING

September 22, 1983
Washington Hilton Hotel
9:00am-1:00pm

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ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COTH ADMINISTRATIVE BOARD MEETING
June 30, 1983

PRESENT

Earl J. Frederick, Chairman*
Haynes Rice, Chairman-Elect*
Mitchell T. Rabkin, MD, Immediate Past Chairman*
James W. Bartlett, MD
Jeptha W. Dalston, PhD
Spencer Foreman, MD
Irwin Goldberg
Sheldon S. King
Glenn R. Mitchell
David A. Reed
C. Thomas Smith
Nancie Noie, AHA Representative

GUESTS

Robert M. Heyssel, MD
Thomas K. Oliver, Jr., MD

STAFF

James D. Bentley, PhD
John A. D. Cooper, MD
Joseph C. Isaacs
Thomas J. Kennedy, Jr., MD
Richard M. Knapp, PhD
Nancy E. Seline
John F. Sherman
Emanuel Suter, MD
Melissa Wubbald

COTH Administrative Board Meeting
June 30, 1983

I. Call to Order

Mr. Frederick called the meeting to order at 9:00am in the Farragut Room of the Washington Hilton Hotel. Before moving to the printed agenda, he indicated Dr. Knapp wished to make an announcement and present two additional action items. Dr. Knapp reported that Laurence B. McCullough, PhD, Senior Research Scholar, Kennedy Institute of Ethics, Georgetown University would speak at the COTH General Session of the AAMC Annual Meeting with the title, "Ethical Dilemmas and Economic Realities".

A. Prospective Payment Assessment Commission

Dr. Knapp described the origin and purpose of the OTA Prospective Payment Commission as well as the selection process by which individuals would be appointed to the Commission. After brief discussion, the following action was taken.

ACTION: It was moved, seconded, and carried that the COTH Administrative Board recommend that the AAMC nominate John W. Colloton for a position on the Commission.

B. Counting Residents for Medicare Payment

In the Medicare program's instructions for calculating residents in order to compute the hospital's adjustment for the indirect costs of medical education under prospective payment, the number of full-time equivalent residents is defined as the sum of:

- o interns and residents employed 35 or more hours per week, and
- o one-half of the total number of interns and residents working less than 35 hours per week.

In a supplement to the advance agenda, a staff-prepared paper noted the inappropriateness of this definition, the likelihood that the definition permitted double counting of residents, and the unclear status of clinical fellows in counting residents. In light of these issues, staff requested Board approval to meet with HCFA to suggest an alternative definition for residents based upon assigned time. While some Board members expressed a reluctance to suggest a definition which could restrict local flexibility and lower the indirect cost adjustment and while Dr. Heyssel opposed defining clinical fellows as residents, the Board agreed that retention of the indirect adjustment required a careful counting of residents and that clinical fellows did help distinguish the complexity and intensity of illness of a major teaching hospital's patients and their related costs.

ACTION: It was moved, seconded, and carried to recommend to the AAMC Executive Council that staff meet with HCFA and congressional staff to describe the weaknesses in HCFA's present instructions for counting residents and to urge adoption of the following alternative:

The number of full-time equivalent residents should be determined from the resident's assigned training time with one full-time equivalent equal to 12 man-months of training at the hospital. If three individual residents each spend four months in training at the hospital, the three residents are to be counted as one FTE resident. Assigned time, not the form or source of stipend payment, is to be used in counting residents. Further:

- o When a resident is assigned to more than one hospital for training, unassigned time -- e.g., annual leave, sick leave and conference travel -- should be allocated among the hospitals in proportion to the assigned time the resident spends at each hospital.
- o Advanced trainees -- e.g., clinical fellows, senior residents -- training for subspecialty practice are to be included in the resident count based on assigned time in the hospital's clinical services unless the trainee bills hospital patients a professional fee for service rendered.
- o Residents assigned to non-provider training settings -- e.g., research laboratories, non-provider clinics -- are not to be included in the FTE count for the months assigned the hospital.

Following additional extensive discussion of the Medicare prospective payment program, it was recommended that the Chairman, Mr. Frederick, request the AAMC Executive Council approve establishment of an ad hoc committee to monitor the development of the program and recommend response to proposed regulations implementing the program.

II. Consideration of the Minutes

ACTION: It was moved, seconded, and carried to approve the minutes of the April 21, 1983 Administrative Board Meeting.

III. Membership Applications

The Board began its discussion of membership by reviewing the staff-prepared document "COTH Membership Requirements." The Board agreed with the staff perception that additional quantitative information needed to be used in differentiating full and corresponding members.

ACTION: It was moved, seconded, and carried that, in order to preserve a commonality of interest among hospitals with full membership in COTH, hospitals with fewer than 30 full-time equivalent (FTE) residents should be classified as corresponding members.

The Board next reviewed a list of present full hospital members having fewer than four approved residencies and/or less than 30 FTE residents.

ACTION: It was moved, seconded, and carried that staff should annually validate data on COTH full members reporting fewer than four residencies or 30 residents and if a full member agrees it has fewer than four programs or 30 residents, the hospital should be reclassified as a corresponding member.

The Board then considered the present practice of allowing non-hospital entities such as medical education foundations and consortia to join as corresponding members when hospital members of the consortia, though eligible, have not joined the Council as full members.

ACTION: It was moved, seconded, and carried that the Council's purpose of serving the needs and interests of hospitals committed to medical education could best be fulfilled if corresponding membership for non-hospital entities (e.g., multi-hospital systems, consortia, foundations, associations) was granted only when each hospital qualifying for full membership within the entity has joined as an individual member.

ACTION: It was further moved, seconded, and carried that two current non-hospital entities -- the Southwestern Michigan Area Health Education Center and the Tulsa Medical Education Foundation -- should be allowed to continue as corresponding members.

The final section of the staff report lists 151 general hospitals shown in the Directory of Residency Training Programs as having a medical school affiliation and at least four residencies but not belonging to COH. The Board recommended staff prepare a mailing describing the Council and the AAMC and inviting these hospitals to join. In a number of cases, individual board members identified hospitals where they would personally invite the hospital's chief executive to join COH.

Having completed its review of the staff report on membership, the Board considered three membership applications.

ACTION: It was moved, seconded and carried to approve

- (1) BAPTIST MEDICAL CENTERS, Birmingham, Alabama for full membership;
- (2) ST. JOSEPH MEDICAL CENTER, Wichita, Kansas for full membership;
- (3) GERMANTOWN HOSPITAL AND MEDICAL CENTER, Philadelphia, Pennsylvania for corresponding membership.

This latter recommendation was based upon Germantown Hospital and Medical Center having 25-26 FTE residents, a voluntary rotating Director of Medical Education, and no full-time salaried chiefs of service.

Dr. Knapp concluded the membership portion of the agenda by informing the Board that the University of Louisville had discontinued its membership for its University Hospital because of the long-term lease of the hospital to Humana. Noting that COH membership is limited to tax-exempt 501(C)(3) and governmental hospitals. Dr. Knapp asked the Board for guidance if Humana requested membership. The Board recommended that the Association have its legal counsel review the issue of having tax paying members within a 501(C)(3) association and report counsel's findings at the Board's September meeting.

IV. Department of Teaching Hospitals Activities and Initiatives Mr. Frederick reviewed the open forum discussion of the previous evening and asked for discussion about what directions should be taken for the future. Following full

discussion, the staff was requested to develop a white paper assessing the environment for teaching hospitals, and what role the AAMC/COTH envisions for itself. The staff was asked to have this paper available as early as possible prior to the September 21-22 Administrative Board meeting.

V. Review of 1983 COTH SPRING MEETING

Mr. Frederick indicated that Mr. Mitchell had agreed to chair the Planning Committee for the 1984 COTH SPRING MEETING to be held May 16-18 in Baltimore. Dr. Knapp requested guidance on a number of matters. The following decisions were reached.

- o Beginning in 1984, registration refunds will be given only if cancellation notice is received seven days prior to the meeting date;
- o Attendance by individuals in state and national organizations who work with teaching hospitals will continue to be encouraged;
- o San Francisco was confirmed as the meeting site in 1985; it was agreed to meet in Philadelphia in 1986.

There had been concern that an increasing number of individuals had begun to attend without the institutional chief executive officer. A breakdown of the attendance figures from the May, 1983 meeting in New Orleans is as follows:

1. Number of CEO's that attended the meeting (including speakers)	124
2. Number of speakers that were not CEO's	8
3. Number of non-CEO's attending accompanied by their CEO	24
4. Number of non-CEO's attending but not accompanied by their CEO	14
5. Number of "others" to include representatives from other health related fields	16
6. AAMC staff	12
TOTAL	198

It was agreed that since the number of individuals attending without the COTH member chief executive is small, no action should be taken. However, the policy that requires CEO attendance should be continued.

VI. Payment for Physician Services in a Teaching Setting

The Board reviewed the report of the Committee on Payment for Physician Services in Teaching Hospitals, and discussed the various options for action presented in the report. Because Section 948, passed in 1980, contains substantial improvements over the previous language and because the possible change would benefit such a small number of institutions, the Board recommended a very cautious approach.

ACTION: It was moved, seconded, and carried to recommend to the Executive Council a two-part response to HCFA's plan to develop proposed regulations implementing Section 948 of P.L. 96-499: (1) Copies of the report "Payment for Physician Services in a Teaching Setting" should be distributed to appropriate HCFA, HHS, and Congressional staff; and (2) the AAMC should prepare language and work to assist efforts to amend Section 948 to exclude Medicaid patients from the procedure for determining physician fees in teaching settings.

VII. Plan of Action for Dealing with PGY-2 Match Issues

Dr. Cooper introduced the subject of the controversial selection of students into post-graduate year 2 (PGY-2) positions at times and by processes which are incompatible with the National Residency Matching Program (NRMP). This practice has caused students to make premature decisions and schools to provide academic evaluations based on inadequate information. Dr. Cooper referred the Board to page 56 of the Executive Council Agenda for a synopsis of the issues. He expressed the Association's concern that this matter be resolved to protect the best interests of the students, program directors and schools. Dr. Bartlett asked if the problem of "early draft" of residents into PGY-2 positions was limited to certain specialties. Dr. Cooper responded that while all of the academic societies have an interest in this issue, it does seem to be more troublesome in certain specialties.

ACTION: After this brief discussion, the Board adopted the staff recommendations that:

- o The AAMC continue to involve the parties with interests at stake in this matter in discussions about the nature and scope of the problem;
- o An analytic summary of the responses to Dr. Cooper's letter eliciting the cooperation of the members of the Council of Academic Societies be prepared;
- o A list of problems and suggested remedies be developed and that the list include consideration of incentives for compliance and sanctions for non-compliance; and
- o Staff in consultation with the leadership of the councils and the OSR, selected program directors, and the staff of the NRMP develop a set of recommendations to be considered by the interested parties at the AAMC Annual Meeting, and those recommendations be ones that are likely to win the endorsement of the AAMC, NRMP, and a preponderance of the program directors in the troublesome specialties.

VIII. ECFMG Constitutional Issues

Dr. Suter explained that the Educational Commission for Foreign Medical Graduates (ECFMG) is considering several changes in its constitution and bylaws relating to the composition of its Board of Trustees. The AAMC is a sponsoring organization of the ECFMG. Of particular concern to the AAMC is the proposed policy statement under which ECFMG trustees would be elected by the ECFMG Board from nominees submitted by the sponsoring organizations. This is viewed as an effort by the

ECFMG to increase its independence from the founding organizations since the current practice allows the sponsoring organizations to directly appoint their own representatives to the ECFMG Board.

ACTION: It was moved, seconded, and carried to recommend to the AAMC Executive Council that it advise the AAMC representatives to the ECFMG Board to vote against the proposed bylaws change that would alter the process of nomination to the Board of Trustees and that the Council request the AAMC President to advise other ECFMG sponsors of the Association's position. In addition, it was recommended that individuals who have served two consecutive four-year terms be required to wait four years before becoming eligible to serve again.

XI. Loan Forgiveness for Physicians in Research Careers

Dr. Oliver reviewed an AAMC proposal for a loan forgiveness program to attract more physicians into careers in academic research. This proposal appeared on pages 71-77 of the Executive Council Agenda and was prepared for consideration by potential Congressional sponsors. It would forgive all indebtedness for legitimate educational expenses for new faculty members, with repayment at 20% per year over five years. These faculty members would be required to have at least two years of research training beyond the core of their residency program and would have to continue to engage principally in research training during the repayment period. Only these young faculty recruited by academic institutions into tenure track positions at the level of assistant professor and above would be eligible.

In response to a query, Dr. Oliver admitted that the integration of NIH research programs into the proposal was not addressed. Dr. Heyssel wondered whether the proposed program could provide the tuition for medical students who pursue research careers and then fulfill the other criteria established. He noted that this approach would be similar to the National Health Service Corps (NHSC), which does not view a research career as an option for service paybacks. Dr. Foreman suggested that it might be worthwhile to pursue an expansion of NHSC to include a research payback option.

ACTION: It was moved, seconded, and carried to endorse in principle the loan forgiveness proposal for physicians in research careers, as presented on pages 71-77 of the Executive Council Agenda.

X. Statement of Principles on NIH

Dr. Cooper noted that at the April meetings of the Administrative Boards and the Executive Council, pending authorization proposals for the National Institutes of Health were discussed. It was determined that the AAMC should not support any of the bills because each violated basic principles held by the Association's constituents. However, these principles had never been clearly articulated in a single statement. Staff was asked to develop a document that could be used as the basis for generating strong public support for the NIH and its continuation in its present organizational format. Two papers have been drafted -- one for the internal academic medicine community, some of whom have contributed to the problems identified in the pending bills, and the other for a broader community of the general public, including members of Congress and their aides. These drafts appear on pages 179-101 of the Executive Council Agenda.

Mr. King expressed concern that the papers smack greatly of protectionism and portray a "leave us alone" attitude which may be looked upon unfavorably. Dr. Cooper noted that Dr. John Sherman is developing a strategy paper that will address such concerns and provide options on how best to disseminate the documents.

This was an informational agenda item and required no action by the Board.

XI. Adjournment

The meeting was adjourned at 12:30pm.

WILLIAMS, MYERS AND QUIGGLE
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WILLIAM M. WILLIAMS
(1921-1932)
EDMUND B. QUIGGLE
(1921-1935)
PAUL FORREST MYERS
(1921-1965)

September 7, 1983

Joseph A. Keyes, Esquire
Staff Counsel
Association of American
Medical Colleges
One Dupont Circle, N. W.
Washington, D. C. 20036

Dear Mr. Keyes:

Under AAMC's Articles of Incorporation and Bylaws voting membership in the Association of American Medical Colleges is limited to educational and scientific organizations described in IRC Section 501(c)(3) which are public charities described in Section 509(a)(1) or (2) of the Internal Revenue Code. They include medical schools, certain hospitals involved in medical education and certain academic societies active in the field of medicine and biomedical sciences.

You have asked us to review the possibility of AAMC's extending membership eligibility to certain proprietary institutions which do not meet these tests.

This question has been raised with us by organizations similar to AAMC and has been an issue during the processing of applications for exemption of such similar organizations.

In our opinion, such a step should not be taken without obtaining from the Internal Revenue Service an advance ruling that expansion of your membership in such a fashion will not affect AAMC's exemption from Federal income tax as a 501(c)(3) educational and charitable institution.

The basic Service position is set forth in Revenue Ruling 69-633, 1969-2 C.B. 121. Revenue Ruling 69-633 dealt with the question of whether contributions by the member hospitals or other organizations to a taxable cooperative hospital service organization providing laundry services to its member institutions would affect the tax exempt status of "contributing" organizations. The holding was that it would not,

provided all of the member organizations were exempt under Section 501(c)(3) as charitable, educational or scientific. However, if the laundry included members not exempt from tax and the member exempt 501(c)(3) hospitals made contributions to the laundry in excess of their proportionate share based upon benefits derived, exemptions of the 501(c)(3) members might be adversely affected. "Similarly, a contribution by any other exempt organization might also inure to the benefit of the proprietary hospital and adversely affect the contributing organization's exempt status."

If the Internal Revenue Service should determine that the services provided to the proprietary members were not merely incidental to the exempt purposes of the contributing organization, the exemption of the contributing organizations could be subject to challenge as violating the private inurement provisions of Section 501(c)(3).

The Internal Revenue Service has taken such a position with respect to associations of colleges and universities similar to AAMC. Over a number of years, we have converted a number of associations of colleges and universities into 501(c)(3) entities. In each case the Internal Revenue Service required that all of the active voting members be entities exempt under Section 501(c)(3).

The import of the one ruling in which the Service has acted favorably in this regard is not clear. Revenue Ruling 74-146, 1974-1 C.B. 129, dealt with an exempt organization which accredits colleges and universities which included some nonexempt members (proprietary schools). The Internal Revenue Service found that the accrediting program was "designed to foster excellence in education, and develop criteria and guidelines for assessing educational effectiveness * * * It assures the educational community, the general public, and other agencies or organizations that an accredited educational institution has clearly defined and appropriate educational objectives, has established conditions under which their achievement can reasonably be expected, appears in fact to be accomplishing them substantially, and is so organized, staffed, and supported that it can be expected to continue to do so." Two factors were noted. The first was that proprietary schools represented a small minority of the members of the organization (accreditation resulted in membership in such cases). Secondly, it held that any private benefit that may accrue to the few proprietary members because of their accreditation was incidental to the exempt purpose of improving the quality of education.

The Service would probably apply similar criteria in this case. However, depending upon the facts, the Service might hold that the benefits accruing to proprietary members of AAMC are not merely incidental and, therefore, the exemption under 501(c)(3) might be in jeopardy. Even if the "incidental benefits" test were met, the Internal Revenue Service might hold that inclusion of any significant number of such entities

would endanger AAMC's 501(c)(3) status. It is possible that the Service might take a different position if only the educational components of the proprietary institutions were admitted to membership.

If AAMC were to lose its exempt status under Section 501(c)(3), it should qualify for exemption from taxation under Section 501(c)(4) (social welfare) and/or Section 501(c)(6) (trade association). However, there are a number of important benefits which are available to Section 501(c)(3) organizations which are not available to Section 501(c)(4) or (c)(6) organizations. Among these are the following:

1. Contributions and bequests by individuals and corporations to 501(c)(3) entities are deductible by the donors for Federal income tax purposes.
2. 501(c)(3) entities need not have qualified pension plans under Section 401 but may make payments towards annuities of their employees which are basically limited only to 20 percent of includible compensation with provisions for past benefits. (Section 403(b).) As in qualified plans, the payments are not taxable to the employees until they receive pension distributions after retirement. Moreover, under Section 403(b) (as interpreted by the Internal Revenue Service regulations), employees may elect to take a reduction in taxable wages and have the amount applied by the 501(c)(3) employer to the purchase of an additional Section 403(b) annuity without being taxed on the amount (i.e., salary/annuity option-"tax sheltered annuities"). This, of course, is the TIAA-CREF program.
3. The restrictions imposed upon private foundations by the Tax Reform Act of 1969 with respect to grants made by it are such that few, if any, private foundations will make substantial grants to any entities other than 501(c)(3) exempt organizations.
4. As a 501(c)(4) or (c)(6) organization, AAMC might not be eligible for certain Federal and state grants.
5. Section 501(c)(3) status usually entitles an organization to state and local tax exemption as an educational or charitable entity.
6. AAMC would not be eligible for exemption from Federal excise taxes. For example, exemption from the communications tax is granted to nonprofit operating educational institutions described in Section 170(b)(1)(A)(ii) as well as nonprofit hospitals described in Section 170(b)(1)(A)(iii). (See Sections 4253(j) and 4253(h).) The Internal Revenue Service has extended this exemption to an association made up entirely of nonprofit operating educational institutions described in Section 170(b)(1)(A)(vi) even though the association was not itself a nonprofit operating educational organization because "the function of [the organization] is to carry out activities of [its] member institutions, each of which is a nonprofit educational organization." As a

September 7, 1983

result, "the facilities or services furnished to the association are deemed to be for the exclusive use of their member institutions." (Revenue Ruling 63-15, 1963-1 C.B. 187.) In a recent private letter ruling, the Service has held that the similar exemption from Federal excise tax imposed on gasoline under IRC Sections 4041(g)(4) and 4221(a)(5) does not apply to an association of operating educational organizations if the association has one or more proprietary members. (Private Letter Ruling 8132103 issued May 15, 1981.)

I would note that, if AAMC was forced to give up its exemption under 501(c)(3) and became exempt under 501(c)(4) or 501(c)(6), it could form an exempt subsidiary to perform its exclusively educational and charitable functions which could be qualified as a "public" charity under Section 509(a)(3). However, such a change might significantly affect your operations.

In our opinion, the Internal Revenue Service, based upon the rulings and actions cited above, has a very negative attitude towards the inclusion of proprietary members in an exempt 501(c)(3) organization such as AAMC unless the benefits accruing to such members are not material and further the exempt purposes of the organization. Revenue Ruling 74-146, cited above, does indicate that under certain unusual circumstances the Service will recognize the possibility of such an organization including for-profit entities in membership. However, the ruling is very narrow in its scope and cannot be relied upon. In our opinion, if AAMC does wish to consider including in its membership proprietary institutions (other than as affiliated nonvoting "contributors" receiving no material benefits), a ruling from the Internal Revenue Service should be sought in advance of any such change.

We hope this is responsive to your inquiry. If you have any other questions, please call them to our attention.

With best regards,

Very truly yours,

WILLIAMS, MYERS AND QUIGGLE

By: Jack Myers

By: J. L. Quiggle

MEMBERSHIP APPLICATIONS

Four hospitals have applied for membership in the Council of Teaching Hospitals. The applicants and the staff recommendations for type of membership are:

<u>HOSPITAL</u>	<u>STAFF RECOMMENDATION</u>
Children's Hospital New Orleans, Louisiana	Corresponding Membership
Methodist Hospitals of Memphis Memphis, Tennessee	Full Membership
Metropolitan Hospital Center New York, New York	Full Membership
Orlando Regional Medical Center Orlando, Florida	Full Membership



APPLICATION FOR MEMBERSHIP

Membership in the Council of Teaching Hospitals is limited to not-for-profit -- IRS 501(C)(3) -- and publicly owned hospitals having a documented affiliation agreement with a medical school accredited by the Liaison Committee on Medical Education.

INSTRUCTIONS: Complete all Sections (I-V) of this application.

Return the completed application, supplementary information (Section IV), and the supporting documents (Section V) to the:

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

I. HOSPITAL IDENTIFICATION

Hospital Name: CHILDREN'S HOSPITAL
Hospital Address: (Street) 200 HENRY CLAY AVENUE
(City) NEW ORLEANS (State) LOUISIANA (Zip) 70118
(Area Code)/Telephone Number: (504) 899-9511
Name of Hospital's Chief Executive Officer: BRUCE G. SATZGER
Title of Hospital's Chief Executive Officer: EXECUTIVE DIRECTOR

II. HOSPITAL OPERATING DATA (for the most recently completed fiscal year)

A. Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn):	<u>105</u>	Admissions:	<u>2,860</u>
Average Daily Census:	<u>56.8</u>	Visits: Emergency Room:	<u>2,704</u>
Total Live Births:	<u>N/A</u>	Visits: Outpatient: Clinic:	<u>26,987</u> <u>8,912</u>

B. Financial Data

Total Operating Expenses: \$ 14,326,000

Total Payroll Expenses: \$ 8,488,000

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: \$ 261,300
 Supervising Faculty: \$ -- University paid.

C. Staffing Data

Number of Personnel: Full-Time: 385
 Part-Time: 73

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 116
 With Medical School Faculty Appointments: 37

Clinical Services with Full-Time Salaried Chiefs of Service (list services):

SEE ATTACHED

Does the hospital have a full-time salaried Director of Medical Education?: Not Full-Time

III. MEDICAL EDUCATION DATA

A. Undergraduate Medical Education

Please complete the following information on your hospital's participation in undergraduate medical education during the most recently completed academic year:

<u>Clinical Services Providing Clerkships</u>	<u>Number of Clerkships Offered</u>	<u>Number of Students Taking Clerkships</u>	<u>Are Clerkships Elective or Required</u>
Medicine	_____	_____	_____
Surgery	_____	SEE ENCLOSURE	_____
Ob-Gyn	_____	_____	_____
Pediatrics	{ 3 LSU Wards 3 LSU Clinics 2 TU Clinics 6 Electives 2 Required	_____	_____
Family Practice		_____	_____
Psychiatry	_____	_____	_____
Other: _____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

B. Graduate Medical Education

Please complete the following information on your hospital's participation in graduate medical education reporting only full-time equivalent positions offered and filled. If the hospital participates in combined programs, indicate only FTE positions and individuals assigned to applicant hospital.

<u>Type of Residency</u> ¹	<u>Positions Offered</u>	<u>Positions Filled by U.S. & Canadian Grads</u>	<u>Positions Filled by Foreign Medical Graduates</u>	<u>Date of Initial Accreditation of the Program</u> ²
First Year Flexible	_____	_____	_____	_____
Medicine	_____	_____	_____	_____
Surgery	1	_____	_____	N/A
Ob-Gyn	_____	_____	_____	_____
Pediatrics	6	_____	_____	N/A
Family Practice	_____	_____	_____	_____
Psychiatry	_____	_____	_____	_____
Other:				
<u>Orthopaedics</u>	5	_____	_____	N/A
<u>Urology</u>	1	_____	_____	N/A
<u>Radiology</u>	2	_____	_____	N/A
<u>Anesthesiology</u>	1	_____	_____	N/A
<u>Dentistry</u>	2	_____	_____	N/A
<u>TOTAL</u>	<u>18</u>	_____	_____	_____

¹As defined by the LCGME Directory of Approved Residencies. First Year Flexible = graduate program acceptable to two or more hospital program directors. First year residents in Categorical* and Categorical programs should be reported under the clinical service of the supervising program director.

²As accredited by the Council on Medical Education of the American Medical Association and/or the Liaison Committee on Graduate Medical Education.

IV. SUPPLEMENTARY INFORMATION

To assist the COTH Administrative Board in its evaluation of whether the hospital fulfills present membership criteria, you are invited to submit a brief statement which supplements the data provided in Section I-III of this application. When combined, the supplementary statement and required data should provide a comprehensive summary of the hospital's organized medical education and research programs. Specific reference should be given to unique hospital characteristics and educational program features.

V. SUPPORTING DOCUMENTS

- A. When returning the completed application, please enclose a copy of the hospital's current medical school affiliation agreement.
- B. A letter of recommendation from the dean of the affiliated medical school must accompany the completed membership application. The letter should clearly outline the role and importance of the applicant hospital in the school's educational programs.

- 1) Name of Affiliated Medical School: Louisiana State University
Dean of Affiliated Medical School: Paul F. Larson, M.D.
- 2) Name of Affiliated Medical School: Tulane University
Dean of Affiliated Medical School: James T. Hamlin, III., M.D.

Information Submitted by: (Name) Bruce G. Satzger
(Title) Executive Director

Signature of Hospital's Chief Executive Officer: *Bruce G. Satzger* (Date) June 30, 1983

**SCHOOL OF
MEDICINE IN NEW ORLEANS**
Louisiana State University
Medical Center
1542 Tulane Avenue
New Orleans, LA 70112-2822
Telephone: (504) 568-4006



LSUMC

Office of the Dean

May 30, 1983

TO WHOM IT MAY CONCERN:

The Children's Hospital located in the city of New Orleans is one of the two hospitals used by this school for its educational programs in the area of Pediatrics. We use it at an undergraduate level, for house officer training as well as for specialty programs for our fellows. The hospital itself has had a very positive growth phase in the past three years which has enhanced our educational programs immensely. Furthermore, we feel that the quality of our Department of Pediatrics and our educational endeavors in the area of Pediatrics are closely associated with this hospital.

There is no question that the Children's Hospital in New Orleans is a vital member of our teaching hospitals.

Sincerely yours,

Paul F. Larson, M.D.
Dean

PFL/sep
cc: Bruce G. Satzger

Tulane University Medical Center

School of Medicine
1430 Tulane Avenue
New Orleans, Louisiana 70112
(504) 588-5462

Office of the Dean

June 17, 1983

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

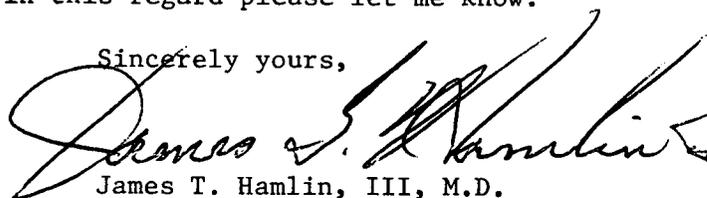
Dear Dr. Knapp:

I have been requested to submit a letter of recommendation for the application of Children's Hospital of New Orleans for membership in the Council of Teaching Hospitals. I am very pleased to comply for I feel that membership in COTH will be beneficial to the hospital and to Tulane's affiliation.

Childrens Hospital has been an affiliate of Tulane for many years. Over the years this has grown and now includes programs in the Department of Pediatrics and all of its subspecialty areas as well as the pediatric specialities of the Departments of Orthopaedics, Neurology, Dermatology, Neurosurgery and Urology. It is involved in both housestaff and medical student program. We are working to develop even closer programs with Children's by recruiting additional full time Tulane faculty that will be based at the hospital for all of their clinical and teaching responsibilities

If you need additional information in this regard please let me know.

Sincerely yours,



James T. Hamlin, III, M.D.
Dean

cas



APPLICATION FOR MEMBERSHIP

Membership in the Council of Teaching Hospitals is limited to not-for-profit -- IRS 501(C)(3) -- and publicly owned hospitals having a documented affiliation agreement with a medical school accredited by the Liaison Committee on Medical Education.

INSTRUCTIONS: Complete all Sections (I-V) of this application.

Return the completed application, supplementary information (Section IV), and the supporting documents (Section V) to the:

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

I. HOSPITAL IDENTIFICATION

Hospital Name: Methodist Hospitals of Memphis
Hospital Address: (Street) 1265 Union Avenue
(City) Memphis (State) Tn. (Zip) 38104
(Area Code)/Telephone Number: (901) 726-8132 (W.W. Rush)
Name of Hospital's Chief Executive Officer: Judge T. Calton
Title of Hospital's Chief Executive Officer: President

II. HOSPITAL OPERATING DATA (for the most recently completed fiscal year)

A. Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn):	<u>1,369</u>	Admissions:	<u>47,165</u>
Average Daily Census:	<u>1,060</u>	Visits: Emergency Room:	<u>75,035</u>
Total Live Births:	<u>2,334</u>	Visits: Outpatient or Clinic:	<u>15,063</u>

B. Financial Data

Total Operating Expenses: \$ 167,280,970

Total Payroll Expenses: \$ 75,391,879

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: \$ 2,171,285

Supervising Faculty: \$ 256,686

Sal. & Op. Exp. Interns & Res. \$ 3,169,582

C. Staffing Data

Number of Personnel: Full-Time: 9
 Part-Time: 1 ?

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 300 Act. 198
 With Medical School Faculty Appointments: 247 Assoc. 82
 Jr. 173

Clinical Services with Full-Time Salaried Chiefs of Service (list services):

Internal Medicine _____
General Surgery _____

Does the hospital have a full-time salaried Director of Medical Education?: Yes

III. MEDICAL EDUCATION DATA

A. Undergraduate Medical Education

Please complete the following information on your hospital's participation in undergraduate medical education during the most recently completed academic year:

<u>Clinical Services Providing Clerkships</u>	<u>Number of Clerkships Offered</u>	<u>Number of Students Taking Clerkships</u>	<u>Are Clerkships Elective or Required</u>
Medicine	<u>12</u>	<u>12</u>	<u>4-required/8-elec.</u>
Surgery	<u>9</u>	<u>9</u>	<u>Elective</u>
Ob-Gyn	<u>0</u>		
Pediatrics	<u>0</u>		
Family Practice	<u>0</u>		
Psychiatry	<u>0</u>		
Other: _____			
<u>Physical Diagnosis or Introduction to Clinical Skills</u>	<u>18</u>	<u>18</u>	<u>Required</u>

B. Graduate Medical Education

Please complete the following information on your hospital's participation in graduate medical education reporting only full-time equivalent positions offered and filled. If the hospital participates in combined programs, indicate only FTE positions and individuals assigned to applicant hospital.

<u>Type of Residency</u> ¹	<u>Positions Offered</u>	<u>Positions Filled by U.S. & Canadian Grads</u>	<u>Positions Filled by Foreign Medical Graduates</u>	<u>Date of Initial Accreditation of the Program</u> ²
First Year Flexible	<u>14</u>	<u>15</u>	<u>0</u>	<u>** 1979</u>
Medicine	<u>25</u>	<u>25</u>	<u>0</u>	<u>1973</u>
Surgery	<u>14</u>	<u>14</u>	<u>0</u>	<u>* Date Unknown</u>
Ob-Gyn	<u>1</u>	<u>1</u>	<u>0</u>	<u>UTCHS Integrated Program</u>
Pediatrics	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
Family Practice	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
Psychiatry	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
Other:				
<u>Neurosurgery</u>	<u>3</u>	<u>3</u>	<u>0</u>	<u>UTCHS</u>
<u>Radiology</u>	<u>12</u>	<u>12</u>	<u>0</u>	<u>1943</u>
<u>Pathology</u>	<u>4</u>	<u>3</u>	<u>0</u>	<u>1965</u>
<u>Otolaryngology</u>	<u>2</u>	<u>2</u>	<u>0</u>	<u>UTCHS</u>
<u>Ophthalmology</u>	<u>4</u>	<u>4</u>	<u>0</u>	<u>UTCHS</u>
<u>Orthopedics</u>	<u>2</u>	<u>2</u>	<u>0</u>	<u>UTCHS</u>
<u>Plastic Surg.</u>	<u>1</u>	<u>1</u>	<u>0</u>	<u>UTCHS</u>

¹As defined by the LCGME Directory of Approved Residencies. First Year Flexible = graduate program acceptable to two or more hospital program directors. First year residents in Categorical* and Categorical programs should be reported under the clinical service of the supervising program director.

²As accredited by the Council on Medical Education of the American Medical Association and/or the Liaison Committee on Graduate Medical Education.

** Approx. approval for Flexible Program-Evolved from Rotating which had been approved for over 40 years. Initial date unknown!
 * This program has been accredited well over 35 years.

Total Residents = 101

IV. SUPPLEMENTARY INFORMATION

To assist the COTH Administrative Board in its evaluation of whether the hospital fulfills present membership criteria, you are invited to submit a brief statement which supplements the data provided in Section I-III of this application. When combined, the supplementary statement and required data should provide a comprehensive summary of the hospital's organized medical education and research programs. Specific reference should be given to unique hospital characteristics and educational program features.

V. SUPPORTING DOCUMENTS

- A. When returning the completed application, please enclose a copy of the hospital's current medical school affiliation agreement.
- B. A letter of recommendation from the dean of the affiliated medical school must accompany the completed membership application. The letter should clearly outline the role and importance of the applicant hospital in the school's educational programs.

Name of Affiliated Medical School: Univ. of Tn Center for the Health Sc.

Dean of Affiliated Medical School: Robert L. Summitt, M.D.

Note: all affiliation agreements are departmental

 Information Submitted by: (Name) W.W. Rush
Shirley P. Woodard
 (Title) Medical Education Coordinator

Signature of Hospital's Chief Executive Officer:
Judge I. Colton (Date) MAY 27, 1983



June 22, 1983

James D. Bentley, Ph.D.
Associate Director
Department of Teaching Hospitals
Association of American Medical Colleges
1407 Union Avenue
Suite 808
Memphis, TN 38104

Dear Dr. Bentley:

I am writing this letter to support the application of the Methodist Hospitals of Memphis for membership in the Council of Teaching Hospitals of the Association of American Medical Colleges. The Methodist Hospitals of Memphis function in close educational affiliation with the University of Tennessee College of Medicine, at the undergraduate and graduate medical education levels. Integral parts of our undergraduate course in physical diagnosis is carried out within the Methodist Hospital and involves the full-time and volunteer staff of the Methodist Hospital. Portions of our core clerkship in Neurology take place in the Methodist Hospital, and a number of senior electives are available and highly subscribed within the Methodist Hospital. The Methodist Hospital is integrally involved in our Residency Programs in Ophthalmology, Otolaryngology, Neurosurgery, Orthopaedic Surgery and Plastic Surgery. Recently, our residency in Obstetrics and Gynecology has formed an affiliation with the Methodist Hospital in addition.

On the basis of the involvement of the Methodist Hospital and its medical staff in the educational programs of the University of Tennessee College of Medicine, I highly endorse the application of the Methodist Hospitals of Memphis for membership in the Council of Teaching Hospitals of the Association of American Medical Colleges.

Sincerely yours,

Robert L. Summitt, M.D.
Dean, College of Medicine

RLS:jdh

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ARTICLES OF AFFILIATION OF DEPARTMENTS OF MEDICINE
METHODIST HOSPITAL AND UNIVERSITY OF TENNESSEE

IT IS HEREBY APPROVED:

- I. That the Methodist Hospital formally affiliate its Internal Medicine Residency Program with the University of Tennessee Medical Units for the purpose of unifying and standardizing the quality of the medical teaching programs within the city of Memphis and hereby pledges its dedication to the training of competent and qualified specialists in Internal Medicine.
- II. That the training program of each hospital (City of Memphis Hospital and Methodist Hospital) will be independent, but integrated, with a voluntary interchange of trainees under the discretion and direction of the respective program directors. It is understood that Methodist Hospital residents will receive at least two-thirds of their training at Methodist Hospital.
- III. That the Methodist Hospital Internal Medicine Residency Program will fulfill the requirements of the Board of Internal Medicine and Residency Review Committee for a fully accredited residency training program with rotations and staff representation in all the major Internal Medicine Subspecialties.
- IV. That all Methodist Hospital attending staff participating in the residency program will have teaching appointments at both the Methodist Hospital and the University of Tennessee Department of Medicine upon recommendation and approval by the Department of Medicine at the University of Tennessee and Department of Medicine at the Methodist Hospital; and that University instructors likewise may be given appointment to the consultant staff of the Methodist Hospital upon application and approval in accordance with the Medical Staff Bylaws.
- V. That whereas staff members from the Methodist Hospital will have teaching assignments at both hospitals, consideration will be given to coordinating these assignments so that both teaching programs are adequately staffed at all times.
- VI. That the affiliated Methodist Hospital Internal Medicine Residency Program will seek a full time Director of Internal Medicine, and one or two part-time assistant directors salaried by the Methodist Hospital.

VII. That appointments to contracted positions in the Department of Internal Medicine at Methodist Hospital will require consultation with and agreement between the University of Tennessee Department of Internal Medicine and the Internal Medicine Departmental Committee of the Methodist Hospital before final approval by the Methodist Hospital Administration.

VIII. That recruitment and approval of Methodist Hospital house staff will remain the province of the Medical Education Committee of the Methodist Hospital.

IX. That the Methodist Hospital will not seek to develop independent subspecialty training programs in Internal Medicine outside the auspices of the University of Tennessee Department of Medicine, unless such programs meet the approval of both hospital departments.

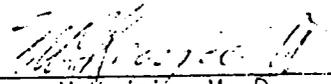
X. That the stipends for all house staff of the Methodist Hospital Internal Medicine Program will be salaried by the Methodist Hospital, whether they are assigned to the Methodist Hospital or to the University of Tennessee. Also, all University residents will be salaried by the Methodist Hospital during their rotations at the Methodist hospital.

XI. That the Director of Internal Medicine at the Methodist hospital will work in close association with the Departmental Chairman of the University of Tennessee in the design, organization and implementation of the Internal Medicine Teaching Program at the Methodist Hospital.

XII. That no changes in this agreement will be made except by mutual agreement of the Chairman of the Department of Internal Medicine at the University of Tennessee Medical School and the Chairman of the Department of Internal Medicine at the Methodist Hospital with approval by the Chief Executive Officer of both Methodist Hospital and the University of Tennessee.

Page 3 of 3

Signed:

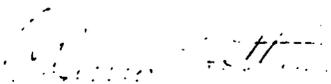


Eugene McKenzie, M. D.
Chairman, Department of Internal
Medicine, Methodist Hospital
Memphis, Tennessee

Gene H. Stollerman, M. D.
Professor and Chairman, Department
of Medicine, University of Tennessee
Medical School
Memphis, Tennessee

Irvin D. Fleming, M. D.
Chairman, Medical Education
Committee, Methodist Hospital
Memphis, Tennessee

T. Albert Farmer, Jr., M. D.
Dean, University of Tennessee
Medical School
Memphis, Tennessee



C. Henry Hottum, F.A.C.H.A.
Executive Director
Methodist Hospital
Memphis, Tennessee

Joseph E. Johnson, Ph.D.
Chancellor, University of Tennessee
Medical School
Memphis, Tennessee

January 18, 1973



COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

APPLICATION FOR MEMBERSHIP

Membership in the Council of Teaching Hospitals is limited to not-for-profit -- IRS 501(C)(3) -- and publicly owned hospitals having a documented affiliation agreement with a medical school accredited by the Liaison Committee on Medical Education.

INSTRUCTIONS: Complete all Sections (I-V) of this application.

Return the completed application, supplementary information (Section IV), and the supporting documents (Section V) to the:

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

I. HOSPITAL IDENTIFICATION

Hospital Name: METROPOLITAN HOSPITAL CENTER
Hospital Address: (Street) 1901 First Avenue
(City) New York (State) New York (Zip) 10029
(Area Code)/Telephone Number: (212) 360-6262
Name of Hospital's Chief Executive Officer: Ms. Harriet Dronka
Title of Hospital's Chief Executive Officer: Executive Director (Acting)

II. HOSPITAL OPERATING DATA (for the most recently completed fiscal year)

A. Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn):	<u>597</u>	Admissions:	<u>18,483</u>
Average Daily Census:	<u>482</u>	Visits: Emergency Room:	<u>73,964</u>
Total Live Births:	<u>1974</u>	Visits: Outpatient or Clinic:	<u>269,481</u>

B. Financial Data

Total Operating Expenses: \$ 87,319,000

Total Payroll Expenses: \$ 50,833,000

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: \$ 12,761,000
 Supervising Faculty: \$ -0-

C. Staffing Data

Number of Personnel: Full-Time: 2724
 Part-Time: 171

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 610
 With Medical School Faculty Appointments: 598

Clinical Services with Full-Time Salaried Chiefs of Service (list services):

see attached (#1)

Does the hospital have a full-time salaried Director of Medical Education?: yes

II. MEDICAL EDUCATION DATA

A. Undergraduate Medical Education

Please complete the following information on your hospital's participation in undergraduate medical education during the most recently completed academic year:

<u>Clinical Services Providing Clerkships</u>	<u>Number of Clerkships Offered</u>	<u>Number of Students Taking Clerkships</u>	<u>Are Clerkships Elective or Required</u>
Medicine	<u>16</u>	<u>16</u>	<u>Required</u>
Surgery	<u>24</u>	<u>24</u>	<u>Required</u>
Ob-Gyn	<u>56</u>	<u>56</u>	<u>Required</u>
Pediatrics	<u>45</u>	<u>45</u>	<u>Required</u>
Family Practice	<u>00</u>	<u>00</u>	<u>Not Offered</u>
Psychiatry	<u>30</u>	<u>30</u>	<u>Required</u>
Other: <u>Medical Sub-Internship</u>	<u>12</u>	<u>12</u>	<u>Required</u>
<u>Neurology</u>	<u>35</u>	<u>35</u>	<u>Required</u>
<u>See Attached (#2)</u>			

B. Graduate Medical Education

Please complete the following information on your hospital's participation in graduate medical education reporting only full-time equivalent positions offered and filled. If the hospital participates in combined programs, indicate only FTE positions and individuals assigned to applicant hospital.

<u>Type of Residency</u> ¹	<u>Positions Offered</u>	<u>Positions Filled by U.S. & Canadian Grads</u>	<u>Positions Filled by Foreign Medical Graduates</u>	<u>Date of Initial Accreditation of the Program</u> ²
First Year Flexible	_____	_____	_____	_____
Medicine	59	16	43	1953
Surgery	27	21	6	1953
Ob-Gyn	16	4	12	1953
Pediatrics	23	3	20	1953
Family Practice	_____	_____	_____	_____
Psychiatry	31	6	24	1953
Other: <u>Child Psych</u>	6	1	5	1953
<u>Anesthesia</u>	15	0	15	1953
<u>Neurology</u>	4	0	4	1953
<u>Dermatology</u>	4	4	0	1953
<u>Emerg. Med.</u>	6	3	3	1953
<u>Ophthalmology</u>	5	5	0	1953

See Attached (#3)

¹As defined by the LCGME Directory of Approved Residencies. First Year Flexible = graduate program acceptable to two or more hospital program directors. First year residents in Categorical* and Categorical programs should be reported under the clinical service of the supervising program director.

²As accredited by the Council on Medical Education of the American Medical Association and/or the Liaison Committee on Graduate Medical Education.

IV. SUPPLEMENTARY INFORMATION

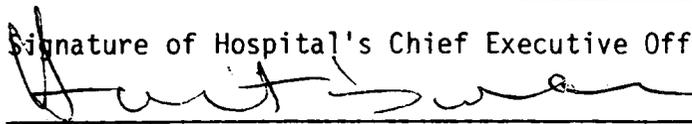
To assist the COTH Administrative Board in its evaluation of whether the hospital fulfills present membership criteria, you are invited to submit a brief statement which supplements the data provided in Section I-III of this application. When combined, the supplementary statement and required data should provide a comprehensive summary of the hospital's organized medical education and research programs. Specific reference should be given to unique hospital characteristics and educational program features.

V. SUPPORTING DOCUMENTS

- A. When returning the completed application, please enclose a copy of the hospital's current medical school affiliation agreement.
- B. A letter of recommendation from the dean of the affiliated medical school must accompany the completed membership application. The letter should clearly outline the role and importance of the applicant hospital in the school's educational programs.

Name of Affiliated Medical School: New York Medical College
Dean of Affiliated Medical School: Samuel H. Rubin, M.D.
Provost & Dean

Information Submitted by: (Name) Harriet Dronska
(Title) Executive Director (Acting)

Signature of Hospital's Chief Executive Officer:  (Date) 27 July 1983

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B. Graduate Medical Education

Please complete the following information on your hospital's participation in graduate medical education reporting only full-time equivalent position offered and filled. If the hospital participates in combined programs, indicate only FTE positions and individuals assigned to applicant hospital.

<u>Type of Residency</u> ¹	<u>Positions Offered</u>	<u>Positions Filled by U.S. & Canadian Grads</u>	<u>Positions Filled by Foreign Medical Graduates</u>	<u>Date of Initial Accreditation of the Program</u> ²
ORTH. SURG.	7	7	0	1953
PATHOLOGY	10	0	10	1953
RADIOLOGY	12	7	5	1953
REHAB. MED.	5	2	3	1953
UROLOGY	3	0	3	1953
<u>TOTAL</u>	<u>233</u>	<u>79</u>	<u>153</u>	

¹As defined by the LCGME Directory of Approved Residencies. First Year Flexible = graduate program acceptable to two or more hospital program directors. First year residents in Categorical* and Categorical programs should be reported under the clinical service of the supervising program director.

²As accredited by the Council on Medical Education of the American Medical Association and/or the Liaison Committee on Graduate Medical Education.

SUPPLEMENTARY INFORMATION

Metropolitan Hospital Center, one of the oldest public hospitals in the country, had its beginning in 1875. Originally situated on Wards Island, Metropolitan was known as the Homeopathic Hospital and occupied buildings previously used by the Inebriate Asylum of New York City. In 1894, the hospital moved to Blackwell's Island (now Roosevelt Island) and was renamed Metropolitan Hospital.

Metropolitan Hospital is now located in New York City and was officially designated a Center in 1965. The hospital's affiliation with New York Medical College (then the New York Homeopathic Medical College) began in 1875 and is the oldest medical college affiliation in the United States.

In May of 1969, the Governor of the State of New York signed legislation establishing the New York City Health and Hospitals Corporation and, as mandated by the legislation, Metropolitan Hospital Center became a member of the Corporation on July 1, 1970.

Metropolitan Hospital Center is a 597 bed general public hospital serving the health needs of the East Harlem community in New York City.

As in the past, Metropolitan Hospital Center remains committed to supporting quality graduate medical education programs as outlined in our application.

KO:jat



NEW YORK MEDICAL COLLEGE

111 West 57th Street, New York 10019
(212) 347-5090

OFFICE OF THE PROVOST AND DEAN

June 22, 1983

Council of Teaching Hospitals
1 Dupont Circle, N.W. - Suite 200
Washington, D. C. 20036

Gentlemen:

This letter is written to strongly support the application of Metropolitan Hospital Center for membership in the Council of Teaching Hospitals.

Metropolitan Hospital has been a primary affiliate of New York Medical College since 1968. All of its attending staff must have faculty appointments at New York Medical College. The hospital maintains 241 residency positions in 17 training programs, many of which are integrated with our other university hospitals. Clerkships are provided our students in all the major disciplines. The hospital has had a tradition of maintaining high quality educational programs for students and housestaff.

It is for all these reasons that I am pleased to recommend membership for Metropolitan Hospital Center in our Council.

Sincerely yours,

Samuel H. Rubin, M.D.
Provost and Dean

SHR: jc



COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

APPLICATION FOR MEMBERSHIP

Membership in the Council of Teaching Hospitals is limited to not-for-profit -- IRS 501(C)(3) -- and publicly owned hospitals having a documented affiliation agreement with a medical school accredited by the Liaison Committee on Medical Education.

INSTRUCTIONS: Complete all Sections (I-V) of this application.

Return the completed application, supplementary information (Section IV), and the supporting documents (Section V) to the:

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

I. HOSPITAL IDENTIFICATION

Hospital Name: ORLANDO REGIONAL MEDICAL CENTER
Hospital Address: (Street) 1414 SOUTH KUHL AVENUE
(City) ORLANDO (State) FLORIDA (Zip) 32806
(Area Code)/Telephone Number: (305) 841-5243
Name of Hospital's Chief Executive Officer: GARY STRACK
Title of Hospital's Chief Executive Officer: PRESIDENT, CHIEF EXECUTIVE OFFICER

II. HOSPITAL OPERATING DATA (for the most recently completed fiscal year)

A. Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn):	<u>1,000</u>	Admissions:	<u>40,335</u>
Average Daily Census:	<u>689</u>	Visits: Emergency Room:	<u>56,250</u>
Total Live Births:	<u>4,698</u>	Visits: Outpatient or Clinic:	<u>5,039</u>

B. Financial Data

Total Operating Expenses: \$ 89,370,676

Total Payroll Expenses: \$ 46,577,354

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: \$ 1,605,877*
 Supervising Faculty: \$ 979,145

*Excluding:
 -health insur
 -Life insur
 -Liability

C. Staffing Data

Number of Personnel: Full-Time: 2,658
 Part-Time: 365

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 497
 With Medical School Faculty Appointments: 35

Clinical Services with Full-Time Salaried Chiefs of Service (list services):

PEDIATRICS PATHOLOGY

INTERNAL MEDICINE

Does the hospital have a full-time salaried Director of Medical Education?: YES - VICE-PRESIDENT, MEDICAL EDUCATION

III. MEDICAL EDUCATION DATA

A. Undergraduate Medical Education

Please complete the following information on your hospital's participation in undergraduate medical education during the most recently completed academic year:

Clinical Services Providing Clerkships	Number of Clerkships Offered	Number of Students Taking Clerkships	Are Clerkships Elective or Required
Medicine	<u>EXTERNSHIPS are offered in all disciplines the rotations are for a duration of four (4) weeks. Each discipline has an individually structured program.</u>		
Surgery	<u>There were approximately 120 students who rotated through ORMC in 1982.</u>		
Ob-Gyn	_____		
Pediatrics	_____		
Family Practice	<u>In the next six months, we anticipate establishing CLERKSHIPS in all six residency programs plus Emergency Medicine and Anesthesia.</u>		
Psychiatry	_____		
Other: <u>EMERGENCY MEDICINE</u>	_____		
<u>ANESTHESIA</u>	_____		
_____	_____		

B. Graduate Medical Education

Please complete the following information on your hospital's participation in graduate medical education reporting only full-time equivalent positions offered and filled. If the hospital participates in combined programs, indicate only FTE positions and individuals assigned to applicant hospital.

<u>Type of Residency</u> ¹	<u>Positions Offered</u>	<u>Positions Filled by U.S. & Canadian Grads</u>	<u>Positions Filled by Foreign Medical Graduates</u>	<u>Date of Initial Accreditation of the Program</u> ²
First Year Flexible	---			
Medicine	15	12	1	1950
Surgery	16	13	3	1950
Ob-Gyn	12	6	6	1950
Pediatrics	12	3	9	1978
Family Practice	---			
Psychiatry	---			
Other:				
<u>ORTHOPAEDICS</u>	10	8	2	1956
<u>PATHOLOGY</u>	8	4	4	1957
<u>TOTAL =</u>	<u>73</u>	<u>46</u>	<u>25</u>	

¹As defined by the LCGME Directory of Approved Residencies. First Year Flexible = graduate program acceptable to two or more hospital program directors. First year residents in Categorical* and Categorical programs should be reported under the clinical service of the supervising program director.

²As accredited by the Council on Medical Education of the American Medical Association and/or the Liaison Committee on Graduate Medical Education.

IV. SUPPLEMENTARY INFORMATION

To assist the COTH Administrative Board in its evaluation of whether the hospital fulfills present membership criteria, you are invited to submit a brief statement which supplements the data provided in Section I-III of this application. When combined, the supplementary statement and required data should provide a comprehensive summary of the hospital's organized medical education and research programs. Specific reference should be given to unique hospital characteristics and educational program features.

V. SUPPORTING DOCUMENTS

- A. When returning the completed application, please enclose a copy of the hospital's current medical school affiliation agreement.
- B. A letter of recommendation from the dean of the affiliated medical school must accompany the completed membership application. The letter should clearly outline the role and importance of the applicant hospital in the school's educational programs.

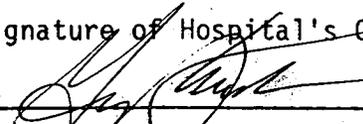
Name of Affiliated Medical School: UNIVERSITY OF FLORIDA

Dean of Affiliated Medical School: WILLIAM B. DEAL, M.D.

Information Submitted by: (Name) RAYMOND C. RAMAGE, M.D.

(Title) VICE-PRESIDENT, MEDICAL EDUCATION

Signature of Hospital's Chief Executive Officer:



GARY STRACK

(Date) AUGUST 9, 1983

RCK PRESIDENT, CHIEF EXECUTIVE OFFICER

J. HILLIS MILLER HEALTH CENTER
COLLEGE OF MEDICINE

UNIVERSITY OF FLORIDA

GAINESVILLE

Area Code: 941 352-1000
Box J-215 University of Florida

William B. Deal, M.D.
Dean

J. Lee Dockery, M.D.
Associate Dean

July 28, 1983

Raymond C. Ramage, M.D.
Vice President for Medical Education
Orlando Regional Medical Center
1414 South Kuhl Avenue
Orlando, Florida 32806

Dear Ray:

It was a pleasure to talk with you today.

It is my understanding that the Orlando Regional Medical Center would like to become a member of the Council of Teaching Hospitals and that some evidence of affiliation with a medical school is necessary. Please feel free to use this letter in support of your application to the Council of Teaching Hospitals.

As you know, we do have definite affiliation agreements in the Departments of Medicine and Pediatrics with the Orlando Regional Medical Center. Also, we are working on an umbrella affiliation agreement between the College of Medicine and the Orlando Regional Medical Center at the present time. This agreement, I believe, is in its final stages and will require only the endorsement of the Executive Committee of the College of Medicine and the appropriate committee at Orlando Regional Medical Center for institution.

Hopefully, this will be of help to you. If I can provide further information to you, please ask.

Best wishes.

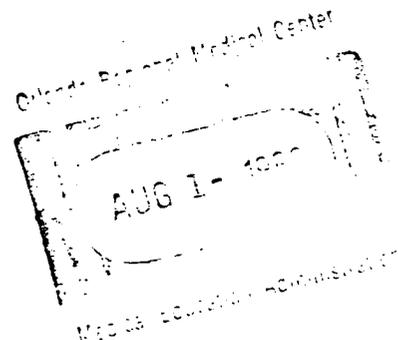
Sincerely,

Will

William B. Deal, M.D.
Dean, College of Medicine
Associate Vice President
for Clinical Affairs

WBD/ky

cc: J. L. Dockery, M.D.



1182

AFFILIATION AGREEMENT

Between

The University of Florida

Department of Pediatrics

and

The Orlando Regional Medical Center

Department of Pediatrics

OBJECTIVES:

The overall objectives of an affiliation between the Department of Pediatrics, College of Medicine, University of Florida and the Department of Pediatrics, Orlando Regional Medical Center are to enhance the medical education programs of both departments, to assist practicing physicians and other health professionals through educational offerings in continuing medical education and to facilitate optimal care for the children of Central Florida by providing well trained general pediatricians.

In order to be both viable and meaningful, this affiliation must provide benefits for both institutions. Both institutions have therefore agreed to the following:

I. FACULTY - EDUCATIONAL LINKAGES:

- A. The Department of Pediatrics, College of Medicine, University of Florida agrees to provide staff support (primary faculty, dual appointments, or senior Fellows) at least one day per month to the Department of Pediatrics of the Orlando Regional Medical Center to present grand rounds, consult on patient care challenges, provide teaching rounds for the housestaff and to conduct informal group discussions.

The Director of Medical Education in Pediatrics, Orlando Regional Medical Center, will be responsible for coordinating these teaching activities with the Chairman of the Department of Pediatrics at the University of Florida or his designee. The honorarium and travel expenses for such visits shall be encompassed within the overall fiscal arrangements of this affiliation agreement.

- B. The Director of Medical Education in Pediatrics at the Orlando regional Medical Center and all other full-time faculty within that Department of Pediatrics will spend the equivalent of 12 days per year at the University of Florida. During this time, the faculty will become involved within the fabric of the Department of Pediatrics (U/F) — educational program -- either at the Departmental or Divisional level. Such involvement shall be at the discretion of the Chairman of the Department of Pediatrics (U/F) or his designee after appropriate consultation with the Director of Medical Education in Pediatrics (ORMC) and the individual faculty member. Under certain circumstances, an equivalent educational experience may be substituted for the above involvement, after consultation and agreement with the Chairman of both Departments of Pediatrics. All expenses associated with such Orlando full-time faculty participation will be borne by the Orlando Regional Medical Center. The Department of Pediatrics (U/F) commits itself to making every attempt to aid the faculty of the Orlando program in acquiring the appropriate lodging at the most reasonable cost. Such full-time faculty, including the Director of Medical Education in Pediatrics, upon the

Orlando Regional Medical Center, will be eligible for a clinical appointment at the University of Florida consistent with the individual faculty member's past training, present responsibilities and academic achievement. Such appointments shall be made by the Chairman of the Department of Pediatrics (U/F) with the approval of the Dean of the College of Medicine.

Future full-time faculty in the Department of Pediatrics of the Orlando Regional Medical Center should be recruited in tandem by both Departments. The qualifications and professional attributes of such full-time faculty should be reviewed by the Chairman of the Department of Pediatrics (U/F) and the appropriate Division Chiefs and faculty of that administrative sub-unit, so that the appropriate individuals at the Orlando Regional Medical Center Educational Program may have the benefit of such advice prior to the final appointment.

- C. Attending pediatricians at the Orlando Regional Medical Center, committed to the Residency Training Program in Pediatrics, will spend the equivalent of one week each year at the U/F Shands Teaching Hospital participating in various aspects of the educational program -- such involvement will be determined by the Chairman of the Department of Pediatrics (U/F) in consultation with the individual faculty member and the Chairman of the Department of Pediatrics of the Orlando Regional Medical Center Pediatric Program.

Under certain circumstances, an equivalent experience at another medical center may be substituted for the above involvement after consultation and agreement with the Chairman of both Departments of Pediatrics. Attending pediatricians at the Orlando Regional Medical Center who participate in the above educational experiences shall, upon the recommendation of the Chairman of the Department of Pediatrics at the Orlando Regional Medical Center, be eligible for a clinical faculty appointment with the Department of Pediatrics at the University of Florida at a level consistent with their professional qualifications. Such appointments shall be made by the Chairman of the Department of Pediatrics (U/F) with the approval of the Dean of the College of Medicine.

II. HOUSESTAFF - EDUCATIONAL LINKAGES:

- A. The Department of Pediatrics (U/F) will continue to aid the Department of Pediatrics of the Orlando Regional Medical Center (ORMC) in the recruitment of housestaff. Such aid may include, but not be limited to, advice regarding further development of the present recruitment brochure, incorporating the present recruitment material of the ORMC Pediatric Program with the material distributed by the Department of Pediatrics (U/F) to all prospective housestaff and the referral of prospective candidates to the Orlando Program.

- B. Residents of the Orlando Regional Medical Center will spend rotations in Pediatrics at the U/F. These shall be three month blocks of time during the second and third year of training. These

rotations may be selected by the individual houseofficer with the approval of the Director of Medical Education of ORMC and the Chairman of Pediatrics of the U/F or his designee. Each resident from the ORMC Pediatric program shall participate fully in all aspects of the educational program and fall under the same guidelines and policies as the housestaff from the U/F program. The qualifications and educational experience of the ORMC housestaff will be reviewed by the staff of the Department of Pediatrics of the U/F prior to the beginning of the rotation. All costs associated with such residency rotations at the U/F (including salaries, fringe benefits, food and lodging) shall be borne either by the ORMC or the involved houseofficer as appropriate. The U/F shall assist in every way to make the appropriate cost-beneficial arrangements for such housestaff from the ORMC. Professional and general liability coverage for the ORMC housestaff rotating through the Shands Teaching Hospital will be covered through the ORMC Trust Fund (see attachment).

- C. The Department of Pediatrics, U/F, will make every effort to encourage their housestaff to participate in elective rotations at the ORMC. Such rotations both in content and duration, will be recommended by the Chairman of the Department of Pediatrics (U/F) or his designee and reviewed and approved by the Director of Medical Education in Pediatrics at the ORMC.

Salaries and lodging expenses for such housestaff will follow the same guidelines as in other U/F-affiliated programs, i.e.,

housestaff salaries and lodging costs will be borne by ORMC. ORMC commits itself to ensuring that lodging and food would be provided to the houseofficer from the U/F at the lowest possible cost. The J. Hillis Miller Insurance Trust Fund of the U/F would continue to provide professional liability insurance for all U/F housestaff within the Orlando educational environment.

III. MEDICAL STUDENTS:

The U/F Department of Pediatrics will make every effort to encourage participation in elective rotations at the ORMC in pediatrics by medical students of the U/F. The educational aspects of these medical student rotations shall be decided jointly by the Chairman of both Departments of Pediatrics. Lodging, food, and other monetary and administrative matters relating to the medical student education program will be decided jointly by the Dean of the College of Medicine (U/F), and the ^{Vice Pres-} ~~Director~~ ^{ident for Medical Education} ~~of Medical Affairs~~, ORMC. Professional and general liability coverage of such U/F medical students rotating through the ORMC will be covered by the J. Hillis Miller Health Center Insurance Trust Fund.

IV. The Department of Pediatrics (U/F) and the Department of Pediatrics of the ORMC, commit themselves to developing optimal educational linkages at both the faculty and housestaff levels and to explore ways of linking the educational programs on a regional basis.

Since child health care within the hospital setting is becoming increasingly regionalized, both the staff of the U/F Department of Pediatrics

and the staff of the Department of Pediatrics (ORMC), recognize the intrinsic flux of patients between the two centers -- particularly since their natural patient flow areas are contiguous.

Furthermore, whenever feasible and in the best interest of patient care, educational needs, and national standards of child health care joint programs within sub-specialty areas should be developed.

V. The Department of Pediatrics (U/F) shall offer the following considerations to the Department of Pediatrics (ORMC):

1. Monthly staff visitations of the equivalent of one day for educational purposes including coverage of travel expenses & honorarium.
2. Annual evaluation of program by the Chairman of the Department of Pediatrics (U/F) along with a written report of the findings of such an evaluation.
3. Periodic meetings between the Director of Pediatric Education the ORMC and the Chairman of the Department of Pediatrics (U/F) to provide continuing guidance and counsel regarding educational aspects of the pediatric training program.
4. Periodic meetings between the Chairman, Department of Pediatrics (U/F) and members of the clinical and full-time faculty to provide guidance and counsel to the educational program.
5. Appropriate review of programmatic material submitted to the Residency Review Committee.

6. Intrinsic administrative costs associated with the Department Pediatrics (U/F) involvement in a community-based educational program.
7. Increased faculty effort and teaching in relating to housestaff from another training program.
8. Continuous availability of sub-specialty consultative services to the staff of the ORMC.

In view of the above considerations, the ORMC agrees to donate to the Department of Pediatrics (U/F) an unrestricted donation of \$19,200 per year to be paid in quarterly amounts of \$4,800 at the beginning of each quarter of the fiscal year. The fiscal year shall be effective October 1 through September. Invoices will be forwarded to ORMC at the end of each quarter: December 31, March 31, June 30, and September 30.

- VI. This affiliation agreement may be modified at any time during the period of the contract providing there is approval of both involved parties. Furthermore, this agreement will be renegotiated during an annual review in September of each year; in order that an affiliation agreement may be signed by all involved parties by October 1st of each academic year to apply to the succeeding academic year.

Colin J. Condron

Colin J. Condron, M.D.
Chairman
Department of Pediatrics
Orlando Regional Medical Center

Gerold L. Schiebler

Gerold L. Schiebler, M.D.
Chairman
Department of Pediatrics
University of Florida

Raymond C. Ramage

Raymond C. Ramage, M.D.
Vice President of Medical Education
Orlando Regional Medical Center

William B. Deal

William B. Deal, M.D.
Associate Vice President for
Clinical Affairs & Dean,
College of Medicine,
University of Florida

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AFFILIATION AGREEMENT

Between The University of Florida Department of Pediatrics
and The Orlando Regional Medical Center

Attachment

Orlando Regional Medical Center housestaff rotating through Shands Teaching Hospital will be covered through the ORMC Self Insurance Trust Fund in relationship to professional and general liability claims. The Trust Fund number is 37570 and is with the First National Bank of Orlando.

The limits of the self insurance fund are \$100,000. The Orlando Regional Medical Center is a member of the Florida Patient's Compensation Fund for an unlimited amount of coverage.

MEDICAL CENTER OFFICIALS AND THE AAMC

From time to time the Association hears from individuals in the academic health center (other than formally identified AAMC constituent representatives) who would like to be more involved in AAMC activities. These individuals are usually vice presidents for health affairs or presidents of medical centers. The requests are frequently related to the AAMC's communications network (e.g., "pink memoranda"), but also include vague comments about wanting to "be involved" in AAMC activities.

Some deans apparently circulate some, but not all, pink memos, and this had led to requests from other medical center officials to be included on the AAMC mailing list. Several years ago the Executive Committee authorized the circulation of selected pink memos on legislative and regulatory issues to members of the Association of Academic Health Centers. This had been fairly successful in reducing such inquiries, but recently similar requests have come from individuals who are not AAHC members. Because of the varying organizational patterns at medical centers, it is difficult to identify by title alone all such administrators who might be interested in AAMC memos. Further, the Association has always taken the position that its communications are sent to the institutional representatives only, and a general mailing list is not maintained.

There is no channel for these individuals to be active in the Association unless they are distinguished service members (in which case they are invited to spring council meetings and receive publications, but not pink memos) or serve on an AAMC committee (very rare).

It appears to Association staff that in many academic medical centers individuals other than the dean and hospital administrator are acquiring substantial authority and responsibility for decisions impacting on medical education. This is particularly true with respect to financing issues and the operation of patient care services. If there is a power shift occurring at medical centers, the Association should be considering how this impacts on its membership and its own position as spokesman for academic medicine. This will be a topic at the December Officers' Retreat, but staff wishes to elicit comment from the Administrative Boards which could be incorporated into the background paper for that discussion.

Questions for Discussion

1. Should the Association consider expanding its communications network? If so, on what issues and how should recipients be identified?
2. Is there some kind of participatory role that can be identified for officials who hold positions above or equal to the dean or hospital administrator in the medical center hierarchy?
3. Is the AAMC/AAHC relationship basically competitive or can it be cooperative? What are our options under each mode?

Survey of Capital Financing Needs of Teaching Hospitals

During the summer, representatives of Peat, Marwick, Mitchell and the Morgan Guarantee Trust Company proposed joining with the AAMC to conduct a questionnaire survey of the capital financing needs of teaching hospitals, attachments A and B. Given recent concern among CEO's about access to and financing of capital resources and Medicare's plan to pay capital costs on a prospective basis, AAMC staff recommend:

that the Administrative Board approve AAMC participation in a study of teaching hospital financial needs. If approved, staff will meet with Peat, Marwick and Morgan Guarantee representatives to design the necessary questionnaire, distribute it to all non-Federal COTH members, and prepare the report on survey findings.



Peat, Marwick, Mitchell & Co.
345 Park Avenue
New York, NY 10154

August 10, 1983

Dr. James Bently
Associate Director
Department of Teaching Hospitals
American Association of Medical Colleges
1 DuPont Circle, N.W.
Suite 200
Washington, D.C. 20036

Dear Dr. Bently:

This letter will amplify the telephone conversation you had with Mr. Norm Hirsch of Peat, Marwick & Mitchell during the week of August 1st. In that conversation he proposed that Peat, Marwick & Mitchell and Morgan Guaranty Trust Company jointly conduct a survey of the capital financing needs of the nation's teaching hospitals under the auspices of the American Association of Medical Colleges. ✓

As does the health care industry in general, teaching hospitals face an increasingly complex set of challenges in the form of changing formulaes for third party reimbursement, legislative restrictions and increasing capital financing needs during a period of credit market volatility. The results of the survey we propose can provide information useful in legislative consideration of crucial issues, such as the preservation of the tax-exempt financing of teaching hospitals. The survey would also assist the health-care industry in highlighting public policy aspects of hospital facility requirements and identifying capital allocation problems.

The actual scope of the survey is yet to be fully developed, but can include questions on the hospitals' facilities, debt structures and past capital financing activities, future capital needs, anticipated sources and timing of funding and key capital financing ratios. We estimate that a survey of the approximately 450 Council of Teaching Hospital members can be accomplished within six months, after which a special report and/or a presentation could be produced for your members. We would be happy to work directly with the AAMC staff or with a steering committee of representative hospitals, whichever you prefer. We believe that this survey is unique and will benefit the American Association of Medical Colleges by providing information seldom gathered and presenting it in aggregate form, as well as disaggregated by regions, hospital sizes and utilization levels.

At present, there is no such comprehensive survey of capital needs and plans for the teaching hospital segment of the tax-exempt municipal bond market. From the perspective of our two firms, we believe that a survey of the type we are proposing would be of considerable interest not only to teaching hospital professionals, be also to municipal bond underwriters, feasibility study consultants and institutional investors.



Dr. James Bently
American Association of Medical Colleges
August 10, 1983
2

After you review this letter, we hope that representatives from Morgan and Peat Marwick could meet with the Association to discuss structuring this project to the maximum advantage of the AAMC membership. In addition, we would like to discuss the function and organization of representatives of the AAMC who could work with our two organizations in implementing this survey. We stand ready to meet with you as soon as possible in Washington, D.C. Should you have any questions, please contact Norm Hirsch or Jean Skolnik at Peat, Marwick and Mitchell (212-758-9700) and John Raben (212-483-5011) or Alan Anders (212-483-5285) at Morgan Guaranty.

Sincerely,

Jean Skolnik

Alan S. Anders

Attachment B

Morgan Guaranty Trust Company of New York 23 Wall Street, New York, NY 10015

Alan L. Anders
Vice President

Telephone 212 483-5285

**The
Morgan
Bank**

August 24, 1983

Dr. James Bently,
Associate Director
Department of Teaching Hospitals
American Association of Medical Colleges
1 DuPont Circle, N.W.
Suite 200
Washington, D.C. 20036

Dear Dr. Bentley:

I am writing with reference to an earlier letter of August 10 from myself and Jean Skolnik of Peat Marwick. In that letter, Morgan Guaranty and Peat Marwick proposed a survey of capital needs of teaching hospitals as something which might be of benefit and interest to the AAMC and its member institutions.

I was delighted to hear through Jean that the AAMC would like to explore further with Morgan and Peat Marwick the possibility and details of such a survey. I understand that we are awaiting the return of the AAMC's Director from vacation before taking the next step. As it happens, I will be departing shortly for two weeks of vacation as well, and I wanted to ensure, by means of this letter, that these several weeks without any additional progress on this project were not construed as any lack of continued interest on Morgan's part.

I will be back in the office on September 12. I hope that shortly thereafter we can arrange a meeting at the AAMC offices in Washington at which you and your staff can meet directly with representatives of Peat Marwick and Morgan Guaranty to fully explore the details involved in undertaking the proposed survey.

I look forward to meeting you at that time.

Sincerely,

Alan L. Anders

Paying Capital Costs Under Medicare

Background

In adopting the Medicare prospective payment system, Congress expressed a strong interest in eliminating retrospective cost reimbursement for capital expenses.

- Congress indicated capital projects initiated on or after March 1, 1983 may be paid differently from projects initiated before that date;
- Congress required HHS to complete a major study of alternative methods of paying for capital; and
- Congress provided that if retrospective cost payments continue beyond September 30, 1986, no payment shall be made for major new capital expenses unless the project is approved by a Section 1122 planning agency.

In light of these developments and in keeping with its advocacy of a prospective payment system, the American Hospital Association has prepared a discussion draft on "Incorporating Capital Costs into Medicare Prospective Prices," attachment A.

Recommended Board Action

In reviewing the document, Board members are asked to address the following issues:

- Should the AAMC adopt the objective of replacing institutionally specific, retrospective cost payments for capital with prospectively specified capital payments?
- Should the AAMC support the general principle that there are only two capital costs: return of capital and return on capital?
 - Should the return of capital be based on historical costs?

-- Should an additional capital cost be added to preserve the purchasing power of capital?

- Should the AAMC support the general principle that capital payments should not vary with ownership, the status, or present capital structure of the hospital?

-- Implicitly, this principle leads to using industry averages rather than hospital specific capital expenses to compute capital payments.

- Should the AAMC endorse a single consolidated prospective price which includes funds for both operations and capital in one amount or should the AAMC favor separate prospective payments for operations and capital?

- Should the AAMC support including a distinct "new technology component" in computing capital payments?

-- Are there any suggestions for a specific percentage increase for new technology?

- Should the AAMC support a transition mechanism based on a percentage phase-in or a retrospective cost based floor?
- If the AAMC endorsed the discussion draft for Medicare payments, should the same principles and mechanisms be advocated for all payers?

IT IS RECOMMENDED THAT THE ADMINISTRATIVE BOARD ENDORSE THE GENERAL PRINCIPLES, DESIGN CONSTRAINTS, AND MECHANICS OF THE CAPITAL PAYMENT ALTERNATIVE DEVELOPED IN THE AHA'S DISCUSSION DRAFT.

DRAFT FOR DISCUSSION ONLY

INCORPORATING CAPITAL COSTS INTO MEDICARE PROSPECTIVE PRICES

July 1983

Office of Public Policy Analysis
American Hospital Association

BACKGROUND

The Social Security Act Amendments of 1983 include a major change in the way Medicare will pay hospitals for most inpatient acute services beginning October 1, 1983. Payment will be based on a prospectively determined price for each discharge, with discharges classified into diagnostic related groups (DRGs). The key capital-related provisions of the legislation are as follows:

- . Capital costs (depreciation, interest on long term debt, and lease expenses) will continue to be reimbursed on a reasonable cost basis until October 1, 1986, at which time capital costs are to be blended into DRG prices.
- . Investor-owned hospitals will continue to receive a return on equity factor. The amount, however, has been reduced from one-and-one-half to one times the rate of interest earned by the Hospital Insurance Trust Fund.
- . The Secretary of the Department of Health and Human Services is required to complete by October 1984 a study of methods by which capital, including return on equity, can be incorporated into Medicare prices by 1986.
- . Under a new payment system for capital, Congress has stated that costs associated with capital projects initiated between 1983 and 1986 may or may not be treated in the same manner as projects initiated earlier.
- . State section 1122 capital expenditure review programs are mandatory beginning in 1986, unless legislation has been passed by that time to incorporate capital costs into prospective prices.

OBJECTIVE

To formulate a position on incorporating capital costs into Medicare prospective prices.

GENERAL PRINCIPLES

For capital to be realistically reflected in a hospital's (or any other economic entity's) prices, the following basic principles must be recognized:

- . All capital has a cost, regardless of its source.
- . A hospital's cost of capital, like that of any other economic entity, is composed of two basic elements:

1. Return of Capital: The cost of consuming capitalized assets. In accounting terms, this is depreciation expense and is intended to replace the capital invested, rather than the assets themselves. (While arguments can be made for viewing capitalized lease expenses as a subcomponent of a "return on capital" element of capital cost [see (2) below], or as a hybrid of the two types of returns, for simplicity's sake this report treats lease expenses as a return of capital).
2. Return on Capital: The cost of using money, whether from debt or equity sources.* This cost minimally includes the time value of money, i.e. inflation, and also reflects such factors as opportunity cost and risk. For borrowed capital, this cost is easily identifiable as interest expense. For investor-owned hospitals, the cost of equity capital is expressed as dividends and capital gains to investors. For not-for-profit hospitals, the cost of equity capital is expressed as the services returned to the community (e.g. free care to the needy, specialty and low volume services, etc.) and the demonstrated capacity to remain fiscally viable in order to continue to serve the community and meet its future expectations.**
 - . Payment for capital (in aggregate) should reflect the amount of capital invested and should not vary as a result of management decisions with respect to ownership, tax status, capital structure, or individual hospital economic circumstances.***
 - . The method of paying for capital must provide a reasonable expectation that adequate returns for both cost-of-capital elements will continue to be made available to well-managed hospitals so that they can continue to meet the needs of their communities and the expectations of their investors.

* Included in equity are retained earnings as well as stockholder or philanthropic investments.

** Under a competitive pricing system, hospitals would individually set prices to balance operating and capital costs against market forces. However, because prices under the Medicare payment system are set administratively rather than competitively, and because the prices are increasingly based on averages, a minimum cost of equity capital must be explicitly factored into Medicare payments. If a return on equity capital were required to be recovered totally by keeping operating costs below DRG prices, the average-performing hospital would be unable to recover its cost of equity capital in treating Medicare inpatients.

*** Special payment treatment, separate from and in addition to other operating and capital payments, is appropriate, however, with respect to hospitals with high percentages of Medicare or low income patients or hospitals with approved education programs.

DESIGN CONSTRAINTS

In addition to the above principles, the following design constraints should guide the incorporation of capital into Medicare prospective prices:

- The capital payment method should create incentives for cost-effective strategic planning and capital investment decision-making by hospitals, with no bias to the extent possible with respect to either capital-labor mix or debt-versus-equity financing decisions.
- From the perspectives of both hospitals and the federal government, the capital payment method should increase overall financial predictability and be relatively easy to understand and administer.
- Any new capital payment method should recognize and account for, where necessary, the transitional needs of hospitals that have recently incurred or may soon incur substantial capital expenditures.

INCORPORATING CAPITAL INTO MEDICARE PROSPECTIVE PRICES: MECHANICS

Based on the above principles and design constraints, the following approach for incorporating capital into Medicare prospective prices is suggested.

1. Consolidated Price

All capital costs should be incorporated into Medicare prospective prices, yielding a single price to the hospital, without earmarking amounts for either capital or operations.

The retrospective, cost-based, pass-through approach to paying for capital is administratively costly and cumbersome, and can be expected to intensify the perceived need for federally supported or mandated state certificate of need laws or section 1122 programs, with potential additional regulatory controls or restrictions such as state level capital expenditure approval caps, interest rate ceilings, or limits on hospital access to tax-exempt bonds. Also, the pass-through approach continues incentives to substitute capital for labor and to finance capital from debt rather than equity sources.

On the other hand, an approach which incorporates capital costs into Medicare prices introduces for capital the same incentives and flexibility for cost-effective decision-making inherent in Medicare prospective pricing for operating costs. Capital-labor mix and debt-versus-equity decisions are not inherently biased under this approach, and overall financial predictability is enhanced for both hospitals and the federal government.

A combination approach (e.g, one which includes a capital factor in Medicare prices to cover major movable equipment costs, while continuing to treat fixed equipment, plant, and land acquisition costs as a pass-through) retains the negative aspects of the pass-through approach. Additionally, it would be extremely difficult if not impossible to design and administer, because data is currently unavailable nationally on the portion of various types of Medicare capital costs attributable to movable equipment versus facilities and fixed equipment.

2. Capital Factors to be Incorporated in Price

- A. *Both return-of-capital and return-on-capital factors should be incorporated into Medicare prospective prices in the initial year using industry-wide capital cost averages rather than institution-specific experience.*

While an institution-specific approach has the advantage of recognizing the circumstances of the individual hospital and thereby obviating the need for a transition mechanism, it "locks" the institution into one point in its capital cost cycle. In order to avoid locking a hospital into the current point in its capital cost cycle, institution-specific update computations would be necessary each year, not unlike the pass-through approach with all of its administrative and incentive weaknesses.

On the other hand, an industry-wide averaging approach with a transition period is simple to understand and administer; and does not arbitrarily lock a hospital into one point in its capital cost cycle. Preliminary data suggest that, while individual hospital capital-related accounting costs as a percentage of operating costs vary considerably among hospitals, they are cyclical, with hospitals appearing to move periodically to and through the industry-wide average at some point in their capital cycles.* To be workable and fair, an industry average approach must be combined with a transition mechanism (see below). The transition mechanism provides the means for meeting the needs of hospitals that have recently incurred or may soon incur substantial capital expenditures, and also limits any dislocations that might occur in the capital markets.

- B. *The return of capital element should be incorporated into Medicare prices by adding a percentage which reflects industry-wide depreciation and lease costs as a percentage of industry-wide operating costs (net of capital and direct teaching costs, to be consistent with the price base). The return on capital element should also be incorporated into Medicare prices*

*Further analysis is needed, however, to determine whether capital cost cycles vary by classes of hospitals and/or regions.

by adding a percentage. In this instance, the percentage should be based on an appropriate return-on-capital rate applied to the industry-wide debt-plus-equity base. The resultant industry-wide total dollar return on capital should then be divided by industry-wide operating costs (net of capital and direct costs of approved education programs) to obtain a uniform percentage return on capital factor to be included in each Medicare price.

The return-on-capital percentage factor provides minimally for the costs of both debt and equity capital. Any additional return on capital must be earned. For not-for-profit hospitals, defining the equity portion of the debt-plus-equity base as unrestricted fund balance less long term investments is believed to be comparable to current Medicare definitions used in paying a return on equity to investor-owned hospitals.

3. Annual Update

*After the first year, the entire Medicare price should be annually updated using an expanded hospital market basket, with no distinction made between capital and operating components of the price.**

A consolidated price, with no explicit distinction between operating and capital components, avoids the possibility of separate and potentially contradictory treatment of the two types of costs. Also, it is easier to administer and it allows hospitals to manage within an overall price, without dictating or artificially suggesting which dollars are meant for which use.

4. Technology

A separate factor for technology improvements should also be applied in the annual updating of Medicare prices.

The two cost-of-capital elements, return of and return on capital, relate to preserving the hospital's existing capital base and, as such, do not recognize the hospital's need for new capital to take advantage of technology improvements. As is the case currently with respect to Medicare pricing for operating costs, an explicit, minimum technology improvement factor should be applied in annually updating the consolidated prices to recognize the increases in both capital and operating costs associated with medical technology improvements.

* However, under the "payment floor" transition mechanism discussed below, two price schedules are required during the transition period: one which includes capital, and one which excludes capital.

5. Transition

A transition to this pricing approach should be accomplished by a "floor" method whereby at their annual election, hospitals are paid either their incurred capital-related costs as presently defined by the Medicare program, or the Medicare prices which incorporate capital as described above. The "actual cost" floor should be applied to capital obligated as of a specified date, as well as to subsequent capital expenditures that can be demonstrated to be necessary to eliminate or prevent imminent safety hazards, or comply with licensure, certification, or voluntary accreditation standards. Once a hospital elects Medicare prices which incorporate capital costs, it should be prohibited from electing the floor payment option in the future.*

A fixed-term, (e.g. 5-10 years) transition mechanism is necessary in order to protect hospitals whose capital costs initially vary substantially from the average.** The "floor" transition method protects hospitals which have recently undertaken large projects, and addresses any perceived concerns over a rash of capital spending in the early period of transition. Additionally, it protects hospitals which may soon need to incur substantial capital expenditures in order to correct safety hazards or comply with licensure, certification, or accreditation standards.

CONCLUSION

The method outlined above for incorporating capital into Medicare prospective prices has the following attributes:

- . It appears adequate in that it recognizes the cost of capital, regardless of its source, thereby providing a reasonable expectation that capital will continue to be available to all well-managed hospitals.
- . It is fair in that the transition mechanism protects outstanding debt and recognizes the needs of hospitals that may soon incur major capital expenditures in order to comply with voluntary and governmental life/safety codes and standards.

* In order to recognize the Medicare payment environment within which both debt and stockholder investors made their investment decisions in the pre-transition period, investor-owned hospitals opting for floor payments should continue to receive a return on equity, based on the equity extant as of the specified date and only modified based on changes that can be demonstrated to have subsequently resulted from compliance with life/safety codes.

** Many hospitals confronted with a major capital expenditure in the first few years of the new pricing program may not require "floor" payments because they are able to either delay or reduce the expenditures or structure necessary debt in line with the new pricing system.

- . It is uniform in that payment for capital applies equally to all hospitals, regardless of capital structure; ownership; tax status; or individual hospital economic circumstances.
- . It provides for predictable payment into the future.
- . It provides incentives to plan for and manage capital expenditures in light of available resources, unlike the current system of cost-based reimbursement.
- . It favors neither debt nor equity in its design.
- . It has no inherent bias to substitute capital for labor, or vice versa.
- . It maintains management's decision-making prerogatives by not distinguishing between capital and operating dollars in payments.
- . It does not "lock" hospitals into their current capital structure.
- . It can be readily applied to either institution-specific prices or to regional or national average prices.



**association of american
medical colleges**

JOHN A. D. COOPER, M.D., PH.D.
PRESIDENT

September 6, 1983

202: 828-0460

Ms. Betty Lou Dotson
Director
Office of Civil Rights
Department of Health and Human Resources
330 Independence Avenue, S. W., Rm. 5400
Washington, D. C. 20201

RE Proposed Rule: Nondiscrimination on the Basis of Handicap
Relating to Health Care for Handicapped Infants

Dear Ms. Dotson:

On behalf of the members of the Association of American Medical Colleges, I am writing to express our grave displeasure with the revised version of the regulation addressing the provision of health care to handicapped infants published on July 5, 1983. A federal district court judge nullified the original regulation, calling it "arbitrary and capricious" and "a hasty and ill considered (method of addressing) one of the most difficult and sensitive medical and ethical problems facing our society." After such an admonishment, it is distressing to find that the Department of Health and Human Services could reissue the regulations virtually unchanged. The implication in the regulation, particularly in the preamble, that health care providers callously allow handicapped children to die from lack of treatment or nutrition is offensive to all health care providers and particularly to those who have devoted their professional lives to caring for sick children.

Just a few decades ago, most sick newborns died within a few hours of birth and premature infants were not expected to live more than a few days. Through the efforts of many health care professionals, the prognosis for these infants has changed radically. The many technological advances and the new skills in neonatology substantially have reduced the mortality rate for the severely ill and premature infants. In fact, since 1970 infant mortalities have been halved.

It is ironic that the professionals that make it possible for infants with critical problems to have a chance at life are treated in a proposed federal regulation as if they would habitually disregard a handicapped infant's needs. This assumption is false. Hospitals and their medical staffs provide care for all patients to the best of their ability. Teaching hospitals have a particular commitment to patients in need of critical care, including the infants that are the subject of this regulation. At the 350 nonfederal teaching hospital members of the AAMC, there were more than 720,000 births in 1980. More than three-quarters of these teaching hospitals provide premature nurseries and more than 70 percent have neonatal intensive care units.

Additionally, teaching hospitals and the medical schools with which they are associated train new physicians and engage in new areas of research to perpetuate and enhance their ability to care for critically ill infants.

Ms. Betty Lou Dotson
September 6, 1983

Traditionally, the parents and the physicians have made the very difficult decisions regarding the treatment that should or should not be rendered to children with life-threatening conditions. While some may disagree with the choice made in some of the cases, it should be recognized that the parents and physicians believed themselves to be acting in best interests of the child. The question raised by the case of Infant Doe and the resultant public outcry is how can the public voice its opinion regarding what is in the best interests of the child, presuming that this public voice would be less likely to concern itself with any physical or mental handicap of the child, or with the costliness of rendering continuous treatments to a child so handicapped.

The Department of Health and Human Services' answer to this question is that there ought to be an "alarm system" comprised of posted notices and toll free hot lines by which anonymous tipsters can summon teams of representatives from state child protection agencies and/or the Office of Civil Rights. This proposed approach is seriously flawed for several reasons:

- In the event there is a case in which a child is wrongfully denied treatment or nutrition, the HHS approach provides no assurance that the authorities would be called in time to take steps to protect the child.
- It is highly likely that this approach will result in a number of hospitals and physicians being falsely accused of inappropriately withholding treatment or nutrition. The few weeks in which the first "Baby Doe" regulation of the Department was in effect provided ample evidence that such false accusations would occur. These false accusations can be made either by well intentioned but uninformed people or by crank callers who may seek to harass the institutions or physicians involved.
- Perhaps the most disturbing consequence of the Department's proposed rule is the affect this method has on other infants. For example, during the period in which the original rule was in effect, an investigation was made on a "hot line" tip that Siamese twins at Strong Memorial Hospital in Rochester, New York were not receiving adequate care. This tip prompted the Office of Civil Rights to intercede. While everything possible had been done for the twins, the investigation and the investigators' lack of knowledge of the appropriate procedures to follow in conducting this inquest delayed the return of these infants to their mother. The mother, who was recovering in a nearby community hospital, was thus denied access to her infants during a significant portion of those few days they survived. The furor caused by the presence of the investigatory team and the newspaper accounts of the incident disturbed the parents of another infant so greatly that they removed their child from Strong Memorial before its treatments had been completed, thus jeopardizing its health.
- The investigations resulting from these false accusations are disruptive and time consuming and, most importantly, impair the hospital's ability to provide proper care for all of the infants in

its nurseries by usurping the time of the medical and nursing staff that would otherwise be spent in rendering care.

- Posted notices, whether they are scattered about the units or located in the nurses' station, are seen by the families of children whose care is in no way being questioned. Those families may incorrectly infer from the notice that the hospital or some of the physicians have wrongfully withheld treatment on previous occasions. This inference would unnecessarily increase the family's anxiety when it is already under a great deal of stress. In addition to the stress to the parents, the staff of these units are demoralized by the signs and by the parents' reaction to the signs.
- By involving the state child protection agencies in the investigation of such cases, the proposed rule would seriously drain the already inadequate resources of these agencies and involve them at a time when they can lend no expertise in deciding the best course for treatment of the child. A more appropriate time for involving such agencies would be once a decision has been made that the child is treatable, but the parents refuse to allow the treatment. Then, the state child protection agencies would be acting as they might for a child of Jehovah's Witnesses to secure the rights of the child to treatment.

It is time a more thoughtful approach to this matter was seriously considered. After much deliberation and study of the issues involved, the President's Commission on Ethical Behavior in Medicine and Biomedical and Behavioral Research recommended the establishment of ethics review boards within each institution or community to address all cases involving persons of any age group in which a decision to forego life sustaining treatment must be made. Several representatives of health care provider organizations have tailored this ethics review board concept to address these cases, and the resultant Infant Bioethical Review Committees (IBRCs) are described in the proposed amendment to the Medicare Conditions of Participation submitted with the comments of the American Academy of Pediatrics. This approach offers several advantages:

- All cases of infants for whom a decision must be made regarding the provision of life sustaining treatment will be addressed by the IBRC either through determination of a hospital policy or review of the individual cases.
- The alternatives for the child can be thoroughly discussed, including the help available for people with the same disabling condition as the infant.
- The review would occur as part of normal hospital procedure for such cases, thereby minimizing the disruption of services to other seriously ill infants. Also, because the review is required for all such cases, no inferences will be made that the treatment rendered by the physician(s) and health care team involved is faulty.

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- Notice of the existence and function of the IBRC can be made in such a way as to not alarm the families of infants whose care is not in question; further, the deliberations of the IBRC on a particular case shall be made in confidence, which also will minimize the anxiety to the other parents.
- Finally, the recommendation that we are advancing would be issued under the authority of the Secretary to set conditions for participation and avoids problems associated with reliance on Section 504 which is of dubious applicability.

We strongly urge you to consider withdrawing your proposed regulation and to substitute the proposal to establish IBRCs. If my staff or I may be of further assistance in helping you to consider this matter, please contact me at (202) 828-0460.

Sincerely,

Original signed by

John A. D. Cooper, M.D.

John A. D. Cooper, M.D.

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