MEETING SCHEDULE
COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD

January 23-24, 1985
Washington Hilton Hotel

WEDNESDAY, January 23, 1985

2:00-4:00pm	NEW ADMINISTRATIVE BOARD MEMBERS ORIENTATION SESSION AAMC Conference Room (One Dupont Circle, #200)
5:30pm	JOINT MEETING OF AAMC ADMINISTRATIVE BOARDS Georgetown West Room (hotel)
7:00pm	JOINT RECEPTION AND DINNER OF AAMC ADMINISTRATIVE BOARDS Georgetown East Room (hotel)

THURSDAY, January 24, 1985

8:00am	COTH ADMINISTRATIVE BOARD MEETING Jackson Room
Noon	JOINT AAMC ADMINISTRATIVE BOARDS LUNCHEON Conservatory Room
1:00pm	AAMC EXECUTIVE COUNCIL BUSINESS MEETING Military Room

A G E N D A

COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD MEETING

January 24, 1985
Washington Hilton Hotel
Jackson Room
8:00am-Noon

XII. AAMC SURVEY ON FACULTY PRACTICE PLANS — Executive Council Agenda - Page 50

XIII. AUPHA PROPOSED INITIATIVE — Page 93

XI. OTHER BUSINESS

XII. ADJOURNMENT

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COTH ADMINISTRATIVE BOARD MEETING
September 13, 1984

PRESENT

Haynes Rice, Chairman
Sheldon S. King, Chairman-Elect
Earl J. Frederick, Immediate Past Chairman
J. Robert Buchanan, MD
Jeptha W. Dalston, PhD
Spencer Foreman, MD
Robert E. Frank
Irwin Goldberg
William B. Kerr
Eric B. Munson
David A. Reed
C. Thomas Smith
Thomas J. Stranova
William T. Robinson, AHA Representative

ABSENT

Glenn R. Mitchell

GUESTS

Robert M. Heyssel, MD
Richard Janeway, MD

STAFF

David S. Baime
James D. Bentley, PhD
John A. D. Cooper, MD
Richard M. Knapp, PhD
Thomas J. Kennedy, Jr., MD
Len T. Koch
Karen L. Pfordresher
Nancy E. Seline
Melissa H. Wubbold

COTH ADMINISTRATIVE BOARD
Meeting Minutes
September 13, 1984

I. CALL TO ORDER

Mr. Rice called the meeting to order at 9:00am in the Jackson Room of the Washington Hilton Hotel.

II. CONSIDERATION OF THE MINUTES

ACTION: It was moved, seconded, and carried to approve the minutes of the June 28, 1984 COTH Administrative Board meeting.

III. PAYING CAPITAL COSTS IN COTH HOSPITALS

Dr. Bentley opened discussion of capital payment under the Medicare program by reviewing the five areas of consensus reached by the ad hoc committee chaired by Mr. Frank, and recalling that the Board had considered several transition period options at its June meeting. Because the deans and faculty were less comfortable with this issue in June than the COTH Board, staff was requested to redraft the agenda paper to include numerical examples for the most discussed options. The revised paper was included in the agenda. Dr. Bentley reviewed the examples individually. In the discussion period, Mr. Smith suggested that the recommended action be modified to state that the percentage add-on should be at a level consistent with Medicare's present percentage for capital expenditures. This was agreeable to all. Dr. Dalston suggested that the recommended principles failed to address the particular capital needs of the research-intensive hospitals but acknowledged that historical data did not demonstrate above average capital costs for this group. Dr. Foreman questioned whether an example with a $30 million project was adequate to describe the implications of the policy options for COTH members. In response, Dr. Bentley noted the project was equal to 85% of the hospital's annual expense budget.

ACTION: It was moved, seconded, and carried that the COTH Administrative Board adopt as Association policy on paying capital costs under Medicare the five areas of consensus recommended by the Ad Hoc Committee and the transition period option which allows a hospital its choice of (1) cost reimbursement for depreciation and interest or (2) a prospective percentage add-on that is no less than Medicare's current percentage for capital expenditures.

IV. MODIFYING THE MEDICARE PAYMENT SYSTEM

Dr. Bentley introduced this topic by recalling that the Board's January meeting was cancelled because of snow. To prepare for Congressional interest in the prospective payment system, Drs. Knapp and Bentley contacted each Board member and discussed the AHA's proposal for a "blended" rate. All Board members favored supporting the AHA's proposal; however, the action remained an informal one. The present agenda item was developed in order to have a formal decision on the AHA's proposal. Dr. Bentley then reviewed the AHA's proposal and concluded that it appeared to be in the best interest of COTH members.

ACTION: It was moved, seconded, and carried that the COTH Administrative Board endorse the DRG specific price blending proposal of the American Hospital Association and that the AAMC work with the AHA to incorporate this feature into the Medicare prospective payment system.

. . . . .

At this point the Chairman indicated that he had a number of announcements to make. He indicated that there is a heavy testimony schedule ahead over the next two weeks. He will be making a presentation on "uncompensated care" that afternoon before the National Council on Health Planning and Development. He reminded Board members that the Council is chaired by Yoshi Honkawa of Cedars-Sinai Medical Center in Los Angeles. On Thursday, September 20, Mort Rapoport, MD, President, University of Maryland Hospital, will appear before the Special Committee on Health Care Cost Containment of the National Conference of State Legislators. He will discuss the issues of financing graduate medical education, uncompensated care, diagnostic case mix, regional and standby services, and the provision of an environment for clinical research and technology development.

On Friday, September 21, Tom Smith, President, Yale-New Haven Hospital, will present testimony to the Health Subcommittee of the Senate Finance Committee on financing graduate medical education. (This testimony was postponed and rescheduled for October 1.) On Friday, September 28, Dr. Heyssel will present testimony to the Health Subcommittee of the Senate Finance Committee on the subject of "uncompensated care."

The Chairman then recalled that at the June COTH Administrative Board meeting, a motion was passed requesting that the AAMC review the possibility of joining with the Association of Academic Health Centers in their study of the pro's and con's of university ownership of teaching hospitals. He reported that had been accomplished and a joint grant proposal has been submitted to a foundation with excellent funding prospects.

The Chairman then asked Mr. Frederick to report on the COTH Nominating Committee interaction with the AHA Nominating Committee. Mr. Frederick reported that on June 30 he and Dr. Knapp had made an appearance before the AHA Nominating Committee and had submitted three names to the Committee for consideration as AHA Board members. He indicated that he had heard from Mr. Robinson who staffs that committee in early August with the news that he himself had been nominated to serve on the American Hospital Association Board. He indicated that while he found the situation to be somewhat awkward, he was honored with the opportunity and after due consideration agreed to accept the nomination to the Board.

The Chairman next asked Mr. Kerr to report on the AHA Metropolitan Hospital Section. Mr. Kerr indicated that the Section had discussed fully the AHA capital proposal and wished to make it clear that the capital "add on" for Medicare purposes would be added to the "full base." He also reported that the American Hospital Association had exhibited a strong level of interest and commitment to the issue of uncompensated care, and efforts were being made to come up with practical proposals that might have some possibility of showing some progress on the issue.

Finally, he reported that on the Sunday of the week of the AAMC Annual Meeting, the Section would be holding a one day meeting entitled, "Survival Strategies for Metropolitan Hospitals in a Changing Environment." He urged COTH Administrative Board members to attend.

The Chairman then called on Dr. Dalston to report on the teaching hospital committee of the Association of Academic Health Centers. Dr. Dalston indicated that the reponses to the survey on priority areas of interest were coming in and would be shared with the Board as soon as they were available. He indicated that a discussion had been held concerning the joint study on the university ownership of teaching hospitals. The next meeting of the committee will be held shortly after the AAHC meeting in Key West next month.

At this point the Chairman distributed a letter that Dr. Cooper had written to Mr. Gilbertson concerning the criteria for selection of a new president of the American Hospital Association and the needs and prospects for the health industry in the near future. A copy of the letter is included as Appendix A to these minutes. The Chairman indicated that he felt that relationships with the American Hospital Association, while always good, had been substantially strengthened over the past year. He felt that a letter would be in order expressing those thoughts and thanking Alex McMahon for being so responsive.

The Chairman next called on Dr. Knapp to make some announcements. He covered the following matters:

- On July 5, 1984 all members of the COTH Administrative Board received a carbon copy of a letter to Mr. Frederick from L. Donald Slaughter, MD. A copy of that letter is included as Appendix B to these minutes. Dr. Knapp indicated that the AAMC Office of the President is aware of this letter and it has been reviewed by AAMC Counsel.

- The Board was reminded that Professor Judy R. Lave, PhD, of the University of Pittsburgh is under contract to the AAMC to produce a paper entitled, "The Medicare Adjustment for the Indirect Costs of Graduate Medical Education: Historical Development and Current Status." A final draft of the paper has been submitted to the Department of Teaching Hospitals staff for review and comment. It is expected that the paper will be available shortly after the AAMC Annual Meeting.

- The leadership group from hospitals with burn centers has awarded a contract to ICF, Inc. to develop a national coalition of burn center hospitals. Mr. Joseph Rees, a government relations/ public affairs consultant with The Keefe Company, is working with ICF to do the organizational development work while ICF will do most of the substantive technical reimbursement and analytical work. A copy of the proposal was distributed to Board members for review.

- It was noted that Mr. Rice will be appearing before the National Council on Health Planning and Development to present testimony entitled, "Uncompensated Care and the Teaching Hospitals." A copy of the testimony was distributed to the Board for review.

- A large three-ring bound notebook entitled, "Peer Review Organization Objectives: A Synopsis" had been made available by the Health Care

Financing Administration (HCFA) which included a compilation of summaries of objectives negotiated and included in the contracts for each PRO area for the first 31 contracts that had been signed. The only contracts that had been signed which were in areas in which COTH Board members were located were in the states of Missouri and North Carolina. Copies of those two contracts were distributed for Board members to review. A variety of concerns were expressed by individual Board members concerning the extent to which the objectives set forth in the contracts were realistic. It was stated that in many cases these contracts had been negotiated by the leadership of a state medical society. In some cases the objectives may have been overstated in order to obtain the contract from a competing organization. Dr. Knapp explained that there had been a variety of pressures placed upon individuals and organizations in the negotiating situation and Dr. Carolyne Davis in a recent meeting had indicated that she would be willing to review once again the contract objectives six months subsequent to their signature. Whether or not this program will be operated as an educational venture with a spirit of cooperation or whether or not it will be a regulatory oriented program remains to be seen and undoubtedly will vary from state to state. All members were urged to become actively involved in the PRO negotiation and operation within their respective states.

- Dr. Knapp indicated that the Survey of Universityy Owned Teaching was proceeding slowly and would become available in late 1984. He also indicated that the results of the Survey to Determine the Implications of the Medicare Prospective Payment System were also not being returned as rapidly as had been hoped. A report will be prepared for the Board. However, the staff is not completely convinced that the results are such that one would have confidence to release them to the general membership and the public broadly.

V. LETTER FROM AMERICAN PHYSICAL THERAPY ASSOCIATION

Mr. Rice at this point in the meeting distributed a letter from David M. Brown, MD, Dean Designate at the University of Minnesota. A copy of this letter is included in these minutes as Appendix C. The letter concerns the position of the American Physical Therapy Association that the degree to be awarded to students who enroll in entry level education for the physical therapist after December 31, 1990, and satisfactorily complete all requirements, shall be the first professional degree in physical therapy and shall be a graduate or post baccalaureate degree. Dr. Brown urged that the AAMC take a strong position to oppose this move. Mr. Rice asked the Board members whether or not they felt COTH/AAMC should become involved in this issue. Following general discussion, it was agreed that this was an issue that should be taken up through proper channels at the American Hospital Association. If support were needed from the AAMC it was recommended that such support should be forthcoming for the position taken by the American Hospital Association.

VI. PROCESS FOR SELECTION OF NEW AAMC PRESIDENT

At this point in the meeting, the COTH Administrative Board was joined by Dr. Heyssel and Dr. Janeway, AAMC Chairman and Chairman-Elect respectively. Dr. Heyssel introduced Dr. Janeway and indicated that they had agreed that the

selection process should be initiated during Dr. Janeway's term of office, and that Dr. Janeway would therefore appoint a search committee. Dr. Janeway outlined his initial thoughts on the subject and asked the COTH Board members for their advice and consultation. The following observations and suggestions were made:

- It was recommended that a search firm be employed to work with the search committee. It was felt that the search committee would not likely be organized to provide the backup support for its activities and that it would be unwise and awkward to charge any current AAMC staff member with this responsibility. The search firm should be one that has excellent connections to the worlds of foundations, governments, business and industry, hospitals as well as scientists and academic posts. It was recommended that the committee be appointed with all deliberate speed. Already a variety of undercurrents are developing and the appointment of a committee with a specific charge would serve to provide some direction to this activity.

- It was recommended that qualifications and criteria be set forth early in the search process. Several Board members believed this to be extremely important so that substantive debate over qualifications becomes the issue rather than personal dynamics. There are also several qualification matters that need to be determined early (e.g., whether or not the individual is a physician and the extent to which a science background is important). It was recommended that the short and long range expectations be set forth in the charge so that the question of whether a person with a short time left in his/her career would be appropriate or whether a younger person would be a better selection.

- It was recommended that the objectives of the Association be re-assessed and included in the charge to the Committee. Relationships with other organizations and expectations for the future of the AAMC are matters that ought to be assessed in the context of selecting a new chief executive.

- It was recommended that close attention be given to process. All members of the AAMC should believe they have had an opportunity to have their views recognized. In addition, it was felt that the search committee should consult widely with other hospital and medical organizations to determine their expectations and views of the future.

VII. HEALTH CARE IN THE 1990'S: TRENDS AND STRATEGIES

The report entitled, "Health Care in the 1990's: Trends and Strategies," sponsored by the American College of Hospital Administrators and completed in conjunction with Arthur Andersen & Co. was briefly reviewed. Dr. Knapp reported that Dr. Cooper had served as a respondent to the Delphi questionnaire and did have the opportunity to review the initial questionnaire. Some Board members expressed concern about how some of the questions were asked. For example, concerning whether research and education costs should continue to be financed out of the patient care dollar, it was believed that the two issues should have been separated rather than combined since they are substantially different. Others believe that the questions were worded in such a way as to force an answer in a way which did not really reflect one's views on the subject. There was also some

question as to whether or not in some cases the document sounded like an advocate document rather than a descriptive one. Notwithstanding these concerns, there was general agreement that it was helpful to have a good summary view of the environment in which individual institutions must operate and that the survey was a useful way of doing so.

VIII. JCAH REPORT ON ACADEMIC HEALTH CENTER HOSPITALS

A JCAH internal memorandum from Dr. Roberts to the Accreditation Committee concerning academic health center hospitals was discussed as it appeared in the agenda book. The following points were made in the discussion.

- The tone of the report seems to imply a negative view of external evaluation. However, it was suggested that these institutions, and departments and divisions within them, subject themselves to many evaluation processes. The negative view is specific to the JCAH. It is suggested in the report that because of the high caliber of the practitioners in academic centers and the "fishbowl" nature of the scrutiny placed on these practitioners, competence is constantly under review. Thus, there is a feeling on the part of the JCAH that the view in the academic community is that the JCAH requirement of formalized systems to assess compentence, and specifically the privileged delineation process, is duplicative and unnecessary. It was the consensus on the part of the Board that this did not reflect their view.

- Also expressed in the document is a JCAH view that it is is probably more helpful to tap into the teaching and research processes to judge their effectiveness in monitoring and improving the quality of care rather than requiring a parallel system of quality assurance. This also was not a view that was shared by the Board.

- There was also a discussion of the difference between qualified versus competent, process versus outcome, and the quality of the surveyors as a generalized problem.

In summary the Board felt that there was a stereotyped approach perceived to be the view of the academic community with regard to quality assurance on the part of the JCAH with which the COTH Administrative Board did not agree. It was requested that this report be placed on the agenda once again for review either at the October 29 Administrative Board breakfast or the January 1985 Administrative Board meeting.

IX. MATCHING MEDICAL STUDENTS FOR ADVANCE RESIDENCY POSITIONS

The AAMC recently examined the selection process for specialty residency positions that commence at least one year after graduation (PGY-2). The Council of Academic Societies presented a proposal that all internships (PGY-1) and residency (PGY-2 and beyond) positions be offered only through the National Residency Matching Program (NRMP), rather than the current practice of individual specialties conducting independent matching activities. The proposal also stated that medical schools should not release summary reports of student achievement until October 1 of the senior year.

ACTION: It was moved, seconded, and carried to endorse the resolution as presented. However, it was suggested that the October 1 date for letters of achievement be separated from the NRMP issue so that the matters can be debated separately.

X. REPORT OF THE PROJECT PANEL ON THE GENERAL PROFESSIONAL EDUCATION OF THE PHYSICIAN

The General Professional Education (GPEP) Report entitled "Physicians for the Twenty-First Century" was distributed to the Board for their review and action. Note was made that the Council of Deans wished to revise the recommendation that appeared in the Agenda for Executive Council Meeting.

ACTION: It was moved, seconded, and carried that the COTH Administrative Board support the Council of Deans' revised recommendation which reads as follows:

> The AAMC is indebted to this distinguished panel of educators for its search examination of the challenges facing those preparing physicians for the 21st century. The examination itself has stimulated parallel and collaborative inquiries at both medical schools and undergraduate colleges. This three-year effort has set in motion a process of self-renewal that will be given additional impetus by the publication of the Panel's Report.
>
> It is an extraordinarily useful agendaof issues and the AAMC therefore commends it to its members and to all of those engaged in the enhancement of education for medicine.
>
> We are very hopeful that the report will stimulate a high level of attention and personal commitment by the faculties of member medical schools. In its continuing efforts to assist its member schools in improving the quality of physician education, the AAMC will create a formal mechanism to review the report and to advise on its use in the development of policies and the design of Association programs.

XI. LOW LEVEL RADIOACTIVE WASTE DISPOSAL

Dr. Kennedy and staff reported that the deadline allowing states to deny access for disposal of low level radioactive waste is January 1, 1986. Currently there are only 3 states with approved sites, although the law encourages multi-state compact arrangements. These compacts must be approved by the legislature of each member state. After January 1, compacts can, by law, exclude non-compact states from using their disposal sites.

Suggested AAMC activities to encourge compact formation included: alerting membership to encourage local inititatives, lobby the governors' offices to encourage action, working with the AHA in forwarding this issue to a broader constituency.

Dr. Kennedy also reported on the status of the student loan consolidation for medical school graduates. The Senate will soon consider S. 2491, a bill to reauthorize and revise the expiring consolidation program. The major difference

between House and Senate bills is whether or not the criteria of "need" should be applied to eligibility for consolidation of loans. S. 2491 is consistent with AAMC policy that subsidy be based on documented need.

ACTION: It was moved, seconded, and unamimously approved that the AAMC should suport the position incorporated in S. 2491, using a "needs analysis" for loan consolidation eligibility.

A report on the definition of classified information in Department of Defense regulations and the Department of Commerce's Export Administration Act was briefly presented by Dr. Kennedy for the information of the Board. Focusing on chemistry innovations, the Act could threaten academic freedom. University presidents are currently addressing the issue of possible restrictions of the flow of scientific information that this may present.

XII. MEMBERSHIP APPLICATIONS

Following discussion and appropriate consideration, the following action was taken:

ACTION: It was moved, seconded, and carried to approve:

(1) VETERANS ADMINISTRATION MEDICAL CENTER, Mountain Home, Tennessee for full membership;

(2) BAYFRONT MEDICAL CENTER, St. Petersburg, Florida for corresponding membership.

Dr. Knapp reported that subsequent to the September 13 Action approving Women's Hospital in Las Vegas, Nevada for corresponding membership, it was learned that this hospital is a for-profit institution. This Action is in direct violation of the current AAMC bylaws and Dr. Knapp indicated that he was sending the chief executive of that institution a letter of apology for the failure to more accurately discern the situation, but that current AAMC policy does not permit the participation of investor-owned hospitals in the affairs of the Council of Teaching Hospitals. A copy of that letter is included in these minutes as Appendix D.

XIII. ADJOURNMENT

With no new business, the meeting was adjourned at 12:30pm.

association of american medical colleges

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

(202) 828-0460

September 11, 1984

E. E. Gilbertson
Chairman, Criteria Committee
c/o Michael Guerin
American Hospital Association
840 North Lake Shore Drive
Chicago, Illinois 60611

Dear Mr. Gilbertson:

The purpose of this letter is to respond to your request for a summary of my thoughts on both the future of the health care industry and, in particular, the leadership qualities that will be needed by the next AHA president. I wish to call attention to the enclosed document entitled, "New Challenges for the Council of Teaching Hospitals." The significant major trends facing teaching hospitals and the significant needs of teaching hospitals are set forth. In addition, the advocacy, economic, information, education, and research roles we see on behalf of our teaching hospital constituents are outlined in the report.

There is one matter reviewed in the document to which I believe special attention should be given. On page nine, a list of new hospital organizations competing for national attention is provided. In addition to these hospital organizations, a myriad of physician and other provider organizations are increasing their staff time and attention to issues of concern to the American Hospital Association. The president of the American Hospital Association must have the interest and ability to work with a broad group of private sector organizations, many of which are interested in the same issues. This particular need for an individual who can provide effective linkages to lead to broad consensus is very likely to be increasingly difficult in the competitive environment of the future.

I would hope the individual chosen to succeed Alex McMahon would be sensitive to the following major issues:

- The current competitive environment may very easily result in reducing access to hospital and medical services for those who are unable to pay. Leadership on this issue is vital to the future of our medical care system;
- Basic and clinical research must be supported. Research in the medical sciences has made significant advances in the past two decades, and we must maintain our leadership position in the world;
- A high quality environment for undergraduate and graduate medical education must be maintained;

- o There is a need to understand the interdependent nature of education, clinical research, and the complex services provided in the medical center environment. These institutions must not be viewed as islands apart from the medical care system but rather as the backbone of the medical system;

- o Constant attention must be paid to the relationship between physicians and hospitals as well as other provider organizations. A constructive relationship is vital to providing quality medical services in the future.

Some of my observations are generic, and I know pertain to all segments of the hospital constituency. Others are particularly directed at teaching hospitals. I hope you will consider each of these points as you move ahead in your deliberations. I would be happy to discuss these matters with you if you should so wish.

Sincerely,

John A. D. Cooper

John A. D. Cooper, M.D.

Enclosure

Appendix B

L. DONALD SLAUGHTER, M.D.
Behavioral Toxicology
Internal Medicine
3724 Kimberly Way
Carmichael, California 95608
(916) 486-1825

July 5, 1984

Earl J. Frederick, President
Council of Teaching Hospital Officers, 1982-83
Children's Memorial Hospital
2300 Children's Plaza
Chicago, Illinois 60614

Dear Mr. Frederick:

I am enclosing a copy of a letter to medical school members of the AAMC concerning proposed federal legislation to expand centralized authority over physicians along with a copy of "Anatomy of a Modern Inquisition" to indicate some of the hazards of combining psychiatric propaganda and psychiatric political terrorist tactics with the interstate doctors' credentialling process and network. I believe that it must be especially important to you and your hospital since on the last page of the documentation I have included, there is a copy of a letter addressed to the director of medical education at the Children's Memorial Hospital which is dated August 31, 1976 from Emergency Medical Systems, Inc. of San Francisco and a Dr. Ronald I. Jacoby, M.D.; which was in the Interstate Doctors' Credentialling process and from a member of the interstate doctors' credentialling chain inquiring about me.

Could you explain to me what this Dr. Ronald Jacoby was doing writing to your hospital (Childrens' Memorial Hospital) in Chicago Illinois? How did Dr. Visotsky answer that inquiry? Why did he answer that inquiry six months later? Was I ever affiliated in any way with Childrens' Memorial Hospital? I do know that this same Dr. Ronald Jacoby caused me to lose several non-medical as well as several medical positions with all the economic and other losses and damages associated.

Do you understand or see any danger in a "health care program violation information system" by federal legislation and by further centralization of power in a computer system in Washington, D.C. from which to "sanction physicians nationally"?

Sincerely,

L. Donald Slaughter, M.D.

cc: Mr. Haynes Rice
Mitchell T. Rabkin, M.D.
James W. Bartlett, M.D.
Jeptha W. Dalston, Ph.D.
Spencer Foreman, M.D.
Irvin Goldberg
Sheldon S. King
Glenn R. Mitchell
David A. Reed
John V. Sheeban
C. Thomas Smith
Robert E. Frank
William T. Robinson
Council of Academic Societies

UNIVERSITY OF MINNESOTA
TWIN CITIES

Department of Laboratory Medicine and Pathology
Medical School
Box 198 Mayo Memorial Building
420 Delaware Street S.E.
Minneapolis, Minnesota 55455
(612) 373-8623

August 28, 1984

John A. D. Cooper, M.D., Ph.D., President
Association of American Medical Colleges
Suite 200
One Dupont Circle
Washington, D.C. 20036

Dear John:

The American Physical Therapy Association (APTA) has mandated that as of January 1, 1985, "all accredited baccalaureate degree and postbaccalaureate certificate educational programs for the physical therapist include with their completed self-study a copy of their plan for transition to the first professional degree in physical therapy at the graduate or postbaccalaureate degree level". This is consonate with ATPA's position that, "The degree to be awarded to students who enroll in entry-level education for the physical therapist after December 31, 1990, and satisfactorily complete all requirements shall be the first professional degree in physical therapy and shall be a graduate or postbaccalaureate degree".

I am concerned that the justification for this unilateral action is adequate to warrant this conclusion and that the costs for the education programs are prohibitive.

I urge that the AAMC take a strong position to oppose this move. The timing is particularly crucial since the 1985 date of declaration locks in the decision making process.

Has the Executive Council taken any action on this matter?

Thank you for your attention to this.

Sincerely,

David M. Brown, M.D.
Professor and Dean Designate

DMB:cj

association of american medical colleges

September 24, 1984

Ms. Willa J. Stone
Administrator
Women's Hospital
2025 East Sahara Avenue
Las Vegas, Nevada 89116

Dear Ms. Stone:

On July 11, 1984 I notified you that the COTH Administrative Board and AAMC Executive Council had endorsed Women's Hospital's application for corresponding membership in the Council of Teaching Hospitals (Attachment A). The final step in COTH membership is approval for membership by the AAMC Assembly at its Annual Meeting. Recently, I have learned that Women's Hospital is a for-profit corporation. As stated in the membership application materials sent to you and on the face of the application completed by Women's Hospital (Attachment B), COTH is limited to 501(c)(3) and publicly (i.e., governmentally) owned hospitals. As a for-profit hospital, Women's Hospital is not eligible for membership in COTH, and the application will not be presented to the AAMC Assembly.

I apologize for any misunderstanding this matter may have caused. Because no dues invoice was mailed, no dues have been paid and, thus, there is no need for a refund.

The issue of investor owned hospital participation in the Council of Teaching Hospitals was discussed and debated at the COTH Spring Meeting last May, and will be discussed once again at the institutional membership meeting in Chicago. I've enclosed a copy of the spring meeting program and the Chicago agenda for your review. This issue has also been raised in the attached publication, "New Challenges ..." on page 9.

If there are ways in which we can be helpful to you, I hope you will call upon us. However, I do request that Women's Hospital not identify itself as a member of either the Association of American Medical Colleges or its Council of Teaching hospitals.

Thank you.

Sincerely,

Richard M. Knapp, Ph.D. Director
Department of Teaching Hospitals

RMK/mrl
Attachments

cc: Robert M. Daugherty, Jr., M.D., Ph.D.
Dean, University of Nevada
School of Medicine

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COTH ADMINISTRATIVE BOARD MEETING
October 29, 1984

PRESENT

Haynes Rice, Chairman
Sheldon S. King, Chairman-Elect
Earl J. Frederick, Immediate Past Chairman
J. Robert Buchanan, MD
Jeptha W. Dalston, PhD
Spencer Foreman, MD
Robert E. Frank
Irwin Goldberg
William B. Kerr
Glenn R. Mitchell
Eric B. Munson
David A. Reed
Thomas J. Stranova
William T. Robinson, AHA Representative

ABSENT

C. Thomas Smith

GUESTS

Donald Avant, JCAH
James Roberts, MD, JCAH

STAFF

James D. Bentley, PhD
Richard M. Knapp, PhD
Karen L. Pfordresher
Nancy E. Seline
Melissa H. Wubbold

COTH ADMINISTRATIVE BOARD
Meeting Minutes
October 29, 1984

I. CALL TO ORDER

Mr. Rice called the meeting to order at 7:00am in Room #412 of the Conrad Hilton Hotel in Chicago.

II. CONSIDERATION OF THE MINUTES

ACTION: It was moved, seconded, and carried to approve the minutes of the September 24, 1984 COTH Administrative Board Meeting.

III. INVITATIONAL CONFERENCE CALLED BY THE AMERICAN BOARD OF MEDICAL SPECIALTIES

Dr. Knapp reported that the AAMC had introduced a resolution to amend the bylaws of the American Board of Medical Specialties at its 1984 interim meeting. The amendment would have required that the ABMS approve changes in specialty board certification requirements that lengthen the period of required training or that stipulate requirements that impinge on the training programs of other specialties. The Board was reminded that this resolution resulted from actions taken by all AAMC Administrative Boards and the Executive Council. The resolution, which was supported by the American Hospital Association and endorsed by the Association of Academic Health Centers, was generated in part from the debate stimulated by the American Board of Pathology's announcement that physicians seeking certification in pathology must complete a year of broad clinical training before entering the Pathology Program. Before the meeting of the American Board of Medical Specialties, the leadership of that organization had decided to sponsor an invitational conference on the impact of the certification process on graduate medical education. That being the case, the AAMC was requested to withdraw its resolution. The October 3, 1984 memorandum from the ABMS outlining the details of the conference are included as Appendix A to these minutes. Dr. Knapp suggested that the Board consider the fact that there would be over 50 representatives from the specialty boards and residency review committees, and three individuals who might have overall institutional responsibilites. Following brief discussion, the Board took the following action:

ACTION: The ACGME approved essentials for graduate medical education emphasize the importance of institutional responsibility as a compliment to departmental or program responsibility. The planned ABMS conference on the "impact of the certification process on graduate medical education" has a heavy emphasis at the departmental/program level because invitees include all ABMS members as well as representatives from residency review committees. No comparable representation is provided for the institutional level perspective.

It was therefore moved, seconded, and carried that the COTH Administrative Board requests that the ABMS expand its

invitation list to include a significant number of senior executives from hospitals sponsoring residency programs.

The Chairman requested that Dr. Cooper write a letter reporting this action by the Board to the ABMS. A copy of the letter sent by Dr. Cooper as well as Dr. Langsley's response are attached as Appendix B to these minutes.

IV. THE HOSPITAL FUND

Dr. Knapp reported that a small group of teaching hospital chief executives, stimulated and provided with staff support by the leadership of the Department of Epidemiology and Public Health at Yale University, have been working to establish a short term cash management fund. The fund is to be modeled on the Common Fund, a successful fund exclusively for colleges, universities and independent schools. The Common Fund was extensively described in materials provided in the COTH Administrative Board agenda book. The development of the Hospital Fund is at the stage where it needs approval from the Office of the Comptroller of the Currency. In a draft letter to the Deputy Comptroller, a copy of which appears as Appendix C to these minutes, the applicants proposed to state, "the concept of the Hospital Fund, Inc. was first proposed some months ago by the Department of Epidemiology and Public Health of Yale University in coordination with the leadership of the Council of Teaching Hospitals."

A number of Board members had a variety of questions concerning the proposed Hospital Fund and the issue of whether or not the COTH Administrative Board should endorse it. Among the questions raised were the following:

- Why was the Common Fund successful? Was it the university members or the financial advisors who made the difference?
- Why can't the Common Fund be expanded to include hospitals?
- Why endorse this particular Fund?
- Is there an urgency to endorsing this fund?
- Should we separate endorsement to the Comptroller of the Currency from endorsement to hospitals?

It was agreed that until these questions are satisfactorily addressed no action should be taken. Mr. Rice requested that Drs. Buchanan and Foreman, and Messrs. Goldberg, King, and Smith serve as a committee to explore these questions. It was also agreed that if the group was satisfied, it could speak for the Board and determine what appropriate action should be taken. A conference call concerning this issue was held on November 15. A summary of the call is included as Appendix D to these minutes.

V. NOMINATING COMMITTEE REPORT

The Chairman called on Mr. Frederick, Chairman of the COTH Nominating Committee for his report. Mr. Frederick indicated that there were 21 nominations to the AAMC Assembly for a three-year term and one nomination to the AAMC Assembly for a one-year term. He stated that given the time, there was no need to read those 22 names. He reported the following nominations:

For a single year to fill out an Administrative Board position	Jeptha W. Dalston, PhD University of Michigan Hospitals Ann Arbor
For three three-year terms on the Administrative Board	Robert J. Baker University of Nebraska Hospital and Clinics, Omaha
	Gary Gambuti St. Luke's-Roosevelt Hospital Center, New York
	James J. Mongan, MD Truman Medical Center, Kansas City
For a three-year term on the AAMC Executive Council	William B. Kerr University of California San Francisco

In addition to these nominations, Mr. Rice will become Immediate Past Chairman, Mr. King will become Chairman, and for COTH Chairman-Elect, the Nominating Committee recommended C. Thomas Smith, President, Yale-New Haven Hospital in New Haven, Connecticut. Mr. Frederick indicated that no action was necessary; the Nominating Committee slate would be brought before the COTH Business Meeting later in the day for action.

VI. JOINT COMMISSION ON ACCREDITATION OF HOSPITALS

At its September meeting, the Administrative Board reviewed a JCAH study of hospital accreditation in academic medical centers. A draft letter to Dr. James Roberts of the JCAH conveying the Board's observations was reviewed. (A copy of this letter appears as Appendix E to these minutes.) It was recommended that the Board's position be restated in more positive terms and that the third point in the letter be divided into two separate points; one concerning the quality of JCAH surveyors and another concerning the emphasis on outcome of a process rather than the process itself. A final copy of the letter sent on November 8 appears as Appendix F to these minutes.

Following review of the letter, a discussion ensued concerning the extent to which the JCAH might use teaching and research processes in monitoring and improving the quality of care rather than requiring a parallel system of quality assurance. The matter of peer participation in the survey process rather than paid reviewers was discussed as was the matter of flexibility in the standards. It was also suggested that certain quality assurance events could be scheduled such that the surveyors would be able to participate in them rather than just read the minutes of these events. It was suggested that the surveyors need to "feel" the process as it takes place. At this point in the meeting, James S. Roberts, MD, of the JCAH staff joined the meeting. He also introduced Donald Avant of the JCAH staff.

Dr. Roberts opened his remarks by stating that the reason the study report was undertaken and the report was written was that the JCAH felt that there is an opportunity for private sector accreditors to solidify their position in the

current environment. To do so it was felt that the wholehearted support of the "medical center segment" of the hospital field was needed. He indicated that similar scepticism and criticism have been "aired" by those hospitals under 50 beds. That set of institutions feels that the standards are set for academic medical centers. He indicated that approximately 3,000 surveys are done each year and therefore a balance needs to be struck between survey efficiency, cost, and the quality of the product that is produced for the hospital.

When the review of the standards by medical center representatives was initiated, the JCAH was aware that it was not getting a random review. He indicated that they wanted an honest evaluation and criticism, and therefore they included individuals with whom they were well acquainted and institutions where they had easy access. He indicated that there was criticism of the surveyors and a general feeling that they do not give useful advice to the institutions. However, he indicated that he felt that if the surveyors were perfect, there still would be a problem. He said one thing that came across in the interviews was that the JCAH is asking physicians to do things that they normally do but in ways that make them not want to do them. There have been suggestions that a teaching hospital "peer" be added to the team. He asked what would be expected of this individual and what would be the implication of doing so on those groups who rely on the accreditation process for certification (e.g., Medicare and 40 Medicaid programs).

Lastly, he indicated that there was a definite feeling on the part of those who were interviewed that this is a fine way to keep the government out of the accreditation process but that it is not a very useful process to assist institutional managers and practitioners. In response to Dr. Roberts' presentation, the following observations were made:

- With regard to the "fox in the hen house" point (including a "peer" on the team), the Liaison Committee on Medical Education is almost totally staffed by peer volunteer surveyors, and yet it is approved by the Office of the Commissioner on Education.

- There is a general feeling that the surveyors are finding problems which to our way of thinking seem to be very minor. The addition of a peer to the survey team could guide the team to assure that it identified matters which were pertinent to medical center issues as they relate to quality.

Dr. Foreman called attention to Appendices III and IV of the JCAH report in which the rank order of contingencies was set forth comparing university hospitals with all hospitals. He pointed out the consistencies of these items, particularly in the Appendix which excluded building and grounds items. This matter may suggest that the dissatisfaction that is being expressed is that the list of standards is not up to the task. It may be that the standards need to be reviewed and that an understanding surveyor or a peer on the survey team will provide the answers to the wrong questions. The appropriate question is, "Do the standards we have now have anything to do with the quality of care provided in these institutions?" A large number of individuals in these institutions seem to believe that the standards and the processes for measuring them have very little to do with quality of care. The question then is whether or not an organization like the JCAH can measure the product. In other words, how does one define quality and

can one relate the processes at which we're looking to the quality of the service provided.

Dr. Roberts indicated that in the final analysis, "We ought to be able to look at like services with like standards." Therefore, a different standard or process for measuring the standard would probably not be appropriate. Dr. Roberts thanked the Board for its discussion and indicated that the JCAH intended to proceed further with this issue using a committee the composition of which had been selected from lists submitted by the AAMC and the AAHC. The following individuals will be serving on that committee:

Harry N. Beaty, MD
Dean, Northwestern University
Medical School

Joseph S. Gonella, MD
Dean, Jefferson Medical College of
Thomas Jefferson University

William I. Jenkins
Hospital Administrator
Milwaukee County Medical Complex

Donald G. Kassebaum, MD
Director, University Hospital
Oregon Health Sciences University

Jack M. Layton, MD
Chairman, Department of Pathology
University of Arizona College of Medicine

James S. Roberts, MD
Vice President for Accreditation
Joint Commission on Accreditation
of Hospitals

Paul M. Seebohm, MD
Executive Associate Dean
University of Iowa College of Medicine

David B. Skinner, MD
Chairman, Department of Surgery
University of Chicago Pritzker
School of Medicine

George A Wolf, Jr., MD
Emeritus Professor of Medicine
University of Vermont College of Medicine

James D. Bentley, PhD
Association of American Medical Colleges

On behalf of the Administrative Board Mr. Rice thanked Dr. Roberts and his colleague for joining the Board on such short notice early in the morning.

VII. ADJOURNMENT

Dr. Foreman, on behalf of the Administrative Board, expressed thanks to Chairman Haynes Rice for the wit, skill, and efficiency with which he had lead his colleagues over the past year as they deliberated the many difficult issues before them. The Board concurred with Dr. Foreman and joined him in thanking Mr. Rice. There being no further business, the meeting was adjourned at 9:00am.

AMERICAN BOARD OF MEDICAL SPECIALTIES

One American Plaza, Suite 805 Evanston, Illinois 60201 312/491-9091

October 3, 1984

TO : ABMS Members (Boards and Associate Members)

FROM : Donald G. Langsley, M.D., Executive Vice President

SUBJECT: Invitational Conference on Impact of the Certification Process on Graduate Medical Education

At the request of the Executive Committee, the ABMS Committee on Graduate Medical Education (COGME) consisting of Dr's Laurence Finberg, Robert King, Nicholas Pisacano, Richard Reitemeier and Lawrence Scherr, have organized an invitational conference on Impact of the Certification Process on Graduate Medical Education.

The Conference will take place on Saturday, February 23, 1985 at the O'Hare Westin Hotel in Chicago.

I attach a copy of the program for that Conference.

Each ABMS Member (Boards and Associate Members) will be invited to send one representative to the Conference. Each of the 24 RRC's will also be invited to send one representative to the Conference. We have also invited the AMA to send a representative.

This memo is sent to provide advance notice so that you can select the representative of your board or organization. Please let me know as soon as feasible who that person will be.

At a later time we will send information for those who may require hotel reservations for either Friday or Saturday night.

Donald G. Langsley, M.D.

Attachment:

Program for ABMS

Invitational Conference on Impact of the Certification Process on Graduate Medical Education

Date: Saturday, February 23, 1985 9:30 AM to 4:00 PM

Place: O'Hare Westin Hotel, Chicago

Goal: To discuss the impact of the certification process on graduate medical education in an era of changing economic factors and concern about support of graduate medical education. To discuss various options and recommendations, especially about the role of the specialty boards and the ABMS in setting standards for certification of medical specialists.

Invitees: will be one representative from each board and RRC and each Associate Member of ABMS, a representative of the AMA, the Executive Committee, ACGME Representatives and Chairman of COCERT.

9:30 - 10:00 AM	Keynote speaker. The speaker is presently being identified and is an individual with broad experience in medical education.	
10:00 - 10:30 AM	Economic Impact of certification on GME and its Funding	Eugene Staples
10:30 - 11:00 AM	Value of Standard Setting to the Profession	John A. Benson, Jr, MD
11:00 - 11:30 AM	Is Research Training an Appropriate part of Fellowship Training?	Joseph W. St. Geme, Jr,
11:30 - 12:00 PM	Sharing Autonomy Among Those Concerned with Graduate Medical Education	Thomas B. Ferguson, MD
12:00 - 1:00 PM	Lunch	
1:00 - 2:30 PM	Workshops to develop recommendations and Options	
2:30 - 4:00 PM	Panel Discussion - Plenary Session	

aamc association of american medical colleges

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

(202) 828-0460

November 6 1984

Donald G. Langsley
Executive Vice President
American Board of Medical Specialties
One American Plaza
Suite #805
Evanston, Illinois 60201

Dear Don:

At its meeting on October 29, the Administrative Board of the AAMC Council of Teaching Hospitals was informed about the invitational conference on the impact of the certification process on graduate medical education and reviewed your memorandum of October 3.

Following discussion, the COTH Administrative Board took the following action:

> The ACGME-approved essentials for graduate medical education emphasize the importance of institutional responsibility as a complement to departmental or program responsibility. The planned ABMS conference on the "Impact of the Certification Process on Graduate Medical Education" has a heavy emphasis at the departmental/program level because invitees include all ABMS members as well as representatives from Residency Review Committees. No comparable representation is provided for the institutional level perspective. Therefore, the COTH Administrative Board requests that the ABMS expand its invitation list to include a significant number of senior executives from hospitals sponsoring residency programs.

I believe the COTH Administrative Board has made a very important point, and I urge that you expand the invitation list to include a substantial number of teaching hospital executives.

Sincerely,

John

John A. D. Cooper, M.D.

One Dupont Circle, N. [illegible] igton, D.C. 20036

AMERICAN BOARD OF MEDICAL SPECIALTIES

One American Plaza, Suite 805 Evanston, Illinois 60201 312/491-9091

November 23, 1984

John A. D. Cooper, M.D.
One Dupont Circle, N.W.
Washington, DC 20036

Dear John:

Your letter of November 6 suggesting that the invitation list for the Conference on Impact of the Certification Process on Graduate Medical Education be expanded has received considerable discussion among the group planning the conference and the ABMS officers.

We point out that the purpose of the meeting is to stimulate discussion among the Members of ABMS who would have to agree to any change in the current process in changing certification requirements. We hope to exchange information with the residency review committees and to consider the impact of current pressures on funding graduate medical education. The point of view of teaching hospital executives will certainly be put forth by Eugene Staples and by the representatives of the AHA and AAMC (you may wish to send Bob Heyssel as your representative, though that is your choice). A former ABMS President will discuss the issues of sharing autonomy. We feel that the issues will be set forth in an equitable fashion. Those with whom the suggestion has been discussed felt that expanding the conference with a larger group of teaching hospital executives might be misinterpreted and could well be counter-productive.

Accordingly, we feel that the present list of one representative from each ABMS member would be a more useful group and would not open the ABMS to pressure for multiple representatives from other areas. Let me asssure you that the planning group feels that this is a real effort by ABMS to explore the possibility of sharing autonomy and that we would prefer to avoid even the appearance of counter-productive pressures.

Cordially,

Donald G. Langsley, M.D.
Executive Vice President

DGL/dl/2

cc: William E. Laupus, M.D.

October , 1984

Mr. Dean Miller
Deputy Comptroller for Trusts
Office of the Comptroller
of the Currency
419 L'Enfant Plaza East, S.W.
Washington, D.C. 20219

Dear Mr. Miller:

The Philadelphia National Bank (the "Bank") hereby applies for the written approval of the Comptroller of the Currency under Section 9.18(c)(5) of the Comptroller's Regulations for the establishment and maintenance by the Bank of a common trust fund (the "Common Trust Fund") for certain nonprofit hospitals and hospital associations. The Common Trust Fund is proposed to be established in conjunction with the recent organization of The Hospital Fund, Inc., a new Connecticut nonprofit membership corporation whose members will consist of hospitals and other health care institutions which are exempt from taxation under Section 501(c)(3) of the Internal Revenue Code of 1954, as amended, and hospital associations which are tax-exempt under Section 501(c)(6) of the Code.

The concept of The Hospital Fund, Inc. was first proposed some months ago by representatives of the Department of Epidemology and Public Health of Yale University in coordination with the leadership of the Council of Teaching Hospitals. It came about partly in response to the perceived need for nonprofit hospitals to begin employing more innovative techniques in the management of their finances, as one element of an overall effort to stem the alarming escalation of health care costs in the nation. The results of the preliminary investigations made by members of this Department suggested that an important area in which nonprofit hospitals have generally lagged behind the large proprietary health care organizations has been the efficiency with which they have invested their endowment and other funds.

As a result of these investigations, a group of concerned leaders of the medical-academic community concluded that the investment funds of nonprofit hospitals, unlike those of the large proprietary institutions, are generally invested inefficiently on an individual basis. Based upon these findings

the group has organized a new nonprofit steering organization, The Hospital Fund, Inc., to explore and develop opportunities for its member nonprofit hospitals to improve the returns on their investment portfolios through the use of more effective investment techniques.

The Hospital Fund, Inc. proposes to address the goal of improved efficiency in the investment of the funds of its member nonprofit institutions by entrusting them to a large regional bank with demonstrated trust capability, one which could give these hospitals access they would not otherwise have to a specialized wholesale money-market management tailored to their needs. The Hospital Fund, Inc. approached The Philadelphia National Bank because of its experience of ten years with a comparable fund organized for the collective investment of assets of nonprofit educational institutions.

The Bank has agreed to undertake the investment of the short-term assets of these nonprofit hospitals in its Trust Department. To maximize the prospects for favorable investment returns, the Bank proposes to develop a special trust investment program responsive to the requirements of these hospitals. For added efficiencies, the Bank proposes to invest the funds of the individual member hospitals primarily through a common trust fund of the Bank. In view of the unique nature of the proposal, the Bank has determined to form a new common trust fund exclusively for this program.

For its part, The Hospital Fund, Inc. would serve as an intermediary or liaison with the participating nonprofit hospitals, to represent them in their relationship with the Bank and to advise the Bank concerning their special requirements. Each participating hospital or hospital association would be required to be a member of the corporation and would be charged a modest fee in amount sufficient to defray the corporation's administrative expenses. The corporation would remain nonprofit.

Enclosed are three copies of the proposed "Plan of the Common Trust Fund for Hospitals", designed to create the Common Trust Fund in which the designated assets of the Bank's client nonprofit hospitals would normally be invested. The method of operation of the proposed Common Trust Fund is described generally in the enclosed Plan. It may be noted that the common fund will be accessible only to members of The Hospital Fund, Inc. which have established bona fide trust relationships with

the Bank. As indicated in the Plan, the Common Trust Fund will at all times be invested in assets of high quality and liquidity, such as U.S. government and federal agency securities and prime money-market instruments. Contributions and withdrawals would be permitted daily on the basis of current fair market values calculated daily.

Although the Bank has prepared a prototype form of trust agreement which it would be prepared to enter into with a member nonprofit hospital or hospital association to establish the initial trust relationship with the client institution, the Bank would not insist upon rigid adherence to this or any other standardized form for creating the trust relationship. What would be important for the program is that the client hospital or hospital association be a nonprofit health care institution or association tax-exempt under Section 501(c)(3) or 501(c)(6) of the Internal Revenue Code of 1954, as amended.

The Bank and The Hospital Fund, Inc. anticipate that collective investment of these funds through a common trust fund will be the most efficient way of implementing the program. Accordingly, it is expected that each participating institution will authorize the Bank to invest its funds in this fashion. However, the underlying relationship between the Bank and the client institution will be a traditional trust relationship, and this will require that the decision to invest the funds collectively will not necessarily be automatic. Consequently, when the Bank's fiduciary duties to its client so indicate, the Bank will not hesitate to withdraw the funds from collective investment. We enclose for your information a draft of a form of prototype trust agreement that the member hospitals could use to create the initial trust relationship with the Bank.

One further comment of a general nature. The program described above will not be available, much less promoted, to the general public. Rather, access to it will be strictly limited to nonprofit tax-exempt hospitals and hospital associations which become members of The Hospital Fund, Inc. The program will not be advertised or otherwise promoted by the Bank.

You will note that the Plan conforms in substantially all respects with the requirements of subsection (b) of Section 9.18 of the Comptroller's Regulations applicable to common trust funds generally. Because the fund and its operation will vary in minor respects from the requirements of subsection (b) of Section

9.18, approval is requested to operate the fund under subsection (c)(5) of Section 9.18, which permits funds received or held by a national bank as fiduciary to be invested collectively, to the extent not prohibited by local law, in such other manner as is approved in writing by the Comptroller. We are advised by counsel that the organization and operation of the Common Trust Fund will not be prohibited by Pennsylvania law.

Under Section 9.18(b)(9)(i) of the Comptroller's Regulations, no funds may be invested in a participation in a collective investment fund if as a result of such investment the participant would have an interest aggregating in excess of ten percent of the then market value of the fund. In view of the nature of the investments authorized for the proposed fund and the type of institutions involved, it would be unnecessarily confining to require that the limit of ten percent always be observed. At the outset of a new collective trust fund such as this one, the amounts of short-term funds available to the various participating trusts often vary widely, so much so that it would seem undesirable to limit any one participation to ten percent.

As the membership of The Hospital Fund, Inc. and familiarity with the program both grow in the initial years, it may be expected that the ten percent ceiling will become a norm to be observed in practice most of the time. However, the readily marketable nature of the assets of the fund, which would include highly liquid government securities and similar investments, should afford substantial protection against the potential effects of large and unexpected withdrawals. Moreover, the Plan would specifically authorize the Bank to limit withdrawals in exceptional circumstances when the best interests of the participants require. Thus, we believe that under the circumstances the Comptroller could approve the Plan under subsection (c)(5) of Section 9.18, despite the absence of the customary 10% ceiling, without doing violence to the policies underlying Section 9.18 generally.

Section 9.18(b)(12) of the Comptroller's Regulations requires that a national bank administering a collective investment fund have the exclusive management of the fund, and this requirement would be observed in all fundamental respects in the fund in question. The Bank will exercise exclusive management of the fund. In the management of the portfolio of the Common Trust Fund the Bank would be assisted by its

investment advisory affiliate, Fischer, Francis, Trees & Watts, Inc. ("FFTW"). FFTW is an experienced and well regarded professional money manager with a national reputation for excellence in short-term fixed-income investments, the type of assets in which the Fund would be primarily invested.

FFTW's role would be closely confined by guidelines established and reviewed from time to time by the Bank in consultation with The Hospital Fund, Inc. Furthermore, such individual portfolio transactions as are agreed to by the Bank to be negotiated by FFTW would be subject to constant supervision by responsible Bank trust officers through electronic links between the Bank and FFTW.

In view of the experience gained in the past decade of a working relationship between the Bank and FFTW, and taking into account the Bank's ability to monitor transactions in a timely fashion and direct correcting trades immediately if required, we believe it may fairly be said that the proposed Common Trust Fund will at all times remain under the Bank's exclusive control for Regulation 9 purposes.

If the Comptroller approves the proposed Common Trust Fund, the Plan will be submitted to the Bank's Board of Directors for its approval. Following such approval and formal execution of the Plan, an executed copy of the Plan will be filed with the Comptroller.

Please do not hesitate to call me if you should require further explanation of the proposal before you review the enclosed papers or if otherwise you need any additional information concerning it. If you anticipate that the Comptroller will have difficulty in concurring with the conclusions expressed above, we would appreciate an opportunity to discuss them with you in person at your early convenience. We thank you for your consideration of this matter.

Very truly yours,

association of american medical colleges

MEMORANDUM

November 27, 1984

TO: The Record

FROM: Dick Knapp

SUBJECT: Telephone Conference Call Concerning The Hospital Fund

As recommended at the October 29 COTH Board meeting Drs. Buchanan and Foreman and Messers. Goldberg, King, and Smith were invited to meet by telephone at 11:00 a.m. on November 15 with Bill Kellet, President, The Hospital Fund and Stephen Francis of Fischer, Francis, Trees, and Watts (FFTW) in New York City. FFTW is an investment firm specializing in fixed income securities which would manage The Hospital Fund's investments on a day-to-day basis. Dr. Buchanan and Mr. King were not able to participate; Jim Bentley and I were on the conference call. Mr. Smith served as chairman for the meeting. The memorandum provided to all participants on the call is attached to this memorandum.

Mr. Francis expressed empathy with the Board's caution, understanding the care with which any product might be endorsed, particularly one with which the Board has little, if any, familiarity. In retrospect, he indicated he didn't see the need for an endorsement at this time. The lawyers have subsequently stated that the decision of the Comptroller General must rest on legal grounds. Endorsements would really have no impact.

Mr. Francis further stated the Fund is a commercial enterprise, albeit a worthy one. He recommended the Board continue to withhold judgement, and take no action. Board members at the meeting concurred.

Mr. Kellet suggested an opportunity to present the "product" to the Board would be welcomed and any help in publicizing the initiation and development of the Fund would be appreciated. Mr. Smith suggested an announcement in normal COTH/AAMC communications might be appropriate, but that evaluating products of any type probably is not the best use of the COTH Board's time, and is not the most useful role for the Board. Other Board members concurred.

The telephone conference meeting was adjourned at 11:20 a.m.

One Dupont Circle, N.W./Washington, D.C. 20036 / (202) 828-0400

aamc association of american medical colleges

MEMORANDUM November 6, 1984

TO: J. Robert Buchanan, M.D., Spencer Foreman, M.D., Irwin Goldberg, Sheldon King, C. Thomas Smith

FROM: Dick Knapp

SUBJECT: The Hospital Fund

Attached is another copy of the material from the October 29 COTH Board agenda book concerning THE HOSPITAL FUND. You'll remember that the development of the Fund is at the stage where it needs approval from the Office of the Comptroller of the Currency. In the draft letter to the Deputy Comptroller, the applicants propose to state, "the concept of the Hospital Fund, Inc. was first proposed some months ago by representatives of the Department of Epidemology and Public Health of Yale University in coordination with the leadership of the Council of Teaching Hospitals."

Among the questions raised at the Board meeting on October 29 in Chicago were the following:

- Why was the Common Fund successful? Was it the university members or the financial advisories who made the difference?
- Why can't the Common Fund be expanded to include hospitals?
- Why endorse this particular fund?
- Is there an urgency to endorsing this fund?
- Should we separate endorsement to the comptroller of the currency from endorsement to hospitals?

In order to respond to these as well as other possible questions, a conference call has been arranged at 11:00 a.m., November 15 with Bill Kellet, who would be President of the proposed fund, and Stephen Francis of Fischer, Francis, Trees and Watts in New York City.

Dr. Buchanan and Mr. King will not be able to participate in the conference call. I beleive it would be appropriate for Mr. Smith to chair the session, and I think it would be best to question Messrs. Kellet and Francis, then ask them to absent themselves from the call while the matter is discussed, and a decision reached. Please put this call on your calendar. If you have any further questions, please call me at (202) 828-0490.

One Dupont Circle, N.W./Washington, D.C. 20036 / (202) 828-0400

association of american medical colleges

DRAFT 10/19/84

October 19, 1984

James S. Roberts, M.D.
Vice President for Accreditation
Joint Commission on Accreditation
of Hospitals
875 North Michigan Avenue
Chicago, Illinois 60611

Dear Jim:

At its September 28, meeting, the Administrative Board of the Council of Teaching Hospitals reviewed your June 7 memorandum on accreditation in academic health centers. In its discussion, the Board made three observations:

- The COTH Administrative Board does not share the apparent perceptions of some in academic medicine that the JCAH duplicates other accreditation organizations and is unnecessary because of the internal evaluation activities of the center.

- The COTH Administrative Board does not believe that the hospital's internal process for education and research presently provide an adequate substitute for JCAH quality care standards.

- The COTH Administrative Board does believe that continued efforts need to be made to improve the quality of JCAH surveyors and to have the surveyors emphasize the outcome of a process rather than the process itself.

While the Board will continue to review and study your memorandum to become more fully aware of your findings, both the Board and staff welcome your interest in our members and are pleased that you are proceeding with a committee to explore the role educational/research process could play in JCAH accreditation.

Sincerely,

Richard M. Knapp, Ph.D.
Director
Department of Teaching Hospitals

RMK/mrl

One Dupont Circle, N.W./Washington, D.C. 20036 / (202) 828-0400

association of american medical colleges

November 8, 1984

James S. Roberts, M.D.
Vice President for Accreditation
Joint Commission on Accreditation
of Hospitals
875 North Michigan Avenue
Chicago, Illinois 60611

Dear Jim:

At its September 28 and October 29 meetings, the Administrative Board of the Council of Teaching Hospitals reviewed your June 7 memorandum on accreditation in academic health centers. In its discussion, the Board made these observations:

- The COTH Administrative Board believes that the JCAH does not duplicate other accreditation organizations and its role is not obviated by the internal evaluation activities of the medical center.
- The COTH Administrative Board believes that the hospital's internal process for education and research presently serve a different purpose than the JCAH quality care standards.
- The COTH Administrative Board believes that continued efforts need to be made to improve the quality of JCAH surveyors.
- The COTH Administrative Board believes that continued efforts need to be made to have the surveyors emphasize the outcome of a process rather than the process itself.

While the Board will continue to review and study your memorandum to become more fully aware of your findings, both the Board and staff welcome your interest in our members and are pleased that you are proceeding with a committee to explore the role educational/research process could play in JCAH accreditation.

Sincerely,

Richard M. Knapp, Ph.D.
Director
Department of Teaching Hospitals

RMK/mrl

One Dupont Circle, N.W./Washington, D.C. 20036 / (202) 828-0400

MEMBERSHIP APPLICATIONS

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

HOSPITAL	STAFF RECOMMENDATION
St. Peter's Medical Center New Brunswick, New Jersey	Full Membership
Shadyside Hospital Pittsburgh, Pennsylvania	Full Membership

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: St. Peter's Medical Center

Hospital Address: (Street) 254 Easton Avenue

(City) New Brunswick (State) New Jersey (Zip) 08903

(Area Code)/Telephone Number: (201) 745-8555

Name of Hospital's Chief Executive Officer: Sister Marie de Pazzi, C.S.J.P.

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):	420	Admissions:	23,044
Average Daily Census:	405	Visits: Emergency Room:	38,526
Total Live Births:	3,062	Visits: Outpatient or Clinic:	11,145

B. Financial Data

Total Operating Expenses: $ 48,822,339

Total Payroll Expenses: $ 24,738,945

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: $ 1,842,157 (Residents)
Supervising Faculty: $ 2,649,694 (all physicians)

C. Staffing Data

Number of Personnel: Full-Time: 1151
Part-Time: 498

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 307
With Medical School Faculty Appointments: 289

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

Medicine	Obstetrics/ Gynecology	Pediatrics & Neonatology	Pathology
Emergency Medicine	Surgery	Oncology	Infectious Diseases Pulmonary Medicine Cardiology

Does the hospital have a full-time salaried Director of Medical Education?: NO

. 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	4	4	Required
Surgery	0	0	"
Ob-Gyn	6	6	"
Pediatrics	6	6	"
Family Practice	Periodic 4th year clerks take an elective in Family Medicine		
Psychiatry			
Internal Medicine		5	Elective
Other: Cardiology		18	"
Hema/Onc.		1	"
Med. Oncology		9	"
~~Pediatrics~~		1	"
Maternal Fetal Med.		2	"
Emergency Room		10	"
Orthopaedic Surg.		15	"

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.

Type of Residency[1]	Positions Offered	Positions Filled by U.S. & Canadian Grads	Positions Filled by Foreign Medical Graduates	Date of Initial Accreditation of the Program[2]
First Year Flexible				
Medicine	27	4	23	July 1, 1981
Surgery	7.2	6.2	1	July 1, 1976
Ob-Gyn	7	4	3	July 1, 1977
Pediatrics	19	0	19	July 1, 1975
Family Practice	19	18	1	July 1, 1980
Psychiatry				
Other: Pathology	4	1	3	July 1, 1975
Radiology	1	1	0	July 1, 1984

[1]As 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.

[2]As 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 Medicine & Dentistry of N.J. RUTGERS MEDICAL SCHOOL

Dean of Affiliated Medical School: Richard C. Reynolds, M.D.

Information Submitted by: (Name) Frank M. Coe

(Title) Executive Vice President

Signature of Hospital's Chief Executive Officer:

Sr Marie de Pazzi (Date) November 30, 1984

Sister Marie de Pazzi, C.S.J.P.
President

UNIVERSITY OF MEDICINE AND DENTISTRY OF NEW JERSEY

RUTGERS MEDICAL SCHOOL

Busch Campus
Piscataway, New Jersey 08854

RECEIVED
NOV 1 1984

October 30, 1984

Sister Marie dePazzi, C.S.J.P.
President
St. Peter's Medical Center
New Brunswick, NJ 08903

Dear Sister de Pazzi:

I am pleased that St. Peter's Medical Center is planning to submit an application for membership on the Council of Teaching Hospitals. St. Peter's Medical Center is a teaching hospital and plays an important part in carrying out the education msisions of the University of Medicine and Dentistry of New Jersey-Rutgers Medical School.

St. Peter's Medical Center is a major affiliated teaching hospital of Rutgers Medical School. In the fall of 1984 there are currently 84 residents working at St. Peter's Medical center who are part of the medical school's residency programs. There are 27 residents in medicine, 19 in pediatrics, 7 in ob/gyn, 7 in orthopedics, 4 in pathology, 19 in family medicine, and one in radiology.

St. Peter's also serves as an important educational resource for third year medical students. There are always assigned to St. Peter's 11 students for third year medical clerkships and six students each in pediatrics and ob/gyn for obligatory third year clerkships. In addition, a variable number of fourth year students take electives at St. Peter's Medical Center.

Over the past several years, St. Peter's has played an evolving and ever-increasing role in medical education activities in association with Rutgers Medical School. St. Peter's contributes to faculty support, particularly in thos programs where student and resident activity takes place at St. Peter's Medical Center. St. Peter's is a vitally important hospital to meet the educational needs of Rutgers Medical School.

I strongly support the recognition of St. Peter's Medical Center as a member of the Council of Teaching Hospitals.

Sincerely,

Richard C. Reynolds

Richard C. Reynolds, M.D.
Dean

ehs

DEC 06 1984

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: SHADYSIDE HOSPITAL

Hospital Address: (Street) 5230 CENTRE AVENUE

(City) PITTSBURGH (State) PA (Zip) 15232

(Area Code)/Telephone Number: (412) 622-2121

Name of Hospital's Chief Executive Officer: CLIFFORD M. LEBO

Title of Hospital's Chief Executive Officer: PRESIDENT/CHIEF EXECUTIVE OFFICER

II. HOSPITAL OPERATING DATA (for the most recently completed fiscal year) (1983-84)

A. Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn):	464	Admissions:	16,231
Average Daily Census:	390	Visits: Emergency Room:	23,025
Total Live Births:	504	Visits: Outpatient or Clinic:	100,018

B. Financial Data

Total Operating Expenses: $ 68,239,563

Total Payroll Expenses: $ 39,982,710

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: $ 1,513,938
Supervising Faculty: $ 812,850

C. Staffing Data

Number of Personnel: Full-Time: 1457
Part-Time: 258

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 209
With Medical School Faculty Appointments: 110

Clinical Services with Full-Time Salaried ~~Chiefs of Service~~ (list services): (Directors of Clinical Service Depts.)

MEDICINE ANESTHESIOLOGY PATHOLOGY

SURGERY EMERGENCY MEDICINE

Does the hospital have a full-time salaried Director of Medical Education?: yes, William M. Cooper, M.D.

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:

Clinical Services Providing Clerkships	Number of Clerkships Offered	Number of Students Taking Clerkships	Are Clerkships Elective or Required
Medicine	varies	25	Elective
Surgery	2	0	Elective
Ob-Gyn	-	-	-
Pediatrics	-	-	-
Family Practice	18	18	Elective
Psychiatry	-	-	-
Other: Radiology	1	1	Elective
Anesthesiology	2	2	1-Elective, 1-Required

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.

Type of Residency[1]	Positions Offered	Positions Filled by U.S. & Canadian Grads	Positions Filled by Foreign Medical Graduates	Date of Initial Accreditation of the Program[2]
First Year Flexible	6	4	2	Sept. 1982
Medicine	20	5	15	Febr. 1963
Surgery				
Ob-Gyn				
Pediatrics				
Family Practice	19	19	0	Oct. 1970
Psychiatry				
Other: Pathology	6	0	6	May, 1955
Cardiology Fellowship	3	0	3	n/a
Gastroenterology Fellowship	1	0	1	n/a
**Diagnostic Radiology	5 FTE	5	0	Nov. 1973
**Anesthesiology	1 FTE	1	0	Nov. 1962
TOTALS	61	34	27*	

[1]As 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.

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

Programs of the Hospitals of the University of Pittsburgh which we are affiliated with.

The institution has made a decision to limit the number of foreign medical graduates in all of the training programs.

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 Pittsburgh, School of Medicine

Dean of Affiliated Medical School: Thomas Detre, M.D.

Information Submitted by: (Name) William M. Cooper, M.D.

(Title) Director, Medical Education

Signature of Hospital's Chief Executive Officer:

_____ (Date) 11/30/84

Clifford M. Lebo, President

University of Pittsburgh

SCHOOL OF MEDICINE
Office of the Dean

October 26, 1984

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

Dear Dr. Knapp:

It is my pleasure to endorse most enthusiastically the application of Shadyside Hospital for membership in the Council of Teaching Hospitals.

Shadyside Hospital has long been affiliated with the University of Pittsburgh School of Medicine. A study conducted by the Office of the Dean in 1977 documented the existence of active student clerkships in anesthesiology, primary care, community medicine, otolaryngology and surgery, as well as the teaching of physical diagnosis in that institution. Currently, I can confirm that more than fifty medical students will receive a portion of their clinical education at Shadyside Hospital during this academic year in medicine, pathology, surgery, radiology, community medicine, anesthesiology, emergency medicine and neurology, and in the second-year course in physical diagnosis.

Since 1977, relationships between the School of Medicine and Shadyside Hospital have developed further with the addition of links in graduate medical education. Our Department of Radiology established a part of its formal teaching program with Shadyside Hospital in 1978 and received approval from the Accreditation Council for Graduate Medical Education in that same year. Presently five full-time equivalent residents receive an integral part of their postgraduate training there annually on a rotational basis.

The School's Department of Community Medicine, through its Division of Family Medicine, began a formal arrangement for shared teaching of family practice residents at Shadyside Hospital in 1983. A copy of that affiliation agreement which spells out the details of responsibilities for each party is enclosed.

The Department of Anesthesiology has also initiated a tie with Shadyside Hospital. This effort consists of a pilot project in residency training in anesthesiology that at present involves 1.5 full-time resident equivalents.

SCAIFE HALL, 3550 TERRACE STREET, PITTSBU

In all, we now have in place a series of strong, mutually supported teaching and training endeavors with Shadyside Hospital. The Hospital plays a large and valuable role as an important resource for this medical school in carrying out its mission. The emphasis by both parties is clearly on medical education at several levels within our first professional degree curriculum, and also on graduates who are pursuing clinical specialty training. Through these joint activities, Shadyside Hospital has achieved a major, supportive and essential place in the programs of the School of Medicine.

Sincerely,

Thomas Detre, M.D.

Thomas Detre, M.D.
Interim Dean

TD/bkk

Enclosure

cc: Dr. William M. Cooper

aamc association of american medical colleges

January 7, 1985

John C. Gaffney
Executive Director
Saint Joseph Hospital
601 North 30th Street
Omaha, Nebraska 68131

Dear John:

I have your letter of December 10 confirming the November 19 merger of the St. Joseph Hospital into the American Medical International organization. With regard to investor-owned hospital participation in the Council of Teaching Hospitals, your understanding is correct. Section 1. of the AAMC bylaws under the membership heading reads as follows:

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

Any change in the AAMC bylaws requires action by the AAMC Assembly, which is the delegate body of the AAMC and meets during the fall AAMC Annual Meeting.

The subject of investor-owned hospital participation has been and will continue to be debated and discussed in governance bodies of the AAMC.

Until such time as a firm policy decision is reached, we will continue to include St. Joseph Hospital as a member of the Council of Teaching Hospitals.

Sincerely,

Richard M. Knapp, PhD
Director
Department of Teaching Hospitals

RMK/mhw

P.O. 20036 / (202) 828-0400

Saint Joseph Hospital

life...is our business

601 North 30th Street ■ Omaha, Nebraska 68131-2197
402/449-4000

December 10, 1984

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

Dear Dick:

As you are aware, Saint Joseph Hospital and American Medical International have had ongoing discussions about the potential merger of our hospital into the AMI organization. On November 19, this merger was accomplished.

As I understand the COTH bylaws, they preclude an investor-owned hospital being a member. We are respectfully requesting that the Saint Joseph Hospital membership under AMI be continued. This will undoubtedly necessitate a bylaws change for the Council of Teaching Hospitals.

Dick, as I mentioned to you before, it is the intention of AMI and certainly the management of Saint Joseph Hospital to continue to be the primary teaching facility for the health science schools of Creighton University. The necessary contractual commitments between the hospital and AMI are in place to insure our continued role as an academic medical center. We hope the Board of Directors of the Council of Teaching Hospitals will look favorably upon our request for a bylaws change.

I look forward to hearing from you soon.

Sincerely,

John C. Gaffney
Executive Director

JCG/ls

cc: Dr. O'Brien
Creighton University

CREIGHTON
UNIVERSITY

Vice President
For Health Sciences

December 14, 1984

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

Dear Dick:

As you know Creighton University's interest and involvement with the AAMC and the Council of Teaching Hospitals is very important to us. I am aware that the recent acquisition of St. Joseph Hospital, our primary teaching hospital and a member of COTH, by American Medical International jeopardizes its membership in COTH. I am also aware that John Gaffney has written to you requesting that St. Joseph Hospital's membership be continued. I wish to endorse this request and to urge strongly that COTH take whatever steps are necessary to revise its by-laws so that we may continue to participate in COTH affairs.

I believe it important for the Council of Teaching Hospitals to recognize that St. Joseph is going to continue to function as a full-service teaching hospital dedicated to all the health science schools of Creighton University and that AMI has made a very strong commitment to enhance the teaching programs conducted at and supported by the Hospital. To exclude St. Joseph from membership simply because it is investor-owned seems to me to be basing membership on an irrelevant factor. Surely the standard for judging a teaching hospital, and its membership in the most important organization of teaching hospitals, should be how well it defines and attains its educational goals, not who owns it.

You may be assured that AMI will continue in its educational mission because of the contractual relationships it has with the Creighton Omaha Regional HealthCare Corp., from whom it acquired the hospital, and the affiliation agreements with Creighton University and the Boys Town National Institute. AMI has not only made their voluntary commitment to our academic missions, but it has contractually agreed to it in legally binding documents.

I sincerely hope that the Council of Teaching Hospitals will find it possible to accommodate St. Joseph and will be able to affect the appropriate change in its by-laws.

If I can help you in this matter in any way, please let me know.

Sincerely yours,

Dick

RICHARD L. O'BRIEN, M.D.
Acting Vice President for
Health Sciences and Dean,
School of Medicine

RLO/sn

California at 24th Street Omaha, Nebrask (402) 280-2973 Telex: 910-622-9287

INSTITUTIONS HAVING DROPPED MEMBERSHIP IN THE COUNCIL OF TEACHING HOSPITALS, 1980-84

1. Rancho Los Amigos Hospital, Downey, CA - 1980
2. McLean Hospital, Belmont, MA - 1980
3. Gorgas Hospital, Ancon, Canal Zone - 1980
4. Children's Hospital of Philadelphia, Philadelphia, PA - 1980
5. Greater SE Community Hospital (Corresponding) Washington, DC - 1980
6. Health Sciences Center Hospital, Lubbock, TX - 1980
7. Beckley Appalachian Regional Hospital (Corresponding), Beckley, WV - 1981
8. St. Thomas Hospital, Nashville, TN - 1981
9. Lutheran Medical Center, Brooklyn, NY - 1981
10. The Queen's Medical Center, Honolulu, HI - 1982
11. Veterans Administration Medical Center, Salt Lake City, UT - 1982
12. Prince George's General Hospital, Cheverly, MD - 1982
13. Abbott-Northwestern Hospital (Corresponding), Minneapolis, MN - 1982
14. Methodist Hospital of Illinois (Corresponding), Peoria, IL - 1982
15. Ball Memorial Hospital, Muncie, IN - 1982
16. Martin Luther King Jr. General Hospital, Los Angeles, CA - 1982
17. Mayaguez Medical Center, Mayaguez, PR - 1982
18. Schwabb Rehabilitation Center, Chicago, IL - 1982
19. The Jewish Hospital and Medical Center of Brooklyn, Brooklyn, NY - 1983
20. University of Louisville Hospital, Louisville, KY - 1983
21. Veterans Administration Medical Center, Kansas City, MO - 1983
22. LDS Hospital, Salt Lake City, UT - 1983
23. Orthopedic Hospital, Los Angeles, CA - 1983
24. Worcester City Hospital, Worcester, MA - 1984
25. Veterans Administration Medical Center, Clarksburg, WV - 1984

26. Jewish Hospital, Louisville, KY - 1984.

27. Lubbock General Hospital, Lubbock, TX - 1984

28. Memorial Hospital (Corresponding), Chattanooga, TN - 1984

29. Little Company of Mary Hospital (Corresponding), Evergreen Park, IL - 1984

30. Community Hospital of Indianapolis, Inc. (Corresponding), Indianapolis, IN - 1984

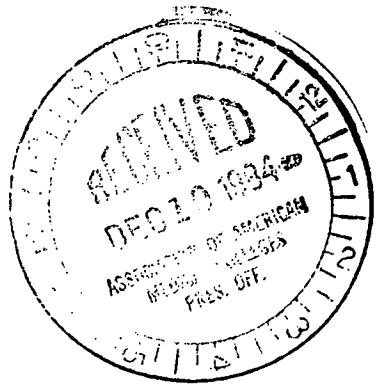
31. The Community Hospital of Springfield (Corresponding), Springfield, OH - 1984

JCAH

Joint Commission on Accreditation of Hospitals
875 North Michigan Avenue
Chicago, Illinois 60611
312/642-6061

John E. Affeldt, MD
President

December 6, 1984



John A. Cooper, M.D., Ph.D.
President
Association of American
Medical Colleges
Suite 200
1 Dupont Circle NW
Washington, DC 20036

Dear Dr. Cooper

The purpose of this letter is to request your assistance in identifying potential candidates for the position of President of the Joint Commission on Accreditation of Hospitals (JCAH). Dr. John E. Affeldt has recently announced his intention to retire from the JCAH by August 1986. During his tenure, Dr. Affeldt has served the JCAH with distinction and is an example of the type of person that we are seeking your assistance in finding.

The Board of Commissioners of the JCAH recently appointed a Search Committee to solicit potential candidates and to nominate a successor to the Board. The Committee would appreciate your forwarding any suggested recommendations to C. S. Lewis, Jr., M.D., Chairman, JCAH Search Committee, P.O. Box 148069, Chicago, Illinois 60614.

The Bylaws of the JCAH mandate that the President be a qualified doctor of medicine. The position requires past expertise and an excellent record in management experience and results. Individuals nominated should have an understanding of and dedication to quality health care and accreditation as well as a respected national stature throughout the health care industry.

The JCAH President reports to the Board of Commissioners, which is composed of 21 Commissioners appointed to the JCAH by the member organizations and one Commissioner who is appointed by the Board to serve as the public member. In addition to the 22 Commissioners, the five chief executive officers of the member organizations have the right to attend meetings of the Board with the privilege of the floor.

JCAH currently serves three primary functions: 1) to develop and continually refine standards for accreditation that reflect national consensus consistent with the current state-of-the-art; 2) to conduct surveys of facilities and programs to measure and encourage their compliance with these standards, and in recognition of substantial conformance, to award certificates of accreditation; and 3) to provide educational programs and publications to enhance understanding and utilization of the accreditation methodology.

The scope of JCAH extends to hospitals, psychiatric facilities, long term care facilities, ambulatory health care organizations, and hospices. It is desirable, although not a requirement, that candidates have expertise in two or more of these areas. In addition, it is important that candidates possess the vision and creativity necessary to lead the JCAH through this period of evolving changes in the health care industry. It is critical that the candidate have excellent negotiating skills and the capability to achieve consensus in a positive and constructive manner. Excellent management skills are also imperative. Candidates should be capable of serving as articulate spokesmen for JCAH in working relationships with leaders of government, business and major health care organizations in the country.

The Search Committee appreciates any assistance you can provide in this important endeavor. Your recommendations will be held in confidence. We would like to have your nomination by March 15, 1985.

Yours sincerely,

C. S. Lewis

C. S. Lewis, Jr., M.D.
Chairman, Search Committee

association of american medical colleges

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

January 3, 1985

(202) 828-0460

C. S. Lewis, Jr., M.D.
Chairman, Search Committee
Joint Commission on Accreditation
of Hospitals
P.O. Box 148069
Chicago, Illinois 60614

Dear Dr. Lewis:

I apologize for not responding more promptly to your letter inviting assistance in identifying candidates to replace John Affeldt as President of the Joint Comission on Accreditationof Hospitals. The holidays and my absence from the office have been responsible for the delay.

We have assembled some names but would like to discuss them with the Administrative Board of the Council of Teaching Hospitals at its meeting on January 25. This method will permit us to get broader input on potential candidates, and we can still meet your deadline of March 15.

Sincerely,

John A. D. Cooper

John A. D. Cooper, M.D.

bcc: Dr. Knapp (with incoming)

One Dupont Circle, N.W., Suite 200, Washington, D.C. 20036

INVESTOR OWNED TEACHING HOSPITAL MEMBERSHIP IN THE COUNCIL OF TEACHING HOSPITALS

The attached letter from John Gaffney, Executive Director, St. Joseph Hospital in Omaha directly raises the issue of investor owned hospital participation in COTH/AAMC. Under the current rules for determining membership in the Council of Teaching Hospitals, a hospital must qualify as a public hospital or a not-for-profit institution. Thus, hospitals owned or leased by investor owned corporations such as Humana Hospital University (leased) and St. Joseph Hospital in Omaha (recently acquired by AMI) are excluded from membership in COTH. Hospitals managed by an investor owned corporation, such as the hospital of the University of Mississippi and the University of Medicine and Dentistry of New Jersey, are eligible to continue membership. Those attending the COTH Spring Meeting in Baltimore this past May heard descriptions of the situations at the University of Louisville, McLean Hospital in Boston, and The George Washington University Hospital. The matter of investor owned hospital membership in COTH was discussed at the Baltimore Spring Meeting, and once again, at the request of the COTH Administrative Board, at the COTH Business Meeting this past November. The following points were made in these discussions (the attached letter from John Ives, Executive Vice President, Shands Hospital, is an excellent example of a thoughtful COTH constituent viewpoint.):

- The arguments for participation of investor owned hospitals in COTH are logical and to some degree persuasive. However, there are strong and emotional views on each side of the issue that need to be considered;
- Inviting investor owned hospital participation could be a very divisive move at this point since there is not clear consensus in the COTH constituency;
- Inviting such organizations to participate would be one more step toward legitimizing them as an acceptable and productive component of the health care industry;
- Bringing for-profit institutions into the COTH would dilute the ability of the organization to develop the type of public perception necessary for effective advocacy in public policy forums;
- One of the objectives of COTH is information sharing among member hospitals. Investor owned organizations are reluctant to share basic data and information, particularly concerning financial matters;
- Is the purpose of COTH to bring together teaching hospitals or those with common profit missions? In other words, should ownership be a factor in COTH membership;
- If an organization supports our goals and is interested in participation, perhaps it should be given the opportunity to do so;
- If these investor owned hospitals are not invited to participate another organization could develop representing teaching hospitals; and

- The principal teaching hospitals at which two medical schools (Louisville and Creighton) conduct their undergraduate medical education programs are not eligible for membership. Others may soon follow a similar pattern.

Application of current policy is represented by the letter of September 24 to the Women's Hospital in Las Vegas. Also attached is a letter from Association counsel relating to membership of such hospitals in the AAMC.

Questions for Discussion:

1. Is it appropriate for the COTH/AAMC to represent broadly the community of medical education, and yet exclude some organizations participating in medical education because of their ownership status?

2. Are there other positive or negative points that need to be raised in the debate?

3. What is the process the Board would recommend to address and reach a conclusion on this issue?

Saint Joseph Hospital

Life...is our business

601 North 30th Street ■ Omaha, Nebraska 68131-2197
402/449-4000

December 10, 1984

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

Dear Dick:

As you are aware, Saint Joseph Hospital and American Medical International have had ongoing discussions about the potential merger of our hospital into the AMI organization. On November 19, this merger was accomplished.

As I understand the COTH bylaws, they preclude an investor-owned hospital being a member. We are respectfully requesting that the Saint Joseph Hospital membership under AMI be continued. This will undoubtedly necessitate a bylaws change for the Council of Teaching Hospitals.

Dick, as I mentioned to you before, it is the intention of AMI and certainly the management of Saint Joseph Hospital to continue to be the primary teaching facility for the health science schools of Creighton University. The necessary contractual commitments between the hospital and AMI are in place to insure our continued role as an academic medical center. We hope the Board of Directors of the Council of Teaching Hospitals will look favorably upon our request for a bylaws change.

I look forward to hearing from you soon.

Sincerely,

John C. Gaffney
Executive Director

JCG/ls

cc: Dr. O'Brien
Creighton University

CREIGHTON
UNIVERSITY

Vice President
For Health Sciences

December 14, 1984

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

Dear Dick:

As you know Creighton University's interest and involvement with the AAMC and the Council of Teaching Hospitals is very important to us. I am aware that the recent acquisition of St. Joseph Hospital, our primary teaching hospital and a member of COTH, by American Medical International jeopardizes its membership in COTH. I am also aware that John Gaffney has written to you requesting that St. Joseph Hospital's membership be continued. I wish to endorse this request and to urge strongly that COTH take whatever steps are necessary to revise its by-laws so that we may continue to participate in COTH affairs.

I believe it important for the Council of Teaching Hospitals to recognize that St. Joseph is going to continue to function as a full-service teaching hospital dedicated to all the health science schools of Creighton University and that AMI has made a very strong commitment to enhance the teaching programs conducted at and supported by the Hospital. To exclude St. Joseph from membership simply because it is investor-owned seems to me to be basing membership on an irrelevant factor. Surely the standard for judging a teaching hospital, and its membership in the most important organization of teaching hospitals, should be how well it defines and attains its educational goals, not who owns it.

You may be assured that AMI will continue in its educational mission because of the contractual relationships it has with the Creighton Omaha Regional HealthCare Corp., from whom it acquired the hospital, and the affiliation agreements with Creighton University and the Boys Town National Institute. AMI has not only made their voluntary commitment to our academic missions, but it has contractually agreed to it in legally binding documents.

I sincerely hope that the Council of Teaching Hospitals will find it possible to accommodate St. Joseph and will be able to affect the appropriate change in its by-laws.

If I can help you in this matter in any way, please let me know.

Sincerely yours,

Dick

RICHARD L. O'BRIEN, M.D.
Acting Vice President for
Health Sciences and Dean,
School of Medicine

RLO/sn

California at 24th Street Omaha, Nebras (402) 280-2973 Telex: 910-622-9287

SHANDS HOSPITAL
at the University of Florida
Gainesville, Florida 32610

John E. Ives
Executive Vice President
Box J-326
(904) 392-3771

November 6, 1984

Mr. Sheldon King
Executive Vice President
Stanford University
Stanford, California 94305

Dear Sheldon:

I have thought more about the short discussion at the COTH meeting regarding membership of investor-owned hospitals as members of the AAMC and COTH. I am putting my view of the matter in writing as there are a couple of other points I wish to make beyond those I made at the meeting.

First, I had a question in my mind as to whether a not-for-profit 501(c)(3) or 501(c)(6) organization could have for-profit members. This question has been researched for the Florida Hospital Association in the past. A discussion with the President of that organization discloses that their best legal advice regarding the tax situation is that there is no threat to their not-for-profit status as a result of having for-profit members.

One way of looking at this question is to look at the way many of us perceive the AAMC/COTH mission. I for one, and I think others agree, see the mission as educational, the dissemination of information to the membership, and representation with the federal government and other agencies.

If we agree on the above and look at the three areas, I can explain some of my questions about having investor-owned hospitals as members.

With regard to education, I would find their participation in educational activities of the COTH perfectly acceptable, as most of the activities deal with matters that are not controversial between for-profits and not-for-profits. In this arena, the viewpoint of the for-profits might occasionally be useful.

On the matter of dissemination of information, I would make several different points. The first point is that much of the information which is disseminated by COTH is information collected from its membership. Our experience in Florida is that the information which will be proffered on a voluntary

basis by the for-profits is limited. Historically, they do not like to provide basic information about the finances or other material regarding their operations which might offer others a competitive advantage. It is clear that some of this reluctance is mitigated by the fact that Medicare cost reports are public documents and, in our case, state reports required by cost containment boards and other such state agencies are also public information. I do not know how this lack of response would affect the ability of COTH to respond to its membership's desire for information regarding fellow members.

Many of us see the most important present activity of the COTH as representation with the federal government. Some of us have been concerned with the already diverse membership that the COTH is trying to represent. It is clear that the community teaching hospital's needs, desires, and wants vis-a-vis the federal government are often at odds with the needs, wants, and desires of the university teaching hospitals. Some of us feel that the needs of the university teaching hospitals are being subordinated to the larger membership of community hospitals. Whether this is the case or not is not terribly important, as that is the perception. It seems to many of us who have observed associations which serve both profit and not-for-profit hospitals that this representation tends to be very weak and often presents the association in a light which is unfavorable to all. It is simply impossible on many occasions to represent those who have profit as a primary motive and those who have other missions, such as education and service, as a primary motive. Legislators are quick to perceive the weakness in the arguments of those who attempt to represent both and, as a result, over time, tend to disregard or even hold with some contempt the individuals and views representing and represented by those organizations.

There will be a percentage of so-called university teaching hospitals which are owned by for-profit companies. This number will increase over the number that we see today. Personally, I do not believe that a majority of the teaching hospitals will be included, but a significant number may. Therefore, I do not believe that we should hide our heads in the sand about these hospitals. However, I also believe that there is no rush to welcome with open arms these institutions which have chosen to sell to investor-owned chains. We have time to wait to see what direction they take. I do not believe that the association will lose influence over the near term if it does not accept these members. I believe that to defer any change would enable us to get a clearer picture of what is going to happen, and perhaps give us a clearer impression of what we ought to do.

I have three other random thoughts bearing on this subject, one of which is that the College of Medicine associated with these institutions is already a member of the AAMC and most of the correspondence from the AAMC is addressed to at least the Dean. As a result, the Dean can share whatever information is sent with the Hospital Director.

Dick Knapp has proposed the possibility of a corresponding membership for these institutions, one which would allow them to be on mailing lists, allow them to participate in certain activities, but would not afford them a seat at the table (a vote). I would assume that if such a membership were offered it would be with a clear understanding that representation of that institution with the federal government and others would not be included as part of the arrangement. This should not be a problem as they all have their strong lobbyists in Washington already.

Finally, I believe that the perception that there were "ten votes for, ten votes against, and 300 people who did not understand the question" is accurate. Most of the country has not been involved with the for-profit hospitals, particularly the large chains. They tend to prevail across the south; therefore, a large number of our members have not had any opportunity to learn what they are about, to understand their mode of operation, or to really clearly have exposed to them the goals of these for-profit institutions. If I am correct in this thought, it will be very difficult for the COTH to come to any real conclusion regarding this matter until there is further exposure, which might argue for my suggestion that we do nothing at the present time.

Sincerely yours,

John E. Ives
Executive Vice President

JEI:nh

cc: Richard M. Knapp, Ph.D.
Mr. Robert Baker

association of american medical colleges

September 24, 1984

Ms. Willa J. Stone
Administrator
Women's Hospital
2025 East Sahara Avenue
Las Vegas, Nevada 89116

Dear Ms. Stone:

On July 11, 1984 I notified you that the COTH Administrative Board and AAMC Executive Council had endorsed Women's Hospital's application for corresponding membership in the Council of Teaching Hospitals (Attachment A). The final step in COTH membership is approval for membership by the AAMC Assembly at its Annual Meeting. Recently, I have learned that Women's Hospital is a for-profit corporation. As stated in the membership application materials sent to you and on the face of the application completed by Women's Hospital (Attachment B), COTH is limited to 501(c)(3) and publicly (i.e., governmentally) owned hospitals. As a for-profit hospital, Women's Hospital is not eligible for membership in COTH, and the application will not be presented to the AAMC Assembly.

I apologize for any misunderstanding this matter may have caused. Because no dues invoice was mailed, no dues have been paid and, thus, there is no need for a refund.

The issue of investor owned hospital participation in the Council of Teaching Hospitals was discussed and debated at the COTH Spring Meeting last May, and will be discussed once again at the institutional membership meeting in Chicago. I've enclosed a copy of the spring meeting program and the Chicago agenda for your review. This issue has also been raised in the attached publication, "New Challenges ..." on page 9.

If there are ways in which we can be helpful to you, I hope you will call upon us. However, I do request that Women's Hospital not identify itself as a member of either the Association of American Medical Colleges or its Council of Teaching hospitals.

Thank you.

Sincerely,

Richard M. Knapp, Ph.D. Director
Department of Teaching Hospitals

RMK/mrl
Attachments

cc: Robert M. Daugherty, Jr., M.D., Ph.D.
Dean, University of Nevada
School of Medicine

WILLIAMS, MYERS AND QUIGGLE
ATTORNEYS AND COUNSELORS AT LAW
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AREA CODE 202-333-8900

ROBERT HOLT MYERS
JOHN HOLT MYERS
JAMES W QUIGGLE
S CHURCHILL ELMORE
JOE L OPPENHEIMER
ROBERT O TYLER
THOMAS ARDEN ROHA
MARC E ALBERT

SUSAN L FLAHERTY

WILLIAM M V
1892-1931
EDMUND B C
1892-1933
PAUL FORBES
1892-1965

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

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: _____

By: _____

PROPOSAL TO STUDY RESIDENCY STAFFING

A year ago, Jack Kasten and Barry Decker, M.D. of Arthur D. Little met with Dick Knapp and Jim Bentley to discuss an AD Little proposal to develop a "housestaff productivity reporting system." As designed, the study would have involved at least 30 COTH hospitals in a multi-year study comparing assigned residents with clinical service workload. Because Knapp and Bentley were lukewarm about the study and they did not perceive a distinct member interest in the topic, no further action was taken.

During the past year, at least four COTH members and one medical school have expressed an interest in collecting and comparing resident staffing data. As a result and with a strong interest from one hospital's chief of staff, Jim Bentley met again with Jack Kasten on April 5. Following that discussion, and in response to specific suggestions to conceptualize the study as a one year pilot with 6-10 participating hospitals, Mr. Kasten submitted the attached proposal and business plan.

Staff request that Board members review the AD Little proposal and discuss the following recommendations:

- o if at least six hospitals (from the list of 116 where medical school chairmen are hospital chiefs) agree to participate in a one year pilot, the AAMC should contract with AD Little to undertake the study;
- o participating hospitals should support the study on an "equal share basis" the costs of the study, excluding the costs of AAMC staff time and AAMC staff travel; and
- o AAMC staff should participate in the initial project meeting, each of the hospital site visits, and the final study meeting.

Acorn Park
Cambridge, Massachusetts 02140
617 864-5770 Telex 921436

Arthur D Little Inc

December 14, 1984

Mr. James Bentley
Association of American
Medical Colleges
Suite 200
One DuPont Circle, N.W.
Washington, D.C. 20036

Dear Mr. Bentley: ADL Reference 1-7006

It was a pleasure to meet with you to discuss the proposed study of resident staffing patterns in major teaching hospitals. As you know, we have been interested in the development of empiric national data on resident staffing for some time. Although we had originally proposed a larger study, we appreciate that you are now interested in a smaller study emphasizing the development of appropriate methods before embarking on a wider application. This letter contains our proposal for the conduct of such a study.

DEFINITIONS

Resident staffing patterns or productivity is measured by the number of full-time equivalent (FTE) residents assigned to service activities per unit of service produced. Classically, productivity is measured by units of output per unit of input; however, hospitals commonly use the inverse of this ratio. Furthermore, since labor and proportionally related costs (such as payroll taxes and fringe benefits) comprise so large a percentage of the total, hospitals concentrate on full-time equivalent labor as the unit of input.

We appreciate that residents are students and that policy decisions in different programs commit varying amounts of time to activities not directly related to service. Failure to account for these commitments would produce aberrations in the productivity ratios. Accordingly, the unit of input has been defined as FTE residents assigned to service activities.

The unit of output will vary with the clinical activity to which the resident is assigned. DRG-weighted cases, inpatient consultations, outpatient visits and Emergency Room visits will be used to measure the units of output. Resident time, in full-time equivalents, will be

allocated to inpatient, consulting, outpatient and Emergency Room activities and compared with the appropriate output denominator. We do not propose to develop a weighted denominator for dissimilar units of service. "Adjusted patient days," for example, attempts to incorporate outpatient visits in a patient day denominator but is no more accurate than any other equivalence factor.

Traditionally, beds, occupied beds, cases, and patients days have all been used to measure the unit of output for inpatient services. We propose a case unit adjusted for the level of complexity, specifically DRG-weighted cases which equals observed cases times a complexity index. This approach adjusts for the greater level of input required for more complex care.

PARTICIPATING TEACHING HOSPITALS

The Association of American Medical Colleges will be responsible for the selection and recruitment of from six to ten teaching hospitals for participation in this pilot study. We anticipate that selection and recruitment will be completed during the month of January, 1985.

Each participating hospital must assign a staff member to serve as the local coordinator for the study. This staff member will participate in a training session for the study and be responsible for the uniform collection of data from the various services in his or her hospital. Each participating hospital must be able to provide one year of standard discharge abstract data on computer tape.

SCOPE OF WORK

Arthur D. Little, Inc., will provide the staff and other resources to conduct a comparative study of resident staffing patterns in the six to ten teaching hospitals selected by the Association of American Medical Colleges. We will:

(1) Prepare the data collection instruments and conduct a training session for the coordinators from each hospital during February, 1985;

(2) Visit each participating hospital once, and be available to resolve any data collection problems during the months of March and April, 1985;

(3) Analyze the collected data during the month of May, 1985; and

(4) Deliver a report of our findings to the AAMC and the participating hospitals during the month of June 1985.

APPROACH

A. Data Collection

Exhibits I and II illustrate the data collection instruments to be used by the coordinators in each participating Academic Health Center. Exhibit I would be completed for each training program in the hospital; Exhibit II pools the data for the entire institution.

Exhibit I identifies the number of FTE residents (at each year of training) assigned to service activities and allocates their time (at each year of training) to inpatient, outpatient, consulting and Emergency Room activities. Exhibit I provides the units of input to be used in the calculation of productivity ratios.

Exhibit II identifies the units of output for outpatient, consulting and Emergency Room activities. A number of other units of output, pertinent to selected services, are included in Exhibit II. DRG-weighted cases will be determined from the discharge abstract tape requested in Exhibit II.

B. Analysis

The DRG-weighted inpatient case load for any service is the observed number of cases multiplied by a Complexity Index (C.I.), determined by comparison with similar services in all study hospitals. To determine the Complexity Index, we first define mean ALOS by DRG for all study hospitals. These means determine the expected length of stay for each patient that would have occurred had the norms of the study universe pertained in each hospital. The Complexity Index is the expected ALOS on each serviced by the observed ALOS for patients on similar services in all study hospitals.

If total hospital charges are available on the discharge abstract tape, we will also determine the Complexity Index by charge weights. We will first adjust 57.5 percent of the total charges for factor

price differences using published HCFA wage indices for each area. We will then determine the relative charge weight for each DRG in the total study sample and assign these charge weights to each individual patient in the study. The Complexity Index for any service equals the sum of the charge weights for discharged patients divided by the number of patients.

Since the study hospitals comprise the reference universe for the complexity adjustment, mean inpatient productivity can be determined directly from the number of assigned resident FTEs per 100 cases. Norms for the study hospital group will be determined as in Exhibit III from data available in Exhibits I and II and the discharge abstract tapes.

C. Results

Given the staffing norms shown in Exhibit III (for all study hospitals) and the output of each service (Exhibit II and the discharge abstract tapes), we will determine and report "expected" staff in FTEs for each program.

$$\text{unpatient FTEs} = \frac{\text{DRG-weighted cases}}{100} \times \text{inpatient norm}$$

$$\text{outpatient FTEs} = \frac{\text{Outpatient visits}}{100} \times \text{outpatient norm}$$

$$\text{consulting FTEs} = \frac{\text{Consultations}}{100} \times \text{consulting norm}$$

$$\text{E.R. FTEs} = \frac{\text{E.R. visits}}{100} \times \text{E.R. norm}$$

Exhibit IV shows an example of the service productivity report for each hospital participating in the study.

Total resident staffing in each program is the sum of service staff (reported in Exhibit IV) and resident time allocated to research and

authorized off-service assignments. These nonservice assignments reflect educational policy decisions in each program. Nevertheless, comparisons with similar programs in other institutions are meaningful. Exhibit V compares FTEs committed to research and off-service rotations in each program with norms for similar services in the other study hospitals.

STAFF

I will be in overall charge of these Arthur D. Little, Inc., efforts on your behalf and I will report to you during the conduct of the study. Ann Venable will manage the study on a day-to-day basis. Barry Decker, M.D. will serve as a consultant for the study. Jack Shoemaker will conduct the data processing and analysis. Biographies of the listed personnel are appended to this letter.

DURATION AND COST

We anticipate that the study will be completed within six months and reported to you during June 1985.

For a six hospital study, we propose that you authorize a budget of $60,000 to cover professional services and expenses. Our invoices, which are payable upon receipt, will be submitted commencing the first of the second calendar month in which this agreement is effective and will be in the amount of $10,000 per month for six (6) months.

For each additional hospital (up to a total of 10), we propose that you authorize an additional budget of $8,000. For each additional hospital, the monthly billing amount will be increased by $1,200. After completion of the work, we will submit a final invoice based upon the total number of hospitals in the study.

GENERAL PROVISIONS

Our work for clients is conducted on a confidential basis, and we will treat information developed for you in accordance with our Established Professional Standards.

Neither party will use the name of the other for advertising or promotional purposes without prior permission in writing, nor are our reports to be used in whole or in part outside your organization without our prior written approval.

Our work will be on a best efforts basis. We expect that the results will meet the objectives sought, and we have assigned to the work

Mr. James Bentley
Association of American Medical Colleges

professional personnel having the required skills, experience and competence. In any event, our liability for damages direct or consequential resulting from this work will be limited to the amount paid to us hereunder.

Any change in this agreement shall be confirmed in writing. This agreement shall be interpreted according to the laws of the Commonwealth of Massachusetts.

This offer shall remain open for a period of thirty (30) days from the date of this letter, unless extended in writing.

Our agreement may be terminated on ten days' written notice by either party, or within such lesser time as we may find necessary to conclude the work currently under way and summarize our findings for you. In that event, you will be responsible only for the professional services and expenses which have been committed to that time.

ACCEPTANCE

We appreciate the opportunity to work with you on this assignment. To authorize us to proceed, please sign and return the enclosed copy of the proposal.

Very truly yours,

Jack Kasten

Jack Kasten

/smt
Letter in duplicate

Approved for

ARTHUR D. LITTLE, INC.

By: Martha Cotton
Authorized Contracting Officer

Accepted for
ASSOCIATION OF AMERICAN
MEDICAL COLLEGES

By_____

Title_____

Date_____

Enclosures:
Biographies
Exhibits I-V

EXHIBIT I

HOSPITAL: ACADEMIC YEAR July ____ to June ____

PROGRAM: CATEGORY (circle one) Voluntary State City

PROGRAM DIRECTOR:

	Filled Positions Your Program	+	FTE Rotations From Other Programs	-	FTE Commitment to Research	-	FTE Rotations*** Off-Service	=	Service FTE
PGY 1									
PGY 2									
PGY 3									
PGY 4									
PGY 5*									
Other									
TOTAL									

FTE ASSIGNMENTS **

	Inpatient	+	Outpatient	+	Consulting	+	Emergency Room	= TOTAL
PGY 1								
PGY 2								
PGY 3								
PGY 4								
PGY 5*								
Other								
TOTAL								

*Includes clinical fellows
**Average annual distribution
***Includes authorized meeting time

NOTE: Service FTEs and total FTE assignments should be equal for each year of training

EXHIBIT II

HOSPITAL: ACADEMIC YEAR July _____ to June _____

RESPONDENT: CATEGORY Voluntary State City

	Outpatient Visits	ER Visits	Consultations
Service 1			
2			
3			
4			
.			
.			
.			
.			
n			
TOTAL			

X-Ray Procedures
R_o R_x Treatments
Autopsies
Surgical Path Specimens
Operations
Deliveries

Please submit a discharge abstract tape covering academic year with appropriate definitions for service codes and discharge status codes as well as tape format.

EXHIBIT III

NORMS FOR STUDY HOSPITALS
FTE RESIDENTS ASSIGNED TO SERVICE ACTIVITIES

	(1) FTEs per 100 cases	(2) FTEs per 100 outpatient visits	(3) FTEs per 100 consultations	(4) FTEs per 100 ER visits
Service 1				
2				
3				
4				
.				
.				
.				
.				
.				
n				
TOTAL				

EXHIBIT IV

HOSPITAL ———— RESIDENT STAFF COMPARED WITH STUDY HOSPITALS

	Inpatient FTEs			Outpatient FTEs			Consulting FTEs			E.R. FTEs			Total Service FTEs		
	Observed	Expected	Ratio	Observed	Expected	Ratio	Observed	Expected	Ratio	Observed	Expected	Ratio	Observed	Expected	Ratio
Service 1															
2															
3															
4															
.															
.															
.															
.															
n															
TOTAL															

EXHIBIT V

RESEARCH AND OFF-SERVICE ROTATIONS IN COMPARABLE PROGRAMS

PROGRAM (i.e., Medicine, Surgery, etc.)

		Service FTEs	Research and Off-Service Rotation FTEs	Total FTEs	% Research and Off-Service
Hospital	1				
	2				
	3				
	4				
	.				
	.				
	.				
	.				
	.				
	10				
TOTAL					

JACK KASTEN

Mr. Kasten, head of the Health Care Management Section, and one of the Vice Presidents of the company, has a background and experience in a wide variety of activities in hospital, medical, and public health administration, and has been with Arthur D. Little, Inc., since 1970.

Since joining Arthur D. Little, Mr. Kasten has been involved in all of the health care activities of the company and in the development of the Public Affairs Center. He has led cases in hospital organization and management, program planning, and community health planning, and has been responsible for overall direction of national studies in hospital utilization review and development of standards for hospitals. He directed a descriptive study on Prospective Reimbursement Experiments at six sites in the U.S. in conjunction with the Harvard Center for Community Health and Medical Care. Recently, he has been responsible for evaluation of several major municipal institutions and their relationships with local governmental bodies. In addition, he maintains responsibility for the field training of young professionals affiliated with educational programs in health services management and medical care organization.

Mr. Kasten has led efforts to explore opportunities in health care for several major industrial clients. The opportunities explored included the development of a centralized sterile supply service, industrial counseling and psychiatric services, chain laboratory and hospital food services. He has also assessed market position and physician staff practice patterns for community hospitals and commercially operated institutions. He has been for a number of years, and is currently, involved with a number of prepaid group practices and total medical care systems advising on organizational problems and planning activities.

In Arthur D. Little's international health care assignments, Mr. Kasten was responsible for reviewing and advising the professional staff who developed the organizational structure for and commissioning of major teaching hospitals in Latin America and reorganized an entire Ministry of Health for another international client.

Prior to joining Arthur D. Little, Mr. Kasten had a wide variety of professional experience in medical and hospital administration, including several public health and international assignments and five years on the faculty of the program in Medical and Hospital Administration at the School of Public Health, University of Pittsburgh. He joined Arthur D. Little after five years as Director of Clinical Services and Associate Director of the Beth Israel Hospital in Boston where his work included all aspects of professional care, teaching programs, and relationships with the Harvard Medical School and community agencies. During this period, he was also intimately involved in the development of the Harvard Community Health Plan, a medical school-based prepaid group practice.

JACK KASTEN (continued)

Mr. Kasten is a member of the National Board of the Easter Seal Society and chairs its Task Force of the Easter Seal Research Foundation. He was Chairman of the Executive Board of the American Public Health Association from 1978-80 and served as the Chairman of the Medical Care Section in 1975. He is also a member of the American College of Hospital Administrators and the American Bar Association.

Mr. Kasten has participated in a broad range of teaching activities in medical care administration and public health law. He is Adjunct Professor in the Department of Public Health of the School of Medicine, Boston University; and holds a regular appointment as Lecturer in Health Services Administration at the Harvard School of Public Health. He has been Visiting Professor of Health Law at the University of Missouri and External Examiner at the Faculty of Medicine, University of the West Indies. Mr. Kasten is a member of the Council on Education for Public Health, the accrediting body for Schools of Public Health.

His consultative experience prior to joining Arthur D. Little includes advising on the development of the hospital affiliations of the University of the West Indies in Mona, Jamaica, and assistance in program development in numerous areas of public health and medical care for the governments of Barbados and St. Lucia under the sponsorship of the Pan American Health Organization. In addition to his consultative reports, Mr. Kasten has published several articles in the field of medical care administration, and has participated extensively in research projects related to medical care organization and health law.

Mr. Kasten received his undergraduate education at Michigan State University, his Master of Public Health degree from the University of Michigan, and his Juris Doctor from Boston College Law School. He is a member of the Bar in Massachusetts and the District of Columbia.

BARRY DECKER, M.D., F.A.C.P.

Barry Decker, M.D., is a senior member of the Health Care Management Section of Arthur D. Little, Inc. Dr. Decker was trained as an internist and rheumatologist and has served as a full-time medical educator, a medical staff administrator, and as the director of a Regional Medical Program. Since joining Arthur D. Little, Inc., in 1970, Dr. Decker has managed programs of health services research and evaluation research as well as providing planning and management consultations.

Dr. Decker directed the Evaluation of the Experimental Medical Care Review Organization (EMCRO) Program. Initially, this study led to a descriptive report, EMCRO Programs (DHEW Publication No. (HSM) 73-3017). Subsequently, a 13-volume final report was completed evaluating the impact of the various approaches to medical review and the behavioral characteristics which accounted for the varying success of these programs. Dr. Decker led a team which designed prototype Professional Standards Review Organizations (PSRO) for HEW. This report was published by Regional Peer Review, in 1973, and is now in a second printing. Dr. Decker subsequently developed for HEW the curriculum for regional seminars on PSRO.

Dr. Decker directed Arthur D. Little, Inc., participation in a study of the uniqueness of children's hospitals conducted for the National Association of Children's Hospitals and Related Institutions (NACHRI). The study compared nine children's hospitals (all major university teaching services) with paired general hospitals. Arthur D. Little, Inc., evaluated the intensity of care as measured by diagnostic mix and nursing service requirements.

Dr. Decker has conducted areawide bed need and utilization studies for all acute care hospitals in Rhode Island; Columbus, Ohio; and Cleveland, Ohio. These studies projected areawide utilization and bed needs by various methods including case-mix adjusted compensations for prolonged length of stay. In Columbus and Rhode Island, the allocation of bed needs to individual hospitals was completed.

Dr. Decker evaluated the feasibility of a cancer center at Vanderbilt University and initiated a community-based cancer center in Cleveland, Ohio. He evaluated the feasibility of an HMO at Cleveland Metropolitan General Hospital which is a major teaching center for Case-Western Reserve School of Medicine. Dr. Decker supervised the development of a Center for Health Enhancement at the Massachusetts General Hospital (a major teaching service for Harvard) and an evaluation of inpatient utilization at the Clinical Center of the National Institutes of Health. Dr. Decker has completed several assignments for the Yale-New Haven Hospital involving inpatient bed need projections and the justification of comparative costs.

BARRY DECKER, M.D., F.A.C.P. (continued)

Dr. Decker has led or participated in many consultations for individual community hospitals designed to: develop long-range strategic and/or facility plans; audit professional or administrative performance; evaluate or implement cooperative joint ventures; or otherwise address specific current problems faced by the hospitals. Assignments have been completed for large and small hospitals located in both metropolitan areas and smaller towns in multiple states.

Prior to joining Arthur D. Little, Inc., Dr. Decker was the Director and Chief Executive Officer of the Northeast Ohio Regional Medical Program and an Assistant Professor of Preventive Medicine at the Case Western Reserve University School of Medicine. This program emphasized an evaluation of the health needs of a four million service population and the stimulation of service programs to meet these needs. During this period, Dr. Decker served on the Health Manpower Council of the Ohio Comprehensive Health Planning Agency and was liaison officer supervising the design of a statewide health facility and manpower information system.

Previously, Dr. Decker was Medical Director of a 900-bed teaching hospital in Youngstown, Ohio, where he was responsible for medical management, evaluation, education, and planning. Earlier, Dr. Decker had been Director of Medical Education at the Memorial Hospital in Richmond, Virginia. His detailed knowledge of national, regional, and local health services was built on prior experience in the private practice of internal medicine in Richmond, Virginia, and full-time teaching and research in rheumatology at the Medical College of Virginia. Dr. Decker was trained in internal medicine and rheumatology at the Mayo Clinic and Foundation.

Dr. Decker received an A.B. from Columbia College, and M.D. from the New York University School of Medicine, and an M.S. (medicine) from the University of Minnesota. Dr. Decker is a member of Phi Beta Kappa, the Alpha Omega Alpha honorary medical fraternity and a fellow of the American College of Physicians. He is a diplomate of the American Board of Internal Medicine and licensed to practice in New York, Minnesota, Ohio, Virginia, and Massachusetts. Dr. Decker is the author of 26 articles, monographs, and books on medicine, medical evaluation and health planning.

ANN VENABLE

Ann Venable, a member of the Health Care Management Section of Arthur D. Little, Inc., works primarily in the areas of policy and program evaluation. Her current and recent activities include:

- For the Health Care Financing Administration, Department of Health and Human Services, studying the implementation experience of clinics participating in the Urban Clinics Demonstration Project as a guide to potential nationwide changes in Medicare reimbursement for physician extenders.

- For the Office of the Secretary, Department of Health and Human Services, evaluating the impact of cost containment incentives built into employee health insurance plan options.

- For the Center for Disease Control, surveying consumer knowledge about health insurance and developing guidelines for consumer education to improve decision-making in the choice of health insurance policies.

- For the Financial Executives Research Foundation, studying corporate activities to contain health care costs, including benefit restructuring, development of alternative delivery systems, and prevention and health promotion programs.

- For the Tri-Service Medical Information System project, U.S. Department of Defense, directing the evaluation of a pilot project in outpatient medical record automation in three military hospitals.

- For the Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, monitoring the historical development and community impact of the Bedford-Stuyvesant/Crown Heights Demonstration Project, and experiment in assistance to fiscally distressed hospitals.

- Also for the Office of the Assistant Secretary for Planning and Evaluation, development of case studies of three hospital-sponsored experiments in reorganization of outpatient services.

Other projects have included an evaluation of the structure and functioning of a voluntary hospital's governance organization, training of Bureau of Health Planning staff in survey and evaluation methodology, evaluation of the adequacy of staffing and funding in health systems agencies, and a study of coordination between mental an physical health planning in nine states.

ANN VENABLE (continued)

Before joining Arthur D. Little, Inc., Ms. Venable was on the staff of Educational Services Incorporated (now Education Development Center), where she participated in developing a social science curriculum for the elementary grades.

She is a graduate of Radcliffe College and holds an M.A. in Teaching from the Harvard Graduate School of Education.

JACK SHOEMAKER

Jack Shoemaker, a member of the Health Economics Unit of Arthur D. Little, Inc., has provided programming support and analysis for several projects in the health services and health care fields. Mr. Shoemaker's primary resposibility has been to cull information from a broad spectrum of sources and to develop programs for mainframe and micro computer installations to analyze and evaluate health care related problems. Some of the projects he has participated on are described below.

- As part of an on-going evaluation of automated support systems scheduled for installation at 168 Department of Defense (DoD) hospitals, Mr. Shoemaker consolidated DoD military hospital data into one central data file. Using this file as a master relational database, programs were developed for mainframe and micro enviroments which were flexible enough to support many methods of evaluation and analysis without the need to re-program for each task.

- For a project which evaluated the impact of prospective rate setting on hospital revenues in the State of New York, Mr. Shoemaker cross-matched cost, revenue, and utilization data supplied by state agencies and the American Hospital Association. Based on this data and the new rate-setting methodology, a simulation model was developed to examine future hospital revenues.

- Mr. Shoemaker has extensive experience working with DRGs. A hospital client in New York felt that its case-mix index under-reported and misrepresented the actual complexity of its cases. Using a full year of discharge data supplied by the client, and DRG grouping programs developed at Arthur D. Little and elsewhere, a new case-mix index was calculated to support the client's appeal of the original case-mix index.

In addition, Mr. Shoemaker has provided programming support for econometric projects in the Regulatory Economics Unit. He is familar with a variety of programming and application languages, and is a graduate of the Massachusetts Institute of Technology with a B.S. in Economics.

State Waivers From the Medicare Payment System

One issue which has been gaining attention in recent months is the provision of the Social Security Amendments of 1983 which gives the Secretary the authority to grant waivers from the Medicare Prospective Payment System to states that wish to use alternate payment schemes. The states must agree to meet certain criteria to receive these waivers. If the state is one of the four that currently has a waiver (Maryland, Massachusetts, New Jersey or New York), it must agree to have a state rate setting system that: (1.) applies to substantially all non-acute care hospitals in the state; (2.) applies to at least 75% of all inpatient revenues, (3.) provides assurances that payors, hospital employees and patients are treated equitably; (4.) assures that the Medicare expenditures will not be greater over a three-year period than they otherwise would have been; (5.) does not preclude HMOs or CMPs from negotiating directly with hospitals; and (6.) prohibits payments under Part B for nonphysician services provided to inpatients.

States that are considering establishing rate setting programs and which would be applying for a waiver for the first time must agree to the terms set forth above and must agree to establish a system that: (1.) is operated by the state or its designated entity; (2.) is prospective; (3.) mandates such reports as the Secretary requires; (4.) provides assurances that it will not reduce inpatient treatment to low income, high cost, or emergency patients; (5.) will not reduce payments without 60 days notice to the hospitals and the Secretary; (6.) has been developed in consultation with local officials regarding the impact on public hospitals.

One of the reasons this issue is likely to receive more attention this coming year is that the waivers for Maryland and New York are up for review. New Jersey has just been granted a new waiver after lengthy and somethimes heated negotiations with HHS, and this is thought to portend similar difficulties for Maryland and New York. Massachusetts' waiver will be reconsidered the following year.

There are several apparent reasons for the controversy surrounding these waivers. First, some people in the Reagan administration believe that if there is a resonable federal system for Medicare payment, then it ought to apply to everyone. A total national system would be easier to administer and would ensure that all hospitals are treated similarily.

Secondly, OMB has expressed concern that there are no controls on the amount of money spent on waivered states' programs. While the states must provide assurances prior to obtaining the waiver that Medicare expenditures will not exceed the amount Medicare would otherwise pay, there is no mechanism by which overpayments would be returned. For example, in the recent negotiations for renewal of the New Jersey waiver, the state and HHS argued over whether or not the New Jersey system would cost Medicare more, with the state asserting there would be a three year savings of approximately $190,000 and HHS insisting it would cost $50,000,000 more. New Jersey ultimately prevailed.

A corollary objection to the state waivers, which has been raised by the Federation of American Hospitals (FAH) is that in a budget neutral system, if the waivered states receive more than they otherwise would have, less Medicare money is available for the non-waivered states. FAH issued a report in early 1984 asserting that the four states had received more than they otherwise would have. The states attacked this report, pointing out several errors in the calculation used by FAH and pointing to their own data which indicated a net savings for Medicare.

The Federation of American Hospitals has expressed its opposition to state waivers because it is opposed to any form of all payer systems. In contrast, the American Hospital Association took a position in support of waiver opportunities for local initiatives (In "AHA Position on Medicare Prospective Pricing", approved by the House of Delegates 2/2/83.)

The opinion of COTH members regarding the granting of state waivers varies greatly. Approximately 26% of the non-federal members of COTH are in the four currently waivered states. From comments made to AAMC staff, it seems that many of these COTH members are generally more satisfied with their state programs than they believe they would be with the Medicare Prospective Payment System. In part, this may be because the state systems offer something not available from the federal Medicare program, such as payment for indigent care. However, other member hospitals in waivered states are dissatisfied with their state program because it is viewed as a method of shifting responsibility for inadequate payments from Medicaid programs. COTH members in non-waivered states have opinions on waivers largely related to their expectation of the potential for establishing a reasonable state program.

In the past, the AAMC has taken the position that state rate systems are acceptable if: (1.) the system is based on the full financial requirements of the hospital; (2.) the system is run by an independent agency with a small number of commissions; (3.) the agency is independent of any governmental or private payer of hosptial services; (4.) the agency operates under clearly defined formal procedures adopted after public hearings; and, (5.) the agency provides due process for those affected. (Testimony submitted to the Subcommittee on Health, Committee on Finance of the U.S. Senate, March 13, 1979.)

Staff Recommendation

In view of the AAMC's concerns with the Prospective Payment System and with finding appropriate mechanisms for financing indigent care, the staff recommends that the Board adopt a resolution supporting the continued opportunity for states to be granted waivers from the Medicare payment system as long as they do not receive more Medicare payments than the amount they would have otherwise received. This recommended resolution would support leaving states with the flexibility to adopt their own program, but would not advocate that states do so.

Policy Positions for Medicare Budget Proposals

Background

Once again this year, the Federal budget process will be used to introduce major changes in policy and funding for government programs. All reports indicate that major changes will be proposed in Medicare's prospective payment system. While the details of the budget proposals are continually being revised, all proposals appear to include both a freeze on DRG prices and a reduction in the resident-to-bed adjustment. In addition, some proposals include a reduction in the passthrough for direct medical education expenses. In this ever-changing situation, staff recommends that the COTH Administrative Board approve seven policy positions to guide Association action on Medicare budget proposals. The recommended policies have been stated broadly in order to be responsive to whatever is included in final budget proposals and to provide flexibility during budget negotiations. If these policy positions are supported by the Board, they should be presented to the Executive Council at its afternoon session.

Recommendations:

It is recommended:

#1. that the AAMC vigorously oppose any freeze in DRG prices

RATIONALE: The prospective payment system was enacted to encourage hospitals to reduce costs. Every available piece of evidence indicates hospitals are responding by reducing their costs. Moreover, and contrary to those who felt the system would be manipulated, hospitals have also experienced a drop in admissions. Clearly, hospitals have responded to the national mandate. Therefore, in an economy that is still experiencing significant inflation and

with a Medicare population that includes growing numbers of the very old and frail elderly, the AAMC believes it is inappropriate to impose a price freeze and fail to recognize the increased costs hospitals must incur for the personnel, goods, and services they buy.

#2. that the AAMC work vigorously to see that any freeze in DRG prices is accompanied by a freeze in the blend of historical base, regional, and national prices used to determine a hospital's payments

RATIONALE: In four of the nine census regions -- New England, the Great Lakes, the Northern Plains, and the Pacific Coast states -- the regional urban price is greater than the national urban price. Beginning October 1, the contribution of the national urban price in computing Medicare payments will increase from 12.5 percent to 37.5 percent. Thus, automatic change in the "blend" used to compute payments will lead to an outright reduction in payments for urban hospitals in those four census regions if Medicare prices are frozen. In the Council of Teaching Hospitals, 48 percent of the membership is located in these four census regions.

#3. that the AAMC vigorously oppose any change or reduction in the passthrough for direct medical education costs until the Association's Committee on Financing Graduate Medical Education has completed its recommendations and those recommendations have been adopted by the AAMC Executive Council

RATIONALE: As a result of clinical education payments, teaching hospitals incur necessary costs beyond those required solely for patient care. A change in Federal policy for supporting clinical education should not be a by-product of a budget cut. This is especially important because other payers may cite the budget cut as a basis for reducing their financial support and changing their policy on clinical education. The Association should work to see that public policy on financing gradute medical education is fully debated and resolved prior to altering the current passthrough.

#4. that the AAMC encourage HCFA to update each hospital's published case mix index using data from the hospital's first year under prospective payment

RATIONALE: The published case mix index numbers for many hospitals are incorrect because old, poorly coded sample data were used. As a result, HCFA is observing numerous anomalies in hospital payments. Adjusting the budget proposals to compensate for but not correct these anomalies is introducing long-term and little understood biases into the system. This recommendation would have the AAMC urge HCFA to correct the underlying deficiency, the case mix index used to determine the hospital's cost base and the standardized data in computing regional and national prices.

#5 that the AAMC support correcting the wage index numbers for communities but seek an amendment to the law eliminating the current requirement that the new index numbers be applied retroactively to October 1, 1983

RATIONALE: The wage index numbers used since the beginning of prospective payment are based on incorrect data. The 1984 Tax Reform Act requires HCFA to obtain correct data, recompute the index numbers, and retroactively adjust PPS payments back to October 1, 1983. For hospitals with an increasing index this is not a problem. For hospitals with a declining index, the hospital will have to simultaneously adjust to a lower payment rate and return the past overpayment. This could create major financial problems. Moreover, the retroactive adjustment suggests that corrections in PPS data should be applied back to the start of the program. This seems inconsistent with the prospective nature of the system.

#6. that the AAMC support recomputing the resident-to-bed adjustment using current hospital resident and bed data, up-to-date corrected hospital case mix indices, corrected wage indices, and using a regression equation which incorporates only variables used in determining hospital DRG payments

RATIONALE: The resident-to-bed adjustment was originally developed to create a "level playing field" between teaching and non-teaching hospitals. It is now

attacked as overpaying teaching hospitals and arbitrary cuts are being proposed. The AAMC should oppose arbitrary cuts in the adjustment because an equally arbitrary decision could also be made to eliminate it. In opposing an arbitrary cut, the AAMC would argue to re-estimate the adjustment using accurate resident, bed, case mix,, and wage data. In addition, the AAMC should argue that the equation used to set the adjustment not include variables excluded from prospective payment such as bed size or urban area size.

#7. that, if the American Hospital Association's proposal for a DRG specific blended rate, which the AAMC has endorsed and supported, does not receive Congressional approval, the AAMC seek a DRG price formula that is based 50% of regional average costs and 50% on national average costs

RATIONALE: As the hospital specific component of DRG price decreases, weaknesses in the design of the system are becoming more obvious. The continuing move to using only the national average price to make payments will reveal further weaknesses. At the present time, it is not clear why urban hospitals in New England, the Great Lakes, the Northern Plains, and the Pacific states have costs above the national average. Absent an understanding of the higher costs in the regions and with no clear evidence that hospitals in these four regions are less efficient than those in the other five regions, it seems premature to move to prices set using only the national average. The American Hospital Association has developed and the AAMC has supported a refinement that would set prices using a DRG specific blend of an average price and a hospital-specific price. This remains the AAMC's preferred option. However, if the AHA proposal fails to attract necessary political support, a fallback provision of 50% regional prices and 50% national prices would retain "incentives" for the winners while providing "damage control" for those who lose for reasons that are not understood.

AUPHA
ASSOCIATION OF UNIVERSITY PROGRAMS IN HEALTH ADMINISTRATION
1911 NORTH FORT MYER DRIVE, SUITE 503/ARLINGTON, VIRGINIA 22209/(703) 524-5500

GARY L. FILERMAN, Ph.D.
President

January 3, 1985

Richard Knapp, Ph.D.
Council on Teaching Hospitals
Association of American Medical Colleges
One Dupont Circle, N.W., Suite 200
Washington, DC 20036

Dear Dick:

In early June the National Fund for Medical Education and the Kellogg Foundation held a conference in Georgia to assess progress of their projects and impacting medical education to encourage more cost effective physician behavior. I was a presentor at that session and my presentation led to several suggestions for follow up activities designed to stimulate a more effective interface between administration and clinical leadership.

The most promising of those was an initiative from the Center for Educational Development at Illinois. We convened a meeting in Chicago in August which involved leaders of major teaching hospitals, the medical schools and the health administration programs in the city. My intent was to create a consortium of leaders in residency level education and in health administration to identify new patterns of education for both residents in health administration and medicine. That focal point was the result of the conclusion from the Kellogg conference that previous investments in undergraduate medical education did not show much promise.

The enclosed letter presents the follow up to those discussions. It seems to me that we are on to something of significant potential. AUPHA has been the focal point for the health administration side and perhaps at this point it would be constructive to bring in COTH on the medical education side and thus have a pair of consortia at the national and local levels which would use the Chicago metropolitan area as a laboratory. I have long entertained the hope that we could collaborate and this may present that opportunity.

I am optimistic that funding is obtainable and could be so structured as to provide some support for the National Advisory Committee which in my new concept would be a joint AUPHA/COTH endeavor. As you know, our own financial constraints are severe so the project must be approached in a way which assures some return on our investment of energy. That can wait for later consideration but in the meantime I invite your response to me on the substance of the letter and then I will respond to the folks in Illinois. Best wishes for the New Year. I look forward to hearing from you.

Sincerely yours,

Gary L. Filerman

/ko't

THE UNIVERSITY OF ILLINOIS AT CHICAGO

Center for Educational Development
808 South Wood Street
Box 6998, Chicago, Illinois 60680
(312) 996-3590

December 19, 1984

Gary Filerman, Ph.D., President
Association of University Programs
in Health Administration
Suite 503
1911 Fort Meyer Drive
Arlington, VA 22209

Dear Gary:

It has been a long time since September 13, 1984, and you may be wondering about the progress of the proposal that we discussed. Since that time, we have been meeting extensively with various relevant individuals. In this brief report, we would like to bring you up to date on the present state of project development and suggest an approach for the future.

As you are well aware, during our dinner meeting we were provided with a proposal on cost-containment education developed by Northwestern University. This proposal has been funded by the Pew Foundation and is now being implemented. The educational interventions included in that grant incorporate, in summary form, most of the educational strategies utilized in past research. As a consequence of this the three of us decided that our efforts should complement, not duplicate, the Northwestern project. We agreed that four or five educational institutions in the Chicago area should serve as our case study sites, that our project should have a strong research base, and the general goal should be to develop innovative ways to bring physician leaders in graduate medical education and hospital administrators together for the purpose of affecting graduate medical education.

Therefore, we began contacting responsible individuals at Rush Medical College (Wayne Lerner), Children's Memorial Hospital (Earl Frederick), Mercy Hospital and Medical Center (Sr. Shiela Lyne), Lutheran General Hospital (Dr. Leighton Smith, head of the department of Family Practice), Wyler Hospital of the University of Chicago (Drs. Ron Anderson and Jay Berkelhamer) and the University of Illinois Hospital (Mr. James Malloy). Dr. Stephen Shortell of Northwestern University expressed interest in the project and agreed to serve as an advisor on the methodology of organizational change.

We have had fruitful discussions with Wayne Lerner and he is quite enthusiastic about participation. He is of the opinion that physicians are not likely to change as a result of the financial threat to teaching hospitals arising from prospective payment. He felt that educational interventions should include a curricular offering on the new market forces that are changing the health care delivery system. According to him, this type of intervention would be acceptable to program directors and residents and be likely to result in a more cost conscious and better prepared physician. Wayne, in conjunction with Dr. Russe (dean of the medical school) has issued a memorandum to all chiefs of service inviting them to consider the attached proposal. As of today, the heads of the departments of family practice and obstetrics-gynecology have expressed interest. We will know the responses of the other services within the next month.

Earl Frederick is in the process of revising the organizational structure of Children's Memorial Hospital to separate the components of education and patient care. This is a bulit-in intervention that could be used to assess the effects of an administrative level organizational change on graduate medical education. While Mr. Frederick is willing to cooperate, he does not wish to increase the stress that his programs directors are feeling as a result of the hospital reorganization.

Sr. Shiela is interested in the idea of the research proposal and has promised to raise the issue with several programs that might be candidates for participation. Dr. Anderson is anxious to work with us and introduced us to Dr. Berkelhamer, who is director of outpatient pediatrics. The type of intervention that Dr. Berkelhamer is interested in implementing has to do with feedback to residents about their cumulative ordering behavior. This makes it similar to the Northwestern proposal. We are exploring other options with him, but he is busy and has limited time to participate in reserach.

At Lutheran General Hospital and the University of Illinois, the type of interventions that seem acceptable to our faculty contacts have mainly to do with patterns of resident supervision within individual programs. Thus, at many of the institutions where we have been in touch with "interested" faculty it seems as if the changes that they are willing to institute are similar to the educational-level interventions that characterize the Northwestern project.

In considering the above results of our first stage of planning, we would like to suggest the following approach for your consideration. We still strongly support the idea that the project goals should be to:

(1) develop joint decision-making structures that include physician leaders in graduate medical education and hospital administrators so as to create an environment in which physicians would become cost effective deliverers of health care, and

(2) identify information that could be added to the curriculum of programs in hospital administration.

We now believe that the focus of the project should be on the role of the hospital administrator in bringing about needed changes in the teaching hospital. In other words, we would not concentrate on changing graduate medical education directly but on the role of the hospital administrator in making the needed changes in graduate medical education. This still requires us to understand the teaching hospital as an organization (in fact the requirement is now stronger), but the analysis focuses on:

(1) how teaching hospitals are changing or will change based on the new financial environment,
(2) what skills will teaching hospital administrators need to "keep up" with and rationally direct the changes, and
(3) how can these skills best be taught/learned.

The results of this project should, therefore, be directly relevant to the 138 existing programs in health administration. This of course includes new ways of structuring graduate medical education and some of the of the other issues that we have been considering. The new focus, however, frees us somewhat from the need to identify interventions to implement in specific graduate medical education programs.

The general approach that we have been discussing thus far can be utilized to good effect in this project. We envision two general groups contributing their specialized skills and expertise. First, a working group consisting of representatives from CED, AUPHA, and perhaps a hospital administrator and physician would be responsible for developing the methodology for the project and doing the actual data collection. An advisory group, consisting of a nationally-known panel of hospital chief executive officers and graduate medical education program directors would review the plans and the data generated by the working group at several day-long meetings per year. A possible design for this project includes a series of data collection and data analysis steps that might be structured as follows:

(1) select a sample of teaching hospitals and through a questionnaire/interviews with administrators, physicians, other personnel assess the changes (e.g., organizational, administrative, financial) that are occurring,

(2) do some in depth case studies of organizations where certain types of changes have been attempted to determine the new roles/skills that are required of hospital administrators,

(3) design ways to include these in the curriculums of health administration programs.

The advisory group would be utilized to both react to the data collected and to assist in the planning of next steps. Since the composition of this advisory group is critical to the success of the project, your input is essential. Some of the participants at the September 13th meeting might serve as a core onto which others could be added.

The products of this research would be as follows:

(1) the possibility of direct curriculum additions/changes in health administration programs to reflect the changing nature of the teaching hospital and role of the hospital administrator,
(2) continuing education programs for hospital administrators/graduate medical education program directors to inform them about new and innovative ways to manage teaching hospitals , and
(3) a general addition to the literature about the teaching hospital as a complex organization and way that teaching hospitals are evolving as a result of changed economic conditions.

We will, in this revised project plan, have addressed the original goals of the project but in a different, and hopefully more manageable and relevant way. Direct interventions, if they occur at all, will be confined to the end of the project. Descriptive analysis, with an emphasis on individual, organizational, and environmental level variables, will be the major focus.

Please let us know your thought on this. We are continuing to stay in touch with all our contacts. This new approach will not negate the work that we have done thus far.

With best wishes for happy holidays.

Sincerely,

Mohan L. Garg, Sc.D.
Professor

Barbara M. Barzansky, Ph.D.
Assistant Professor

MLG/BB/amg

[Jan 23-24, 1985]

AGENDA
COUNCIL OF ACADEMIC SOCIETIES
ADMINISTRATIVE BOARD

January 23, 1985

5:30 - 7:00 p.m.
Georgetown West Room

JOINT ADMINISTRATIVE BOARDS MEETING

The Executive Council has appointed a Committee on Financing Graduate Medical Education, chaired by J. Robert Buchanan, M.D. The Committee has met twice and will meet again on January 15. Dr. Buchanan will report on the progress of the Committee and lead a joint Administrative Boards meeting in discussing issues and options considered by the Committee.

7:00 - 9:00 p.m.
Georgetown East Room

JOINT ADMINISTRATIVE BOARDS RECEPTION AND DINNER

January 24, 1985

8:00 - Noon
Independence Room

CAS ADMINISTRATIVE BOARD MEETING

Noon - 1:00 p.m.
Conservatory Room

JOINT ADMINISTRATIVE BOARDS LUNCHEON

AGENDA
COUNCIL OF ACADEMIC SOCIETIES
ADMINISTRATIVE BOARD

January 23-24, 1985

MINUTES
COUNCIL OF ACADEMIC SOCIETIES
ADMINISTRATIVE BOARD

September 12-13, 1984
Washington Hilton Hotel
Washington, D.C.

PRESENT:

Board Members

Robert L. Hill, Chairman
Philip C. Anderson
David H. Cohen
William F. Ganong
Harold S. Ginsberg
Joseph E. Johnson, III
Douglas E. Kelly
Jack L. Kostyo
Frank G. Moody
Virginia V. Weldon

Staff

David Baime*
Janet Bickel*
Robert Boerner*
Christine T. Burris
John A. D. Cooper*
Carolyn Demorest
James Erdmann
Thomas J. Kennedy*
Leonard Koch*
David B. Moore
John F. Sherman*
Elizabeth M. Short
August G. Swanson

Guests

Robert M. Heyssel*
Richard Janeway*
Donald G. Langsley
Richard S. Wilbur*

I. FINANCING GRADUATE MEDICAL EDUCATION

The CAS Administrative Board convened jointly with the Boards of the Council of Teaching Hospitals, Council of Deans, and the AAMC Committee on Financing Graduate Medical Education at 1:00 p.m., September 12 for a plenary session on Financing Graduate Medical Education. The session was chaired by Dr. Robert Heyssel, who emphasized that change in funding patterns for house staff is rapidly occurring and urged attendees to evaluate the problem and take action. Paying for graduate medical education from patient care revenues is becoming an issue as hospitals compete for patient care revenues. Health maintenance organizations (HMO) and preferred provider organizations (PPO) emphasize price, which often precludes contracts with the more expensive teaching hospitals. Teaching hospitals are not as cost effective in part because of the amount of money which is spent on graduate medical education. Nationally, the house staff stipends alone are $2 billion. The key concerns are: how can graduate medical education be funded and by what mechanism should GME funds be distributed?

* present for part of the meeting

Three speakers presented their views on the subject. The first, John W. Colloton of the University of Iowa, described the relationship between patient care services and societal contributions of teaching hospitals. The latter comprises 30 percent of these hospitals' costs and includes development of new technologies (44 percent), charity care (34 percent), and health education programs (22 percent). Payments for societal contributions are shared by government, private health plans, and HMO-PPO payors, each of whom must soon decide who will finance the societal contributions over the long term.

Gerard Anderson of Johns Hopkins emphasized the importance of understanding the problem, defining the products, determining why some products are more expensive at a teaching hospital, and then evaluating policy options. He presented an overview of the massive five-year study funded by HHS and conducted by Arthur Young & Co. This study is examining six questions:

- how is a teaching hospital defined?
- how does teaching status affect the variation in total expenditures (physician and hospital) from hospital to hospital?
- how do case mix measures compare?
- how do funds flow within an academic medical center?
- do residents substitute for physicians and/or hospital staff?
- do alternative physician structures affect output?

The study expects to provide much useful information; unfortunately, there is no provision for extensive data analysis at the present time.

Finally, Dr. Robert Petersdorf of the University of California, San Diego, introduced a provocative proposal for funding housestaff. He proposed to limit the federal support for graduate medical education to funding stipends, benefits, and overhead costs for approximately 54,000 positions annually. This number of positions would provide the equivalent of three years of graduate medical education for all US medical school graduates. Further specialty training would have to be funded from private sources. The 20 percent decrease in residency programs would come at the expense of programs not affiliated with medical schools, programs of poorer quality, and programs of subspecialty training. Elimination of marginal and unaffiliated residency programs would have the effect of reducing training opportunities for graduates of foreign medical schools and thus help to reduce the number of physicians in the US without cutting enrollment in the American medical colleges. He proposed general tax revenues as a source of funds because physicians are a national resource and felt that graduate medical education should be removed from the care reimbursement system.

II. BUSINESS MEETING

A. ACTION ITEMS - CAS Board

1. Approval of Minutes

The minutes of the June 27-28, 1984 CAS Administrative Board meeting were approved as published.

2. Chairman's Report

Dr. Hill reported briefly on the meeting of the Executive Committee earlier that morning with particular emphasis on the philosophy concerning the search for a successor to Dr. Cooper. Dr. Hill indicated that Drs. Janeway and Heyssel would be speaking with each Administrative Board that morning to present the current plan of action and to receive feedback from the Boards.

3. Membership Applications

Drs. Johnson and Kelly had been asked to review the application of the American College of Psychiatrists for membership in the CAS, and Drs. Anderson and Kostyo had been asked to review the application of the American Orthopaedics Association for membership. Their recommendation was that both applications be approved.

ACTION: The CAS Administrative Board voted to approve the applications for CAS membership.

4. Revision of CAS Rules and Regulations

The CAS Administrative Board was asked to consider a proposed revision of the CAS By-Laws pertaining to the composition of the CAS Nominating Committee. After brief discussion a motion was made, seconded, and carried that the proposed revision be approved.

ACTION: The CAS Administrative Board approved the proposed revision with a recommendation that it be considered by the full Council at the Annual Meeting on October 29, 1984.

5. Dr. Robert Heyssel and Dr. Richard Janeway presented the proposed selection process for chosing a suitable successor to Dr. John Cooper. The Executive Council will appoint a Search Committee to be chaired by Dr. Janeway. The committee will consist of six or seven persons, some of whom will be past chairmen of AAMC Councils. The first task of the committee will be to develop a detailed position qualification statement. Committee members will talk with high ranking officials and will examine the 'Future Directions' papers written by each of the Councils to develop an outline of the AAMC's chief executive job. The position qualifications will be shared with the Administrative Boards and will be the basis for selection of the new AAMC president. The Search Committee will then contract with an executive search firm to locate and interview the most highly qualified prospective executives. The Search Committee will maintain utmost confidentiality throughout the process and will negotiate with their final choice(s). The Executive Council will be asked to give the final approval on the Search Committee's decision. The newly formed Search Committee will begin their work in November 1984 in an attempt to complete the effort during 1985.

ACTION: The CAS Administrative Board members are asked to recommend to the Executive Council prospective Presidential Selection Committee members prior to the Annual Meeting.

6. CAS "Future Challenges" Document

The CAS Administrative Board considered a revised draft of the "Future Challenges" paper. Discussion focused on the purpose and use of this document. The utility of presenting a list of issues which some Board members regard as fundamentally without solution, particularly in the area of medical education, was specifically questioned. Dr. Swanson reminded the Board that the primary purpose of the "Future Challenges" document is to present a statement to the full Council and to the Association describing "where we are in the development of the CAS...and what we might do in the future."

Several Board members also stressed the need to regard the document as an agenda for discussion of possible issues of interest to the Council in the future instead of as an implicit promise by the CAS to resolve these issues. It was further suggested that the central theme of the document should not be whether or not these issues have solutions, but rather whether or not such problems are appropriate for consideration by the CAS.

It was also proposed that this document might be instructive in presenting issues to Council members that they perhaps were unaware of, and would be useful in providing Council members with input into the future agenda of the CAS.

Given the breadth and scope of the issues presented in the current draft as well as the Board's disagreement of the particular relevance to the CAS of any individual issue, the Administrative Board requested staff to survey the Council members on the various questions contained within the "Challenges" paper and to make the results of this survey available at the Annual Meeting in October. Council members are to be surveyed as to which individual issues they consider to be highly relevant, relevant, or not relevant to the CAS. Council members also will be asked to rank those issues which they consider highly relevant in the order of their importance.

ACTION: The Council of Academic Societies Administrative Board asked staff to survey the members of the CAS Council on the individual elements of the "Future Challenges" document prior to the discussion of the document at the Annual Meeting.

7. Proposed Statement on Animal Research

Dr. John Sherman recommended that the AAMC adopt a formal statement expressing the Association's position on the use of live animals in biomedical research and education. The CAS Board reviewed the proposed statement on animal research presented in the agenda and agreed that it was timely for AAMC to have such a policy.

ACTION: The CAS Administrative Board approved the statement on animal research and recommended that it be adopted by the Executive Council at the January 1985 meeting.

B. ACTION ITEMS - Executive Council

1. Report of the Project Panel on the General Professional Education of the Physician

The Board renewed its discussion on the report of the Panel on the General Professional Education of the Physician and College Preparation for Medicine. In preparation for the Sunday plenary and workshops on the GPEP Report to be held at the Annual Meeting, Board members reacted to the Report's individual conclusions to which they have been assigned.

The general feeling expressed by the Board is that while the overall aspirations of the Report are laudable, the realities of the issues addressed present difficulties for the implementation of the Report's recommendations.

Several Board members reiterated their uneasiness over the implications of the Report for the basic sciences, particularly what they perceived as a lack of recognition on the part of the Panel of the problems facing the basic sciences in the medical school curriculum.

The Board also expressed concern that faculties might interpret the document as having the full endorsement of the AAMC. However, the Board members were willing to receive the document as a starting point for the consideration of medical education. The discussion concluded with consideration of the COD Administrative Board's proposal for an AAMC statement to accompany the public release of the Report.

ACTION: The CAS Administrative Board voted to approve the COD Administrative Board's proposed statement in response to the GPEP Report with the following modifications:

...It is an ~~extraordinary~~ useful agenda of issues and the AAMC therefore ~~commends it to~~ *suggests that it be considered by* its members and to all of those engaged in the enhancement of education for medicine.

...the AAMC will create a formal mechanism to review the report and to advise on its use in the development of *AAMC* policies and the design of Association programs.

2. Matching Medical Students for Advanced Residency Positions

The resolution urging that all internship and residency programs utilize the National Resident Matching Program, which was passed by the CAS Board at the June Board meeting, is now before the other Councils and the Executive Council. The CAS Board reread the resolution and reaffirmed their approval of the document.

ACTION: The Council of Academic Societies enthusiastically supports the resolution to encourage all internship and residency programs to participate in the National Resident Matching Program for any positions offered to medical students.

3. Paying Capital Costs in COTH Hospitals

ACTION: The CAS Administrative Board approved the report of the COTH Capital Costs Committee including its recommendation that AAMC advocate a choice of cost reimbursement for depreciation and interest or a prospective percentage capital add-on for teaching hospitals during the Medicare transition to full prospective payment of capital costs.

4. DRG Price Blending Proposal

ACTION: The CAS Administrative Board agreed to endorse the DRG-specific price blending proposal of the American Hospital Association.

5. Student Loan Consolidation

Dr. Tom Kennedy summarized the legislative history of the student loan consolidation program whose legislative authority lapsed in November 1983. The original legislation offered students with Title IV (Department of Education) indebtedness greater than $7,500 the opportunity to consolidate their loans under the authority of Sallie Mae at a 7 percent interest rate over 20 years. In 1983 the House passed a bill which would continue the program in much the same way. The Senate is still considering legislation, which differs from the House bill by inclusion of a needs test to determine eligibility. The AAMC has traditionally supported the notion that subsidy should be based on documented need. The CAS Board considered whether AAMC staff should work to include the Senate provisions in the final program structure and perhaps facilitate the program's reenactment.

ACTION: The Council of Academic Societies supports the ocncept of "needs analysis" for student loan consolidation eligibility and recommends that the AAMC work to secure the passage of a student loan consolidation program.

C. DISCUSSION ITEMS - CAS Board

1. CAS Annual Meeting Plans

The CAS Board reviewed the plans for the Annual Meeting of the Council of Academic Societies. The Report on the General Professional Education of the Physician (GPEP) will be discussed Sunday afternoon, October 28, 1984 from 1:30-5:00 p.m. There will be a one-hour plenary session with talks by David Alexander, D.Phil. and August Swanson, M.D. The participants will then have the opportunity to discuss one of the GPEP conclusions in a working group led by a CAS Board member. The participants will reconvene for a brief round-up/panel discussion by the working group leaders. The Board members who will lead the groups are as follows:

Conclusion 1 - Dr. Weldon/Dr. Kostyo
Conclusion 2 - Dr. Ginsberg/Dr. Cohen
Conclusion 3 - Dr. Johnson/Dr. Moody
Conclusion 4 - Dr. Kelly/Dr. Ganong
Conclusion 5 - Dr. Anderson/Dr. Wilson

The CAS Annual Business meeting will be held Monday afternoon from 1:30-5:00 p.m., October 29, 1984. The agenda will include discussion of the "Future Challenges for CAS" paper.

2. Agenda for the CAS Interim (Spring) 1985 Meeting

The CAS Board members discussed several ideas for the theme of the Spring meeting, including a potpourri of several small topics. The subject of the previous afternoon's plenary, "Financing Graduate Medical School Education", was received with the most enthusiasm. There was a concern that basic scientists might not perceive their role in this topic where the driving force is the changing patterns in clinical services. It was decided that the topic should be broadened to include an examination of support for all graduate education. A suggested title is: Changes in the Environment and Support of Medical and Graduate Education.

D. DISCUSSION ITEMS - Executive Council

1. Low Level Radioactive Waste Disposal

The CAS Board noted the current complacency about this issue, at both the state and national levels. The officials involved appear to assume that the January 1, 1986 deadline to develop regional waste disposal sites will be moved forward. At the same time the public is overly concerned about the effects of nuclear waste and resists actions to dispose of nuclear waste in their home states. Dr. Weldon suggested that the AAMC could go on the offensive with an effective public information campaign. Several Board members inquired about other professional associations, suggesting that the AAMC could increase its impact by joining with likeminded scientists to push for legislative action on both the state and national level.

ACTION: The CAS Board will discuss possible courses of action after staff obtains additional information and reports back to the Board.

APPOINTMENT OF 1985 CAS NOMINATING COMMITTEE

Section V, #1 of the CAS Bylaws reads as follows:

> "The Nominating Committee shall be comprised of a Chairman and six members. The Chairman, three basic science, and three clinical science individuals shall be appointed by the CAS Administrative Board from among representatives of the member societies. Not more than one representative may be appointed from a society and not more than two members may be current members of the Administrative Board. The Nominating Committee shall report to the Council at its Annual Meeting a slate of nominees for Administrative Board vacancies. Additional nominations for these positions may be made by any representative to the Council present at the meeting. The Committee will also recommend to the AAMC Nominating Committee candidates for Chairman-Elect of the Association of American Medical Colleges."

On the following pages is a list of all CAS Representatives from which the Board must choose at least three basic scientists and at least three clinical scientists to serve on the CAS Nominating Committee. The Board also must select a chairman for the Nominating Committee. Traditionally, the Chairman and Chairman-Elect of the CAS are members of the Nominating Committee. Several alternates should also be selected. The Committee will meet by conference call some time in May or early June to develop a slate of nominees to fill one basic and two clinical science positions. The Committee will also nominate a clinical scientist as Chairman-Elect of CAS.

The 1981-1984 CAS Nominating Committees are listed below.

1981

Daniel X. Freedman, M.D., Chairman
Robert M. Berne, M.D.
F. Marian Bishop, Ph.D.
David M. Brown, M.D.
David H. Solomon, M.D.
Warren Stamp, M.D.
Frank C. Wilson, M.D.

1982

David M. Brown, M.D., Chairman
Joseph R. Bianchine, Ph.D.
T. R. Johns, M.D.
Franklyn G. Knox, M.D., Ph.D.
John T. Sessions, Jr., M.D.
Frank C. Wilson, M.D.
Robert D. Yates, Ph.D.

1983

Frank C. Wilson, M.D., Chairman
Arthur J. Donovan, M.D.
Thomas W. Langfitt, M.D.
Robert M. Blizzard, M.D.
Robert L. Hill, Ph.D.
Howard E. Morgan, Ph.D.
Leonard Jarett, M.D.

1984

Robert L. Hill, Ph.D., Chairman
S. Craighead Alexander, M.D.
Lewis Aronow, Ph.D.
Joe Dan Coulter, Ph.D.
Gordon Kaye, Ph.D.
Virginia V. Weldon, M.D.
Benson R. Wilcox, M.D.

COUNCIL OF ACADEMIC SOCIETIES REPRESENTATIVES

(by society)

BASIC SCIENCES

American Association of Anatomists
- Dr. John V. Basmajian
- Dr. William P. Jollie

American Society for Cell Biology
- Dr. Daniel Branton
- Dr. Richard S. Young

Association of Anatomy Chairmen
- Dr. Douglas E. Kelly

Association for the Behavioral Sciences and Medical Education
- Evan G. Pattishall, Jr., MD
- Shirley Nicholas Fahey, Ph.D.

American Society of Biological Chemists
- Dr. Robert L. Hill

Association of Medical School Depts. of Biochemistry
- Dr. Donald B. McCormick
- Dr. Rose Johnstone

American Society of Human Genetics
- David Rimoin, MD
- Frank Ruddle, MD

Association of Medical School Microbiology Chairmen
- Harold S. Ginsberg, MD

Society for Neuroscience
- Dr. David H. Cohen
- Dr. Joe Dan Coulter

American College of Neuropsychopharmacology
- Arnold Friedhoff, MD
- Oakley Ray, Ph.D.

American Society for Clinical Pharmacology & Therapeutics
- Carl C. Peck, MD
- George N. Aagaard, MD

American Society for Pharmacology and Experimental Therapeutics
- Dr. Lewis Aronow
- Dr. William L. West

Association for Medical School Pharmacology
- Paul C. Bianchi, Ph.D.
- William L. West, Ph.D.

American Physiological Society
- Jack L. Kostyo, Ph.D.
- George A Hedge, Ph.D.

Association of Chairmen of Depts. of Physiology
- Dr. William F. Ganong
- Dr. Howard E. Morgan

CLINICAL SCIENCES

American Academy of Allergy
- Paul Vanarsdel, MD

Association of University Anesthetists
- C. Philip Larson, Jr., MD
- Nicholas M. Greene, MD

Society of Academic Anesthesia Chairmen
- S. Craighead Alexander, MD
- Robert M. Epstein, MD

American Association for the Study of Liver Diseases
- Dr. David H. Van Thiel
- Dr. Paul D. Berk

American Federation for Clinical Research
- Benjamin D. Schwartz, MD, Ph.D.
- Gary W. Hunninghake, MD

American Society for Clinical Investigation
- Robert Glickman, MD
- Joseph L. Goldstein, MD

Central Society for Clinical Research
- Murray L. Levin, MD

Plastic Surgery Research Council
- Robert L. Ruberg, MD
- Jane A. Petro, MD

Society for Gynecologic Investiation
John M. Bissonnette, MD
William Spellacy, MD

Society for Pediatric Research
Lawrence A. Boxer, MD
William F. Balistreri, MD

Association of Professors of Dermatology, Inc.
Philip C. Anderson, MD

Society of Critical Care Medicine
Solomon G. Hershey, MD

Society of Teachers of Emergency Medicine
Richard M. Nowak, MD
Glenn C. Hamilton, MD

Endocrine Society
Jo Anne Brasel, MD
Virginia V. Weldon, MD

Association of Departments of Family Medicine
Thornton Bryan, MD
Ken Goss, MD

Society of Teachers of Family Medicine
B. Lewis Barnett, Jr., MD
Jack M. Colwill, MD

American Association for the Surgery of Trauma
Donald S. Gann, MD
William R. Drucker, MD

American Surgical Association
Jerome J. DeCosse, MD, Ph.D.
Walter Lawrence, MD

Association of Academic Surgery
John Clark, MD
Caliann G. Lum, MD

Society for Surgery of the Alimentary Tract, Inc.
John R. Brooks, MD
John Cameron, MD

Society of Surgical Chairmen
Frank G. Moody, MD
David B. Skinner, MD

Society of University Surgeons
Morris D. Kerstein, MD
John W. Harmon, MD

American College of Physicians
Marvin Turck, MD
Thomas W. Burns, MD

Association of American Physicians
Leighton E. Cluff, MD
Alfred Jay Bollet, MD

Association of Professors of Medicine
Joseph E. Johnson, III, MD
Norman G. Levinsky, MD

Association of Program Directors in Internal Medicine
Louis M. Sherwood, MD
James Klinenberg, MD

American Gastroenterology Association
James Christensen, MD
Douglas McGill, MD

American Society of Hematology
Paul R. McCurdy, MD
Ernest R. Jaffe, MD

American Academy of Neurology
Jerry G. Chutkow, MD
Rosalie A. Burns, MD

American Neurological Association
Kenneth P. Johnson, MD
Frank M. Yatsu, MD

Association of University Professors of Neurology
Donald Silberberg, MD
Ludwig Gutmann, MD

Child Neurology Society
Gwendolyn R. Hogan, MD
Samuel Shelburne, MD

American Association of Neurological Surgeons
Robert Grossman, MD
Nicholas Zervas, MD

American College of Obstetricians and Gynecologists
Harrison C. Visscher, MD
Harry S. Jonas, MD

Association of Professors of Gynecology and Obstetrics
Joseph C. Scott, Jr., MD
Douglas R. Knab, MD

American Academy of Ophthalmology
Robert D. Reinecke, MD
Joel G. Sacks, MD

Association of University Professors of Ophthalmology
George Weinstein, MD
Robert Kalina, MD

American Academy of Orthopaedic Surgeons
Charles V. Heck, MD
Frank C. Wilson, MD

American Orthopaedic Association
Robert B. Greer, MD
C. McCollister Evarts, MD

Association of Orthopaedic Chairmen
Wilton H. Bunch, MD, Ph.D.
John P. Adams, MD

Association of Academic Departments of Otolaryngology
Robert I. Kohut, MD
Warren Y. Adkins, MD

Society of University Otolaryngologists
John M. Fredrickson, MD
Jerome Goldstein, MD

American Pediatric Society
Myron Genel, MD
Charles A. Alford, MD

Association of Medical School Pediatric Department Chairmen, Inc.
Thomas K. Oliver, MD
Robert M. Blizzard, MD

American Academy of Physical Medicine and Rehabilitation
B. Stanley Cohen, MD
Arthur E. Grant, MD

Association of Academic Physiatrists
William E. Stass, Jr., MD
Theodore M. Cole, MD

American Association of Plastic Surgeons
Hal G. Bingham, MD
Charles E. Horton, MD

Plastic Surgery Educational Foundation
R. Barrett Noone, MD
Paul N. Manson, MD

American Association of Chairman of Departments of Psychiatry
Jerry M. Wiener, MD
Robert L. Leon, MD

American College of Psychiatrists
Robert L. Williams, MD
Robert O. Pasnau, MD

American Association of Directors of Psychiatric Residency Training
Peter B. Henderson, MD
George L. Ginsberg, MD

American Psychiatric Association
Daniel X. Freedman, MD
Herbert Pardes, MD

Association for Academic Psychiatry
Larry Silver, MD
Carolyn Robinowitz, MD

Association of Directors of Medical Student Education in Psychiatry
Marshall Swartzberg, MD
George U. Balis, MD

Association of University Radiologists
A. Everette James, Jr., MD
Paul J. Friedman, MD

Society of Chairmen of Academic Radiology Departments
Ralph Alfidi, MD
Larry P. Elliott, MD

American Association for Thoracic Surgery
Clarence S. Weldon, MD
Judson G. Randolph, MD

Thoracic Surgery Directors Assn.
Benson R. Wilcox, MD
Hermes C. Grillo, MD

Society of University Urologists
William L. Parry, MD
Harry C. Miller, Jr., MD

Society for Health and Human Values
Joel Frader, MD
David C. Thomasma, Ph.D.

Association of Pathology Chairmen
Leonard Jarett, MD
Rolla B. Hill, Jr., MD

Academy of Clinical Laboratory Physicians and Scientists
Paul E. Strandjord, MD

Association of Teachers of Preventive Medicine
David L. Rabin, MD
Jay Noren, MD

MEMBERSHIP APPLICATION
COUNCIL OF ACADEMIC SOCIETIES
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

MAIL TO: AAMC, Suite 200, One Dupont Circle, N.W., Washington, D.C. 20036
Attn: Mr. David Moore

NAME OF SOCIETY: The American Society for Clinical Nutrition

MAILING ADDRESS: 9650 Rockville Pike
Bethesda, MD 20814
USA

PURPOSE: To encourage undergraduate and graduate education and research in human nutrition in health and disease, to provide opportunity for intestigators to present and discuss their research in human nutrition, and to provide a journal or journals for publication of meritorious work in experimental and clinical nutrition. A further major aim of the Society is to promote the proper application of the findings of nutrition research to the practice of medicine and related health professions and to provide reliable clinical nutrition information to the professional community and the public.

MEMBERSHIP CRITERIA: Conducted and published meritorious original investigations in clinical nutrition.

NUMBER OF MEMBERS: 630

NUMBER OF FACULTY MEMBERS: -0-

DATE ORGANIZED: September 2, 1959

SUPPORTING DOCUMENTS REQUIRED: (Indicate in blank date of each document)

Revised 1984 1. Constitution & Bylaws

May 4-5, 1984 2. Program & Minutes of Annual Meeting

(CONTINUED NEXT PAGE)

QUESTIONNAIRE FOR TAX STATUS

1. Has your society applied for a tax exemption ruling from the Internal Revenue Service?

__X__ YES _____ NO

2. If answer to (1) is YES, under what section of the Internal Revenue Code was the exemption ruling requested?

501(c)3

3. If request for exemption has been made, what is its current status?

X a. Approved by IRS

___ b. Denied by IRS

___ c. Pending IRS determination

4. If your request has been approved or denied, please forward a copy of Internal Revenue letter informing you of their action.

Ann Knight
(Completed by - please sign)

11-1-84
(Date)

MEMBERSHIP APPLICATION
COUNCIL OF ACADEMIC SOCIETIES
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

MAIL TO: AAMC, Suite 200, One Dupont Circle, N.W., Washington,D.C. 20036 Attn: Mr. David Moore

NAME OF SOCIETY: American Geriatrics Society

MAILING ADDRESS: 10 Columbus Circle Room 1470
New York, NY 10019

PURPOSE: See Article II from the American Geriatrics Society, Inc. By-Laws

MEMBERSHIP CRITIERIA: See back of Membership Brochure

NUMBER OF MEMBERS: 4600 Members

NUMBER OF FACULTY MEMBERS:

DATE ORGANIZED: 1942; Incorporated July 17, 1952

SUPPORTING DOCUMENTS REQUIRED: (Indicate in blank date of each document)

April 23, 1976 1. Constitution & Bylaws

May 17, 1984 2. Program & Minutes of Annual Meeting

(Continued on Next Page)

QUESTIONNAIRE FOR TAX STATUS

1. Has your society applied for a tax exemption ruling from the Internal Revenue Service?

✓ YES _____ NO

2. If answer to (1) is YES, under what section of the Internal Revenue Code was the exemption ruling requested?

501 (c) 3

3. If request for exemption has been made, what is its current status?

✓ a. Approved by IRS

___ b. Denied by IRS

___ c. Pending IRS determination

4. If your request has been approved or denied, please forward a copy of Internal Revenue letter informing you of their action.

Linda M. Heddesheimer
(Completed by + please sign)

24 Sept 1984
(Date)

FUTURE CHALLENGES FOR THE COUNCIL OF ACADEMIC SOCIETIES

During the past year, the Council of Academic Societies has been engaged in identifying and discussing the future challenges facing medical school faculties in the areas of medical education, research, and patient care. The first stage of this process occurred during the CAS Spring Meeting in April. At that time, following the time-honored faculty tradition of full participatory democracy, the entire Council discussed a variety of issues that it considered important in the areas highlighted above. Subsequent to these discussions, staff prepared a preliminary draft of the issues paper for consideration by the Administrative Board at its June and September meetings. The initial draft of the paper identified a large number of issues of interest without making a serious effort to assign any priorities for action to each. Discussion was guided by the following three questions:

(1) Have the major issues facing faculties been identified?
(2) Are there significant issues that have been omitted?
(3) Are the issues that have been identified germane to the CAS?

At the September meeting, the Board decided to enlist the aid of the Council representatives to answer these questions and to decide the priorities for the issues identified. In late September, the current draft of the paper was forwarded to the representatives from each society. The representatives also received a copy of a survey, which asked them to rate each of twenty-four possible action items identified within the paper on the basis of whether the item had a high, average, or low priority for the CAS. In addition, representatives were asked to rank the top five issues from among those that they considered to have a high priority.

The results of the survey were made available during the Council's discussion of the document at the Annual Meeting of the CAS in Chicago on October 29. Fifty-six percent of the societies responded, with an equal proportion of basic science and clinical societies represented. The following items were given the highest priority most often in the survey:

(1) The CAS should continue strong advocacy for biomedical research appropriations.
(2) The CAS should continue efforts to achieve increased funding for research training.
(3) The CAS should work with departmental chairmen to increase the institutional priority for medical student education.
(4) The CAS should focus more attention on examining policies and initiatives for support of junior research faculty/new investigators.
(5) The CAS should provide a forum for discussion and development of policies to balance competing interests in an atmosphere of constrained funding.
(6) The CAS should undertake an examination of how medical student education programs are supported.
(7) The CAS and individual academic societies should involve themselves in efforts to limit restrictions on the use of animals in research.

In addition, basic scientists supported the following items:

(8) The CAS should provide a forum for the presentation and discussion of knowledge and skills that should be shared by all disciplines in the biomedical sciences.

(9) The CAS should examine how faculty involvement in planning and implementing improvements in medical education can be enhanced.

And clinicians expressed interest in these topics:

(10) The CAS should become involved in policy issues related to faculty practice efforts and their relation to the overall academic missions of faculty.
(11) The CAS should support the establishment of an AAMC-wide Task Force to discuss proposed policies and funding for graduate medical education.

During Council discussion it was noted that most of the top priority issues centered on challenges to the faculty in their roles as biomedical investigators. One veteran Council member commented that this emphasis accorded with the role of the CAS in relation to the other two Councils as it had evolved over the last 15 years. He observed that while all members of the academic community were concerned about a wide range of issues, a tradition had developed that the COD took the lead in issues related to medical student education, the COTH led in issues of patient care, and the CAS led in the area of biomedical research.

The Council agreed that the next logical step would be for representatives to review the document and the identified priorities with their respective societies before formulation of any final action agenda. In considering possible agendas in response to issues highlighted by the Council, it is important to be aware of current CAS/AAMC activities in these areas.

(1) The CAS should continue strong advocacy for biomedical research appropriations.

Both the CAS and the Association have been intimately involved in efforts to unite the research community in advocacy for appropriate budget requests for NIH and ADAMHA research through the Ad Hoc Group on Medical Research Funding. The Ad Hoc Group's strategy of agreement by the research community on a single overall budget request for NIH and ADAMHA has received favorable response from the Appropriations Committees and has contributed significantly to the Congressionally mandated increases for biomedical research appropriations in a time of fiscal austerity.

(2) The CAS should continue efforts to achieve increased funding for research training.

Within the Ad Hoc Group's "bottom line" budget requests, the CAS and the AAMC have supported proposals for the distribution of additional funding across different types of programs, including research training and research career awards, as well as the provision of funds to meet the National Academy of Science recommended number of research trainees and to expand the research career/scientist award programs. These efforts proved very successful in 1985 when a 33 percent increase in the NIH NRSA budget was approved.

(5) The CAS should provide a forum for discussion and development of policies to balance competing interests in an atmosphere of constrained funding.

In 1983 the CAS Interim Meeting was devoted to a discussion of the relative balance of funding among various components of the NIH portfolio during an era of constrained funding. At that time attention was focused on the limitations in funding for research training and other components of the grants portfolio because of the squeeze on a fixed budget occasioned by funding 5,000 R01s.

(4) The CAS should focus more attention on examining policies and initiatives for

support of junior research faculty/new investigators.

(11) The CAS should support the establishment of an AAMC-wide Task Force to discuss proposed policies and funding for graduate medical education.

The CAS Spring Meeting in 1985 will be devoted to a discussion of "Supporting Graduate Education in the Biomedical Sciences." This meeting will deal with both pre- and post-doctoral Ph.D. training as well as clinical fellowships and research training for M.D.s. CAS representatives will also have a chance to discuss the progress of the AAMC's Ad Hoc Committee on Funding Graduate Medical Education. The Administrative Board will have an opportunity at the January meeting to review the recent policy discussions of the NIH Director's Advisory Committee concerning the extramural awards program, especially in regard to its support of new investigators.

(7) The CAS and individual academic societies should involve themselves in efforts to limit restrictions on the use of animals in research.

With regard to efforts to limit restrictions on the use of animals in research, the CAS has been actively involved in the Association's participation in an ad hoc steering committee instrumental in the merger of the NSMR and the ABR. This joining of resources within the scientific community will provide a unified program of educational and legislative activities to both academic institutions and research societies. The AAMC has also been working with the AMA and the APS to raise the level of awareness of this problem among a variety of medical and scientific organizations. In addition, the CAS is planning an exhibit of educational materials at the 1985 CAS Spring Meeting. This exhibit will inform the academic societies about the types of materials currently available for use in public education programs on animal research.

(10) The CAS should become involved in policy issues related to faculty practice efforts and their relation to the overall academic missions of faculty.

The January Administrative Board agenda includes a discussion of a proposed survey of Deans and faculty which would help to identify and articulate policy concerns related to faculty practice plans. This survey represents the first stage in an Association examination of practice plans occasioned by the high priority assigned to this issue in both the CAS and COD issues papers.

(3) The CAS should work with departmental chairmen to increase the institutional priority for medical student education.

(6) The CAS should undertake an examination of how medical student education programs are supported.

(8) The CAS should provide a forum for the presentation and discussion of knowledge and skills that should be shared by all disciplines in the biomedical sciences.

(9) The CAS should examine how faculty involvement in planning and implementing improvements in medical education can be enhanced.

These items within the area of medical student education should be considered as part of CAS/AAMC GPEP follow-up activities.

CAS SPRING MEETING
March 14-15, 1985

Supporting Graduate Education in the Biomedical Sciences

Thursday, March 14

10 a.m. - Noon — Supporting Graduate Doctoral Education

Predoctoral Education of Ph.D.s

Robert M. Bock, Ph.D.
Dean, Graduate School, U. of Wisconsin-Madison
Chair, Basic Biomedical Sciences Panel
IOM Committee on Research Personnel

Postdoctoral Ph.D. Education

Frank G. Standaert, M.D.
Chair, Pharmacology, Georgetown University
Member, Basic Biomedical Sciences Panel

Noon - 1:30 p.m. — LUNCH

1:30 p.m. - 3 p.m. — Supporting Graduate Medical Education

Subspecialty Clinical/Research Training for MDs

Research Training for MDs

James B. Wyngaarden, MD
Director, National Institutes of Health

3 p.m. - 4:30 p.m. — DISCUSSION GROUPS

4:30 p.m. - 5:30 p.m. — Financing Graduate Medical Education

Report from AAMC Ad Hoc Committee on Residency Training

J. Robert Buchanan, MD
General Director, Massachusetts General Hospital
Chairman, AAMC Committee

5:30 p.m. - 7:30 p.m. — RECEPTION

Friday, March 15

8:30 a.m. - Noon — BUSINESS MEETING

'ANIMAL ROOM' AT THE CAS SPRING MEETING

In the past few years the scientific community has been threatened with federal, state, and local laws which would restrict the use of live animals for biomedical research. For some time it seemed tha the 'Animal Lobby' was so patently wrong that the American public would see through their emotional arguments without further comment. Unfortunately, this is not continuing to be the case. In recognition of the need to tell the pro-biomedical research side of the story, several scientific organizations have produced brochures, films, and policy statements about specific proposed political activities. Unfortunately, not enough pro-science organizations have spoken out, and not enough members of the public understand the crucial nature of animal research activities. Therefore, to assist those organizations who might wish to join the pro-science forces in a more active way, a compendium of the available brochures and videotapes will be made available in an "animal room". Meeting attendees who visit the room will have the opportunity to view "A Question of Life" by the California Biomedical Research Association and "Will I Be All Right, Doctor?" by The Foundation for Biomedical Research, to take home copies of brochures, and to review policy statements made by other scientific organizations.

NIH EXTRAMURAL RESEARCH AWARD SYSTEM

In response to continuing concern with and criticism of the current grant awarding mechanism by the scientific community the NIH Director's Advisory Committee (DAC) recently conducted a day-long discussion of the NIH extramural awards system. The meeting, which was held on November 19, 1984, continued a dialogue that began on September 30-October 1 with a retreat for the Director, members of his staff, and the Institute Directors. Both meetings explored the underlying philosophy and structure of the NIH extramural award system and considered possible options to simplify the current peer review system, maintain incentives for new investigators to seek research careers, stabilize the research environment for investigators through longer award periods and increased emphasis on past productivity, and assure an equitable review for all applications including clinical research proposals.

Two central issues emerged from these meetings. Does the current two-tiered system of review by scientific peer groups and institute advisory councils function in an effective and efficient manner in selecting grant recipients? And, are the grants themselves structured to produce maximum benefit, for both the investigator's research career and the scientific enterprise as a whole.

In his opening remarks at the November DAC meeting, Dr. Wyngaarden pointed out that the fundamental principle of the NIH extramural awards system -- to distribute funds through national competition based on scientific merit and technical feasibility -- was formulated at a time when the philosophy was that such funding was an investment. Since then, the competition for funding has dramatically increased. Through the mid-1960s, the NIH budget annually increased by 24 percent in terms of purchasing power. But since 1968, the annual increase in purchasing power has been only two percent, and between 1979 and 1982, the NIH budget lost 12 percent in purchasing power. Meanwhile, the number of applications has tripled during the last decade, and the number of R01 and P01 grants has grown from 9,000 to over 18,000. Extramural research funds accounted for 65 percent of the total NIH budget in 1983, compared with 44 percent in 1972. Still, there has been a continued decrease in the payline for grant applications to the 160-180 range. In 1984, NIH was able to fund only 32 percent of all grant applications.

This increasing competitive pressure has resulted in a shift from a philosophy of investment to one of procurement, which, in turn, has produced increased demands for accountability. Grant applications require much more specification than ever before, run into hundreds of pages, and take from three to six months to prepare. The drive for accountability has also shortened the length of the awards being made; virtually all first-time awards are for three years. Shorter awards require investigators to organize and submit applications for renewal 15 to 18 months after the original award. Thus the trend is increasingly towards safe research with quick pay-offs. Young investigators are particularly pressured by such tight schedules because of the time required to establish laboratories.

Peer Review

The first part of the DAC meeting dealt with the grant review process; both the study sections and the advisory councils. While it was agreed that no alternative to peer review was desired, it also was acknowledged that significant concerns over the mechanics of the review still exist within the scientific community. Dr. Wyngaarden expressed some of the concern of the extramural community by asking whether the system was capable of distinguishing between degrees of excellence in research

proposals. Several other issues were raised, including the "behavior" of the study sections. Dr. Howard Morgan, chairman of the Department of Physiology at The Pennsylvania State University, noted that many study sections replace outgoing members with individuals from the same laboratories or with associates, thus perpetuating a limited set of views within that section. Others criticized the heavy workload of the study sections, stating that some study section members read only those applications assigned specifically to them. It was pointed out that the number and complexity of the grant applications encourages study sections to focus only on what is wrong with the applications -- a practice critics claim discourages submission of valid, but incomplete research ideas. The large number of applications also was blamed for study sections using less experienced reviewers, a charge critics claim is substantiated by "non-germane" critiques in the pinksheets summarizing the study section's review.

The institutes' advisory councils also came under criticism from members of the DAC. The purpose of the review by the councils is unclear to some observers. Critics charged that some councils are not scientifically competent to review decisions made by study sections, that they do not receive adequate staff support from the institutes, and that they only serve as "instant replay" for the peer review. The increasing politicization of appointment to institute advisory councils was also decried. It was suggested that councils might make more use of ad hoc consultants and that councils should become better equipped to perform their oversight function. However, there was no consensus within the committee of specific steps to accomplish these solutions.

Extramural Awards

The second set of issues surrounds the awards themselves, particularly the length of the awards. Concern was expressed that the current system of renewal every three years places extreme constraints on the investigators. Individuals must make a heavy investment to enter a system where only 35 percent of the applicants are funded and where the "half-life" for investigators is only seven years. There was much discussion of the wisdom of a system that loses trained investigators after such a relatively short period of time. It was also noted that the necessity of reapplying after only 15 to 18 months means that some individuals, especially new investigators, may not have an adequate time to demonstrate adequate research performance before renewal.

Discussion focused on what the desirable characteristics of the award system would be for investigators at different career stages: new, mid-career, and established investigator. There was significant sentiment toward extending the length of grant awards beyond three years. It was felt that this would benefit new investigators by providing them more time for startup and allowing them to establish evidence of independent productivity before renewal. Problems identified for mid-career investigators included hiatuses in funding when the competitive renewal score of an excellent investigator just misses the payline cutoff. Possibilities for interim funding were discussed.

Dr. Vernon Mountcastle of Johns Hopkins noted that while peer review has "the power to weed out those who do not have the capacity for sustained discovery throughout an extended career," mistakes do happen in the present system. He proposed a system where an institute could carry an investigator for up to two years, while the investigator applied for a grant. Dr. Mountcastle's system would require that the individual's institution make the decision to extend funding and a significant contribution to that funding.

Established investigators were felt to need a system which acknowledges their exceptional track records and makes awards based upon past performance more than proposed research. Members of the DAC heard from both the NCI and the NINCDS about their newly instituted programs to support established investigators at the "peak" of their careers. Dr. Vincent DeVita, director of the NCI, noted that his institute's Outstanding Investigator Awards will provide stability to proven researchers by consolidating their research support and providing it for a longer period of time. The premise of the awards is to support the investigator, not a specific project. Dr. Murray Goldstein, director of the NINCDS, described the Javits Awards program. Like the NCI award, the Javits Award is intended to provide support for seven years. Unlike the NCI award, however, the applicant cannot specifically apply for these awards. NINCDS staff examines applications for regular grants to identify those individuals whose records might warrant a seven year commitment.

The tenor of the meeting was toward the support of longer award cycles for investigators at each "life stage." It was felt that this change would increase stability, enhance creativity and research productivity, diminish unproductive stress, and reduce the aura of futility that surrounds the awards system, discouraging young people from seeking research careers.

Caution was urged by Dr. Wyngaarden, who pointed out that extending the commitment base would cost more money in the long run, which would mean fewer new grants if the current tight budget situation continues. Another criticism was heard from Dr. Mountcastle who disagreed with the concept of stability and characterized research as "a Darwinian system where peer review selects those best able to continue." He emphasized that extensive efforts to support investigators, as opposed to projects, were not warranted.

No final policy conclusions were reached at the meeting, but it is clear from both this last meeting of the DAC and its December 1983 meeting devoted to Research Training that the NIH is considering changes in research policy in areas of key interest to members of CAS. There has not been a systematic review of these aspects of biomedical science policy by CAS/AAMC in recent years. The NIH is actively seeking the advice of the science community in regard to its research and training policies.

Recommendation

That CAS consider establishing a Working Group or urging the establishment of an AAMC ad hoc committee on federal research training and career development policies.