



**association of american  
medical colleges**

# **AGENDA**

**FOR**

**COUNCIL OF TEACHING HOSPITALS**

**ADMINISTRATIVE BOARD MEETING**

**April 16, 1987**

**8:00 a.m.**

**Washington Hilton Hotel**

**Independence Room**

## COTH ADMINISTRATIVE BOARD

Chairman: Spencer Foreman, MD  
Montefiore Medical Center

Chairman-Elect: J. Robert Buchanan, MD  
Massachusetts General Hospital

Immediate Past Chairman: C. Thomas Smith  
Yale-New Haven Hospital

Secretary: John E. Ives  
Shands Hospital

Gordon M. Derzon  
University of Wisconsin Hospital  
and Clinics

Gary Gambuti  
St. Luke's-Roosevelt Hospital

Jerome H. Grossman, MD  
New England Medical Center, Inc.

William H. Johnson, Jr.  
University of New Mexico  
Hospital

Larry L. Mathis  
The Methodist Hospital

James J. Mongan, MD  
Truman Medical Center

Charles M. O'Brien, Jr.  
Georgetown University Hospital

Raymond G. Schultze, MD  
UCLA Hospitals and Clinics

C. Edward Schwartz  
Hospital of the University  
of Pennsylvania

Barbara A. Small  
Veterans Administration  
Medical Center

Jack Owen  
AHA Representative

## COTH MEETING DATES

### COTH ADMINISTRATIVE BOARD MEETINGS

April 15-16, 1987

The Washington Hilton Hotel  
Washington, DC

June 17-18, 1987

Same

September 9-10, 1987

Same

### COTH SPRING MEETINGS

May 13-15, 1987

The Fairmont Hotel  
Dallas, TX

May 11-13, 1988

The New York Hilton Hotel  
New York, NY

May 10-12, 1989

The Hotel del Coronado  
San Diego, CA

### AAMC ANNUAL MEETINGS

November 7-12, 1987

The Washington Hilton Hotel  
Washington, DC

November 12-17, 1988

The Marriott Hotel  
Chicago, IL

October 28-November 2, 1989

The Washington Hilton Hotel  
Washington, DC

MEETING SCHEDULE  
COUNCIL OF TEACHING HOSPITALS  
ADMINISTRATIVE BOARD

April 15-16, 1987  
Washington Hilton Hotel  
Washington, DC

WEDNESDAY, April 15, 1987

6:00p           JOINT ADMINISTRATIVE BOARDS SESSION  
                  Monroe West Room

6:45p           JOINT BOARDS RECEPTION AND DINNER  
                  Monroe East Room

THURSDAY, April 16, 1987

8:00am           COTH ADMINISTRATIVE BOARD MEETING  
                  Independence Room

12:00noon       JOINT AAMC ADMINISTRATIVE BOARDS LUNCHEON  
                  Conservatory Room

1:00pm           AAMC EXECUTIVE COUNCIL BUSINESS MEETING  
                  Georgetown East Room

# A G E N D A

## COUNCIL OF TEACHING HOSPITALS ADMINISTRATIVE BOARD MEETING

April 16, 1987  
WASHINGTON HILTON HOTEL  
Independence Room  
8:00am-12:00noon

- I. CALL TO ORDER Dr. Foreman
- II. CONSIDERATION OF MINUTES
  - A. September 11, 1986 Page 1
  - B. January 22, 1987 Page 11
- III. OFFICER, COMMITTEE, AND STAFF REPORTS
  - A. COTH Chairman Dr. Foreman
  - B. COTH Spring Meeting Chairman Dr. Mongan
    - o Final Program Page 20
    - o Informal Evening with Dr. Petersdorf
  - C. COTH Nominating Committee Mr. Smith
    - o Presentation to AHA Nominating Committee
  - D. AAMC Chairman Dr. Stemmler
    - o AAMC/AAHC Forum
  - E. AAMC President Dr. Petersdorf
    - o Physician Supply Task Force
  - F. Vice President for Clinical Services Jim Bentley
    - o Housestaff Survey of Stipends and Benefits
    - o Survey of Financial and Operating Data for Academic Medical Center Hospitals
    - o Update on Ambulatory Education Grant Page 21
    - o Update on Teaching Hospital Policy Analysis Grant Page 24

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- o Update on Medicare's Indirect Medical Education Adjustment Page 26

IV. ACTION ITEMS

A. Membership Applications

- o Children's Medical Center Dayton, Ohio Page 27

Staff Recommendation: Full Membership

- o Dana-Farber Cancer Institute Boston, Massachusetts Page 34

Staff Recommendation: None

- B. Committee on Strategies for Promoting Academic Medical Center Report Gayle McNutt  
Executive Council  
Agenda - Page 13

- C. Committee on Faculty Practice Report Executive Council  
Agenda - Page 20

D. Graduate Medical Education Issues

- o Proposal for International Medical Scholars Program Executive Council  
Agenda - Page 32
- o ACGME Policy Matters Executive Council  
Agenda - Page 29
- o Transition Committee Report Followup Handout

- E. Use of Animals in Medical Education Executive Council  
Agenda - Page 48

- F. Change in AAMC Retirement Policy Executive Council  
Agenda - Page 12

V. DISCUSSION ITEMS

- A. JCAH Accreditation and the Academic Medical Center Executive Council  
Agenda - Page 49

- B. 1990 COTH Spring Meeting Preferences Page 42

- C. COTH Directory: Format and Information Page 43

- D. Annual Meeting Program Page 48

- E. Legislative Report Handout

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VI. INFORMATION ITEMS

- |  |                                       |
|--|---------------------------------------|
| A. Limited Liability for Officers<br>and Directors       | Executive Council<br>Agenda - Page 90 |
| B. Appointment of AAMC Task Force on<br>Physician Supply | Executive Council<br>Agenda - Page 92 |
| C. NSF Proposed Misconduct in Science<br>Policy          | Executive Council<br>Agenda - Page 97 |

VII. ADJOURN

ASSOCIATION OF AMERICAN MEDICAL COLLEGES  
COTH ADMINISTRATIVE BOARD MEETING  
September 11, 1986

PRESENT

C. Thomas Smith, Chairman  
Sheldon S. King, Immediate Past Chairman  
Spencer Foreman, MD, Chairman-Elect  
Robert J. Baker  
J. Robert Buchanan, MD  
Gordon M. Derzon  
Gary Gambuti  
John E. Ives  
Larry L. Mathis  
Eric B. Munson  
Charles M. O'Brien, Jr.  
Raymond G. Schultze, MD

ABSENT

James J. Mongan, MD  
Barbara A. Small  
AHA Representative

GUESTS

Richard Janeway, MD  
Edward J. Stemmler, MD  
Virginia V. Weldon, MD

STAFF

James D. Bentley, PhD  
James B. Erdmann, PhD  
Robert Jones  
Richard M. Knapp, PhD  
Sonia M. Kohan  
Robert G. Petersdorf, MD  
Nancy E. Seline  
John F. Sherman, PhD  
August G. Swanson, MD  
Judith L. Teich  
James Terwilliger  
Kathleen Turner  
Melissa H. Wubbold

# COTH ADMINISTRATIVE BOARD MEETING MINUTES

September 11, 1986

## I. CALL TO ORDER

Mr. Smith called the meeting to order at 8:00a in the Map 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 18-19, 1986 COTH Administrative Board meeting.

Before moving directly to the agenda, Mr. Smith reminded Board members that this would be the last meeting of the Board as it was presently constituted. He indicated that the Board would not have a breakfast meeting in New Orleans as has been the custom in the past as it is not believed to be necessary.

As indicated, Jim Mongan, MD has agreed to chair the COTH Spring Meeting Planning Committee for the 1987 COTH Spring Meeting which will be held in Dallas, May 13-15. Serving on that committee with Dr. Mongan will be Paul Griner, MD, Strong Memorial Hospital, Rochester, NY; David Hitt, Methodist Hospital, Dallas; Delanson Hopkins, Rhode Island Hospital, Providence; Barabara Small, Veterans Administration Medical Center, San Diego; and Michael Stringer, University of California Medical Center, San Diego. The committee will be meeting on November 10. If Board members have any recommendations, it was suggested they contact Dr. Mongan as soon as possible.

In the August 15 Board memorandum announcing the September meeting, Board members were reminded that John Reinertsen serves as a member of the Professional and Technical Advisory Panel of the Hospital Accreditation Program of the JCAH. Before adjournment, the Chairman indicated that he hoped the Board would briefly discuss problems that institutions may be having with any aspect of the hospital accreditation program.

Mr. Smith introduced Jim Terwilliger, a staff associate in the Department of Program Planning and Policy Development; and Sonia Kohan, a new member of the staff of the Department of Teaching Hospitals. Sonia is a native of Johnstown, PA, who earned a BS from Penn State and recently was awarded a Master's Degree from the Health Systems Management Program at Rush University in Chicago. She joined the department as an Administrative Fellow on July 15, 1986, and Mr. Smith asked that each Board member welcome her to the group.

## III. DISCUSSION WITH THE AAMC PRESIDENT

Mr. Smith welcomed Dr. Petersdorf to the COTH Administrative Board meeting, and indicated the group's pleasure at having the opportunity of an introductory discussion with him. Dr. Petersdorf expressed his pleasure at being selected to serve as the AAMC President and indicated he had some general observations that he would like to share with the group, and then answer questions or listen to observations that members of the Board might have. The following points summarize his presentation:

- o The Council of Teaching Hospitals presently has four of 21 members of the AAMC Executive Council. He indicated that the matter of equity and governance of the AAMC for all constituent bodies was an item to which he was giving attention. The matter needs to be approached sensibly and with sensitivity.



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September 11, 1986

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- o There is a need to find a way to involve house officers in the AAMC organization. This is probably an activity which would best be served by an organizational relationship to the Council of Teaching Hospitals.
- o The relationships of the various groups (e.g., Group on Public Relations, Group on Business Affairs, Group on Medical Education, etc.) to AAMC councils and their staffing within various departments of the AAMC does need to be re-examined.
- o Jim Bentley has been made a member of the AAMC Executive Staff.
- o Graduate medical education funding issues are responsibilities that rest firmly with the constituents and Board of the Council of Teaching Hospitals. Different ways need to be found to meet the service responsibilities currently met by the housestaff, and resistance needs to be forthcoming in the constant requests of chiefs of service for more house officers.
- o In an effort to ascertain the views of the constituents with regard to the current and future mission of the AAMC, a survey questionnaire will be sent to all constituents. They will be asked what they do and do not consider worthwhile, what might be done in addition to current services, and what services might not be needed.
- o There appears to be no medium range plan of what the Association hopes to accomplish on a three to five year basis. There is some question as to whether or not one can have such a plan if the major focus of the organization is on affairs in Washington, DC. An effort will be made to formalize a visitation program to member institutions to be sure the "Washington mentality" does not dominate the thinking of the staff. An effort will be made to determine whether or not a medium to long range planning document would be a useful project to undertake.

The following questions were raised:

- o What is the current and future thinking with regard to the relationship with the Association of Academic Health Centers? This is a "tricky" issue on which the staff and the leadership are working. It is very important, and every effort will be made to bring the two organizations closer together.
- o Is any consideration being given to changing the name of the organization? Probably the name that would best suit this organization is the Association of Academic Health Centers; however, that name is already in use. The Association of Academic Medical Centers gives a decisively medical orientation to the organization, and might not be much of an improvement over the current Association of American Medical Colleges.
- o The role of the housestaff in the organization was identified. Is any similar role being considered for purposes of doctoral candidates in the basic sciences disciplines? This is a good suggestion which should be given some consideration.

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September 11, 1986

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- o The wide variety of organizations, particularly in the Council of Teaching Hospitals, and the fact that many of them do not feel a strong allegiance to the organization, suggests the possibility that a subset of councils or a regional council or organization might be a useful exercise to get closer to the membership. Is any consideration being given to such structural change? There is a tradeoff here between an organizational approach and fragmentation of the organization and its decision making process. Perhaps a better way to approach this issue might be to identify particular staff members who exhibit expertise with respect to the particular kind of subsets of the organization to which the question refers.
- o How would you characterize current relationships with the American Hospital Association and the American Medical Association? Relationships with both these organizations appear to be very good. Settings have arisen where Carol McCarthy from the AHA has been present at meetings where AAMC staff has also been present; the staff has excellent relationships with the staff of the American Hospital Association. Meetings have been arranged with Jim Sammons, MD, and Roy Schwartz, MD and relationships with these two individuals are being developed carefully and hopefully improving. There will be those occasions when disagreements arise, but efforts will be made to work them out quietly with as little public display as possible.
- o Has any thought been given to the organizational location or representation of faculty practice plan issues and those individuals who are responsible for faculty practice plans? That is an excellent question and an important issue. It will be addressed, but how this group will be represented or where best to place this responsibility is not yet clear.
- o Is there a role for the AAMC in international medical education? There was at one time a Division of International Medical Education within the AAMC. That division no longer exists. The organization has been pursued many times for staff time and financial contributions to various international medical education efforts. Kat Turner has been responsible for some recent efforts in that regard, and while efforts will be stepped up a bit, it is not an item which will be on the front burner of the AAMC agenda in the immediate future.

Mr. Smith thanked Dr. Petersdorf for his thoughts and his candor.

IV. AMBULATORY CARE TRAINING ACT

The Board was asked to consider what position the AAMC should take regarding a bill introduced by Senator Kennedy entitled the Ambulatory Care Training Act of 1986. A lengthy description of the bill, the AAMC's previous positions on similar proposals, and the questions to be considered by the Board were provided in the Executive Council agenda. Dr. Knapp began the discussion by noting the item in the Executive Council agenda and asking if the Board members had any questions regarding its content. There being none, the Board proceeded to discuss the five questions and the overall strategy problem summarized at the end of the agenda item. These questions were:

- o Whether funding for residents in the ambulatory care setting should come through the teaching hospital?

- o Whether the AAMC should support a weighting system which differentially supports residents entering various specialty programs?
- o What the AAMC's reaction should be to the publication of data on the amount of Medicare funds paid to each institution for graduate medical education?
- o What the AAMC's position should be regarding the elimination of Medicare payment for foreign medical graduates who had not passed the FMGEMs exams, but who had been previously certified by the ECFMG?
- o What the AAMC's position should be regarding the proposed linkage between the reduction in the payments for the Medicare direct medical education passthrough and the reduction in the count of residents used in the calculation of the indirect medical education adjustment?

The overall strategic question that the Board was asked to address was whether or not the AAMC should support any change in graduate medical education payments at this point, given the advice from many key congressional staff members that the very healthy financial positions of teaching hospitals might lead to cutbacks in their payments if new proposals were introduced.

The Board took up each question in order. On the first question, it was agreed the teaching hospital had long served as the source of funding for residency training. By retaining this single primary source of funding, the hospital retained central control over the quality of the education provided in the nonhospital-based training settings. There was a consensus that residents in ambulatory care settings, regardless of whether those settings were otherwise affiliated with a hospital, could be paid for and should be paid for, from teaching hospital revenues.

With respect to the weighting system contained in the proposed bill, it was noted that there were no disincentives proposed but that the introduction of a weighting system could lead to inclusion of disincentives (or negative weights) in the future. In addition, there was opposition to federal government intervention into the types of training programs conducted by each hospital, believing that each hospital should determine what types of residency training programs were best suited for the patient population for which it was providing care. Finally, there would need to be a clear consensus on the objectives the incentives were to serve if those incentives were to be supported. Therefore, the Board opposed the weighting system proposed in the bill.

The proposed publication of hospital-specific information regarding Medicare payments for graduate medical education was discussed briefly by the Board in light of remarks made the previous evening by Dr. William Roper, administrator of the Health Care Financing Administration. Dr. Roper had indicated that he believed the public deserved more information, including mortality/morbidity rates of various institutions, and price and payment information available from the Health Care Financing Administration. It was agreed that publication of most types of information and data, including education cost payments, is not something the AAMC can responsibly oppose. However, it was recommended that it would be appropriate for the members of the Council of Teaching Hospitals to be made aware that such publication was likely, regardless of whether the Kennedy bill was passed or not. The Board also believed that the AAMC should not take a new position with regard to funding for foreign medical graduates.

The AAMC's traditional position has been to oppose Medicare funding for all foreign medical graduates. No change in this position was thought to be appropriate for the foreign medical graduates who had been certified by the ECFMG but had not passed the FMGEMs exam. The Board understood that some might raise the argument that the proposal was unfair since the FMG's in question had met all of the criteria for certification when they had taken the exam, and that this would represent an ex-post-facto change of rules.

There was a lengthy discussion regarding the proposed linkage between the counts for the direct and indirect medical education payments. There was some confusion as to why there should be a difference in the two counts and why such a difference should be supported. Dr. Foreman clarified that the intent of the direct medical education payment was simply to pay for the allowable stipends and benefits received by the housestaff as well as the allowable faculty salaries and the other administrative costs of the residency training programs, but that the indirect medical education adjustment was a proxy factor for severity of illness of the patients in a teaching hospital and a whole host of other factors which were somewhat related to the fact that the hospital conducted residency training programs. Ms. Seline and Dr. Bentley provided further clarification regarding the separable purposes of the direct and indirect medical education adjustments and went on to explain that the purpose served by the direct medical education adjustment required that residents be counted as prescribed by the rules set forth under the Consolidated Omnibus Budget Reconciliation Act, which allowed full payment for residents up to their initial residency training period plus one year (with a maximum of five years) and after a transition year, half payment for residents in their advanced training years. However, the indirect medical education adjustment was intended to measure characteristics of the institution, not to influence the types of residency training programs established by the hospital. In measuring those characteristics, HCFA counted all of the residents and fellows present in the institution in 1982, and incorporated all of those residents into the determination of the regression analysis which produced the formula used to pay the adjustment. Since all residents were incorporated into the determination of this formula, which is merely a proxy variable, the Board believed it was appropriate to continue to count all of those residents in the "pay out" of the indirect medical education adjustment. The Board had taken a similar position in 1985 when the proposed reductions in payments for direct medical education would have curtailed payments for residents in the sixth and seventh year of training or their second year or beyond for fellowship training. Thus, this position was merely an extension of the Board's previous position.

In considering the overall strategy question, Dr. Knapp made the Board aware of advice that the AAMC had been given in the spring of 1986 from key staff members of the House and Senate committees. Those key staff members had indicated that the AAMC's members were particularly vulnerable to cuts in payments as a result of the Inspector General's report indicating large profits in teaching hospitals. The staffers believed there would be little sympathy for teaching hospitals during the policy debates. Their advice was to keep teaching hospital issues from being raised. If an issue was brought to the table, even an issue such as the Ambulatory Care Training Act in which there was both a positive and negative side, it was probable the negative provision would be enacted but the increases proposed would be rejected. In following that advice, the AAMC staff has acted to keep the AAMC out of the limelight in pertinent discussions.

believing that if the Congressmen and Senators are not forced to think in particular about teaching hospitals for one proposal or another, they will not be inclined to make specific cuts that will harm teaching hospitals. The AAMC has thus resisted attempts to move the bill forward. Notwithstanding the AAMC's resistance, the bill was drafted by Dr. Reiselbach (an IOM fellow working in Senator Kennedy's office) and introduced by Senator Kennedy, and it received immediate support of Senators Heinz and Hatch. The Association of Academic Health Centers upon seeing the bill sent out a fairly positive statement describing the bill. For this reason, the bill has received some attention, and is likely to receive more attention within the academic medical community as Dr. Reiselbach contacts various groups of individuals and others involved in the academic medical community and asks for support of this proposal.

V. THE MEDICARE DIRECT MEDICAL EDUCATION PASSTHROUGH AND THE INDIRECT EDUCATION ADJUSTMENT: FUTURE ISSUES

Dr. Bentley opened the discussion about possible proposals to change Medicare funding of direct medical education payments and the indirect medical education adjustment. For the direct payment, responses to an AAMC survey by 110 COTH members were used to demonstrate the large variation present in hospital costs per resident. The staff is concerned that this variation will be used by the Administration and perhaps Congress to set limits on GME payments. For the indirect adjustment, continuing increases in the case mix indices for teaching hospitals are expected to result in proposals to recalculate downward the percentage used for the indirect adjustment. With no Administrative Board meeting scheduled until January and with HCFA and congressional staff developing proposals, AAMC staff sought guidance from the Board on appropriate AAMC positions.

The Board first directed its attention to the direct medical education payments and the variation in allowable costs per resident. Messrs. Gambuti and Baker stated their view that much of the variation represented efforts to maximize reimbursement. Dr. Foreman expressed two concerns: first, that the available AAMC data was confounded with errors and; second, that an effort should be made to understand the reasons for the variations before taking any policy position on them. Without disagreeing with Dr. Foreman, Dr. Buchanan noted that if CBO finds similar variation in costs per resident, the AAMC should not jeopardize its reputation by defending absolutely the variation in costs per resident. Mr. Munson supported the need for credibility and noted the discussion of the variation had not been shared yet with the membership. Mr. Baker suggested it might be possible to go on the offensive by defining a standard for the cost of graduate medical education. This suggestion stimulated a discussion of the variation in faculty salaries paid to support GME. Mr. Smith noted this variation might be locally necessary, and was technically allowable; however, the payer was beginning to view the variation as unacceptable. Dr. Buchanan observed that the responses from COTH members were clustered with a number of "outliers." Dr. Foreman agreed this was true for the presented data but opposed accepting the mean or median as an appropriate cost just because it was a statistical average. The Board consensus was that the AAMC should alert its COTH members to the variation in costs per resident and suggest "bench marks" that hospital CEO's could use to assess their hospital's vulnerability to payment limitations. The Board encouraged staff to work with HCFA and CBO staff in order to explore the factors contributing to the variation in costs per resident.

The discussion of the indirect adjustment was quite brief with Board members taking the position that the AAMC should hold to its present policy that the adjustment is an empirically determined value which will change as other factors in the system change. To ensure that COTH members understand the causes of further decreases in the indirect adjustment, the Board urged staff once again to alert COTH members and explain what lies ahead.

#### VI. THE COMMONWEALTH FUND GRANT TO ANALYZE TEACHING HOSPITAL DATA

During the summer, The Commonwealth Fund approved a three-year grant to the AAMC to assemble, analyze, and publicly report data on teaching hospitals and the impacts of alternative public policies on them. Jim Bentley briefly summarized how the grant grew out of the efforts of the Commonwealth Fund Task Force on Academic Medical Centers and outlined the approach anticipated for the project.

#### VII. REPORT ON ISSUES BEFORE THE ACCREDITATION COUNCIL ON GRADUATE MEDICAL EDUCATION

Dr. Foreman and Mr. Munson delivered a report on the five issues currently before the Accreditation Council on Graduate Medical Education (ACGME). These issues are:

1. Resident Stipends and General Essentials: Page 2 of the General Requirements section of the Essentials of Accredited Residencies was modified by the addition of a sentence under "Facilities and Resources" which reads, "Further, financial support of residents is necessary to assure that residents are able to fulfill the responsibilities of their educational programs." This change was ratified by the Committee on Structure and Functions; it was accepted instead of suggested language which would have made the issue of financial support an essential for accreditation.
2. Fees/Reserves: The issue concerns the size of the reserves the ACGME should have. Currently, there is a reserve of approximately three months of the annual operating budget. The American Board of Medical Specialties (ABMS) feels that this reserve should be closer to 8-12 months. Dr. Foreman and Mr. Munson expressed their feeling that a three month reserve is sufficient for the ACGME's purposes. Dr. Foreman stated that the ACGME has unlimited "tax" authority in that institutions must pay for surveys, so that it does not need huge reserves.
3. Performance of AMA as ACGME contractor: Dr. Foreman and Mr. Munson stated that there is dissatisfaction with the AMA's performance, and that the means of evaluating this performance are insufficient. There is "mounting dissatisfaction" with the quality of staff support; the American Hospital Association appears to be the most dissatisfied. The quality of staffing provided by the AMA apparently does not compare favorably to that provided by the AAMC; the capabilities and quality of the AAMC staff are more highly regarded.
4. Malpractice Insurance and General Essentials: The Committee on Structure and Functions considered a request submitted by the Council on Medical

Education of the American Medical Association to revise the General Requirements with regard to professional liability coverage for residents. The Committee decided to reconsider the matter at its next meeting after staff has had an opportunity to conduct additional research into the legal ramifications of the concerns raised during the Committee's discussion.

5. Anesthesiology 4th Year: Mr. Munson reported that this proposal passed eight to seven.

#### VIII. NIH CENTENNIAL CELEBRATION

Dr. John Sherman reported that the National Institutes of Health will be observing the 100th anniversary of the establishment of the Hygienic Laboratory of the Marine Hospital, Staten Island, its predecessor agency in the federal government for medical research. The centennial celebration events will occur over a year-long period beginning October 1, 1986, and the Centennial Committee is seeking contributions to defray the costs of the centennial observances.

The AAMC Executive Council approved a donation of \$5,000. to the NIH Centennial Committee, and adopted a resolution honoring the NIH Centennial. Dr. Sherman also reported that there will be special recognition of NIH at the AAMC Annual Meeting in New Orleans in October.

#### IX. CALIFORNIA BALLOT PROPOSAL

Dr. John Sherman reported on an amendment to the November 1986 California ballot which proposes a ceiling of \$64,000 for salary and fringe benefits on employees of the State of California. The amendment offers a provision to establish the governor's salary at \$80,000./year; all other state salaries would be tied to this and would be limited to 80% of that figure (\$64,000.). The amendment would also not permit sick leave or annual leave to be carried forward to the next year.

Discussion centered on the potentially devastating effects which this amendment would have on medical education, biological research, and patient care throughout the state of California. If the amendment is enacted, it is estimated that 90% of the faculty of the state medical schools would suffer significant reductions in income. Although the amendment contains a provision that could be used to exempt select classes of employees, the exemption would require a two-thirds roll call vote of the legislature.

Dr. Schultze and Mr. King pointed out that although many organizations are opposed to the amendment, the electorate may not be sufficiently aware of its implications and may not be taking it seriously enough. A coalition of concerned individuals and organizations has been established to fight proposition 61, and seems to be gaining momentum in gathering support to oppose the amendment. Dr. Schultze also reported that a group at the University of California at Los Angeles is participating in a "doomsday" exercise to study the possible effects of the amendment and potential responses to it, such as "privatizing" the University of California.

AAMC staff recommendations concerning this issue were: 1) a letter from the AAMC to the coalition deploring the potential consequences of the amendment, and 2) the coalition request for a financial contribution to the campaign be declined.

ACTION: It was moved, seconded, and carried that the above staff recommendations be adopted.

X. AAMC POSITION ON NBME SCORE REPORTING

At its June meeting, the Executive Council voted that the AAMC should use its influence to encourage NBME to report scores on a pass/fail basis only to both students and medical schools. This action was taken after the issues was brought to the Council's agenda under new business. Several individuals expressed concern that there had not been adequate debate or discussion of the subject and that proper procedure had not been followed. As a result, Dr. Virginia Weldon requested action on whether the Executive Council should reopen this issue for further discussion and another vote.

ACTION: It was moved, seconded, and carried to recommend the Executive Council reopen this issue.

XI. ADJOURNMENT

Prior to adjournment, the Chairman reminded the Board that the COTH staff suite at the Annual Meeting in New Orleans will be open late afternoon and early evening on Sunday, October 26. Individuals should feel free to stop by and bring a friend. The suite number has not been assigned as yet but will be under Dick Knapp's name. Also, there will be a reception at 5:00p, Monday, following the COTH General Session. The Chairman urged that those Board members who had not yet registered for the Annual Meeting do so.

The Chairman indicated that it had been a pleasure to serve as Chairman of the AAMC Council of Teaching Hospitals Administrative Board for the past year. Dr. Buchanan, on behalf of the Administrative Board, expressed thanks to Mr. Smith for his excellent leadership throughout the year. There being no further business, the meeting was adjourned at 11:45a.



ASSOCIATION OF AMERICAN MEDICAL COLLEGES  
COTH ADMINISTRATIVE BOARD MEETING  
January 22, 1987

PRESENT

Spencer Foreman, MD, Chairman  
J. Robert Buchanan, MD, Chairman-Elect  
C. Thomas Smith, Immediate Past Chairman  
Gordon M. Derzon  
Jerome H. Grossman, MD  
William H. Johnson, Jr.  
Larry L. Mathis  
James J. Mongan, MD  
Charles M. O'Brien, Jr.  
Raymond G. Schultze, MD  
C. Edward Schwartz  
Barbara A. Small  
Jack Owen, AHA Representative

ABSENT

Gary Gambuti  
John E. Ives

GUESTS

John W. Colloton  
Edward J. Stemmler, MD  
Virginia V. Weldon, MD

STAFF

James D. Bentley, PhD  
Linda Fishman  
Richard M. Knapp, PhD  
Sonia M. Kohan  
Robert G. Petersdorf, MD  
Nancy E. Seline  
John F. Sherman, PhD  
August G. Swanson, MD  
Judith L. Teich  
Kathleen Turner  
Melissa H. Wubbold

COTH ADMINISTRATIVE BOARD MINUTES  
Meeting Minutes  
January 21, 1987

I. CALL TO ORDER

Dr. Foreman called the meeting to order at 8:30 p.m. in the Map Room of the Washington Hilton Hotel. He welcomed three new Board members: Jerome Grossman, M.D., of the New England Medical Center; William Johnson, of the University of New Mexico; and Edward Schwartz, the chief executive officer of the University of Minnesota. Dr. Foreman also welcomed Jack Owen of the American Hospital Association, who replaced Bill Robinson as the AHA's representative to the COTH Board.

II. CHAIRMAN'S REPORT

Dr. Foreman informed the Board that a COTH nominating committee had been appointed. By tradition, this committee consists of the immediate past chairman, the current COTH chairman and a member at large. Thus, this year, the nominating committee consists of C. Thomas Smith, as chairman, Dr. Foreman, and Glenn Mitchell, the chief executive officer of the Alliance Health System. Dr. Foreman also reported on several other appointments to AAMC committees. Sheldon King will serve as chairman of the AAMC Nominating Committee; David Weiner, the president of Children's Hospital of Boston, will serve as a member of the Flexner Award Committee; Alethea Caldwell, the president of the University of Arizona Hospitals and Clinics will serve as a member of the Accreditation Council on Graduate Medical Education; and C. Thomas Smith and Mitchell Rabkin, M.D., the president of Beth Israel Hospital in Boston, will serve on the AAMC's newly appointed committee which is considering including housestaff into the AAMC. In addition, John Colloton, who has served for four years as a member of the Prospective Payment Assessment Commission, will not be seeking a reappointment and the AAMC has nominated Sheldon King to replace him.

At Dr. Foreman's request, Jim Bentley introduced a new staff member of the Department of Teaching Hospitals, Linda Fishman. Dr. Bentley noted Ms. Fishman's undergraduate and graduate degrees from the University of Washington, and her previous experience in working with the firm of Lewin and Associates and with Ruth Hanft in consulting on academic medical center issues. Dr. Bentley described Linda's new role as developing the teaching hospital database which is integral to the AAMC's contract with the Commonwealth Fund.

Dr. James Mongan, the chairman of the COTH Spring Meeting Planning committee, was called upon to describe the progress on that meeting. Dr. Mongan noted that the Planning Committee had met, outlined a plan for the meeting, and asked staff to follow up on the outline. Dr. Mongan said the plan was for the meeting to begin Wednesday evening with dinner and a speaker, with H. Ross Perot being sought as the after-dinner speaker for the program. On Thursday morning, the Planning Committee suggested that the meeting concentrate on the issue of how to assess the quality of care. The Committee suggested calling upon Dr. Philip Caper, president of Codman Research Group; Dr. David Solomon, a professor of medicine

and the associate director of the multi-campus division of geriatric medicine at UCLA; Dr. Dennis O'Leary, the president of the Joint Commission on Accreditation on Hospitals and Henry Werronen, president of the marketing firm of Werronen Company, Inc. as speakers on the quality issue. On Thursday afternoon, the Planning Committee thought it appropriate to explore issues of physician payment by inviting Dr. Paul Ginzburg, the new executive director of the Physician Payment Review Commission; Dr. Robert Heyssel, president of the Johns Hopkins Health System; and Dr. James Todd, deputy senior executive vice-president of the American Medical Association to speak regarding the changing relationships between physicians and hospitals. On Friday morning, the Planning Committee felt that the meeting should take a futuristic perspective, and suggested inviting Roy Amara, president of the Institute of the Future and Albert Williams, senior economist at the Rand Corporation to discuss what the future would be like and how academic medical centers can cope with a changing environment. In supplementing Dr. Mongan's remarks, Dr. Knapp noted that Larry Mathis, president of the Methodist Hospital System and David Hitt, president of Methodist Hospital in Dallas were planning a reception for the COTH spring meeting attendees on Thursday evening.

### III. MINUTES OF BOARD MEETING OF SEPTEMBER, 1986

The Board did not address the September minutes during its meeting of January 21, 1987. Bad weather conditions forced the Board to curtail its meeting.

### IV. ESTABLISHMENT OF THE JOINT AAMC/AAHC FORUM

This was an action item, asking for endorsement of the Association's participation in a forum with the Association of Academic Health Centers. It was presented to the Board briefly by Dr. Foreman; there was general agreement as to the value of such an effort, and the Board voted to approve the action.

### V. FINAL REPORT FROM THE AD HOC COMMITTEE ON GRADUATE MEDICAL EDUCATION AND THE TRANSITION FROM MEDICAL SCHOOL TO RESIDENCY

The Board was asked to approve the final report and authorize the implementation of the Committee's recommendations. Dr. August Swanson described two categories of recommendations in the report: recommendations that are widely accepted and recommendations that require further exploration and negotiations. Widely accepted recommendations include: changing the National Residency Matching Program schedule; improving the universal application form; improving the Deans' letters; assuring the appropriate use of NBME test scores; and restraining excessive audition electives. Recommendations that require further exploration include improving the coordination of PGY-1 and PGY-2 selections; establishing uniform timing of release of Deans' letters and transcripts; and incorporating the General Requirements into the accreditation of graduate medical education. In addition, the Committee recommended that the AAMC convene an annual forum to review the progress made in improving the transition.

Dr. Swanson stated that the NRMP is now planning to change the match schedule in 1988 and the AAMC will assist in the process. The Deans will be asked to consider these dates at their spring meeting.

Board members were asked for comments on the report. Dr. Foreman, Chairman of the Ad Hoc Committee, commented on two issues addressed in the report: institutional responsibility and the usefulness of the Deans' letters. Dr. Foreman stated that the need for institutional responsibility on how and when candidates are selected for programs started out as the centerpiece of the report. The Committee attempted to focus on the need for institutionally driven, rather than programatically driven, processes for the selection of residents. A proposal to accredit the institution for overall compliance through application of the General Requirements independent of individual program accreditation, i.e. adherence to the Special Requirements, was defeated, and resulted in the "watered-down" recommendation in the report.

Dr. Swanson explained that at the September meeting of the ACGME Executive Committee the proposal was perceived as an AAMC recommendation to diminish the authority of the Residency Review Committees; this was clearly not the intent of the proposal. Dr. Swanson noted a high level of paranoia among some individuals.

Dr. Foreman next commented on a "perhaps even more troublesome" issue -- the usefulness of the Deans' letters in the selection process. Competition for a stable number of residency positions has made criteria for selection increasingly important. Many program directors view the Deans' letters as virtually useless in the selection process and have been forced to rely more on objective data such as relatively "old" MCAT scores or audition electives. Dr. Foreman acknowledged that the recommendation on Deans' letters will be difficult to enforce. A larger issue is how the Deans' letters might be made more useful in the selection process, thereby reducing reliance on other measures.

On the subject of audition electives, Dr. Swanson showed Board members an analysis of data from a guide to senior electives and residency positions, "Should I Do a Senior Elective At . . .?" published by the Association of Professors of Gynecology and Obstetrics. Most professors said a senior elective is generally beneficial in obtaining a PG-1 position in their departments, although a significant number of respondents gave no response.

Dr. Buchanan stated it was unfortunate that the ACGME took the position it did regarding the institutional responsibility area. Dr. Swanson stated that all parts of ACGME should be in agreement and Dr. Petersdorf will encourage the ACGME and other groups to focus their attention on using the General Requirements. Dr. Foreman pointed out that the annual forum on the status of the transition will be a way to follow this issue. It was moved, seconded and carried that:

the Administrative Board recommends that the Executive Council approve the report and authorize the implementation of the recommendations of the committee.

## VI. AAMC POSITION ON NBME SCORE REPORTING

At the September 1986 meeting, the Executive Council voted to reopen the issue of encouraging for the NBME to report its examination scores on a pass/fail basis. The Council of Deans and Academic Societies discussed this matter in October. No

firm consensus existed among the constituencies favoring pass/fail reporting. Therefore, the staff recommended that the Executive Council rescind its action of June 1986 and support the development of a program by the NBME to improve the use of its examination scores. It was moved, seconded, and carried that:

the Administrative Board recommends that the Executive Council rescind its action of June 1986 and support the development of a program by the NBME to improve the the use of its examination scores.

#### VII. IMPENDING NEW YORK LEGISLATION AND THE NBME

Dr. Swanson explained the proposed New York legislation to prohibit the use of the NBME as the licensure exam in that state unless the National Board changes its policy of limiting access to graduates of LMCE accredited schools. Before Dr. Swanson commented in detail on the legislation, Dr. Foreman requested a brief description of all of the tests medical students must pass in order to become licensed. The examinations described were:

- 1) Medical College Admissions Test (MCAT) - selects people for admission to medical school
  - Administered by the AAMC in conjunction with the American College Testing Program
- 2) Medical Science Knowledge Profile (MSKP) - established in 1980 by the NBME
  - Acts as the entrance examination for students in foreign medical schools or other health programs who wish to transfer to American medical schools
  - Equivalent to the NBME examination Part I
- 3) NBME examinations Part I - Taken at end of second year of medical school
  - Part II - Taken in fourth year of medical school
  - Part III - Taken after PGY I year
  - Only available to graduates of LCME accredited programs
  - Considered licensing exam in 48 states
- 4) Federation Licensing Examination (FLEX) - Licensing exam (required in Louisiana and Texas)
  - Administered by each state's medical board
  - Dr. Swanson believes this test is easier than the NBME
  - Only 25% of medical school graduates take this exam

- It is one of the required exams for FMG

5) Foreign Medical Graduates Examination in the Medical Sciences (FMGMS)

- Required exam for FMGs to enter U.S. residency programs
- Successful completion of the exam earns ECFMG certificate

At the completion of this brief summary, Dr. Swanson agreed to write a report describing each of the tests in more detail.

Dr. Swanson then returned to a discussion of the agenda item. The New York Assembly will be voting on a bill, supported by family members and students of foreign medical schools to prohibit the use of the NBME as the licensing exam in the state because of the NBME's policy to only allow medical school graduates of accredited programs to take the test. Currently, FMGs must successfully complete the ECFMG's FMGMS test as well as the FLEX test to be licensed physicians. The supporters of the bill feel that this is unfair and are putting pressure on the legislators to pass the bill and on New York deans to persuade the NBME to change its policy. Both groups, the deans as well as the NBME have asked the AAMC to endorse their views.

Dr. Swanson proposed that the AAMC encourage the policy change in order to end the political dispute and prove beyond a doubt that the FMGs are not as well prepared as U.S. medical school graduates. He believes that most FMGs would not pass the examination. Dr. Foreman suggested that perhaps the NBME could allow FMGs to take the exam but not provide a certificate. Other members of the Board thought this course of action could result in court actions. Another point of view was expressed by Dr. Buchanan who strongly supported the NBME's position of not change its policy. He believes that any change in policy would be a rallying point for the supporters of this bill and give them the opportunity to manipulate the reason for the change to their own advantage. The final comment on this issue was that the ECFMG staff supported the NBME's stand and wanted to maintain their role in certifying FMGs.

#### VIII. MEDICARE PAYMENT ISSUES

While waiting for Dr. Petersdorf to arrive, Dr. Knapp noted that absence of a Medicare payment agenda did not reflect a lack of staff interest. Rather, this year's proposals were so similar to prior year proposals that established policies provided the necessary staff guidance. The Board then discussed the variation being found in cost per resident and the implication of this variation for Congressional action. Dr. Foreman asked Dr. Bentley to identify the institutions with high costs per resident in order to develop a consensus group of those primarily concerned with this subject. A final suggestion was to keep the cost per resident issue on the agenda. Dr. Foreman also requested a study on the relationship between student indebtedness and specialty choice.

IX. REPORT FROM AAMC PRESIDENT, DR. PETERSDORF

A. AAMC Reorganization

Dr. Petersdorf joined the Board and spoke on the reorganization of the AAMC staff. He stressed that there was no intent of a change in governance structure, with the exception of whether housestaff might be integrated into the organization. He described the existing administrative structure as "highly centralized," and detailed the following changes:

- o The Office of the President will be expanded. Responsibilities will include:
  - 1) Dr. Petersdorf - (equivalent of Chief Executive Officer) - responsible primarily for external relations,
  - 2) Dr. Sherman - (equivalent of Chief Operating Officer) - responsible for day-to-day activities of staff; and
  - 3) Dr. Knapp - head of centralized Office of Government Relations which will serve all divisions;
- o The Council of Deans will be moved to the jurisdiction of the Division of Academic Affairs;
- o Student Programs will become the Section for Student and Educational Programs (of the Division of Academic Affairs) rather than a separate division;
- o Joe Keyes will become the Association's General Counsel as well as Vice President for the Division of Institutional Planning and Development.
- o The consulting firm of Coopers and Lybrand has been retained by the AAMC to study the question of how the Division of Business Affairs might be reorganized.

Dr. Petersdorf then described the five operating divisions of the organization under the new plan, and the role of the Vice President responsible for each division:

- o Vice President for Biomedical Research (a new person to be recruited) responsible for visibility and credibility regarding research issues, and for issues relation to manpower, industry relations, and research policy;
- o Vice President for Academic Affairs (Dr. Swanson) - in addition to this position, associate Vice President will be recruited to be the chief staff person for the Council of Deans;
- o Vice President for Clinical Service (Dr. Bentley) - this division will be responsible for staffing the Council of Teaching Hospitals as well as for a newly formed Group on Faculty Practice representing interests of clinically active faculty; will "try to discourage the adversarial nature of hospital/medical school relations";

- o Vice President for Institutional Planning (Mr. Keyes) - this division will now incorporate the section for Operational Studies as well as the LCME, Management Education Programs, the Group on Institutional Planning, and the Group on Business Affairs;
- o Vice President for Public Information (new person to be recruited) - the Association is attempting to recruit a major media person for this position. The mission of the division will be to explain the academic medical centers to the public. The Journal of Medical Education will be revamped, and efforts made to enhance public education and awareness regarding the Association and the role of the AMCs.

Dr. Petersdorf emphasized that all of the AAMC staff are meant to serve all of the Councils, he described the new organizational structure as a matrix with Councils on one axis and staff on the other.

The major costs entailed in the reorganization are the renovation of offices and the recruitment of new staff. It is expected that new revenues will also be generated, e.g. in revamping the JME, advertising revenues will be created. Other new services should also begin to produce new revenues, so that the costs may be offset; the plan is also that some of the changes will be gradual, in order to reduce the financial impact of the Association.

#### B. Health Manpower Initiatives

Dr. Petersdorf stated that the Association needs to have a position on the physician supply issues. Our constituents and others look to us for leadership on issues such as this. Dr. Petersdorf is planning to develop a task force whose responsibility would be to analyze and interpret available data on such issues as foreign medical graduates, alternative ways of supplying manpower, and potential impact of suggested changes. The task force would be responsible for delivering an interim report at a major session at this November's Annual Meeting. The Board was asked to consider a motion to support the creation of the Task Force; it was moved, seconded, and carried.

#### X. STUDENT LOAN DEFERMENT

Dr. Knapp opened the discussion by summarizing the staff report on the variation in loan deferment policies for residents and fellows. The report, prepared at the request of the AAMC Group on Student Affairs, described how some schools and hospitals are believed to be deferring loan payments for all training years rather than only the two intended by the Congress. Therefore, staff was recommending sending schools and hospitals an advisory opinion stating the risks faced when deferral extends beyond two years. Dr. Foreman, agreeing with the recommendation, noted that the advisory opinion would place any member that did not conform to the two year policy in a difficult position. To assure the dry and detailed staff report receives appropriate attention, he recommended that a cover letter with a short, eye-catching warning be used to distribute the report. It was moved, seconded and carried.



## XI. TAXATION OF UNRELATED BUSINESS INCOME

The final item on the agenda was a discussion of Congressional concern with the taxability of unrelated business income earned by tax-exempt organizations. The debate over the 1986 tax reform act has stimulated interest in this area, especially by the House Committee on Ways and Means and its chairman, Mr. Rostenkowski. Dr. Knapp summarized the Committee's plan to hold hearings on this topic and invited the Board to provide staff with general guidance. Dr. Foreman noted the recent Harvard Business Review article had further stimulated interest in this issue.

In the general discussion, Dr Foreman suggested separating the issue into tax recovery (i.e., IRS) issues and unfair competition (i.e., FTC) issues. Mr. Mathis note that the assumption that hospital reorganization has eliminated this issue is incorrect. Some Congressmen are concerned that not-for-profit funds were used to capitalize the for-profit subsidiary while others believe a not-for-profit parent accepts a lower level of economic performance than a for-profit parent would. Mr Owens stated that the AHA is actively working on this issue. Following its discussion, the Board consensus was that the AAMC should support and work with others on the issue rather than take a major leadership role on it.

## XII. ADJOURNMENT

The meeting adjourned at 10:45 a.m. to allow Board members to leave for the airports before the snowstorm further disrupted air travel.

## 1987 COTH SPRING MEETING

May 13-15, 1987  
Fairmont Hotel  
Dallas, Texas

### WEDNESDAY, MAY 13

4:00-6:30p Registration

AN INFORMAL EVENING WITH  
ROBERT G. PETERSDORF, MD  
AAMC President

6:30-7:00p Cocktails

7:00-10:00p Dinner

### THURSDAY, MAY 14

7:15-8:00a Registration and Continental  
Breakfast

8:00a-12:15p Morning Session

Presiding  
Spencer Foreman, MD  
President  
Montefiore Medical Center  
COTH Chairman

ASSESSING AND MARKETING  
QUALITY OF CARE

*"The Rand/UCLA Approach to  
Assessing Quality of Care"*

David H. Solomon, MD  
Professor of Medicine  
Associate Director, Multicampus  
Division of Geriatric Medicine  
University of California, Los  
Angeles, School of Medicine

12:30-2:00p

Luncheon

2:00-5:00p

PAYING PHYSICIANS:  
CHANGES AND THEIR  
IMPLICATIONS FOR  
HOSPITALS

Presiding  
J. Robert Buchanan, MD  
General Director  
Massachusetts General Hospital  
COTH Chairman-Elect

*"Emerging Perspectives on Payment  
for Physician Services"*

Paul B. Ginsburg, PhD  
Executive Director  
Physician Payment Review  
Commission

*"Variations in Admission Rates:  
The Meaning for Quality  
Assessment"*

Philip Caper, MD  
President  
Codman Research Group

Coffee Break

*"The JCAH Agenda for Change:  
Implications for Hospital CEO's"*

Dennis S. O'Leary, MD  
President  
Joint Commission on  
Accreditation of Hospitals

*"Marketing Medical Center Quality"*

Henry J. Werronen  
President  
Werronen Company, Inc.

*"Evolving Faculty Relationships  
with Hospitals and Health Care  
Corporations"*

Robert M. Heyssel, MD  
President  
The Johns Hopkins Health System

*"Taking the Pulse of the  
Practicing Physician"*

James S. Todd, MD  
Senior Deputy Executive Vice  
President  
American Medical Association

6:00-7:30p

Reception  
Dallas Museum of Art

Courtesy of Texas COTH  
Member Institutions

### FRIDAY, MAY 15

7:30-8:00a Continental Breakfast

8:00-10:30a

Presiding  
C. Thomas Smith  
President  
Yale-New Haven Hospital  
COTH Immediate Past Chairman

THE DEVELOPING  
ENVIRONMENT FOR  
ACADEMIC MEDICINE

*"Looking Ahead at American  
Health Care"*

Roy Amara, PhD  
President  
The Institute for the Future

*"How Academic Medical Centers  
Cope with Harsh Environments"*

Albert P. Williams, PhD  
Senior Economist  
The Rand Corporation

Coffee Break

10:30a-12:00n Staff Reports on AAMC Activities

Update on Study of Transition  
of Medical Education to Ambulatory Settings

In October of 1986, the AAMC was awarded a contract by the Health Resources and Services Administration to study the transition of medical education from the inpatient setting to ambulatory care settings. The study is based on the premise that there have been substantial changes in the inpatient population of most teaching hospitals during the past few years due to changes in payment policies and technology. Some patients are no longer hospitalized, while others are hospitalized only after diagnosis or discharged before they have completed therapy. As a result, medical educators must determine how to meet the clinical educational needs of medical students and residents to observe care for a wide spectrum of illnesses throughout the course of the illness.

The AAMC chose to examine the question of how to educate students and residents outside the traditional hospital inpatient setting by concentrating on six selected specialties. The advisory panel for this study (attachment A) suggested that the six specialties be: internal medicine general surgery, pediatrics, family medicine, psychiatry and ophthalmology. To determine what changes had been made in undergraduate and graduate training programs, the AAMC suggested a two-phase study. First a series of telephone interviews would be conducted with educational leaders in each of the chosen specialties. The interviews would include the president of the specialty board, the chairman of the Residency Review Committee, and the highest elected officials of the chairmen's and program director's societies.

The second phase would involve site visits to nine academic medical centers to learn how each center was addressing the challenge. The academic medical centers were selected upon the recommendation of the advisory panel to include academic medical centers that differed by location, organizational structure of the medical school, relationship to their primary teaching hospital(s), and public or private ownership. However, the major criterion upon which choices were made was that there had to be some reason to believe that the academic medical center was doing something unique or interesting in restructuring the clinical experiences of its students or residents. The sites chosen were:

- University of North Carolina
- Mayo Medical Foundation
- University of North Carolina
- Boston University
- Southern Illinois University
- University of Washington
- University of California at Los Angeles
- The Johns Hopkins University
- Eastern Virginia Medical School

## Progress

To date, telephone interviews have been conducted with leaders in internal medicine, surgery, and psychiatry and have been started with the leaders in ophthalmology. The remaining telephone interviews will be completed by June. In addition, the first five site visits will have been completed by April 15th.

From these first set of interviews and site visits, it is clear that:

- (1.) The supposition that the inpatient population has changed significantly is true;
- (2.) Most, although not all, educators concur that there should be changes in training programs to include a variety of practice sites such as ambulatory clinics, nursing homes, psychiatric clinics, and HMOs;
- (3.) A variety of approaches are being tried by the medical centers to broaden the student and resident experiences, ranging from the use of private practitioners as perceptors, to the use of simulated patients, to the construction of new ambulatory care clinics large enough to accommodate students; and,
- (4.) Significantly barriers are impeding the progress of these efforts. The barriers include the relative inefficiency of education in a clinic setting, the inefficiencies in patient care delivery concomitant with the educational function, the perception that there is less of value to learn from ambulatory patients, the difficulty faculty have in obtaining tenure and promotions if their practice is largely ambulatory, and the need to have residents provide services to hospitalized patients.

A report of this project is due in October of this year. A draft report will be reviewed with the advisory panel in late summer so that revisions can be made and a document generated prior to the AAMC's annual meeting.

## BETTER POLICY ANALYSIS CAPABILITIES FOR TEACHING HOSPITALS

### A Project Update

The Commonwealth grant project is proceeding and AAMC staff are making progress toward the development of a teaching hospital database for policy analysis and advocacy. The first seven months of the project have been used to organize the resources necessary to implement the project. In recent weeks, the AAMC has received acceptances from all those who were invited to serve on the Advisory Committee and the initial analyses of teaching hospital data are being conducted.

#### Composition of the Advisory Committee

A 14 member advisory committee is being chaired by John Dunlop, PhD, and is composed of eight individuals and five organizational representatives (Attachment A). In addition, Dr. Dunlop is planning to identify and invite a senior business executive to serve on the committee. In a February meeting, Dr. Dunlop, Dick Knapp, and Jim Bentley agreed that the Advisory Committee should meet later this year when a full agenda of issues and accomplishments can be presented.

#### Initial Data Analyses

At present, AAMC staff, with the Johns Hopkins' Center for Hospital Finance and Management as subcontractor, are studying the 1985 AHA Annual Survey data tape to update the AAMC's 1982 publication, A Description of Teaching Hospital Characteristics. This monograph will contain current aggregate data on teaching hospital operations and services. The review will be widely disseminated to COTH members and the public. Recent data will also enable all AAMC staff to answer constituents' inquiries about teaching hospitals.

AHA data tapes from 1980-84 will also be studied to collect data for three reports that will describe and analyze:

- o The differences among COTH member hospitals, including the characteristics of academic medical centers and other COTH members;
- o The differences between COTH members, other teaching hospitals, and general short-term acute care community hospitals;
- o The economic distribution of teaching hospitals, particularly COTH members.

By undertaking three preliminary reports, staff hope to explore issues of data quality while producing the reports as a useful byproduct.

ADVISORY COMMITTEE

JOHN DUNLOP, PhD, Chairman  
Harvard University

STUART ALTMAN, PhD  
Heller Graduate School  
Brandeis University

RICHARD BERMAN  
McKinsey and Company

DON DETMER, MD  
University of Utah

ROBERT HEYSSEL, MD  
The Johns Hopkins Health System

WILLIAM KERR  
University of California,  
San Francisco

GERALD LEVEY, MD  
University of Pittsburgh

WILLIAM LUGINBUHL, MD  
University of Vermont

JOSEPH NEWHOUSE, PhD  
The Rand Corporation

Organizational Representatives

CAROL MC CARTHY, PhD, JD  
American Hospital Association

JAMES SAMMONS, MD  
American Medical Association

CARL SCHRAMM  
Health Insurance Association  
of America

SAMUEL THIER, MD  
Institute of Medicine

BERNARD TRESNOWSKI  
Blue Cross/Blue Shield

## INDIRECT MEDICAL EDUCATION ADJUSTMENT

When the initial legislation and regulations for prospective payment were being developed, Congress and HCFA worked with the best available data. In most cases, this was 1981 cost report and patient billing data. As more current and refined data have become available, Congress and HCFA have made a number of corresponding changes. For example, the original indirect adjustment of 11.59% was reduced to 8.7% when better data became available and to 8.1% when the disproportionate share adjustment was added. The AAMC accepted this change because the Association's policy called for setting the adjustment percentage at the correct level based on an empirical statistical analysis.

In its 1986 proposed rule for PPS, HCFA published 1985 case mix indices for all hospitals. The results differed substantially from the original 1981 indices. In some hospitals this represents primarily a change in coding; in other hospitals it represents a real change in type of patient treated. Regardless of the cause, the 1985 data showed more variation in index values than the 1981 data. As a result, the case mix variable in PPS is accounting for more of the variation in hospital costs than it has before, and there is expected to be less variation related to the resident-to-bed ratio. Similarly, better wage index and disproportionate share data are expected to change the percentage for the indirect adjustment.

Preliminary data being analyzed by the Congressional Budget Office (CBO) show that when 1984 cost data for teaching and non-teaching hospitals are compared the adjustment should be 6.9%. When up-to-date data on the disproportional share adjustment are included in the model, the adjustment falls to 4.6%. The AAMC has a policy of supporting an empirically correct adjustment (1) derived from up-to-date data and (2) using a regression equation which includes only PPS payment variables. However, given the rapidly changing nature of the present estimates for the adjustment, the impact of alternative policies for disproportional share payment on the adjustment, the significant impact of including or excluding data from New York State on the adjustment, and the fact that the most recently used statistical models and data have not been publicly presented, the AAMC cannot endorse any specific revision to the adjustment.



COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES  
APPLICATION FOR MEMBERSHIP

Membership in the Council of Teaching Hospitals is limited to organizations 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  
One Dupont Circle, N.W. -  
Suite 200  
Washington, D.C. 20036

I. HOSPITAL IDENTIFICATION

Hospital Name: The Children's Medical Center

Hospital Address: (Street) One Children's Plaza

(City) Dayton (State) OH (Zip) 45404-1865

(Area Code)/Telephone Number: ( 513 ) 226-8300

Name of Hospital's Chief Executive Officer: Laurence P. Harkness

Title of Hospital's Chief Executive Officer: President and Chief Executive Officer

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

Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn):	<u>155</u>	Admissions:	<u>5,352</u>
Average Daily Census:	<u>92</u>	Visits: Emergency Room:	<u>30,793</u>
Total Live Births:	<u>0</u>	Visits: Outpatient or Clinic	<u>56,101</u>



## B. Financial Data

Total Operating Expenses: \$ 34,743,429

Total Payroll Expenses: \$ 18,182,762

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: \$ 408,100

Supervising Faculty: \$ 1,137,129

## C. Staffing Data

Number of Personnel: Full-Time: 633  
Part-Time: 388

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 139

With Medical School Faculty Appointments: 105

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

See attached Supplement "A".

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

## III. MEDICAL EDUCATION DATA

### A. Undergraduate Medical Education

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

<u>Clinical Services Providing Clerkships</u>	<u>Number of Clerkships Offered</u>	<u>Number of Students Taking Clerkships</u>	<u>Are Clerkships Elective or Required</u>
Medicine	<u>0</u>	<u>0</u>	
Surgery	<u>12</u>	<u>36</u>	<u>Required</u>
Ob-Gyn	<u>0</u>	<u>0</u>	
Pediatrics	<u>100</u>	<u>100</u>	<u>Required</u>
Family Practice	<u>0</u>	<u>0</u>	
Psychiatry	<u>8</u>	<u>104</u>	<u>Required</u>
Other: _____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

## B. Graduate Medical Education

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

<u>Type of Residency</u> <sup>1</sup>	<u>Positions Offered</u>	<u>Positions Filled by U.S. &amp; Canadian Grads</u>	<u>Positions Filled by Foreign Medical Graduates</u>	<u>Date of Initial Accreditation of the Program</u> <sup>2</sup>
First Year Flexible	0	0	0	
Medicine	0	0	0	
Surgery	0	0	0	
Ob-Gyn	0	0	0	
Pediatrics	31	31	0	1981
Family Practice	0	0	0	
Psychiatry	0	0	0	
Other: <u>Med/Ped.</u>	4	4	0	Program started- 1983

<sup>1</sup>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.

<sup>2</sup>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: Wright State University School of Medicine

Dean of Affiliated Medical School: William D. Sawyer, M.D.

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Information Submitted by: (Name) Maurice D. Kogut, M.D.

Vice President for Medical Affairs, The Children's Medical Center  
(Title) Professor and Chair, Department of Pediatrics, Wright  
State University School of Medicine

Signature of Hospital's Chief Executive Officer:

Laurence P. Harkness

(Date) 2 3 87

## SUPPLEMENT "A"

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

<u>Name of Division Chief</u>	<u>Clinical Service</u>
Sherman J. Alter, M.D.	Infectious Diseases
Harold Chen, M.D.	Medical Genetics
Sherry E. Courtney, M.D.	Neonatology
Martha Franz, M.D.	Pulmonary Medicine
Cheryl Fryer, M.D.	Nephrology
Charles Goodwin, M.D.	Surgical Education
Katherine Hott, M.D.	Psychiatry
Elvira Jaballas, M.D.	Ambulatory Services
G. Frank Johnson, M.D.	Radiology
Daniel Lacey, M.D., Ph.D.	Neurology
James Lehner, M.D.	Orthopedics
Stephen Newman, M.D.	Gastroenterology
Douglas Prince, M.D.	Emergency Medicine
Alan Shafer, M.D.	Pediatric Surgery
Robert Stout, M.D.	Hematology/Oncology
Haig Tozbikian, M.D.	Anesthesiology
Margaret Turk, M.D.	Physical Medicine & Rehabilitation
Dwight Tuuri, M.D.	Cardiology
Maria Urban, M.D.	Endocrinology
Ray Wong, M.D.	Pathology

#### IV. Supplementary Information.

The Children's Medical Center (CMC) is a tertiary pediatric health-care facility that offers a full range of in-patient services, including nearly 50 subspecialty and general out-patient clinics. The Department of Pediatrics, Wright State University School of Medicine is based at CMC. Through a strong affiliation with the School of Medicine, CMC provides teaching facilities and research laboratory space to the School of Medicine faculty. CMC is the only children's hospital serving the greater Dayton area, and it receives referrals from throughout Ohio, southeastern Indiana and Kentucky. CMC has developed sound clinical programs in all of the pediatric subspecialties as well as in pediatric pathology, pediatric surgery, physical medicine and rehabilitation, and radiology, including nuclear medicine, ultrasonic diagnostic techniques and computerized tomography.

During their third year, all of the approximate 100 medical students at Wright State University School of Medicine rotate through CMC for their pediatric clerkship experiences. The clerkship in pediatrics is for two months in duration; one month is spent on the inpatient services and one month in the outpatient clinics. In addition to the pediatric clerkship, some of the Year III medical students also rotate through CMC for pediatric surgery, and Year IV medical students choose electives offered by the Department of Pediatrics at CMC.

Beginning July 1, 1986, there were 31 career residents in pediatrics in the Wright State University Pediatric Residency Program. The bulk of the in-patient experiences and subspecialty training for the pediatric residents is at CMC. In addition, residents from all three of the family practice residency programs and the emergency medicine residency program in Dayton rotate through CMC for their pediatric experiences. Surgical, psychiatry and orthopedic residents also rotate through CMC.

In addition to the pediatric residency program, together with the Department of Medicine, the Department of Pediatrics is also responsible for a combined medicine/pediatric residency program. The pediatric training for these residents also occurs at CMC.

There is an active research program in the Department of Pediatrics. During 1985-1986, approximately \$960,000 in funding was available for research. In addition, in regard to delivery of health care and education, members of the faculty received grants or contracts from various agencies totalling up to approximately \$385,000. Approximately 2,000 square feet of new research laboratory space will be built at CMC during the academic year 1986-87 to allow for research activities of the faculty.

# WRIGHT STATE

Wright State University  
Dayton, Ohio

School of Medicine  
Office of the Dean  
P.O. Box 927  
Dayton, Ohio 45401

513/873-2933

January 28, 1987

Laurence P. Harkness  
President and Chief Executive Officer  
Children's Medical Center  
One Children's Plaza  
Dayton, OH 45404

Dear Larry:

I am delighted to support Children's Medical Center's (CMC) application for membership in the Council of Teaching Hospitals of the Association of American Medical Colleges. CMC is a vital affiliate and an integral component of the educational, research and service programs of the Wright State University School of Medicine. CMC is the site of the School's Department of Pediatrics. It is the principal location for the teaching program and faculty activities in the specialty. The School of Medicine's pediatric and the combined medicine/pediatric residency programs could not exist without your institution. Your support of the pediatric components of other integrated and affiliated residency programs throughout the community is significant. Presently the residencies in dermatology, emergency medicine, general surgery, anesthesiology, psychiatry, family practice, orthopedic surgery, pathology and plastic surgery have pediatric components.

In addition to housing and supporting the department of pediatrics including both general pediatrics and the pediatric subspecialties of hematology/oncology, genetics, gastroenterology, endocrinology, pulmonology, infectious diseases and nephrology, CMC supports and interacts with other departments of the School of Medicine, i.e., Emergency Medicine, Psychiatry, Physical Medicine and Rehabilitation, Neurology, Pathology and Surgery.

As a community-based institution, the Wright State University School of Medicine relies on its affiliated institutions for its clinical activities. I am proud to include Children's Medical Center among our most important and major affiliates. I heartily support the inclusion of CMC as a member of the Council of Teaching Hospitals of the American Association of Medical Colleges.

Cordially,



William D. Sawyer, M.D.  
Dean

WDS:keg



COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

APPLICATION FOR MEMBERSHIP

Membership in the Council of Teaching Hospitals is limited to organizations 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  
One Dupont Circle, N.W.  
Suite 200  
Washington, D.C. 20036

I. HOSPITAL IDENTIFICATION

Hospital Name: Dana-Farber Cancer Institute

Hospital Address: (Street) 44 Binney Street

(City) Boston (State) MA (Zip) 02115

(Area Code)/Telephone Number: ( 617 ) 732-3000

Name of Hospital's Chief Executive Officer: Baruj Benacerraf, M.D.

Title of Hospital's Chief Executive Officer: President

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

Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn):	<u>57</u>	Admissions:	<u>2223</u>
Average Daily Census:	<u>44</u>	Visits: Emergency Room:	<u>0</u>
Total Live Births:	<u>0</u>	Visits: Outpatient or Clinic	<u>25388</u>

B. Financial Data

Total Operating Expenses: \$ 67,243,000

Total Payroll Expenses: \$ 29,110,980

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: \$ 309,000

Supervising Faculty: \$ 133,700

C. Staffing Data

Number of Personnel: Full-Time: 959  
Part-Time: 253

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 90

With Medical School Faculty Appointments: 90

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

Medicine Pediatric Oncology \_\_\_\_\_

Medical Oncology \_\_\_\_\_

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

III. MEDICAL EDUCATION DATA

A. Undergraduate Medical Education

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

<u>Clinical Services Providing Clerkships</u>	<u>Number of Clerkships Offered</u>	<u>Number of Students Taking Clerkships</u>	<u>Are Clerkships Elective or Required</u>
Medicine	_____	_____	_____
Surgery	_____	_____	_____
Ob-Gyn	_____	_____	_____
Pediatrics	_____	_____	_____
Family Practice	_____	_____	_____
Psychiatry	_____	_____	_____
Other: <u>Medical Oncology</u>	<u>24</u>	<u>12 - 16</u>	<u>Elective</u>
<u>Pediatric Oncology</u>	<u>12</u>	<u>3</u>	<u>Elective</u>
_____	_____	_____	_____



## B. Graduate Medical Education

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

<u>Type of Residency<sup>1</sup></u>	<u>Positions Offered</u>	<u>Positions Filled by U.S. &amp; Canadian Grads</u>	<u>Positions Filled by Foreign Medical Graduates</u>	<u>Date of Initial Accreditation of the Program<sup>2</sup></u>
First Year Flexible				
Medicine	9	9	0	BWH 2/8/58 BI 6/7/55
Surgery				
Ob-Gyn				
Pediatrics				
Family Practice				
Psychiatry				
Other:				

<sup>1</sup>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.

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

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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: Harvard Medical School

Dean of Affiliated Medical School: Daniel C. Tosteson, M.D.

Information Submitted by: (Name) John W. Pettit

(Title) Chief Administrative Officer

Signature of Hospital's Chief Executive Officer:

Ben J. Ben (Date) 5/2/67

Dana-Farber Cancer Institute  
Supplement to Application for  
Council of Teaching Hospitals Membership

Teaching and Research Activities

● Education

The Dana-Farber Cancer Institute is a teaching hospital affiliated with the Harvard Medical School. All members of the Institute's professional medical and research staff hold appointments at the Medical School and are therefore involved in a variety of ways in the teaching of medical students. Institute medical staff act as Attending Physicians at the Brigham and Women's Hospital, the Beth Israel Hospital, and the Children's Hospital.

Interns and residents in Medicine from the Beth Israel and Brigham and Women's Hospitals serve on the Institute's Medical Oncology inpatient service as part of their general training. Interns and residents from Children's Hospital serve on the pediatric oncology unit of the Children's Hospital.

The Institute offers a Medical Oncology Fellowship Program designed to provide a broad-based experience in oncological medicine, clinical chemotherapy and research. The Program emphasizes both the applied and fundamental aspects of the investigation and treatment of neoplastic disease.

The first year of the program is wholly clinical. It is designed to provide an initial, intensive exposure to medical oncology under conditions where the Fellow assumes a major role in the management of patients. Fellows function both as primary care physicians as well as consultants to other Harvard-affiliated hospitals, including the Brigham and Women's Hospital.

The Pediatric Fellowship Program in Hematology and Oncology is a joint endeavor of the Institute and the Children's Hospital. Outpatient pediatric oncology care is provided at the Institute, and inpatient oncology and hematology and outpatient hematology are provided at Children's Hospital.

The first year of the program is also wholly clinical; Fellows function as primary care physicians in the Jimmy Fund Clinic of the Institute and on the Children's Hospital oncology service.

The Institute offers twenty-four elective clerkships in medical oncology annually to Medical School students.

## ● Research

The Institute has substantial research programs in clinical treatment and the basic sciences.

In support of its major clinical goals, the Institute is committed to innovation and the consolidation of innovation in cancer diagnosis and treatment. Innovation and the consolidation of innovation involve scientific and clinical extrapolation from treatments and diagnostic techniques of known clinical efficacy to analogous treatments and techniques based on advances in understanding and evaluating underlying biological mechanisms and the subsequent evaluation of treatments and diagnostic techniques.

In the basic sciences the Institute is committed to the study of cancer, a complex set of diseases which pose a large array of problems to the biomedical scientist. Solutions to these problems are sought in studies to define the biology of the cancer cell, studies of how cancers arise and how they might be prevented from occurring, studies of ways to detect cancer at an early stage and to properly diagnose it, and finally, studies of how best to treat the cancer patient. Institute scientists have also been prominent among those engaged in the genetic definition of the AIDS virus, knowledge critical to the development of methods to control and potentially cure the disease.

Twenty-three major basic science research laboratories function at the Institute. These laboratories are: Biostatistics and Epidemiology, Cancer Control, Cancer Genetics, Cancer Pharmacology, Cell Growth and Regulation, Eukaryotic Transcription, Gene Regulation, Immunobiology, Immunogenetics, Immunopathology, Medicine, Membrane Immunochemistry, Molecular Biology, Molecular Carcinogenesis, Molecular Genetics, Molecular Immunology, Neoplastic Disease Mechanisms, Pediatric Oncology, Radiation Biology, Structural Molecular Biology, Tumor Immunology, Tumor Virology, and Tumor Virus Genetics. Direct funding (excluding overhead) for research was \$26,547,000 in fiscal year 1986.

# Harvard Medical School



25 Shattuck Street  
Boston, Massachusetts 02115  
(617) 732-1760

Dean for Medical Services  
Professor of Surgery

March 18, 1987

Richard M. Knapp, Ph.D., Director  
Council of Teaching Hospitals  
Association of American Medical Colleges  
One Dupont Circle, N.W.  
Washington, D.C. 20035

Dear Dr. Knapp:

I understand that the Dana-Farber Cancer Institute is a candidate for membership as a teaching hospital in the Council of Teaching Hospitals. I am pleased to describe the Institute's affiliation with the Harvard Medical School and its role in medical education and research within this relationship.

The Institute has been formally allied with the School since 1972, when it was known as the Children's Cancer Research Foundation. As a federally-designated Comprehensive Cancer Center, the Dana-Farber Cancer Institute functions on several levels as an integral component of the academic programs of the Medical School. All members of the Institute's professional medical and research staff hold teaching or research appointments at the Medical School and are engaged in a variety of ways in the instruction of medical students. For example, the Institute offers twenty-four elective clerkships in medical oncology annually to medical students. Interns and residents in Medicine rotate through the Institute from the Harvard affiliated residency training programs sponsored by Brigham and Women's Hospital and Beth Israel Hospital, and fellowships in Clinical Oncology and Pediatric Oncology are sponsored by the Institute. In addition, the Institute provides training for at least 125 graduate students in a variety of areas in the biological and related sciences as part of the requirements for the award of Ph.D. degree by Harvard University.

This strong relationship between Harvard and the Institute has been enhanced by the appointment of Baruj Benacerraf, M.D., as President of Dana-Farber Cancer Institute. He serves concurrently as Professor and Chairman of the Department of Pathology at the Harvard Medical School. Lastly, the Institute is an active member of the Harvard Medical Center, an independent and autonomous corporation whose membership is comprised of the Harvard Medical School and its major affiliated teaching hospitals and medical institutions.

Richard M. Knapp, Ph.D.

-2-

March 18, 1987

It is for these cogent reasons that the Harvard Medical School endorses the application of the Dana-Farber Cancer Institute for membership as a teaching hospital in the Council of Teaching Hospitals.

Sincerely,

*Mitchell W. Spellman*  
Mitchell W. Spellman, M.D.  
Dean for Medical Services

Executive Vice President  
Harvard Medical Center

MWS:iam

## 1990 COTH SPRING MEETING PREFERENCE

The 1987 COTH Spring Meeting marks the 10th anniversary of annual spring meetings for the Council. To date, site selection for this meeting has focused on four criteria: 1/ a "business" hotel rather than a resort hotel, 2/ a major city having an airport with direct connections to other major cities, 3/ the number of COTH members in the area, and 4/ regional rotation of the meeting site. As a result, the COTH Spring Meeting has been held in the following cities.

1978	St. Louis, MO
1979	Kansas City, MO
1980	Denver, CO
1981	Atlanta, GA
1982	Boston, MA
1983	New Orleans, LA
1984	Baltimore, MD
1985	San Francisco, CA
1986	Philadelphia, PA
1987	Dallas, TX

In 1988 the meeting will be held May 11-13 at the New York Hilton in New York City. In 1989, the meeting will be held in a resort hotel, the del Coronado in San Diego.

In order to secure a meeting site for the 1990 Spring Meeting, staff must make some decisions in the next 60 days. To assist the staff, the Board is asked to discuss its preferences on the following topics:

### I. Meeting Site

- A. Business hotel in a major city; e.g., Chicago, Houston
- B. Resort hotel near a major city; e.g., Scottsdale
- C. Resort hotel in recreating setting; e.g., Orlando, Hilton Head Island

II. If the choice of a business hotel in a major city is selected, should we return to cities already used or smaller cities like Charleston, SC or Cincinnati?

III. Meeting Format: If a resort site is favored, should the meeting provide unscheduled time for recreation (golf, swimming) or for touring (Disney World)?

IV. Meeting Location: Should an effort be made to rotate the meeting to different geographic sites?

## COTH DIRECTORY

The COTH Directory has followed a similar format since its inception in 1968. As shown in Attachment A, each member hospital is listed along with its:

- o Accreditation and facility codes derived from the AHA directory (Guide Issue);
- o Some basic inpatient, outpatient, expense, and personnel data derived from the COTH Directory questionnaire;
- o Medical school affiliation(s) derived from the ACGME Directory of Approved Residencies (greenbook); and
- o Number of FTE residents and residency programs, also derived from the COTH Directory questionnaire.

In a number of ways, the Directory is difficult to use. First, the accreditation and facility codes, which duplicate material in the AHA Guide Issue, require constant referencing against a key at the front of the Directory. Second, the listing of residency programs provides no information on the relative size of different programs. Third, aside from the CEO, no information on senior staff is provided. As a result, staff finds the Directory to be of limited usefulness. Therefore, it is suggested that the COTH Administrative Board discuss alternatives for the future COTH Directory. Two possibilities are:

- o Reducing the Directory to include only CEO name, hospital address, telephone number, number of FTE residents, and approved residency programs. An example is provided as Attachment B;
- o Revising the Directory to eliminate the use of numerical codes, expand staff and residency data, and eliminate approval and facility codes already provided in the AHA Guide Issue. An example is provided as Attachment C.

In the discussion, Board members are asked to address what would be the most useful information the Directory could provide, and how sensitive member institutions might be about publication of any new data items.



# MEMBER HOSPITALS, U.S.: DISTRICT OF COLUMBIA

ATTACHMENT A

Hospital, Administrator, Address, Telephone, Approval and Facility Codes	Classification Codes			Inpatient Data			Emergency Room Visits	Out Patient Visits	Expenses (Thousands of dollars)		Personnel
	Control	Service	Stay	Beds	Census (Total Births)	Admissions			Total	Payroll	

For definitions and explanations  
of Approvals and Facility Codes  
see pages xi-xii

**District of Columbia General Hospital** 14 10 S 478 342 14,481 82,353 122,103 94,751 64,653 2,320  
 Sherman P. McCoy  
 Acting Executive Director  
 19 and Massachusetts Avenue, S.E.  
 Washington, District of Columbia 20003  
 Tel. 202/675-5000  
 A-3-5-9-10-14 F-1-2-3-5-6-7-8-9-10-11-  
 12-14-15-16-17-20-23-24-26-34-35-36-37-  
 39-40-42-43-44-45-46-47-51-52-53-54  
 /504

**The George Washington University Hospital** 23 10 S 503 386 17,119 47,910 - 111,344 71,489 2,633  
 Philip S. Birnbaum  
 Dean of the Medical Center for  
 Administrative Affairs  
 901 23rd Street, N.W.  
 Washington, District of Columbia 20037  
 Tel. 202/676-3241  
 A-3-5-9-10-14 F-1-2-3-4-5-6-7-8-9-10-11-  
 12-13-14-16-17-20-23-24-25-26-27-29-30-  
 32-35-36-39-40-42-44-45-47-53-54/044

**Georgetown University Hospital** 21 10 S 550 413 18,799 23,687 73,768 106,751 61,584 2,248  
 Charles M. O'Brien, Jr.  
 Administrator  
 3800 Reservoir Road, N.W.  
 Washington, District of Columbia 20007  
 Tel. 202/625-0100  
 A-2-3-5-9-10-14 F-1-2-3-4-5-6-7-8-9-10-  
 11-12-13-14-15-16-17-20-23-24-26-27-28-  
 30-32-33-34-35-36-38-40-42-43-44-45-46-  
 49-51-52-53-54/045

**Howard University Hospital** 23 10 S 513 368 13,222 54,593 93,222 114,410 65,121 2,791  
 Haynes Rice  
 Hospital Director  
 2041 Georgia Avenue, N.W.  
 Washington, District of Columbia 20060  
 Tel. 202/745-6100  
 A-2-3-5-9-10-14 F-1-2-3-4-5-6-7-8-9-10-  
 11-12-14-16-17-20-23-24-26-27-28-30-32-  
 33-34-35-36-37-39-40-42-43-44-45-46-47-  
 52-53-54/043

# MEMBER HOSPITALS, U.S.: DISTRICT OF COLUMBIA

Medical School Affiliation	Residents in Training				Approved Graduate and Undergraduate Educational Programs
	FIRST POST M.D. YEAR		TOTAL		Residencies By Specialty
	Filled	FMG Filled	Filled	FMG Filled	

For  
Codes see  
pages xiii-xiv

M-01002  
M-01003

68

23

171

63

It Med

(Derm, Neur Surg, Neurol, ObG, Oph,  
Orth, Ped, Rad, Surg, Urol)

M-01001  
G-01002

47

5

203

16

Anes, Derm, It Med, Neur Surg, Neurol,  
Nuc Med, ObG, Oph, Orth, Path,  
Phys Med/Rehab, Plast Surg, Psych, Rad,  
Surg, Thor Surg, Urol

(Emerg Med, Ped)

M-01002  
G-01001

44

2

163

39

Aller, Anes, Emerg Med, It Med,  
Neur Surg, Neurol, Nuc Med, ObG, Oph,  
Orth, Oto, Path, Ped, Plast Surg, Psych,  
Rad, Surg, Urol, Trans

M-01003

75

11

318

51

Aller, Anes, Col Surg, Derm, Emerg Med,  
Fam Prac, It Med, Neur Surg, Neurol,  
Nuc Med, ObG, Oph, Orth, Oto, Path, Ped,  
Phys Med/Rehab, Plast Surg, Prev Med,  
Psych, Rad, Surg, Thor Surg, Urol, Trans

	Residents		Residency Programs
	Total	% FMG	
Georgetown University Hospital Charles M. O'Brien, Jr. Administrator 3800 Reservoir Road, N.W. Washington, District of Columbia 20007 Tel. 202/625-0100	163	24%	Aller, Anes, Emerg Med, It Med, Neur Surg, Neurol, Nuc Med, ObG, Oph, Orth, Oto, Path, Ped, Plast Surg, Psych, Rad, Surg, Urol, Trans

STATE

CITY

HOSPITAL NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_

AFFILIATIONS: MEDICAL SCHOOL \_\_\_\_\_  
HOSPITAL ALLIANCE: \_\_\_\_\_  
HOSPITAL SYSTEM: \_\_\_\_\_

EXECUTIVE STAFF:	<u>NAME</u>	<u>TITLE</u>	<u>TELEPHONE</u>
CEO	_____	_____	_____
COO	_____	_____	_____
CFO	_____	_____	_____
MD	_____	_____	_____
MD	_____	_____	_____

OPERATING DATA:

BEDS	OUTPATIENT VISITS _____	MEDICARE CMI _____
GENERAL SERVICE _____	EMERGENCY ROOM VISITS _____	TRAUMA DESIGNATION _____
INTENSIVE CARE _____	SURGICAL PROCEDURES _____	NICU DESIGNATION _____
NEWBORN _____	INPATIENT _____	
ADMISSIONS _____	OUTPATIENT _____	
PATIENT DAYS _____		
OCCUPANCY _____		

EDUCATIONAL DATA:

<u>RESIDENTS</u>	<u>PROGRAMS</u>	<u>RESIDENTS</u>	<u>PROGRAMS</u>
_____	FAMILY PRACTICE	_____	MEDICAL SPECIALTIES
_____	GENERAL SURGERY	_____	SURGICAL SPECIALTIES
_____	INTERNAL MEDICINE	_____	SUPPORT SPECIALTIES
_____	OBSTETRICS/GYNECOLOGY	_____	
_____	PEDIATRICS	_____	TRANSITIONAL YEAR
_____	PSYCHIATRY		
TOTAL RESIDENTS= _____			
%FMG= _____			

ATTACHMENT C

## ANNUAL MEETING PROGRAM

The 1987 AAMC Annual Meeting, to be held in Washington, DC, includes a number of major changes. First, the opening plenary session will begin at 4:30p on Sunday, November 8, and focus on the presentation of awards and honors. The opening session will be followed by a hosted reception to which all attendees are invited. Second, the Monday meetings will be organized around the theme "The Supply of Physicians: Toward a National Policy." The morning plenary session will feature four speakers addressing the topic from different perspectives. Following a break for lunch, a joint council session of the COD, CAS, and COTH will be held to address the new AAMC Task Force on Physician Supply. After the joint council session, individual councils may meet. To adapt COTH activities to the new meeting format, staff proposes:

- o To hold a COTH luncheon and business meeting from 12:00-1:30p on Monday, November 9. In addition to presenting departing Board members with a token of appreciation, the outgoing COTH Chairman would present his report;
- o To hold a COTH program session following the joint council meeting, probably, 3:00-5:00p. Ideally, this session would relate to the day's program theme. Examples of session topics could include:
  - Defining privileges in a competitive physician marketplace
  - Providing hospital services with fewer residents
  - Expanding ambulatory training in a tertiary hospital
  - Managing the increasing AIDS patient load
  - The hospital-practice plan interface: cooperation or competition?

Board members are requested to express their views on preferred topics and possible speakers.