EA-B

COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
1346 Connecticut Avenue, N.W.
Washington, D.C. 20036
202/223-5364

AGENDA — Draft

EXECUTIVE COMMITTEE MEETING #68-3
Thursday and Friday, May 9 and 10, 1968
Hotel Dupont Plaza
1500 New Hampshire Avenue, N.W.
Washington, D.C. 20006
202/483-6000

Thursday, May 9, 1968:

6:30 p.m.	Reception -- Dupont Room (Lower Level)	
7:00 p.m.	1. Dinner Meeting 2. Presentation S. Douglass Cater, Jr.[1] Robert Q. Marston, M.D.[2]	
10:00 p.m.	Recess	

Friday, May 10, 1968:

9:30 a.m. (to allow for early checkout from Dupont Plaza, if desired. A "working lunch" will be served at 12:30 in the Conference Room)	Reconvene -- Conference Room -- 4th Floor, Dupont Circle Building, 1346 Connecticut Avenue, N.W. 202/223-5364	
	3. Approval of Minutes, Executive Committee Meeting #68-2, January 11 & 12, 1968	Tab 1 ✓
	4. Report on Action Items from Executive Committee Meeting of January 11 & 12	Tab 2a-f
	5. Report on Study to Implement "A Guide to Hospitals" (see page 6 of Minutes of Executive Committee Meeting #68-2)	
	6. Status Report on Membership	Tab 3 ✓
	7. New Members Elected by Mail Ballot: A. Scott & White Memorial Hospital* Temple, Texas	

2a. list of actions
b. letters (2) re osteop. ✓
c. Abstract of House Test ✓
~~d. [illegible]~~
d. Contract ✓ & Exe Com ✓
e. AAMC reorg chart ✓
f. COTH reorg chart

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1. Special Assistant to the President of the United States
2. Acting Administrator, Health Services and Mental Health Administration, and Director Division of Regional Medical Programs, National Institutes of Health

B. Nussa Municipal Hospital*
San Juan, Puerto Rico
C. Grasslands Hospital*
Valhalla, New York
D. Wilford Hall USAG Hospital**
Lackland Air Force Base
San Antonio, Texas
E. Veterans Administration Hospital**
Providence, Rhode Island
F. University of Arizona**
Tuscon, Arizona

8. New Applications for Membership — Tab 4
A. Nominated by a Dean
1. Schwab Rehabilitation Hospital
Chicago, Illinois

9. Other Membership Possibilities
A. Hospitals Offering 3 of 5 COTH Required Residencies and Internship Programs — Tab 5a
B. Hospitals Offering 2 of 5 COTH Required Residencies and Internship Programs — Tab 5b
C. Hospitals with Internship Programs and 3 Residencies (But Not Those Required for COTH Membership) — Tab 5c

10. Inquiry into Possibilities for Membership -- Postgraduate Medical Institute
Boston, Massachusetts — Tab 6

11. Progress Report on Contracts
A. Teaching Hospital Information Center (signed and ongoing -- see Tab 2e)
B. Study Regarding Effect of Recent Social Legislation on Patient Population in Teaching Hospitals (In Negotiation)

12. Report of Committees — ~~Tab 7~~
A. Committee on Modernization and Construction Funds for Teaching Hospitals
1. Minutes, Meeting of 2/19/68 — Tab 7a
2. White Paper — Tab 7b
3. Concern -- AHA Definition of a Teaching Hospital — Tab 7c
B. Committee on Financial Principles for Teaching Hospitals
1. Minutes, Meeting of 1/25/68 — Tab 7d
2. Recommended Addition of Frances J. Sweeney, Jr., M.D., Hospital Director, Jefferson Medical College Hospital, to Committee — Tab 7e
3. Draft Statement of Financial Principles (not reviewed by Committee) — Tab 7f
4. Regional Conferences on Health Care Costs — Tab 7g

* 1967-68 half-year dues
** Dues become effective July 1, 1968

C. AAMC-COTH Committee on Federal Health Programs and Federal Health Legislation — Tab 7a
D. COTH-AHA Presidential Officers Meeting — Tab 7b

13. AHA Statement on Financial Requirements of Health Care Institutions and Services — Tab 8

14. Resignation of Lee Powers, M.D., and Successor

15. Commemorative Resolution -- A. J. "Gus" Carroll — Tab 9

16. COTH Regional Meetings
A. Agendas from Western, Midwest/Great Plains, Northeastern, and Southern Meetings — Tab 10a
B. Recommendation from Southern Regional Meeting — Tab 10b
C. Correspondence from Committee of Interns and Residents of the New York Municipal Hospitals to the City of New York — Tab 10c

17. Annual Meeting -- 1968 — Tab 11

18. Position Statement by Association of Hospital Directors of Medical Education — Tab 12

19. COTH Permanent Membership Certificate — Tab 13

20. Information Items
A. Report on Progress of Completion of COTH History
B. Coth Hospitals Participating in PAS and MAP — Tab 14a
C. Council of Academic Societies Workshop on Graduate Education — Tab 14b

21. Future Meetings of the Executive Committee — Tab 15

22. Other Business

23. Adjournment -- 4:00 p.m.

COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
1346 Connecticut Avenue, N.W.
Washington, D.C. 20036
202/223-5364

MINUTES

MEETING OF EXECUTIVE COMMITTEE (#68-2)

Hotel Dupont Plaza
1500 New Hampshire Avenue, N.W.
Washington, D.C. 20036
Thursday & Friday, January 11 & 12, 1968

Present:

Lad F. Grapski, Chairman
LeRoy S. Rambeck, Chairman-Elect
Stanley A. Ferguson, Immediate Past Chairman
Matthew F. McNulty, Jr., Secretary
Ernest N. Boettcher, M.D., Member
Leonard W. Cronkhite, Jr., M.D., Member
Charles R. Goulet, Member
LeRoy E. Bates, M.D., Member
Charles H. Frenzel, Member
T. Stewart Hamilton, M.D., COTH Member to AAMC Executive Council (Friday only)
Dan J. Macer, Member
Lester E. Richwagen, Member
Richard D. Wittrup, Member
Joseph McNinch, M.D., Director, Southeastern Office, AHA (Invited participant)
John Parks, M.D., President, AAMC (Thursday only)
Robert C. Berson, M.D., Executive Director, AAMC (Thursday only)
Grace W. Beirne, Staff Assistant, COTH
Fletcher H. Bingham, Ph.D., Assistant Director, COTH
Elizabeth A. Burgoyne, Secretary to the Director, COTH

Absent:

Harold H. Hixson, Ex-Officio Member, COTH Member to AAMC Executive Council
Russell A. Nelson, M.D., Ex-Officio Member, COTH Member to AAMC Executive Council

The Executive Committee was joined for lunch on Friday, January 12, by James H. Cavanaugh, Ph.D., Director, Office of Comprehensive Planning and Development, U.S.P.H.S., and by Thomas G. Moore, Jr., Director, Office of Legislation, Office of the Surgeon General, U.S.P.H.S.

I. Call to Order:

The Thursday evening meeting was called to order at 8:20 p.m. by Mr. Lad F. Grapski, Chairman, Council of Teaching Hospitals. A dinner and reception, starting promptly at 6:00 p.m., preceded the evening meeting.

II. Presentation:

Chairman Grapski welcomed the members to the second meeting of the COTH Executive Committee for the 1967-68 Administrative Year. He then presented John Parks, M.D., and Robert C. Berson, M.D., President and Executive Director of the AAMC, respectively. They discussed the expanding character of the AAMC and the various aspects of mutual activities of medical schools and teaching hospitals, following which there was a general discussion.

III. Recess:

Following Doctors Parks and Berson's presentation, Chairman Grapski extended to them the appreciation of the members of the Executive Committee for joining them. Subsequently, the Chairman adjourned the meeting at 10:00 p.m.

IV. Reconvene - Roll Call of the Committee:

Chairman Grapski reconvened the meeting at 8:30 a.m. on Friday, January 12, and roll call was taken. Attendance was as noted previously in these minutes.

Item 3: Approval of Minutes:

ACTION #1 IT WAS MOVED THAT THE MINUTES OF THE OCTOBER 27 and 30, 1967, MEETINGS OF THE COTH EXECUTIVE COMMITTEE BE APPROVED AS PRESENTED. THE MOTION WAS SECONDED AND APPROVED UNANIMOUSLY.

Item 4: Status Report on Membership, FY 1967-68:

Mr. McNulty reported that the 1967-68 paid membership to date is 316; unpaid, 18; old members unpaid, 17, and new members unpaid, 1.

Item 5: New Applications for Membership:

Mr. McNulty brought the Committee's attention to the application for COTH membership submitted by Monmouth Medical Center, Long Branch, New Jersey. He recommended approval as the applicant met the internship and residency requirements.

ACTION #2 THERE WAS A MOTION THAT MONMOUTH MEDICAL CENTER BE APPROVED FOR MEMBERSHIP. THE MOTION WAS SECONDED AND PASSED UNANIMOUSLY.

Item 6: Inquiries as to Possibilities for Membership:

Mr. McNulty presented the recent correspondence with Detroit Osteopathic Association, a corporate body of three osteopathic hospitals which is interested in joining COTH. He said that the COTH staff had no firm stand and would accede to the wishes of the Committee Members. Following, there was a full discussion of the ramifications and possibilities of accepting an osteopathic institution.

ACTION #3 IT WAS AGREED THAT MR. McNULTY SHOULD DISCUSS THE QUESTION OF ADMITTING OSTEOPATHIC HOSPITALS WITH ROBERT C. BERSON, M.D., EXECUTIVE DIRECTOR, AAMC, TO DETERMINE THE AMMC STAND WITH REGARD TO OSTEOPATHIC INSTITUTIONS. FURTHER ACTION WOULD BE TAKEN BY COTH PENDING RESULTS OF SUCH DISCUSSION.

Item 7: Report of Committees:

A. Committee on Modernization and Construction Funds for Teaching Hospitals:

Mr. Frenzel reported on the activities of this Committee, bringing special

attention to Actions 2 and 4 of their December 12 meeting; Action 2 being the decision to have that Committee report to the COTH Executive Committee and have COTH report as a unit to the AAMC Committee on Federal Health Programs, instead of the COTH Committee reporting only to the AAMC Committee. Action 4 was the decision to have members of the Committee on Modernization and Construction Funds contact various members of the National Advisory Commission on Health Facilities on an informal level to establish lines of communication for future "input".

In response to a question from Mr. Rambeck concerning the Federal spending "freeze", Mr. Frenzel reported that the Committee took the action of referring that issue to the COTH Committee on Financial Principles for Teaching Hospitals, since it was more properly in their domain, and that the AAMC Committee on Federal Health Programs had discussed it briefly. There seemed to be general awareness that the "freeze" was not a temporary situation, due particularly to the expense of the war in Vietnam.

Mr. Goulet asked if it would be appropriate to express COTH's concern about the "freeze" formally to the AAMC Committee on Federal Health Programs, since it is especially detrimental to the physical development of hospitals where commitments have been made in the area of training and clinical research, and have the Committee on FHP's express this concern on behalf of the total AAMC to the appropriate bureau or agencies.

ACTION #4 MR. GOULET MOVED THAT THE EXECUTIVE COMMITTEE PRESENT A FORMAL EXPRESSION OF THE CONCERN OF THE COUNCIL OF TEACHING HOSPITALS REGARDING THE FEDERAL FUND "FREEZE" TO THE AAMC COMMITTEE ON FEDERAL HEALTH PROGRAMS - PARTICULARLY SINCE IT AFFECTS A HOSPITAL'S PHYSICAL DEVELOPMENT IN AREAS OF

TRAINING AND CLINICAL RESEARCH WHERE COMMITMENTS HAVE ALREADY BEEN MADE- WITH THE RECOMMENDATION THAT THEY EXPRESS THIS CONCERN TO THE APPROPRIATE PARTIES ON BEHALF OF THE TOTAL AAMC. THE MOTION WAS SECONDED BY DR. HAMILTON AND PASSED UNANIMOUSLY.

In summation, Mr. Frenzel noted the scheduled February 19 meeting of the Committee on Modernization and Construction Funds for Teaching Hospitals and the fact that the Committee recommends the presentation of a position paper and a further sampling study of the Boston questionnaire responses in an attempt to document the modernization need.

B. Committee on Financial Principles for Teaching Hospitals:

Mr. Goulet reported that at its meeting of January 25, the Committee will consider a draft set of principles related to cost distribution in medical centers and a paper to be prepared by Gerhard Hartman, Ph.D., and his staff at the University of Iowa Hospitals, as well as the "Guide to Hospitals: Establishing Indirect Cost Rates for Research Grants and Contracts with the Department of Health, Education, and Welfare", the latter still being considered by a committee appointed by Mr. James Kelly (HEW Comptroller), including in its membership Mr. Goulet, Mr. McNulty, Lawrence Martin (Comptroller, Massachusetts General Hospital and Member, COTH Committee on Financial Principles for Teaching Hospitals) and Dr. Bingham. This Committee, he noted, is more involved in considering the implementation of the principles as opposed to an examination of the principles. Mr. Goulet further reported that Edwin L. Crosby, M.D., Executive Vice President and Director of the AHA had sent a letter to Mr. Kelly stating that the AHA had not accepted the principles in this document.

Dr. Bingham reported that a Subcommittee to evolve the implementation procedures had been appointed and had met three times to date. These meetings were devoted primarily to working through the principles at various hospitals in order to develop the appropriate format for implementation.

In response to Mr. McNulty's question as to where the Kelly Committee stands in point of time, Dr. Bingham noted that it is working against a June 30 deadline. Thus, there should be a report for the full committee within a month.

Mr. Grapski then asked for a report from Thomas Campbell on the AAMC-HEW Cost Finding Information Study, and from Mr. McNulty on the progress of the "Gus Carroll" Study, since they were related to the same general subject.

Mr. Campbell stated that his group plans to take the 1958 A. J. Carroll Study and expand it, modify it, or whatever else is necessary to the whole medical center to develop a cost analysis for the total medical center complex. He noted that the Study is being supervised by a Design Review Committee and will involve the following seven medical centers: University of Utah, University of Iowa, Ohio State University, University of Michigan, New York University, Bowman-Gray (North Carolina Baptist Hospitals), and Jefferson Medical College. Mr. Campbell observed that while he had been working on the study only since January 1, it was started early last fall - with the first deadline for initial information on personnel costs from the medical centers being January. In response to a query from Dr. Bates as to whether the Study would take into account program income as well as costs to give a total and realistic picture of the medical center in terms of gross and net income and expense, Mr.

Campbell noted that while he agreed that the other side of the ledger should be studied, this particular program was primarily concerned with the methodology of allocation. Mr. McNulty reiterated that the Study was an exercise in methodology that would present a "gross" picture only, but stressed that in the complex medical center of today, even the identification of costs is an achievement. Mr. Rambeck echoed Dr. Bates' sentiment that there is a need to get the income side in the picture fairly soon since it has been too long neglected.

Mr. McNulty reported that Mr. A. J. Carroll is still involved with the translation of the data he accumulated into written form and that he is now working on the fourth and final section.

Members then returned to discussion of the "Guide to Hospitals", with Mr. Rambeck moving that the Executive Committee recommend that the AAMC submit a formal protest about the "Guide" to HEW, suggesting that it be revised. Dr. Hamilton seconded the motion. Mr. Goulet noted that Mr. McNulty had sent a strong and explicit letter of objection to HEW, as did the AHA. Dr. Hamilton said that COTH is duty bound to go on record against the "Guide", suggesting that it would strengthen our position to go through the Executive Council of the AAMC.

ACTION #5 MR. RAMBECK MOVED THAT THE COTH EXECUTIVE COMMITTEE RECOMMEND THAT THE AAMC REGISTER WITH HEW A FORMAL PROTEST OF THE "GUIDE FOR HOSPITALS". DR. HAMILTON SECONDED THE MOTION. THE MOTION WAS CARRIED UNANIMOUSLY, WITH THE GROUP FURTHER RECOMMENDING THAT COTH WORK THROUGH THE AAMC EXECUTIVE COUNCIL AND SUGGEST THAT THE FORMAL PROTEST SUBMITTED TO HEW

CONTAIN THE SPECIFIC REVISIONS PROPOSED BY MR. GOULET'S COMMITTEE ON FINANCIAL PRINCIPLES FOR TEACHING HOSPITALS.

C. Committee on Federal Health Programs:

Mr. McNulty mentioned that the most vital information that had been produced at meetings of the Committee on FHP's was distributed to the Executive Committee in the form of Executive Committee Memorandum No. 1968-8E. He also said that a new method of financing medical education is being studied, the current approach being a "so much per student" method. The types of programs under consideration are outlined and appear following the text as a permanent part of the minutes. Mr. McNulty said that the AAMC had no predictions about the acceptability of this to Congress and that Congress adjourned in a conservative frame of mind and would probably be even more conservatibe at reconvention. He did reemphasize the need for contacting Congressmen at the local level. He said that at the moment there was no way of second-guessing where cuts would appear.

Mr. Ferguson and Mr. Macer brought up the question of universities closing down medical and dental schools. Mr. McNulty said that may happen as a result of decreasing quality when funding stops. Mr. Ferguson noted that many schools have stopped their building programs such as Harvard, Johns Hopkins, and that problems would occur in places like Meharry and Howard, where there are the social implications of the latter two being among the few training centers for Negro students. Mr. Goulet and Mr. Frenzel both noted that it would be interesting to see what happened to faculty structure if and when research support were to be withdrawn, both gentlemen guessing that the number of people left in research would diminish since people tend to work where there are adequate support funds.

Mr. McNulty reported that the AAMC now has an administrative commitment that in the legislative history there would be language to the effect that they will negotiate with whomever is the appropriate party. The administration, in relation to the 15% overhead has stated, "You tell us where to put it and we will put it there".

D. COTH-AHA Liaison Committee:

1) AHA Representation on COTH Committee and Construction and Modernization Funds.

As an introduction, Mr. McNulty called the Committee's attention to the minutes of the October 3 meeting.

Dr. McNinch then reported that he is official secretary of the Committee. In commenting on the October meeting, he noted that Dr. Crosby had reiterated the need for close liaison between the two in developing legislative coordination of all hospitals. He said Mr. McNulty had told Dr. Crosby that the AHA Guide Issue does not provide certain informational items of interest and import to teaching hospitals. Dr. Crosby agreed to cooperate in an attempt to get such information included. Dr. McNinch noted that the rest of the COTH-AHA Liaison Committee meeting consisted of a report from Mr. McNulty on the prime activities of COTH.

Dr. McNinch said he felt a good way to improve liaison was through cooperation on a committee-staff level. He mentioned specifically the suggestion that the COTH Executive Committee consider the inclusion of someone from the AHA Council on Government Relations on the COTH Committee on Modernization and Construction Funds for Teaching Hospitals- the suggestion proposing further that he be a non-teaching hospital person.

Mr. McNulty confirmed the discussion saying the suggested people were Horace M. Cardwell and John W. Kauffman. There was general agreement that an overlapping liaison structure with the AHA would be beneficial.

ACTION #6 THERE WAS AGREEMENT THAT COTH-AHA LIAISON SHOULD BE FLEXIBLE AND SHOULD BE EXPLORED BY THE COTH STAFF, PARTICULARLY IN THE WAY IT EXISTS WITH ROBERT C. LINDE AS AHA REPRESENTATIVE TO COTH COMMITTEE ON FINANCIAL PRINCIPLES.

2) Report regarding status of HAS specialist for teaching hospitals:

Mr. Wittrup then introduced the topic of the AHA program on Hospital Administration. He and several other Committee members mentioned that the level of participation among COTH member hospitals is quite low. Some individuals mentioned limiting factors such as the limited cost accounting facilities in some hospitals and the varying unique problems of teaching hospitals - as well as the often-found fact that administrators approached by HAS who run complex centers may not be aware of certain accounting details. Dr. McNinch and Mr. Wittrup noted the HAS activity and enthusiasm in the Southeast. The group generally agreed that from within, COTH should push for fuller and more active cooperation on the part of members with HAS.

3) Report of Informal Discussion:

Mr. McNulty reported concurrence with Dr. McNinch's suggestion that the COTH-AHA Liaison Committee is the best mechanism of report to the AHA of COTH activities and other liaison activity. He then stated that Dr. Crosby may feel concerned since he is not talking with the deans. He

said that gradually deans may become active in COTH programs, especially since the personality of the AAMC is gradually changing and becoming more comprehensive.

General discussion was to the effect that liaison with the AHA is a necessary and desirable goal to be attained through cooperation on a staff/committee level to expand the understanding that is already existing since all COTH members are AHA members. Mr. McNulty voiced the group's sentiment that a profitable liaison could exist between the AHA and the AAMC Committee on Federal Health Programs. Dr. McNinch said he would relate the discussion to Dr. Crosby for his consideration.

Item 8: Appointment of Nominating Committee for Administrative Year 1967-68:

ACTION #7 IT WAS MOVED THAT THE APPOINTMENT OF THE NOMINATING COMMITTEE BE APPROVED. THE MOTION WAS SECONDED AND PASSED UNANIMOUSLY. THE APPROVED MEMBERSHIP FOR 1967-68 FOLLOWS: STANLEY A. FERGUSON, CHAIRMAN: DONALD CASELEY, M.D.. HAROLD H. HIXSON: RUSSELL A. NELSON, M.D.

Item 9: Discussion of Theme and Specific Content for 1968 Annual Meeting:

Mr. McNulty indicated the AAMC has a Program Committee which will probably consider a theme common to the AAMC and COTH as an initial possibility. He emphasized the major problem of trying to determine in January what will be applicable and pertinent in the Fall.

Mr. Rambeck suggested the involvement of the medical center - teaching hospital in total state planning programs since they are currently pulled

two ways - either total involvement or lack of it. Mr. Grapski and Mr. Ferguson said the report of the Manpower Commission might be a good source of ideas. Mr. Rambeck said a study of quality factors and whether quality is reduced by any specific type of payment system is also a timely subject. Another suggested topic for the COTH program was Group Practice - the Government's definition, the physician's definition, and the manner in which it is currently carried out. Also, Dr. Cronkhite said various phases of university and hospital manpower need to be discussed, citing the example of laboratory technicians currently being required to have an Associate's degree in some circumstances. Mr. Richwagen agreed saying that there is an increasing emphasis on credentials rather than practical knowledge. The group agreed to submit any further suggestions to the COTH staff.

12:30 p.m. Luncheon:

The Executive Committee was joined for lunch at 12:00 p.m. by James A. Cavanaugh, Ph.D., Director, Office of Comprehensive Planning, USPHS, and Thomas G. Moore, Jr., Director, Office of Legislation, Office of The Surgeon General, USPHS. The two men discussed the status of current legislation affecting teaching hospitals and the probable role of Comprehensive Planning in the future delivery of health services.

Item 10: AHA Definition of a Teaching Hospital:

Mr. McNulty presented the AHA definition and said that at the COTH-AHA Liaison Committee meeting, Dr. David Wilson, AHA President, had said that the definition was somewhat indefinite to him.

Dr. McNinch stated that there had been much discussion about the wording since the AHA felt it had to get into every kind of hospital with every

kind of teaching function for which it could hope to get funds. Mr. Goulet said he was afraid that such a fund-seeking-oriented definition might distort the teaching activities. Mr. Rambeck noted that the AHA definition evolved because the term "teaching hospital" appeared in so much legislation, adding that although the definition is somewhat watered down, it is the best they could get through the Council on Government Relations. Mr. Goulet felt that the hospital should let the program define the method or form of support based on specific analysis of programs that Congress wanted to support. He proposed deletion of the word "teaching" in favor of saying "hospitals engaged in educational activities" within the program of a specific piece of legislation. His argument was that support should not be generic to education but specific to the program - and the hospital should be the valid entity to engage in it.

Mr. Ferguson interpreted the phrase reading "or programs which present certificates" to mean that if you had a public program of instruction and gave a certificate in any area involving patient service, then you are in education. Mr. Ferguson suggested a change of wording to drop the word "recognized" - just call them "certificates, diplomas or degrees". That way you are covered and don't have to worry over "recognized by whom". Dr. Cronkhite said he preferred to have it read "prepares people for the performance of a recognized hospital task". Mr. Frenzel said that no matter how you looked at the definition, it reads that any hospital that starts any program of instruction becomes a teaching hospital. Mr. Goulet suggested leaving it up to the agencies to decide the degree to which an institution satisfies the purposes of the act and actually does the job they say they are going to do - as is going on now with research grants.

Mr. Frenzel agreed and amplified saying that then you don't qualify the hospital, you qualify the teaching program. The group, in general, agreed.

Item 11: Recent Reports and Studies Relevant to Health Facilities: Mr. McNulty said the item called for no action or deep study at this time. The prime purpose of presentation is to show how much consideration is being given to this issue on a national level, although any real worth needs to be investigated so that at the May meeting the staff will present recommendations as to how they relate to the long-range staff and program activity of COTH.

Dr. Boettcher asked if the Health Care Analysis was a precursor to the Commission on Health Facilities. Mr. McNulty said it was an "in-house study", the report of which would probably be combined with the report of the National Advisory Commission on Health Facilities, when evolved. Mr. Ferguson mentioned that the draft of the in-house study was presented to the Advisory Commission on Health Manpower with the hope of using it to implement that Commission's report but decided that it would be almost impossible for that Commission to try to put the manpower question together with the facilities since it is very difficult to try to label the staff and decide what is effective and beneficial in relation to the facilities. Mr. McNulty agreed and restated the probability that elements of the Analysis report may be combined with the Report of the National Advisory Commission on Health Facilities.

Item 12: National Advisory Commission on Health Manpower: Since committee members had all received and read the report of the Commission, Mr. McNulty's only comment was to note that the report recommends the grant-in-aid and low-interest loan programs of support as the two

"poles". Mr. Goulet stated that grants-in-aid tend to keep hospitals obsolete. Mr. Wittrup agreed but said that a grant gives the government the right to restrict use of the money as it may desire.

Item 13: Conference on Costs of Health Care Facilities:

Mr. McNulty reported that the staff had no further comment to make other than the belief that any report will probably be of more practical use to commercial groups for promotional purposes than it will to the health care field. Mr. Wittrup said that it is interesting to note how studiously they avoid the entire issue of the basic organizational pattern in the community hospital. He commended Herman and Ann Somers for raising the question in "Medicare and Hospital Issues and Answers" when they quoted someone as saying that the relationship between the hospital and existing private practice is the core of the problem and that everybody will go everywhere they can to avoid the issue.

Item 14: National Advisory Commission on Health Facilities:

Mr. Grapski noted that this item had been sufficiently covered by prior discussion.

Item 15: IRS Regulations Regarding Sale of Over-the-Counter Pharmaceutical Supplies:

Mr. McNulty reported that a memorandum had been sent to the membership on this subject, adding that the AHA summary prepared by Arthur Bernstein was very complete and helpful in this regard. He said further that attorneys would meet at some of the regional meetings to discuss this question. Discussion was to the effect that the initial issue may have been raised by commercial pharmacies. However, the government seems to have realized that any extra tax income was negligible and many of the

officials who instigated this move in the IRS have since left. The general conclusion reached was that the IRS ruling would not affect current drug sales in the hospital, the only changes being rulings about people asking for the filling of prescriptions written by physicians not from the institution.

Item 16: Health Legislation Recently Enacted:

Mr. McNulty had no comment other than that the staff wanted to be sure it was on the agenda. Mr. Wittrup indicated that his hospital had experienced difficulty in determining where certain services belonged - under Part A or Part B. Dr. Cronkhite also indicated the tax liability issue of the disparity between physicians who gather together to practice at a full-time salary with the institution collecting fees on their behalf, the institution not being liable for taxes.

Item 17: Federal Health Legislation Expiring in 1968 and 1969:

Mr. McNulty stated that the listing of expiring legislation appeared again for emphasis and the items will be coming up soon in the legislature. COTH will have input through its three members on the AAMC Committee on Federal Health Programs.

Item 18: Status of Proposed Projects:

Mr. McNulty reported that we are hoping for DHEW contracts to conduct two projects which had been previously approved by the Executive Committee. One is to study the feasibility of establishing a Teaching Hospital Information Center similar to the King Edwards Hospital Fund in England, to serve as a recipient of all information related to hospitals and then submit pertinent information to hospitals and related institutions. The other project is a study of the impact of Title 18 and Title 19 and related development of teaching hospitals. The latter project was prompted by the great number of

inquiries from many sources concerning patient mix, age, financial status, degree of illness, etc.

ACTION #8 THE EXECUTIVE COMMITTEE AGAIN ENDORSED UNANIMOUSLY BOTH THE FEASIBILITY EXPLORATION AND, IF DETERMINED AFFIRMATIVE BY STAFF, THE DEVELOPMENT OF A TEACHING HOSPITAL INFORMATION CENTER STUDY AND A STUDY OF THE IMPACT OF TITLES 18 & 19, AND FURTHER AUTHORIZED MR. McNULTY TO PROCEED WITH NEGOTIATIONS AND FINAL ARRANGEMENTS SUBJECT TO AAMC EXECUTIVE COUNCIL APPROVAL TO SECURE FUNDING (DHEW-FOUNDATIONS, ETC.) TO ASSIST IN UNDERWRITING THE COST OF SUCH PROJECTS.

Item 19: Informational Report on:

A & B: Yale-New Haven Study--HEW-AAMC Cost Study:

Mr. Grapski indicated that this item was well covered during the report of the Committee on Financial Principles and moved to the next item.

Item 20: Future Meetings of the Executive Committee:

Mr. McNulty indicated that the next meeting was May 9-10, but that the September 12-13 dates may need to be changed because of conflict with a rescheduled AHA meeting.

ACTION #9 THE COMMITTEE AGREED TO CHANGE THE SEPTEMBER MEETING DATES TO SEPTEMBER 5-6, 1968, IN WASHINGTON, D.C.

Item 21: Other Business:

ACTION #10 IN HIS CAPACITY AS COTH CHAIRMAN, MR. GRAPSKI CHARGED THE COTH STAFF TO DRAW UP A DRAFT OF REVISED RULES AND REGULATIONS TO BE DISTRIBUTED TO MEMBERS UPON ITS COMPLETION FOR THEIR INTENSIVE CONSIDERATION PRIOR TO A FULL DISCUSSION OF THE DRAFT OF PROPOSED REVISIONS AT THE MAY 9-10 MEETING OF THE EXECUTIVE COMMITTEE.

Mr. McNulty then gave a capsule review of current AAMC organizational status. He told of the activities of the Ways and Means Committee in

an attempt to adjust the AAMC's structure to the rapidly expanding programs and increasing demands. This Committee has outlined an organization which would have as its legislative body members from each AAMC "council" and from this body, evolve an Executive Committee which would have a much broader base. The Institutional Meeting on February 10 is similar to a "dry run" of having members meet more as an assembly than as a legislative body.

The second item Mr. McNulty mentioned was a call for any suggestions of subject matter for COTH Regional Meetings. He then moved on to the subject of the COTH budget. Because of the expanded program activity, COTH expenses are rapidly catching up to the income. While the staff is attempting to cut down on internal expenses, these cuts cannot be that significant. The three ways to increase income, as COTH must do to keep up with its program activities are: 1) grants, which we are working on but which are only temporary; 2) increased dues; and 3) increased membership. Mr. Ferguson suggested that the staff draw up a summary of current and anticipated COTH activity, with a breakdown as to what part of the activity is representation, what part information-gathering and distribution, what part is evaluation, etc. Mr. Wittrup suggested a dues raise on a graduated basis according to the institution size, as the AAMC has done with the medical schools. Mr. McNulty emphasized that he raised the matter only to get the committee's thoughts so that they would be prepared to discuss it at the next meeting.

ACTION #11 IT WAS AGREED THAT COTH STAFF PREPARE A SUMMARY OF CURRENT AND ANTICIPATED PROGRAM ACTIVITY WITH A BREAKDOWN AS TO WHAT IS AN ACTIVITY OF REPRESENTATION, INFORMATION-GATHERING, ETC. SO THAT MEMBERS COULD DISCUSS IN RELATION

TO AN ESTABLISHMENT OF PRIORITIES AT THE MAY MEETING AND THEN PROCEED TO DISCUSS THE BUDGET.

Adjournment: There being no further business, Mr. Grapski adjourned the meeting at 3:45 p.m.

REPORT ON ACTION ITEMS FROM THE JANUARY 11 AND 12
MEETING OF THE EXECUTIVE COMMITTEE

ACTION #3 IT WAS AGREED THAT MR. McNULTY SHOULD DISCUSS THE QUESTION OF ADMITTING OSTEOPATHIC HOSPITALS WITH ROBERT C. BERSON, M.D., EXECUTIVE DIRECTOR, AAMC, TO DETERMINE THE AAMC STAND WITH REGARD TO OSTEOPATHIC INSTITUTIONS. FURTHER ACTION WOULD BE TAKEN BY COTH PENDING RESULTS OF SUCH DISCUSSION.

see Tab 2b

ACTION #4 MR. GOULET MOVED THAT THE EXECUTIVE COMMITTEE PRESENT A FORMAL EXPRESSION OF THE CONCERN OF THE COUNCIL OF TEACHING HOSPITALS REGARDING THE FEDERAL FUND "FREEZE" TO THE AAMC COMMITTEE ON FEDERAL HEALTH PROGRAMS - PARTICULARLY SINCE IT AFFECTS A HOSPITAL'S PHYSICAL DEVELOPMENT IN AREAS OF TRAINING AND CLINICAL RESEARCH WHERE COMMITMENTS HAVE ALREADY BEEN MADE- WITH THE RECOMMENDATION THAT THEY EXPRESS THIS CONCERN TO THE APPROPRIATE PARTIES ON BEHALF OF THE TOTAL AAMC. THE MOTION WAS SECONDED BY DR. HAMILTON AND PASSED UNANIMOUSLY.

see Tab 2c

ACTION #5 MR. RAMBECK MOVED THAT THE COTH EXECUTIVE COMMITTEE RECOMMEND THAT THE AAMC REGISTER WITH HEW A FORMAL PROTEST OF THE "GUIDE FOR HOSPITALS". DR. HAMILTON SECONDED THE MOTION. THE MOTION WAS CARRIED UNANIMOUSLY, WITH THE GROUP FURTHER RECOMMENDING THAT COTH WORK THROUGH THE AAMC EXECUTIVE COUNCIL AND SUGGEST THAT THE FORMAL PROTEST SUBMITTED TO HEW CONTAIN THE SPECIFIC REVISIONS PROPOSED BY MR. GOULET'S COMMITTEE ON FINANCIAL PRINCIPLES FOR TEACHING HOSPITALS.

Report Only

ACTION #6 THERE WAS AGREEMENT THAT COTH-AHA LIASION SHOULD BE FLEXIBLE AND SHOULD BE EXPLORED BY THE COTH STAFF, PARTICULARLY IN THE WAY IT EXISTS WITH ROBERT C. LINDE AS AHA REPRESENTATIVE TO COTH COMMITTEE ON FINANCIAL PRINCIPLES.

Report Only

ACTION #7 IT WAS MOVED THAT THE APPOINTMENT OF THE NOMINATING COMMITTEE BE APPROVED. THE MOTION WAS SECONDED AND PASSED UNANIMOUSLY. THE APPROVED MEMBERSHIP FOR 1967-68 FOLLOWS: STANLEY A. FERGUSON, CHAIRMAN: DONALD CASELEY, M.D., HAROLD H. HIXSON; RUSSELL A. NELSON, M.D.

No Report

ACTION #8 THE EXECUTIVE COMMITTEE AGAIN ENDORSED UNANIMOUSLY BOTH THE FEASIBILITY EXPLORATION, AND IF DETERMINED AFFIRMATIVE BY STAFF, THE DEVELOPMENT OF A TEACHING HOSPITAL INFORMATION CENTER STUDY AND A STUDY OF THE IMPACT OF TITLES 18 & 19, AND FURTHER AUTHORIZED MR. McNULTY TO PROCEED WITH NEGOTIATIONS AND FINAL ARRANGEMENTS SUBJECT TO AAMC EXECUTIVE COUNCIL APPROVAL TO SECURE FINDING (DHEW-FOUNDATIONS, ETC.) TO ASSIST IN UNDERWRITING THE COST OF SUCH PROJECTS.

See Tab 2d

ACTION #9 THE COMMITTEE AGREED TO CHANGE THE SEPTEMBER MEETING DATES TO SEPTEMBER 5-6, 1968, IN WASHINGTON, D.C.

No Report

ACTION #10 IN HIS CAPACITY AS COTH CHAIRMAN, MR. GRAPSKI CHARGED THE COTH STAFF TO DRAW UP A DRAFT OF REVISED RULES AND REGULATIONS TO BE DISTRIBUTED TO MEMBERS UPON ITS COMPLETION FOR THEIR INTENSIVE CONSIDERATION PRIOR TO A FULL DISCUSSION OF THE DRAFT OF PROPOSED REVISIONS AT THE MAY 9-10 MEETING OF THE EXECUTIVE COMMITTEE.

See Tab 2e

ACTION #11 IT WAS AGREED THAT COTH STAFF PREPARE A SUMMARY OF CURRENT AND ANTICIPATED PROGRAM ACTIVITY WITH A BREAKDOWN AS TO WHAT IS AN ACTIVITY OF REPRESENTATION, INFORMATION-GATHERING, ETC. SO THAT MEMBERS COULD DISCUSS IN RELATION TO AN ESTABLISHMENT OF PRIORITIES AT THE MAY MEETING AND THEN PROCEED TO DISCUSS THE BUDGET.

See Tab 2f

March 5, 1968

Ralph F. Lindberg, D.O.
Executive Director
Detroit Osteopathic Hospital Corporation
12523 Third Avenue
Detroit, Michigan 48203

Dear Doctor Lindberg:

I have not forgotten your letter of November 28, 1967, to Robert C. Berson, M.D., inquiring as to membership possibility in the Council of Teaching Hospitals for the Detroit Osteopathic Hospital. As you will remember, I replied by letter of December 7, 1967, indicating that at that point, the "Rules and Regulations" of the Council of Teaching Hospitals (COTH) were specific as to membership, indicating that there was a requirement for a relationship with a school of medicine, or a major commitment to post-graduate medical education.

Since my letter of December 7, there has been considerable discussion by the Association of American Medical Colleges (AAMC) concerning an enlargement of its base of membership and a corresponding broadened program responsibility. I had hoped that these discussions would have become definitive by this time so that I might write to you and indicate what view the total AAMC might have toward encompassing additional disciplines active in the health field. Having waited now for several months, I did feel a responsibility to reply and inform you that the position at this time is still the same as it was in December--that the criteria for membership in the Council of Teaching Hospitals is necessarily related to medical education activity.

If current and continuing discussions do materialize into an organizational structure that could be responsive to the interest mentioned in your letter of November 28, I shall certainly bring such information to your attention. In the meantime, I do encourage you and your colleagues to maintain your individual membership in the AAMC. In addition, I would call attention to the Annual Meeting of the Council of Teaching Hospitals which is concurrent with the Annual Meeting of the Association of American Medical Colleges, being held this year in Houston, Texas, from Friday, November 1, through Monday morning, November 4, 1968. I hope it is possible for you to attend that Annual Meeting. If so, I would look forward to the pleasure of our meeting.

Cordially,

MATTHEW F. McNULTY, JR.
Director, COTH
Associate Director, AAMC

MM:eb

May 6, 1968

Mr. Lawrence W. Mills, Secretary
Bureau of Professional Education
American Osteopathic Association
212 East Ohio Street
Chicago, Illinois 60611

Dear Mr. Mills:

Is there any chance that I could see you in your office for a little while late in the afternoon Thursday the 9th or early in the morning Friday the 10th of May? Since meeting you at the American Council on Education on February 22, I have been hoping one of my frequent trips to Chicago would allow me a little time for this purpose. I now find there will be, or could be, a little time during this week's trip.

I think purely informal discussion of what may be overlapping interests between schools of medicine and of osteopathy, would certainly be enlightening to me and might be helpful.

I realize this is extremely short notice and that the hours that would work for me may be impossible for you. I plan to call you from our office in Evanston sometime on Thursday.

Sincerely yours,

Robert C. Berson, M.D.
Executive Director

RCB/cls

bcc: Dr. Frank G. Dickey

SUMMARY OF STATEMENT OF THE AAMC BEFORE THE SUBCOMMITTEE
ON LABOR-HEW OF THE COMMITTEE ON APPROPRIATIONS
U.S. HOUSE OF REPRESENTATIVES-APRIL 30, 1968

ACTION #4 from Minutes of the COTH Executive Committee Meeting, January 12, 1968

Mr. Goulet moved that the Executive Committee present a formal expression of the concern of the Council of Teaching Hospitals regarding the Federal fund "freeze" to the AAMC Committee on Federal Health Programs - particularly since it affects a hospital's physical development in areas of training and clinical research where commitments have already been made - with the recommendation that they express this concern to the appropriate parties on behalf of the total AAMC. The motion was seconded by Dr. Hamilton and passed unanimously.

Following this action, as recommended at the January 12, 1968 COTH Executive Committee Meeting, the AAMC Committee on Federal Health Programs was apprised of COTH concern regarding the Federal fund "freeze". Below is a summary of the statement presented by Robert C. Berson, M.D., Executive Director, AAMC to the House of Representatives Appropriations Subcommittee for Departments Labor-HEW for the record. Additionally, informal verbal presentations were made by Doctors Franklin G. Ebaugh, Dean of Boston University School of Medicine, Robert H. Felix, Dean of St. Louis University School of Medicine, and Charles A. LeMaistre, Vice Chancellor for Health Affairs of the University of Texas Medical Branch. The members of the subcommittee present appeared interested and seemed to understand the severity of the situation. The committee requested that the AAMC draft specific language for use in the committee report, which would delineate specifically the need for the requested increased amounts over the amounts that had been recommended by the administration. This is considered to be a most unusual action of this particular subcommittee and is viewed as an encouraging sign of their interest and desire to be of assistance.

The prepared statement began by describing the AAMC as representing all of the schools of medicine, 338 of the major teaching hospitals and 28 of the major academic medical societies in the United States. Additionally, it expressed gratitude for the opportunity to present its views on the proposed appropriations for fiscal 1969, which directly affects the future health of the public through programs operated in the medical schools and teaching hospitals. It was pointed out that while the testimony would be directed primarily to the need for appropriations needed for established programs, within the limits of their authorizing legislation, the AAMC is also deeply concerned about the very large fiscal problems our country is facing which make decisions about the allocation of federal resources enormously difficult and important at this time. Reference was made to the rising costs of health services and the shortages of physicians and other trained health professionals which are linked to these rising costs. In spite of the opinions expressed in some quarters of the need to turn out more "people doctors" and fewer physicians well-grounded in scientific knowledge, the statement pointed out the significant contributions the medical schools and teaching hospitals have made to society as a result of biomedical research. The statement stressed the continued need for such research in order to find the answers for the prevention of cardiovascular diseases, cancers, the rheumatic diseases, renal diseases, hepatitis, the psychoses and a host of others.

The various legislation which had been enacted to provide funds for this purpose was reviewed such as the Health Professions Educational Assistance Act of 1963, providing matching grants for the construction of educational facilities and the Health Professions Educational Assistance Amendments of 1965, providing basic and special improvement grants for the operation of schools in the health professions and scholarship and loan funds for their students. The statement then noted that it is now abundantly clear that the demand for health services is far greater than had been predicted and there is a desperate shortage of physicians and other health professionals.

A paragraph of particular interest to COTH stated "The hospitals of this country have stretched their resources to the limit in providing services to patients who had no other recourse and many of them in providing education for many categories of health workers. They have not had the money with which to replace, modernize, or expand their facilities nearly enough to meet the current and future demands of society. The needs for modernization and expansion are particularly severe in teaching hospitals. For example, a recent study showed that in 214 of the teaching hospitals, which contain a total of 115,000 beds, 35 percent are over 35 years old and another 16 percent are between 21 and 35 years old. 120 of them plan to replace 27,500 beds and 142 plan to add 24,000 beds in the next 10 years. The cost of construction in these hospitals is estimated $4 billion over a period of 10 years. At this time, when so many of the demands and expectations of society can only be met by increases in several of the outputs of medical schools and teaching hospitals, the resources of these institutions are stretched to the limit. A year ago, we reported to this committee, 'Every university medical center in the United States, both state and private, is in trouble financially and some are in desperate straits.' The Congress did increase the appropriations slightly over the previous year and in this fiscal year, for the first time, the basic improvement grants to eligible schools will be paid at the full amount authorized by Congress and a small number of special improvement grants will be made. In the meantime, the pressure on institutions from rising costs and increasing demands has increased."

The statement concluded, "The AAMC is convinced that the support of medical schools should continue to come from the variety of sources which have made possible their development thus far. It is also convinced, however, that each medical school is, to some extent, a national resource and that each should do what it can to respond to national needs and demands. Medical schools have done so in the past and can be depended upon to make every effort to do so in the future, but we believe that it is logical and necessary for the federal government to substantially increase its support of the 'Regular Operating Programs' of medical schools in proportion to the national needs for the several outputs of medical schools. We do not think it is logical or realistic to expect state or local governments, universities, foundations, individuals or corporations to increase their support of medical schools quickly enough or in large enough amounts to respond to national needs as they develop."

The difference of opinion between the President and the Chairman of the House Committee on Ways and Means over additional taxes and levels of federal spending and the impending reductions in appropriations undoubtedly will have a severe effect on all federal programs including those relating to medical schools and teaching hospitals.

III. Council of Teaching Hospitals

A. Proposed contract to support a study of the impact of Titles XVIII and XIX and related development on teaching hospitals. Mr. McNulty summarized the purpose as studying the impact of Medicare and Title XIX in terms of changing patient population and other implications. $224,000 is the money sum being discussed for a two-year period. Dr. Berson noted the Council had approved beginning the negotiations.

ACTION: On motion, seconded and carried, the Council approved the submission of a proposed COTH-USPHS contract to support a study of the impact of Titles XVIII and XIX and related development of teaching hospitals with the provision that the negotiated contract adhere generally to the original proposal.

B. Proposed contract to support a one-year study of the feasibility of establishing and maintaining a teaching hospital information center. Mr. McNulty emphasized the number of inquiries at COTH for information relative to teaching hospitals. He noted that discussion of this contract stressed the fact that the first year would be a study of feasibility. The cost range discussed is $75,000 - $136,000.

ACTION: On motion, seconded and carried, the Executive Council approved COTH's proposed negotiation of a contract to support a one-year study of the feasibility of establishing and maintaining a teaching hospital information center.

IV. Federal Health Programs

The minutes of the Federal Health Programs Committee's last meeting were called to the Council's attention, as was Dr. Hubbard's statement at the hearings on the Health Manpower Act of 1968. The need to have spokesmen present the views of the AAMC concerning several pieces of legislation and appropriations was stressed. It was reported that Robert Felix will spend about half of his time at AAMC's Washington office to help with the many things that need to be done this spring.

Dr. Parks commented on the positive aspects of S.3095 (Health Manpower Act of 1968), as well as noting with pleasure that subsequent to Dr. Hubbard's testimony, the AMA presented a very supportive statement at the hearings.

There followed discussion concerning various pieces of legislation. Dr. Parks urged Council members to contact him if they felt there was something the Federal Health Programs Committee should study.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
800 NORTH QUINCY STREET
ARLINGTON, VIRGINIA 22203

Bureau of Health Services

REFER TO:
CB: FCL
PH 110-68-41

APR 25 1968

Association of American Medical Colleges
Council of Teaching Hospitals
1346 Connecticut Avenue, N.W.
Washington, D.C. 20036

Attention: Matthew F. McNulty, Jr.
Director

Gentlemen:

Enclosed is a signed copy of the contract executed by the Contracting Officer on behalf of the Government.

Any changes in the terms or conditions of the contract must be made in writing by the Contracting Officer. In the event changes are requested or recommended they should be submitted in writing to this office.

You are requested to sign and return the enclosed copy of this letter acknowledging receipt of the contract.

Sincerely yours,

Murray N. Weinstein
Contracting Officer

Enclosures:
Signed Copy of Contract
Contract Receipt Acknowledgment

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE

NEGOTIATED CONTRACT

CONTRACT NO	PAGE 1 OF 10 PAGES
PH 110-68-41	
NEGOTIATED PURSUANT TO	TYPE OF CONTRACT
41 USC 252(c)(10)	Cost Reimbursement

ISSUING OFFICE

Bureau of Health Services
800 North Quincy Street
Arlington, Virginia 22203

CONTRACT FOR

Study for a Teaching Hospital Information Center

CONTRACTOR *(Name and Address)*

Association of American Medical Colleges
Council of Teaching Hospitals
1346 Connecticut Avenue, N.W.
Washington, D.C. 20036

ACCOUNTING AND APPROPRIATION DATA

Appropriation: 7580370
Allowance: 8-2330 ca 0/150/000

(RFP PH 110-OC-9(8))

PLACE OF PERFORMANCE

Washington, D.C.

CONTRACT AMOUNT

$71,240.00

MAIL VOUCHERS TO

EXECUTED BY BOTH PARTIES

See ARTICLE XVI

SPONSOR

Office of Research and Development, BHS

EFFECTIVE DATE	EXPIRATION DATE
APR 2 4 1968	14 months after effective date

CONTRACTOR REPRESENTS

1. That it ☐ is, ☒ is not, a small business concern. If he is a small business concern and is not the manufacturer of the supplies to be furnished hereunder, he also represents that all such supplies ☐ will, ☐ will not, be manufactured or produced by a small business concern in the United States, its possessions, or Puerto Rico. (A small business concern for the purpose of Government procurement is a concern, including its affiliates, which is independently owned and operated, is not dominant in the field of operation in which it is contracting and can further qualify under the criteria concerning number of employees, average annual receipts, or other criteria, as prescribed by the Small Business Administration.) (See Code of Federal Regulations, Title 13, Part 121, as amended, which contains detailed definitions and related procedures.)
2. That it is a ☐ REGULAR DEALER IN, ☐ MANUFACTURER OF, the supplies covered by this contract.
3. That it is an ☐ INDIVIDUAL, ☐ STATE OR LOCAL AGENCY, ☐ PARTNERSHIP, ☐ JOINT VENTURE, ☑ NONPROFIT, ☐ EDUCATIONAL INSTITUTION, ☐ CORPORATION organized and existing under the laws of the state of ILLINOIS

The Contractor agrees to furnish and deliver all the supplies and perform all the services set forth in the attached Special Provisions, for the consideration stated herein. The rights and obligations of the parties to this contract shall be subject to and governed by the Special Provisions and the General Provisions. To the extent of any inconsistency between the Special Provisions or the General Provisions and any specifications or other provisions which are made a part of this contract, by reference or otherwise, the Special Provisions and the General Provisions shall control. To the extent of any inconsistency between the Special Provisions and the General Provisions, the Special Provisions shall control.

IN WITNESS WHEREOF, the parties hereto have executed this contract on the day and year last specified below.

Association of American Medical Colleges	UNITED STATES OF AMERICA
NAME OF CONTRACTOR	
BY Robert C. Berson	BY Murray N. Einstein
SIGNATURE OF AUTHORIZED INDIVIDUAL	SIGNATURE OF CONTRACTING OFFICER
Robert C. Berson, M.D.	Murray N. Einstein Contracting Officer
TYPED NAME	TYPED NAME
TITLE Executive Director	
April 22, 1968	APR 2 4 1968
DATE	DATE

SIGNED COPY

PHS-4910-1 (9-66)

THIS CONTRACT CONSISTS OF:

1. COVER PAGE PHS 4910-1

2. CONTENTS OF CONTRACT PHS 4910-2

3. SPECIAL PROVISIONS PHS-4910-3

ARTICLE I	DESCRIPTION AND SCOPE OF WORK
ARTICLE II	ARTICLES AND SERVICES TO BE FURNISHED AND DELIVERY
ARTICLE III	NOTICE TO THE GOVERNMENT OF DELAYS
ARTICLE IV	REVIEW AND APPROVAL
ARTICLE V	DESIGNATION OF PROJECT OFFICER
ARTICLE VI	DESIGNATION OF PROJECT DIRECTOR
ARTICLE VII	DISSEMINATION OF INFORMATION
ARTICLE VIII	PUBLICITY AND PUBLICATIONS
ARTICLE IX	DEVELOPMENT AND USE OF FORMS
ARTICLE X	IDENTIFICATION OF DATA
ARTICLE XI	CONSULTANT SERVICES
ARTICLE XII	PROCUREMENT OF ALL MATERIAL, DATA, AND SERVICES
ARTICLE XIII	ADMINISTRATION OF GOVERNMENT OWNED PROPERTY
ARTICLE XIV	FINANCIAL MANAGEMENT REPORT
ARTICLE XV	COMPENSATION
ARTICLE XVI	SUBMISSION OF INVOICES AND PLACE OF PAYMENT

4. GENERAL PROVISIONS, HEW FORM 315 (REV. 8/64) NEGOTIATED Cost-Reimbursement Contract and "Alterations to Contract General Provisions" dated February 13, 1968.

ARTICLE I - DESCRIPTION AND SCOPE OF WORK

A. SERVICES TO BE RENDERED:

The Association of American Medical Colleges and its Council of Teaching Hospitals will perform a study relative to the establishment of a formal mechanism of information accumulation, evaluation and dissemination regarding research, experimentation and demonstration that is accomplished or ongoing, which is beneficial to those involved in the administration of teaching hospitals. Additionally they will study ways for the encouragement of innovation and experimentation, and for the evaluation of present administrative systems and structures in teaching hospitals, and ways of providing a constant stimulus for continued research relating to the interface relationships between teaching hospitals, medical schools and, where appropriate, the overarching medical center.

The following services will be undertaken by the Contractor: Quarterly progress reports will be forwarded to the Office of Research and Development, Bureau of Health Services (See attached Schedule of Responsibilities).

B. STUDY RELATIVE TO THE POSSIBILITY OF ESTABLISHING A METHODOLOGICAL DESIGN FOR INFORMATION DISSEMINATION:

One of the most significant features that will be studied is that relative to the possibility of establishing a methodology designed specifically for the dissemination of a constantly changing body of information. The period of study and examination of various alternate mechanisms, preceding the actual development will necessarily be both intensive and extensive. Various existing programs, such as the King Edward Fund in Great Britain and the Cooperative Information Center for Health Management Studies at the University of Michigan, will be examined for methodological content.

The approach will be both eclectic and innovative in nature. It will be eclectic in the sense that it will seek to incorporate those component elements of existing systems that prove workable and feasible for the specific purposes of this design.

It will be innovative in the sense that it will consider the introduction of new conceptual methodologies, either when none are found to be appropriate, or when those that are available do not fit the optimal pattern.

A new concept in information dissemination will thus be studied as to its feasibility. One of the provisions in the Schedule of Responsibilities (below) indicates that the study once devised, will be subjected to ongoing examination and testing to insure that the mission for which it was devised is, in fact, being accomplished.

C. SCHEDULE OF RESPONSIBILITIES FOR THE COUNCIL OF TEACHING HOSPITALS

1. The Contractor will undertake the study, examination and development of a system for the acquisition, accumulation, evaluation and dissemination of information of particular interest to those involved in the administration of teaching hospitals.

2. The staff will include a Project Director who will work closely with the Office of Research and Development, Bureau of Health Services and other interested agencies, both governmental and voluntary, who have a high degree of interest in teaching hospitals.

3. The Contractor will make a complete study relative to the establishment and subsequent maintenance of a current Information Center, regarding research and demonstration activities being carried out in teaching hospitals, especially as these activities relate to the structural features of the functional organization and new concepts in physical planning and architectural design. Among other interests, the Information Center should have two foci of involvement. The first would deal with computer aids to administration and the application of modern management techniques such as systems analysis and operations research. The second point of emphasis would be computer aids to the practice of medicine, specifically the application of computer technology to existing medical information systems.

4. Contractor will undertake and establish an active surveillance of research and demonstration activities with regard to: the medical management of the patient, the varying roles of health personnel activities in relation to patient care, and the organization of medical and health care services as these activities are accomplished in the teaching hospital.

5. Contractor will assess the efficacy of other similar types of information dissemination activities, such as the Kind Edward Fund in Great Britain and the University of Michigan Abstract series, to insure that its own techniques of transmitting knowledge and technology are the most educationally efficient ones available, and will experiment within its own program to insure that new methodologies are tested and adopted when proven successful.

ARTICLE II - ARTICLES OR SERVICES TO BE FURNISHED AND DELIVERY TIME

The Contractor shall submit to the Chief, Projects Review Branch, Office of Research and Development, Bureau of Health Services, 800 North Quincy Street, Arlington, Virginia 22203, the following items in the quantities and during the time periods listed below:

ITEM	DESCRIPTION	QUANTITY	DELIVERY
1	Progress Report - including a description of difficulties encountered and the solution to these problems.	10 copies	Thirty (30) days following the close of each quarter.
2	Final Report - Summarizations of the data derived from the study, analyses and critiques thereof, and recommendations.		
	a. Preliminary Draft	10 copies	Twelve (12) months after effective date of contract.
	b. Final Report	25 copies	Fourteen (14) months aftereffective date of contract.

ARTICLE III - NOTICE TO THE GOVERNMENT OF DELAYS

Whenever the Contractor has knowledge that any actual or potential situation is delaying or threatens to delay the timely performance of this contract, the Contractor shall within ten days give notice thereof, including all relevant information with respect thereto, to the Contracting Officer.

ARTICLE IV - REVIEW AND APPROVAL

Review and approval of the work hereunder shall be performed by the Project Officer or his duly authorized representative.

ARTICLE V - DESIGNATION OF PROJECT OFFICER

Thomas McCarthy, Ph.D. of the Office of Research and Development, BHS is hereby designated as the Project Officer for this contract. The Project Officer or his authorized representative's responsibility will be to coordinate with the Contractor in administering the technical aspects of this contract. The Project Officer is not authorized to make any changes which affect the contract amount, terms, or conditions. The Contracting Officer is the only party authorized to bind the Government.

ARTICLE VI - DESIGNATION OF PROJECT DIRECTOR

A. Work and services shall be conducted under the direction of Mr. Matthew F. McNulty, Jr. until a Project Director shall be appointed with approval of the Government. The Project Director shall be selected and assigned no later than three (3) months after date of contract and shall perform not less than nine (9) man-months under this contract.

B. The Project Director is considered essential to the work being performed hereunder, and he shall not be diverted to other programs without the written consent of the Contracting Officer.

C. The Government reserves the right to approve any necessary successor to the designated Project Director.

ARTICLE VII - DISSEMINATION OF INFORMATION

Prior approval shall be obtained from the Project Officer for release of information relating to this contract.

"Information" includes, but is not limited to, news releases, articles, manuscripts, brochures, advertisements, still and motion pictures, speeches, trade association meetings, symposia, etc.

Requests for approval should be forwarded three (3) weeks in advance of desired release date to permit sufficient time for review and evaluation.

ARTICLE VIII - PUBLICITY AND PUBLICATIONS

A. The Contractor agrees that it will acknowledge Public Health Service support whenever projects funded in whole or in part by this contract are publicized in any news media.

B. The Contractor shall include in any publication resulting from the work performed under this contract an acknowledgement substantially as follows:

"The project upon which this publication is based was performed pursuant to Contract No. PH 110-68-41 with the Public Health Service, Department of Health, Education, and Welfare."

ARTICLE IX - DEVELOPMENT AND USE OF FORMS

Any forms which may be developed by the Contractor under this contract for use in the collection of information, upon identical items, from ten or more persons, shall be submitted to the Project Officer for review and approval prior to their use. The Project Officer shall be responsible for obtaining clearance from the Bureau of the Budget, if required, prior to his approval for use by the Contractor.

ARTICLE X - IDENTIFICATION OF DATA

The Contractor shall identify the technical data delivered to the Government pursuant to the requirements of this contract with the number of this contract, and the name and address of the Contractor or subcontractor who generated the data.

ARTICLE XI - CONSULTANT SERVICES

The Contractor agrees to request information as to whether or not any consultant to be utilized under this contract performs similar services for the Public Health Service at a lesser consultant rate than that offered under this contract, and if so, to advise the Contracting Officer accordingly prior to the formalization of an agreement for consultant services.

ARTICLE XII - PROCUREMENT OF ALL MATERIAL, DATA, AND SERVICES

Except as otherwise provided herein, procurement of all material, data, and services necessary for performance under the terms of this contract shall be the responsibility of the Contractor.

ARTICLE XIII - ADMINISTRATION OF GOVERNMENT OWNED PROPERTY

In accordance with the Government Property clause of the contract, Mr. Marcus T. Dodge, Contract Branch, Bureau of Health Services is hereby designated as the Property Administrator for this Contract. The Contractor agrees to furnish to the Property Administrator an inventory of Government-owned Property (Government Furnished and/or Contractor Acquired) within six (6) months after the effective date of this contract and every six (6) months thereafter. The inventory shall be submitted in the format shown on Exhibit A which is made a part of this contract.

Further, the Contractor agrees to provide storage facilities, including proper identification and protection, for all Government-owned Property (Government Furnished and/or Contractor Acquired) upon completion of the contract until disposition instructions are provided, without cost to the Government. Such disposition instructions shall be provided by the Government to the Contractor not later than sixty (60) days after Contractor submission of final inventory.

ARTICLE XIV - FINANCIAL MANAGEMENT REPORT

Once each quarter the Contractor shall prepare and submit to the Contracting Officer three (3) copies of a quarterly Financial Management Report which shall reflect the elements of cost during the reporting period, unliquidated commitments, and the Contractor's projection of quarterly expenditures to contract completion. The initial report shall be prepared for the quarter following the effective date of the contract, and subsequent reports shall be prepared as of the last day of each succeeding quarter. The reports hereunder shall be submitted to the Contracting Officer by the 30th day of the month following the end of each quarter.

ARTICLE XV - COMPENSATION

A. The total cost to the Government for the performance of this contract shall not exceed $71,240.00. The Contractor agrees to use its best efforts to perform all work and obligations under this contract within the total cost set forth herein, subject to the clause of the General Provisions entitled "Limitation of Cost."

B. For the performance of this contract, the Government shall reimburse the Contractor the cost thereof (hereinafter referred to as "allowable cost") determined by the Contracting Officer to be allowable in accordance with the clause of the General Provisions entitled "Allowable Cost and Payment," and the provisions below:

1. Purchase Orders and Subcontracts

a. The following shall require prior written approval of the Contracting Officer:

(1) purchase or rental of items of nonexpendable property having unit value exceeding $100.00 (For the purpose of this contract, nonexpendable property means property or equipment having a normal life expectancy of one year or more.) and

(2) purchase orders or subcontracts for any of the work contemplated under this contract exceeding $1,000.00.

b. The Contractor shall give advance notification to the Contracting Officer of all proposed purchase orders of subcontracts which require prior approval in accordance with the clause of the General Provisions entitled "Subcontracts." The advance notification shall include:

(1) a description of the supplies or services to be called for by the subcontract;

(2) identification of the proposed subcontractor and an explanation of why and how the proposed subcontractor was selected, including the degree of competition obtained;

(3) the proposed subcontract price, together with the Contractor's cost or price analysis thereof; and

(4) identification of the type of subcontract to be used.

2. Consultants

a. Any fee or other payment to consultants in excess of $100.00 per day requires prior written authorization by the Contracting Officer.

3. Salaries and Wages

a. Salaries and wages of employees directly employed in performing the work required by this contract.

b. Actual cost of fringe benefits.

4. Travel

Travel and subsistence expenses exclusively in direct performance of this contract.

a. The Contractor shall be reimbursed for actual transportation costs and travel allowances (per diem) of personnel, authorized to travel under this contract, in accordance with the established policy of the contractor. Such transportation cost shall not be reimbursed in an amount greater than the cost of first class rail or of economy air travel, unless economy air travel and economy air travel space are not available and the contractor certifies to the facts in the voucher or other documents submitted for reimbursement. Actual reasonable travel allowances (per diem) shall be reimbursed in accordance with the Contractor's established policy.

b. The Contractor shall be reimbursed for the cost of travel performed by its personnel in their privately-owned automobiles at the rate of $.10 per mile, not to exceed the cost by the most direct economy air route between the points so traveled. If more than one person travels in such automobile, no additional charge will be made by the Contractor for such travel between such points.

c. Travel for general scientific meetings and foreign travel requires prior written authorization by the Contracting Officer.

5. Rental, Rearrangement and Alteration of Facilities

a. It is expressly understood and agreed that no cost for rental or lease of facilities including office space shall be charged as a direct cost to this contract.

b. Rearrangement, alteration, or relocation of facilities requires prior written authorization by the Contracting Officer.

6. Purchase or Rental of Office Equipment

a. It is expressly understood and agreed that no cost for any item of general office equipment (desks, chairs, typewriters, dictaphones, etc.) shall be charged as a direct cost to this contract.

7. Overtime

a. Overtime, shift or other incentive premium requires prior written authorization by the Contracting Officer.

8. Indirect Costs

a. Indirect costs shall be determined in accordance with Clause 27 of the General Provisions of this contract. Meanwhile, indirect costs under this contract shall be provisionally reimbursed in an amount equal to 30% of total direct costs less Equipment in excess of $500.00, Alterations and Renovations, and Subcontracts.

C. Notwithstanding any provision to the contrary, the Contractor shall not incur costs unless the prior written authorizations of the Contracting Officer has been obtained as required herein. Incurrence with the intent of claiming reimbursement as direct costs shall therefore be at the Contractor's own risk, when without such prior authorization.

ARTICLE XVI - SUBMISSION OF INVOICES AND PLACE OF PAYMENT

A. Once each month the Contractor may submit to the Government an invoice for the allowable cost to the Contractor for the performance of the work hereunder. The Government shall make provisional payment of all invoices submitted hereunder pending the completion of a final audit of the Contractor's cost records. Invoices shall be submitted in accordance with Billing Instructions, a copy of which is attached hereto as ANNEX A.

B. To expedite the payment of invoices or vouchers under this contract, the invoices or vouchers (except COMPLETION INVOICE OR VOUCHER) shall be sent directly to the Paying Office for payment, as follows:

PAYING OFFICE
Fiscal Branch
Division of Finance
U. S. Public Health Service
9000 Rockville Pike
Room 320, NBOC #1
Bethesda, Maryland 20014

(Where applicable, invoices or vouchers shall be sent through the cognizant DCAA Auditor.)

C. THE COMPLETION INVOICE OR VOUCHER will be forwarded to the aforementioned paying office through the U. S. Public Health Service, Bureau of Health Services, 800 North Quincy Street, Arlington, Virginia 22203, marked for the attention of the Contracting Officer, Room 315.

IV

WAYS AND MEANS COMMITTEE REPORT
PROPOSED NEW ORGANIZATIONAL CHART

After careful and deliberate evaluation of the feedback on the reorganization proposal from the regional meetings, individual members, the Council of Academic Societies, and the Council of Teaching Hospitals, the attached plan was adopted unanimously by the Executive Council of the Association of American Medical Colleges at the March 29th meeting for presentation to the Institutional Membership on May 22, 1968.

To clarify previous concerns, the following changes were made from the previous proposal:

1. The name of the organization would remain the same - The Association of American Medical Colleges
2. The composition of the Assembly (Box 1), which would meet once a year, would be as follows:

   Each Dean from the Council of Deans (currently 10) (1)
   A maximum of 35 representatives of the Council of Academic Societies (2)
   Ten percent of the number of members of the Council of Teaching Hospitals with a maximum of 35 representatives (currently 34 representatives) (3)

3. The Executive Committee of the Executive Council (Box 4) would consist of the Chairman, the Chairman-elect, the full-time President and three others elected yearly by the Executive Council.

4. As in the past, the Group on Student Affairs, the group of Business and Finance Officers, the group of Public Relations Officers, any future groups, such as on Graduate Medical Education, would report directly to the Executive Council.

---

(1) 88 medical schools are Institutional Members and 13 are Provisional Institutional Members
(2) 22 societies are members of the Council and 6 have been recommended for membership by the Executive Council but not acted upon by the Institutional Members
(3) 337 teaching hospitals are members of the Council

#6735-2/pm

1.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Annual Assembly of Members

All Deans -	currently 100
C.A.S.- up to 35 -	currently 29
10% of COTH-up to 35 -	currently 34
	163

Nominating Committee
Chairman
Chairman-elect

Vice Presidents

FEDERATION FOR HEALTH EDUCATION

AMA Council on Medical Education
Assoc. of Dental Schools
Assoc. of Schools of Allied Health Professions
Assoc. of Schools of Public Heal..
Assoc. of Schools of Pharmacy
Assoc. of Amer.Vet.Med. Colleges
Appropriate Nursing Associations
AAMC

A.H.A
Am. H.A.

2.

EXECUTIVE COUNCIL

Chairman	
Chairman-elect	
Chairman Council of Deans	+ 8
Chairman C.A.S.	+ 3
Chairman C.O.T.H.	+ 2
President	19

ulltime President as enior Executive Officer

4.

Executive Committee

Chairman
Chairman-elect
President
3 others elected by Exec.Council
6

6.

OUNCIL OF DEANS

COUNCIL OF ACADEMIC SOCIETIES

7.

COUNCIL OF TEACHING HOSPITALS

Correspondence Code:

B. Not Interested in Membership
D. Rules and Regulations and Application sent; no response
G. Applied, accepted; no response; dropped from mailing list
H. Unable to join at time of last correspondence
K. Applied previously; not approved
M. No response to original letter (May - June, 1966)

Numerical Code:

1. U.S. Army
2. Veterans Administration
3. U.S. Air Force
4. U.S. Navy
5. U.S. Public Health Service Hospitals

HOSPITALS OFFERING THREE OF FIVE COTH REQUIRED
RESIDENCIES AND INTERNSHIP PROGRAMS

Total Hospitals on Following List = 136

DRAFT

General Membership Memorandum
No. 68- G
May , 1968
Subject: Additional Strengthening of COTH Staff

1. Background Information Contributing to This General Membership Memorandum:

The Regional Meetings for the Council of Teaching Hospitals are now complete. At these Regional Meetings, your COTH staff attempted to alert the membership of the volume of work that is coming into COTH headquarters. Additionally, we attempted to emphasize that the abundance of opportunities provided real pay off potential beyond that which can be accomplished by the present professional staff. At these Regional Meetings, we mentioned that one avenue of accomplishing these additional opportunities was either to increase the membership, increase the dues, or some combination of these alternatives. We are not promoting any of these activities through this memorandum, merely recording the possibilities.

2. Suggestions By Membership of Another Means of Providing COTH Staff Support:

Prior to the Regional Meetings, as well as subsequent to them, several members have suggested the possibility of a COTH Fellowship activity, whereby those administrators of teaching hospitals that are interested in enlarging the administrations scope of knowledge of the Federal process could select a senior individual and assign him to COTH headquarters for a period of six to twelve months. COTH would provide the office space, secretarial and clerical support, and the home. Teaching Hospital Institution would finance the travel, continuing salary, lodging and other usual incidentals.

With many governmental bureaus and agencies that, in some measure, affect the activities of teaching hospitals, we believe that an experience of this nature could be most beneficial to the individual and to his home institution. Additionally, we believe that with the possible reorganization of the AAMC that an opportunity of this nature would provide rich exposure to the other components of the AAMC, the Council of Deans, the Council of Academic Societies and so forth.

It is the purpose of this memorandum to promote such a Fellowship Program and to inquire of the membership, if they are interested in such a proposal; if they have an individual in mind who might fit into such a program; and if the program were started immediately would they be in a position to support such an activity?

We have enclosed a response form for your convenience, as well as to help us gauge the attitude of the membership.

Attachment:

COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
1346 Connecticut Avenue, N.W.
Washington, D.C. 20036
202/223-5364

STATUS REPORT ON MEMBERSHIP

TOTAL MEMBERSHIP: 338 (Not including present applicant - Schwab Rehabilitation Institute)

Nominated by a Dean	221
Qualified by I & R Program	117

Canadian Members	5
Puerto Rican Members	2
Canal Zone Member	1

NUMBER OF VETERANS ADMINISTRATION HOSPITALS IN TOTAL MEMBERSHIP: 51

Western Region	6
Midwest/Great Plains Region	14
Southern Region	18
Northeastern Region	13

NUMBER OF PUBLIC HEALTH SERVICE HOSPITALS IN TOTAL MEMBERSHIP: 4

Western Region	1
Midwest/Great Plains Region	0
Southern Region	2
Northeastern Region	1

MILITARY HOSPITALS: 1 - Wilford Hall U.S. Air Force Hospital, Lackland AFB, San Antonio, Texas (Southern Region)

STATES WITH NO MEMBER HOSPITALS: 8

Western Region	6	(Alaska, Montana, Nevada, Wyoming, Idaho, New Mexico)
Midwest/Great Plains Region	2	(North Dakota, South Dakota)
Southern Region	0	
Northeastern Region	0	

DISTRIBUTION OF MEMBER HOSPITALS BY REGION:

Western Region	39	(Includes 3 hospitals in 3 providences in Canada)
Midwest/Great Plains Region	86	(Includes 1 hospital in 1 providence in Canada)
Southern Region	71	(No Canadian hospitals in Southern Region)
Northeastern Region	142	(Includes 1 hospital in 1 providence in Canada)

INTERNSHIPS OFFERED IN U.S. HOSPITALS: 13,521

Filled	7,225	
COTH Members	5,300	
Non-COTH Hospitals	1,925	
Internships Filled in COTH Hospitals as Percentage of Total Filled	73%	
Residency Positions Offered and Filled (study yet to be accomplished)	?	

UNIVERSITY of HEALTH SCIENCES

(312) 226-4100 2020 West Ogden Avenue • Chicago, Illinois 60612

- THE CHICAGO MEDICAL SCHOOL
- MOUNT SINAI HOSPITAL MEDICAL CENTER
- SCHOOL of RELATED HEALTH SCIENCES
- SCHOOL of GRADUATE and POST-DOCTORAL STUDIES

April 15, 1968

Mr. Matthew F. McNulty, Jr.
Director, COTH
Association of American Medical Colleges
1346 Connecticutt Ave., N.W.
Washington, D. C.

Dear Mr. McNulty:

I am pleased to nominate the Schwab Rehabilitation Hospital for membership in the Council of Teaching Hospitals of the Association of American Medical Colleges, and to support their application.

The Schwab Rehabilitation Hospital, 1401 So. California Boulevard, Chicago, Illinois 60608, is Administered by Aaron M. Rosenthal, M.D., Medical Director, Chairman and Professor, Department of Rehabilitation Medicine, The Chicago Medical School; and Mr. Hubert P. Kirkel, Executive Director.

It is among the major teaching hospitals affiliated with The Chicago Medical School, and serves a highly important segment of our medical education programs for students, interns, residents and allied health professionals.

Their membership in the Council of Teaching Hospitals will greatly aid and strengthen the efforts to which all of us are dedicated.

Sincerely,

THE CHICAGO MEDICAL SCHOOL

LeRoy P. Levitt, M.D.
Dean

LPL:sj
cc: Dr. Taylor
Dr. Rosenthal
Dr. Whitehall
Mr. Kirkel

Charles H. & Rachel M.
SCHWAB REHABILITATION HOSPITAL
1401 SOUTH CALIFORNIA BOULEVARD ● CHICAGO, ILLINOIS 60608
TELEPHONE 522-2010 (Area 312)

Hubert P. Kirkel
Executive Director

Aaron M. Rosenthal, M.D.
Medical Director

April 22, 1968

Mr. Matthew F. McNulty, Jr.
Director
Council of Teaching Hospitals
Association of American Medical Colleges
1346 Connecticut Avenue, N.W.
Washington, D. C. 20036

Dear Mr. NcNulty:

Please find enclosed three copies of our application for membership in the Council of Teaching Hospitals of the Association of American Medical Colleges. This application is submitted in accordance with the COTH standard that requires nomination by the dean of a medical school which is a member of AAMC. In this connection, reference is made to a letter of April 15, 1968 from Dr. LeRoy P. Leavitt, Dean of the Chicago Medical School, to you supporting this application for COTH membership.

Please do not hesitate to contact me if any other data is required in support of this application or our nomination by the Chicago Medical School. Thank you for your assistance in this matter.

Sincerely,

Hubert P. Kirkel

HPK/jl
Enclosures
cc: LeRoy P. Leavitt, M.D.
Dean
The Chicago Medical School

PLEASE READ INSTRUCTIONS ON REVERSE SIDE

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership in the Council of Teaching Hospitals

(Please type)

Hospital: SCHWAB REHABILITATION HOSPITAL
Name

1401 South California Boulevard
Street

Chicago — Illinois — 60608
City — State — Zip Code

Principal Administrative Officer: Mr. Hubert P. Kirkel
Name

Executive Director
Title

Hospital Statistics:

Date Hospital was Established: 1912

Average Daily Census: 70

Annual Outpatient Clinical Visits: 1,805

Approved Internships:

Type	Date Of Initial Approval by CME of AMA*	Total Internships Offered	Total Internships Filled
Rotating			
Mixed			
Straight			

Approved Residencies:

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total Residencies Filled
Medicine			
Surgery			
OB-Gyn			
Physical Medicine and Rehabilitation	June 15, 1963	8	6 (1967-1968)
Psychiatry			

Information submitted by:

Hubert P. Kirkel
Name

Executive Director
Title

April 22, 1968
Date

Signature

*Council on Medical Education of the American Medical Association and/or with appropriate A.M.A. Internship and Residency Review Committees.

PLEASE READ INSTRUCTIONS ON REVERSE SIDE

Instructions:

Please complete all copies and return three copies to the Council of Teaching Hospitals, Association of American Medical Colleges, 2530 Ridge Avenue, Evanston, Illinois 60201, retaining the blue copy for your file.

Membership in the Council:

Hospitals as institutions will be members of the Council and each institution will be represented by a designated person, designated by the hospital, for the purpose of conducting the business of the Council.

Membership in the Council will be annually determined and consist of:

a. Those hospitals nominated by a medical school member of the AAMC from among the major teaching hospitals affiliated with the school,

and

b. Teaching hospitals which are either nominated by a medical school member of the AAMC on the basis of important affiliations for the purposes of medical education or which have approved internship programs and full residencies in three of the following five departments: Medicine, Surgery, OB-Gyn, Pediatrics, Psychiatry, and are elected to membership by the members of the Council of Teaching Hospitals.

All members will vote at the annual meeting for officers and members of the Executive Committee. Voting on all other matters will be limited to one representative member for each medical school, who, in order to give broad representation, shall consult with the other teaching hospital members in his geographic region before votes are taken.

If nominated by School of Medicine, complete the following:

Name of School of Medicine Chicago Medical School

Name of Parent University University of Health Sciences

Name of Dean of School of Medicine LeRoy P. Leavitt, M.D.

Complete address of School of Medicine 710 South Wolcott Avenue
Chicago, Illinois 60612

FOR AAMC OFFICE USE ONLY:

Date _____ Approved _____ Disapproved _____ Pending _____

Remarks: _____

Invoiced _____ Remittance Received _____

#5350-5

List #1

HOSPITALS OFFERING THREE OF FIVE COTH REQUIRED RESIDENCIES AND INTERNSHIP PROGRAMS

	Name & Address	Affiliation	Internship Rot.	Internship Others	Residencies Med.	Residencies OB/Gyn	Residencies Ped	Residencies Psych	Residencies Surg	Others
B	Carraway Methodist Hospital 1615 25th Street, North Birmingham, Alabama 35234		x		x	x			x	3
M	Lloyd Noland Hospital P.O. Box 483 Fairfield, Alabama 35064		x			x	x		x	4
H	Maricopa County General Hosp. 3435 West Durango Street Pheonix, Arizona 85009		x		x	x	x		x	1
M	Kern County General Hospital 1830 Flower Street Bakersfield, Calif. 93305		x		x	x	x		x	5
3	David Grant USAF Hospital Travis AFB Fairfield, California 94535		x		x	x	x		x	1
H	Fresno General Hospital 445 South Cedar Avenue Fresno, California 93702		x		x	x	x		x	2
M	Glendale Adventist Hospital 1509 East Wilson Avenue Glendale, California 91206		x		x	x			x	2
2	Veterans Administration Hospital 5901 East 7th Street M-95 Long Beach, Calif. 90804				x			x	x	10
M	Queen of Angels Hospital 2301 Bellevue Avenue Los Angeles, California 90026		x			x	x		x	4
2	Veterans Administration Hospital (Sepulveda) 16111 Plummer Street Los Angeles, California 91343				x			x	x	0
H 4	U.S. Naval Hospital 8750 Mountain Boulevard Oakland, California 94627		x		x	x	x	x	x	7

	Name & Address	Affiliation	Internship Rot.	Internship Other	Residencies Med	Residencies OB/Gyn	Residencies Ped	Residencies Psych	Residencies Surg	Others
H	Orange County Gen. Hosp. 101 Manchester Avenue Orange, Calif. 92666	M-95	X		X	X	X	X	X	7
B	Riverside County Gen. Hosp. 9851 Magnolia Avenue Riverside, Calif. 92503	M-12	X		X	X	X		X	4
	Mercy Hospital 4077 Fifth Avenue San Diego, Calif. 92103		X	X	X	X			X	2
M 4	U.S. Naval Hospital Park Boulevard San Diego, Calif. 92134		X		X	X	X		X	9
K	Children's Hospital and Adult Med. Center of S.F. 3700 California Street San Francisco, Calif. 94119	L-16	X	X	X		X	X		5
D	Kaiser Foundation Hosp. 2425 Geary Boulevard San Francisco, Calif. 94115	L-12 L-16	X	X	X	X	X		X	1
B 1	Letterman Gen. Hosp. Presidio San Francisco, Calif. 94129		X		X	X	X		X	9
M	St. Luke's Hospital 1580 Valencia Street San Francisco, Calif. 94110		X		X	X	X			1
M	St. Mary's Hospital 2200 Hayes Street San Francisco, Calif. 94117		X		X	X	X	X	X	1
M	San Francisco Gen. Hosp. 1001 Portrero Avenue San Francisco, Calif. 94110	M-16	X		X	X	X		X	9
H	Santa Clara Valley Medical Center 751 S. Bascom Avenue San Jose, California 95128	L-15	X		X	X	X		X	5
	San Mateo County Gen. Hosp. 222 39th Avenue San Mateo, Calif. 94403				X	X	X	X	X	3
M	Denver General Hospital West 6th Avenue & Cherokee St. Denver, Colorado 80204	C-17	X		X	X	X	X	X	8
D 1	Fitzsimons General Hospital Peoria & Colfax Denver, Colorado 80204	L-17	X		X	X	X		X	7

Corresponding Status	Name & Address	Affiliation	Internship Rot.	Internship Others	Residencies Med.	Residencies OB/Gyn	Residencies Ped	Residencies Psych	Residencies Surg	Others
	St. Joseph Hospital 1035 Franklin Street Denver, Colorado 80218		x	x	x	x			x	3
H 2	Veterans Administration Hospital 1055 Clermont Denver, Colorado 80220	M-17			x			x	x	11
D	Norwalk Hospital 24 Stevens Street Norwalk, Connecticut 06852		x		x		x		x	1
	Stamford Hospital 190 W. Broad Street Stamford, Connecticut 06902		x		x	x			x	1
H	District of Columbia General Hospital 19th and Mass. Ave.,S.E. Washington, D.C. 20003	M-19 M-20 M-21	x	x	x	x	x	x	x	8
M 1	Walter Reed General Hospital 6825 16th Street, N.W. Washington, D.C. 20012	M-19 L-20	x		x	x	x	x	x	12
	Baptist Memorial Hospital 800 Miami Road Jacksonville, Florida 32207		x		x	x	x		x	2
	St. Luke's Hospital 1900 Boulevard Jacksonville, Florida 32206				x	x	x		x	0
M	Orange Memorial Hospital 1416 South Orange Avenue Orlando, Florida 32806		x		x	x	x		x	4
D	Tampa General Hospital Davis Islands Tampa, Florida 33606		x		x	x	x		x	5
M	Crawford W. Long Memorial Hospital 35 Linden Avenue, N.E. Atlanta, Georgia 30308	G-75	x		x	x			x	2
M	Georgia Baptist Hospital 300 Boulevard N.E. Atlanta, Georgia 30312		x	x	x	x	x		x	1

Corresponding Status	Name & Address	Affiliation	Internship Rot.	Internship Others	Residencies Med.	Residencies OB/Gyn	Residencies Ped	Residencies Psych	Residencies Surg	Others
M	Piedmont Hospital 1968 Peachtree Road N.W. Atlanta, Georgia 30309		x		x	x			x	1
M	St. Joseph's Infirmary 265 Ivy Street N.E. Atlanta, Georgia 30303		x	x	x	x	x		x	2
M	University Hospital University Place Augusta, Georgia 30902	M-24	x		x	x	x		x	4
M	Memorial Hospital of Chatham County Waters Avenue and 63rd Street Savannah, Georgia 31405		x		x	x			x	2
M	St. Francis Hospital 2260 Liliha Street Honolulu, Hawaii 96817		x		x	x			x	1
H 1	Tripler General Hospital Moanalua Gardens Honolulu, Hawaii 96438		x		x	x	x		x	4
	Northwestern University Medical Center 303 East Chicago Avenue Chicago, Illinois 60611		x	x	x	x	x	x	x	11
M	U.S. Naval Hospital Great Lakes, Illinois 60088		x		x	x			x	0
M	St. Francis Hospital 530 N.E. Glen Oak Avenue Peoria, Illinois 61603		x		x	x	x		x	4
D	St. Joseph Infirmary 735 Eastern Parkway Louisville, Kentucky 40202		x		x	x	x		x	1
M	Confederate Memorial Medical Center 1541 Kingshighway Shreveport, Louisiana 71101	G-37	x		x	x	x	x	x	6
	Greater Baltimore Medical Center 6701 N. Charles St. Baltimore, Md. 21204	G-38	x	x	x	x	x		x	2

Corresponding Stat

	Name & Address	Affiliation	Internship Rot.	Internship Others	Residencies Med.	Residencies OB/Gyn	Residencies Ped	Residencies Psych	Residencies Surg	Others
M	Mercy Hospital 301 St. Paul Place Baltimore, Md. 21202	M-39	x	x	x	x	x		x	1
H 4	U.S. Naval Hospital Rockville Pike Bethesda, Md. 20014	M-19 L-20 L-21	x		x	x	x	x	x	9
	Boston City Hospital 808 Harrison Avenue Boston, Mass. 02118	M-40 M-41 M-42		x	x	x	x	x	x	10
M 1	U.S. Naval Hospital 1 Broadway Chelsa, Mass. 02150	L-40	x		x	x	x		x	3
M	St. John Hospital 22101 Moross Road Detroit, Michigan 49201		x		x	x			x	0
M	Hurley Hospital 6th Avenue and Begole Sts. Flint, Michigan 48502		x		x	x	x		x	3
M	Butterworth Hospital 100 Michigan Street, N.E Grand Rapids, Michigan 49053		x	x	x	x	x		x	3
M	Highland Park General Hospital 369 Glendale Avenue Highland Park, Mich. 48203		x		x	x			x	0
M	Pontiac General Hospital Seminole At West Huron Pontiac, Michigna 48053		x		x	x	x		x	1
K	William Beaumont Hospital 3601 West 13 Mile Road Royal Oak, Michigan 48072		x		x	x	x		x	3
M	Saginaw General Hospital 1477 North Harrison Street Saginaw, Michigan 48605		x		x	x	x		x	1
B	Mayo Graduate School of Medicine 200 First St. S.W. Rochester, Minn. 55901	G-93			x	x	x	x	x	14

Corresponding Status	Name & Address	Affiliation	Internship Rot.	Internship Others	Residencies Med.	Residencies OB/Gyn	Residencies Ped	Residencies Psych	Residencies Surg	Others
M	St. Luke's Hospital 4400 J. N. Nichols Parkway Kansas City, Missouri 64111	G-33	x		x	x			x	3
M	Homer G. Phillips Hospital 2601 Whittier St. St. Louis, Missouri 63113	L-49	x		x	x	x		x	4
M	St. Louis City Hospital 1515 Lafayette Avenue St. Louis, Missouri 63104	M-48 M-49	x	x	x	x	x		x	6
H	St. Louis County Hospital 601 South Brentwood Blvd. St. Louis, Missouri 63105		x		x	x			x	0
K	Jersey City Medical Center 50 Baldwin Avenue Jersey City, New Jersey 07304		x	x	x		x		x	5
M	Newark City Hospital 65 Bergen St. Newark, New Jersey 07170	M-53	x	x	x	x	x		x	4
	St. Joseph's Hospital 703 Main Street Patterson, New Jersey 07503	G-59	x	x	x	x			x	3
M	Bernalillo County Indian Hospital 2211 Lomas Blvd., N.E. Albuquerque, New Mexico 87100	M-96	x	x	x	x	x	x	x	2
	Bataan Memorial Methodist Hospital 5400 Gibson Blvd. S.E. Albuquerque, New Mexico 87108	G-96			x		x		x	2
2	Veterans Administration Hospital 2100 Ridgecrest Dr. Albuquerque, New Mexico 87110	L-94			x			x	x	2
	St. Peter's Hospital 315 S. Manning Blvd. Albany, New York 12208	L-94	x		x	x	x		x	2
	Sisters of Charity Hospital 2157 Main Street Buffalo, New York 14214		x		x	x			x	2

Corresponding Status	Name & Address	Affiliation	Internship Rot.	Internship Others	Residencies Med.	Residencies OB/Gyn	Residencies Ped	Residencies Psych	Residencies Surg	Others
M	Charles S. Wilson Memorial Hospital 33-57 Harrison St. Johnson City, New York 13790		x		x	x			x	2
	North Shore Hospital Valley Road Manhasset, New York 11030		x	x	x	x	x			1
	Nassau Hospital First Street Mineola, New York 11501	G-59	x		x	x			x	3
	Mount Vernon Hospital 12 N. 7th Avenue Mt. Vernon, New York 10550		x		x	x			x	1
	Bellvue Hospital Center First Ave. and 27th St. New York, New York 10016	M-57 M-58 M-60		x	x	x	x	x	x	12
G	Bronx Municipal Hospital Pelham Parkway and Eastchester Rd. New York, New York 10401	M-56	x	x	x	x	x	x	x	12
M	Coney Island Hospital Ocean and Shore Parkways Brooklyn, New York 11235		x	x	x	x	x		x	2
M	Flushing Hospital and Medical Center 44-14 Parsons Boulevard Flushing , New York 11335	G-59	x		x	x	x		x	2
M	Greenpoint Hospital 300 Skillman Avenue Brooklyn, New York 11211		x		x	x	x		x	1
	Hospital of Einstein College of Medicine 1825 Eastchester Rd. New York, New York 10401	L-56			x		x		x	9
	Jamaica Hospital 89th Ave & Van Wyck Expressway Jamaica, New York 11418	G-59	x		x	x			x	1
H	Jewish Memorial Hospital Broadway and 196th St. New York, New York 10040		x		x	x	x		x	1

	Name & Address	Affiliation	Internship Rot.	Internship Others	Residencies Med.	Residencies OB/Gyn	Residencies Ped	Residencies Psych	Residencies Surg	Others
	Knickerbocker Hospital 70 Convent Ave. New York, New York 10027		x	x	x	x			x	1
	Metropolitan Hospital 1901 First Avenue New York, New York 10029	M-59		x	x	x	x	x	x	8
M	Morrisania City Hospital 168th St. and Gerard Avenue New York, New York 10452		x	x	x	x	x		x	7
	New York Infirmary Stuyvesant Square & 15th St. New York, New York 10003		x		x	x			x	0
M	New York Polyclinic Medical School and Hospital 345 West 50th St. New York, New York 10019		x	x	x	x	x		x	5
M.	St. Vincent's Hospital of the Borough of Richmond 355 Bard Avenue Staten Island, New York 10310	G-59	x		x	x	x	x	x	2
G	Unity Hospital 1545 St. Johns Place Brooklyn, New York 11213	M-60	x		x	x			x	1
M	Wyckoff Heights Hospital 374 Stockholm Street Brooklyn, New York 11237	G-59	x		x	x	x		x	1
H 4	U.S. Naval Hospital 179th Street and Linden Blvd. St. Albans, New York 11425		x		x	x			x	5
2	Veterans Administration Hospital Irving Ave. & University Pl. Syracuse, New York 13210		M-63			x		x	x	10
	St. Thomas Hospital 444 N. Main St. Akron, Ohio 44310			x		x	x		x	2

	Name & Address	Affiliation	Internship Rot.	Others	Residencies Med.	OB/Gyn	Ped	Psych	Surg	Others
M	Fairview General Hospital 18101 Lorain Avenue Cleveland, Ohio 44111		x		x	x	x		x	3
G	Huron Road Hospital 13951 Terrace Rd. Cleveland, Ohio 44112		x		x	x			x	3
M	Riverside Methodist Hospital 3535 Olentangy River Road Columbus, Ohio 43214	M-69	x		x	x			x	4
	Good Samaritan 1425 W. Fairview Ave. Dayton, Ohio 45406		x		x	x			x	1
D	Trumbull Memorial Hospital 1350 East Market Street Warren, Ohio 44482		x			x	x		x	1
M	St. Anthony Hospital 601 N.W. 9th Street Oklahoma City, Oklahoma 73102	L-70	x		x	x	x		x	4
M	Hillcrest Medical Center 1120 South Utica Street Tulsa, Oklahoma 74104		x			x	x		x	1
M	St. John's Hospital 1923 South Utica Street Tulsa, Oklahoma 74104		x			x	x		x	1
M	Abington Memorial Hospital 1200 York Road Abington, Pennsylvania 19001		x		x	x			x	3
D	Harrisburg Polyclinic Hospital Third and Radnor Streets Harrisburg, Pennsylvania 17105		x		x		x		x	0
B	Germantown Dispensary and Hospital East Penn and East Wister Street Philadelphia, Pennsylvania 19144	x L-74 L-76			x	x	x		x	2
M	Lankenau Hospital Lancaster and City Line Aves. Philadelphia, Pa. 19151	M-73	x		x	x			x	2

Corresponding Status	Name & Address	Affiliation	Internship Rot.	Internship Others	Residencies Med.	Residencies OB/Gyn	Residencies Ped	Residencies Psych	Residencies Surg	Others
G	Mercy-Douglass Hospital 5000 Woodland Avenue Philadelphia, Pa. 19143	L-75	x		x			x	x	0
H 4	U.S. Naval Hospital 17th and Pattison Ave. Philadelphia, Pennsylvania 19145	M-73	x		x	x	x	x	x	8
M	Robert Packer Hospital 200 South Wilbur Avenue Sayre, Pennsylvania 18840		x		x		x		x	4
M	Ponce District General Hospital Bo Machuelo Ponce, Puerto Rico 00732		x		x	x	x		x	1
G.	San Juan City Hospital De Diego Avenue, Stop 22 San Juan, Puerto Rico		x		x	x	x		x	
G	Columbia Hospital of Richland County 2020 Hapton Street Columbia, South Carolina 29204		x			x	x		x	1
K	Greenville General Hospital 100 Mallard Street Greenville, South Carolina 29601			x		x	x		x	3
M	Baroness Erlanger Hospital 261 Wiehl Street Chattanooga, Tennessee 37403		x		x	x			x	5
G	Methodist Hospital 1265 Union Avenue Memphis, Tennessee 38104		x	x	x	x			x	5
			(dropped membership)							
D	Nashville Metropolitan General Hospital 72 Hermitage Avenue Nashville, Tennessee 37210	M-83		x	x	x	x		x	5
M	Methodist Hospital of Dallas 301 West Colorado Blvd. Dallas, Texas 75208	L-84	x	x	x	x	x		x	2
A 1	William Beaumont General Hospital Hayes Street El Paso, Texas 79290		x		x	x	x		x	
M	St. Joseph's Hospital 1919 La Branch Houston, Texas		x		x	x			x	3

	Name & Address	Affiliation	Internship Rot.	Internship Others	Residencies Med.	Residencies OB/Gyn	Residencies Ped	Residencies Psych	Residencies Surg	Others
	St. Luke's Episcopal Hospital 6720 Bertner Avenue Houston, Texas 77025	M-86			x	x			x	4
B 1	Brooke General Hospital Fort Sam Houston San Antonio, Texas 78234		x		x	x	x		x	9
M	Latter-day Saints Hospital 325 8th Avenue Salt Lake City, Utah 84103	L-87	x		x	x			x	6
B	DePaul Hospital Kingsley Lane and Granby St. Norfolk , Va. 23505	L-90	x		x	x			x	3
	Norfolk General Hospital 600 Greslam Dr. Norfolk, Va. 23507		x		x	x			x	5
M	U.S. Naval Hospital Portsmouth, Virginia 23703		x		x	x	x		x	1
	King County Hospital 325 Ninth Avenue Seattle, Washington 98104	M-91	x	x	x	x	x	x	x	9
1	Madigan General Hospital Fort Lewis Tacoma, Washington 98431	L-91	x		x	x	x		x	1
	Baptist Hospital 1000 W. Moreno Pensacola, Fla. 32501		x		x	x			x	2
	Escambia General Hospital 1200 N. Leonard St. Pensacola, Fla. 32501		x		x	x			x	1
	Sacred Heart Hospital 5151 N. 9th Ave. Pensacola, Fla. 32504		x		x	x			x	1
M	Waterbury Hospital 64 Robbins Hospital Waterbury, Connecticut 06720		x		x		x		x	3
	St. Luke's Hospital 5535 Delmar Blvd. St. Louis, Mo. 63112	L-49	x	x	x	x			x	2

Corresponding Status	Name & Address	Affiliation	Internship Rot.	Internship Others	Residencies Med.	Residencies OB/Gyn	Residencies Ped	Residencies Psych	Residencies Surg	Others
2	Veterans Administration Hospital 130 W. Kingsbridge Rd. Bronx, New York 10468	L-56			x			x	x	12
D	Jewish Hospital 3208 Burnet Avenue Cincinnati, Ohio 45229		x	x		x	x		x	3

HOSPITALS OFFERING TWO OF FIVE COTH REQUIRED RESIDENCIES AND INTERNSHIP PROGRAMS

Total Hospitals on Following List = 106

Correspondence Code:

B. Not Interested in Membership
D. Rules and Regulations and Application sent; no response
G. Applied, accepted; no response; dropped from mailing list
H. Unable to join at time of last correspondence
K. Applied previously; not approved
M. No response to original letter (May - June, 1966)

Numerical Code:

1. U.S. Army
2. Veterans Administration
3. U.S. Air Force
4. U.S. Navy
5. U.S. Public Health Service Hospitals

List #2

HOSPITALS OFFERING TWO OF FIVE COTH REQUIRED RESIDENCIES AND INTERNSHIP PROGRAMS

	Name & Address	Affiliation	Internship		Residencies					Others
			Rot.	Other	Med	OB	Ped	Psyc	Surg	
	Pima County General Hospital 2900 S. 6th Ave. Tucson, Ariz. 85713		x	x	x				x	1
	St. Mary's Hospital West St. Mary's Road Tucson, Ariz. 85703		x	x	x				x	1
K	Tucson Medical Center Grant Road & Veverly Road Tucson, Ariz. 85716		x	x	x				x	1
	California Hospital 1414 S. Hope St. Los Angeles, Calif. 90015		x			x			x	1
	French Hospital 4131 Geary Blvd. San Francisco, Calif. 94118		x		x				x	1
	Southern Pacific Memorial Hospital 1400 Fell St. San Francisco, Calif 94117	G-16	x	x	x				x	2
	U.S. P.H.S. Hospital 15th Ave. & Lake St. San Francisco, Calif. 94116	L-16	x	x	x				x	2
	General Rose Memorial Hospital 1050 Clermont St. Denver, Colo. 80220	G-17	x		x				x	2

	Name & Address	Affiliation	Internship		Residencies					Others
			Rot.	Other	Med	OB	Ped	Psyc	Surg	
D	Colorado State Hospital 1600 W. 24th St. Pueblo, Colo. 81003	G-17						x	x	0
	Greenwich Hospital Perryridge Road Greenwich, Conn. 06830		x		x				x	1
	Lawrence & Memorial Hospitals 365 Montauk Ave. New London, Conn. 06320		x		x				x	0
	St. Mary's Hospital 56 Franklin St. Warerburg, Conn. 06702		x			x			x	2
	Mount Park Hospital 701 Sixth Street, S. St. Petersburg,Fla. 33701		x			x			x	2
	Macon Hospital 777 Hemlock St. Macon, Ga. 31201		x	x		x			x	0
	MacNeal Memorial Hospital 3249 S. Oak Park Ave. Berqyn, Ill. 60402		x			x			x	2
	Grant Hospital 551 W. Grant Place Chicago, Ill. 60614		x				x		x	2
B	St. Vincent's Hospital 120 W. Fall Creek Pkwy Indianapolis, Indiana 46207		x	x		x			x	3
	Iowa Methodist Hospital 1200 Pleasant St. Des Moines, Ia. 50308	L-32	x				x		x	2

	Name & Address	Affiliation	Internship		Residencies					Others
			Rot.	Other	Med	OB	Ped	Psyc	Surg	
K	Wesley Medical Center 550 N. Hillside Ave. Wichita, Kansas 67214	G-33	x		x				x	3
	St. Joseph Hospital 1400 Harrodsburg Rd. Lexington, Ky. 40504		x	x			x		x	3
	J. W. Norton Memorial Inf. 231 W. Oak St. Louisville, Ky. 40203	G-35	x					x	x	1
M	Southern Baptist Hospital 2700 Napoleon Avenue New Orleans, La. 70115	L-37	x			x			x	2
	Bon Secours Hospital 2025 W. Fayette St. Baltimore, Md. 21223		x			x			x	0
	Franklin Square Hospital 110 N. Calhoon St. Baltimore, Md. 21223		x			x			x	0
	Lutheran Hospital of Maryland 730 Ashburton St. Baltimore,Md. 21216		x			x			x	0
	Provident Hospital 1514 Division St. Baltimore, Md. 21217		x				x		x	1
	South Baltimore General 1213 Light St. Baltimore, Md. 21230		x			x			x	0
5	U.S.P.H.S. Hospital Wyman Park Dr. & 31 St. Baltimore, Md. 21211		x	x	x				x	3

	Name & Address	Affiliation	Internship		Residencies				Others
			Rot.	Other	Med	OB	Ped	Psyc	Surg	
	New England Deaconess Hospital 185 Pilgrim Rd. Boston, Mass.. 02215	L-41 G-42	x	x	x				x	5
5	U.S. P.H.S. Hospital 77 Warren St. Brighton, Mass. 02135	L-40	x		x				x	0
	Cambridge City Hospital 1493 Cambridge St. Cambridge, Mass. 02139	L-41	x	x	x				x	2
	Malden Hospital Hospital Road Malden, Mass. 02148	L-40	x		x				x	1
B	Memorial Hospital 119 Belmont St. Worcester, Mass. 01605		x		x				x	2
	Oakwood Hospital 18101 Oakwood Blvd. Dearborn, Michigan 48124		x			x			x	2
	St. Joseph Mercy Hospital 2200 E. Grand Blvd. Detroit, Mich. 48211		x			x			x	0
	McLaren General Hospital 401 Ballenger Highway Flint, Mich. 48502		x			x			x	3
	St. Mary's Hospital 201 Lafayette Ave. S.E. Grand Rapids, Mich. 49503		x			x			x	2
M	Borgess Hospital 1521 Gull Rd. Kalamazoo, Mich. 49001		x				x		x	2
D	Bronson Methodist Hospital 252 E. Lovell St. Kalamazoo, Mich. 49006		x				x		x	1

	Name & Address	Affiliation	Internship		Residencies				Others	
			Rot.	Other	Med	OB	Ped	Psyc	Surg	
	Mourt Sinai Hospital 737 E. 22nd St. Minneapolis, Minn. 55404	L-45	x		x				x	1
	Northwestern Hospital 810 E 27th St. Minneapolis, Minn. 55407	L-45	x	x	x				x	1
	St. Joseph's Hospital 69 W. Exchange St. St. Paul, Minn. 55102	G-45	x			x			x	1
3	U.S.A.F. Hospital Kessler AFB Biloxi, Miss. 39534	L-37	x		x				x	0
	Menorah Medical Center 4949 Rockhill Road Kansas City, Mo. 64110	G-33	x	x	x				x	3
	Deaconess Hospital 6150 Okland Ave. St. Louis, Mo. 63139		x			x			x	0
	Atlantic City Hospital 1925 Pacific Ave. Atlantic City, N.J. 08401		x		x				x	2
	Englewood Hospital 350 Engle St. Englewood, N.J. 07631		x		x				x	1
K	Hackensack Hospital 22 Hospital Pl Hackensack, N.J. 07631		x		x				x	2
	Mountainside Hospital Bay & Highland Aves. Montclair, N.J. 07042		x		x				x	2
	Middlesex General Hospital 180 Somerset St. New Brunswick, N,J, 08903		x		x				x	1

	Name & Address	Affiliation	Internship		Residencies				Others
			Rot.	Other	Med	OB	Ped	Psyc	Surg	
	St. Peter's General Hospital 254 Easton Ave. New Brunswick, N,J, 08903	G-99	x		x				x	1
	Orange Memorial Hospital 188 S. Essex Ave. Orange, N.J. 07051		x		x				x	2
	Muhlenberg Hospital Park Ave. & Randolph Rd. Plainfield, M.J. 07061		x		x		x			1
	St. Francis Hospital 601 Hamilton Ave. Trenton, N.J. 08629		x			x			x	1
	Deaconess Hospital of Buffalo 1001 Humboldt.Pkwy. Buffalo, N.Y. 14208		x			x			x	3
D	Mercy Hospital 565 Abbott Rd. Buffalo, N.Y. 14220	G-19	x		x				x	1
	Beekman-Downtown Hospital 170 Williams St. New York, New York 10038		x	x	x				x	1
	Columbus Hospital 227 E. 19th St. New York, New York 10003		x		x				x	1
M	French Hospital 330 W 30th St. New York, New York 10001	G-59	x	x		x			x	0
	Hospital for Joint Diseases & Medical Center 1919 Madison Ave. New York, New York 10035		x		x				x	3
	Jewish Chronic Disease Hospital 86 E 49th St. Brooklyn, New York 11230	L-61	x		x				x	3
D	Mary Immaculate Hospital 152-11 89th Ave. Jamaica, New York 11432		x				x		x	1

	Name & Address	Affiliation	Internship		Residencies				Others	
			Rot.	Other	Med	OB	Ped	Psyc	Surg	
	Staten Island Hospital 101 Castleton Ave. Staten Island, N.Y. 10301		x			x			x	1
K B 5	U.S.P.H.S. Hospital Bay & Vanderbilt Sts. Staten Island, N.Y. 10304	G-21	x	x	x				x	7
	Sydenham Hospital 565 Manhattan Ave. New York, New York 10301		x			x			x	0
	Ellis Hospital 1101 North St. Schenectady, New York 12308	G-54	x			x			x	2
K	St. Joseph's Hospital 301 Prospect Ave. Syracuse, New York 13203	M-63	x	x		x			x	2
	Watts Hospital Broad St. & Club Blvd. Durham, N.C. 27705	L-64 G-65	x	x			x		x	2
	St. Luke's Hospital 5th St. North At Mills Ave. Fargo, N.D. 58102	G-45	x			x			x	0
	Aultman Hospital 625 Clarendon Ave., S.W. Canton, Ohio 44710		x			x			x	1
	Mercy Hospital 723 Market St. Canton, Ohio 44702		x			x			x	1
	Lutheran Hospital 2609 Franklin Blvd. Cleveland, Ohio 44113		x		x				x	1
	St. Vincent Charity Hospital 2351 E 22nd St. Cleveland, Ohio 44115		x		x				x	6

Name & Address	Affiliation	Internship		Residencies				Others	
		Rot.	Other	Med	OB	Ped	Psyc	Surg	
Children's Hospital 17th St. & Livingston Park Columbus, Ohio 43205	M-69					x		x	4
St. Elizabeth Hospital 49 Hopeland St. Dayton, Ohio 45408		x			x			x	3
Lakewood Hospital 14519 Detroit Ave. Lakewood, Ohio 44107		x		x				x	0
St. Vincent Hospital & Medical Center 2213 Cherry St. Toledo, Ohio 43608		x			x			x	2
Toledo Hospital 2142 N. Cove Blvd. Toledo, Ohio 43606		x			x	x			3
Youngstown Hospital & Youngstown, Ohio 44501		x	x	x				x	4
Good Samaritan Hospital & Medical Center 1015 N.W. 22nd Ave Portland, Oregon 97210		x	x	x				x	4
Providence Hospital 700 N.E. 47th Ave. Portland, Oregon 97213		x		X				x	1
St. Vincent Hospital 2447 N.W. Westover Rd. Portland, Oregon 97210	G-71	x		x				x	2
Allentown Hospital 17th & Clew Sts. Allentown, Pa. 18102	G-73	x			x			x	3
Altoona Hospital 700 Howard Ave. Altoona, Pa. 16603		x			x			x	2
Bryn Mawr Hospital Bryn Mawr Ave. Bryn,Mawn, Pa. 19020		x		x				x	2
Hamot Hospital 4 E 2nd St. Erie, Pa. 16512		x			x			x	3

	Name & Address	Affiliation	Internship		Residencies				Others	
			Rot.	Other	Med	OB	Ped	Psyc	Surg	
	St. Vincent Hospital 232 W 25th St. Erie, Pa. 16512		x			x			x	2
	Methodist Hospital 2301 S. Broad St. Philadelphia, Pa. 19148	M-73	x			x			x	0
	Nazareth Hospital 2601 Holme Ave. Philadelphia, Pa. 19152		x		x				x	2
P	Children's Hospital of Pittsburgh 125 DeSoto St. Pittsburgh, Pa. 15213	M-77		x			x		x	9
	Columbia Hospital 312 Penn Ave. Wilkinsburg, Pa. 15221		x			x			x	0
	Charleston County Hospital 326 Calhoon St. Charleston, S.C. 29401	M-79			x				x	1
M	St. Joseph Hospital 220 Overton Ave. Memphis, Tenn.. 38101		x			x			x	1
	Thomas D. Dee Memorial Hospital 2440 Harrison Blvd. Ogden, Utah 84401	L-87	x			x			x	2
	Holy Cross Hospital 1045 E 1st. South St. Salt Lake City, Utah 84102	L-87	x			x			x	2

	Name & Address	Affiliation	Internship		Residencies				Others
			Rot.	Other	Med	OB	Ped	Psyc	Surg	
	Riverside Hospital J, Clyde Morris Blvd. Newport News, Va. 23606		x			x			x	2
	Providence Hospital 17th & E. Jefferson St. Seattle, Wash. 98122	G-91	x	x	x				x	3
	Swedish Hospital Medical Center 1212 Columbia St. Seattle, Wash. 98104	L-91	x			x			x	4
M	Virginia Mason Hospital 1111 Terry Ave. Seattle, Washington 98101	L-91	x	x	X				x	3
K	Sacred Heart Hospital 101 W 8th Ave. Spokane, Washington 99204		x			x			x	3
	Charleston General Hospital Brooks St. & Elmwood Ave. Charleston, W. Va. 25325		x		x				x	4
K	Ohio Valley General Hospital 2000 Eoff St. Wheeling, W. Va. 26003		x			x			x	3
	Lutheran Hospital - Gundersen Clinic 1836 South Ave. La Crosse, Wisc. 54601		x				x		x	0
	Columbia Hospital 3321 N. Maryland Ave. Milwaukee, Wisconsin 53211	G-94	x		x				x	3
	Lutheran Hospital of Milwaukee 2200 W. Kilbourn Ave. Milwaukee, Wisconsin 53233	G-94	x	x		x			x	3
	St. Joseph's Hospital 5000 W. Chambers St. Milwaukee, Wisconsin 53210	L-94	x			x			x	2

HOSPITALS WITH INTERNSHIP PROGRAMS AND THREE RESIDENCY PROGRAMS (but not those required for COTH members)

Total Hospitals On Following List = 37

Correspondence Code:

B. Not Interested in Membership
D. Rules and Regulations and Application sent; no response
G. Applied, accepted; no response; dropped from mailing list
H. Unable to join at time of last correspondence
K. Applied previously; not approved
M. No response to original letter (May - June, 1966)

Numerical Code:

1. U.S. Army
2. Veterans Administration
3. U.S. Air Force
4. U.S. Navy
5. U.S. Public Health Service Hospitals

HOSPITALS WITH INTERNSHIP PROGRAMS AND THREE RESIDENCY PROGRAMS (but not those required for COTH members)

Hospital	Affiliation	Internship	Residency Programs			
Arkansas Baptist Medical Center 1700 W. 13th Street Little Rock, Ark. 72201	G-11	Rot.	Oph.	Path.	Rad.	Surg.
Herrick Memorial Hospital 2001 Dwight Way Berkeley, California 94704		Rot.	GP	Path	Psych	
St. Mary's Long Beach Hospital 509 E. 10th Street Long Beach, Calfiornia 98103		Rot.	GP	Path	Rad	
Children's Hospital Medical Center of Northern California 51 St. & Grove St. Oakland, California 94609	L-16	Other	Ortho.	Path	Ped	Ped. Card.
Huntington Memorial Hospital 100 Congress St. Pasadena, California 91105		Rot.	Neurosurgery Surg.		Path	Plast
San Bernardino County General Hospital 780 E. Gilbert St. Salinos, California 93901	L-12	Rot.	Anes.	GP	Surg	
St. Joseph's Hospital 355 Buena Vista Ave. San Francisco, Calif. 94117		Rot.	Ortho.	Path.	Surg.	
Santa Barbara Cottage Hospital 320 W. Pueblo St. Santa Barbara, Calif. 93105		Rot.	GP	Path	Rad	Surg
Santa Barbara General Hospital San Antonio Road Santa Barbara, Calif. 93105		Rot.	GP	Rad	Surg	
St. Luke's Hospital 607 E. 19th Ave. Denver Colorado 80203		Rot.	Path	Rad	Surg	
Sisters of Mercy Hospital 1619 Milwaukee St. Denver, Colorado 80206		Rot.	GP	Path	Surg	
Danbury Hospital 95 Locust St. Danbury, Conn. 06810		Rot.	GP	Path	Surg	

	Hospital	Affiliation	Internship	Residency Programs			
	Doctor's Hospital 1815 Eye Street, N.W. Washington, D.C. 20006		Rot.	Med	Path	Rad	
B	Variety Children's Hospital 6125 S.W. 31st St. Miami, Florida 33155	L-23	Other	Anes	Ortho	Path	Ped
	Columbus Hospital 2520 N. Lakeview Ave. Chicago, Illinois 60640		Rot.	Path	Rad	Surg	
	Ravenswood Hospital 1931 W. Wilson Ave. Chicago, Ill. 60622		Rot.	GP	Path	Surg	
	St. Anne's Hospital 4950 W. Thomas St. Chicago, Ill. 60622	G-27	Rot.	Ortho	Path	Surg	
	West Suburban Hospital 518 N. Austin Blvd. Oak Park, Ill. 60302		Rot	GP Ped	ObG	Ortho	Path
	Swedish Hospital 914 S. 8th St. Minneapolis, Minn. 55404		Rot.	Path	Rad	Surg	
	Children's Mercy Hospital 1710 Independence Ave. Kansas City, Mo. 64106	M-33 G-47	Other	Anes Rad	Ortho	Ped	Ped All
	St. Barnabas Medical Center 94 Old Short Hills Road Livingston, N.J. 07039		Rot.	Anes Surg	Path	Plast.	
D	Morristown Memorial Hospital 100 Marlison Ave. Morristown, N.J. 07960		Rot.	GP	Path	Surg	
	Memorial Hospital Northern Blvd. Albany, N.Y. 12204		Rot.	Path	Plast	Surg	
	Children's Hospital of Akron Buchtel Ave at Bowery St. Arkon, Ohio 44308		Other	Ortho	Path	Ped	
	Christ Hospital 2139 Rubuera Ave. Cincinnati, Ohio 43219		Rot. Other	GP Urol	Neuro	Plast	Surg

	Hospital	Affiliation	Internship	Residency Program			
	St. Alexis Hospital 6606 Carnegie Ave. Cleveland, Ohio 44103		Rot.	Anes.	Path.	Surg	
	St. Joseph Hospital 205 W. 20th St. Lorain, Ohio 44502		Rot.	GP	Path	Rad	
	Shadyside Hospital 5230 Centre Ave. Pittsburgh, Pa. 15232		Rot.	Path	Med	Thor	
	Wilkes-Barre General Hospital N. River and Auburn Streets Wilkes-Barre, Pa. 13702		Rot.	Path	Surg	Urol	
	Memorial Hospital Prospect St. Pawtucket, R.I. 02860		Rot.	GP	Med	Path	
D	Children's Medical Center 2306 Wilburn St. Dallas,Texas 75219	M-84	Other	Neuro Ped. Card.	Neur	Ped Rad	Ped All Thor
	Baptist Memorial Hospital 111 Dallas Street San Antonio, Texas 78205		Rot.	GP	Path	Rad	
	Santa Rosa Medical Center 745 W. Houston St. San Antonio, Texas 78207		Rot.	Ortho Rad	Path	Ped	Plast
	St. Luke's Hospital 803 N. 2nd St. W. Salt Lake City, Utah 84103	L-87	Rot.	Anes	Ortho	Surg	
D	St. Luke's Hospital 2900 W. Oklahoma Ave. Milwaukee, Wisconsin 53215		Rot.	GP	Surg	Path	Rad
	Evangelical Deaconess Hospital 620 N. 19th Street Milwaukee, Wisc. 53233		Rot.	GP	Path	Rad	Surg
	Louis A. Weiss Memorial Hospital 4646 Marine Drive Chicago, Ill. 60640		Rot.	GP	Med	Path	

POSTGRADUATE MEDICAL INSTITUTE
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April 5, 1968

Matthew F. McNulty, Jr.
Director, COTH
Associate Director, AAMC
1346 Connecticut Avenue, N.W.
Washington, D.C. 20036

Dear Matt:

Thank you for your note to me on the copy of your letter to Mr. Pyke. A question I have is whether or not you feel that Postgraduate Medical Institute is eligible in some way to become a member of AAMC, and particularly of COTH. At the present time Postgraduate Medical Institute is involved with the development or implementation of educational programs in more than 80 hospitals in the New England area. While we are not a medical school, we do utilize the services of several medical schools in this area in this cooperative activity. It would seem to me that while we do not fit within the specific framework for membership eligibility in your organization, someplace might be found for us to participate actively in the organization. Please let me know your thoughts about this.

Best regards,

Sincerely yours,

Norman S. Stearns, M.D.
Medical Director

NSS:wr

April 26, 1968

Norman S. Stearns, M.D.
Medical Director
Postgraduate Medical Institute
22 Fenway Street
Boston, Massachusetts 02215

Dear Norm:

Since the pleasure of our earlier discussion in Chicago in February and as augmented by your letter of April 5, I have continued to give consideration to the possibility of other than a teaching hospital institution being eligible for membership in the Council of Teaching Hospitals.

The original Rules and Regulations for membership eligibility in COTH (copy attached) were not meant to be exclusive of activities such as your Postgraduate Medical Institute. In fact, the membership eligibility might best be described as being contemplated for teaching hospitals and not projected beyond that specific type of organizational entity as a medical education institution.

I have discussed your letter with several members of the Executive Committee of COTH. They, too, were interested in the facet of membership eligibility raised by your inquiry. The subject will be an agenda item for the mid-May meeting of the COTH Executive Committee (listing of membership is attached). As I shall indicate in the next paragraph, I believe that the consideration by the Executive Committee of broadening membership eligibility criteria at this particular time will be one of condideration and recommendation that the question be continued over several meetings while various aspects are explored, including a determination as may be possible of how many organizations of what type might there be in the same category as the Postgraduate Medical Institute.

Another factor to which I alluded heretofore is the present reorganization of the AAMC. The Association of American Medical Colleges is undertaking a broadening of its financial base, an enlargement of its membership, and both an intensification and expansion of its program activity. Until that total AAMC reorganization becomes finalized, there are several other aspects of the eligibility requirements for membership in COTH that are being held in abeyance by the COTH Executive Committee

I trust the foregoing is both an explanation and reasonable indication of the ability of this Council to respond to your inquiry of April 5th. We shall write to you subsequent to the May Executive Committee Meeting if for no other reason than to keep you informed concerning any discussion of this particular subject matter. In very brief summary, then, the question you raised is an interesting one; it merits and will receive both consideration and decision but the decision possibility may be slower in evolution because of some of the reasons cited heretofore than most of us would desire. We do, however, trust that the factors involved are understood.

Best regards.

Cordially,

Matthew F. McNulty, Jr.
Director, COTH
Associate Director, AAMC

Attachments: Membership roster
COTH Rules and Regulations

MCN:cr

COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
1346 Connecticut Avenue, N.W.
Washington, D.C. 20036
202/ 223-5364

MINUTES
COMMITTEE ON MODERNIZATION AND CONSTRUCTION FUNDS FOR TEACHING HOSPITALS
FEBRUARY 19, 1968
MAYFLOWER HOTEL
10:00 a.m. to 4:00 p.m.

PRESENT:

Richard T. Viguers, Chairman
Lewis H. Rohrbaugh, Ph.D., Vice-Chairman
Charles H. Frenzel
Harold H. Hixson
Robert C. Hardy
David Littauer, M. D.
Richard D. Vanderwarker
John H. Westerman
John W. Kauffman, AHA Representative

STAFF:

Matthew F. McNulty, Jr.
Grace W. Beirne
Fletcher H. Bingham
Elizabeth Burgoyne
Thomas W. Campbell
William G. Reidy

ABSENT:

J. Theodore Howell, M. D.
John H. Knowles, M. D.

Committee was joined for luncheon at 12:30 p.m. by William L. Kissick, M. D., Executive Director, National Advisory Commission on Health Facilities.

I. Call to Order.

Chairman Viguers called the meeting to order at 10:00 a.m. Roll call was taken as noted above.

II. Welcome to John W. Kauffman, Chairman, AHA Council on Government Relations:

Chairman Viguers, on behalf of the Committee Members welcomed Mr. Kauffman in his capacity as an AHA representative, and also in a personal capacity as Administrator of the Princeton Hospital in Princeton, New Jersey.

III. Welcome to Thomas J. Campbell, Assistant Director AAMC Division of Operational Studies.

Mr. Viguers welcomed Mr. Campbell to the meeting. At the Chairman's request Mr. Campbell gave a brief summary of the AAMC-HEW study he is involved with. He noted that the study, using 7 medical centers as information resources, will attempt to develop broad principles and methodology on program costs in medical centers.

IV. Approval of Minutes - Meeting of December 12, 1967.

ACTION #1 DR. LITTAUER MOVED THAT THE MINUTES OF THE MEETING OF DECEMBER 12, 1967 BE APPROVED AS PRESENTED. THE MOTION WAS SECONDED BY MR. FRENZEL AND CARRIED UNANIMOUSLY.

V. Report on Action Items from last Committee meeting and other outstanding Action Items from previous meetings.

Mr. McNulty referred to Action Items from the December 12 meeting and reported accomplishment as follows:

ACTION #2

Mr. McNulty said that the structural relationship between this committee, the AAMC Committee on Federal Health Programs, and the COTH

Executive Committee has been established with the Committee on Modernization and Construction Funds reporting to the COTH Executive Committee which will, when deemed appropriate, recommend action to the AAMC, FHP Committee.

ACTION #3

The problem of inadequate overhead for direct research and training grants has been referred to the COTH Committee on Financial Principles for Teaching Hospitals and had appeared on the January 25 agenda of that Committee. That Committee had understood the issue and had agreed on a direct approach to Mr. Karol at HEW. Mr. Viguers noted that HEW had said that the Bureau of the Budget could not change the policy while BoB stated that only an administrative decision was required on the matter.

Mr. McNulty noted that this discussion also covered the report on Action #5 to the effect that the Federal "Fund Freeze" issue has also been referred to the Committee on Financial Principles.

ACTION #4

Each member of the COTH Committee was assigned a member of the National Advisory Commission on Health Facilities to establish informal lines of communication. At the request of the Chairman, Mr. McNulty commenced going through the list of Commission members first stressing that any contact made has been or should be "low key."

Boisfeuillet Jones, Commission Chairman - Mr. McNulty reported that in his letters and conversations with Mr. Jones, Mr. Jones had

indicated that he does not know yet, quite what will evolve beyond the general concept of an assessment of the health care system. He said Mr. Jones' chief problem would be coming up with a set of answers that while satisfying the authorities, would also be meaningful. Mr. Viguers noted that the chief medical man at New England Medical Center Hospitals is a close friend of Bo Jones and is planning on making "low key" comments to him. In response to questions concerning a probable issuance date for the report, Mr. McNulty indicated that Mr. Jones had said that while the original "reporting" date was in mid to late October, the Commission now has decided to accelerate their report - although not so much that it would be out by spring. Mr. McNulty also noted that there are some other elements that may influence the Commission's activities. These are: a) the feeling of a need for solid, feasible recommendations because of the lack of anything direct from any of the plethora of recent Federally-sponsored Committees, Commissions and conferences; b) the timing since Hill-Burton expiration, the retirement of Senator Hill, continually rising costs, etc. have led to heavy mail from constituents saying either that they can get no health care or can get health care only at high cost; and c) the makeup of the Commission, with its members, particularly Dr. Kissick and Mr. Jones, being people who have been directly involved in the delivery of health care.

Dr. Samuel Andelman - Mr. McNulty reported that Mr. Goulet has agreed to get in touch with him but has nothing specific to report as yet.

Dr. James Appel - Mr. McNulty said that a Pathologist on the staff of The Pennsylvania Hospital has gotten to Dr. Appel a message on the needs of teaching hospitals generally. Comments were that Dr. Appel is a very independent man and thus far has shown no opinion one way or the other.

Mrs. Angie Ballif - Mr. McNulty reported that Vernon L. Harris spoke with Mrs. Ballif briefly prior to her departure for the Commission's most recent Washington meeting. Mr. Harris, having pointed out teaching hospital examples in neighboring states, noted that she was welfare-oriented and shows no leaning either way. Mr. Harris is to meet with her for a longer period.

George E. Cartmill, Jr. - Mr. McNulty reported a brief conversation with Mr. Cartmill but noted that as Past President of the AHA and a teaching hospital administrator, Mr. Cartmill is acutely aware of all aspects of the problem nationwide.

Dr. Leonides G. Cigarroa - Mr. McNulty reported contact with Dr. Cigarroa through Harold Swicegood (Texas Medical Center Hospitals) and Truman Blocher, M. D. (Vice President, Texas Medical Branch, Galveston). Both men noted that Dr. Cigarroa had done a great deal of research and contacted many hospital administrators around the country to determine what their needs are and how they can be met at a lower rate. Dr. Cogarroa will visit Mr. Swicegood and Dr. Blocher in Galveston during the first week of March.

Charles E. DeAngelis - Mr. Vanderwarker said that he has not contacted Mr. DeAngelis yet but will do so upon his return to New York.

Dr. James L. Dennis - Mr. Hardy said that Mr. Dennis can speak knowledgeably of the needs of teaching hospitals and emphasize the necessity of providing the health manpower which emanates from these teaching institutions. Mr. Hardy said that Dr. Dennis' comments were that the Commission has not really resolved its direction yet in its deliberations and is now discussing problems more than solutions.

Honorable Conrad M. Fowler - Mr. McNulty contacted Dr. Joseph Volker at the University of Alabama who in turn got in touch with Judge Fowler. Dr. Volker said that the Judge is a very capable and efficient man but has little knowledge about the subject matter.

Honorable Wm. L. Guy - Mr. Westerman reported that Governor Guy is concerned by the great multitude of programs and the lack of means by which policy can be identified. He also said existing programs seem to assume that all people needing health care are on either the East or West Coast. The Governor is looking more for policy than for programs from this Commission.

Very Reverend Monsignor Harrold A. Murray - Mr. McNulty noted that Msgr. Murray is very aware of the present health care system in the United States and hopes to introduce an element of realism in the Commission's deliberations. In discussion the two men had spoken of ways to finance modernization and construction.

Howard N. Nemerovski- Mr. Hixson spoke with him by phone and was very impressed. Mr. Nemerovski was very appreciative of Mr. Hixson's offer to help in providing background information and plans follow up very soon in a "briefing session" with Mr. Hixson.

Dr. David E. Rosengard - Chairman Viguers said Dr. Rosengard operates a private clinic in Boston and is a "changed man" since being appointed to the Commission. Mr. Viguers hopes to get to see him soon.

Mrs. Fay O. Wilson - Dr. Littauer, who has met with Mrs. Wilson twice, noted that she is the only Negro on the Commission and that Cedars-Sinai has a slight affiliation with some of Mrs. Wilson's students at the Los Angeles City College Nursing Department. They discussed the needs for modernization and construction and the role of teaching hospitals, although her point of view was somewhat restrictive. After discussing the flood of material the Commission was getting, they agreed to keep in touch.

David Sullivan - Mr. Vanderwarker has not yet contacted Mr. Sullivan, and suggested that someone such as Irvin G. Wilmot might have more success in meeting with him.

William L. Kissick, M. D. - Mr. McNulty described Dr. Kissick as a very aggressive, capable and intelligent individual. He noted further that Dr. Kissick would be joining the Committee for lunch, so no further comments were deemed necessary.

In subsequent comments related to the Commission, Dr. Littauer inquired if COTH is satisfied that it is projecting its ideas. Mr. McNulty said he would not begin to be satisfied until each member of the Commission has face-to-face contact with at least one member of this Committee or some co-operating COTH member. He said COTH could present some written summary of problems and solutions,

but in his opinion it is better to establish personal rapport and an awareness of teaching hospitals, probably until the Committee adopts some definite direction at which time a written document may be of more value. He emphasized that if we submitted something now, not only might it be lost in the great amount of material already sent to the Commission, but also the Commission might take an entirely new tack and COTH would not be able to adapt its statement to the new approach.

Dr. Rohrbaugh asked if the Committee had a specific point of view. Mr. McNulty said the staff had not sensed one in terms of a specific mechanism which would satisfy the needs of teaching hospitals and Chairman Viguers noted, saying that there is a general statement in the "White Paper" but no specific funding methodology has been put forth. Dr. Rohrbaugh thought it would be beneficial to propose definite alternatives; Dr. Littauer said this Committee should have a viewpoint somewhat parallel to legislation such as grants-in-aid, loans, etc. in order to accomplish our objectives, especially since legislation is being enacted concerning funding and it is generally agreed that the Commission's Report will doubtless influence legislation.

ACTION #6

Mr. McNulty said the Executive Committee has reviewed the AHA definition of teaching hospital and saw no conflict - the AHA definition covering all types of teaching in a hospital setting.

ACTION #7

Mr. McNulty said a draft has been prepared of a paper and would be covered under Agenda Item No. 9

VI. Recent statement of definitions by American Hospital Association.

Mr. McNulty said this was a "report back" item. Mr. Kauffman said two definitions of the same term often lead to confusion. He asked for any "compromise" that the AHA might consider. Subsequent discussion brought up several points, including the fact that COTH's criteria for membership do not include paramedical education. Mr. Frenzel said that since the difference between the two definitions was so great, there was chance for little compromise beyond inserting a qualifying statement recognizing the peculiar characteristics of the COTH type of teaching hospital. General comments were that some conclusion be reached since it is most practical for the AHA and COTH to be unified on legislative actions.

ACTION #2 IT WAS AGREED THAT THE QUESTION OF THE AHA DEFINITION OF "TEACHING HOSPITAL" AS OPPOSED TO THAT OF COTH (AS DETERMINED BY "WHITE PAPER" AND MEMBERSHIP CRITERIA) BE REFERRED TO THE COTH-AHA LIAISON COMMITTEE AND TO THE MARCH COTH-AHA MEETING FOR COORDINATION.

VII. Report: Meeting of the Organization of University Health Center Administrators, January 20-22, 1968.

Dr. Rohrbaugh reported that the OUHCA unanimously decided upon liaison with the COTH Committee on Modernization and Construction Funds for Teaching Hospitals. Mr. McNulty said the backing of that group would be very helpful to the COTH Committee.

VIII. Date of next meeting.

ACTION #3 IT WAS AGREED THAT THE NEXT MEETING OF THE COTH COMMITTEE ON MODERN-

IZATION AND CONSTRUCTION FUNDS BE HELD ON MONDAY, JUNE 17, 1968 IN WASHINGTON.

IV. Other Business.

Mr. Vanderwarker expressed concern about obtaining joint venture tax exemption for activities which have been merged in an attempt to reduce costs. Miss Beirne clarified that if the hospital is actually involved, it is tax-exempt. If it is operated by a commercial organization, it is liable for taxation.

ACTION #4 MR. HIXSON MADE THE MOTION, SECONDED BY DR. LITTAUER, THAT THE COMMITTEE FORWARD THE QUESTION OF TAX EXEMPTION FOR JOINT VENTURES TO THE COMMITTEE ON FINANCIAL PRINCIPLES, THE AAMC COMMITTEE ON FEDERAL HEALTH PROGRAMS AND THE AHA WITH THE STRONG RECOMMENDATION THAT THESE BODIES EXPLORE THE ISSUE AND GO ON RECORD WITH A STATEMENT OF CONCERN AND SUGGESTION OF REMEDIAL ACTION.

Dr. Rohrbaugh mentioned that he and Mr. Viguers had been asked to visit with Senator Edward Kennedy. Prior to the upcoming visit, Senator Kennedy sent a "batch" of proposed legislation, which Dr. Rohrbaugh reviewed for the Committee members.

The Meeting was adjourned for lunch at 12:30.

The Committee was joined by William L. Kissick, M. D., for lunch. Dr. Kissick outlined the general structure and direction of the Commission and then answered various questions from Committee members.

X. Discussion of proposed "White Paper" on need for modernization and construction funds for teaching hospitals.

Mr. McNulty called attention to the proposed "White Paper", stressing that the draft emphasized philosophy over data and did not propose hard and fast solutions but urged that action be taken soon because of the increasingly growing rate of obsolescence of facilities.

The following points were stressed: (1) Dr. Littauer said he would like to see included a stress on "teaching hospitals" meaning educational, research, patient care and community service activity centers, which tailors itself to a need for certain physical facilities and Mr. Frenzel agreed it could be much more specific as to the needs.

(2) Several members felt the phrase "islands of excellence" sounded rather exclusive. Therefore, it was agreed to replace the word "islands" with, for example, "centers".

(3) It was agreed, following Mr. Viguers' suggestion, that just after the first paragraph, a statement be inserted that describes the total health care system of the United States. In this picture of the continuum it could be shown where the teaching hospital falls.

(4) It was agreed that in part 3 of paragraph 2, some stress of the essentiality of teaching hospitals in the production of physician manpower be made; and that in part 4 the urban location of hospitals be similarly emphasized.

(5) Committee generally felt that the draft should stress potential technological advances that can take place almost solely in the university - hospital complex. Also, they felt the general time limit within the draft for a period of ten years was good.

(6) Dr. Rohrbaugh asked the route of a White Paper. Mr. McNulty said the White Paper, upon approval by this Committee, goes to the COTH Executive Committee, then to the AAMA Executive Council. The Executive Council may, if they feel it controversial or debatable, may refer it to the AAMC Institutional Membership. Once totally approved, the White Paper is distributed to the AAMC mailing list (COTH members, deans, vice presidence, etc.) and to legislators, voluntary and public organizations active in the total health field, etc. Mr. Viguers suggested the possibility of putting the draft on the agenda for a meeting of the COTH-AHA Liaison Committee for comment, and Mr. McNulty concurred. The total process of official approval is three to nine months.

(7) General concluding comments were to the effect that it may be well to divide the paper into two parts, 1) problems, and 2) suggested solutions; that in page 2, paragraph 2, sentence 2, it might be wise to eliminate the word "primary" since it might contradict the AAMC statement on regional medical planning; that it would, as stated earlier, be good to place the teaching hospital in its perspective as part of the continuum.

XI. Review: Proposed study of need of funds for expansion of teaching hospitals.

Mr. McNulty said the questionnaire was to obtain more specific data concerning some of the needs that became evident in the original questionnaire. This survey would, tentatively, solely cover expansion.

Mr. Hixson suggested inclusion of some questions to demonstrate educational activities and the extent to which the institution expects to expand educational programs concurrent with physical expansion.

ACTION #5 IT WAS AGREED THAT COMMITTEE MEMBERS PRE-TEST THE QUESTIONNAIRE IN THEIR OWN INSTITUTIONS AND SEND COMMENTS ON ITS WORKABILITY AND PRACTICABILITY, AS WELL AS RESULTS, TO MR. McNULTY.

THE MEETING WAS ADJOURNED AT 3:55 P.M.

~~IN ORDER TO~~ CONTINUE TO MEET SOCIETY'S EXPECTATIONS FOR EXCELLENCE

In Service and In Service

A Statement of the Urgent Need For
Modernization and Construction Funds For
Teaching Hospitals

Better Comment on Suggest Trust H-B funds

and

Proposals For The Support of
Teaching Hospital Facilities By the Federal Government

Preliminary Draft-
For Discussion Only-
Not for Publication

I. THE PROBLEMS FACING THE NATIONS TEACHING HOSPITALS

All communities of this nation must take the action necessary to provide personal health services of high quality to all people in each community. These services should embrace those activities directed toward the promotion of good health, application of established preventive measures, early detection of disease, prompt and effective treatment, and physical, social, and vocational rehabilitation of those with residual disabilities. This broad range of personal health services has become patterned along the basis of a continuum services ranging from the promotion of health to rehabilitation after illness. Organizationally and institutionally, this continuum for the care of the acutely and chronically ill ranges from the home care program, the nursing home, the community hospital to the modern teaching hospital. Each of these components must have adequate support, if the entire health care system is to operate in an unfragmented, comprehensive fashion.

Significant gains have recently been made in removing the economic, geographic and social barriers to the availability of health care. The pace of progress has accelerated in recent months and years. The people of this nation have made it abundantly clear that they demand adequate medical care which is readily available, freely accessible, and individually acceptable. Recent social legislation reflects this national resolve. The possibility of progress toward achievement of these new national goals is a dual one of shortage of both manpower and facilities capable of delivering the health services and medical care which society will continue to expect or demand.

The teaching hospital will be the locus of the confrontation when the forces of rising expectations and effective demand meet headon with the hard facts of acute shortage of manpower and facilities. This Nation, and its teaching hospitals, faces a major crisis. The teaching hospital crisis is due to many factors:

(1) It is the teaching hospital that contributes significantly to the education and training of the nation's physician manpower;

(2) It is the teaching hospital which provides national norms and standards of excellence of patient care for a large proportion of our population;

(3) It is in the teaching hospital that much of the scientific investigation is done to advance the state of medical knowledge; and

(4) It is in the teaching hospital that new and more efficient "model systems" of rendering medical care are developed, tested, and made operationally feasible.

For purposes of this statement, a teaching hospital is one which has demonstrated a primary responsibility and significant commitment to the education and training of the nation's supply of physician manpower. The design and direction of this commitment to medical education may take many forms. The hospital may provide, on the basis of a joint venture with a medical school, the clinical instruction of the medical student. The development of the internship and residency programs, which have become such fundamental components of modern medical education, have provided additional educational responsibilities, because a major portion of this educational effort is being provided in

the teaching hospital. Finally, the teaching hospital may be involved in programs of continuing medical education, thereby insuring that the physician practicing in proximity to the hospital has exposure to the most recently developed diagnostic and therapeutic techniques.

The primary function of any hospital, is the care of the sick and injured of the community or region. Additional responsibilities of the teaching hospital are the expansion of medical knowledge through scientific research and more recently, the efforts related to disease prevention and active public health measures. Thus, the teaching hospital is that singular social instrument which encompasses the interface where medical knowledge is acquired, disseminated, and utilized.

The program of needed education facilities begins with a definition of the educational activities to be housed within the hospital institution. This definition must include the types of teaching and training programs, the numbers and types of persons involved in each, the instructional methods to be involved in each, and the locale and resources within the hospital that are involved. A teaching hospital requires additional space throughout. Enough space to house the additional functions, people and equipment of a teaching hospital is its problem, and may increase the total size by as much as 50 percent. (From 800 to 900 square feet per bed to 1200 square feet for teaching hospitals). In terms of cost, this can reflect a variance in cost from $30 to $35 per square feet for non-teaching hospitals and $65 to $70 per square feet for teaching hospitals. These additional spacial needs take the form of; examination-treatment rooms, designed to support teaching; clinical laboratories by service; classrooms; seminar-conference

rooms; and resident's offices.

While these are the more evident spacial needs of teaching hospitals, there are other features of the teaching hospital that contribute directly to increased space needs. Patients generally are tested more extensively with a wider range of results in teaching hospitals. This is because the teaching hospital attracts the sicker patients, there are more difficult diagnostic problems and there is a greater variety of available tests. The ultimate result of this is the need for larger clinical laboratories. The teaching hospital must allow for research and experimentation in operational methods and patient care in addition to their rapidly expanding programs in clinical research. Occasionally particular research facilities are needed to attract a particular type of staff. Commitments of this nature can, and do, require 1000 square feet of research space per person. As the hospital assumes more care and teaching roles, the full-time staff becomes larger which requires offices, research and out-patient facilities for them within the hospital.

These hospitals have been assigned other particular responsibilities by society. These additional social assignments are best characterized by the phrase, "center of medical excellence". The community of teaching hospitals have responded to this social responsibility by becoming such "centers" and their status of excellence can be related closely to both the science and technology of medicine. These few hospitals have been characterized as the summit of the health care pyramid, the capstone of the nation's hospital system. The high standards of clinical excellence and patient care provided by these teaching hospitals necessitate that these hospitals accept referrals from other physicians, of

those patients which present difficult problems of diagnosis or which require therapeutic services available solely in the teaching hospital.

More recently, these hospitals have accepted society's additional charge that they become positive "health centers", for all social and economic classes. This development takes on added significance when it is noted, that a large portion of the nation's teaching hospitals are located in the urban "center city", with all of the issues related to such geographic location. The teaching hospital, as a health center, is becoming the single most effective social and technical instrument available to both the medical educator and practicioner, as well as the community of which it is a part, for the solution of problems of medical care delivery.

The functional demands that are placed on the scarcity of resources of the nation's teaching hospitals promote a certain measure of constant internal stress. The demands on the teaching hospital for facilities and equipment for classrooms must be applied against the simultaneous demand for facilities and equipment for the laboratories for scientific investigation, which must be further applied against the development of a specialized patient care unit. All of these decisions relating to the conflicting demands for facilities, equipment and manpower are resolved in an economic calculus, the overriding determinant of which is the chronic, and continuing shortage in supply of the major resources. This is true with regard to institutional facilities which are often physically or functionally obsolete, or more seriously nonexistent.

Our nation relies on such teaching hospitals for the graduate education of physicians and other health manpower, the establishment of standards for the promotion of better health, the best care of the sick and injured, the continued advancement of medical knowledge and the transfer of this new technology to the patient's bedside. It is imperative that these facilities receive more adequate capital financing support, as a matter of national policy, if they are to remain the social instruments that will best serve the overarching interests of the community in matters of health and disease in an optimal, yet efficient, fashion.

II. THE NEED FOR SOLUTIONS TO THE STATED PROBLEM

Because the problem of facility need for teaching hospitals can only be resolved through a prompt and comprehensive national effort, it is essential that representatives of the teaching hospital community outline the basic financial capital requirements which they believe necessary to accomplish the purpose of preservation of excellence in these multi-purpose institutions. To this end, the Council of Teaching Hospitals of the Association of American Medical Colleges is suggesting certain principles of Federal programs of assistance for modernization and expansion of the facilities of these institutions. The need for such capital financing is urgent. All of the many interrelated component areas for patient care, education, research and community service of the teaching hospital are continually affected by the existing advances everpresent in medicine and the sciences basic to medicine. Correspondingly, there is an unceasing demand on these institutions for personnel, equipment, and most importantly, adequate,

modern, up-to-date facilities.

Financing For Modernization, Replacement and Expansion of the Nation's Teaching Hospitals

A. The Need:

The dilemma facing hospitals in financing construction is due basically to the fact that hospitals are non-profit organizations, being reimbursed most frequently on a cost basis. The economics introduced by a situation such as this do not provide for an accumulation of surplus. Depreciation charges received, even when funded, most often must be used for renovation, or maintenance of existing plant and equipment rather than for modernization or expansion of plant facilities.

In 1967, the Council of Teaching Hospitals of the Association of American Medical Colleges sampled its membership to determine the extent of need for modernization and expansion among 250 of its members. Federal and Canadian hospitals were not included. Replies were received from 214 hospitals providing an 85% return.

Of the approximately 115,000 beds represented in the survey, 35% were over 35 years old and an additional 16% were between 21 and 35 years old. Of the 85% responding hospitals, 120 planned to replace 27,500 beds over the next ten years and 142 planned to add 24,000 beds during the same period of time. For all forms of construction, including replacement, renovation and expansion, the estimated attendant cost, for the ten year period, is $4 billion.

The reliability and validity of this study have more recently been verified by a series of circumstances and events that have taken place. Governor Rockefeller of New York has estimated that $1 billion is needed for the construction and modernization of all hospitals in the State of New York alone, and is working toward the development of legislation that will accomplish this purpose.

A study completed by the Hospital Planning Council for Metropolitan Chicago resulted in the determination that $370 million was needed for modernization and $720 million was needed for facility replacement of the 69 hospitals in that city. In a special study of 6 teaching hospitals totalling approximately 6000 beds in that city, this same Council determined that the costs of modernization would approximate $156 million and the cost of replacement $300 million.

Since the teaching hospitals serve a combination of community, regional and national purposes and because their strength is divided through a diversity of forms of ownership and control, the Council of Teaching Hospitals, Association of American Medical Colleges, favors both Federal and local participation, as well as the use of borrowed capital, in the construction of teaching hospitals.

Federal Funds should be provided under conditions that will:

1) be sufficient to encourage action that is both prompt and adequate;
2) encourage the facility modernization and expansion of existing teaching hospitals;

3) encourage an institution's continuing effectiveness in maintaining diversity in its sources of financial support;

4) recognize the indispensibility of the multiple purposes of the teaching hospital, i.e., patient care, education, research and service to the community and the beneficial influences which these multiple functions have in the standards of excellence maintained by the teaching hospital.

Proposals

1) The Council of Teaching Hospitals, Association of American Medical Colleges, recommends that Congress pass a program that would provide assistance in the form of a combination grant and loan formula. It would seem that one such program might be:

a. The teaching hospital, in applying under the provision of this program, must assure Federal authorities that it has 10% of the proposed contruction monies.

b. The Federal government would grant the applicant 20% of the total estimated cost at the time construction begins.

c. The Federal government assures the applicant 35% of the construction monies from government borrowing. The principle and interest would be paid by the government over a period not to exceed 10 years.

d. The Federal government would authorize the applicant to borrow 35% on a straight loan or bond issue basis, payable over a period not to exceed 25 years. The government would insure both interest and principle.

2) Because of the severity of the problem and the immediate need for modernization in teaching hospital, it is further recommended that the Congress appropriate $220 million per year over a ten year period to provide the necessary financial support for such a program.

Appendix B

PROPOSED DEFINITION OF A TEACHING HOSPITAL (AHA)

Approved by Council on Government Relations
October 1-3, 1967

Definition

A teaching hospital is one that allocates part of its resources to conduct, in its own name or in formal association with a college or university, formal educational programs or courses of instruction in the health disciplines that lead to the granting of recognized certificates, diplomas, or degrees, or that are required for professional certification or licensure.

Interpretation

1. The allocation of resources in facilities, personnel, and funds must be adequate to demonstrate the discharge of corporate responsibility for the support and high quality of the teaching programs.

2. Educational programs or courses of instruction are "formal" when based upon published or recorded curricula covering specified periods of study and have faculty qualification and student admission requirements established or agreed to by the hospital. They are not work-and-learn or on-the-job training arrangements that primarily augment the hospital's capability to provide services. Further, the hospital controls, or agrees to, the appointment of faculty and selection of students except during the term of agreements that give a college or medical school exclusive authority therefor.

3. Certificates, degrees, or diplomas must be recognized and accepted by national educational agencies, professional qualifying bodies, or state approving authorities. This implies that the courses or educational programs themselves meet standards generally recognized in the health field.

RCL
9/22/67

COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
1346 Connecticut Avenue, N.W.
Washington, D.C. 20036
202/223-5364

MEETING OF COMMITTEE ON FINANCIAL PRINCIPLES FOR TEACHING HOSPITALS

SEVEN CONTINENTS V.I.P. LOUNGE
O'HARE AIRPORT
CHICAGO, ILLINOIS
January 25, 1968
10:00 a.m. - 4:00 p.m.

Present:

Charles R. Goulet, Chairman
Richard D. Wittrup, Vice-Chairman
V.L. Harris
Gerhard Hartman, Ph.D.
Bernard J. Lachner
Lawrence E. Martin
Roger B. Nelson, M.D.
Irvin G. Wilmot
Robert C. Linde, AHA Representative

ARTHUR F. KLIPPEN, M.D.

Staff:

Matthew F. McNulty, Jr., Director, COTH; Associate Director, AAMC
Fletcher H. Bingham, Ph.D., Assistant Director, COTH
Lee Powers, M.D., Director, Division of Operational Studies (Portion of afternoon only)
Thomas J. Campbell, Assistant Director, Division of Operational Studies, AAMC
A.J. Carroll, Assistant Director, Division of Operational Studies, AAMC

Also Present:

Roger L. Amidon, Ph.D.

Absent:

Reid T. Holmes

I. Call to Order:

The meeting was called to order at 10:00 a.m. by Charles R. Goulet, Chairman.

II. Approval of Minutes

The minutes of the October 17 meeting of the Committee on Financial Principles for Teaching Hospitals were approved as previously circulated.

III. Discussion: Selected Financial Principles

Mr. Goulet noted that he had provided the selected principles (see attached) in order to present a point of departure for the Committee's deliberations. After discussion regarding the substantive content of the principles, and with special emphasis on the thought that the development of any financial principles may be somewhat arbitrary and based on assumptions as well as analysis, there was concern expressed by some members of the Committee regarding the wisdom of attempting to develop such principles.

Mr. Goulet and Mr. Wittrup, two members of the Executive Committee, then commented on the underlying rationale that had been exhibited by the Executive Committee in forming this Committee and providing its charge. After lengthy discussion regarding this proposal, the Committee agreed.

ACTION #1: THE CHAIRMAN APPOINT A SUBCOMMITTEE WHICH WOULD DEVELOP A STATEMENT OF FINANCIAL PRINCIPLES FOR TEACHING HOSPITALS FOR REVIEW, CONSIDERATION AND ACTION BY THE FULL COMMITTEE.

ACTION #2: THAT EACH MEMBER OF THE COMMITTEE WOULD REVIEW THE DRAFT STATEMENT OF FINANCIAL PRINCIPLES PREPARED BY MR. GOULET AND WOULD WRITE TO HIM, FOR FUTURE SUBMISSION TO THE SUBCOMMITTEE, EITHER REFINEMENTS IN THE CONTENT, OR OTHER SUBSTANTIVE AREAS WHICH THEY FEEL SHOULD BE INCLUDED.

IV. Discussion: P.P.B.S. - A Design Potential for Teaching Hospitals

Dr. Hartman commented on the paper prepared by he and Roger L. Amidon, Ph.D., noting particularly the need for a position statement relating to the need for awareness, analysis and introduction of new and sophisticated managerial and fiscal techniques in teaching hospitals. He noted further that the concept of P.P.B.S. was being systematically implemented in various Federal agencies, including the Department of Health, Education and Welfare. Following the discussion, the Committee agreed to:

ACTION #3: URGE, THROUGH COTH STAFF, TO THE EDITOR OF THE JOURNAL OF MEDICAL EDUCATION, THAT THE PAPER "P.P.B.S. - A DESIGN POTENTIAL FOR TEACHING HOSPITALS" BE GIVEN EVERY CONSIDERATION FOR EARLY PUBLICATION BY THE JOURNAL.

V. Selected Problems of Medicare Reimbursement

Mr. Wittrup introduced several problem areas of medicare reimbursement which he was experiencing. Following his presentation, there was a general discussion during which it was noted that the items which he had noted were being handled differently in different geographical regions.

VI. Problems of Inadequate Overhead on Direct Research Grants and Training Grants

Mr. Goulet noted that this item had been referred to the Committee on Financial Principles for Teaching Hospitals by the Committee on Modernization and Construction Funds for Teaching Hospitals at their meeting of December 12. Mr. Goulet noted further that the question had been originally introduced by Mr. Richard T. Viguers, the Chairman of that Committee. Mr. Martin noted that, as a member of the Department of Health, Education and Welfare's Grants Administration Advisory Committee, he knew

of this problem and that he had been in contact with both DHEW and the BOB. He noted that there was some interest exhibited in removing the 8% indirect cost overhead on training grants, but that it would be necessary to provide appropriate data supporting its removal. After further discussion the following actions were introduced.

ACTION THERE WAS A UNANIMOUS EXPRESSION THAT THE 8% CEILING ON INDIRECT COSTS FOR TRAINING GRANTS WAS AN UNNECESSARY HARDSHIP ON HOSPITALS.

ACTION THAT COTH STAFF CONTACT MR. IRVING J. LEWIS, DEPUTY DIRECTOR, BOB, STRONGLY URGING THAT THE 8% CEILING BE REMOVED, AND FURTHER NOTING THAT THE COUNCIL, THROUGH THE COOPERATION OF HOSPITALS IN THE BOSTON AREA, WOULD BE WILLING TO PROVIDE ADDITIONAL INFORMATION IN SUPPORT OF THIS REQUEST AS DESIRED.

ACTION THAT THE AMERICAN HOSPITAL ASSOCIATION BE URGED TO CONSIDER THE ADVISABILITY OF CONTACTING THE VARIOUS APPROPRIATE FEDERAL AGENCIES IN SUPPORT OF THE REMOVAL OF THIS CEILING.

ACTION THAT COTH STAFF BRING THIS ITEM TO THE ATTENTION OF THE AAMC EXECUTIVE COUNCIL URGING THAT THIS COUNCIL RECORD ITS SUPPORT OF THIS COTH COMMITTEE ACTION.

VII. Report: Recent Developments Regarding A Guide to Hospitals: Establishing Indirect Cost Rates for Research Grants and Contracts with the Department of Health, Education and Welfare.

Mr. McNulty reported that there had been recent correspondence between the AHA and Mr. James F. Kelly, Comptroller, DHEW, in which the AHA once again noted that the Guide had not had the concurrence of the AHA prior to its distribution as had been asserted by DHEW. Mr. McNulty noted further

that although this exchange of correspondence documented the resolution of a previous misunderstanding, that the Guide was now published and activities were ongoing regarding its implementation.

VIII. Report: Activities of DHEW Committee to Develop Implement Procedures for Hospital Cost Principles and Its Subcommittees

Dr. Bingham reported that the full Committee had met on October 23 to consider the implementation at which time a subcommittee had been appointed to develop the necessary procedures. He noted that the subcommittee had met four times since October, including one meeting each at Passavant Memorial Hospital (Chicago, Illinois) and Memorial Sloan-Kettering Hospital (New York) in order to develop such procedures. He noted further that this subcommittee was not considering the problem of the four non-allowable items contained in the Guide; depreciation on Federally financial buildings and equipment, interest, bad debts and gain or loss on sale of plant and equipment.

ACTION THE COMMITTEE AGREED THAT ITS POSITION ON THIS ITEM SHOULD BE THAT THERE BE ONLY ONE, RATHER THAN MULTIPLE COST REPORTING FORMATS FOR THE DHEW. ADDITIONALLY, THERE WAS AGREEMENT THAT COTH STAFF SHOULD CONTACT APPROPRIATE OFFICIALS WITHIN THE BOB EXPRESSING ITS CONCERN ABOUT THE NONALLOWABLE COSTS OF THE FOUR ITEMS AS CONTAINED IN THE GUIDE.

IX. Report: Recent Revision of Protocol for AAMC - DHEW Cost Allocation Study

Mr. McNulty reported that, in a recent letter to Secretary Gardner, Mr. Nathaniel H. Karol had indicated that the "study's principle objective is to develop a model system of program cost finding for each component of the medical center complex." He continued that these were not in accord

with his understanding of the purposes of the study. Dr. Powers, Director, Division of Operational Studies, had joined the meeting, and indicated that although he did not feel this to be a matter of major concern, he would write to Mr. Karol questioning him about the use of the term "model system". After further discussion, it was agreed that:

ACTION COTH STAFF WOULD DISTRIBUTE TO EACH HOSPITAL REPRESENTED IN THE COST FINDING STUDY A COPY OF THE ORIGINALLY AGREED UPON OBJECTIVES OF THE STUDY. FOLLOWING THIS DISTRIBUTION, EACH MEMBER WOULD CORRESPOND WITH THE CHAIRMAN, (WITH A COPY TO COTH STAFF) INDICATING THEIR OWN PERCEPTION OF THE GRAVITY OF THE DEVIATION OF THIS MOST RECENT REVISION BY MR. KAROL FROM THE ORIGINAL DOCUMENT.

X. Physician Services for "Staff" or "Service" Patients

Mr. Wittrup noted that upon reading the datagram on "Educational Support Needs of Schools with Limited Financial Resources", he was reminded again of the cost which many schools must be bearing in connection with providing physician "services" to service patients. He indicated that he felt this to be an important issue, first because of the drain against education resources which might be involved, and second, because of the financial leverage, comparable to that resulting from research grants, which a medical school might acquire with professional fee income.

Following lengthy discussion, there was a consensus of opinion that the full efforts of the Committee should be directed toward the completion of the AAMC-DHEW Cost Finding Study before any additional statistical data be developed. There was further opinion expressed that, upon completion of this study, information may be available, which could be of benefit in answering questions of this nature.

XI. Other Business

Mr. Goulet asked Mr. A.J. Carroll how he stood with regard to the completion of the Yale-New Haven study. Mr. Carroll noted that with two to three weeks of concentrated effort, the study might be completed. He noted, however, that he was unable to "free up" any such period.

ACTION IT WAS AGREED THAT MR. McNULTY WOULD DISCUSS WITH AAMC THE POSSIBILITY OF PROVIDING MR. CARROLL WITH ENOUGH TIME, WITHOUT OTHER RESPONSIBILITIES, TO COMPLETE THE REMAINDER OF THIS STUDY.

XII. Date of Next Meeting

The date of the next meeting was set for Thursday, June 6, 1968.

XIII. There being no further business, the meeting adjourned at 3:45 p.m.

1. Because of the multiple purposes of a medical center, it is essential that costs related to research, education, and patient services be separated.

2. The separation of costs should not only be made by major category, but should also be made by specific programs within each category, e.g. in-patient services, out-patient services, etc.

3. The separation of costs should be based upon sound cost accounting principles.

4. The bases for allocation of costs should be well understood within the institution and, where necessary, within the community and by third parties.

5. Although it is essential that a number of the functions in a modern medical center must be carried out simultaneously, and indeed it is essential that they be done so, institutions should arrive at reasonable bases for the allocation of expenses between the major functions and programs.

6. General educational research costs should be borne by the University, except where there is clear assignment of such educational or research responsibilities to the hospital.

7. If research and educational costs are assigned to the hospital, full reimbursement for these costs should be provided from available sources whether from the community, university or institutional sources.

8. The costs related to education and research, where conducted within the hospital setting, should include costs associated with the provision, replacement and maintenance of capital facilities.

9. Distribution of costs for physicians' services should be carefully considered by the medical school and the hospital in relation to service, education and research. The method of apportionment should be well understood and should be based upon a realistic appraisal of the prevailing situation. The costs associated with undergraduate educational programs should be separated from the costs of graduate medical education.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

FEB 27 1968

Mr. Thomas J. Campbell
Assistant Director, Division of
Operational Studies
Association of American Medical Colleges
2530 Ridge Avenue
Evanston, Illinois 60201

Dear Mr. Campbell:

Recent discussions have indicated that it may be desirable to clarify the objectives and anticipated results of the Cost Information Study which the Association of American Colleges and the Department of Health, Education, and Welfare are jointly sponsoring in cooperation with seven major medical centers.

The basic motivation of the Department in connection with this study is the strengthening of grantee institutions. We would hope to do this in two ways: first, by assisting the centers involved in the study to develop cost information systems that more adequately meet their internal management needs and disseminating the results of these efforts so that other institutions might profit from them; second by modifying our own reporting requirements to the extent that they are not consonant with the systems developed as a consequence of this study, on the assumption that a system acknowledged to be adequate for institutional management needs should yield information needed to satisfy Federal requirements as a logical by-product.

The seven medical center participants in this study were selected for their diversity in the expectation that in consequence the data yielded would be widely applicable. Each center is expected to apply cost allocation techniques to its own environment in conjunction with those elements of its existing system which are considered to be useful and effective. Our expectation is that there will emerge seven distinct systems with broad similarities but also with marked differences reflecting the diversity in the organization and activities of the seven centers.

We would hope that these seven systems might then be presented in an array of cost allocation techniques, which would constitute a useful model for all institutions in that they might be expected to find in this array elements which they could all adapt (with or without modification) to their respective environments.

I enjoyed meeting you last week, and look forward to a continued fruitful relationship with the Association of American Medical Colleges on matters which are of common concern.

Sincerely yours,

Nathaniel H. Karol
Director, Division of Grants
Administration Policy

cc: Mr. Nelson Wahlstrom

CRENSON--(202) WO 3-6436 (Office)
(301) 825-8754 (Home)

(2) By Invitation

U.S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
Office of the Secretary
Washington, D.C. 20201

FOR RELEASE IN P.M. PAPERS
Wednesday, April 17, 1968

HEW-T83

A series of Regional Conferences on Health Care Costs will begin in June, Wilbur J. Cohen, Acting Secretary of Health, Education, and Welfare, announced today.

"The regional conferences," Acting Secretary Cohen noted, "will provide forums for productive discussions on experiments and demonstrations relating to health care costs while maintaining or improving the quality and the delivery of medical care."

Under authorization provided in the Social Security Amendments of 1967, a program is already underway to find methods of reimbursing hospitals and doctors that will have built-in incentives for efficiency and economy and, at the same time, maintain a high level of quality care.

Under that program, hospitals and other health care institutions, physicians, and organizations and associations, including private health insurance organizations which pay for health services, have been invited to submit proposals for experiments. Such experimental approaches and other work now being done in the health care field will be discussed at the Secretary's Regional Health Care Conferences.

Following up on the National Conference on Medical Care Costs held last year, the Secretary's Regional Conferences on Health Care Costs will bring together regional leaders from the health community, the insurance industry, labor, and the general public.

The Social Security Administration has been assigned lead responsibility for planning and organization of the regional conferences in consultation with Dr. Philip R. Lee, Assistant Secretary for Health and Scientific Affairs, and other agencies of the Department of Health, Education, and Welfare. The first conference is tentatively scheduled for June in the region including the States of Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota and South Dakota. E. Albert Kreek, Regional Assistant Commissioner of Social Security, will be in charge of organizing and arranging for the conference.

# # #

EXISTING HEALTH LEGISLATION EXPIRING IN 1968 OR 1969

a)	P.L. 88-443	Hospital and Medical Facilities Amendments of 1964 (Hill-Burton)	Expires 1969
b)	P.L. 88-497	Graduate Public Health Training Amendments of 1964 (Project Grants)	Expires 1969
c)	P.L. 88-581	Nurse Training Act of 1964	Expires 1969
d)	P.L. 89-109	Community Health Services Extension Amendments of 1965 Includes: 1) Vaccination Assistance Act of 1962 2) Migrant Health Projects Grants	Expires 1968
e)	P.L. 89-115	Health Research Facilities Amendments of 1965	Expires 1969
f)	P.L. 89-239	Heart Disease, Cancer and Stroke Amendments of 1965	Expires 1968
g)	P.L. 89-290	Health Professions Educational Assistance Amendments of 1965	Expires 1969
h)	P.L 89-751	Allied Health Professions Personnel Training Act	Expires 1969

STATUS AS OF MAY 8, 1968

a) -Senate hearings have not as yet been scheduled. Senator Hill presently is conducting his subcommittee hearings on appropriations for Departments Labor-HEW. In his appearance before that subcommittee recently Secretary Wilbur Cohen stated that he looked forward to the recommendations of the National Advisory Commission on Health Facilities "so that the Hill-Burton program which expires on June 30, 1969, may be continued, improved and expanded as a continuing reminder of the remarkable contributions of our distinguished Chairman (Senator Lister Hill)."

b), c), e), g), and h) - Provisions for extension are included in the Health Manpower Act of 1968 (S. 3095 and H R. 15757) (copy of fact sheet attached) (copies of legislation and hearings in separate envelope). Hearings have been completed and printed in Senate - no action is scheduled presently in House.

d)- 1) - Legislation introduced by Senator Hill and Representative Boland (S.3093 - H.R.15619). No action scheduled in either body presently.
2) - Legislation passed Senate May 6, 1968. Provision for extension included in Regional Medical Program extension legislation in House.

f)- Provisions for extension are included in legislation (S. 3094 and H.R. 15758) House hearings have been completed but not printed No action presently is scheduled in the Senate. (copy of fact sheet attached)(copy of legislation in separate envelope) The House bill includes two additional titles - Title II - Extension of Special Grants for Health of Migratory Workers and Title III - Alcoholic and Narcotic Addict Rehabilitation

Of additional interest may be legislation introduced by Senator Edward M. Kennedy (D) Mass. which would establish a National Advisory Council of Health Policies (S. 3331)and a Joint Committee on Health Affairs (S. Con. Res. 69) (brief description of this legislation attached)(copy of legislation in separate envelope)

Separate envelope also contains edited copy of Secretary's Advisory Committee on Hospital Effectiveness Report.

From the office of

Senator Edward M. Kennedy

of Massachusetts

SENATOR KENNEDY ASKS COORDINATED HEALTH SYSTEM

FOR RELEASE TO A.M.'S
April 22, 1968

Senator Edward M. Kennedy today offered a series of proposals to coordinate the American health care system.

In testimony submitted to the Subcommittee on Executive Reorganization, Senator Kennedy outlined these proposals:

> Establishment of a National Advisory Council on Health Policies, located within the Administration, to have the responsibility of setting goals for a national health policy.
>
> Establishment of a Joint Committee on Health Affairs, which would have the broad responsibility for evaluating and assessing the impact of health legislation passed during the last two Congresses.

The Council, as envisioned by the Senator, would be composed of three members appointed by the President. It would make an initial two-year evaluation of Government participation in medical care programs, and then present its report to the President, the Congress and the nation. The first report would include a statement of specific national health goals, and offer a program for meeting these goals. After this initial report, the Council would thereafter submit an annual report which would measure the progress in the year toward meeting these goals.

The Joint Congressional Committee on Health Affairs would be composed of 12 Senators and 12 Representatives appointed by the Speaker and the President of the Senate respectively. It would be viewed as an ad-hoc unit, to be established in the second session of the 90th Congress and with the proviso to report its findings and recommendations by June 30, 1971, when it would be abolished.

The Joint Committee would have four primary responsibilities: first, it would review all existing legislation relating to health; second, it would assess the effectiveness of these programs, identifying and making recommendations to overcome any gaps and overlaps in existing legislation; third, it would suggest changes within the Executive Branch that could be made to coordinate and improve the administration and planning of programs; and fourth, it would project the direction and future needs in health.

"If enacted," noted Senator Kennedy, "these two proposals can pave the way for reducing rising health costs as well as broadening the availibility of health services to all Americans."

U.S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE

FACT SHEET: Health Manpower Act of 1968

Background

In removing the barriers which have kept many people from access to adequate health care, a critical need is for health manpower--the right numbers and kinds of people in the right places.

Since 1960, there have been concerted efforts--new legislative authority, new programs, new and increased financial support --to improve the Nation's supply of such needed manpower. New schools have been established, and the integrity and capability of old schools have been strengthened.

Since 1960, for example, 16 new medical schools have been authorized--

> One admitted its first students in 1964, two in 1966, and four in 1967. Five others are scheduled to commence operations in 1968, two in 1969, and one each in 1970 and 1971.
>
> In 1960, when the program began, only 8,173 students were admitted to medical school. By 1971, there will be places for more than 10,000.

There have been comparable increases in the training of both professional and nonprofessional nurses, radiological technicians, clinical laboratory workers, and other health personnel.

There are now about three million people in the health occupations. But by 1975, another million will be needed.

To achieve this goal, it is necessary to provide additional facilities, student assistance, improved training programs, and innovative educational methods. Above all, it is necessary to develop the skilled professional leadership to give direction, strength and supervision to the team effort in health services.

Proposal

To meet these requirements, the proposed legislation would:

-- Extend the Health Professions Educational Assistance Program for four additional years. Grants would be authorized for construction of facilities, education improvement, and student assistance. Eligible institutions would include those engaged in the training of physicians, dentists, optometrists, podiatrists, and osteopaths.

-- Extend the Nurse Training Program for four additional years to provide assistance to diploma, collegiate, and associate degree schools of nursing. Assistance would include construction grants, support and program improvement grants, and student assistance.

-- Extend the Allied Health Professions Personnel Training Program for ~~four~~ one additional years. Grants for construction of teaching facilities, educational improvement grants, development grants and advanced traineeships would be provided to schools engaged in the training of those personnel in the professions allied to the medical profession, such as medical technologists.

-- Extend the Graduate Public Health Training Program for four additional years. Assistance would include public health traineeships as well as project grants to schools of public health, schools of nursing, and schools of engineering for public health training.

-- Extend the Health Research Facilities Construction Program for four additional years. This would expand the Nation's research capacity in the field of health.

U.S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE

FACT SHEET: Regional Medical Programs

Background

The Regional Medical Programs were authorized for three years by the Heart Disease, Cancer, and Stroke Amendments of 1965.

Their purpose is the development and implementation of action programs to capitalize on new medical knowledge and techniques, and evolve more effective organization of health resources for delivering the full benefits of currently available knowledge and skills for the diagnosis and treatment of heart disease, cancer, and stroke.

Of the expected 54 programs to cover the entire Nation, 53 have now been funded for planning activities. (The Puerto Rico program has not yet been funded.) Of these, 8 are now being funded for operational activities, or are in the final stages of funding negotiations.

These include the States of Kansas, Missouri, and Wisconsin; the two-State area of Washington and Alaska; the areas surrounding Albany, New York, and Rochester, New York; the Tennessee-Midsouth region, and the Intermountain region, including Utah and portions of 5 other States.

More than $40 million has been awarded to date for planning and operational activities.

Authorization for these programs expires June 30, 1968.

Proposal

The legislation would extend the authority for the planning and operation of the Regional Medical Programs for 5 more years.

It includes several technical amendments providing for appropriate modifications based on the initial experience. The amendments would:

-- Specify that Federal hospitals may participate in regional programs and share in funds granted to nonfederal applicants.

-- Permit the referral of patients by practicing dentists as well as by practicing physicians (important for detection and treatment of cancer of the mouth).

-- Enlarge the membership of the National Advisory Council from 12 to 16 members.

-- Authorize grants for services to meet the special needs of a number of the regions.

-- Permit up to one percent of program appropriations to be used for program evaluation.

-- Permit the Trust Territories as well as the States to participate in the programs.

American Hospital Association
840 North Lake Shore Drive
Chicago, Illinois 60611
312-645-9561

Office of the Director

March 18, 1968

Dear Matt

I just wanted you to know how much I enjoyed having lunch with you, Lad and Lee at the Mayflower last week. I am as convinced as you are that we should continue this sort of thing until we can decide what best to do.

With best wishes,

Cordially

Edwin L. Crosby, M.D.
Director

Mr. Matthew F. McNulty Jr.
Director, COTH
Associate Director
Association of American Medical Colleges
1346 Connecticut Avenue, N.W.
Washington, D.C. 20036

American Hospital Association
840 North Lake Shore Drive
Chicago, Illinois 60611
312-645-9561

Office of the Director

May 6, 1968

Dear Matt

Thank you very much for inviting me to your upcoming meeting of the Executive Committee on May 9 and 10. I'm sorry I can't be there because it conflicts with the meeting of the Board of Trustees of the AHA.

I'm glad that Joe McNinch can be there to represent us. Please keep me posted.

Sincerely

Edwin L. Crosby, M.D.
Director

Matthew F. McNulty, Jr.
Director, COTH
Association of American Medical Colleges
1346 Connecticut Avenue, N.W.
Washington, D.C. 20036

American Hospital Association
840 NORTH LAKE SHORE DRIVE CHICAGO, ILLINOIS 60611
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STATEMENT ON THE FINANCIAL REQUIREMENTS OF HEALTH CARE INSTITUTIONS AND SERVICES

PART I

Approved by Board of Trustees
February 9, 1968

INDEX

FOREWORD

The development of the prepayment movement, the growth of private health insurance, and the increased participation by government in the financing of hospitals quickly made it essential that, if equity were to be attained and the community needs met, a set of principles of payment for hospital care had to be formulated and promulgated.

After long discussions and explorations with many related agencies, the American Hospital Association's House of Delegates approved the Principles of Payment for Hospital Care in 1953. The document proved of great value and was widely used. The Association kept the Principles of Payment under constant study and revised the document from time to time. In each instance, the revision was approved by the Association's House of Delegates. In 1965, a Statement on Reimbursement was approved by the Board of Trustees. In 1966, the Association developed a companion document, Principles of Payment for Home Health Services. It also began to work on a set of principles of payment for extended care services.

It then became apparent that an overall statement applicable to the financial needs of all types of health care institutions, including home health care services, should be prepared as a master document replacing the Principles of Payment for Hospital Care, the Principles of Payment for Home Health Services, and the Statement on Reimbursement.

This document, the Statement on the Financial Requirements of Health Care Institutions and Services, Part I, supersedes the aforementioned Principles of Payment and the Statement on Reimbursement. It does not include accounting references such as were found in these documents. These will be detailed in the forthcoming Part II of this statement. The accounting principles essential to the implementation of this Part I can be found in the American Hospital Association publications, Cost Finding for Hospitals, Chart of Accounts for Hospitals, and Uniform Hospital Definitions. Since several methods of payment for health care services involve charges as factors to be related to the method of payment, the American Hospital Association statement, Factors to Evaluate in the Establishment of Hospital Charges, is also a necessary reference to implementation of this statement.

CHAPTER I. FINANCING THE HEALTH CARE SYSTEM

Our health care system is more a complex than a system, a complex of institutions and services, sometimes integrated, sometimes fragmented. The sum of its total parts must be expressed in services to the people rather than in profits for shareholders. In order that this objective be reached, the system must guarantee that necessary services are provided to the public, effectively, efficiently and economically. The community has a right to expect hospitals and other health care institutions to cooperate to a maximum degree in meeting this primary objective. Health care institutions will be ultimately judged by their contributions to the welfare of the community through patient services, education, research, and community health projects. The public has a right to expect that the health care system accept the necessary coordination, self-discipline and controls to meet these ends.

The need for discipline in the health care system to assure delivery of high quality health care has a corollary: adequate financing for health care services and facilities. The delivery of high quality health care requires of itself a vast complex of professional services, institutions, allied health organizations and agencies, educational programs, research activities and community health projects. Similarly, the system has multiple sources of payment – self-pay patients, contracting agencies, private insurance, tax levies, governmental grants, donations, grants and endowments.

From these various sources must come adequate financing and financing that goes beyond just out-of-pocket expenses for operation. Payment for health services must also be sufficient to permit maintenance, expansion, and revisions and replacement of physical plant, and the conduct of educational and research programs having an acceptable approval. Further, the sources of financing must recognize that health care institutions as community service organizations must be financed at a level that recognizes the objectives of community service including health services for needy patients.

Health care institutions must act responsibly in developing multiple sources of income to meet the financial needs incurred in providing services. Community precedent and practice vary as to how the health care system is financed. Individual institutional needs will vary within areas and regions. The degree to which financial needs are met by the income from contracting agencies will be determined by negotiation. The degree to which financial needs are met by income from sources other than contracting agencies will depend upon community precedents, the operating philosophy, and the opportunities and initiative of the individual governing authority.

Community needs for health services will change as the community changes, through population shifts and through socio-economic movements. The services themselves will change as knowledge increases. Buildings and equipment are the more visible; but the dynamic features – people and knowledge – are by far the more important. As the health facilities and services must

be sensitive to changing times, so must the purchasers of health care. Changing patterns of benefits and varying methods of payment to provide incentives for appropriate use of the health care alternatives are essential.

Services and the organization of services, and facilities and the organization of facilities through such steps as mergers and closures, must change as the needs of the people and the capabilities of the system change. There is no virtue in change for change's sake alone. On the other hand, passivity in the face of needed change cannot preserve the status quo, it can but hobble the system's orderly progress. These points are pertinent to all elements of the system but especially to those that are charged with the orderly guidance of change, the planning agencies.

As can be seen from the above, all the organizations in the system – service, financing, planning – are increasingly interrelated and share the ultimate purpose of maintaining the highest standards of quality possible in the delivery of health care, guided by judicious use of available health care dollars.

This document does not spell out a single way to finance health care institutions and services, but rather identifies the elements of financial requirements, and sets guidelines for implementing financial resources to assure the public that its need for high quality care is being met at a price deserving its continual approval.

CHAPTER II. ELEMENTS OF FINANCIAL REQUIREMENTS

The purpose of this chapter is to delineate the elements of financial requirements of health care institutions that must be met if they are to maintain current economic stability. All of the elements apply to some institutions and some of the elements apply to all.

A. Current Operating Needs

1. Patient Care

   Expenses incurred in providing patient care, such as salaries and wages, employee fringe benefits, services and supplies, and other identifiable operating needs, excluding depreciation (see Chapter II, C, for discussion of funds for capital needs).

2. Interest

   A reasonable rate of interest on necessary and properly borrowed funds for operating cash purposes and plant capital needs.

3. Services of Members of Religious Orders

   The monetary value assigned to services donated by sisters or by other members of religious orders.

4. Educational Programs

   Expenses for educational programs having an acceptable approval.

5. Research Programs

   Expenses of approved and identifiable research programs directly related to patient care.

B. Revenue Losses

1. Credit Losses

   The unrecovered portion of expense attributable to care of patients who fail to fully meet the obligation incurred for services provided by health care institutions.

2. Patients Unable to Pay

   The unrecovered expenses incurred in providing services to patients who, because of inadequate financial resources, are relieved wholly or in part of financial responsibility for services received.

C. Capital Needs

Health care institutions must maintain their financial resources at a level that will enable them to:

- Plan and initiate new services and programs in support of advances in medical science and technology.
- Preserve and improve physical plant and equipment necessary to meet community need.

The capital needs of a health care institution must be continually evaluated by the nonprofit or governmental governing authority, or in the case of for-profit institutions, the owner or his representatives, in the context of the continuing place of the institution in the community's health system. A collaborative effort – governing authority or owner, administrator, medical staff, and planning agency – is essential for the best results.

It is often difficult to determine the level of financial resources required to meet capital needs. Yet if these financial resources are not available, the current and future economic stability of health care institutions and their continuing efforts to provide for the public's health care needs on a ready-to-serve basis will be imperiled.

1. Plant Capital

a. Preservation and Replacement of Plant and Equipment

The governing body of a health care institution must, legally and morally, protect all assets entrusted to its custody. Funds must be available, therefore, to finance projects involving plant capital assets that because of deterioration and obsolescence must be replaced in the best interest of the public's health care needs.

b. Improvement of Plant

Advances in medical science, and in the technology of delivering health care services, often require expenditures for new units of equipment and facilities. Such expenditures represent a different element than that of preservation and replacement of plant and equipment. Sufficient financial resources must be available for continued additional investment in the improvement of plant and equipment in order that health care institutions can keep pace with changes in the health care system.

c. Expansion

Health care institutions are expected to meet increased demands that result from population growth, discontinuance

of other existing services, and changes in the public's concept of the delivery of health care services. In order to be in a position to respond to the demands of increased community needs, health care institutions must anticipate their future growth patterns and plan for the needed expansion of their facilities. There must be assurance that adequate resources will be available to finance such individual programs, when consistent with comprehensive areawide planning.

d. Amortization of Plant Capital Indebtedness

Health care institutions increasingly use borrowed funds to meet plant capital needs. Prudent fiscal management requires health care institutions to provide sufficient resources so that funds can be specifically designated for the amortization of plant capital indebtedness.

2. Operating Cash Needs

Because of increases in operating expenses, the amount of operating cash required to meet fiscal obligations as they come due may be subject to frequent upward change. An adequate level of operating cash must be maintained so that excessive short-term borrowing, or improvident use of endowment funds can be avoided. A flow of funds adequate to maintain a viable cash position when operations change, expenses increase, or services are improved, is essential to current financial stability.

D. Return on Investment

Investors in for-profit health care institutions need a fair return on their investments.

CHAPTER III. IMPLEMENTATION

Chapter II delineated the elements of financial requirements of health care institutions. This chapter sets forth guidelines for meeting these financial requirements.

Because financial needs vary with the scope of operation, community service objectives, and many other factors, financial needs must be determined for each health care institution on an individual basis.

The absence of precision in the method of measurement of capital needs does not eliminate the institution's capital needs and the obligation of the contracting agencies to share in the responsibility of providing for these needs. Even when the agreement has been reached on measurement, the health care institution and contracting agencies may honestly differ on capital needs and operating needs. In such cases the extent to which these elements are to be recognized must be determined by negotiations carried out in a context of thoughtful evaluation of the role of the individual health care institution, within the health care system, in meeting community needs.

A. Current Operating Needs

1. Patient Care

Expenses involved in patient care services account for the major portion of the dollar volume necessary for the operation of health care institutions. The negotiations with contracting agencies should provide for payment in sufficient amounts to cover the expense of providing patient care contracted for in behalf of the agency's beneficiaries. Similarly, the rate established for self-pay patients should permit full recovery of such expenses.

As health care institutions have their greatest stake in proper payment for patient care services, so do contracting agencies have a correspondingly large stake in efficient management of the provision of such services. The health care institution must be in the position to demonstrate management concern with the most efficient method of delivery of these patient care services. Salaries, wages, and fringe benefits should be reasonably comparable, and demonstrably so, to community rates and practices or to other health care institutions in the area. The health care institution and the contracting agency have a responsibility to work out an equitable method of retroactive adjustment, where appropriate, to cover underpayments or overpayments during specified periods of time (see also Chapter IV, B.6).

2. Interest

The method of payment must include an allowance for reasonable interest expense arising from the use of funds borrowed for plant capital needs and operating cash purposes.

Reasonable interest is allowable on loans made from donor-restricted funds, monies funded for future capital needs, or the pension fund.

Income from invested operating funds, unrestricted endowment, gifts, and grants not assigned for specific purposes by their donors or the governing body should be used to reduce the interest expense on outside funds borrowed for plant capital purposes such as the acquisition of land and buildings, equipment, and capital improvements. This does not apply to funds borrowed for current operating cash needs, provided it can be demonstrated that the total amount and application of such borrowed funds is consistent with prudent fiscal management.

3. Services of Members of Religious Orders

The amount included as representing the value of the services donated by sisters or other members of religious orders should not exceed the amounts paid to other employees for similar work and should be identifiable as an operating expense in the records of the institution.

4. Educational Programs

Expenses arising from the conduct of educational programs having an acceptable approval should be met through tuition, scholarships, grants, or other community resources. However, the payment agreement should establish the responsibility of each contracting agency for its appropriate share of any demonstrable financial need created by the failure of the resources listed above to meet the full amount of the expense of conducting approved and accredited educational programs.

5. Research Programs

Revenue generated from services provided to patients should not be the primary source of funds to support research programs. Primary support for research should come from endowments, gifts, grants, or other community resources. However, it must be recognized that any remaining portion of the expenses arising from research directly relating to patient care, not fully underwritten by funds obtained from endowments, gifts, grants, or other community resources, represent a financial need. Therefore, the payment agreement should establish the responsibility of each contracting agency for its appropriate share of this unmet financial need.

B. Revenue Losses

1. Credit Losses

The payment agreement should establish, in conformance with local conditions, the responsibility of each contracting agency for its

appropriate share of unrecovered expense arising from credit losses. Determination of responsibility for an appropriate share should be guided by the following criteria:

a. A policy has been established by the governing authority of the institution dealing with the handling of credit and collections. Such policy should set forth the collection procedure to be followed, including the aging of accounts and a definition of the time interval at which an account shall be ruled uncollectible.

b. Diligent efforts have been made to apply and maintain the established collection procedure.

2. Patients Unable to Pay

Each contracting agency should assume, in conformance with local conditions, its appropriate share of the unrecovered expense of providing services to patients who have been relieved in part, or in whole, of financial responsibility for those services, but only to the extent that it is not being met by funds available from other designated resources.

C. Capital Needs

As stated in Chapter II, C, the capital needs of a health care institution must be continually evaluated by the nonprofit or governmental governing authority, or in the case of for-profit institutions, the owner or his representatives, in the context of the continuing place of the institution in the community's health system. A collaborative effort – governing authority or owner, administrator, medical staff, and planning agency – is essential for the best result.

1. Plant Capital

The method of payment must reflect the financial requirements of health care institutions for preservation and replacement of plant, equipment and services; improvement of plant; and expansion of plant and equipment. In the ordinary course of private enterprise these requirements are met by available funds generated from operation through the pricing structure, or by borrowing funds and repaying from operating revenue. Excessive expenditure or accumulation are controlled through active competition in the marketplace. The health care system has its own controls and competitive forces, but is not subject to the marketplace to the same degree as the rest of the private enterprise system. A major problem in the health care service field is how to distribute the dollars available for supporting plant capital needs to those health care institutions that should modernize, improve and expand, and withhold support from those who should not. In the light of rapidly rising costs and increasing public sophistication, the issue cannot be ignored.

Initially health care institutions generated plant capital largely through benevolences, operating income or tax levies. Since World War II, contracting agencies have gradually incorporated factors in their payments that were designed to offset depreciation and support growth and development. With the accelerating incidence of prepayment, these factors have increasingly become a primary subject of negotiation. Health care institutions have sought to broaden the factors relating to plant capital needs. Contracting agencies, in the absence of effective areawide planning mechanisms, have moved cautiously in meeting the demands for greater support of plant capital needs, but have done so impartially among individual health care institutions.

The following method of financing plant fund capital by contracting agencies is offered as a means of coupling the payment and planning processes so that they reinforce one another.

a. The method of payment would include an appropriate share of an amount that, when funded, would be sufficient to provide each institution with a revolving fund to meet the ongoing costs incurred by the institutions for equipment (Types I and II, Hill-Harris). This fund would finance adequately the purchase of necessary equipment at existing price levels.

b. The method of payment would include an amount representing the contracting agency's appropriate share of the payment required for the amortization of existing capital indebtedness.

c. The method of payment would include an arrangement whereby the contracting agency agrees to pay its appropriate share of the funds the health care institution needs to provide* for the acquisition of land, replacement of buildings, expansion of plant, equipment and services. The arrangement should be consistent with community precedent of financing, including the use of philanthropic resources, government tax resources, or other financing resources (gifts, legacies, and bequests). Endorsement of the project(s) by the areawide planning agency having jurisdiction over the area served by the health care institution must be obtained before contracting agencies make such payments. Further, payments made under such arrangements in excess of current expenditure for these purposes must be funded by the institution.

When the institution and contracting agency agree to finance capital needs by the method enunciated in (a), (b), and (c) above, each of such capital items must be identifiable in the accounting records of the health care institution.

It is recognized that, at least during a transitional period, individual institutions may elect, with the mutual agreement of contracting agencies, to be paid on the current negotiated basis,

*"Provide" in this sense permits prospective accumulation of construction funds or retrospective payments to amortize debt.

including use of depreciation. When such an alternative is used, the payment for capital needs should be consistent with planning principles established for the community.

Under all methods of payment for plant capital financing, the institution should be encouraged to appeal directly to the local community for philanthropic support.

2. Operating Cash Needs

The method of payment must meet operating cash needs by:

a. Assuring a rapid flow of the cash paid for services provided to beneficiaries of contracting agencies.

b. Providing a cash advance when the need for such has been demonstrated as essential for prudent financial management.

c. Providing for a one-time supplemental advance to compensate for the lag between the time an expense is incurred, a billing is submitted, and payment received. This lag time should be reviewed periodically and the supplemental advance adjusted to reflect any change that has taken place.

D. Return on Investment

The method of payment should provide for a reasonable return on investment of for-profit health care institutions. The return should bear a reasonable and fair relationship to the degree to which the capital needs of nonprofit institutions are met.

For-profit institutions must be subject to the same planning disciplines as nonprofit institutions and the return on investment of such for-profit institutions should reflect the degree of consistency with planning.

E. Income from Sources Other Than Patients

1. Restricted Endowment Funds or Gifts

Income from endowment funds or gifts restricted by donors to use for the care of specific groups of patients should be used to reduce the cost of providing services to such patients.

2. Income from Invested Operating Funds, Unrestricted Funds and Gifts, and Nonpatient Services

Except as stipulated in Chapter III, A.2, income from invested operating funds, from general endowment funds, from unrestricted gifts, or from nonpatient services should not be used to reduce the payment made by contracting agencies.

3. Special Income

Income received to cover specific projects or salaries paid to special employees should be deducted from expenses before determining the amount of payment to be made by contracting agencies.

F. Method of Payment

The merits of any method of payment should be judged on the basis of public accountability, provider equity, simplicity, ease of administration, economy of implementation, and its ability to react to current conditions and to provide a rapid flow of funds from purchaser to provider.

The application of any method of payment must be preceded by justification of the individual health care institution's financial needs in a manner mutually acceptable to provider and purchaser. Such justification includes (a) the application of accepted accounting techniques, (b) development of short-range and long-range planning objectives, and (c) endorsement of such objectives by the planning agency in the area in which the health care institution operates.

The financial stability of a health care institution may be jeopardized if contracting agencies apply differing methods of payment within an individual institution. Several methods of payment are employed by contracting agencies, e.g., charge-based, average per diem, ratio of charges applied to costs, inclusive rate, per capita, increment payments based on a pre-approved budget, and varying combinations of the foregoing. Practices vary by sections of the country and by contracting agencies. Ordinarily, the method involved is arrived at after extensive negotiation between the providers and the agency. As a result, some of the apparent differences among these methods are minimized. However, health care institutions should be protected against the selective application of various methods by various contracting agencies, resulting in the institution's inability to obtain appropriate payment for the sum of the services for which these agencies are cumulatively responsible.

In addition, the method of payment should be designed to provide incentives for sound and efficient management practices. The incentives built into the method of payment must be keyed sensitively to other incentive forces, such as accreditation and planning.

Another important element in the design of the agreement negotiated with a contracting agency is that it cover a broad range of ambulatory and inpatient services. Restrictions in coverage, for example, exclusion of ambulatory services, may lead to higher costs to the public for health care and limit the availability of a comprehensive continuum of health care benefits.

The agreement should achieve a sensitive balance that protects the equity of contracting agencies and preserves the rights of management.

If a hospital's costs depart substantially from other hospitals of similar size, scope of services and utilization, maximum reimbursement may be established through agreement reached between third-party purchasers and hospitals. It should be recognized that variation in hospital cost may be attributed to a variety of circumstances and, therefore, decisions as to whether a cost is unreasonable or not become a matter of judgment. To assure a maximum degree of equity, hospitals subjected to such judgments should be provided an opportunity to have their situation reviewed and evaluated through an established review procedure.

The agreement should avoid contractual complexities that add measurably to the administrative expense of health care institutions. It is absurd when complexities of a method of payment produce an administrative expense greater than the cost of providing the health care service itself.

Currently, no one method has emerged that combines the strengths and eliminates the weaknesses of all the others. The health care institution and the contracting agency should conduct ongoing analyses of the effect of the methods of payment on the institution and the agency.

CHAPTER IV. OBLIGATIONS AND RESPONSIBILITIES

Health care institutions and the agencies that purchase their services occupy, to some degree, opposing positions in the continuing process of balancing provider and consumer interests. It must be recognized, however, that if even differing points of view are discussed within an atmosphere of mutual regard, the result is bound to be more satisfactory than one fashioned in an atmosphere of outright antagonism. It is important to acknowledge that provider and purchaser have a strong tie and both have community obligations that override the self-serving interests of the institution and/or the agency. In this chapter the obligations and responsibilities of each, separately and jointly, to the community they serve are set forth.

A. Health Care Institutions

1. Standards of Care

Health care institutions must demonstrate their willingness to provide acceptable standards of service by meeting the requirements for accreditation, as set forth by the Joint Commission on Accreditation of Hospitals and other appropriate professional groups.

2. Utilization Review

It is the joint responsibility of health care institutions and their medical staffs to monitor the utilization of patient care services. Their objectives should be the efficient and effective production of health care services while maintaining or upgrading the quality of those services.

3. Health Education

Health care institutions should, by individual and group action, conduct continuing community service programs designed to educate the public how to keep well and how to use health care facilities so as to maintain a maximum level of health at the minimum expenditure of health care dollars, consistent with this objective.

4. Development and Promotion of Joint Programs

Health care institutions must seek the most economical, efficient, and effective way of delivering their services. Whenever possible, they should organize in sectional or regional groups so that they can participate in the development and promotion of joint programs for improved methods of delivering their services. Such methods include, but are not limited to, group purchasing, shared laundry, shared computer facilities, and continuing experimentation with methods and systems.

5. Self-Analysis

Health care institutions should strive for higher levels of performance through a continuing program of self-analysis. Management consultants and methods' engineers are effective tools in the process of self-analysis. Participation in such endeavors as the Hospital Administrative Services Program and Cost Allocation Program sponsored by the American Hospital Association will assist the institution to upgrade management by comparative analyses and cost appraisals.

6. Audit and Public Disclosure

Every health care institution has an obligation to disclose to the public evidence that all its funds are being effectively utilized or retained, in accordance with its stated purpose of operation.

Such disclosure will be deemed to have been made if the evidence is made available on request to patients, their contracting agency, their benefactors, and others with a legitimate interest in this information. The financial statements necessary to support the evidence should be prepared in accordance with accepted accounting principles consistently applied, and should be accompanied by the stated opinion of an independent certified public accountant as to their adequacy.

7. Short-Range Planning Requirements

In order to justify its working capital needs, each health care institution should prepare a formal statement setting forth its management and service objectives for the coming fiscal year. Supporting these objectives should be a time schedule for their implementation, an estimate of the amount of the funds required to finance their implementation and the anticipated sources of these funds.

8. Long-Range Planning Requirements

Each health care institution should maintain a master plan detailing the future growth and development of its facilities and services. This master plan must be coordinated with the overall plan for health care services and facilities endorsed by the existing areawide planning agency having jurisdiction over the area in which the health care institution is located. This master plan should be supported by a time schedule for its implementation, an estimate of the capital outlay required for its completion, and a projection of the possible source of the funds required to finance its implementation.

9. Verification of Cost Data

Health care institutions receiving payment on the basis of agreements designed to meet their financial needs should provide accurate and audited cost data, capable of verification by those contracting agencies with whom they have such agreements.

B. Contracting Agencies

1. Development of Broad Benefit Coverages

Contracting agencies should accelerate their exploration and development of the ways and means of making available to their beneficiaries the broadest spectrum of health care benefits possible, covering both inpatient and ambulatory and home health care needs.

2. Promotion of Broad Benefit Coverages

Contracting agencies should conduct continuing educational programs designed to encourage the public to increase that portion of its income set aside to prepay its health care needs, until the optimal level of prepaid health care benefits has been reached.

3. Beneficiary Responsibility

Contracting agencies should develop the most effective methods of consistently advising their beneficiaries of their role in the judicious use of health care facilities and the essentiality of public cooperation in acceptance of this role to the conservation of the health care dollar.

4. Effective Administration

Contracting agencies should explore, develop, and exploit every possible management system to improve their administration to maximize the use of the health care dollars for the purchase of health care services.

5. Public Disclosure

Contracting agencies have an obligation to disclose to the public evidence that all its funds are being effectively utilized or retained in accordance with their stated purpose of operation.

6. Current Payment and Retroactive Adjustment

Contracting agencies purchasing services provided by a health care institution should include in their method of reimbursement a system that will assure an adequate flow of cash to cover the

time lag between the date when the institution pays for salaries, supplies, and services, and the date when payment is received on services rendered to beneficiaries of the contracting agencies. In addition, the amounts paid by contracting agencies should be based on the total financial needs of the institution as defined for the period in which the services were provided and purchased. It should also be recognized that the method of payment may require that the payment of a retroactive adjustment be made by either the health care institution or the contracting agency.

7. Modification or Reduction in Payment

a. Contracting agencies may modify or reduce payments to non-cooperating and non-accredited health care institutions after adequate notification of such intent.

b. Contracting agencies may modify or reduce payments to health care institutions that have carried out expansion and improvement projects that disregard the recommendations of a comprehensive areawide planning agency after adequate notification of such intent.

C. Joint Obligations of Health Care Institutions and the Contracting Agencies

1. Incentive Programs

Health care institutions and the contracting agencies that purchase their services should cooperatively develop incentive programs that will motivate the institutions to deliver their services as efficiently and economically as possible. Such programs should be designed to punish inefficient operation or lower standards of performance and to reward efficient and economical operation and high standards of performance.

2. Mutual Agreement

The method and amount of payment to health care institutions by contracting agencies should be established by mutual agreement of the parties concerned and should be based on this Statement on the Financial Requirements of Health Care Institutions and Services, Part I.

3. Mutual Availability of Fiscal and Statistical Data

There is a mutual responsibility on the part of health care institutions and contracting agencies that purchase their services to make available, upon request, fiscal and administrative statistics and data necessary for a continuing agreement on the amount of payment and services provided.

GLOSSARY OF TERMS

Areawide Comprehensive Health Planning Agency -

An agency with representation from health professionals, health institutions, and a majority of consumers that provides assistance in planning, recommends goals and planning methods, provides areawide information, and works with other planning agencies, such as city planners, in the area to assure the availability of optimum health services.

Benefits -

Those health care services that a contracting agency or insurance company has agreed, under certain terms and conditions, to purchase for its beneficiaries.

Capital Needs -

The financial support and resources necessary for health care institutions to plan and initiate new services and programs, and to preserve, improve, and expand physical plant and equipment.

Contracting Agencies -

Those organizations or agencies that purchase, in whole or in part, health care services provided to their subscribers, or beneficiaries, by health care institutions with which the agency has a formal or implied contract.

/Included within the definition of contracting agencies as used in this statement are voluntary nonprofit prepayment health service plans, governmental agencies, voluntary nonprofit social and welfare agencies and nonprofit comprehensive health service programs./

Current Operating Needs -

The expenses of maintaining the day-to-day functions and activities of a health care institution that must be met by a current flow of revenue.

Donated Services -

Services donated by sisters or by other members of religious orders. Our use of this term specifically excludes the services of volunteer workers serving the health care institution as individuals or through organized groups.

Equipment -

Fixed, major movable and other items of equipment included as plant assets and whose acquisition cost must be capitalized.

Expenses -

Expired costs, including those proportionate costs of plant assets that are currently utilized in meeting community health service objectives.

Financial Needs -

The total resources necessary for maintaining the financial stability of a health care institution as it carries out its community service objectives and, in the case of for-profit institutions, a reasonable return on investment.

Formula -

Statement of components of financial needs to be recognized for reimbursement.

Governing Authority -

The governing board of a not-for-profit or for-profit health care institution, the owners or individual owner of a health care institution, a governmental agency or bureau who have charge, control and management of the property, affairs, and funds of health care institutions.

Health Care Institutions -

All nongovernmental and governmental establishments with permanent facilities and with medical services for patients (such as hospitals, extended care institutions, nursing care institutions, and institutions providing outpatient or home care services). These are the institutions defined as "medical care institutions" in the document, Classification of Health Care Institutions.

Interest -

Charge made for borrowed money.

Loss -

(1) The excess of all expenses over revenues for a fiscal period, or (2) the excess of all or the appropriate portion of the cost of assets over related proceeds, if any, when the items are sold, abandoned, or either wholly or partially destroyed by casualty or otherwise written off. Losses of type (2) are analogous to the use of the term "expenses" in this statement and may be deducted from revenues in the income statement.

Master Plan -

The term "master plan" is used to designate the institution's plan and program to maintain its service program for the community. An institution's master plan should be comprehensive, well documented, and approved by the governing authority. The plan should be reviewed at regularly scheduled intervals and updated as necessary. Implementation of the plan, i.e., expansion of services and bed capacity of the institution, should be reviewed with the local areawide planning agency and implementation should be made in line with community requirements for health services.

Method of Payment -

The method of payment is the system by which contracting agencies utilize the formula to reimburse health care institutions for services provided.

Operating Cash Needs -

The amount of cash that must be available to finance current operating expenditures.

Plant Capital -

Buildings and equipment necessary to produce health care services.

Reimbursement -

The amount paid to health care institutions for purchased services.

Return on Investment (Profit) -

Compensation, other than wages or rent, accruing to investors in a health care institution organized on a for-profit basis.

Revenue Losses -

The excess of operating expenses over collectible patient revenue for a fiscal period.

Special Income -

Excess of revenue over expense from such sources as earnings from equipment rentals, vending machines, snack bars, gift shops, parking lots, meal service, medical record transcripts, radio and television rentals, etc.

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COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
MEMORIAL

A. J. "GUS" CARROLL

WHEREAS: A. J. "Gus" Carroll has been an outstanding member of the staff of the Association of American Medical Colleges; and,

WHEREAS: He has made notable contributions to the field of fiscal management for both medical schools and teaching hospitals, including a number of important studies for the AAMC; and

WHEREAS: His interest in the financing of medical education was exhibited through his many efforts to improve the financial structure of these institutions engaged in medical education; and,

WHEREAS: He was a distinguished colleague and a warm friend who was greatly esteemed by all of his associates from the Council of Teaching Hospitals; therefore,

BE IT RESOLVED:
That the Executive Committee of the Council of Teaching Hospitals, Association of American Medical Colleges on behalf of all of teaching hospital member administrators, note with deepest regret the death of A. J. "Gus" Carroll and wish to commemorate his work as a memorial to his life, while also expressing to Mrs. A. J. Carroll, the deepest of sympathy on her loss. The Executive Committee instructs the staff of the Council of Teaching Hospitals to formally express to Mrs. Carroll through this resolution the profound sympathy from the membership of the Council of Teaching Hospitals.

COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
1346 Connecticut Avenue, N.W.
Washington, D.C. 20036
202/223-5364

MEETING OF COTH WESTERN REGIONAL MEMBERSHIP
Sheraton-Thunderbolt Hotel
San Francisco, California
April 4, 1968
10:00 a.m. - 4:00 p.m.

A G E N D A

I. Purpose of COTH Regional Meetings

A. Report to Membership

B. Exposing for Discussion and Evaluation Subject Matter of Current Pertinence

C. Learning of New Developments in Program Subject Matter and/or Reorientation of Emphasis on Program Subject Matter

D. Opportunity for Exchange of Ideas, Experiences and Institutional Development Possibilities Among Hospital Directors with Common Purposes and Responsibilities

II. Report on Continued Development of "Partnership" within the AAMC

A. Participation in Accreditation Surveys

B. COTH Membership on AAMC Executive Council

III. Report on Various Items Regarding the Financing of the Activities of Teaching Hospitals

A. A.J. Carroll, Yale-New Haven Study

B. AAMC-DHEW Program Cost Information Study

C. COTH Committee on Financial Principles

D. Financing House Staff Stipends

E. Physician Payment under Title XIX

F. Payment to Hospital-Based Physicians under XVIII

G. I.R.S. Ruling on Pharmacy Sale of Over-the-Counter Drugs

H. Nonprofit Joint Enterprises

IV. COTH Committee on Modernization and Construction Funds for Teaching Hospitals

V. COTH Representation Activities in the Public and Private Sectors

A. Private Sector

1. COTH-AHA Officers' Meetings
2. Brookings Institution
3. AMA
4. Need for Additional Representation Activities at Federal and Local Levels

B. Public Sector

1. Impending Health Legislation
2. Impending Congressional Investigations

VI. President's Health Message

VII. In-Faculty Group Practice

VIII. JCAH Position Concerning Medical School Externships

IX. Other Business

X. Date of Next Meeting

XI. Adjournment: 4:00 p.m.

COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
1346 Connecticut Avenue, N.W.
Washington, D.C. 20036
202/223-5364

MEETING OF COTH MIDWEST-GREAT PLAINS REGIONAL MEMBERSHIP
O'HARE INN
CHICAGO, ILLINOIS
APRIL 19, 1968
10:00 a.m. - 4:00 p.m.

SUGGESTED AGENDA

I. Call to Order - 10:00 a.m. - Mr. Charles R. Goulet, Member, COTH Executive Committee

II. Welcome, Mr. Stanley A. Ferguson, Immediate Past Chairman, COTH

III. Report to Membership - Mr. Matthew F. McNulty, Jr., Director, COTH

A. Continued Development of "Partnership" with the AAMC

1. COTH Participation in Accreditation Survey
2. COTH Membership on AAMC Executive Council

B. Possible Reorganization of the AAMC

C. Activity of COTH Committees

1. Committee on Financial Principles
2. Committee on Modernization and Construction Funds for Teaching Hospitals

IV. JCAH Position Concerning Medical School Externships

V. Report On Various Items Regarding the Financing of Teaching Hospitals

A. Studies in Progress - Thomas J. Campbell, Assistant Director, AAMC Division of Operational Studies

1. A. J. Carroll, Yale-New Haven Study
2. AAMC-DHEW Cost Information Study

B. Financing House Staff Stipends

C. P.L. 89-97, Titles XVIII & XIX

1. For Those States That Do Not Yet Have an Enabling Act for Medicaid, What Opportunities Exist for Appropriate Legislation to Protect the Interests of Teaching Hospitals

2. Physician Payment Under Title XIX
3. Payment to Hospital - Based Physicians Under Title XVIII
4. In-Faculty Group Practice

D. Budgetary Problems for Those Hospitals with Clinical Research Centers

E. I.R.S. Ruling on Pharmacy Sale of Drugs

F. Nonprofit Joint Enterprises

VI. COTH Representation Activities in the Public and Private Sectors

A. Private Sector

1. COTH-AHA Officers' Meeting
2. Brookings Institution
3. American Medical Association

B. Public Sector

1. President's Health Message and Resulting Legislation Introduced
2. Other Impending Health Legislation
3. Impending Congressional Investigations and Possible Effects on Teaching Hospitals
4. Health Related Activities of Federal Agencies Other Than DHEW
5. Need for Additional Representation at Federal and Local Levels

VII. Other Business

VIII. Date of Next Meeting

IX. Adjournment: 4:00 p.m.

Ernest N. Boettcher, M.D., Member, COTH Executive Committee will serve as chairman following the luncheon break.

COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
1346 Connecticut Avenue, N.W.
Washington, D.C. 20036
202/223-5364

MEETING OF COTH NORTHEAST REGIONAL MEMBERSHIP
NEW YORK UNIVERSITY MEDICAL CENTER
NEW YORK, NEW YORK
THURSDAY, APRIL 25, 1968
10:00 a.m. - 4:00 p.m.

SUGGESTED AGENDA

I. Call to Order - 10:00 a.m. - Mr. Lester E. Richwagen, Member, COTH Executive Committee

II. Greetings from COTH, Mr. Lad F. Grapski, Chairman, COTH

III. Greetings from New York University Medical Center, Mr. Irvin G. Wilmot, Associate Director for Hospitals and Health Services.

IV. Report to Membership - Mr. Matthew F. McNulty, Jr., Director, COTH

A. Continued Development of "Partnership" with the AAMC

1. COTH Participation in Accreditation Survey
2. COTH Membership on AAMC Executive Council

B. Possible Reorganization of the AAMC

C. Activity of COTH Committees

1. Committee on Financial Principles
2. Committee on Modernization and Construction Funds for Teaching Hospitals

V. Report On Various Items Regarding the Financing of Teaching Hospitals

A. Studies in Progress - Thomas J. Campbell, Assistant Director, Division of Operational Studies, AAMC

1. A. J. Carroll, Yale-New Haven Study
2. AAMC-DHEW Cost Information Study

B. Financing House Staff Stipends

C. P.L. 89-97, Titles XVIII & XIX

1. Physician Payment Under Title XIX
2. Payment to Hospital - Based Physicians Under Title XVIII
3. In-Faculty Group Practice

D. Budgetary Problems for Those Hospitals with Clinical Research Centers

E. I.R.S. Ruling on Pharmacy Sale of Drugs

F. Nonprofit Joint Enterprises

VI. Physician Representation on Teaching Hospital Boards' of Trustees

VII. COTH Representation Activities in the Public and Private Sectors

A. Private Sector

1. COTH-AHA Officers' Meeting
2. Brookings Institution
3. American Medical Association

B. Public Sector

1. President's Health Message and Resulting Legislation Introduced
2. Other Impending Health Legislation
3. Impending Congressional Investigations and Possible Effects on Teaching Hospitals
4. Health Related Activities of Federal Agencies Other Than DHEW
5. Need for Additional Representation at Federal and Local Levels

VIII. JCAH Position Regarding Medical School Externships

IX. Other Business

X. Date of Next Meeting

XI. Adjournment: 4:00 p.m.

Mr. Dan J. Macer, Member, COTH Executive Committee will serve as chairman following the luncheon break.

COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
1346 Connecticut Avenue, N.W.
Washington, D.C. 20036
202/223-5364

MEETING OF COTH SOUTHERN REGIONAL MEMBERSHIP
TERRACE ROOM -- HILTON INN
ALTANTA AIRPORT
APRIL 30, 1968
10:00 a.m. - 4:00 p.m.

SUGGESTED AGENDA

I. Call to Order - 10:00 a.m. - Mr. Charles H. Frenzel, Member, COTH Executive Committee

II. Greetings from Southeastern Hospital Conference, Mr. Walter W. Diggs (Administrator, Eugene Talmadge Memorial Hospital, Augusta, Georgia)

III. Report to Membership - Mr. Matthew F. McNulty, Jr., Director, COTH, Associate Director, AAMC

A. Continued Development of "Partnership" with the AAMC

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4. Health Related Activities of Federal Agencies Other Than DHEW
5. Need for Additional Representation at Federal and Local Levels

VII. JCAH Position Regarding Medical School Externships

VIII. Other Business

IX. Date of Next Meeting

X. Adjournment: 4:00 p.m.

Mr. Henry A. Swicegood, Acting Administrator, University of Texas Medical Branch Hospital, Galveston, will serve as chairman following the luncheon break.

COUNCIL OF TEACHING HOSPITALS
Southern Regional Meeting
Atlanta, Georgia
April 30, 1968

MOTION:

I would like to suggest that those meeting petition the Executive Committee, recognizing their concern for and interest in postgraduate medical education, to meet to analyze and define the appropriate role of internship and residency for patient service and education; and have observers from other appropriate bodies such as the AHA and the AMA. And that out of such study a definition would come that would define the standpoint of COTH and the AAMC, and have the definition as a basis for discussion with others. The definition and leadership should come from this body so that there is not a vacuum and the definition does not come from the Federal government or the IRS.

Made by -- William S. Coppage, Jr., M.D.
Chief of Staff
Veterans Administration Hospital
Nashville, Tennessee

Seconded

Carried by vote of 8 to 5

COMMITTEE OF INTERNS AND RESIDENTS OF THE NEW YORK MUNICIPAL HOSPITALS
401 BROADWAY, NEW YORK, N. Y. 10013

REFERRED TO _____

April 17, 1968

Mr. Herbert Haber
Director of Labor Relations
City of New York
250 Broadway
New York, N. Y. 10007

Dear Mr. Haber:

As you are undoubtedly aware, the Committee of Interns and Residents has notified the Commissioner of Hospitals and the Office of Collective Bargaining of the CIR's desire to commence negotiations for a contract period following June 30, 1968. We think that the contemplated negotiations would be facilitated if, at this time, we indicated to you the demands which will be made in such negotiations. Those demands include the following:

1. The following annual salaries:

Interns	$12,000
1st Yr. Residents	13,000
2nd Yr. Residents	14,000
3rd Yr. Residents	15,000
4th Yr. Residents	16,000
5th Yr. Residents	17,000
6th Yr. Residents	18,000
Chief Residents	Add $1,000 to salary otherwise payable

2. A living-out allowance of $1,800 per annum for House Staff members who do not avail themselves of a residence facility at the hospital.

3. A City contribution of $125 per annum to the CIR welfare fund for each House Staff member on the New York City Payroll.

4. A continuation of the following existing House Staff benefits: hospital meals, uniforms, laundry, and provision at the hospital for storage space for each House Staff member for books and clothing and sleeping facilities for House Staff member while on call.

5. Provision of the following in addition to existing security guards:

a. One (1) police officer, 24 hours per day, at each municipal hospital; and

b. An additional police officer, 24 hours per day, at each municipal hospital with psychiatric admissions.

6. Unlimited sick leave.

7. Provision for out-of-hospital living facilities at reasonable rentals for House Staff members who desire to live out.

8. The establishment of appropriate grievance procedure.

9. Ten (10%) per cent night differential.

10. Provision for para-medical teams in each of the municipal hospitals to perform the following procedures:

a. Blood teams for the testing of blood;

b. EKG teams for the taking of electrocardiograms and

c. Intravenous teams.

11. Provision for a central stenographic pool at each municipal hospital for the purpose of transcribing reports prepared by House Staff members.

12. Adequate increase in the number of out-patient clinic clerks for the maintenance of patient records.

13. Adequate increase in the number of ward clerks for the purpose of preparing laboratory slips for the taking of blood tests, EKG's, etc.

14. The creation of a study group comprised of representatives of the Department of Hospitals and the CIR to study and report on a plan for the computerization of record keeping within the municipal hospitals.

15. The incorporation of the terms of any collective bargaining agreement in a written contract.

This will also confirm my earlier advice to you that the CIR will request joint bargaining with the City and with representatives of the voluntary hospitals which have affiliation contracts for the operation of municipal hospitals. I am enclosing herewith a copy of a letter which we are sending today to those voluntary hospitals with affiliation contracts for the operation of municipal hospitals where the CIR represents a substantial portion of the House Staff. We are requesting your cooperation in obtaining the consent of such voluntary hospitals to participate in joint collective bargaining on the demands contained herein.

Pursuant to Rule 3.2 of the Rules of the Office of Collective Bargaining, collective bargaining should commence within ten (10) days of the receipt of our notice of an

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

ANNUAL MEETING

Thursday, October 31, 1968 - Monday, November 4, 1968
Shamrock Hilton Hotel
Houston, Texas

"MEDICAL EDUCATION AND PHYSICIAN MANPOWER"

Bates

Hospital Effectiveness

Rombert

what should teaching hospitals leadership the [illegible] about cost

Tragic [illegible] of teaching programs and influence of comprehensive health planning — (Maier to write)

People to write

THURSDAY, OCTOBER 31, 1968

1:30 - 5:00 PM	Business Fiscal Officers
1:30 - 5:00 PM	Continuation Education
1:30 - 5:00 PM	Society of Teachers of Family Medicine
1:30 - 5:00 PM	GAS - Northeast Regional Group
1:30 - 5:00 PM	Liaison Officers for International Activities
2:00 - 4:00 PM	COTH Executive Committee
6:00 - 8:00 PM	COTH Reception

FRIDAY, NOVEMBER 1, 1968

Plenary Session 9:00 - 12:30 PM

THE ISSUES

9:00 AM	The National Problem (Cohen)
9:45 AM	The State and Community (Dennis)
10:30 AM	The International Problem (Valesquez)
11:00 - 11:30 AM	Presidential Address (Parks)
12:30 - 1:45 PM	COTH Luncheon
2:00 - 5:00 PM	COTH - General Session

POSSIBLE SPEAKERS FOR ANNUAL MEETING

Teaching Hospitals In The Urban Environment	Paul N. Ylvisaker James A. Campbell, M.D.
Hospital ~~Merger~~ Consolidations	Ray E. Brown Ernest C. Shortliffe, M.D.
Manpower	James H. Shannon, M.D. William L. Kissick, M.D.
New Responsibilities In The Federal Government For Health Care	Robert Q. Marston, M.D.
Government Studies Affecting the Hospital	John A. Barr Boisfeuillet Jones
5:15 - 5:45 PM	COTH Nominating Committee - Committee Available to Receive any Nominations from Members
6:00 - 8:00 PM	GSA Social Hour

SATURDAY, NOVEMBER 2, 1968

Plenary Session 9:00 - 12:30 PM

THE SPECIFIC PROBLEMS

9:00 AM	Increased Number or Discrimination (Dr. John Knowles)

9:45 AM	Specific Needs for Medical Manpower A. Panel Presentation - Moderator (Dr. Robert Glaser) 1. Primary Physicians (Willard) 2. Deprived Areas (Dr. Martin Cherkasky) 3. Faculty (Dr. William B. Castle)
11:00 - 11:30 AM	Break - Exhibits and Coffee
11:30 AM	Allan Gregg Lecture (Mr. John Russell)
12:30 - 1:00 PM	COTH Nominating Committee - Committee Available to Receive Nominations for the Members
1:30 - 5:00 PM	COTH - Discussion Group 1 COTH - Discussion Group 2 COTH - Discussion Group 3 COTH - Discussion Group 4

President's Reception
Annual Banquet
Borden Award

SUNDAY, NOVEMBER 3, 1968

Plenary Session 9:00 - 12:30 PM

WHAT CAN BE DONE NOW?

9:00 - 10:00 AM	What Can Be Done Now? (Dr. William Hubbard)
10:00 - 10:30 AM	Break - Exhibits and Coffee
10:30 - 12:30 PM	Panels

I. Physicians for Deprived Areas: Do We Need a Different Reward System?
Moderator - Dr. Roger Egeberg

II. Factors or Barriers Involved in Student Selection for the Study of Medicine
Moderator - Dr. John Caughey

III. Production of Teachers: The of All Schools or a Few Selected Schools
Moderator - Dr. Sherman Milinkoff

IV. Student and Faculty Attitudes Toward Early Career Commitment
Moderator - Dr. Robert Ebert

V. Can the Formal Education of the Physician Be Shortened?
Moderator - Dr. Carleton Chapman

VI. Need for Physicians: Numbers, Redistribution, or Better Utilization
Moderator - Dr. David Greeley

SUNDAY, NOVEMBER 3, 1968 (Continued)

2:00 - 4:00 PM Panels

VII. Will Curriculum Changes Affect Career Choices: Fact or Fancy
Moderator - Dr. John Hogness

VIII. Should Practice Models Be Part of the Curriculum?
Moderator - Dr. Leon Jacobsen

IX. Student Opinions of the Present Medical Curriculum
Moderator - Dr. Harry H. Gordon

X. Training and Distribution of Specialists Local or National Policy
Moderator - Dr. Julium Richmond Parks

XI. The Foreign Medical Graduate: Responsibilities and Liabilities
Moderator - Dr. Dwight Wilbur

XII. International Medicine: Responsibility and Problems
Moderator - Dr. Thomas Hunter

MONDAY, NOVEMBER 4, 1968

Plenary Session 9:00 - 12:00 AM

Reports of Conclusions and Recommendations From Panels by Panel Moderators

1:30 - 5:00 PM Institutional Membership Meeting
1:30 - 5:00 PM COTH - Business Meeting

May 7, 1968

Angelo P. Angelides, M.D.
President
Association of Hospital Directors of
Medical Education
The Lankenau Hospital
Lancaster and City Line Avenues
Philadelphia, Pennsylvania 19151

Dear Angelo:

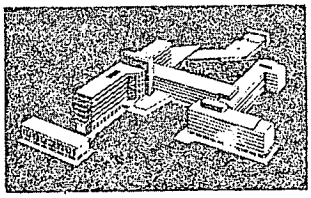
Thank you for your letter of April 24, and the enclosed position paper on the AAMC and AHDME. A series of out-of-town commitments has necessitated this late acknowledgment.

We will be having a meeting of the COTH Executive Committee on Thursday and Friday, May 9th and 10th, and this item will appear on the agenda. I will, of course, be in touch with you after this meeting to indicate the nature of the Committee's deliberations. Additionally, as I am sure you are aware that the Institutional Membership of the Association will be meeting on May 22nd to act on a recommendation by the AAMC Executive Council, that would provide for a broader representation in the goverance of the Association. We will be following this action very closely also, as this office has put forth much effort in this proposal.

I will look forward to receipt of abstract of the two-day conference held in February. I will be in contact with you shortly about COTH-AAMC activities. Until then, best regards.

Cordially,

MATTHEW F. McNULTY, JR.
Director, COTH
Associate Director, AAMC



H. W. Maysent, F.A.C.H.A.
executive director

the lankenau hospital

lancaster and city line avenues • philadelphia, pa. 19151 • GReenwood 7-7600 • MIdway 9-1400

April 24, 1968

Mr. Matthew F. McNulty, Jr.
Association of American Medical Colleges
Council of Teaching Hospitals
1346 Connecticut Avenue, N. W.
Washington, D. C. 20036

Dear Matthew:

Enclosed is the position paper on the AAMC and AHDME. As mentioned in the paper it is a summation of our discussion held back in January. Mention is made of the compilation of statistics of what is represented by AHDME. Jeff Freymann is working on this and as soon as I get a copy I will forward it to you, hopefully before your meeting with the Council.

I would appreciate a note as to your reaction to this short position paper and on how we can start to initiate some interaction between the two associations.

Before closing I would like to mention that the text of the two-day conference held in February is being abstracted and the abstract of the total discussion should be available at the end of May. I am sure Jeff Freymann will forward a copy to you. As I recall there is a lot of interesting material which relates to the subjects discussed in the position paper. In any event I await your reaction.

Sincerely yours,

Angelo P. Angelides, M. D.
Coordinator - Division of
Professional Activities and
Director of Medical Education
President, AHDME

APA:jav
Encl.

AAMC and the AHDME

The position taken in this presentation served as a prologue to a discussion with Matthew F. McNulty, Jr. Director of the Council on Teaching Hospitals of the AAMC, and his assistant, Mr. Bingham in Washington, D.C. on January 23, 1968.

When one reviews the current status of the AAMC, it is an organism in transition, but what form will evolve is as yet unknown. The AAMC is preeminent in the field of undergraduate medical education. Its experience and influence in the graduate medical education field is of secondary importance limited to programs in its teaching hospitals and working in conjunction with the Council on Medical Education of the AMA. Its experience and influence in continuing education is small and except for the promotion of courses in its medical centers has little familiarity with the problems of continuing education in the areas where it is most needed. Continuing education is best conducted on a daily basis in the community hospitals where physicians work and readily communicate with each other, using utilization reviews, medical audits, mortality conferences, staff conferences and rounds, as the principal tools of instruction. Collectively the AAMC has had little experience in this type of continuing education program at the grass roots level.

Analyzing the AHDME similarly, the following is the current status of the Association. There is little concern with undergraduate education in the majority of the hospitals represented by the membership. Initially the DME was solely concerned with graduate medical education, primarily the internship.

In a little over a decade the role of the DME has broadened widely, ranging in responsibility from a Director of Professional Activities to sole involvement in continuing medical education. The latter responsibility is the result of the emerging concept that, regardless of size, all hospitals must have an effective continuing education program to assure modern quality patient care. The transition from primary concern with graduate education to primary concern for continuing education is easily accomplished by the average DME since the methods of instruction used effectively in continuing education are the ones he has used in the conduct of his graduate medical education programs for many years. In fact the success of present graduate education programs is directly related to the concomitant effect on the continuing education of the medical staff.

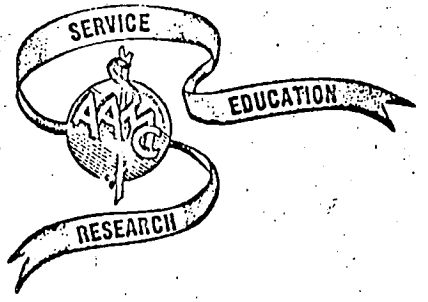
Since education is an arm of patient care, what is the hospital population, physician population and patient population for which each association speaks? The AAMC speaks primarily for the hospitals which are owned and operated by medical colleges (roughly 100), their staffs and the patients from their immediate community with varying percentages on referral from distant areas. However influential this group of hospitals is, the number of hospitals, physicians and patients that the AHDME represents is far larger. Although statistics are presently being compiled and will be available shortly it is safe to state that over 400 hospitals of medium to large size are represented by the AHDME. The numbers are merely to emphasize the relatively narrow but authoritative sphere of influence represented by the AAMC as compared to the large but amorphous sphere of influence represented by AHDME. If the AAMC is to develop an effective continuing education program of national

impact it must be conversant with non-university operated hospitals in this country which serve as the health facility for the large majority of practicing physicians.

Mr. McNulty and Mr. Bingham acknowledge that the above is true if the AAMC is to fulfill its projected role of involvement and concern for the educational needs of the entire health community. This is not to say that the entire membership of the AAMC shares this view.

Mr. McNulty feels that exploration should be conducted to see how the two associations can interface to the mutual advantage of both. He stated that he plans to discuss this with the Council on Teaching Hospitals at its next meeting in May and subsequently with the Executive Committee of the AAMC. It is suggested that initially a liaison group be set up between the AAMC and the AHDME to begin to explore means of cooperating and coordinating our efforts in graduate and continuing education.

Association of American Medical Colleges



This is to certify that

having demonstrated a significant and continuing commitment to medical education is elected to and accorded the full privileges of membership in

The Council of Teaching Hospitals

ORGANIZATION
COPIES

Chairman, COTH

Director, COTH

Date

SEAL

President, AAMC

Executive Director, AAMC

I hereby acknowledge receipt of the

CERTIFICATE OF MEMBERSHIP

of the

COUNCIL OF TEACHING HOSPITALS

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

It is understood that this Certificate is accepted and retained by

_____

_____

only so long as the membership of such institution remains in good standing. It is further understood that in the event of termination of membership the Certificate will be returned to the COUNCIL OF TEACHING HOSPITALS -- Association of American Medical Colleges.

_____
Signature

_____
Title

_____
Date

PLEASE COMPLETE BOTH COPIES OF THIS ACKNOWLEDGMENT, RETURNING ONE TO COTH AND RETAINING THE OTHER COPY FOR YOUR INSTITUTIONAL FILE.

COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
1346 CONNECTICUT AVENUE, N.W.
WASHINGTON, D.C. 20036

Kentucky

COTH HOSPITALS PARTICIPATING IN PAS AND MAP

Total Participating in PAS 71

Total Participating in MAP 51

May 1, 1968

STATE	HOSPITAL	CITY	PAS	MAP
ARIZONA				
	St. Joseph's	Phoenix	X	X
CALIFORNIA				
	Loma Linda University	Loma Linda	X	X
	Memorial Hospital of Long Beach	Long Beach	X	X
	Highland General	Oakland	X	X
	Palo Alto Staff of PASCH	Palo Alto	X	X
	Stanford Staff of PASCH	Palo Alto	X	X
	Sacramento County	Sacramento	X	X
	Mount Zion Hospital and Medical Center	San Francisco	X	
	Presbyterian Medical Center	San Francisco	X	X
	University of California Hospitals	San Francisco	X	X
COLORADO				
	The Presbyterian Medical Center	Denver	X	X
CONNECTICUT				
	Bridgeport	Bridgeport	X	
	St. Vincent's	Bridgeport	X	X
	St. Francis	Hartford	X	
	The Hospital of St. Raphael	New Haven	X	X

STATE	HOSPITAL	CITY	PAS	MAP
DISTRICT OF COLUMBIA				
	Freedmen's	Washington	X	
	Providence	Washington	X	X
	Washington Hospital Center	Washington	X	X
HAWAII				
	The Queen's	Honolulu	X	X
ILLINOIS				
	Mount Sinai Hospital Medical Center	Chicago	X	
	Little Company of Mary	Evergreen Park	X	
IOWA				
	University of Iowa Hospitals	Iowa City	X	X
MARYLAND				
	Church Home and Hospital	Baltimore	X	X
	Sinai Hospital of Baltimore	Baltimore	X	X
	The Union Memorial	Baltimore	X	X
MASSACHUSETTS				
	Robert B. Brigham	Boston	X	
	St. Vincent	Worcester	X	X

STATE	HOSPITAL	CITY	PAS	MAP
MICHIGAN				
	St. Joseph Mercy	Ann Arbor	X	
	Wayne County General	Eloise	X	X
	Blodgett Memorial	Grand Rapids	X	X
	Edward W. Sparrow	Lansing	X	
	Providence	Southfield	X	X
MISSOURI				
	St. John's Mercy	St. Louis	X	X
NEW YORK				
	The Brooklyn	Brooklyn	X	X
	The Cumberland	Brooklyn	X	X
	The Long Island College	Brooklyn	X	X
	City Hospital Center at Elmhurst	Elmhurst	X	
	The Long Island Jewish	New Hyde Park	X	
	Beth Israel	New York	X	
	Bronx Municipal Hospital Center	New York	X	X
	Lincoln	New York	X	X
	Misercordia	New York	X	
	St. Clare's	New York	X	X
	Crouse-Irving	Syracuse	X	
	Grasslands	Valhalla	X	
NORTH CAROLINA				
	Duke University Medical Center	Durham	X	X
	North Carolina Baptist Hospitals	Winston-Salem	X	X

OHIO			
Arkon City	Akron	X	X
Cincinnati General	Cincinnati	X	X
Good Samaritan	Cincinnati	X	X
Saint Luke's Hospital of the Methodist Church	Cleveland	X	X
Mount Carmel	Columbus	X	X
Maumee Valley	Toledo	X	X
OKLAHOMA			
University of Oklahoma Medical Center Hospitals	Oklahoma City	X	X
PENNSYLVANIA			
St. Luke's Hospital of Bethlehem	Bethlehem	X	X
Thomas M. Fitzgerald Mercy	Darby	X	
Albert Einstein Medical Center, Northern Division	Philadelphia	X	
Albert Einstein Medical Center, Southern Division	Philadelphia	X	
Episcopal	Philadelphia	X	X
Misericordia	Philadelphia	X	
Pennsylvania	Philadelphia	X	
The Reading	West Reading	X	X
York	York	X	X
RHODE ISLAND			
Rhode Island	Providence	X	X

SOUTH CAROLINA				
	Medical College	Charleston	X	X
TENNESSEE				
	St. Thomas	Nashville	X	X
TEXAS				
	Baylor University Medical Center	Dallas	X	X
VERMONT				
	Medical Center Hospital of Vermont	Burlington	X	X
WEST VIRGINIA				
	Memorial	Charleston	X	X
WISCONSIN				
	University	Madison	X	X
	Mt. Sinai	Milwaukee	X	X

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
2530 RIDGE AVENUE EVANSTON, ILLINOIS 60201
1346 CONNECTICUT AVE., N.W. WASHINGTON, D.C. 20036

CHEVES McC. SMYTHE, M.D.
ASSOCIATE DIRECTOR
EVANSTON, ILLINOIS

EVANSTON: 312: 328-9505
WASHINGTON: 202: 223-5364

March 15, 1968

Dr. Frank W. McKee, Director
Division of Physician Manpower
Bureau of Health Manpower
Public Health Service
800 North Quincy Street
Arlington, Virginia 22203

Dear Frank:

Attached to this letter is a preliminary program of a Workshop on Graduate Education which the Association is planning to sponsor in the fall of the year.

The precise objectives of this workshop have been left unstated deliberately in this preliminary program. The Planning Committee is anxious that the output of the workshop not be prejudged.

As you look through this proposed program, however, you will see we are attempting to get at the very heart of defining who is responsible for specialty training and under what circumstances. The success of this effort will depend in a large part on both the quality and quantity of the data we hope to be able to bring out between now and early October. All of us are convinced that the effectiveness of the whole workshop will depend on resources which can be brought to bear.

The Planning Committee is convinced that a number of the issues to be raised are entirely pertinent to some of the objectives of the Bureau of Health Manpower.

I am writing about the possibility of our negotiating a limited cost-sharing contract with the Bureau for the support of this workshop. I would welcome an opportunity to talk it over with you, if you wish. Our Committee is to meet in Washington on Thursday, March 28, 1968. If convenient for you, I could meet you on either the afternoon of the 27th, early on the morning of the 28th, late in the afternoon of the 29th, or if you are in your office on the morning of Saturday, the 30th.

May I call you in the interval?

Sincerely yours,

Cheves McC. Smythe, M.D.
Associate Director

CMS/mt
enc.

cc: Dr. Thomas D. Kinney
Dr. Robert C. Berson

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
2530 RIDGE AVENUE EVANSTON, ILLINOIS 60201
1346 CONNECTICUT AVE., N.W. WASHINGTON, D.C. 20036

CHEVES McC. SMYTHE, M.D.
ASSOCIATE DIRECTOR
EVANSTON, ILLINOIS

EVANSTON: 312: 328-9505
WASHINGTON: 202: 223-5364

March 15, 1968

Dr. Jack D. Myers
Professor of Medicine
University of Pittsburgh
School of Medicine
Pittsburgh, Pennsylvania 15213

Dear Jack:

This letter is written for the purpose of inviting the American Board of Internal Medicine to join with the Association of Professors of Medicine in the organization of a workshop to be sponsored by the Council of Academic Societies of the Association of American Medical Colleges. This workshop is scheduled for October 2, 3, 4 and 5, 1968.

Attached to this letter are two enclosures:

(1) A memorandum to the Executive Council of the Association of American Medical Colleges describing the background of the workshop.

(2) A tentative program.

You will note that four specialty areas and one area of basic science are listed as potential groups in the data input part of the program. Why do we turn to internal medicine at this time?

Conversations with Drs. John Hubbard, Craig Borden and Truman Schnabel, Jr. indicate that the Board is going through a period of self-evaluation. They have told us that Dr. Futcher is organizing an inquiry into data now available to you.

Although the bias of any such workshop as this is that the university does indeed have a significant role in graduate medical education, there are a number of practical points involved before the universities commit themselves formally to such a responsibility.

Let us put aside for the moment the realities of highly significant contributions of the Boards over the years and the entirely legitimate concern of the various professional organizations with the qualifications of those who would become their colleagues.

University programs have certain characteristics. These include concern with the form of the educational experience, concentration on the qualitative aspects with the quantitative aspects a secondary consideration of that experience, the need to express verbally such items as qualifications for entry to training, intellectual characteristics of those who enter the training, examination processes as the men go through the training, intellectual characteristics of those who graduate from the training process, acceptance of peer group judgements, etc. To these considerations must be added the entirely practical problems of the interests of those whose resources are being expended to support graduate education. For the time being, this includes hospitals and universities as the predominant institutions. As contributions from third parties grow, one can confidently expect to hear their voices.

What sort of data input would be expected from internal medicine? This question might best be answered by posing another and that is, "What would one like to know about graduate training in internal medicine that he does not now know?" Such questions as 1) the number of men who are entering training, 2) the relation of the intellectual characteristics of the men to their performance on the Boards, 3) comparisons between performances of men assigned to different types of hospitals such as Veterans Administration, community non-affiliated, community-affiliated, and university, 4) comparative performances of individuals taking their training at one location as compared with moving from place to place a year at a time, 5) an assessment of the relative significance of the school of origin as compared to the hospital in which training takes place, 6) comparison of the performance of foreign medical graduates as compared to American medical graduates, 7) correlations between performances on college boards, medical college admission tests, National Boards, Parts 1, 2, and 3, and specialty board examinations are the sorts of quantitative data which we would like to see introduced. Of course, it is realized that the Board does not have all of this information.

In addition to this, there are a number of non-quantitative questions such as 1) why men select the field of internal medicine, 2) why they do not, 3) what are the non-intellectual characteristics of men who select internal medicine, 4) the impact of graduate educational experience on eventual career selection, 5) the relation of expressed goals of training to eventual function.

The major objectives of this conference are:

1. To inventory what is happening in (the state of the art) graduate education in selected fields at a time when major changes in this area of education are to be expected.

2. To reach for a quantitative estimate of the meaning of the assumption of a major defined responsibility in graduate medical education by the universities.

3. To compare the experiences of five specialty groups which have chosen to prepare for change by examining their activities in graduate medical education.

4. To stimulate the collection of data by the other professorial organizations and their specialty boards relevant to a definition of the university component in graduate medical education.

This letter, or its equivalent, is being sent to Chairmen of the Board of Neurological Surgery, Orthopedics and Pediatrics. The President of the appropriate professorial organization in each of these areas is also being written. Dr. James Warren has been informed of the contents of this letter. I hope you will discuss it with him.

If there are any questions, please call. I trust that the American Board will be able to make whatever information it has available for discussion.

Sincerely yours,

Cheves McC. Smythe, M.D.
Associate Director

CMS/mt
enc.

cc: Dr. James Warren
Dr. Palmer Futcher
Dr. Thomas D. Kinney
Dr. Robert C. Berson

March 20, 1968

TO: Members of Executive Council

FROM: Council of Academic Societies

SUBJECT: Proposed Workshop on "The Role of the University in Graduate Education"

At its February meeting both the Council of Academic Societies and the Executive Committee of the Council decided that attention to issues in graduate education was the most appropriate path along which to develop a program for this Council.

In keeping with this decision the Executive Committee of the Council has been developing a program for a workshop. A possible title for this workshop is "The Role of the University in Graduate Education." Dates suggested are October 2, 3, 4, 5, 1968. The ideal location seems to be near Chicago, Detroit, or Cleveland in order to keep down travel costs. An attendance of about 100 is projected. The general format of the workshop will include input of available data from specialty training in internal medicine, neurological surgery, orthopedics, pediatrics, and graduate training in physiology. Subsequently, the implications of these data are to be discussed and appropriate conclusions drawn. Contact is being made with such groups as the professional societies and specialty boards representing the above named specialties, the graduate education section of the Council on Medical Education of the American Medical Association, the subcommittee of the council concerned with graduate education of the National Board of Medical Examiners, and the Advisory Board of Medical Specialties. No opposition to the idea and proposed content of the workshop has yet been encountered.

It is furthermore proposed that the discussion will be recorded and an appropriate publication issued. From the original grant of the National Fund for Medical Education to the Council of Academic Societies, approximately $16,000 will remain at the end of the year. The income of the Council will amount to about $2,000. The Executive Committee of the Council is prepared to assign all of these funds to the support of this workshop. The advisability of soliciting a contract for something less than $10,000 from the Bureau of Health Manpower is being considered.

Attached is a program which describes the thinking about this workshop to date. This workshop should be interpreted as a move by the Association to establish an area of concern in the field of graduate education and the endorsement of the workshop should be accompanied by recognition that as a next step the Association should move to organize a permanent voice in graduate education.

RECOMMENDATION: It is recommended that the Executive Council of the AAMC endorse and support a workshop to be conducted by the Council of Academic Societies and designed to identify the role of the university in graduate education.

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Attachment

SUGGESTED PRELIMINARY PROGRAM FOR A WORKSHOP SPONSORED BY THE COUNCIL OF ACADEMIC SOCIETIES OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

TITLE	The Role of the University in Graduate Education
TIME	October 2, 3, 4, 5, 1968
PLACE	Near an airport of one of the major midwestern cities
ATTENDANCE	About 100
FINANCING	To be underwritten by the Council of Academic Societies, but participants are to be expected to defray their own expenses

PROPOSED PROGRAM

WEDNESDAY, OCTOBER 2, 1968

4:00 to 6:00 PM	Registration
5:30 to 6:30 PM	Refreshments
6:30 to 8:00 PM	Dinner
8:00 PM	Address - The Role of the University in Graduate Biomedical Education
Proposed Chairman - Dr. Thomas Kinney	Speaker to be selected

THURSDAY, OCTOBER 3, 1968

7:00 to 8:00 AM	Breakfast
8:00 to 8:30 AM	Plenary session
Proposed Chairman - Dr. William Holden	
8:30 to 9:15 AM	Orthopedics and the Impact of Learning Theory
9:30 to 10:15 AM	Pediatrics and the Relation of Training to Eventual Social Function
10:30 to 11:00 AM	Break
11:00 to 11:45 AM	Internal Medicine and Self-Evaluation
12:00 to 1:30 PM	Lunch
1:30 to 2:15 PM	Neurological Surgery and the Assessment of Accomplishment
2:30 to 3.15 PM	Physiology's Experience
3:15 to 3:45 PM	Break
3:45 to 5:15 PM	Panel - Basic Science Input Into Training: Its Nature and Content
Proposed Chairman - Dr. Daniel Tosteson	Representatives from anatomy, microbiology, pathology, pharmacology, and biochemistry
5:45 to 6:45 PM	Refreshments
6:45 to 8:00 PM	Dinner
8:00 PM	The Economics of Graduate Education
Proposed Chairman - Dr. Jonathan Rhoads	Speaker to be selected

Attachment

FRIDAY, OCTOBER 4, 1968

7:00 to 8:00 AM	Breakfast
8:30 to 12:00 AM	with 20-minute break in mid-morning

From the list of topics below, ten will be selected for twenty-minute presentations; six for thirty minutes; or four for forty-five minutes or a suitable mixture thereof. Decisions are to be made by the Executive Committee of the Council.

Proposed Chairman -
Dr. John Hubbard

SUGGESTED LIST OF TOPICS

1. Brief presentations of significant data from other areas of specialization.
2. Methods of evaluation.
3. Objectives of evaluation.
4. New patterns of training or training patterns in transition.
5. Tolerance for experimentation.
6. Elimination of non-relevant material.
7. Adaptation to computation.
8. Integration of the last year of generalized with the first year of specialized training.
9. Introduction to sociological awareness.
10. The reward system or the other face of economics.
11. Goals of training - accomplishments of training.
12. Relation of training to eventual function.
13. Cores in graduate training.
14. To whom do the data belong.
15. Etc.

12:00 to 1:30 PM	Lunch
1:30 to 5:00 PM	with 20-minute break in mid-afternoon

Ten discussion groups, each of which will be asked to debate and bring in final recommendations, either for or against, and specific proposals on how to go about accomplishing such propositions as those listed below. Each discussion group leader will be asked to bring in conclusions of his group on Saturday morning.

Proposed Discussion Group Leaders -
Members of the Executive Committee of the Council of Academic Societies and others concerned

PROPOSED LIST OF SIGNIFICANT QUESTIONS

1. In terms of authorization and control undergraduate medical education today is essentially proprietary as related to the role of the individual in the program and is in somewhat the same stage of development as undergraduate medical education was in 1910.

Attachment

2. Each medical school faculty and each teaching hospital staff acting as a corporate body should explicitly formulate and periodically revise their own educational goals and curricula.

3. Each teaching hospital or its medical school faculty should organize its staff through an educational council, a committee on graduate education, or some similar means so as to make its programs of graduate medical education a corporate responsibility rather than the individual responsibility of particular medical-surgical services or heads of services.

4. The medical schools and their teaching hospitals, collectively and individually, have the responsibility for designing a program in graduate education training which will produce physicians prepared and committed to deliver continuous and comprehensive medical care. A number of specific programs designed to realize this goal must be introduced simultaneously in a variety of different settings across the country.

5. The internship as a separate and distinct portion of medical education should be abandoned and the internship and residency areas should be combined under a single period of graduate medical education called a residency and planned as a unified whole.

6. The end of general medical education may occur either while a man is still in school or upon his graduation from medical school, but specialized training should begin upon graduation from medical school. This statement should be seen as encouraging experimentation relating to the continuity of undergraduate and graduate medical education.

7. Although the specialty board should be discouraged from amending their regulations concerning eligibility for examination and certification in a manner to increase the required length of residency training to compensate for any removal of the internship, an attitude of permissiveness and allowance of experimentation in this area should be encouraged.

8. The residency review committees of the specialty boards should include members from outside of that particular specialty. Hospitals should be encouraged to experiment with different forms of basic residency training. Specialty boards and residency review committees should be encouraged to allow experimentation by interpreting liberally those statements of resident requirements that now inhibit new forms of educational organization.

9. Programs of graduate medical education should be approved only if they cover the entire span of training from the first year of graduate medical education through completion of specialty training. The appropriate agencies should work in concert so that state licensure acts and statements of certification be amended to eliminate a requirement of separate internship and substitute for it an appropriately described period of graduate medical education. Cooperative arrangements between many hospitals in a given area and an academic medical center should be encouraged.

Attachment

10. In an effort to strengthen training programs from area to area a commission on graduate medical education specifically charged with the responsibility for planning, coordinating, and periodically reviewing standards for graduate medical education and procedures for its review and the approval of the institutions in which that education is offered should be created. The commission on graduate medical education should number in its membership representatives from the Council on Medical Education of the Association of American Medical Colleges, the Advisory Board for Medical Specialists of the American Hospital Association, the Association of American Medical Colleges, and members from societies-at-large.

5:30 to 6:30 PM	Refreshments
6:30 to 8:00 PM	Dinner
8:00 PM	Address - Medicine and the Urban Minority or the Urban Negroes' View of his Medical Care
Proposed Chairman - Dr. Jack Myers	Speaker to be selected

SATURDAY, OCTOBER 5, 1968

7:00 to 8:00 AM	Breakfast
8:30 to 10:45 AM	Reports from discussion group leaders
10:45 to 11:15 AM	Break
11:15 to 12:00 AM	Report of conference chairman Dr. Thomas Kinney
12:00 AM	Adjourn

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COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
1346 Connecticut Avenue, N.W.
Washington, D.C. 20036
202/223-5364

FUTURE MEETINGS OF THE EXECUTIVE COMMITTEE

1967-1968 Administrative Year:

#68-4	Thursday and Friday September 5 & 6, 1968 Washington, D.C.	
#68-5	Thursday October 31, 1968 Houston, Texas	(reception, dinner & evening meeting at AAMC Annual Meeting)

1968-1969 Administrative Year:

#69-1	Monday November 4, 1968 Houston, Texas	(luncheon and meeting at AAMC Annual Meeting)
#69-2	Thursday and Friday January 9 & 10, 1969 Washington, D.C.	
#69-3	Thursday & Friday May 8 & 9, 1969 Washington, D.C.	
#69-4	Thursday & Friday September 11 & 12, 1969 Washington, D.C.	
#69-5	Thursday October 30, 1969 Cincinnati, Ohio	(evening meeting at AAMC Annual Meeting)

1969-1970 Administrative Year:

#70-1	Monday November 3, 1969 Cincinnati, Ohio	(luncheon and meeting at AAMC Annual Meeting)