

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

AGENDA

EXECUTIVE COMMITTEE MEETING #69-3
Thursday & Friday, May 8 & 9, 1969
Washington Hilton Hotel
1919 Connecticut Avenue, N.W.
Washington, D.C. 20009
202/483-3000

Thursday, May 8, 1969:

- 6:30 p.m. Reception Hemisphere Room - Concourse Level
- 7:15 p.m. 1. Dinner Meeting
2. Presentation:
John A. D. Cooper, M.D., Ph.D.
President, Association of
American Medical Colleges
- 10:00 p.m. Recess

Friday, May 9, 1969:

- 9:00 a.m. Reconvene - Roll Call Military Room - Concourse Level
3. Consideration of Minutes, Meeting #69-2, February 8, 1969, as Distributed 3/11/69 Tab 1
4. Introduction of New COTH-AAMC Staff Members Tab 2
5. Report on Action Items, Meeting #69-2 Tab 3
6. Membership Items
- A. New Applications
- 1) Nominated by a Dean -- Detroit Osteopathic Hospital, Detroit, Michigan, Nominated by William N. Hubbard, Jr., M.D., Dean, University of Michigan School of Medicine Tab 4
- 2) Self-Nomination Tab 5
- a. Greater Baltimore Medical Center
Baltimore, Maryland
- b. Kaiser Foundation Hospital
San Francisco, California
- c. St. John Hospital
Detroit, Michigan
- B. Confirmation of Mail Ballots Tab 6
- 1) St. Mary's Hospital, Minneapolis, Minn.
- 2) Fairview Hospital, Minneapolis, Minn.
- 3) St. Barnabas Medical Center, Livingston, N.J.
- 4) Northwestern Hospital, Minneapolis, Minn.
- C. Statistical Information
- 1) Status Report of Membership Tab 7
- 2) Membership Breakdown by Type of Service Tab 8
- D. COTH Membership Directory

7. Report of Committees
- A. Committee on Financial Principles
- 1) Minutes of Meeting of 3/28 69 Tab 9
 - 2) SSA Regulations Regarding Part B Payments for Services of Supervisory Physicians in a Teaching Hospital. Tab 10
 - 3) Draft Statement of AAMC Principles (HAND OUT)
 - 4) Potential Hearings by Senate Finance Committee Investigating Hospital and Physician Reimbursement under Medicare
 - 5) Annual Report, 1968-69, Associated Physicians of the Cook County Hospital, Chicago Tab 11
 - 6) Appointment of Stanley A. Ferguson as Chairman of Committee on Financial Principles
 - 7) AAMC Memorandum on Dual Payment Tab 12
- B. Committee on Modernization and Construction Funds for Teaching Hospitals
- 1) Testimony of David E. Rogers, M.D., and Richard T. Viguers, presented 3/27/69 Tab 13
- C. COTH Committee on Nominations Tab 14
8. Report of Regional Meetings
- A. Agendas of Four COTH Regional Meetings Tab 15
- B. Meeting of Midwest COD, CAS, COTH called by Clifford G. Grulee, M.D. Tab 16
- C. Subsequent COTH Midwest/Great Plains Region Recommendation Tab 17
9. Annual Meeting
10. AAMC Executive Council Action Concerning COTH-AHA Liaison Committee Tab 18
11. COTH Financial Report, FY 1968-69 Tab 19
12. COTH Budget, FY 1969-70 Tab 20
13. COTH Statement on Comprehensive Planning (HAND OUT) Tab 21
14. Johns Hopkins Fourth and Fifth Annual Health Services Research Seminar Tab 21
15. Report of Other Items
- A. Report on Three Contracts
- 1) Teaching Hospital Information Center
 - 2) Study of the Effects of Recent Social Legislation on Teaching Hospitals
 - 3) Pending - Discussion with SSA, Bureau of Health Insurance Regarding a Contract
- B. Revised DHEW Budget from Nixon Administration
- 1) Summary - COTH GMM No. 69-28G Tab 22
 - 2) AAMC Position on 2% Feature of Revised Budget Tab 23
- C. Facilities Study by New York Chapter, American Institute of Architects and AAMC Meeting Tab 24
- D. Move to National Center for Higher Education
16. Other Old Business
17. New Business
18. Date of Next Meeting - September 11 & 12, 1969
19. Adjournment - 4:00 p.m.

Coffee & Rolls to be served at 8:45 a.m. on Friday in the Military Room & Lunch to be served at 12:30 p.m. on Friday in the Hemisphere Room

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MINUTES

EXECUTIVE COMMITTEE MEETING (#69-2)
Saturday, February 8, 1969
Private Dining Room #5
Palmer House
Chicago, Illinois
9:30 a.m. - 11:30 a.m.

Present:

T. Stewart Hamilton, M.D., Chairman-Elect
Lad F. Grapski, Immediate Past Chairman
L. H. Gunter, Member ✓
Irvin G. Wilmot, Member ✓
Ernest N. Boettcher, M.D., Member ✓
Leonard W. Cronkhite, Jr., M.D., Member
Charles R. Goulet, Member
Charles H. Frenzel, Member
Russell A. Nelson, M.D., Ex Officio Member
Alexander Williams, AHA Representative
Matthew F. McNulty, Jr., Director, COTH
Fletcher H. Bingham, Ph.D., Assistant Director, COTH
Richard M. Knapp, Ph.D., Project Director, COTHRIC
Grace W. Beirne, Staff Associate, COTH
Armand Checker, Staff Associate, COTH
Elizabeth Burgoyne, Secretary to the Director, COTH

Absent:

Roy S. Rambeck, Chairman
David Odell, Member
Charles E. Burbridge, Ph.D., Member
Reid T. Holmes, Member
Joseph H. McNinch, M.D., AHA Representative

I. Call to Order -- Roll Call:

The meeting was called to order at 9:30 a.m. on February 8, 1969, by T. Stewart Hamilton, M.D. Dr. Hamilton assumed the Chair in the absence of Chairman Rambeck, to whom the Committee sent its best wishes for a speedy recovery. Attendance was taken as noted above.

II. Approval of Minutes, Executive Committee Meeting #69-1:

ACTION #1 ON MOTION, SECONDED AND CARRIED, THE MINUTES OF EXECUTIVE COMMITTEE MEETING #69-1, JANUARY 9 AND 10, 1969, WERE APPROVED AS PRESENTED.

Upon approval of the Minutes, Mr. McNulty summarized the results of the actions taken at meeting #69-1 as follows:

- A. Action #2 -- "On motion, seconded and carried, the Executive Committee confirmed the proposed terms of office for members of the COTH Committee on Financial Principles for Teaching Hospitals and the COTH Committee on Modernization and Construction Funds for Teaching Hospitals as presented, and affirmed the policy of staggered terms for standing committees and other such committee activities as appropriate".

Mr. McNulty reported that this action would be implemented at the next meeting of each of the two committees involved.

- B. Action #3 -- "On motion, seconded and carried, the Executive Committee authorized staff to refer the paper on Comprehensive Planning to Richard T. Viguers, Chairman, Committee on Modernization and Construction Funds, for his review, and to forward a copy to each member of the Executive Committee for his comments; and further to consider comments from the members and Mr. Viguers in preparation of a revised paper to be acted upon at the May or sooner meeting of the Executive Committee".

Mr. McNulty reported that the action had been implemented and that a

revised paper was on the agenda for the February 8th meeting, and it was suggested that the paper be considered and discussed at this time using the revision prepared.

- C. Action #4 -- "It was agreed that Staff attempt to meet with representatives of the Carnegie Commission to discuss the source of figures, the proper interpretation of the recommendations, etc. It was also agreed that, if possible, Commission representatives meet with the Committee on Financial Principles prior to the May Executive Committee Meeting."

Mr. McNulty reported that a meeting with Dr. Clark Kerr revealed that the Commission had no specific frame of reference for the figures used and may remove the data when their final report is presented. At least, the Commission has been alerted to the possible problems of the figures cited and seemed interested in working for a better expression of the recommendation within the final report.

- D. Action #6 -- "It was agreed that COTH take no active role, but refer any inquiries concerning the repayment by the drug industry to the AHA, which has maintained an active surveillance of the issue. It was, however, cautioned that this matter should be closely watched by members and staff.

Mr. McNulty reported that since the last discussion, the drug industry has submitted a proposal, not yet accepted by the claimants, to distribute the money and that the AHA is still working with Arnold and Porter to study the proposal and determine its implications.

E. Action #5 -- "On motion, seconded and carried, the Executive Committee accepted the recommendation of the Committee on Financial Principles that staff prepare a questionnaire to be sent first to a sampling of institutions and then to the total membership to assess the current situation with regard to house staff financing and financial patterns of part-time and full-time clinical faculty medical practice, to the end of evolving a set of guidelines, or guiding principles, for such payment."

Mr. McNulty reported that an initial draft of the questionnaire has been prepared. Also, various deans have been contacted for advice with regard to the questionnaire. Mr. Goulet noted that the SSA is conducting a similar survey.

F. Action #9 -- "The concept of inter-representation of the three Councils at joint regional meetings was generally approved with the advice that if such joint regional meetings are held, time be set aside for specific COTH business and that such meetings not become a regular occurrence. It was also suggested that for other than the scheduled Southern meeting, the possibility be posed to COTH membership at other regional meetings to be held in the spring for full consideration."

Mr. McNulty reported that he had met with the Southern deans and that a joint meeting will be held in Atlanta on April 29-30, 1969.

III. COTH Financial Report:

Mr. McNulty called attention to the figures presented, noting that they were projected figures. He further noted that there remain only 19

unpaid institutions at the figure of \$500 (considerably fewer than in previous experience) and that approximately one-half of the institutions had already paid the \$200 dues assessment.

IV. New Applications for Membership:

A. Self-Nomination on the Basis of Approved Educational Programs --

1. St. Luke's Hospital, Kansas City, Missouri:

ACTION #2

ON MOTION, SECONDED AND CARRIED, THE APPLICATION FOR MEMBERSHIP IN THE COUNCIL OF TEACHING HOSPITALS FROM ST. LUKE'S HOSPITAL, KANSAS CITY, MISSOURI, WAS UNANIMOUSLY APPROVED BY THE COTH EXECUTIVE COMMITTEE.

2. North Shore Hospital, Manhasset, New York:

ACTION #3

ON MOTION, SECONDED AND CARRIED, THE APPLICATION FOR MEMBERSHIP IN THE COUNCIL OF TEACHING HOSPITALS FROM NORTH SHORE HOSPITAL, MANHASSET, NEW YORK, WAS UNANIMOUSLY APPROVED BY THE COTH EXECUTIVE COMMITTEE.

V. Reconsideration of Detroit Osteopathic Hospital and Suggestion from William N. Hubbard, M.D., Dean, University of Michigan Medical School:

Mr. McNulty noted that this hospital would not qualify unless recommended by a Dean and that Dean Hubbard had indicated he would write a letter investigating the possibilities of nominating the hospital for COTH membership. However, the University of Michigan has a survey team to examine the educational activity of the Detroit Osteopathic Hospital and any action

should await the results of that survey. It was generally agreed that such a situation was in the realm of the subject matter of the Committee on Membership.

VI. Report -- Meeting of COTHRIC Advisory Committee:

Dr. Knapp reported that the January 30-31, 1969, initial meeting of the Teaching Hospital Information Center Advisory Committee went well. There was endorsement by the COTHRIC Committee of the need for such an activity and there was much discussion about the functions which the center should undertake. The concept of a study of hospital involvement in community services was regarded very favorably by the members. It was agreed by the COTHRIC committee that some demonstration project be conducted by COTHRIC and that the community service survey may be the most important. Mr. McNulty noted that the COTHRIC item would appear on all Regional Meeting agendas.

VII. Discussion of Draft, "The Teaching Hospital and Its Role in Health Planning at the Local and Area Levels":

As background, Mr. McNulty indicated that COTH members and Executive Committee had expressed a need to delineate the relationship of the teaching hospitals to health planning at the various levels. As a result, the initial draft of this paper (presented at the January 9-10, 1969, meeting) had been revised for presentation at this meeting. Dr. Hamilton noted that the paper was not on the agenda for final action, but for intensive discussion in order to give staff further direction for preparing another draft for consideration at the May meeting of the Executive Committee.

It was noted that there should be a focus on the new delivery mechanisms

being developed by teaching hospitals, with the suggestion that the paper present the concept of the teaching hospital as a separate institution to which there was easy access. It was noted that the paper came to a rather abrupt ending and Dr. Boettcher suggested the following closing paragraph, "The role of the teaching hospital as a national resource for educating manpower has gone beyond geographic boundaries and must not be subjugated to local or area-wide concerns, although the teaching hospital must be responsive to area-wide needs."

It was stressed that the paper appears to omit the identification of the consumer's involvement in planning as well as the question of how to get the consumer involved. It must be indicated more explicitly that service activities within the hospital are part of the medical care establishment and must be in that plan.

The emphasis in the paper that the teaching hospital must get involved with the local and area-wide activities was regarded as sound, and noted as being an essential criterion for discussion of any further role of the teaching hospital. It was agreed that in the paper, there should be assurance that the teaching hospital will be included in the local activities but that allowances be made for the unique activities of these institutions which cannot be described in discrete geographical boundaries. It was agreed that any further comments on the paper be forwarded to staff.

ACTION #4

IT WAS AGREED THAT MEMBERS FORWARD FURTHER SUBSTANTIVE AND/OR EDITORIAL COMMENTS ON THE DRAFT PAPER ON COMPREHENSIVE PLANNING TO COTH STAFF TO BE INCORPORATED INTO A FINAL PAPER TO BE ACTED UPON AT THE MAY COTH EXECUTIVE COMMITTEE MEETING.

VIII. Student Activity of February 8th Regarding AAMC Council of Deans:

Dr. Nelson reported briefly on today's meeting of the Council of Deans and the confrontation between the Deans and representatives from various student groups, such as SHO and SAMA with regard to the student demand to receive time on the agenda to discuss various complaints against administration with regard to training of minority students, care to the indigent in the community, and so forth. As the students would not yield the floor, Dr. Anlyan had adjourned the meeting to a closed session.

IX. Informational Items:

A. Hospital Modernization and Improvement Act of 1969 --

Mr. McNulty called attention to the bill as it was introduced and again stressed the need for grass-roots support and encouragement for such measures. With possible budget cuts and the choice of the HEW Assistant Secretary for Health and Scientific Affairs still undetermined, it is important that encouragement of local legislators be undertaken.

B. Position Statement, "Guidelines for Allocating Program Costs in Teaching Hospitals" --

Mr. McNulty called attention to the printed Guidelines and noted that they would be distributed to all COTH members during the week of February 10, 1969.

C. Proposed Commission on Medical Education --

Dr. Hamilton reported that in 1967 the AMA appointed four advisory committees to the Council on Medical Education. From these and other

sources, including a joint committee with representatives from the AMA, AAMC, AHA and Association of Specialty Boards, came recommendations which are leading to consideration of a Commission on Medical Education -- probably developing out of the present liaison arrangement between the AMA and the AAMC which deals with accreditation of schools of medicine. This commission would, or might, deal with all aspects of health education -- undergraduate and graduate, medical and paramedical.

Attached as Appendix A to these Minutes is a copy of the report prepared by the committee which has been distributed to the AAMC Executive Council for consideration. It was suggested that the Executive Committee review the draft proposal and forward any comments to Mr. McNulty and staff prior to April.

ACTION #5

IT WAS AGREED THAT MEMBERS REVIEW THE DRAFT PROPOSAL FOR A COMMISSION ON MEDICAL EDUCATION AND SUBMIT ANY COMMENTS TO THE COTH STAFF PRIOR TO APRIL SO THAT THE COUNCIL OF TEACHING HOSPITALS CAN HAVE INFORMED INPUT INTO THE AAMC EXECUTIVE COUNCIL CONSIDERATION OF THE PROPOSAL.

X. Externship Guidelines:

Mr. McNulty reported that the joint COTH-GSA (Group on Student Affairs) breakfast meeting of February 8th had produced concern from the GSA regarding the organizational determination of externship guidelines. At the

present time, in accord with JCAH standards, determination of the criteria is usually done by deans, which is not always consistent among schools. The morning meeting resulted in agreement that a determined effort would be made to prepare suitable externship criteria. Also, it had been suggested that the guidelines be tested at regional meetings before presentation to any decision-making body. The matter was left with the conclusion that COTH should be aware of what GSA is doing in this regard, but that neither group should recommend or take definitive action without full discussion and consultation with the other.

XI. Discussion of Agenda for AAMC Assembly Meeting:

Mr. McNulty noted that the COTH Representatives to the AAMC Assembly would meet at 11:30 a.m. on February 8th for lunch and would be greeted by Robert B. Howard, M.D. (Chairman-Elect, AAMC) on behalf of the total AAMC. He viewed the meeting as a good opportunity for the COTH people to become acquainted as well as to discuss the issues that were to be presented at the AAMC Assembly meeting that afternoon.

XII. Adjournment:

There being no further business, the meeting was adjourned at 11:20 a.m., with the notation that the next meeting of the Executive Committee would be held in Washington on Thursday evening and Friday, May 8 and 9, 1969.

Final Report
April, Feb 7, 1964

APPENDIX A

ORGANIZATION, COMPOSITION AND FUNCTION OF A
COMMISSION ON MEDICAL EDUCATION

Introduction

This is a proposal to expand the existing Liaison Committee on Medical Education (of the Council on Medical Education of the American Medical Association and the Executive Council of the Association of American Medical Colleges) to form a Commission on Medical Education which would serve as the central authoritative body for medical education in the United States. The Commission would determine policy and establish standards at all levels of medical education and would coordinate the activities of all organizations having responsibility for and interest in the various levels of medical education.

Basis for the Proposal

The proposal to establish the Commission is based on several important principles and current practices:

1. Medical education is a continuum from premedical preparation through the continuing education of the practicing physician and is intertwined with education for the allied health professions and services. While there are specific problems at each level of medical education and in allied health education, to have separate bodies dealing separately with these problems without relation to each other would defy the concept of the continuum and would inevitably lead to divergent policies and conflict within the continuum. Accordingly, there should be a single overall authoritative body to determine policy and establish standards for the entire field of medical education and at least for that portion of allied health education concerned with the education of persons who will provide health care services under the direction or supervision of physicians.
2. Responsibility for medical education and allied health education should be a joint function of the educational institutions and the active profession. Neither the profession by itself, nor the educational institutions by themselves

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have the balance and perspective necessary to establish policy and standards which will result in medical education's being truly responsive to the needs of society. The Association of American Medical Colleges is the organization which most completely represents the universities and colleges providing medical education and allied health education. The American Medical Association is the organization which most completely represents the active profession and is most vitally concerned with the production of health manpower for the care of the patient.

3. The Council on Medical Education of the American Medical Association, acting alone or in liaison with other organizations, currently serves as the responsible body for establishing and maintaining educational standards at all levels of medical education and in many allied health areas. The Council is at the present time the one common denominator for the fields of medical and allied health education.

4. The Association of American Medical Colleges currently serves as a joint body for accreditation of undergraduate medical education, is expanding its interest and activity in the field of graduate medical education, and expects to become involved actively in establishing and maintaining standards for continuing medical education and education in the allied health professions and services. As recommended by the Coggeshall Report, AAMC is therefore moving to assume responsibility for all levels of medical and allied health education, which will bring it into a position parallel to that of the AMA Council on Medical Education.

5. The Liaison Committee on Medical Education of the AMA and the AAMC has for many years been recognized as the official accrediting agency for undergraduate medical education and is now directing its attention to graduate medical education and continuing medical education. During the current academic year, pilot surveys have been carried out in which, in one instance, a medical school and all of its internship and residency programs were surveyed simultaneously and, in another instance, a medical school and its continuing education program were surveyed. The Liaison Committee is therefore already looking ahead to total institutional accreditation involving all levels of medical education. By broadening

and deepening its current interest and activities, it could readily become a Commission on Medical Education with jurisdiction over all levels of medical education and much of allied health education.

6. Many other organizations and institutions currently are active directly or indirectly in establishing and maintaining standards at various levels of medical education and allied health education. The interests and activities of these organizations should be respected and should be permitted to continue within the framework of policies established by an overall authoritative body. This could easily be done if committees of the Commission were established to deal with detailed activities and problems within each of the four areas of undergraduate medical education, graduate medical education, continuing medical education, and education for the allied health professions and services. Each organization now involved in or related to education in one of these specific areas would be appropriately represented on the committee functioning in that area. The committees in turn would be responsible to the overall Commission which would coordinate and guide their separate activities to preserve the integrity of the field.

7. The federal government and the public should be appropriately represented on the Commission and government representatives should participate in the activities of the four committees.

Function and Composition of the Commission on Medical Education

A. General Function

1. The Commission on Medical Education would determine overall policy and coordinate educational standards and procedures within the various levels of medical and allied health education.

2. It would receive recommendations from the four committees and would monitor their activities to insure that they were consistent with overall policies.

3. It would serve as the official accrediting body for all levels of medical education, delegating to its committees such procedural authority as it deemed advisable.

B. Composition

1. The Commission should have as its base major and joint representation from the Council on Medical Education of the American Medical Association and the Executive Council of the Association of American Medical Colleges. The chairman would be alternately from the AMA and AAMC in alternate years, as is now the case for the Liaison Committee on Medical Education.

2. The Commission should also have representation from the federal government and the public.

3. The Commission should currently have representation from the American Hospital Association and the Association of Medical Specialty Boards, since both are vitally concerned at this time with various levels of medical education.

4. The Commission should have room on its membership for two members who would be selected each year on an ad hoc basis by the rest of the Commission to represent areas in which particular problems existed ^{are} or were anticipated.

5. With the above principles in mind, the following composition is recommended: a total membership of 15 members, of whom 4 would be appointed by the Council on Medical Education of the American Medical Association, 4 by the Association of American Medical Colleges, 1 by the American Hospital Association, and 1 by the Association of Medical Specialty Boards. In addition, the Assistant Secretary for Health of the Department of Health, Education and Welfare, or his designee ^{and} would represent the federal government, ^{and} 2 representatives of the public would be selected, 1 each by AMA and AAMC. Finally there would be 2 ad hoc members who would be selected annually by the other members of the Commission.

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6. The Commission would be staffed jointly by AMA and AAMC. The secretary would be alternately from the AMA and AAMC staff, as is now the case for the Liaison Committee on Medical Education.

Function and Composition of the Committees of the
Commission on Medical Education

A. General Organization and Function

1. There would be 4 committees of the Commission on Medical Education, 1 each in the areas of undergraduate medical education, graduate medical education, continuing medical education and education for the allied health professions and services. The Committees would elect their own chairmen. They or their designees would attend meetings of the Commission and would report the actions or recommendations of their committees.

2. Each committee would deal with specific problems within its own area of influence, acting to establish and maintain standards for education in that area. Each would serve as the working body to prepare and propose statements of essentials for educational programs, and to make decisions concerning accreditation of educational programs within its area, subject to approval by the overall Commission. While the Commission would be the official accrediting body, each committee might be delegated the authority to act on accreditation matters within its area.

3. Each committee would relate directly or indirectly to all institutions and organizations having current activities in and interest in the respective fields of education. Active liaison relationships would be established where desirable.

B. Composition

The composition of the four committees would be as follows:

1. Committee on Undergraduate Medical Education, 10 members:
 - 4 members from the Council on Medical Education of the American Medical Association;
 - 4 members from the Association of American Medical Colleges;
 - 1 member from the Department of Health, Education and Welfare, selected by the Assistant Secretary for Health and Scientific Affairs;
 - 1 member from the Student American Medical Association.

2. Committee on Graduate Medical Education, 10 members:
 - 3 members from the Council on Medical Education of the American Medical Association;
 - 3 members from the Association of American Medical Colleges;
 - 1 member from the Association of Medical Specialty Boards;
 - 1 member from the Association for Hospital Medical Education;
 - 1 member from the American Hospital Association;
 - 1 member from the Department of Health, Education and Welfare, selected by the Assistant Secretary for Health and Scientific Affairs;

3. Committee on Continuing Medical Education, 10 members:
 - 4 members from the Council on Medical Education of the American Medical Association;
 - 4 members from the Association of American Medical Colleges;
 - 1 member from the Association for Hospital Medical Education;
 - 1 member from the Department of Health, Education and Welfare, selected by the Assistant Secretary for Health and Scientific Affairs.

4. Committee on Education for the Allied Health Professions and Services, 10 members:
 - 3 members from the Council on Medical Education of the American Medical Association;

3 members from the Association of American Medical Colleges;

2 members from the Association of Schools of Allied Health

Professions;

1 member from the American Hospital Association;

1 member from the Department of Health, Education and Welfare,

selected by the Assistant Secretary for Health and Scientific Affairs.

Authority and Liaison Activities
of the Commission and its Committees

1. The Commission would derive its authority from its parent organizations and from official recognition by bodies such as the National Commission on Accrediting, the U.S. Office of Education and the various state licensure boards. Since the Liaison Committee on Medical Education and the AMA Council on Medical Education now have such authority at various levels of medical and allied health education, it would be a very simple matter to effect the transfer of authority to the new Commission. In all probability this will happen anyway in the natural course of events, since the Liaison Committee is moving to accept broader responsibilities. The formation of the Commission would simply recognize this course of events and would bring it more rapidly to its logical conclusion. The Commission would receive and act upon reports from its Committees and report not less than once a year to its parent bodies.

2. The parent bodies of the Commission would have the right to express approval or disapproval of the policy decisions of the Commission but would not retain authority to veto such decisions. Through many years of cooperative effort, the Liaison Committee on Medical Education has functioned with a minimum of interference from the parent organizations.

3. The presently established authority of other organizations would continue to be recognized and respected within the framework of policy established by the Commission and the activities of its committees. Similarly, existing

liaison relations of AMA and AAMC with other organizations would continue, within the policy framework of the Commission and its committees.

a. In the area of undergraduate medical education, working relations with the Association of Canadian Medical Colleges would continue for survey and accreditation of Canadian medical schools. A recent development in Canada is analogous to this proposal to establish a Commission on Medical Education. In the fall of 1968, there was established the Committee on Coordination of Surveys of Programs in Medical Education, with representation from The ACMC, The Canadian Medical Association, The Royal College of Physicians and Surgeons of Canada, The Association of Canadian Teaching Hospitals, The Canadian Council on Hospital Accreditation, The College of Family Physicians of Canada, The Medical Council of Canada, The Medical Research Council, The Federation of Provincial Medical Licensing Authorities of Canada, and other organizations which may be added. The Committee will coordinate surveys of educational institutions and standardize forms and procedures. A larger Joint Conference Committee on Medical Education will function in communication and liaison without executive authority.

b. In the area of graduate medical education, several other groups currently play major roles in determining policies and standards:

1. There are 19 Residency Review Committees composed of representatives of the AMA-CME and of appropriate specialty board and specialty society representatives. These committees have acted as accrediting bodies for their respective areas of residency training under authority delegated to them by AMA-CME and the corresponding boards and societies. In addition, the Institutional Review Committee of the American Board of Pathology has functioned as the review and accrediting body for pathology residencies without AMA representatives. All of these committees would continue to function after formation of the new

Commission, but they would report their actions to the Commission through its Committee on Graduate Medical Education and the Commission could influence their actions by its policy decisions and recommendations.

2. There are 19 primary specialty boards, autonomous organizations which have profound effect upon graduate medical education through the nature of their requirements for certification. The Advisory Board for Medical Specialties, now being reorganized as The Association of Medical Specialty Boards, has served as a coordinating agency for the various boards, but without executive authority. The Advisory Board has also collaborated with AMA-CME, through the Liaison Committee for Specialty Boards, in establishing standards for recognition of new specialty boards. Because of the important role which specialty certification has played and is now playing in influencing medical educational programs, it is proposed that representatives of the Association of Medical Specialty Boards serve both on the Commission and on the Committee on Graduate Medical Education. Active liaison would also be maintained between the Commission and the specialty boards through the Liaison Committee for Specialty Boards, which would then be a liaison committee of the Commission, through its graduate committee, and The Association of Medical Specialty Boards. The specialty boards and their Association would retain their autonomy and independence after formation of the new Commission, but would undoubtedly be influenced in their activities by the Commission's policy decisions and recommendations.

3. Liaison relations, probably of less formal nature, would also be maintained between the Committee on Graduate Medical Education and the following organizations:

- (a) The Educational Council for Foreign Medical Graduates
- (b) The proposed new Commission on Foreign Medical Graduates
- (c) The Federation of State Medical Boards

(d) The Council of Medical Specialty Societies

(e) The Royal College of Physicians and Surgeons of Canada

(f) The Canadian Medical Association

c. In the area of continuing medical education, only AMA-CME has attempted to establish educational standards and carry out accreditation procedures. The Committee on Continuation Education of AAMC has now recommended that AAMC participate in this accreditation activity. Another major force in continuing education is HEW's Regional Medical Program which is providing the stimulus and financing for new developments.

Educational activities would logically fall under the purview of the Commission's Committee on Continuing Medical Education which included representation from HEW and the Association for Hospital Medical Education (representing the directors of graduate and continuing medical education in community hospitals.) At the request of some of the Canadian medical schools, AMA-CME is already beginning to explore cooperative arrangements with the Association for Continuing Medical Education in Canada (an outgrowth of AAMC) and with the Canadian Medical Association, to include review of Canadian continuing education programs in AMA's accreditation procedures. These liaison relationships could readily be assumed by the new Commission.

d. In the area of education for the allied health professions and services, accreditation procedures and lines of authority are less well established. Consequently it is impossible to spell out all of the organizational and administrative relationships for the new Commission at this time. However, there are certain allied professions and services in which procedures have been standardized and these can provide a base for further development:

(1) AMA-CME now serves as the single common denominator for the accreditation of 10 different allied health educational programs, acting in collaboration with appropriate medical specialty groups and professional associations in each area. Negotiation is now in progress for the establishment of educational standards preparatory to accreditation in several other fields.

(2) Survey and review procedures are carried out by liaison organizations of the appropriate medical specialty societies and professional or technical associations (often called "boards of schools") which then report their recommendations to the Council on Medical Education for its approval.

(3) AMA's Council on Health Manpower and Council on Medical Education are developing guidelines for procedures with newly emerging allied health groups. Basically, this involves definition of the role and function of the new allied health workers by the Council on Health Manpower and determination of the nature and content of the educational programs to produce such workers by the Council on Medical Education.

(4) The recently established Association of Schools of the Allied Health Professions will undoubtedly be an important guiding force in the development of the field and should be represented on the allied health committee of the Commission.

(5) AAMC has recently taken leadership to establish a new Federation of Associations of Schools of the Health Professions, which embraces certain health professions which carry on their educational programs relatively independently. These include dentistry, ~~pharmacy~~, nursing, pharmacy and veterinary medicine in addition to the allied health professions for which medicine has provided educational leadership. While it seems unlikely that most of these allied health fields will want to function under the jurisdiction of the new Commission, it will be important for the Commission to maintain liaison with them, either through the new Federation or individually and separately.

Membership of Commission and Committees

Additional Representatives
from:

Commission - 15

- 4 American Medical Association, Council on Medical Education
- 4 Association of American Medical Colleges
- 1 American Hospital Association
- 1 Association of Medical Specialty Boards
- 2 Public
- 1 Government, Assistant Secretary for Health
- 2 Ad Hoc, to be selected annually

Council of Specialty Societies

Committee on Undergraduate Medical Education - 10

- 4 American Medical Association, Council on Medical Education
- 4 Association of American Medical Colleges
- 1 Department of Health, Education and Welfare
- 1 Student American Medical Association

National Boards

Committee on Graduate Medical Education - 10

- 3 American Medical Association, Council on Medical Education
- 3 Association of American Medical Colleges
- 1 Association of Medical Specialty Boards
- 1 Association for Hospital Medical Education
- 1 American Hospital Association
- 1 Department of Health, Education and Welfare

Medical Specialty Boards

Committee on Continuing Medical Education - 10

- 4 American Medical Association, Council on Medical Education
- 4 Association of American Medical Colleges
- 1 Association for Hospital Medical Education
- 1 Department of Health, Education and Welfare

Committee on Allied Health Education - 10

- 3 American Medical Association, Council on Medical Education
- 3 Association of American Medical Colleges
- 2 Association of Schools of Allied Health Professions
- 1 American Hospital Association
- 1 Department of Health, Education and Welfare

Cost: About \$10,000 per commission representative per year for three years

Budget: Drawn up within limits of this income for three years

Staff Mechanism and Accounting: As handled today between AAMC and AMA in case of Liaison Committee

COMMISSION ON MEDICAL EDUCATION

COMMITTEE ON UNDERGRADUATE MEDICAL EDUCATION

COMMITTEE ON GRADUATE MEDICAL EDUCATION

COMMITTEE ON CONTINUING MEDICAL EDUCATION

COMMITTEE ON ALLIED HEALTH EDUCATION

ECFMG

CFMG

Canadian Medical Association

Royal Coll. Phys. & Surg (Can)

ACMC

Fed. Sch. Allied Health

ACMC

Residency Review Committees

Advisory Board for Medical Specialties

Fed. State Med Bds

Assn. of Schools of Allied Health Prof.

Boards of Schools Liaison Organization

Specialty Societies

Specialty Boards

Medical Specialty Societies

Allied Professional & Technical Soc.

Operation of the Commission and its Committees

A. The Commission would meet 2 - 4 times annually depending upon the number of problems and policy matters requiring consideration. Some of the early meetings would be devoted to determination of the nature of the Commission's activities and its relation to the 4 committees. In general, the Commission would deal with broad policy matters and would coordinate activities among the various levels of medical and allied health education. It would also identify areas needing correction or study and would authorize or recommend whatever action seemed indicated.

As noted above, the Commission would be chaired and staffed alternately by AMA and AAMC as is now the case for the Liaison Committee on Medical Education. Costs of the Commission's activities would be borne equally by AMA and AAMC, although expenses of its members would be the responsibility of the organizations being represented.

B. The 4 committees would probably meet 4 times annually, with the possibility that more frequent meetings might be necessary to deal with special problems. At the present time, for example, the Council on Medical Education's Advisory Committee on Education for the Allied Health Professions and Services has been meeting about every 2 months because of a number of urgent problems in that field, and it is possible that the Commission's Committee would also find it necessary to meet that frequently.

Ultimately it might be anticipated that staffing and financial support for the 4 committees, and for activities carried out under their direction, would be borne equally by AMA and AAMC. However, AMA has been involved in all four areas for many years and carries on extensive staff activities as a part of its regular operations. It would not be expected that AAMC would suddenly match that effort and involvement. Rather there would be projected a gradual increase in the participation of AAMC staff in accreditation and other procedures. Meanwhile AMA would continue to bear the major portion of staff and financial responsibility.

AAMC would have representation equal to AMA on each committee and would be expected to pay the expenses of its representatives, as would other organizations having representation. Each committee would elect its own chairman annually and the chairman or his designè would attend meetings of the Commission. Committee secretaries in all except the undergraduate area would probably come initially from AMA staff, but this responsibility would be shared as rapidly as AAMC staff becomes available.



COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

1346 CONNECTICUT AVENUE, N. W. • WASHINGTON, D. C. 20036 • (202) 223-5364

LISTING OF STAFF MEMBERS
COUNCIL OF TEACHING HOSPITALS

<u>Name</u>	<u>Title</u>
Matthew F. McNulty, Jr.	Director, Council of Teaching Hospitals, and Associate Director, AAMC
Fletcher H. Bingham, Ph.D	Assistant Director, Council of Teaching Hospitals
Grace W. Beirne	Staff Associate, Council of Teaching Hospitals
Richard M. Knapp, Ph.D.	Project Director, Teaching Hospital Information Center (COTHRIC)
Armand Checker	Staff Associate, COTHRIC
Clara J. Williams	Project Director, Study of Effects of Recent Social Legislation on Teaching Hospitals (COTHMED)
Howard R. Veit	Assistant Project Director, COTHMED
Elizabeth B. Knapp	Secretary to the Director, COTH
Catharine A. Rivera	Secretary to the Assistant Director, COTH
Donna D. Dove	General Secretary, COTH
Helen R. McMahon	General Secretary, COTH
Janet Kearns	General Secretary, COTHRIC
Patricia Fairweather	General Secretary, COTH

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

REPORT ON ACTION ITEMS

EXECUTIVE COMMITTEE MEETING (#69-2)
Saturday, February 8, 1969
Chicago, Illinois

<u>ACTION #1</u>	On motion, seconded and carried, the Minutes of Executive Committee Meeting #69-1, January 9 and 10, 1969, were approved as presented.	<u>No Report</u>
<u>ACTION #2</u>	On motion, seconded and carried, the application for membership in the Council of Teaching Hospitals from St. Luke's Hospital, Kansas City, Missouri, was unanimously approved by the COTH Executive Committee.	<u>No Report</u>
<u>ACTION #3</u>	On motion, seconded and carried, the application for membership in the Council of Teaching Hospitals from North Shore Hospital, Manhasset, New York, was unanimously approved by the COTH Executive Committee.	<u>No Report</u>
<u>ACTION #4</u>	It was agreed that members forward further substantive and/or editorial comments on the draft paper on comprehensive planning to COTH Staff to be incorporated into a final paper to be acted upon at the May COTH Executive Committee Meeting.	<u>Appears as a later agenda item</u>
<u>ACTION #5</u>	It was agreed that members review the draft proposal for a Commission on Medical Education and submit any comments to the COTH Staff prior to April so that the Council of Teaching Hospitals can have informed input into the AAMC Executive Council consideration of the proposal.	<u>Verbal Report</u>

March 13, 1969

W. N. Hubbard, Jr., M.D.
Dean
The University of Michigan
Medical School
Ann Arbor, Michigan 48104

Dear Bill:

Thank you very much for your very complete and thoughtful letter of March 10th in which you nominate, for membership in the Council of Teaching Hospitals, the Detroit Osteopathic Hospital of Detroit, Michigan.

I remember very well the initial correspondence we had with Ralph F. Lindberg, D.D., the Executive Director of the Detroit Osteopathic Hospital. As I believe I mentioned to you during our most recent discussion on this application, we did take Dr. Lindberg's initial inquiry to the COTH Executive Committee, which also serves as the committee on selection for membership. The reaction of the Executive Committee was that the Detroit Osteopathic Hospital was not eligible for self-nomination, as this mechanism for application as specified in the COTH Rules and Regulations, was limited to those institutions having appropriate AOA - medical specialty internship and residency approval.

It is the usual procedure when receiving a nomination by a dean for hospital membership in the Council to routinely circulate the nomination to the Executive Committee by mail ballot. In this case, however, I do think that discussion and clarification of existing criteria is necessary and I am therefore circumnavigating this procedure and am scheduling it as an agenda item for the next meeting of the Executive Committee, now scheduled for May 8th and 9th.

I do want to emphasize that I am taking this latter course of action in order to insure full and free discussion on what may be a delicate issue, and not because of the quality of the application.

ed

W. H. Hubbard, Jr., M.D.
March 13, 1969
Page Two

In closing, I do want to take this opportunity to thank you and the other members of your faculty who visited the institution as well as the Executive Committee of the Medical School for your very thoughtful interest in regard to this issue.

We will be in touch with you very shortly after the May 8th and 9th meeting of the Executive Committee.

Until then, Best regards.

Cordially,

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

M:car

bcc: Roy S. Rambeck (with attachment)
T. Stewart Hamilton, M.D. (with attachment)

THE UNIVERSITY OF MICHIGAN

MEDICAL SCHOOL

ANN ARBOR, MICHIGAN 48104

OFFICE OF THE DEAN

March 10, 1969

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

Dear Matt:

I am writing to nominate for membership in the Council of Teaching Hospitals the Detroit Osteopathic Hospital of Detroit, Michigan. This nomination is submitted with the endorsement of the Executive Committee of the Medical School of The University of Michigan.

Over a year ago, correspondence was exchanged between Ralph F. Lindberg, D.O., the Executive Director of the Detroit Osteopathic Hospital, and yourself regarding membership of that hospital in the Council of Teaching Hospitals. At that time the general rules of the COTH were set forth.

In early May of last year, conversations were initiated between Stuart F. Harkness, D.O., Director of Medical Education of the Detroit Osteopathic Hospital, and myself regarding the possibility of nomination of that hospital for membership by this office. After informal discussions it was agreed that visits by our faculty analogous to the residency review visits should be undertaken. The Hospital then prepared the questionnaire forms for residency review in Pathology, Surgery and Internal Medicine. During a one day visit, Dr. C. Gardner Child, 3rd, Chairman of the Department of Surgery, Dr. A. James French, Chairman of the Department of Pathology, Dr. William D. Robinson, Chairman of the Department of Internal Medicine, and I together reviewed the general organization and administration of the training program and the conduct of medical staff affairs. Subsequently, each of these

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MAR 12 1969

REC'D-MICH. S. C.

Dr. M. F. McNulty, Jr.

-2-

March 10, 1969

men spent a minimum of one full day in making the usual on-site review for a residency program.

It can be reported that this is a teaching hospital in the fullest sense of the word. Regular clerkships for osteopathic medical students are conducted in medicine and in surgery. These students come principally from the Chicago School of Osteopathic Medicine. The Hospital has 387 general acute beds and represents the most highly developed training program within osteopathic medicine. In addition to residencies in medicine, surgery and pathology, there are also residencies in radiology, obstetrics and gynecology, ophthalmology, otorhinolaryngology, orthopedics and neurosurgery.

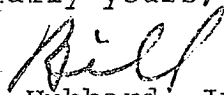
The resources available for the training program both in the number and variety of extensively trained physicians and the richness of research programs and academic affiliation are all much less adequate than would be desirable. On the other hand, every effort is made to practice and teach scientific and humane medicine at the highest achievable level. [The over-all impression of the visitors is that these residency and internship programs would rank at or below the minimum standard set by the review bodies.] On the other hand, the quality and intensity of effort to enhance the quality of the programs and the degree to which resources available are utilized create an admirable educational atmosphere.

At the present time the Wayne State University School of Medicine is accommodating residents and staff members in some of the medical specialties and making its library available to this Hospital staff. The University of Michigan Medical School has agreed to work with representatives of the Detroit Osteopathic Hospital in a continuing effort to assist in the growth of their teaching programs. It is hoped that through membership in the Council of Teaching Hospitals this sort of liaison will be more comfortably made to the mutual advantage of all concerned.

I would be pleased to provide further information if it is useful to your discussions of this nomination.

Best personal wishes,

Cordially yours,


W. N. Hubbard, Jr., M.D.
Dean

WNH:des

FHB
~~CSB~~
EAB
F. K.

McN
3-12-68

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 on 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

S4S-EA
3/5

December 7, 1967

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

Dear Dr. Lindberg:

Your letter of November 28, addressed to Dr. Robert C. Berson, the Executive Director of the AAMC, has been referred to the Council for reply.

The questions posed in your letter, regarding your institution's eligibility for membership, have never arisen before. Correspondingly, no firm policy decision has been made by the COTH Executive Committee, which also serves as an interim membership approval committee, with regard to these issues.

The "Rules and Regulations" of the Council, however, are quite explicit and specific in their definitions of the criteria for membership. As you will note in the attached copy of the "Rules and Regulations", the dual minimum standards for membership are those hospitals either nominated by a medical school member of the AAMC or which have approved internship programs and full residencies in three of the five following departments- Medicine, Surgery, OB-GYN, Pediatrics and Psychiatry.

Because of the uniqueness of the question which you posed, I will pursue it through that organizational element of the Council responsible for such decisions and will be in touch with you once a firm solution has been reached.

Thank you for your interest in the Council.

Very sincerely yours,

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

FHB: vg

cc: Robert C. Berson, M.D. (without attachment)

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DETROIT OSTEOPATHIC HOSPITAL CORPORATION

12523 THIRD AVENUE • DETROIT, MICHIGAN, 48203

November 28, 1967

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NOV 30 '67

AAMC

Mr. Robert C. Berson, Executive Director
Association of American Medical Colleges
2530 Ridge Avenue
Evanston, Illinois

Dear Mr. Berson:

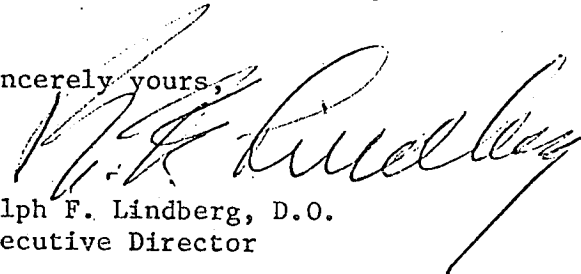
I have been an individual member of the Association of American Medical Colleges for many years and have attended some of the annual meetings. I am the Executive Director of the Detroit Osteopathic Hospital Corporation responsible for the operation of the three hospitals owned and controlled by our nonprofit corporation.

These three hospitals are, Detroit Osteopathic Hospital in Highland Park, Michigan, Riverside Osteopathic Hospital in Trenton, Michigan and Bi-County Community Hospital in Warren, Michigan. All three hospitals are approved by the American Osteopathic Association for the training of interns and residents. Detroit Osteopathic Hospital is an off-campus teaching hospital of the Chicago College of Osteopathy. This is an official affiliation meeting the requirements of the United States Public Health Service in their approval of the grant-in-aid to the Chicago College for a construction program.

My reason for writing this letter is to inquire if the membership requirements of the Council of Teaching Hospitals would permit Detroit Osteopathic Hospital to be a member of this Council in some category or to have some status whereby I, or some members of our teaching staff (who are individual members of the A.A.M.C.) could attend the educational sessions of this Council of Teaching Hospitals.

I shall be happy to supply any additional information should you so desire.

Sincerely yours,


Ralph F. Lindberg, D.O.
Executive Director

RFL:mh

BI-COUNTY COMMUNITY HOSPITAL
WARREN, MICHIGAN, 48099
758-1800

DETROIT OSTEOPATHIC HOSPITAL
DETROIT, MICHIGAN, 48203
869-1200

RIVERSIDE OSTEOPATHIC HOSPITAL
TRENTON, MICHIGAN, 48183
676-4200

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ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership
in the
Council of Teaching Hospitals

From the Office of:
MATTHEW F. McNULTY, JR., DIRECTOR
COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
1346 CONNECTICUT AVENUE, N.W.
WASHINGTON, D.C. 20036
202/223-5364

(Please type)

Hospital: Greater Baltimore Medical Center
Name
6701 North Charles Street
Street
Baltimore Maryland 21204
City State Zip Code

Principal Administrative Officer: Paul O. Becker
Name
Director
Title

Hospital Statistics:
Date Hospital was Established: September 15, 1965
Average Daily Census: 337
Annual Outpatient Clinical Visits: 59,440

Approved Internships:

Type	* Date Of Initial Approval by CME of AMA*	Total Internships Offered	Total Internships Filled
Rotating	<u>Feb. 1966</u>	<u>16</u>	<u>16</u>
Mixed			
Straight (Medicine)	<u>Feb. 1966</u>	<u>4</u>	<u>4</u>

Approved Residencies:

Specialties	* Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total Residencies Filled
Medicine	<u>Feb. 1966</u>	<u>9</u>	<u>9</u>
Surgery	<u>Mar. 1967</u>	<u>6</u>	<u>6</u>
OB-Gyn	<u>Nov. 1967</u>	<u>8</u>	<u>8</u>
Pediatrics	<u>(AFFILIATION</u>	<u>JOHNS HOPKINS HOSPITAL)</u>	
Psychiatry			

Information submitted by:

Paul O. Becker
Name
May 6, 1969
Date

Director
Title
Paul O. Becker
Signature

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

* THESE PROGRAMS, WITH EXCEPTION OF SURGERY, WERE TRANSFERRED PROGRAMS
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FROM HOSP. FOR WOMEN OF MD., BALTO., MD. WHICH CEASED OPERATIONS 9/15/65.

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ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership
in the
Council of Teaching Hospitals

From the Office of:
MATTHEW E. NEWBY, JR., DIRECTOR
COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
1348 CONNELL AVENUE, N.W.
WASHINGTON, D.C. 20036
228/223-5364

(Please type)

Hospital: Kaiser Foundation Hospital Name

2425 Geary Boulevard

San Francisco Street Calif. 94115

City State Zip Code

Principal Administrative Officer: D. D. Nesbit Name

Administrator Title

Hospital Statistics:

Date Hospital was Established: 1954

Average Daily Census: 256

Annual Outpatient Clinical Visits: 660,255

Approved Internships:

Type	Date Of Initial Approval by CME of AMA*	Total Internships Offered	Total Internships Filled
Rotating	<u>1955</u>	<u>18</u>	<u>18</u>
Mixed	<u>Medicine 1966</u>	<u>2</u>	<u>2</u>
Straight	<u>Surgery 1966</u>	<u>2</u>	<u>2</u>
	<u>Pathology 1966</u>	<u>2</u>	<u>0</u>

Approved Residencies:

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total Residencies Filled
Medicine	<u>1956</u>	<u>12</u>	<u>12</u>
Surgery	<u>1957</u>	<u>11</u>	<u>11</u>
OB-Gyn	<u>1955</u>	<u>8</u>	<u>8</u>
Pediatrics	<u>1958</u>	<u>4</u>	<u>4</u>
Psychiatry	<u></u>	<u></u>	<u></u>

Information submitted by:

A. H. Lieberman, M.D. Name

3-27-69 Date

Director of Medical Education Title

A. H. Lieberman Signature

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

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SAINT JOHN HOSPITAL 22101 MOROSS ROAD / DETROIT, MICHIGAN / 48236

PHONE 881-8200

April 28, 1969

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

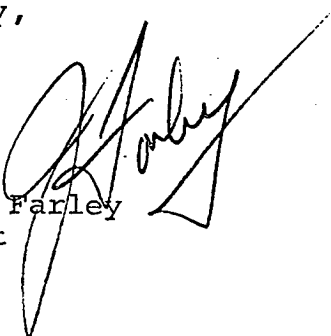
Dear Mr. McNulty:

Enclosed is the completed application for membership of Saint John Hospital in the Association of American Medical Colleges, Council of Teaching Hospitals.

As you can see, in addition to the 27 residencies and 18 internships approved between 1953 and 1956, we have recently added four residencies in pathology. Since these have just been approved, we are now accepting applications for next year. These four positions remain unfilled at this moment.

We are looking forward to membership in the Council of Teaching Hospitals and will await your reply on the decision regarding our application.

Sincerely,


James T. Farley
President

JTF/sy
Encl.

cc: W. E. Rush, M.D.,
Director, Medical Education

AMC-WASH. D. C.
MAY 1 1969
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ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership
in the
Council of Teaching Hospitals

From the Office of:
MATTHEW F. MURPHY, JR., DIRECTOR
COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
1346 CONNECTICUT AVENUE, N.W.
WASHINGTON, D.C. 20036
202/223-5364

(Please type)

Hospital: Saint John Hospital
Name
22101 Moross
Street
Detroit Michigan 48236
City State Zip Code

Principal Administrative Officer: James T. Farley
Name
President and Chief Executive Officer
Title

Hospital Statistics:
Date Hospital was Established: 1952
Average Daily Census: 497
Annual Outpatient Clinical Visits: 23,274 (37,000 Emergency Room Visits)

Approved Internships:

Type	Date Of Initial Approval by CME of AMA*	Total Internships Offered	Total Internships Filled
Rotating	<u>1953</u>	<u>18</u>	<u>18</u>
Mixed	<u></u>	<u></u>	<u></u>
Straight	<u></u>	<u></u>	<u></u>

Approved Residencies:

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total Residencies Filled
Medicine	<u>1956</u>	<u>9</u>	<u>9</u>
Surgery	<u>1954</u>	<u>12</u>	<u>12</u>
OB-Gyn	<u>1954</u>	<u>6</u>	<u>6</u>
PATHOLOGY	<u>1969</u>	<u>4</u>	<u>0</u>
Pediatrics	<u></u>	<u></u>	<u></u>
Psychiatry	<u></u>	<u></u>	<u></u>

Information submitted by:

William E. Rush, M.D.
Name
April 8, 1969
Date

Director of Medical Education
Title
William E. Rush M.D.
Signature

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

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Office of the Dean

January 14, 1969

Mr. Matthew F. McNulty, Jr.
Director Council of Teaching Hospitals
Associate Director AAMC
1346 Connecticut Avenue N.W.
Washington, D.C. 20036

Dear Mr. McNulty:

I should like to recommend for your approval the appointment of three Minneapolis hospitals to the Council of Teaching Hospitals. These hospitals do not meet the usual criteria for membership in that they do not have the required number of approved residency programs. They are, however, each affiliated with the Medical School in programs of medical student and house staff teaching to a significant degree. The existing members of the local Council of Teaching Hospitals have agreed as well to recommend them.

The first of these hospitals is Mount Sinai Hospital of Minneapolis. Mount Sinai Hospital has become a Limited affiliate of the University of Minnesota. Programs of medical student teaching and residency training are conducted in that hospital in Surgery and Internal Medicine. The hospital has employed full-time directors of each of these services who have appointments on the regular faculty of the University of Minnesota Medical School. These directors and other members of the staff and administration have expressed their desire to become a member of the Council of Teaching Hospitals.

Fairview Hospital and St. Mary's Hospital, both of Minneapolis, have combined to provide a program of medical education. At the present time, medical student programs are conducted on a regular basis as a part of the curriculum of this School in Orthopedics, Psychiatry, and Obstetrics. Residency rotations from approved programs of the University of Minnesota are conducted in Orthopedics and Obstetrics. In Orthopedics a member of our full-time faculty is in charge of that program. A director of the obstetrical program is to be hired soon who will be full-time in that hospital and a member of the regular faculty of the Medical School. Dr. William

HEALTH SCIENCES CENTER

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JAN 15 1969
AAMC-WASH., D. C.

Mr. Matthew F. McNulty, Jr.

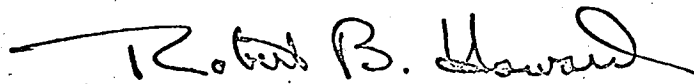
January 14, 1969

Page 2

Mazzitello is Director of Medical Education at St. Mary's Hospital and Dr. Dawes Miller is Director of Medical Education at Fairview Hospital. The existing members of the local Council of Teaching Hospitals favor inclusion of these two hospitals in its membership. Members of the staff of each hospital as well as the administration have requested membership in the Council.

On the basis of their contributions to the teaching program of the University of Minnesota Medical School and the existence of established and significant programs of medical education in the hospitals, I should like to recommend that each of these hospitals be named members of the Council of Teaching Hospitals.

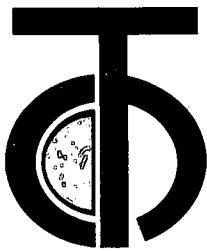
Sincerely yours,



Robert B. Howard, M.D.

Dean

RBH/ljb



COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

1346 CONNECTICUT AVENUE, N. W. • WASHINGTON, D. C. 20036 • (202) 223-5364

Officers and Executive Committee:

Memo: 69-11E

February 28, 1969

Roy S. Rambeck, Chairman *
T. Stewart Hamilton, M.D., Chairman-Elect *
Lad F. Grapski, Immediate Past Chairman
Matthew F. McNulty, Jr., Secretary
L. H. Gunter
David Odell
Irvin G. Wilmot
Ernest N. Boettcher
Leonard W. Cronkhite, Jr., M.D.
Charles R. Goulet
Charles E. Burbridge, Ph.D.
Charles H. Frenzel
Reid T. Holmes
Russell A. Nelson, M.D., Ex Officio Member with Voting Privileges *
Joseph H. McNinch, M.D., AHA Representative
* indicates COTH Representative to AAMC Executive Council

Subject: Application for Membership from St. Mary's Hospital, Minneapolis, Minnesota

The attached application for membership from St. Mary's Hospital seems to be in order. The internship and residency programs have been checked through the resources of the Council of Medical Education of the American Medical Association and have been verified as existing as indicated in the application.

It is the recommendation of your staff that the application for membership in the Council of Teaching Hospitals from St. Mary's Hospital be approved. There is attached a post card for response. It would be helpful if your office could complete the post card as promptly as convenient.

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

Attachment: postal card for return to COTH offices

PLEASE READ INSTRUCTIONS ON REVERSE SIDE

From the Office of:
MATTHEW E. McARDY, JR., DIRECTOR
COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
1346 CONNECTICUT AVENUE, N.W.
WASHINGTON, D.C. 20036
202/223-5364

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership
in the
Council of Teaching Hospitals

(Please type)

Hospital: St. Mary's Hospital

Name

2414 South Seventh Street

Street

Minneapolis, Minnesota 55406

City

State

Zip Code

Principal Administrative Officer: Sister Mary Madonna

Name

Executive Vice President

Title

Hospital Statistics:

Date Hospital was Established: 1887

Average Daily Census: 406 (excluding newborn)

Annual Outpatient Clinical Visits: 19,336

Approved Internships:

Type	Date Of Initial Approval by CME of AMA*	Total Internships Offered	Total Internships Filled
Rotating	<u>1905:see cover letter</u>	<u>14</u>	<u>7</u>
Mixed	<u></u>	<u></u>	<u></u>
Straight	<u></u>	<u></u>	<u></u>

Approved Residencies:

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total Residencies Filled
Medicine	<u></u>	<u></u>	<u></u>
Surgery -orthopedic	<u>1-17-69</u>	<u>2</u>	<u>2</u>
OB-Gyn	<u>1946:see cover letter</u>	<u></u>	<u></u>
Pediatrics	<u></u>	<u></u>	<u></u>
Psychiatry	<u></u>	<u></u>	<u></u>

Information submitted by:

Sister Mary Madonna

Name

February 24, 1969

Date

Executive Vice President

Title

Sister Mary Madonna

Signature

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

PLEASE NOTE ATTACHED LETTER FROM ROBERT B. HOWARD, M.D., DEAN, COLLEGE OF MEDICINE, UNIVERSITY OF MINNESOTA, NOMINATING ST. MARY'S HOSPITAL FOR MEMBERSHIP IN THE COUNCIL.

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 University of Minnesota School of Medicine
University of Minnesota

Name of Parent University _____

Name of Dean of School of Medicine Robert B. Howard, M.D., Dean

From the Office of:
 Complete address of School of Medicine
 MATTHEW F. MORSELEY, JR., DIRECTOR

COUNCIL OF TEACHING HOSPITALS
 ASSOCIATION OF AMERICAN MEDICAL COLLEGES
 1346 CONNECTICUT AVENUE, N.W.
 WASHINGTON, D.C. 20036
 202/223-5364

University of Minnesota Health Science Center
University of Minnesota
Minneapolis, Minnesota 55455

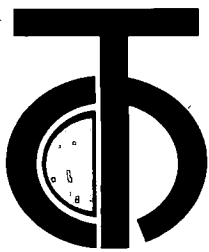
FOR AAMC OFFICE USE ONLY:

Date _____ Approved _____ Disapproved _____ Pending _____

Remarks: _____

Invoiced _____ Remittance Received _____

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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

Officers and Executive Committee:

Memo: 69-12E
February 28, 1969

Roy S. Rambeck, Chairman *
T. Stewart Hamilton, M.D., Chairman-Elect *
Lad F. Grapski, Immediate Past Chairman
Matthew F. McNulty, Jr., Secretary
L. H. Gunter
David Odell
Irvin G. Wilmot
Ernest N. Boettcher
Leonard W. Cronkhite, Jr., M.D.
Charles R. Coulet
Charles E. Burbridge, Ph.D.
Charles H. Frenzel
Reid T. Holmes
Russell A. Nelson, M.D., Ex Officio Member with Voting Privileges *
Joseph H. McNinch, M.D., AHA Representative
* Indicates COTH Representative to AAMC Executive Council

Subject: Application for Membership from the Fairview Hospital, Minneapolis, Minnesota

The attached application for membership from the Fairview Hospital seems to be in order. The internship and residency programs have been checked through the resources of the Council of Medical Education of the American Medical Association and have been verified as existing as indicated in the application.

It is the recommendation of your staff that the application for membership in the Council of Teaching Hospitals from the Fairview Hospital be approved. There is attached a post card for response. It would be helpful if your office could complete the post card as promptly as convenient.

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

Attachment: Postal card for return to COTH offices

RECEIVED
 FEB 27 1969
 AAMC-WASH., D. C.

PLEASE READ INSTRUCTIONS ON REVERSE SIDE

From the Office of:
 MATTHEW F. McHULTY, JR., DIRECTOR
 COUNCIL OF TEACHING HOSPITALS
 ASSOCIATION OF AMERICAN MEDICAL COLLEGES
 1346 CONNECTICUT AVENUE, N.W.
 WASHINGTON, D.C. 20036
 202/223-5364

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership
 in the
 Council of Teaching Hospitals

(Please type)

Hospital: Fairview Hospital
2312 South 6th Street Name
Minneapolis, Minnesota Street
55406 Zip Code
 City State

Principal Administrative Officer: Carl N. Platou Name
Executive Vice President Title

Hospital Statistics:
 Date Hospital was Established: 1916
 Average Daily Census: 337
 Annual Outpatient Clinical Visits: 17,488

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
General Practice <i>Medicine</i>	<u>11-30-40</u>	<u>8</u>	<u>5</u>
Orthopedic Surgery	<u>1-17-69</u>	<u>2</u>	<u>2</u>
OB-Gyn	_____	_____	_____
Pediatrics	_____	_____	_____
Psychiatry	_____	_____	_____

Information submitted by:

Carl N. Platou Name
2/24/69 Date
Executive Vice President Title
Carl N. Platou Signature

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

PLEASE NOTE ATTACHED LETTER FROM ROBERT B. HOWARD, M.D., DEAN, COLLEGE OF MEDICINE, UNIVERSITY OF MINNESOTA, NOMINATING ST. MARY'S HOSPITAL FOR MEMBERSHIP

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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 University of Minn. Health Sci. Center

Name of Parent University University of Minnesota

Name of Dean of School of Medicine Robert B. Howard, M.D., Dean

From the Office of: Univ. of Minn. Health Sci. Center
Complete address of School of Medicine

University of Minnesota

Minneapolis, Minnesota 55455

MATTHEW F. MURPHY, JR., DIRECTOR

COUNCIL OF TEACHING HOSPITALS

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

1346 CONNECTICUT AVENUE, N.W.

WASHINGTON, D.C. 20036

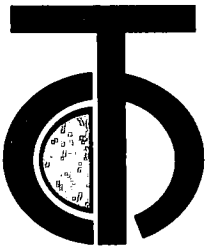
202/223-5364

FOR AAMC OFFICE USE ONLY:

Date _____ Approved _____ Disapproved _____ Pending _____

Remarks: _____

Invoiced _____ Remittance Received _____



COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

1346 CONNECTICUT AVENUE, N. W. • WASHINGTON, D. C. 20036 • (202) 223-5364

Officers and Executive Committee:

Memo: 69-13E
February 28, 1969

Roy S. Rambeck, Chairman *
T. Stewart Hamilton, M.D., Chairman-Elect *
Lad F. Grapski, Immediate Past Chairman
Matthew F. McNulty, Jr., Secretary
L. H. Gunter
David Odell
Irvin G. Wilmot
Ernest N. Boettcher
Leonard W. Cronkhite, Jr., M.D.
Charles R. Goulet
Charles E. Burbridge, Ph.D.
Charles H. Frenzel
Reid T. Holmes
Russell A. Nelson, M.D., Ex Officio Member with Voting Privileges *
Joseph H. McNinch, M.D., AHA Representative
* Indicates COTH Representative to AAMC Executive Council

Subject: Application for Membership from Saint Barnabas Medical Center,
Livingston, New Jersey

The attached application for membership from the Saint Barnabas Medical Center seems to be in order. The internship and residency programs have been checked through the resources of the Council of Medical Education of the American Medical Association and have been verified as existing as indicated in the application.

It is the recommendation of your staff that the application for membership in the Council of Teaching Hospitals from the Saint Barnabas Medical Center be approved. There is attached a post card for response. It would be helpful if your office could complete the post card as promptly as convenient.

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

Attachment: Postal card for return to COTH offices.

PLEASE READ INSTRUCTIONS ON REVERSE SIDE

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership
in the
Council of Teaching Hospitals

From the Office of:
MATTHEW F. McHULTY, JR., DIRECTOR
COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
1346 CONNECTICUT AVENUE, N.W.
WASHINGTON, D.C. 20036
202/223-5364

(Please type)

Hospital: Saint Barnabas Medical Center Name

94 Old Short Hills Road Street

Livingston New Jersey 07039

City State Zip Code

Principal Administrative Officer: John D. Phillips Name

Administrator Title

Hospital Statistics:

Date Hospital was Established: 1865

Average Daily Census: 543

Annual Outpatient Clinical Visits: 12,195

Approved Internships:

Type	Date Of Initial Approval by CME of AMA*	Total Internships Offered	Total Internships Filled
Rotating	<u>Over 50 years</u>	<u>20</u>	<u>20</u>
Mixed	<u></u>	<u></u>	<u></u>
Straight	<u></u>	<u></u>	<u></u>

Approved Residencies:

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total Residencies Filled
Medicine	<u>March 22, 1968</u>	<u>3</u>	<u>3</u>
Surgery	<u>1947</u>	<u>* 8</u>	<u>* 8</u>
OB-Gyn	<u>January 11, 1969</u>	<u>6</u>	<u>2</u>
Pediatrics	<u></u>	<u></u>	<u></u>
Psychiatry	<u></u>	<u></u>	<u></u>

*Four (4) in 4 year program

Four (4) in 1 year program

Information submitted by:

Abdol H. Islami, M.D. Name

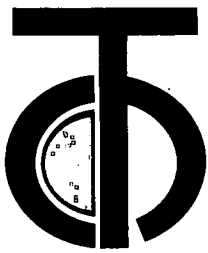
Director, Department of Medical Education Title

February 21, 1969 Date

Abdol H. Islami, M.D., F.A.C.S.

*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



COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

1346 CONNECTICUT AVENUE, N. W. • WASHINGTON, D. C. 20036 • (202) 223-5364

Officers and Executive Committee:

Memo: 69-16E

April 4, 1969

Roy S. Rambeck, Chairman *
T. Stewart Hamilton, M.D., Chairman-Elect *
Lad F. Grapski, Immediate Past Chairman
Matthew F. McNulty, Jr., Secretary
L. H. Gunter
David Odell
Irvin G. Wilmot
Ernest N. Boettcher
Leonard W. Cronkhite, Jr., M.D.
Charles R. Goulet
Charles E. Burbridge, Ph.D.
Charles H. Frenzel
Raid T. Holmes
Russell A. Nelson, M.D., Ex Officio Member with Voting Privileges *
Joseph H. McNinch, M.D., AHA Representative
* indicates COTH Representative to AAMC Executive Council

Subject: Application for Membership from the Northwestern Hospital,
Minneapolis, Minnesota

The attached application for membership from the Northwestern Hospital seems to be in order. The internship and residency programs have been checked through the resources of the Council of Medical Education of the American Medical Association and have been verified as existing as indicated in the application.

It is the recommendation of your staff that the application for membership in the Council of Teaching Hospitals from the Northwestern Hospital be approved. There is attached a post card for response. It would be helpful if your office could complete the post card as promptly as convenient.

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

Attachment: Postal card for return to COTH offices

PLEASE READ INSTRUCTIONS ON REVERSE SIDE

From the Office of:
MATTHEW F. MADDUX, JR., DIRECTOR
COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
1246 CONNECTICUT AVENUE, N.W.
WASHINGTON, D.C. 20036
202/223-5363

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership
in the
Council of Teaching Hospitals

(Please type)

Hospital: Northwestern Name

810 East 27th Street Street

Minneapolis City

Minnesota State

55407 Zip Code

Principal Administrative Officer: Stanley R. Nelson Name

President Title

Hospital Statistics:

Date Hospital was Established: November 20, 1882

Average Daily Census: 351

Annual Outpatient Clinical Visits: 32,579

Approved Internships:

Type	Date Of Initial Approval by CME of AMA*	Total Internships Offered	Total Internships Filled
Rotating	<u>July, 1932</u>	<u>6</u>	<u>1</u>
Mixed			
Straight	<u>July 1, 1966</u>	<u>6</u>	<u>6</u>

Approved Residencies:

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total Residencies Filled
Medicine	<u>July 1, 1947</u>	<u>6</u>	<u>5</u>
Surgery			
OB-Gyn			
Pediatrics			
Psychiatry			

Information submitted by:

Stanley R. Nelson Name

President Title

March 28, 1969 Date

Stanley R. Nelson 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

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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 College of Medical Sciences

Name of Parent University University of Minnesota

Name of Dean of School of Medicine Robert B. Howard, M.D.

Complete address of School of Medicine College of Medical Sciences

From the Office of:

University of Minnesota

Minneapolis, Minnesota 55455

MATTHEW E. LAMBERT, JR., DIRECTOR
COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
1800 CONSTITUTION AVENUE, N.W.
WASHINGTON, D.C. 20036

FOR OFFICE USE ONLY:

Date _____ Approved _____ Disapproved _____ Pending _____

Remarks: _____

Invoiced _____ Remittance Received _____

FH 123
I to 1/23/69
to Bob Howard
to McNulty
Mew
3-22-69

UNIVERSITY OF *Minnesota*

COLLEGE OF MEDICAL SCIENCES
MAYO MEMORIAL BUILDING • MINNEAPOLIS, MINNESOTA 55455

Office of the Dean

March 18, 1969

Mr. Matthew F. McNulty, Jr.
Director Council of Teaching Hospitals
Associate Director AAMC
1346 Connecticut Avenue N.W.
Washington, D.C. 20036

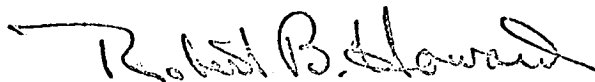
Dear Mr. McNulty:

I should like to recommend for your approval the appointment of an additional Minneapolis hospital to the Council of Teaching Hospitals. This hospital is similar in many respects to the three recommended to you in January in that they do not meet the usual criteria for membership in that it does not have the required house staff training program. It is, however, affiliated with the Medical School in programs of medical student teaching to a significant degree.

The hospital I wish to recommend at this time is Northwestern Hospital of Minneapolis. Northwestern Hospital is a Limited affiliate of the University of Minnesota. The Department of Internal Medicine has a medical student teaching program at that hospital under the direction of Dr. C.J. Watson, formerly Chairman of the University of Minnesota Department of Medicine. Dr. Watson's program receives students during the required rotation through Internal Medicine in the junior year and has been quite popular with students on the senior year elective program. Dr. Watson also has a limited number of house staff in his program, although this is not an integrated part of the house staff training program of the University. Plans are in progress for expansion of the teaching function of this hospital beyond the Department of Internal Medicine. Dr. Watson also conducts a research and research training program at Northwestern Hospital.

On the basis of the contributions of the teaching program at Northwestern Hospital to the University of Minnesota Medical School and the existence of established and significant programs in the hospital, I should like to recommend that Northwestern Hospital of Minneapolis be named a member of the Council of Teaching Hospitals.

Sincerely yours,



Robert B. Howard, M.D.
Dean

HEALTH SCIENCES CENTER
RBH/ljb

RECEIVED

MAR 20 1969

AAMC-WASH., D. C.

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: 351

Nominated by a Dean	223
Qualified by I&R Program	128
Canadian Members	3
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 Air Force Base, San Antonio, Texas (Southern Region)
2 - David Grant USAF Hospital, Travis Air Force Base, California (Western Region)

FOREIGN INSTITUTIONS: 1 - American University Hospital, Beirut, Lebanon (Northeastern Region)

DATE: May 7, 1969

STATES WITH NO MEMBER HOSPITALS: 8

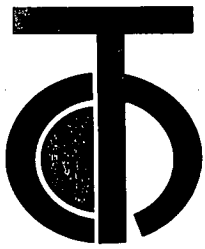
Western Region	6 (Alaska, Montana, Nevada, Wyoming, Idaho, New Mexico)
Midwest/Great Plains Region	2 (North Dakota, South Dakota)
Southern Region	0
Northeastern Region	0

DISTRIBUTION OF MEMBER HOSPITALS BY REGION:

Western Region	41 (Includes 2 hospitals in 2 provinces in Canada)
Midwest/Great Plains Region	90
Southern Region	71 (Includes 1 hospital in the Canal Zone)
Northeastern Region	149 (Includes 1 hospital in 1 province in Canada and 2 hospitals in Puerto Rico)

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)	?



COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

1346 CONNECTICUT AVENUE, N. W. • WASHINGTON, D. C. 20036 • (202) 223-5364

COTH MEMBERSHIP LISTED BY TYPE OF SERVICE

<u>Region</u>	<u>Number</u>						<u>Total</u>
	<u>General</u>	<u>Children</u>	<u>Psychiatric</u>	<u>Ear, Nose & Throat</u>	<u>Maternity</u>	<u>Other</u>	
Northeast	135	4	2	2	1	5	149
Southern	65	2	1	0	0	1	69
Midwest/ Gt. Plains	87	3	1	0	0	1	92
West	39	2	0	0	0	0	41
Total	<u>326</u>	<u>11</u>	<u>4</u>	<u>2</u>	<u>1</u>	<u>7</u>	<u>351</u>

<u>Region</u>	<u>Percentage</u>						<u>Total</u>
	<u>General</u>	<u>Children</u>	<u>Psychiatric</u>	<u>Ear, Nose & Throat</u>	<u>Maternity</u>	<u>Other</u>	
Northeast	91	3	1	1	1	3	100
Southern	95	3	1	0	0	1	100
Midwest/ Gt. Plains	95	3	1	0	0	1	100
Western	95	5	0	0	0	0	100
Total	<u>93</u>	<u>3</u>	<u>1</u>	<u>1</u>	<u>0</u>	<u>2</u>	<u>100</u>

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
Dupont Plaza Hotel
Washington, D.C.
March 28, 1969
10:00 a.m. - 4:00 p.m.

Present:

Charles R. Goulet, Chairman
Richard D. Wittrup, Vice-Chairman
Vernon L. Harris, COTH
William D. Mayer, M.D., COD
Gerhard Hartman, Ph.D., COTH
Arthur J. Klippen, M.D., COTH
Francis J. Sweeney, Jr., M.D., COTH
Lawrence E. Martin, COTH
Reid T. Holmes, COTH
Irvin G. Wilmot, COTH
Robert C. Linde, AHA Representative

Excused:

Robert H. Felix, M.D., COD
Leon O. Jacobson, M.D., COD
Bernard J. Lachner, COTH
Roger B. Nelson, M.D., COTH
Charles C. Sprague, M.D., COD

Also Present:

Howard W. Houser, Instructor, Graduate Program in Hospital and Health
Administration, University of Iowa
Gordon D. Brown, Instructor, Graduate Program in Hospital and Health
Administration, University of Iowa

Staff:

Robert C. Berson, M.D.
Matthew F. McNulty, Jr.
Fletcher H. Bingham, Ph.D.
Richard M. Knapp, Ph.D.
Armand Checker
Howard R. Veit

I. The Chairman Convened the Meeting Promptly at 10:00 a.m.:

II. Introduction and Welcome of New Committee Members:

Mr. Goulet, Chairman welcomed William D. Mayer, M.D., Dean, The University of Missouri School of Medicine as a new member of the committee representing the Council of Deans. It was indicated that three other COD representatives had incurred last minute commitments and thus could not be present. A complete roster of the reconstituted Committee is attached to these minutes.

III. Meeting of November 21, 1968:

The minutes of the November 21, 1968 meeting were approved as distributed.

IV. Report on Action Items of November 21, 1968 Meeting:

The Chairman reviewed the action items from the November 21st meeting and asked Dr. Bingham to comment on the action taken on the following items:

Action #1 The Committee directed the staff to prepare a questionnaire to be sent to selected institutions for the purpose of assessing the current situation with regard to house staff financing and the financial patterns of part-time and full-time clinical medical faculty practice. The staff will solicit evaluations of the proposed questionnaire from members of the Committee. Other data relevant to this issue will also be summarized in a manner meaningfully related to the dimensions of the questionnaire.

Action #2 The Committee directed the staff to prepare a General Membership Memorandum indicating the present and future

Action #2
continued

implications of the issue of "Dual Payment". Member institutions should be encouraged to examine their accounting systems to ensure an avoidance of duplicate payments.

Action #3

The Committee directed its chairman to work with staff to evolve staggered membership terms in order to provide an orderly opportunity for committee participation by all interested individuals.

Action #4

Because the charge to review this issue (financial support of the medically indigent) originated with the AAMC Executive Council and the COTH Executive Committee, the staff was directed to prepare an appropriate response to these two bodies.

Action #5

This issue (financial support for the medically indigent) was recommended for further review at the COTH Southern Regional Meeting in Atlanta on April 30, 1969.

Dr. Bingham indicated that a draft questionnaire had been developed, but that the Committee might wish to review implementation of the survey in view of recent developments. A General Membership Memorandum of payment was prepared, and included in the agenda book for Committee evaluation.

Staggered terms have been worked out for the Committee members which are attached to these minutes. Additionally, the staff has prepared appropriate responses to the AAMC Executive Council and the COTH Executive Committee regarding the Committee's discussion and review of "financial support for the medically indigent". The issue will receive further discussion at the COTH Southern Regional Meeting in Atlanta on April 30, 1969.

V. Report on the February 26th Meeting at the National Institutes of Health on General Clinical Research Centers:

The Chairman and Dr. Bingham, both of whom attended the meeting, reviewed the proceedings of that meeting. The purpose of the meeting was to discuss an October 1, 1968 memorandum from William R. DeCesare, M.D., Chief, General Clinical Research Centers Branch regarding the policy of admission of service patients to general clinical research centers. Both Mr. Goulet and Dr. Bingham stated that the issue did not receive the discussion in depth that was necessary. Thus, it was felt that very little in the way of constructive action resulted from the meeting.

Mr. Martin, reported that the Grants Administration Advisory Committee had also reviewed this issue. He noted that the question to be resolved is whether third party payments should be sought to support the GCRC's. Admissions may be generally classified as follows:

1. the strict research patient who would not otherwise be hospitalized;
2. the patient whose research status is incidental to hospitalization;
3. the strict service patient.

Mr. Martin reported that a consensus was reached by the GAAC that in the latter two cases, third party payment should be sought to the extent possible. The first type of patient clearly should be financed through GCRC funds. It was agreed that the GCRC Committee should be reconvened, selecting those who are fiscally oriented to be present.

ACTION #1 MR. MARTIN AGREED TO MAKE THIS RECOMMENDATION TO
DR. JOHN SHERMAN. THE STAFF WAS ADVISED TO WRITE
TO JOHN SHERMAN CONVEYING A SIMILAR RECOMMENDATION.

The question of who is responsible for the decision of classifying patients into one of the three aforementioned categories was discussed, but remained unresolved. The virtues of "utilization review" and "research protocol"

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committees for this function were explored briefly. It was agreed that these two committees should not be placed in a position which could lead to competition or conflict.

- VI. Report on Correspondence Received from Ernest N. Boettcher, M.D. and William D. Mayer, M.D. -- Possible Action:
- VII. Discussion of Request to Committee from the AAMC Committee on Federal Health Programs:

The Chairman suggested, and the Committee agreed, that these two items (VI and VII) be discussed jointed. Dr. Berson stated that the AAMC Committee on Federal Health Programs had reviewed the issues of Medicare and Medicaid at its most recent meeting on March 11, 1969. It was the consensus of that committee that responsibility of these issues should most effectively be handled by an enlarged COTH-COD Committee on Financial Principles. Dr. Berson further indicated that the probability of hearings before the Senate Finance Committee required that this issue be given high priority.

Intensive discussion ensued, particularly with regard to supervisory physician fees. The underlying dimension of the debate concerned the large number of complex institutional arrangements which are in use to accommodate the funding and administration of house staff and medical faculty private practice. Thus, the result in some cases implies that "duplicate payment" may exist, or at least appear to exist. It was pointed out that the same issue existed in NIH financial negotiations, but that debate is now centered in a more public area with substantially larger dollars involved.

Several avenues of defense were explored and discussed, including the possibility of removing all physicians' fees from Part A. Immediately prior to adjourning for lunch, Dr. Berson indicated that two decisions were necessary:

- 1- the decision of whether or not to respond to the SSA Memorandum:
if so, what approach should be pursued?
- 2- How should the Senate Finance Committee Hearings on Medicaid and Medicare be approached?

At 12:30 p.m. the Committee adjourned for lunch.

Following adjournment for lunch, the Chairman reconvened the meeting at 1:45 p.m.

Lengthy discussion continued regarding reimbursement by the Federal Government for the professional fees of supervisory physicians. The Chairman reiterated Dr. Berson's question concerning a response to the SSA Memorandum and also recommended that guidelines for principles of reimbursement for the supervisory service of physicians in teaching hospitals be developed by the Committee. Before these questions were specifically answered, several pertinent points were raised. It was mentioned that the supervisory services being discussed could be treated as an institutional cost reimbursed to the teaching hospital, which in turn would compensate faculty members. It was generally agreed, however, that this type of reimbursement would have to remain "fee for service" basis because the prevailing attitude among most professional medical organizations, and specifically state medical societies, was in support of the principle of the solo practice of medicine.

Furthermore, it was mentioned that, in fact, the practice of medicine has not been greatly institutionalized in teaching hospitals; and, in most cases, remains essentially solo.

Discussion continued concerning the manner in which supervisory physician's fees were billed. Mr. McNulty mentioned that all Part B intermediaries were recently briefed by the central SSA Office. The group was told to be especially alert to avoid "duplicate payment". Mr. McNulty urged that hospitals be likewise alert to be sure that duplicate billing is avoided. It was mentioned

that much of the confusion over whether physician's services should be billed through Part A or Part B centered around lack of agreement on the part of hospitals, carriers, and intermediaries and the SSA as to the definition of "hospital-based physicians". Does this term include only radiologists, pathologists, etc. or, for the purpose of reimbursement; is it extended to include cardiologists, for example, who are interpreting EKG reports? Evidence was cited from experience that SSA and the carriers do not agree on this matter.

As this discussion concluded it was recommended that the AAMC should not respond to the SSA. Reasons were given in support of this decision:

1. The Chairman stated that he did not think the Committee was yet in a position to speak for the entire membership on these guidelines;
2. Since the SSA's final position on the principles are not yet clear and since there is evidence that SSA and the carriers disagree on certain vital points it is possible that the final interpretations of SSA may be somewhat less severe than anticipated.

Following this decision it was recommended that the following action items be taken:

ACTION #2 THE COTH STAFF SHOULD INFORM SSA REGARDING ITS CONCERN OVER THE MISUNDERSTANDING BETWEEN SSA AND SOME INTER-MEDIARIES REGARDING BILLING PROCEDURES FOR SUPERVISORY PHYSICIANS.

ACTION #3 THE STAFF SHOULD COMMUNICATE TO COTH, COD AND CAS REGARDING THE IMPLICATIONS TO THEM OF SSA'S PRESENT EFFORTS TO DEFINE THE PRINCIPLES OF REIMBURSEMENT OF SUPERVISORY PHYSICIANS. A MEMO TO ACCOMPLISH THIS HAD BEEN DRAFTED BEFORE THE PRESENT MEETING AND IT WAS REVIEWED BY THE COMMITTEE.

ACTION #4 THE STAFF AND CHAIRMAN WILL DRAFT A POSITION PAPER TO PROPOSE ITS OWN GUIDELINES FOR THE REIMBURSEMENT FOR TEACHING SUPERVISORY SERVICES IN HOSPITALS.

THE INSTRUMENT FOR FRAMING THE PAPER WILL BE A SMALL COMMITTEE OF COD, CAS AND COTH REPRESENTATIVES. MR. McNULTY AND THE CHAIRMAN WILL SEE THAT SUCH A COMMITTEE IS ASSEMBLED.

ACTION #5 EFFORTS TO EXPLAIN AAMC POSITION TO THE SENATE FINANCE COMMITTEE WILL BE CONTINUED. SINCE PREVIOUS EFFORTS TO PERSUADE SENATOR LONG HAVE BEEN UNSUCCESSFUL AAMC WILL PURSUE IT WITH OTHER MEMBERS OF THE COMMITTEE.

ACTION #6 THE CHAIRMAN AND THE STAFF WILL BE RESPONSIBLE FOR CONTACTING WITNESSES TO PRESENT CONGRESSIONAL TESTIMONY REGARDING REIMBURSEMENT FOR TEACHING HOSPITAL PHYSICIANS SUPERVISORY SERVICES.

VIII. Review and Revisions of Previously Prepared Memorandum to be Distributed to Accomplish Action #3 Above:

The corrected draft of this memorandum to be sent to COTH, CAS and COD members appears as an attachment to these minutes.

- IX. It was agreed that the next meeting of the Committee would be at the call of the Chairman.
- X. There being no further business, the meeting was adjourned at 3:30 p.m.

Attachments: List of Members of Committee on Financial Principles
Memo on Dual Payment

COUNCIL OF TEACHING HOSPITALS
COUNCIL OF DEANS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
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1968 - 1969

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Vice-Chairman

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Committee on Financial Principles
1968-1969

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(Continued)

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Committee on Financial Principles
1968-1969

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American Hospital Association
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* Indicates two-year (1968-1970) term on Committee

** Indicates one-year (1968-1969) term on Committee

March, 1969

Part B Payments for Services of
Supervising Physicians in a Teaching Setting

A. Conditions Which Must be Met for a Teaching Physician to be Eligible for Part B Reimbursement as an Attending Physician

The physician* must be the patient's "attending physician." This means he must, as demonstrated by performance of the activities listed below, render sufficient personal and identifiable medical services to the Medicare beneficiary to exercise full, personal control over the management of the portion of the case for which a charge can be recognized; his services to the patient must be of the same character, in terms of the responsibilities to the patient that are assumed and fulfilled, as the services he renders to his other paying patients.

1. To be the "attending physician" for an entire period of hospital care, the teaching physician must as a minimum:
 - a. review the patient's history, the record of examinations and tests in the institution, and make frequent reviews of the patient's progress; and
 - b. personally examine the patient; and
 - c. confirm or revise the diagnosis and determine the course of treatment to be followed; and
 - d. either perform the physician's services required by the patient or supervise the treatment so as to assure that appropriate services are provided by interns, residents, or others and that the care meets a proper quality level; and
 - e. be present and ready to perform any service performed by an attending physician in a nonteaching setting when a major surgical procedure or a complex or dangerous medical procedure is performed; for the physician to be an "attending physician" his presence as an attending physician must be necessary (not superfluous as where, for example, the resident performing the procedure is fully qualified to do so) from the medical standpoint; and

*The term "physician" does not include any resident or intern of the hospital regardless of any other title by which he is designated or his position on the medical staff. For example, a senior resident who is referred to as an "assistant attending surgeon" or an "associate physician" would still be considered a resident since the senior year of the residency is essential to completion of the program.

- f. be recognized by the patient as his personal physician and be personally responsible for the continuity of the patient's care, at least throughout the period of hospitalization.

EXAMPLE: A supervising physician carried out all of the activities listed above for a surgical patient but (e). He was not present in the OR when the major surgery was performed because supervision of the 5th-year resident performing the operation was not required. A physician's charge would not be recognized for the surgical procedure because criterion (e) was not met. Therefore, the physician would not be an attending physician for the period of hospital care although he might meet the criteria listed in A.2. below and be held as the attending physician for a portion of the care provided.

Even if the supervising physician chose to be present in the OR, payment could not be made to him for the surgical procedure since his presence was not medically necessary and he could not, therefore, function as the attending physician in connection with the surgery. However, if he was scrubbed and acted as an assistant, payment could be made to him as a surgical assistant if such an assistant was needed and another resident or physician did not fill the role (see item A.2. below).

If the supervising physician was present at surgery, and the surgery was performed by a resident acting under his close supervision and instruction, he would not be the attending surgeon unless it were customary in the community for such services to be performed in a similar fashion to private patients who pay for services rendered by a private physician.

EXAMPLE: A group of physicians share the teaching and supervision of the house staff on a rotating basis. Each physician sees patients every third day as he makes rounds. No physician can be held to be one of these patient's attending physician for any portion of the hospital care although consultations and other services they personally perform for the patient might be covered.

2. A teaching physician may be held to be the attending physician for a portion of a patient's hospital stay: if the portion is a distinct segment of the patient's course of treatment (e.g., the pre-operative or post-operative period) and of sufficient

duration to impose on the physician a substantial responsibility for the continuity of the patient's care; if the physician, as a minimum, performs all of the activities described above with respect to that portion of the stay; and if the physician is recognized as the patient's physician fully responsible for that part of the stay. If a teaching physician is not found to be the attending physician with respect to a portion of a patient's stay, he may not be reimbursed for any service provided to the patient for that portion of the stay unless it is an identifiable service that he personally rendered to the patient.

EXAMPLE: A physician carried out all of the activities listed above for a surgical patient until midway in the post-operative period, when the physician's teaching tour of duty ended. Since he was not responsible for the continuing care of the patient throughout the post-operative period, he cannot be reimbursed as the attending physician for that period.

3. Performance of the activities referred to above must be demonstrated, in part, by notes and orders in the patient's records that are either written by or countersigned by the supervising physician.
4. The services of a teaching physician while visiting patients during grand rounds is basically teaching and does not contribute to an "attending" relationship with any of the patients visited.
5. An emergency-room supervising physician may not customarily be considered to be the attending physician of patients cared for by the house staff. It is only through his direct personal involvement with a patient that a charge may be recognized under Part B. Such an involvement would necessarily include personal examination of the patient as well as direction of and responsibility for the treatment provided.

B. Determining the Amount Payable Under Part B

1. The amount paid for direct medical services rendered by the teaching physician should be related to only that discrete portion of the patient's care for which the physician exercised the pertinent responsibilities of an attending physician outlined in A.1. For example, if the patient's personal physician furnishes services before the hospital admission and after the discharge and the teaching physician becomes the attending physician only with respect to the inpatient care, the lesser extent of the teaching physician's service should be taken into account in recognizing a charge; otherwise the out-of-hospital service would be billed for and paid twice. Similarly, if surgery was performed and the teaching physician rendered identifiable personal service to the patient in the operating

room, it is necessary to determine whether that physician performed services more nearly analogous to a consultant, an assistant at surgery (see first "Example" in part A), or as the "attending" surgeon in order to identify the appropriate reasonable charge. If the physician acted as the attending surgeon but did not render the pre- or post-surgical services generally performed by a private surgeon to a private patient, the difference in service should be reflected in the amount of reimbursement.

2. The following conditions should be taken into account in determining the "customary" charges of teaching physicians for services which they provide as attending physicians to Medicare beneficiaries.
 - a. If the teaching physician has a substantial practice outside the teaching setting (i.e., more than half of the time spent in the practice of medicine is spent caring for people who were his patients before they were hospitalized or who were referred to him by physicians responsible for their care outside the hospital setting), his "customary" charges for services in the teaching setting will be related to the amounts he charges for similar services in his outside practice. Where the services performed in the teaching setting differ from those in the outside practice, reductions should be made for the lesser scope of services provided, time spent, visits or responsibility as an attending physician (not counting supervisory acts as time or visits).
 - b. If the teaching physician does not have a substantial practice outside the teaching setting and the provider has established one or more schedules of charges which are collected for medical and surgical services furnished to a majority of non-Medicare teaching patients, his charges should be related to the provider's schedule of charges which are most frequently collected.

EXAMPLE: A hospital with an approved teaching program receives payment for physicians' services rendered to 80 percent of its non-Medicare patients. Fifty percent are paid for by public assistance under a relatively low payment schedule; 20 percent are covered under a Blue Shield Plan with a somewhat higher fee schedule and the balances are covered under commercial plans. Since collections are made for a majority of patients and the most frequently used schedule of payment is the welfare schedule, the welfare schedule of charges should serve as the basis for determining the teaching physicians' customary charges for Medicare.

- c. Where neither the physician nor the provider has established charges for the physician's services which are in effect for non-Medicare patients, the carrier and intermediary must make the necessary charge and cost determination based on that portion of the physician's compensation which is for services to patients, determined pursuant to the regulations governing reimbursement for the services of provider-based physicians.
3. Where teaching physicians of a hospital, billing through a hospital or other organization, adopt a uniform schedule of charges for the purpose of billing under Part B for the services they provide as attending physicians in the teaching setting, carrier acceptance of the schedule for reimbursement purposes should be based on a finding that the schedule does not exceed the average of reasonable charges which would be determined if each physician were individually reimbursed his reasonable charge for the services involved.
4. In determining the number of visits which may be considered reasonable, e.g., in a course of treatment for which a global fee is not ordinarily charged, the total number of visits which would have been made to the patient in a nonteaching setting should be used as a guide; visits in excess of this number are presumed to be primarily for teaching purposes. Similarly, total reasonable charges for a course of treatment in the teaching setting should be compared with and should not exceed the charges that would be expected in nonteaching settings for similar services. Also, the charges billed for an hour of a teaching physician's services should not exceed the amount of fees the physician generally receives for an hour's work in caring for nonteaching patients.
5. Where payment is made under Part B on a reasonable charge basis, payment may not also be made on a cost basis to the hospital for the same service as a teaching service. Part A payments to the hospital should therefore not be based on the total compensation of the physician if that compensation is in part for patient care. The total compensation should be reduced by the portion paid for patient care in accordance with the applicable provisions of the principles of reimbursement for services of hospital-based physicians to arrive at the hospital cost portion. Allocation of compensation received between both parts of the program should be in accordance with how the physician's time is actually spent. If a physician's only compensation for services in a teaching setting are paid by the hospital and the agreement states that only the supervisory, and not patient care, services are compensated, it is necessary to look behind the words of the agreement by reviewing the physician's actual obligations and activities and determining whether the compensation level is

reasonable for the supervisory and teaching services alone and insufficient to cover patient care services as well. The carrier and intermediary should make this finding jointly.

EXAMPLE: An employment agreement between a physician and the hospital states that he will be paid \$50,000 a year for administration, supervision and teaching. However, he spends one-half of his time in providing patient care. The carrier and intermediary determined that if his compensation were allocated solely to the time the physician spent in the performance of his hospital duties, it would yield an hourly rate of compensation about double the rate paid for similar work elsewhere in the area. Therefore, the carrier and intermediary concluded that only a portion of the compensation was for hospital activities and reimbursable under Part A. Since charges were not customarily billed for the medical services the physician provided, the remainder would serve as a basis for computing the physician's reasonable charges for patient care in accordance with B.2.b. above.

C. Carrier Responsibilities for Claims Review and Verification

1. The carrier is responsible for assuring that the bills being submitted were prepared with an understanding of the conditions governing payment for physicians' services in the teaching setting.

To help carry out this responsibility, carriers will not pay bills (SSA-1490 or SSA-1554) for services rendered in the teaching setting in any month after May 1969, unless:

- a. the chief of the department or service involved certifies on a form furnished by the carrier that each of the billed services for that month meets the pertinent requirements of A.1.; or
 - b. the bill has been signed by the attending physician and he understands that he is certifying that he met the requirements for those services for which the claim is made.
2. The provision of personal and identifiable services must be substantiated by appropriate and adequate recordings entered personally by the physician in the hospital or, in the case of outpatient services, outpatient clinic chart. The carrier is expected as part of its responsibilities to make appropriate checks of patient records, examining admission, progress, and discharge notes to verify that services for which charges are billed met the appropriate coverage criteria. If the carrier

review shows that a significant portion of the services in the sample do not meet the criteria, appropriate steps should be taken to adjust the reimbursement.

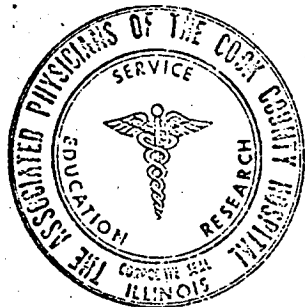
3. Bills must indicate when services are furnished in the teaching setting, the name of the provider and attending physician involved, and the extent of the services provided as an attending physician. The services must be defined and quantified to avoid errors in applying the reasonable charge limitation--e.g., to avoid applying the reasonable charge for a global service where only the surgical procedure or another component service was provided as an attending physician.
4. The carrier will need to carry out the steps necessary to assure itself that these conditions set out in B.1. are met--for example, to assure itself that any schedule of charges proposed for the teaching setting is actually applied and collected.

D. Who May Bill

Where the supervising physician is a member of a group which provides teaching services in a hospital, the Part B payment for services rendered as attending physicians by the group may be billed for:

1. by the physician or a corporation, partnership, or other organization of physicians (including an association of teaching physicians organized for the purpose of billing for and distributing insurance monies and other payments received for professional services to patients) on form 1490;
2. by the hospital on form 1554 provided that the carrier has determined that the certification described in C.l.a. has been executed and complied with; and
3. if the services are performed by a physician who is a faculty member of a medical, osteopathic, or dental school, by the school on form 1490.

The individual physician's authorization is required to be on file in writing with the hospital or other organization to permit any of the above organizations to bill on his behalf. The organization must furnish to the Part B carrier the names of the physicians who have authorized the organization to bill on their behalf, and must agree to keep the carrier informed on a current basis of changes in membership in the group.



Annual Report

1968 - 1969

Associated Physicians

of the

Cook County Hospital

Annual Report

For The Fiscal Year Ended November 30, 1968

and

Report Of The President, March 1, 1969

ASSOCIATED PHYSICIANS
OF THE COOK COUNTY HOSPITAL

519 South Wolcott Street

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Public Relations:
Rowine Brown, M.D., Chairman
Fred Hertwig
John Tobin, M.D.
James R. Hines, M.D.
Philip Williams, M.D.

(1) Resig. February 26, 1969
(2) Resig. February 27, 1969

In this first annual accounting to the membership of the Associated Physicians of The Cook County Hospital, and to the broader, public and private community which has an interest in our activities, I am pleased to be able to report that the plans and objectives which were only spoken of at the last annual meeting of the Medical Staff just one year ago have essentially become reality.

The Board of Directors elected last March has, under the mandate of the membership, created an institution unique in its concept, and without precedent to guide its organization and operations. Almost every one of the eligible, active members of the Medical and Dental Staff of Cook County Hospital have become members and have assigned to the Association their right to reimbursement for their personal professional services, and their direction to the interns and residents assisting in the care of patients at the Hospital. Many have given generously of their time and wisdom to help form our organization and to plan the direction of our activities. The past year's achievements, and our hopes and plans for the future rest squarely on the continuing support and active participation of all of the members of the Association.

The Association is authorized by its members to collect reimbursement for all professional services rendered to all of their patients at the Hospital. As a first step, we have established arrangements with the Illinois Medical Service for the collection of fees for medical and surgical services to Medicare insured in-hospital patients retroactive to July 1, 1966. From this source alone we have already received net fees amounting to almost one and a half million dollars. Procedures for the collection of fees for ancillary services and for out-patient services are still under negotiation. We are also in the process of negotiation with other third party insurers, including the Illinois Department of Public Aid, to the end that eventually, probably within the next year, we shall be receiving reimbursement for the great majority of all professional services rendered to patients of our members at the Hospital.

The Articles of Incorporation of the Associated Physicians of The Cook County Hospital provide that:

"The purposes for which the corporation is organized are to carry on and promote medical and scientific education and research; to educate and train doctors, nurses, technicians and other persons to the extent related or incident to modern hospital

and medical care and services; to promote improved and expanded medical treatment and hospital facilities."

In the furtherance of these purposes, the Board established ad hoc committees to develop specific programs:

(1) the ad hoc Committee for Professional Staff Development, to explore all possibilities, consistent with the Charter, to provide appropriate forms of compensation and benefits for members of the Attending Medical and Dental Staff for their patient care services at the Hospital;

(2) the ad hoc Committee for Department Development, to recommend programs for the improvement of services and facilities of the various departments and to supplement the resources available to the Hospital from County funds;

(3) the ad hoc Committee on House Staff Development, to recommend increased benefits for the interns and residents to assist the Hospital in recruiting and retaining the most highly qualified house staff;

(4) the ad hoc Committee on Scientific Research, to help support the outstanding medical research now being carried out by the staff of the Hospital, and to attract additional scientific investigators and technical assistants to support superior research programs;

(5) the ad hoc Committee on Scholarships and Education, to recommend support for educational programs in the health sciences, and particularly to encourage highly motivated, but economically disadvantaged young people to enter careers in the health sciences.

As a result of the recommendations of these committees, the Board of Directors has appropriated \$1,000,000 in the following categories:

Department Development, \$300,000;

House Staff Development, \$200,000;

Scientific Research, \$200,000;

The Association's Martin Luther King, Jr., Fellowship in Medicine Program, \$100,000.

An additional \$200,000 has been made available to meet critical and urgent needs of the Hospital, as identified by Dr. Robert J. Freeark, Director, which are not provided for by current County appropriations. Specific proposals for the allocation of funds for Professional Staff Development are still under consideration by the Committee.

In recognition of the urgent need for new physical plant facilities for the Hospital, the Board of Directors has authorized the establishment of a "Reserve for Building Fund." Monies allocated to this fund must remain under the control of the Board of Directors of the Association and their ultimate expenditure will be made only in accordance with authorization of the membership of the Association on the basis of specific building plans which may be developed in the future.

The public announcement of the Association's \$1,000,000 program received favorable reaction in the press and other communications media and in professional journals. Our programs and objectives have also received the endorsement and support of medical and hospital professional societies.

Since its inception, the Association has enjoyed the full support and confidence of the principal administrative officers of the Hospital. The Director and the Superintendent of the Hospital are Honorary Members of the Board of Directors and have actively participated in the development of our programs.

It is my firm conviction that our organization has been established on sound principles and that our objectives and programs merit the enthusiastic support which they have received. Although, in a sense, we are traveling through unknown territory and must establish procedures to meet largely unprecedented situations, the ultimate goals of our Association reflect the highest principles of our profession and our institution.

ROBERT J. BAKER, M.D.
President

March 1, 1969
Chicago, Illinois

Opinion of Independent Accountants

The Board of Directors
The Associated Physicians of
The Cook County Hospital
Chicago, Illinois

We have examined the statement of assets, liabilities and fund balances of The Associated Physicians of The Cook County Hospital (a not for profit corporation) as of November 30, 1968 and the related statement of income and expenses and general fund and summary of appropriations for the period from December 8, 1967 (date of incorporation) to November 30, 1968. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

As described in Note A to the financial statements, the Association prepares its financial statements on a modified cash basis of accounting which omits accounts receivable, but does reflect accounts payable and other accruals. Accordingly, the financial statements do not, in our opinion, present financial position or results of operations.

In our opinion, the accompanying statements identified above present fairly the assets, liabilities and fund balances resulting from cash transactions adjusted for accounts payable and accrued expenses of The Associated Physicians of The Cook County Hospital at November 30, 1968 and a summary of the cash transactions and appropriations for the period from December 8, 1967 to November 30, 1968, in conformity with the method of accounting described in the preceding paragraph.

ERNST & ERNST

Chicago, Illinois
February 14, 1969

Statement of Assets, Liabilities and Fund Balances

THE ASSOCIATED PHYSICIANS
OF THE COOK COUNTY HOSPITAL

November 30, 1968

ASSETS

Marketable securities — at cost (approximates market)	\$802,635.94
Cash in banks	64,419.17
Sundry receivables	2,384.23
Fixed assets — at cost	11,558.04
	<u>\$880,997.38</u>

LIABILITIES AND FUND BALANCES

Accounts payable and accrued expenses	\$ 12,967.91
Unpaid appropriations	26,588.81
Equity balance — Note B:	
Invested in fixed assets	\$ 11,558.04
General Fund	<u>829,882.62</u>
	<u>\$841,440.66</u>
	<u>\$880,997.38</u>

See notes to financial statements.

Statement of Income and Expenses and General Fund

THE ASSOCIATED PHYSICIANS OF THE COOK COUNTY HOSPITAL

For the period from December 8, 1967 (date of incorporation) to November 30, 1968

Income:

Amounts received from Medicare fiscal intermediaries	\$1,068,692.02
Amounts received from patients (for Medicare deductibles)	<u>139.82</u>
	1,068,831.84

Expenses:

Operating expenses	\$181,583.09
Professional fees relating to organization of the Association	10,064.29

Appropriations:

During the year	\$40,706.00
Less lapses of unexpended balances	<u>4,962.20</u> <u>35,743.80</u>
	<u>227,391.18</u>

INCOME IN EXCESS OF EXPENSES 841,440.66

Less purchase of fixed assets 11,558.04

GENERAL FUND AT NOVEMBER 30, 1968 \$ 829,882.62

Summary of Appropriations

THE ASSOCIATED PHYSICIANS OF THE COOK COUNTY HOSPITAL

For the period from December 8, 1967 (date of incorporation) to November 30, 1968

Appropriations:

During the year	\$40,706.00
Less lapses of unencumbered balances	<u>4,962.20</u> \$35,743.80

Payments:

During the year	<u>9,154.99</u>
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Unpaid appropriations at November 30, 1968

\$26,588.81

Notes to Financial Statements

THE ASSOCIATED PHYSICIANS OF THE COOK COUNTY HOSPITAL

November 30, 1968

Note A — Corporate Data:

The Associated Physicians of the Cook County Hospital was incorporated on December 8, 1967 as a not for profit corporation. The member physicians have assigned to the Association the rights to fees for all medical services rendered by them to their patients at Cook County Hospital. Net income of the Association is to be used to promote education in health sciences, scientific research, and for improved and expanded medical treatment and facilities at Cook County Hospital.

To date, billings of the Association have been confined to Medicare claims submitted to the United States Department of Health, Education, and Welfare under provisions of the Medicare Act. Through November 30, 1968, the Association has submitted claims to Medicare fiscal intermediaries in the approximate amount of \$2,500,000.00 representing partial claims for services rendered from July 1, 1966 through September, 1968 and has received payment of \$1,068,692.02. Additional billings for the above period are in process and will be submitted as completed.

In addition, Medicare claims have been partially completed for anesthesiology services rendered during the above period, but are being withheld pending completion of negotiations with the fiscal intermediary and the Department of Health, Education, and Welfare concerning reimbursement for anesthesiology and radiology services.

Deductions from payments of claims by the intermediaries for charges payable by beneficiaries amounted to approximately \$425,000.00 at November 30, 1968. The Association has not as yet billed the beneficiaries or other third party payors who may be liable for payment of such amounts.

In addition to reimbursement for services to Medicare insured patients, the Association is entitled to bill, for services rendered by its members, other third party insurers, including Medicaid (Title XIX of the Health Insurance Act) and patients directly. Procedures for such billing are under consideration and in various stages of negotiation with parties concerned.

Because of the aforementioned uncertainties surrounding Medicare billings, the Association has prepared its financial statements on a modified cash basis, giving recognition to income only when the cash is received. Expenses and appropriations are recorded on the accrual basis.

Note B — Appropriations:

On January 6, 1969, the Board of Directors appropriated \$1,000,000.00 for the following purposes:

Scholarship and education	\$ 100,000.00	
Scientific research		200,000.00
Cook County Hospital:		
House staff development	\$200,000.00	
Departmental development	300,000.00	
Emergency Fund	<u>200,000.00</u>	<u>700,000.00</u>
		<u>\$1,000,000.00</u>

On the same date, the Board of Directors established a Reserve for Building Fund in which will be accumulated income in excess of expenses until the Building Fund amount is equal to 20% of the gross revenues of the Association from date of incorporation. At January 31, 1969, this fund amounted to \$46,251.84.

Illinois State Medical Society

360 North Michigan Avenue

Chicago, Illinois 60601

January 20, 1969

Robert J. Baker, M.D.

The Associated Physicians of the Cook County Hospital

519 South Wolcott Street

Chicago, Illinois 60612

Dear Dr. Baker:

Your letter of January 13 and the news release on the activities of the Associated Physicians of Cook County Hospital has been forwarded to this office by Dr. Philip G. Thomsen. Thank you for keeping us informed.

Your organization follows recommendations of the American Medical Association and the Illinois State Medical Society in a teaching situation of this kind. We commend you and your colleagues for displaying foresight in forming this type of medical corporation and the good which you propose to do with the funds collected. The professional fees involved are the property of the physicians who render the service and should be retained under the control of these physicians as you are doing.

You may recall that the Illinois State Medical Society caused legislation to be introduced in the last regular session of the Illinois General Assembly to accomplish this purpose. Unfortunately, this is a most difficult matter to legislate and the bill was eventually withdrawn for practical reasons. There are numerous other situations where the doctors should follow the example established at Cook County Hospital. Failure to do so has led to the practice of medicine by non-medical corporations, a practice which is not in the best interest of patient care.

Sincerely yours,

(signed) Roger N. White

Executive Administrator

American Hospital Association

840 North Lake Shore Drive, Chicago, Illinois 60611

February 17, 1969

Robert J. Baker, M.D.

Associated Physicians of the Cook County Hospital

519 South Wolcott Street

Chicago, Illinois 60612

Dear Doctor Baker:

Thank you very much for your note of January 13th, 1969 which was accompanied by the press release announcing the appropriation of \$1,000,000 of Association funds which will be used for the improvement of health care and education in the health sciences at Cook County Hospital.

This is one of the most exciting and forward actions that our profession has executed in some time, in my opinion. Your Association is to be commended most highly for its concern and its desire to be, "where the action is" — as the saying goes today, in our exciting field of health care services. The fact that the physicians in your Association have seen fit to direct the fees they have earned for the care of their patients at Cook County Hospital and their supervision and direction of the interns and residents assisting in the care of their patients toward the betterment of the health care program for the people of the County is most commendable. The purposes for which the funds are to be generated and utilized are excellent, namely educational, clinical and research developments. I can assure you that your objectives are most compatible with the objectives of the American Hospital Association summarized rather succinctly in the phrase — "better health care for all the people."

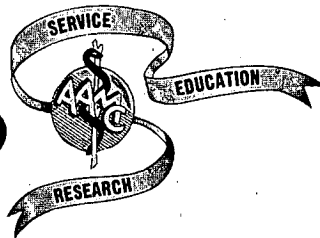
Let me assure you that if there is anything in any way that we in the American Hospital Association can do to be of assistance to you and your associates, we would be more than pleased to hear from you. Our very best wishes to you and your Association for the inauguration of this fine program.

With best wishes,

Yours sincerely,

(signed) George Wm. Graham, M.D.

President



ASSOCIATION OF AMERICAN MEDICAL COLLEGES

1346 CONNECTICUT AVENUE, N.W.

WASHINGTON, D. C. 20036

April 18, 1969

AREA CODE 202: 223-5364

TO: Members of: The Council of Deans, Council of Teaching Hospitals,
and the Council of Academic Societies

SUBJECT: Billing for Supervisory Physicians Under Part B of the Medicare
Program

1. Need for "Personal and Identifiable" Supervision in Order to Bill for Part B
Payment:

One of the regulations that was developed during the implementation of P.L. 89-97 dealt with the problem of payment to supervisory physicians in the teaching setting. In 1966, the Department of Health, Education and Welfare issued a statement concerning the provision for payment under the Medicare program for services rendered to beneficiaries by interns and residents and by attending physicians supervising interns and residents. A key paragraph of that regulation was the following (underscoring supplied):

"This basis of payment is applicable to the professional services rendered to a beneficiary by his attending physician where the attending physician provides personal and identifiable direction to interns or residents who are participating in the care of his patients. In the case of major surgical procedures, as defined by the Joint Commission on Accreditation of Hospitals, and other complex and dangerous procedures or situations, such personal and identifiable direction must include supervision in person by the attending physician. In no case will the attending physician be reimbursed under the medical insurance program for the direction of residents and interns in the care of his patients unless the attending physician has carried out his responsibility to his patient by confirming the diagnosis and determining that the treatment was necessary, specifying the nature of the treatment to be performed, and assuring that any supervision needed by the interns and residents was furnished."¹

¹Section 405.525 of the Social Security Administration Regulation, Number 5, dealing with "The Services of Attending Physicians Supervising Interns and Residents"

2. Increasing Concern Being Expressed by Citizen Groups and Legislative Committees over the Application of the Foregoing Provision:

A number of citizen groups and several legislative committees are expressing concern. Criticism from "users" of Medicare and Medicaid services is reporting that some institutions and some carriers have not established sound methods to document the personal and identifiable services for which the program has been billed either directly or on behalf of a specific physician.

There is little doubt that in this type of situation the responsible Federal agencies will be called upon to initiate action for each carrier to become much more familiar with the institutions in its area and to examine carefully the methods the institution and individual use to determine that the services reportedly performed have indeed been personally and identifiably performed as certified by the user or patient.

A cause for even more concern is the probability that a Committee, or Committees, of Congress will hold hearings on the whole Medicare-Medicaid physician reimbursement program at an unpredictable time during this session of Congress. The staff of one Senate Committee has already collected specific information concerning alleged abuses on the part of some institutions, groups and individuals. The criticism resulting from discussion of such alleged abuses could well spill over to include, by association, institutions which have handled these programs with great care and propriety.

3. Types of Criticism:

The types of criticism so far expressed include senior citizen groups' charges concerning fees for professional services rendered by "supervising" or "teaching" physicians to eligible beneficiaries of Medicare and/or Medicaid programs.

One example describes a published annual report of an association of physicians on the staff of a large hospital. That report indicates that, during the last year (1968), the association had billed the Medicare program for something more than \$2 million; has collected something more than \$1 million; and that no other patients in that hospital were charged for professional services and no effort was made to collect the "deductible" amount provided for in the legislation and the regulations.

The view on this matter of the Medicare program is intended to help beneficiaries pay hospital charges and professional fees that otherwise would be payable from the personal resources of the patient to remove the "charity" factor. The "yardstick" for professional fees being "usual and customary" is the level of charges and fees non-beneficiaries pay for the equivalent services.

Another allegation relates to reported statements from members of the different medical staff of some institutions that they were assigned to make rounds on a certain service for a certain period, did so, were not aware which patients were or were not beneficiaries of the Medicare program, only to learn later that the bills for their professional services to those Medicare patients were submitted by the hospital without the knowledge of the physician and without any participation by the physician in the disposition made of the funds collected.

The view of the Federal agency on this matter is that the physician who renders personal and identifiable professional services to an eligible patient in the course of his supervisory or teaching role is entitled to a fee for those services that is "usual and customary". The physician can, of course, agree to have someone else - including a group or a hospital - collect those fees for him but presumably he would know of such an agreement and, in making it, would acquire some knowledge of the disposition of the funds. Furthermore, it is assumed in such cases that the beneficiary would be knowledgeable of the personal and identifiable services rendered.

Some groups of senior citizens have reported that their members are receiving exactly the same quality of services as they did before the Medicare program was initiated. Further, these groups report vigorously that the services they receive continue to be no different from that care Medicare non-eligible indigent patients now receive. The Medicare non-eligible patient receives no bill for professional services. These groups report that they do not recognize the name of the physicians for whose personal services bills are being submitted to the Medicare intermediary.

The view of the Federal agency on this matter is that the patient should surely be familiar with the physician who rendered him "personal and identifiable services" and that the fees are not "usual and customary" if non-eligible patients receiving equivalent services in the same setting are not expected to pay for them.

The Federal agency is also concerned by the indications that some fiscal intermediaries have not given close attention to the methods institutions use to be certain that the professional services were "personal and identifiable" and therefore eligible for payment. It is predictable that the Congress and others will press SSA and the fiscal intermediaries to give very close attention to these matters in the future and perhaps change the regulations as published in the Federal Register.

4. Teaching Hospitals Being Judged Critically:

Two facts are emphasized with regret. One is that the criticisms of the ways institutions - mostly teaching hospitals - are handling the foregoing aspect of the Medicare program seem to be of great interest and concern to officials of the Congress and public. The other is that if there are teaching hospitals which have handled this matter in a way open to serious criticism and the spotlight of public attention is focused on such institutions, the criticism will spill over, to some extent, on other teaching hospitals which have handled the matter in an entirely appropriate manner.

5. Action by Your Committee and Your Teaching Hospital:

The AAMC, through the Committee on Financial Principles and the Committee on Federal Health Programs is giving this matter much attention as is your staff. Four deans from the AAMC Council of Deans have recently been added to the now COTH-COD Committee to devote attention to this and other important matters.

We believe that this matter is of importance also to the faculties of the schools of medicine, particularly members of the clinical faculties. For this reason, the Chairman of Academic Societies has joined in communicating this memorandum to the total AAMC membership.

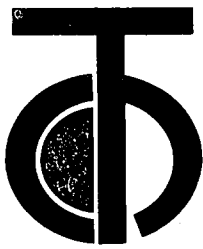
Members of the AAMC staff have good communications with members and staff of the Congress and officials of the agencies. We will keep in close touch with these sources as a means of keeping posted as to what is being planned and to influence as possible appropriate constructive approaches.

In the final analysis, what institutions can do about this matter is much more important than what the AAMC can do. We urge that each institution take a very close look at its policies and practices concerning professional fees for services rendered Medicare and Medicaid patients. Compare these practices closely with the letter and spirit of the legislation and regulations. It is important also to take early steps to see that the fiscal intermediary is entirely familiar with these policies and practices and advised that they are indeed appropriate. If your institution is having any problems with the fiscal intermediary in your area, please keep us informed.

CHARLES R. GOULET
Chairman, COTH-COD
Committee on Financial Principles

CARLETON B. CHAPMAN, M.D.
Chairman, AAMC Committee on
Federal Health Programs

JONATHAN E. RHOADS, M.D.
Chairman, Council of
Academic Societies



COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

1346 CONNECTICUT AVENUE, N. W. • WASHINGTON, D. C. 20036 • (202) 223-5364

General Membership Memorandum

No. 69-26G

April 7, 1969.

Subject: Viguers-Rogers AAMC Testimony
Before Congressional House
Subcommittee -- Send to your
U.S. Congressman

1. Congress Considers Extension of Federal Financing of Health Facility Construction:

Previous COTH General Membership Memoranda have reported the continuing interest of Congress in hospital modernization and construction and in the Hill-Burton program. GMM No. 69-16G called attention to legislation introduced by Senator Jacob Javits (R-NY) and Representative Emanuel Celler (D-NY) which would provide Federal loan guarantees of up to 90% for \$400 million in each of the next three years for hospital modernization and Federal payment of interest charges up to 3% on these loans. Of interest to COTH members was the specific identification of the modernization need of "teaching hospitals" and the high priority given to teaching hospitals in the Javits-Celler bills. Following the Javits and Celler proposals introduced in January, bills since have been introduced in the House of Representatives, one by Harley O. Staggers (D-WVA) H.R. 6797, and the other H.R. 7059 by Paul G. Rogers (D-Fla.). These were both mentioned in COTH REPORT No.19.

2. Brief Review of Staggers and Rogers Bills:

The Stagger's bill, entitled Hospital and Medical Facilities Construction and Modernization Amendments of 1969, would extend the program of grants for construction and modernization of hospitals and other medical facilities for three years. It provides authorization of appropriations for construction grants totalling \$290 million each year and grants for modernization in the amounts of \$75 million for fiscal year 1971; \$95 million for 1972; and \$105 million for 1973. The legislation also provides for loan guarantees for modernization and construction of "private nonprofit" hospitals, facilities for long-term care, out-patient facilities and

rehabilitation facilities of up to 90% with \$350 million a year available for three years. The government would pay interest at the rate of half of the first 6 percent and one-third of the interest above 6 percent up to a ceiling to be set later.

As another feature the Staggers' bill provides for direct loans for the construction and modernization of "public" hospitals and other public medical facilities of up to 90% for \$225 million a year which would be repayable in equal periodic installments over a period of not to exceed 25 years and bear interest at the rate of 3%.

The bill introduced by Representative Rogers would also extend the Hill-Burton hospital construction program by authorizing appropriations for grants for modernization and new construction for the three years beginning July 1, 1970. The Federal share of these grants would total \$285 million for 1971, \$290 for 1972, and \$295 in 1973. The legislation would establish a new "modernization" loan guarantee program under which the amount guaranteed would not exceed 90 percent of the cost of the project. The Federal government would pay one-half of the interest on the guaranteed loan up to a maximum of 3 percent. The maximum principal of loans with respect to which guarantees might be issued would be \$400 million for fiscal year 1970, \$800 million for 1972 and \$1.2 billion for fiscal year 1973.

A further new provision under this legislation provides for grants for the modernization of emergency rooms with \$10 million authorized for each of the three fiscal years.

Finally, under this legislation, allotments to the various States would be made on the basis of population, extent of the need for the type of facility involved, and financial need of the respective states. This allotment formula would apply to the loan guarantee program as well as the grant program for new construction and modernization. A State would retain the right, after receipt of the allotment, to determine priorities in the distribution of the allotment within the State.

3. Dr. Rogers and Mr. Viguers testify on H.R. 6797 and H.R. 7059 in behalf of AAMC:

Hearings on these two bills began March 25, 1969, before the Subcommittee on Public Health and Welfare of the House of Representatives Interstate and Foreign Commerce Committee.

For the benefit of COTH-AAMC members a copy of the full text of the AAMC testimony to the House Subcommittee accompanies this memorandum. In the AAMC testimony presented March 27, 1969, David E. Rogers, M.D., Dean of the Johns Hopkins University School of Medicine spoke first and called for a change in emphasis of the Hill-Burton program from the nation's rural areas to its troubled urban centers, and commented that the health facility needs of our country have shifted from country to city. Dr. Rogers noted that "... The largest and most important urban hospitals are all teaching hospitals...". He stressed that the urgent need to improve the availability of medical care in our inner cities, and the national mandate to produce more health care personnel requires the substantial improvement as well as more of clinical facilities.

In citing the health care problems which are facing the cities, Dr. Rogers called attention to "an enormous movement of people from rural to metropolitan areas which has placed increased demands upon urban teaching hospitals." Re-emphasizing the "critical need of teaching hospitals for modernization and construction funds", Mr. Richard T. Viguers, Administrator of the New England Medical Center Hospitals, Boston, and Chairman, COTH Committee on Modernization and Construction Funds for Teaching Hospitals, articulated the need for increased appropriations for new construction for the next three years and a change in the Hill-Burton allotment formula in order that funding priorities could be shifted from rural areas to the cities.

Mr. Viguers also emphasized AAMC support of the provisions of H.R. 6797 requesting loan guarantees for the modernization and construction of private, non-profit hospitals and endorsed the concept of loans for construction and modernization of public hospitals and other public health facilities.

Finally, support was given for the H.R. 7059 provision to supply grants for modernization of emergency room service in general hospitals.

4. Send Testimony to your U.S. Senators and Representatives:

In light of the earlier COTH Membership Memoranda Nos. 69-9G and 69-21G concerning the national policy formulation resulting 75% from "grass root" persuasion and only 25% from Washington effort, your Staff emphasizes that two very talented AAMC leaders (Rogers and Viguers) dedicated two days (preparation time, waiting time, testimony time, question and answer time and travel time) of effort to most successfully represent our COTH-AAMC interests. If each teaching hospital would now reproduce the attached testimony and send it to your U.S. Representatives and your U.S. Senators with

General Membership Memorandum
No. 69-26G
Page Four

some identification of the individual teaching hospital source but without any other effort, the efforts of Mr. Viguers and Dr. Rogers would be capitalized significantly. Every U.S. Representative and U.S. Senator knows where COTH-AAMC stands; unfortunately, many have not heard from the grass roots so they do not know where you stand. Thirty percent (30%) or approximately 120 COTH teaching hospital members have followed through by contacting their Congressional Representatives. If your hospital has not, the attached documents present an easy opportunity to do so!

5. Additional Copies of Testimony Are Available:

A limited quantity of the AAMC testimony on Hill-Burton Amendments is available at COTH headquarters. We urge each member to read the attached copy thoroughly. Please submit any comments you may have. Please request additional copies if they may be useful to you.

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

Attachment: Copy of Testimony Presented by David E. Rogers, M.D., and Presented by Richard T. Viguers.

STATEMENT OF
DAVID E. ROGERS AND RICHARD T. VIGUERS
IN BEHALF OF
THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES
CONCERNING H.R. 6797 and H.R. 7059
BEFORE THE
HOUSE OF REPRESENTATIVES
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE
MARCH 27, 1969

Mr. Chairman and Members of the Committee:

I am David E. Rogers and I am Dean of The Johns Hopkins University School of Medicine and Medical Director of The Johns Hopkins Hospital in Baltimore. With me today is Mr. Richard T. Viguers, Administrator of the New England Medical Center Hospitals, of Boston. On this occasion, we are spokesmen for the Association of American Medical Colleges, which consists of all the medical schools in the country, 29 distinguished academic societies which include most of the members of faculties of medical schools, and 340 of the leading teaching hospitals in this country. The Association has recently been reorganized so it can more effectively represent the institutions and organizations which play the principal role in the education of large numbers of health personnel for the future, vital roles in the improvement of methods of diagnosis and treatment, and essential roles in the advancement of knowledge.

We strongly support the objectives of the Hospital and Medical Facilities Construction and Modernization Amendments of 1969 and similar legislation the committee is now considering.

Mr. Chairman, if it is agreeable to the committee, I will direct my comments to the importance of urban and teaching hospitals in the total

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pattern of providing health services, and Mr. Viguers will comment on the specific proposals under consideration and certain other important aspects of this legislation.

We are confident that other spokesmen will present the needs of community hospitals for modernization and construction, and will focus our remarks on urban and teaching hospitals because it is their roles and needs with which we are the most familiar.

I would like first to make the point that the largest and most important urban hospitals are all teaching hospitals and many of them were the predecessors of the medical schools with which they are now intimately related. For example, The Johns Hopkins Hospital was a highly effective institution for nearly 10 years before The Johns Hopkins Medical School opened its doors. A great many urban hospitals less closely affiliated with medical schools have for years been the setting in which interns, residents, nurses, technicians, and therapists have been educated. In those very few instances in which teaching hospitals are located in small cities--such as Gainesville, Florida; Madison, Wisconsin; and Iowa City, Iowa--their role is similar to that of urban hospitals in all but one major respect.

The primary role of every hospital is providing diagnosis and treatment for patients. Every urban hospital is of major importance in providing services for the patients in its immediate vicinity. Typically they are located in the "inner city", so they are a primary and vital resource for the people who live and work there. They are also of very great potential importance to everyone in their region, because they serve

as "hospitals of last resort" to which some patients with complex and severe problems are referred for definitive care.

Many of the urban and all other teaching hospitals have long been the settings in which the problems of patients receive the closest and most detailed study and the places where knowledge gained in research laboratories is first applied to those problems. Most improvements in methods of diagnosis and treatment have first been developed in these institutions and then used in smaller community hospitals after they have been perfected and people trained in their use in large hospitals have become available. As hospitals and medical schools are developed in parallel, the bridge between the laboratory and the bedside has become very short indeed. This research function makes heavy special demands on the teaching hospital. The rendering of advanced medical care requires highly skilled health practitioners coupled with prodigious technical apparatus to aid in performing the many diagnostic, therapeutic, and rehabilitative functions so characteristic of the teaching hospital. These hospitals are now also becoming important centers for experimentation in different health delivery systems.

A third major role of these institutions is that of serving as an environment in which the education and training of physicians, nurses, technicians and therapists take place. For example, a medical student begins to learn how to study the problems of patients in the hospital setting before the end of his second year or earlier, and spends nearly all of his time in that setting during the third and fourth years. A typical young physician spends four years working very hard as an intern and then a resident before he moves on to some other role in the profession.

The hospital is the setting for an even larger portion of the education and training of many other categories of health personnel.

At the most recent annual meeting of the AAMC, several far-reaching recommendations relating to an increased output of physicians were adopted. It is now the official position of the Association, in agreement with the wishes of Congress, that prompt and strenuous efforts be made to expand the enrollment of medical schools as a response to the demands and needs of society for more and better trained physicians and other health workers. To achieve this, new medical schools are being built and existing medical schools are expanding their classes. All of these training and educational advances require clinical facilities, and it is imperative that we increase our outpatient and inpatient facilities to provide the clinical basis for training the increased numbers of many categories of health personnel.

The tremendous accomplishments of the Hospital Construction Program since it was enacted more than two decades ago and the responses to that program on the part of local and state governments are well known to the members of this committee. It is no exaggeration to say that if this farsighted program had not been initiated and been extended and improved by subsequent actions of the Congress, we would have already faced a shortage of facilities for meeting the health needs and demands of our society that would have been disastrous. The early emphasis of the program on the creation of hospitals and health facilities in small cities and towns was justified by the fact that at the time there were hardly any modern health facilities in those communities throughout our country. We believe that the emphasis of the program should now shift toward meeting the

needs of urban and teaching hospitals. In the last two decades, there has been an enormous movement of people from rural to metropolitan areas and society has placed increasing demands upon urban and teaching hospitals, but adequate ways to meet their needs for modernization and construction have not yet been developed. State, local and private sources have traditionally been the primary supporters for the construction and modernization of urban and teaching hospitals. Those sources cannot now provide the additional funds needed with the speed required. An imaginative program of Federal support, such as proposed in this legislation, is needed to insure that these institutions will be able to sustain their standards of excellence and respond to the needs and demands of society.

The urban and teaching hospitals are likely to be the loci of the confrontation when the forces of rising expectations and effective demands meet head-on with the hard facts of acute shortages of manpower and facilities. This nation and its teaching hospitals face a major crisis. We urge that the committee give favorable consideration to this legislation and that the Congress promptly enacts it.

I would like now to ask that Mr. Viguers comment on certain specific recommendations that the Association of American Medical Colleges has with regard to this legislation, after which we will be most pleased to answer any questions the members of the committee may have.

TESTIMONY OF THE
COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
ON H.R. 7059 AND H.R. 6797, "HOSPITAL AND MEDICAL FACILITIES
CONSTRUCTION AND MODERNIZATION AMENDMENTS OF 1969"
BEFORE THE
HOUSE OF REPRESENTATIVES
SUBCOMMITTEE ON PUBLIC HEALTH AND WELFARE OF THE
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE
MARCH 27, 1969

Mr. Chairman and Members of the Subcommittee:

I am Richard T. Viguers, Administrator of the New England Medical Center Hospitals. I am Chairman of the Committee on Modernization and Construction Funds for Teaching Hospitals of the Council of Teaching Hospitals, Association of American Medical Colleges. I appear today on behalf of the Teaching Hospitals and the AAMC.

As a preface to my comments, Mr. Chairman, I reiterate our pleasure at being given this opportunity to appear before this Subcommittee today to discuss this very important legislation and to stress additionally the observation that teaching hospitals have very extensive needs for facility modernization and construction.

I have with me a position statement entitled "Meeting Society's Expectations for Excellence in Service and Education". This statement was prepared by the Council of Teaching Hospitals of the Association of American Medical Colleges. This statement reflects most accurately and completely the collective thinking of the Association on the type of legislation before us today. In the interest of the time of the Committee, Mr. Chairman, I shall not read this statement but I do respectfully request that it be included in the record of these hearings.

Mr. Chairman, we recognize that many definitions of teaching hospitals exist. For purposes of clarity, I would like to state the working definition that will serve as the framework for this discussion. A teaching hospital, as commented on in this statement, is one in which the education of physicians and other health manpower is continually taking place. It is the teaching hospital which is producing the health manpower which is so vital if we are to extend and improve our health care system and meet the health care expectations of our fellow Americans. This complex of resources and activities must be so arranged and operated that excellence of patient care, teaching and research are not compromised - but in fact are enhanced in every way possible.

Before commenting on the specifics of this legislation, I would like to make several general observations on the existing pattern of hospital economics and the effect of these economic considerations on capital financing for teaching hospitals.

Without the national emphasis that has attended the sharply mounting operating costs for all hospitals during the last two decades generally, and specifically in the last four years, the teaching hospital system has been steadily heading into an even more troubled dilemma with regard to its capital costs.

Reimbursement formulas of third-party agencies are increasingly based upon "costs" incurred by individual hospitals or health agencies. The "costs" are frequently defined to include allowances for interest on

borrowed capital and depreciation. Theoretically, depreciation funds might be used to retire indebtedness or be applied toward replacement or modernization of buildings and equipment. However, depreciation allowances related to original cost do not suffice to replace plant and equipment during a period of inflationary economy and revolutionary technological development. Depreciation allowances paid to an individual teaching hospital do not assure the institution of necessary funds for capital expenditures for new programs to extend medical care to more and more of society, to obtain the technical equipment to make available the advances in medicine, and to teach medical students and other health science personnel. The intermittent need for capital is in large measure independent of a regular flow of funds arising from a reimbursement formula. A teaching hospital in greatest need for capital at any given time may be the institution with the least available funds at that given time.

The amount of capital funds for building modernization and equipment required by a modern teaching hospital to stay abreast of the rapid technological advances is not only growing, but the sources available to the teaching hospital for capital funds are becoming more restricted.

The teaching hospital is directly related to the fastest moving, least predictable, quickest changing technologies to ever confront an industry. As Dr. Rogers has stressed, there is literally no facet of the escalating developments in the physical and biomedical sciences that does not have very profound implications for teaching hospital facilities. The very rapid pace of hospital technology is highly visible from one year

to the next in both structure and equipment. In addition, very significant numbers of these teaching hospitals are starting from bases of physical plants that are long outmoded.

Let me take just a moment to cite several studies that document the magnitude of the problem that faces the teaching hospitals of the nation:

1. In 1967 the Council of Teaching Hospitals of the Association of American Medical Colleges (although the Council only numbers 350 in membership, there are housed within these institutions approximately 23% of the nation's non-profit acute beds) sampled its membership to determine the extent of need for modernization and expansion. This sample included 250 member hospitals. 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 this survey, 35% were over 35 years old. An additional 16% were between 21 and 35 years old. Of the 214 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.
2. The Hospital Planning Council for Metropolitan Chicago, in studying six teaching hospitals in that metropolitan area in 1966 determined that the costs of modernization for these six institutions would approximate \$156 million and the costs

of replacement, \$300 million.

3. In Philadelphia the capital needs for modernization, replacement and expansion of the hospitals either operated by or affiliated with the area's 5 medical schools as reported in 1968 would total \$278 million as determined by the Philadelphia Hospital Survey Committee.

We have spoken of a crisis facing our nation's teaching hospitals.

This crisis is a result of many social forces. Among them are:

1. The teaching hospital, by virtue of its size and location (usually 300 beds or more in an urban or metropolitan setting) cares for a high percentage of patients from the immediate locality and surrounding regions, and maintains the resources of physical plant, skilled health personnel, complex equipment and a spectrum of services necessary for comprehensive, high quality health care;
2. The teaching hospital contributes significantly to the education of the nation's physicians. In fact, the national medical internship programs and the national medical residency programs for education and training of the medical specialists of this country, as well as many dental, nursing and other allied health science discipline education programs, take place almost exclusively in teaching hospitals;
3. The teaching hospital occupies a critical and central role with other health care programs for initiating the national norms and standards for patient care; and,

4. The teaching hospital is the locus of much of the scientific investigation that is done to advance the state of medical knowledge and patterns of medical care.

With these observations as a broadly based commentary on the critical need of teaching hospitals for modernization and construction funds, we want to indicate, Mr. Chairman, that we are in support of the bills introduced both by Mr. Rogers and the members of this Subcommittee (H.R. 7059) and by the Chairman of the full Committee (H.R. 6797). However, because of the vastness of the need and the immediacy of the problems, we would urge that the larger authorization as contained in H.R. 6797 be adopted. Accordingly, Mr. Chairman, we will address our comments primarily to that legislation. However, we wish to indicate emphatically our support of any legislative measure that will get the job done! The needs of teaching hospitals as one of the most significant vertabrae of health care, education and research of our nation are so great that we urge no doctrinaire approach but only immediate solutions, in which we will join and support vigorously the constructive, affirmative action of the Subcommittee and Committee.

In reviewing the proposed legislation, we believe the following points to be particularly pertinent:

1. The introduction of this legislation to expand and extend the very successful Hill-Burton Program is supported with certain suggested redirections. Since the inception of the original Hospital Survey and Construction Act of 1946, the

funds specifically for modernization.

With regard to this provision, and others on which we will comment in a moment, but at this time Mr. Chairman, we do call the attention of the Committee to the recently completed Report to the President by the National Advisory Commission on Health Facilities (December, 1968). That Commission in its report indicated the following:

"The multiple responsibilities of teaching hospitals for the education of health manpower and scientific research in addition to patient care, result in unique and extensive requirements for assistance in modernization."

The Association is in complete agreement with this statement by the National Advisory Commission. Additionally, many of these hospitals are located in urban areas, and in accordance with recent social mandates, are expanding greatly the existing patient care service functions and responsibilities as well as introducing new forms of care, such as alcoholic and drug addiction clinics, geriatric clinics, community centers, neighborhood health centers, etc. With regard to this specific point, I quote from an Office of Economic Opportunity publication entitled "The Neighborhood Health Center" in which it is noted "Each Neighborhood Health Center has a direct link to a hospital in the community, usually a teaching hospital." At the same time, these teaching hospitals are continuing to serve as regional referral centers for those medical and surgical cases that pose unusual difficulties in terms of diagnosis and therapy. To add yet another dimension to this progression, and as previously emphasized, these institutions also serve as a national

program has expended \$3.1 billion in support of construction and modernization of health care facilities whose total costs come to \$10.4 billion.

Further elaboration of the tremendous benefits to society contributed by the original and successor Hill-Burton programs is unnecessary. The accomplishments and benefits have been documented amply and effectively and are well known to you, Mr. Chairman, and your Committee. The success of the program as a clearly visible example of private enterprise, local, state and national government cooperative partnership is such that, unless there is an alternative so visible and potentially effective as to speak for itself, the present program should be amended to meet delayed needs and new needs - but not abandoned.

The increased authorization amount in H.R. 6797 for the next three years for new construction grants is most gratifying. Our only immediate concern is to emphasize the greatly increased need for these types of funds in our urban areas where so many of the teaching hospitals of the country are located. We respectfully suggest that the allotment formula for construction grant programs be adjusted to conform with the allotment formula contained in H.R. 7059, which provides that allotments shall be made among the states on the basis of population, the financial need, and the extent of need for construction of such facilities.

2. The authorization of appropriations for modernization grants as specified in Title I, Part A, Sec. 102 (a) (2) represents a very significant and progressive legislative attitude to provide

resource through the production of physicians and other allied health manpower. In accordance with the observation by the National Advisory Commission of the unique and extensive requirement of teaching hospitals, as well as other social factors outlined, we recommend strongly that consideration be given to some degree of priority for these hospitals that serve as the nucleus of our health care system not only for this modernization grant feature but for the other provisions contained in this bill.

3. The provision of H.R. 6797 for loan guarantees for modernization and construction for private non-profit hospitals, Title II, Part B of the legislation, is an additional element of the legislation which we endorse. As I just mentioned we again urge consideration of the findings of the National Advisory Commission on Health Facilities with regard to teaching hospitals.

4. We endorse the concept of loans for construction and modernization of public hospitals and other public medical facilities as specified in Title III, Part C of the H.R. 6797 proposed legislation. Of the 350 teaching hospitals that are institutional members of the Council of Teaching Hospitals, 74 are public hospitals (49 of which are state-owned university teaching hospitals). By this is meant that the ownership of these hospitals is vested in a municipality, a county, a state or a hospital district. I am sure that you, Mr. Chairman, and the members of the Committee are aware of the manifold problems that are facing public institutions in such areas as New York, Chicago, Detroit and my own city of

Boston. We believe that special appropriation authority for these teaching hospitals, which have for so long played such an important role in intern and resident education for this country, is a very significant legislative interest.

Mr. Chairman, a recent study conducted by our Council of Teaching Hospitals indicated that visits to the emergency departments of the member hospitals increased 66% during the six-year period from 1961-62 to 1967-68. Because of this very rapid increase, it is with enthusiasm that we endorse the provision contained in H.R. 7059 which provides for grants for the modernization of emergency room service in general hospitals as a benefit to society for the improved treatment of accident victims and the handling of other medical emergencies.

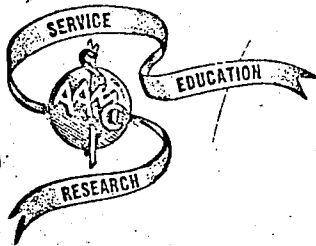
In closing, Mr. Chairman, I do want to emphasize that teaching hospitals are facing extraordinarily difficult times with regard to funding modernization and construction programs. Several ongoing legislative programs are conceived of by some as offering relief but this is true only to a limited extent. As a specific for instance occasionally there have been identified funds available under the program for Health Profession Educational Facilities Construction Act (P.L. 90-490) as a suitable point of access for teaching hospital funding. For most teaching hospitals this act is at best only a theoretical possibility for essentially two reasons: (1) the appropriations for this program over the past several years, when coupled with the wide range of health professions educational facilities it is designed to serve, have not allowed any real measure of relief for

teaching hospitals: and, (2) because the application for funds for teaching hospitals is tied necessarily to medical school affiliation.

Many fine teaching hospital institutions, though non-affiliated, are denied immediately any possible access to such funds. We would acknowledge however, Mr. Chairman, that if these limitations of limited funds and restricted access were removed, both of which have deterred any major source of funding for teaching hospitals, this program might prove very useful for such interest.

Finally, Mr. Chairman, we support H.R. 6797 which extends the authorization of \$60 million a year for three years for research and demonstrations relating to health facilities and services. H.R. 7059 does not include such a provision. This authorization has made possible the establishment of the National Center for Health Services Research and Development which could play an important role in improving the quality and scope and reducing the cost of health services available to the American people. We therefore, strongly favor the authorization of H.R. 6797 which would extend the work of this institution for three more years but we think that the authorization of \$60 million should be increased after fiscal 1970 to a level of perhaps \$100 million by 1973. These relatively small amounts for applied research can be compared with the \$1.1 billion the National Institutes of Health spend yearly for biomedical research.

Thank you very much for this opportunity to appear before you on behalf of the Council of Teaching Hospitals and the Association of American Medical Colleges in support of this urgently needed legislation. We will be pleased to attempt to answer any questions the Subcommittee members may have or endeavor to provide any additional information requested by the Subcommittee.



ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF TEACHING HOSPITALS
1346 CONNECTICUT AVENUE, N.W.
WASHINGTON, D. C. 20036
202/223-5364

MATTHEW F. McNULTY, JR.
DIRECTOR

May 2, 1969

Lad F. Grapski
President
Allegheny General Hospital
320 East North Avenue
Pittsburgh, Pennsylvania 15212

Dear Lad:

On behalf of Roy S. Rambeck, Chairman, Council of Teaching Hospitals, and the COTH Executive Committee, this letter seeks your concurrence for your appointment to the Chairmanship of the Committee on Nominations of the Council of Teaching Hospitals for the year 1968-1969. The proposed membership of this Committee would be as follows:

Stanley A. Ferguson - Member
Harold H. Hixson - Member
Russell A. Nelson, M.D. - Member

If it meets with your approval, the past methodology of operation would be continued through the use of a designated room and appropriate announcement posted at the Annual Meeting of the Council of Teaching Hospitals in Cincinnati, Ohio, during the period of Friday through Monday, October 31 through November 3, 1969.

At this time it is suggested that the times for the Committee to be available to membership would be Friday, October 31st at 5:00 p.m. and Saturday, November 1st at 12:30 p.m. The Committee could then have an executive work session on Sunday, November 2nd at noon. The wishes of the Committee and details of the Annual Meeting may later suggest different times, which could then be arranged.

Presuming your concurrence, there is attached a "work sheet" of those positions which will need to be filled through Nominating Committee action for the 1969-1970 administrative year. As noted, the "work sheet" is effective as of this date. For various reasons (resignations, position changes, illness, etc.), there may occur other changes prior to the Annual Meeting. We shall keep you advised with a periodically up-dated work sheet.

Lad F. Grapski
Page two
May 2, 1969

Assuming no drastic changes in format of the Annual Meeting, the Committee on Nominations would submit its report at the Plenary Business Session on Monday morning, November 3rd. This office stands ready to supply whatever resources are desired by the Chairman and Members in connection with the activity of this Committee.

Cordially,

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

MM:bs

Attachment: Work Sheet Listing Vacancies as of April 30, 1969 to be Filled,
1969-1970 Administrative Year.

cc: Roy S. Rambeck, Chairman, COTH
T. Stewart Hamilton, M.D., Chairman-Elect, COTH
(with attachment)

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

Worksheet Of
Vacancies to be Filled
For COTH Administrative Year 1969-1970
(As of April 30, 1969)

OFFICERS

Chairman	T. Stewart Hamilton, M.D.
Chairman-Elect	_____
Immediate Past Chairman.	Roy S. Rambeck
Secretary.	-Matthew F. McNulty, Jr.
<u>Total Vacancies to be Filled</u>	1

EXECUTIVE COMMITTEE MEMBERS

Three (3) Three-Year Terms (1969-1972)	_____

<u>Total Vacancies to be Filled</u>	3

COTH REPRESENTATIVES TO AAMC EXECUTIVE COUNCIL .

One (1) Three-Year Term (1969-1972).	_____
One (1) Two-Year Term (1969-1971).	_____
<u>Total Vacancies to be Filled</u>	2

COTH REPRESENTATIVES TO AAMC ASSEMBLY

Twelve (12) Three-Year Terms (1969-1970) _____

* One (1) Two-Year Term (1969-1971) _____

** One (1) One-Year Term (1969-1970) _____

Total Vacancies to be Filled. 14

* Under the By-Laws of the AAMC, the Council is entitled to representation of 10% of its membership, the total not to exceed 35. Since election of the 34 representatives for 1968-1969, COTH membership has grown to 350 members, as of April 30, 1969, and thus COTH is entitled to 35 members in the Assembly.

** To complete the term of the late Jack Masur, M.D., who was elected for a term to run through 1970.

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

AGENDA

COUNCIL OF TEACHING HOSPITALS
NORTHEASTERN REGIONAL MEETING
Wednesday, April 16, 1969
10:00 a.m. - 4:00 p.m.
New York University Medical Center
560 First Avenue
New York, New York 10016
212/679-3200

- I. Call to Order and Greetings from COTH -10:00 a.m. - T. Stewart Hamilton, M.D.,
Chairman-Elect, Council of Teaching Hospitals
- II. Greetings from New York University Medical Center - Mr. Irvin G. Wilmot,
Associate Director for Hospitals and Health Services and Member, COTH
Executive Committee.
- III. Approval of Minutes of 1968 Meeting as Distributed August 26, 1968
- IV. Report on Action Item Introduced by William S. Coppage, Jr., M.D., Chief of
Staff, VA Hospital, Nashville, Tennessee, at 1968 Meeting
- V. Report to Membership:
 - A. Appointment of John A. D. Cooper, M.D., Ph.D. As President of the AAMC
 - B. Reorganization of the AAMC
 1. COTH Representation on AAMC Assembly -- COTH Nominating Committee
 2. COTH Representative Appointed as Secretary-Treasurer of the AAMC
 3. Centralization of the AAMC Offices in Washington, D.C.
 - C. General Activity
 - D. Call to Action Memoranda (GM Nos. 69-9G and 69-21G)
 - E. Activity of COTH Committees
 1. Committee on Financial Principles
 2. Committee on Modernization and Construction Funds
 3. Committee on Program Development
 4. Committee on Membership
 5. AAMC Committee on Federal Health Programs
 - F. Research Activities
 1. Progress of the Teaching Hospital Information Center (COTHRIC)
 - a. The Role of the Teaching Hospital in Community Service
 - b. Intern and Resident Study
 - c. Administrators Salary Survey
 - d. Capital Financing of Teaching Hospitals
 2. Study to Determine the Effects of Recent Social Legislation on
Teaching Hospitals (COTHMED)
 3. Possible Utilization Study
- VI. Discussion of S.S.A. Regulations Dealing with Part B Payments for Services
of Supervising Physicians in a Teaching Setting

- VII. Report on Various Items Regarding the Financing of Teaching Hospitals
- A. Studies Recently Completed
 - 1. Program Cost Allocation in Seven Medical Centers: A Pilot Study
 - 2. Program Cost Estimating in a Teaching Hospital
 - B. Financing House Staff Stipends - Reid-Brademas Bill (H.R. 6536)
 - C. Recent I.R.S. Rulings on the Tax Status of House Staff
 - D. P.L. 89-97, Titles XVIII and XIX
 - 1. Physician Payment Under Title XIX
 - 2. Payment to Hospital-Based Physicians under Title XVIII
 - 3. In-Faculty Group Practice - Continued Developments
 - E. Budgetary Problems for Those Hospitals with Clinical Research Centers
 - F. Congressional Investigations Concerning Federal Hospital Reimbursement Formulas
 - G. Commission on Graduate Medical Education
 - H. Commission on Foreign Medical Graduates
- VIII. Joint Commission on Accreditation of Hospitals - Physician Representation on Teaching Hospital Boards of Trustees
- IX. Hospitals' Continuing Relationship with the Medical School Regarding Hospital Appraisal of Interns and the Medical School's Letters of Evaluation
- X. COTH Representation Activities in the Public and Private Sector
- A. Private Sector
 - 1. COTH-AHA Officer's Meeting
 - 2. Brookings Institution - Carnegie Commission Study on the Future of Financing Higher Education
 - 3. American Medical Association
 - 4. American Hospital Association
 - B. Public Sector
 - 1. Impending Health Legislation
 - a. Staggers Bill (H.R. 6797)
 - b. Rogers Bill (H.R. 7059)
 - c. Celler Bill (H.R. 3783)
 - 2. Health Related Activities of Federal Agencies Other than DHEW -
 - a. Bureau of the Budget
 - b. Housing and Urban Development (Mortgage Loans)
 - c. Veterans Administration
 - d. National Science Foundation (Board on Medicine)
 - e. Office of Economic Opportunity (Community Health Program)
 - f. Internal Revenue Service (House Staff Stipends)
 - g. Department of Defense (Health and Medical)
 - h. Department of Labor (Manpower Training)
 - i. Bureau of the Census (Health Related Surveys)
 - j. Appalachian Regional Commission
 - k. Vocational Rehabilitation Administration
 - l. Office of the President of the United States
 - m. Office of Science and Technology
 - n. Council of Economic Advisor
 - o. Department of State (Visa Permits)
 - 3. Need for Additional Representation at Federal and Local Levels
- XI. Other Business
- XII. Date of Next Meeting
- XIII. 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

AGENDA

COUNCIL OF TEACHING HOSPITALS
WESTERN REGIONAL MEETING
Friday, April 18, 1969
10:00 a.m. - 4:00 p.m.
Franciscan Room
Holiday Inn Motel
245 South Airport Boulevard
San Francisco, California 94080

- I. Call to Order and Greetings from COTH- 10:00 a.m. - David Odell, Member, Council of Teaching Hospitals, Executive Committee.
- II. Approval of Minutes of 1968 Meeting as Distributed August 26, 1968
- III. Report to Membership:
 - A. Appointment of John A. D. Cooper, M.D., Ph.D., as President of the AAMC
 - B. Reorganization of the AAMC
 1. COTH Representation on AAMC Assembly - COTH Nominating Committee
 2. COTH Representative Appointed as Secretary-Treasurer of the AAMC
 3. Centralization of the AAMC Offices in Washington, D.C.
 - C. General Activity
 - D. Call to Action Memoranda (GMM Nos. 69-9G and 69-21G)
 - E. Activity of COTH Committees
 1. Committee on Financial Principles
 2. Committee on Modernization and Construction Funds
 3. Committee on Program Development
 4. Committee on Membership
 5. AAMC Committee on Federal Health Programs
 - F. Research Activities
 1. Progress of the Teaching Hospital Information Center (COTHRIC)
 - a. The Role of the Teaching Hospital in Community Service
 - b. Intern and Resident Study
 - c. Administrators Salary Survey
 - d. Capital Financing of Teaching Hospitals
 2. Study to Determine the Effects of Recent Social Legislation on Teaching Hospitals (COTHMED)
 3. Possible Utilization Study
 - G. COTH Participation in AMA-AAMC Accreditation Visits
- IV. Report on Various Items Regarding the Financing of Teaching Hospitals
 - A. Studies Recently Completed
 1. Program Cost Allocation in Seven Medical Centers: A Pilot Study
 2. Program Cost Estimating in a Teaching Hospital
 - B. Financing House Staff Stipends - Reid-Brademas Bill (H.R. 6536)

- C. Budgetary Problems for Those Hospitals with Clinical Research Centers
 - D. Congressional Investigations Concerning Federal Hospital Reimbursement Formulas
 - E. Commission on Graduate Medical Education
 - F. Commission on Foreign Medical Graduates
- V. Discussion of S.S.A. Regulations Dealing with Part B Payments for Services of Supervising Physicians in a Teaching Setting
- VI. Joint Commission on Accreditation of Hospitals - Physician Representation on Teaching Hospital Boards of Trustees
- VII. Hospitals' Continuing Relationship with the Medical School Regarding Hospital Appraisal of Interns and the Medical Schools' Letters of Evaluation
- VIII. COTH Representation Activities in the Public and Private Sector
- A. Private Sector
 - 1. COTH-AHA Officer's Meeting
 - 2. Brookings Institution - Carnegie Commission Study on the Future of Financing Higher Education
 - 3. American Medical Association
 - 4. American Hospital Association
 - B. Public Sector
 - 1. Impending Health Legislation
 - a. Staggers Bill (H.R. 6797)
 - b. Rogers Bill (H.R. 7059)
 - c. Celler Bill (H.R. 3783)
 - 2. Health Related Activities of Federal Agencies Other than DHEW
 - a. Bureau of the Budget
 - b. Housing and Urban Development (Mortgage Loans)
 - c. Veterans Administration
 - d. National Science Foundation (Board on Medicine)
 - e. Office of Economic Opportunity (Community Health Program)
 - f. Internal Revenue Service (House Staff Stipends)
 - g. Department of Defense (Health and Medical)
 - h. Department of Labor (Manpower Training)
 - i. Bureau of the Census (Health Related Surveys)
 - j. Appalachian Regional Commission
 - k. Vocational Rehabilitation Administration
 - l. Office of the President of the United States
 - m. Office of Science and Technology
 - n. Council of Economic Advisor
 - o. Department of State (Visa Permits)
 - 3. Need for Additional Representation at Federal and Local Levels
- 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

PROGRAM

COD - COTH
JOINT SOUTHERN REGIONAL MEETING
Tuesday & Wednesday, April 29 & 30, 1969
The Hilton Inn
Atlanta, Georgia
404/767-0281

Tuesday, April 29, 1969:

11:30 a.m.	Registration
12:00 noon	Fellowship Hour -- Deans and Hospital Directors (Pay Bar)
1:00 p.m.	Luncheon
2:00 p.m. - 4:30 p.m.	<u>Program</u> -- "Problems and Opportunities for the Financing of Teaching Hospitals"
<u>Presiding:</u> Reid T. Holmes, Member COTH Executive Committee, Member COTH Committee on Financial Principles (combined COD-COTH Committee) and Administrator, North Carolina Baptist Hospitals, Inc.	
2:15 p.m. - 3:00 p.m.	<u>Hospital Viewpoint</u> -- Richard D. Wittrup, Vice-Chairman, COTH Committee on Financial Principles and Assistant Executive Vice President, Affiliated Hospitals Center (Harvard)
3:00 p.m. - 3:45 p.m.	<u>Medical School Viewpoint</u> -- William G. Anlyan, M.D., Chairman, Council of Deans and Associate Provost for Medical Affairs, Duke University
3:45 p.m. - 4:30 p.m.	Discussion Period
6:00 p.m. - 7:15 p.m.	Reception (Pay Bar) and Dinner Meeting
7:30 p.m. - 8:00 p.m.	<u>Program</u> -- "Future Developments for the Financing of Teaching Hospitals", David W. Stewart, Managing Director, Rochester Hospital Services Corporation
<u>Presiding:</u> Emanuel Suter, M.D., Chairman, Southern Regional Council of Deans and Dean, University of Florida College of Medicine	
8:00 p.m. - 8:45 p.m.	Discussion Period

COD-COTH JOINT SOUTHERN REGIONAL MEETING PROGRAM

Wednesday, April 30, 1969:

9:00 a.m.

Council of Deans -- Meeting Separately
(see COD Program and Emanuel Suter, M.D.,
Chairman, Southern Regional Council of
Deans, and Dean, University of Florida
College of Medicine)

9:00 a.m.

Council of Teaching Hospitals -- Meeting
Separately (see attached agenda) --
Presiding: Charles H. Frenzel, Member,
COTH Executive Committee and member
AAMC Committee on Federal Health Programs,
Administrative Director, Duke University
Medical Center.

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

AGENDA

COUNCIL OF TEACHING HOSPITALS
SOUTHERN REGIONAL MEETING
Wednesday, April 30, 1969
9:00 a.m. - 4:00 p.m.
The Hilton Inn
Atlanta, Georgia
404/767-0281

- I. Call to Order -- Presiding: Charles H. Frenzel, Member, COTH Executive Committee
- II. Approval of Minutes of 1968 Meeting as Distributed August 26, 1968.
- III. Report on Action Item Introduced by William S. Coppage, Jr., M.D., Chief of Staff, VA Hospital, Nashville, Tennessee, at 1968 Meeting
- IV. Report to Membership:
 - A. Appointment of John A. D. Cooper, M.D., Ph.D. As President of the AAMC
 - B. Reorganization of the AAMC
 1. COTH Representation on AAMC Assembly -- COTH Nominating Committee
 2. COTH Representative Appointed as Secretary-Treasurer of the AAMC
 3. Centralization of AAMC Offices in Washington, D.C.
 - C. General Activity
 - D. Call to Action Memoranda (GMM Nos. 69-9G and 69-21G)
 - E. Activity of COTH Committees
 1. Committee on Financial Principles
 2. Committee on Modernization and Construction Funds
 3. Committee on Program Development
 4. Committee on Membership
 5. AAMC Committee on Federal Health Programs
 - F. Research Activities
 1. Progress of the Teaching Hospital Information Center (COTHRIC)
 - a. The Role of the Teaching Hospital in Community Service
 - b. Intern and Resident Study
 - c. Administrators Salary Survey
 - d. Capital Financing of Teaching Hospitals
 2. Study to Determine the Effects of Recent Social Legislation on Teaching Hospitals (COTHMED)
 3. Possible Utilization Study
- V. Report on Various Items Regarding the Financing of Teaching Hospitals
 - A. Studies Recently Completed
 1. Program Cost Allocation in Seven Medical Centers: A Pilot Study
 2. Program Cost Estimating in A Teaching Hospital
 - B. Financing House Staff Stipends -- Reid-Brademas Bill (H.R. 6536)

- C. Recent I.R.S. Rulings on the Tax Status of House Staff
 - D. P.L. 89-97, Titles XVIII and XIX
 - 1. Physician Payment under Title XIX
 - 2. Payment to Hospital-Based Physicians under Title XVIII
 - 3. In-Faculty Group Practice -- Continued Developments
 - E. Budgetary Problems for Those Hospitals with Clinical Research Centers
 - F. Congressional Investigations Concerning Federal Hospital Reimbursement Formulas
 - G. Commission on Graduate Medical Education
 - H. Commission on Foreign Medical Graduates
- VI. Joint Commission on Accreditation of Hospitals -- Physician Representation on Teaching Hospital Boards of Trustees
- VII. Hospitals' Continuing Relationship with the Medical School Regarding Hospital Appraisal of Interns and the Medical School's Letters of Evaluation.
- VIII. COTH Representation Activities in the Public and Private Sector
- A. Private Sector
 - 1. COTH-AHA Officer's Meeting
 - 2. Brookings Institution -- Carnegie Commission Study on the Future of Financing Higher Education
 - 3. American Medical Association
 - 4. American Hospital Association
 - B. Public Sector
 - 1. Impending Health Legislation
 - a. Staggers Bill (H.R. 6797)
 - b. Rogers Bill (H.R. 7059)
 - c. Celler Bill (H.R. 3783)
 - 2. Health Related Activities of Federal Agencies Other than DHEW --
 - a. Bureau of the Budget
 - b. Housing and Urban Development (Mortgage Loans)
 - c. Veterans Administration
 - d. National Science Foundation (Board of Medicine)
 - e. Office of Economic Opportunity (Community Health Program)
 - f. Internal Revenue Service (House Staff Stipends)
 - g. Department of Defense (Health and Medical)
 - h. Department of Labor (Manpower Training)
 - i. Bureau of the Census (Health Related Surveys)
 - j. Appalachian Regional Commission
 - k. Vocational Rehabilitation Administration
 - l. Office of the President of the United States
 - m. Office of Science and Technology
 - n. Council of Economic Advisors
 - o. Department of State (Visa Permits)
 - 3. Need for Additional Representation at Federal and Local Levels
- 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

AGENDA

COUNCIL OF TEACHING HOSPITALS
MIDWEST/GREAT PLAINS REGIONAL MEETING

Thursday, May 1, 1969

10:00 a.m. - 4:00 p.m.

Westminister Room

Sheraton-O'Hare Motor Hotel

6810 North Mannheim Road

Des Plaines, Illinois

- I. Call to Order and Greetings from COTH - 10:00 a.m. - Ernest N. Boettcher, M.D.
Member, Council of Teaching Hospitals, Executive Committee
- II. Approval of Minutes of 1968 Meeting as Distributed August 26, 1968
- III. Report to Membership:
 - A. Appointment of John A. D. Cooper, M.D., Ph.D. as President of AAMC
 - B. Reorganization of the AAMC
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 - F. Research Activities
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 3. Possible Utilization Study
- IV. Report on Various Items Regarding the Financing of Teaching Hospitals
 - A. Studies Recently Completed
 1. Program Cost Allocation in Seven Medical Centers: A Pilot Study
 2. Program Cost Estimating in a Teaching Hospital

- IV. B. Financing House Staff Stipends - Reid-Brademas Bill (H.R. 6536)
- C. Budgetary Problems for Those Hospitals with Clinical Research Centers
- D. Commission on Graduate Medical Education
- E. Commission on Foreign Medical Graduates

- V. Discussion of S.S.A. Regulations Dealing with Part B Payments for Services of Supervising Physicians in a Teaching Setting

- VI. Discussion: Formation of Midwest/Great Plains COD, COTH, CAS, BOS Group

- VII. Joint Commission on Accreditation of Hospitals - Physician Representation on Teaching Hospitals Boards of Trustees

- VIII. COTH Representation Activities in the Public and Private Sector
 - A. Private Sector
 - 1. COTH-AHA Officer's Meeting
 - 2. Brookings Institution - Carnegie Commission Study on the Future of Financing Higher Education
 - 3. American Medical Association
 - 4. American Hospital Association
 - B. Public Sector
 - 1. Impending Health Legislation
 - a. Staggers Bill (H.R. 6797)
 - b. Rogers Bill (H.R. 7059)
 - c. Celler Bill (H.R. 3783)
 - d. Javits Bill (S. 1733)
 - 2. Health Related Activities of Federal Agencies Other than DHEW
 - a. Bureau of the Budget
 - b. Housing and Urban Development (Mortgage Loans)
 - c. Veterans Administration
 - d. National Science Foundation (Board on Medicine)
 - e. Office of Economic Opportunity (Community Health Program)
 - f. Internal Revenue Service (House Staff Stipends)
 - g. Department of Defense (Health and Medical)
 - h. Department of Labor (Manpower Training)
 - i. Bureau of the Census (Health Related Surveys)
 - j. Appalachian Regional Commission
 - k. Vocational Rehabilitation Administration
 - l. Office of the President of the United States
 - m. Office of Science and Technology
 - n. Council of Economic Advisors
 - o. Department of State (Visa Permits)
 - 3. Need for Additional Representation at Federal and Local Levels

- IX. Other Business

- X. Date of Next Meeting

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

UNIVERSITY OF CINCINNATI
COLLEGE OF MEDICINE
Cincinnati, Ohio, 45219

Office of the Dean-Eden and Bethesda Avenues

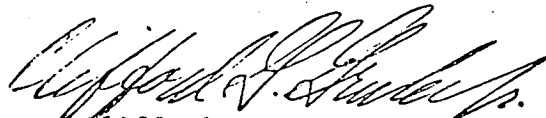
April 1, 1969

Dear Friends:

The Midwest-Great Plains Region of the Association of American Medical Colleges is meeting at the O'Hara Inn, Chicago, Illinois beginning at 2:00, April 21 and ending upon completion of the several sectional meetings at 12:30 p.m. or later on the afternoon of April 22. Enclosed with this letter is a combined agenda and program, a suggested organizational design for our regional organization, rosters of the potential membership including the Council of Deans, the Council of Academic Faculties, the Council of Teaching Hospitals and the Business Officers section, and finally a letter addressed to the University of Missouri Medical Center from the Medicare carrier in that state.

In the event that your institution is not represented in any of the categories of membership we hope such vacancies can be filled by the time of the April meeting so that each of the twenty-five schools can be fully represented. Program pattern and content of future meetings can be anything you want it to be. I think we will all agree, however, that an effective forum is needed for discussing current problems, new ideas and past experiences. Only in this way can we expect to have an effective voice in the national structure of the AAMC and in prospective planning for medical education. We'll look forward to seeing all of you in Chicago on April 21 and 22 and we suggest that you contact the O'Hara Inn directly for room reservations.

Sincerely yours,


Clifford G. Grulee, Jr., M.D.
Dean

CGG:d1
Enclosures

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APR 7 1969

DIRECTOR'S OFFICE

MIDWEST-GREAT PLAINS REGIONAL MEETING
Sheraton-O'Hare Motor Hotel
Chicago, Illinois

AGENDA

April 21, 1969

- 2:00 - 3:00 p.m. Discussion of Organizational Matters
- 3:00 - 5:00 Current Problems in Connection with Medicaid and Medicare - Dr. William D. Mayer, Dean, School of Medicine, University of Missouri
- 6:00 - 7:30 Dinner (Dutch Treat)
- 7:30 - 9:00 Health Manpower - Dr. John A. D. Cooper, Dean of Sciences, Northwestern University Medical School President, Association of American Medical Colleges (as of July 1, 1969)

April 22, 1969

- 9:00 - 10:30 a.m. "Program Cost Allocation in Seven Medical Centers -- A Pilot Study" - Dr. Robert M. Bucher, Dean, School of Medicine, Temple University
- Discussion by -- Dr. Robert C. Hardin, Dean, College of Medicine, University of Iowa, and Mr. Bernard J. Lachner, Representative, Council of Teaching Hospitals, College of Medicine, Ohio State University
- Phase II (The Next Step) - Thomas J. Campbell - Association of American Medical Colleges
- 10:30 - 12:30 Section Meetings
- Council of Faculties (Relationships between the Basic Science and Clinical Departments -- both Intellectually and Professionally)
- Council of Teaching Hospitals -
- Fiscal Officers -
- Council of Deans (Federal Government Organization - Dr. Philip Anderson, School of Medicine, University of Missouri, and a representative from the Bureau of the Budget)
- 12:30 Adjournment

TENTATIVE SCHEDULE OF MEETINGS

October 13 and 14, 1969
January 12 and 13, 1970

RECOMMENDATION FROM COTH MIDWEST/GREAT
PLAINS REGIONAL MEETING - MAY 1, 1969
REGARDING JOINT REGIONAL MEETINGS WITH REPRESENTATIVES
OF THE COUNCIL OF DEANS (COD), COUNCIL OF ACADEMIC
SOCIETIES (CAS) AND BUSINESS OFFICERS SECTION (BOS)

After lengthy discussion, it was unanimously agreed
that there were enough items of unique interest to teaching
hospital administrators and therefore, the Council of Teaching
Hospitals should continue its independent Regional Meeting Series.

Additionally, after full discussion, it was recommended
that no representative of COTH be selected to sit on the Midwest/
Great Plains COD-CAS-BOS-COTH Executive Committee.

Adopted by COTH Midwest/Great Plains
Regional Members at Meeting of May 1,
1969

THE JOHNS HOPKINS UNIVERSITY

DIVISION OF MEDICAL CARE AND HOSPITALS

SCHOOL OF HYGIENE AND PUBLIC HEALTH

615 North Wolfe Street • Baltimore, Maryland 21205

Tel.: 301-955-3200 Cable Address: PUBHYG

April 22, 1969

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

Dear Matt:

Thank you for your letter of 18 April 1969 and the enclosed check for \$2000.00.

The Seminar went very well this year. We are tabulating the evaluation responses and will send you a final report when it is ready.

We are so sorry to hear about your wife's illness and hope that all is going well with her. We will look forward to having you with us at next year's Seminar when we can share the experiences of a rich though exhausting week.

My warmest regards,

John W. Williamson, M.D.

John W. Williamson, M.D.
Associate Professor

(Signed in my absence)

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APR 24 1969
AAMC-WASH., D. C.

THE JOHNS HOPKINS UNIVERSITY

SCHOOL OF HYGIENE AND PUBLIC HEALTH

DEPARTMENT OF MEDICAL CARE AND HOSPITALS

615 North Wolfe Street • Baltimore, Maryland 21205

Tel.: 301-955-3200 Cable Address: PUBHYG

April 30, 1969

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

Dear Matt:

I know that John Williamson will write you in response to your letter of April 18, 1969, to thank you for the check for \$2,000 from the Association. We are most appreciative of the support of the Association for the Seminar and of your interest in obtaining financial support. This made a considerable difference in the outcome of the whole exercise. All of our evidence to date is that the Seminar was successful and we intend to have a fifth one in 1970.

It is perhaps not too early to bring this matter to your attention and to suggest that it would be helpful to know if the AAMC wishes to co-sponsor again the Seminar in 1970. It took us ages to obtain the funds through a contract initially and, of course, your funds only arrived in the nick of time. We shall need to submit a contract early in June for the next Seminar and it will be helpful to know whether the AAMC wishes to sponsor it with us. Perhaps you would let us have your thoughts and eventually a decision on this matter.

We were so sorry to learn of your wife's illness and I do hope that she is now fully recovered. We missed you at the Seminar but were glad to have Messrs. Veit and Checker present.

Again, many thanks for all your help and with kindest regards, I am

Yours sincerely,



Kerr L. White, M.D.

KLW:jmr

CC: John Williamson, M.D.

RECEIVED

MAY 6 1969

AAMC-WASH., D. C.

April 26, 1969

John A. D. Cooper, M.D., Ph.D.
President, Association of American
Medical Colleges
% Office of Dean of Sciences
Northwestern University
Rebecca Crown Building, Room 2145
633 Clark Street
Evanston, Illinois 60201

Dear John:

It was very thoughtful of you to take the time and write per your memorandum of April 15 as to the liaison committee between the AAMC and the AHA.

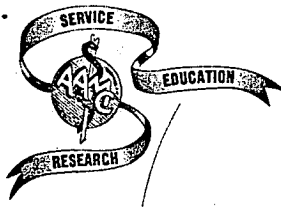
If agreeable with you, why not hold in abeyance any action until I can report to the COIH Executive Committee on Friday, May 9, the action of the Executive Council in enlarging that liaison committee. I expect nothing but affirmation from the COIH Executive Committee, but presenting it to them does preserve the organizational structure and the thoroughness of consideration from all aspects of the AAMC. I would then get in touch with you promptly following our Friday, May 9, meeting.

Incidentally, I hope you will be in attendance, at least, on Thursday evening for the get together and dinner and to give the COIH Executive Committee some observations and also on any portion of the Friday meeting for which you have time.

Best regards.

Cordially,

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



ASSOCIATION OF AMERICAN MEDICAL COLLEGES

INTER-OFFICE MEMO

Retain - 6 mos.	<input type="checkbox"/>
1 yr.	<input type="checkbox"/>
5 yrs.	<input type="checkbox"/>
Permanently	<input type="checkbox"/>
Follow-up Date	<input type="checkbox"/>

DATE April 15, 1969

TO: Mr. Matthew F. McNulty, Jr.

FROM: Dr. John A. D. Cooper

SUBJECT:

In considering the recommendation for an expansion of the liaison with the American Hospital Association, the Executive Committee of the Executive Council recommended that the present liaison committee be expanded to include one member from the Council of Deans, one member from the Council of Academic Societies and the President. This Committee, of course, would include you as a member.

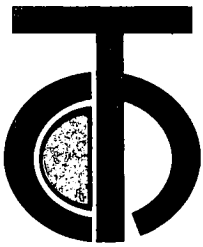
Before moving ahead with their recommendation I wanted to get your reaction and, if you feel it necessary, the views of the appropriate individuals in the Council of Teaching Hospitals on this matter.

Let me know what you think.

jadc/dbh

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APR 22 1969
AAMC-WASH., D. C.

COPIES TO:



COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

1346 CONNECTICUT AVENUE, N. W. • WASHINGTON, D. C. 20036 • (202) 223-5364

General Membership Memorandum
No. 69-28G
April 17, 1969
Subject: New Administration's 1970
Budget Amendments

1. Revised Department HEW Budget for Fiscal Year 1970:

On April 15, 1969 President Nixon recommended a revised budget for Fiscal Year 1970 which includes a number of changes that will affect membership adversely. The first such recommendation involves Hospital Construction Activities. As indicated in General Membership Memorandum No. 69-16G, the earlier budget figure for this program was \$258,415,000 (\$254,400,000 for construction and modernization and \$4,015,000 for operations and technical services.) Additionally the amount of \$15,000,000 was included for the District of Columbia Medical Facilities Construction Act of 1968. The revised budget reduces the total amount by \$104,492,000 with the explanation that the reduction reflects the change in emphasis contained in the Administration's proposals for new medical facilities construction legislation (GMM No. 69-27G). The Administration now proposes that grants in the amount of \$113,500,000 for new hospital construction and modernization be cut from the 1970 budget leaving only \$50 million available for this purpose. A further explanation is given that this reduction is in line with the Administration's legislative proposal to shift from a system of grants to a system of mortgage guarantees as the means of financing the construction and modernization of acute care facilities. Also in keeping with the legislative proposal, the new budget would add \$9,500,000 for the construction of ambulatory, long-term care, and rehabilitation facilities in recognition of these kinds of facilities having the greatest need for direct Federal support. The revised budget would fund the full amount of \$100 million currently authorized for such facilities. It would also eliminate all new positions requested for administration of Hill-Burton activities.

The budget authority for the new program for D. C. Medical Facilities in the amount of \$15,000,000 has been eliminated with the explanation it is assumed that Congress will consider this item as a part of the 1969 Supplemental Appropriation bill but that in the event this is not done, the Executive Branch would expect the item to be funded in 1970.

The \$38,964,000 budget figure for the General Clinical Research Centers program has been reduced by \$3,960,000 to the Fiscal Year 1969 amount of \$35,004,000.

An increase of \$5,000,000 was allowed for Health Professions Special Educational Improvement Grants for medical, dental and related schools with the explanation that by adding money and restructuring the initial request, the amended budget will help medical schools to add 1,600 freshmen students in the fall of 1970, an increase of 1,000 over the program proposed in the January budget. This increase, however is offset by a reduction of \$11,000,000 in the Research Manpower Development Training Grant program with the explanation that the decrease reflects a policy of shifting support from health research manpower to health service manpower. The Student Loan program was reduced \$5,000,000. In the Comprehensive Health Planning program \$18,000,000 has been transferred from the original budget request for project grants into the formula or "bloc grant" portion of the program with the explanation that states will be actively encouraged to use these additional funds for tuberculosis and venereal disease control activities, preferably in conjunction with family-oriented, comprehensive health care programs. Regional Medical Programs has been reduced \$24,691,000 "as a result of an unanticipated carry over balance..."

2. Grants to States for Medical Assistance:

A total reduction of \$505,000,000 in this area is described as being aimed mainly at (1) curbing the rising costs of Medicaid and Medicare, and (2) controlling the so-called non-controllable programs. The following actions are proposed to limit further increases in the cost of the Medicaid program:

1. Payment schedules will be established for doctors and dentists which are based on the prevailing Blue Shield payment plans for non-government medical service.
2. Federal payments for mentally ill patients in State and public institutions will be limited to 120 days.
3. The 2 percent contingency allowed on top of payments to hospitals will be eliminated.
4. Special review of hospital utilization practices will be conducted to cut down on the number of Medicaid patients in nursing homes who could be cared for by other means.
5. Federal matching for Cosmetic Orthodontistry will be eliminated.

It is indicated the above actions will be carried out by changing either Federal regulations or appropriation legislation and that in the aggregate they would reduce Federal outlays for Medicaid by \$267,000,000.

The recommended changes in items 1, 3, and 4, can be effected through changes in existing regulations effective July 1, 1969. Items 2 and 5 would be effected by language in the appropriations legislation prohibiting funds beyond the limitations indicated.

General Membership Memorandum

No. 69-28G

Page Three

3. Reduction in Medicare Costs:

Indicating a reduction of \$65,000,000 the budget amendments refers to current regulations under which hospitals, extended care facilities, and other providers are given an unallocated allowance in computing costs of services with a 2% allowance for non-profit organizations and a 1½ for profit-making organizations. It was indicated new regulations will be issued eliminating this allowance.

4. Further Budget Reductions Anticipated:

The response of Chairman Wilbur Mills (D) Arkansas of the House Ways and Means Committee to President Nixon's proposal to cut \$4 billion from the budget brought forth his recommendation that the Congress should cut another \$5 billion. Senator John J. Williams of Delaware, the ranking Republican on the Senate Finance Committee indicated agreement with Chairman Mills.

5. Recommended Action:

If of interest to your institutions it is recommended that you apprise your U. S. Senators and Representatives of the effects that the 1970 Budget Amendments will have upon your hospitals.

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

4/29/69

DRAFT TEXT OF TELEGRAM TO PRESIDENT RICHARD M. NIXON AND SECRETARY

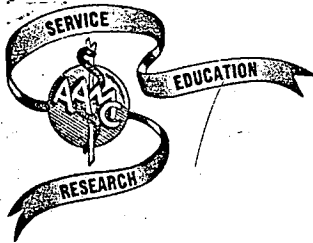
ROBERT H. FINCH

The Association of American Medical Colleges, and most particularly its Council of Teaching Hospitals, views with very grave concern the proposed elimination of the provision in P.L. 89-97 for an unallocated allowance to hospitals in computing the cost of services. This action if implemented would have extremely detrimental effects on those hospitals which have large teaching, research as well as patient service responsibilities. We are in complete accord with the telegram sent to Secretary Robert H. Finch by the American Hospital Association on April 17 which strenuously protested this reduction in reimbursement. Additionally, for the 350 teaching hospital members of this association, representing all of the major teaching hospitals of this country, there is a very dangerous inconsistency with the April 15 Amendments for the FY 1970 DHEW budget. The Budget Amendments authorized a modest \$5,000,000 increase to NIH for "aid to medical schools" with explanation indicating, "out of concern for the need to enlarge the number of physicians being trained by the native medical schools ..." Medical education involves two years of clinical training in teaching hospitals. In addition, all of the some 10,000 interns and 34,640 residents in this country as of 9/1/67 pursuing their necessary graduate medical education beyond medical school are located in the teaching hospitals of this country. The Teaching Hospitals are striving vigorously to enlarge their intern and residency educational capabilities so as to more effectively serve the needs of the nation for accommodating the additional interns and residents that will be produced by expanding medical school enrollments. Yet by decreasing by 2% some of

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the present resources available to those hospitals, there results the dilemma of how to accomplish a need recognized and supported in one measure by this Administration in the face of reduction of resources through the 2% 1970 Budget Amendment elimination. This Association has supported vigorously the need for expanding the enrollment of medical schools, as witnessed by the Joint Statement with the AMA on this subject of March 5, 1968. Such expansion must be on a balanced basis between the medical school preclinical and the teaching hospital clinical phases and facilities. The administrative action proposed in the revised budget, which severely inhibits the capability of the teaching hospital for further growth and development, destroys this balance at the very moment that projected increases in the student bodies of medical schools will place even greater stress on such teaching hospital abilities. This Association is vitally interested in strengthening the sturdy partnership that has developed between medical schools, teaching hospitals and the Federal Government. We do not believe, however, that this action by the Administration represents a way of strengthening this partnership in reaching our common goals. We urgently request that these revisions be abandoned and the allowances under P.L. 89-97 be restored to the FY 1970 Budget before its presentation to Congress.

John A. D. Cooper, M.D., Ph.D.
President



ASSOCIATION OF AMERICAN MEDICAL COLLEGES

2530 RIDGE AVENUE EVANSTON, ILLINOIS 60201

EVANSTON: 312-328-9505

CHICAGO: 312-273-4350

CABLE ADDRESS: AAMC EVANSTON

January 2, 1969

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 Matt:

You are invited to participate in an Exploratory Conference to discuss a proposed study of the Planning, Design, and Construction of Medical Educational Facilities.

The enclosed outline of this project indicates the background for the conference and poses some of the questions to which the participants will wish to address themselves.

The conference is scheduled to begin at noon on Thursday, January 30, 1969 and end at noon on Friday, January 31, 1969. It will be held at the Sheraton-O'Hare Motor Hotel and a reservation card is enclosed for your convenience.

We have been authorized to reimburse your travel and subsistence expenses. Please let me know if you can attend.

Yours sincerely,

Walt

Walter G. Rice, M.D., Director
Division of Operational Studies

WGR/mw
2 encs.

*Routine letter
to participants. I have
visited Mr. Viguers.*

RECEIVED

JAN 6 1969

AAMC-WASH., D. C.

EXPLORATORY CONFERENCE

MEDICAL EDUCATIONAL FACILITIES
PLANNING, DESIGN, AND CONSTRUCTION

Sheraton-O'Hare Motor Hotel
Rosemont, Illinois (Chicago)

January 30 to January 31, 1969

Thursday, January 30

12:00 noon - 2:00 p.m.

Registration

Luncheon

Introduction of Participants

Outline of Objectives of the Conference

2:00 p.m. - 6:00 p.m.

a. Discussion of need for study

b. Discussion of scope, duration, and
content of study

7:00 p.m.

Cocktails and Dinner

Friday, January 31

8:30 a.m. - 12:00 noon

Discussion of the auspices and organization
of study

Recapitulation of Conference

Summary and Conclusions

The conference will be limited to thirty participants and the sessions will be as informal as possible. Each major discussion question will be introduced by a participant. Otherwise, there will be no formal presentations.

PROPOSED STUDY OF MEDICAL EDUCATIONAL FACILITIES

St. Luke 14:28-30

For which of you, intending to build a tower, sitteth not down first, and counteth the cost, whether he have sufficient to finish it?

Lest haply, after he hath laid the foundation, and is not able to finish it, all that behold it begin to mock him:

Saying, this man began to build and was not able to finish.

* * * * *

At the February 1968 meeting the Executive Council of the Association of American Medical Colleges discussed "A Proposal to Initiate a Study of Facilities for Health Education" prepared by Dr. Cheves McC. Smythe (January 29, 1968). Dr. Smythe's memorandum listed the following relevant factors:

1. During the past 15 years approximately \$2 billion has been expended for construction of facilities for health education. Of this about 60% has gone for hospitals and other clinical facilities and 40% for research laboratories and other medical school buildings.
2. It has been estimated that an equivalent sum will be needed in the next 15 years if the medical centers are to keep up with demands now being made upon them. Estimates of projected construction expenditures submitted to the AAMC by the medical centers at various times are of a similar order of magnitude.
3. The current freeze on funding of new construction from federal sources can be expected to continue for at least ten months and possibly longer. When it is relaxed, it will take some time to activate and implement dormant plans. The long lead times characteristic of major construction funded from many public sources will impose a further delay on the construction of new buildings. These considerations suggest that the next two years are an excellent time in which to study recent advances and current thinking in the construction of facilities for health education.
4. The needs of the cities, schools, air and water pollution programs, to cite but a few, can be expected to compete with medicine actively and effectively for funds for social development. Analytical questions will be directed to the cost and size of buildings and to the nature of activities carried out in them. The benefits to be expected will be equated against those of other discriminatory investments.
5. The undoubted benefits and excitement involved in the building of new centers for health education will come increasingly into competition with the realities of renovating the old. If for no other reason than limitations on the potential number of solutions available, this often proves to be a more difficult problem than new construction. Careful study of best methods of remodeling and expansion of the old are as much in order as planning the new.

6. The U.S. Public Health Service Publication--Medical Education Facilities - Planning Considerations - Architectural Guide--is now out of print. This text has served its purpose admirably. Despite the clear intent of its authors that it not become a manual, the needs of any public agency for uniformity, fairness, and objectively verifiable processes in the administration of its responsibilities inevitably creates pressures for specific interpretations. At a time when great changes in the health care systems are in the offing, greater flexibility in buildings should be encouraged. The appearance of another federally sponsored "guide" would be accompanied by the hazard that its suggestions will harden into yardsticks against which all construction requests are to be judged. The Public Health Service is aware of this possibility, and the Bureau of Health Manpower does not intend to reissue this guide at this time. However, some satisfactory substitute must be found. There is little prospect of any decrease in demand from many sources for the valuable help such texts can provide, especially for the many who are new to the complexities of major medical center planning.

7. New patterns of health care will call for new patterns for health education. Such programs will encompass different functions and will call for facilities adapted to their most prominent features.

* * * * *

The minutes of the Executive Council record the following:

"III. Study of Facilities for Medical Education

The Council discussed the desirability, feasibility, and order of priority for further development of a study of medical facilities as set forth in material accompanying the Agenda. Its members agreed that if such a study is initiated, it should consist of program concepts, not mechanical and architectural details, and probably should be presented as a technical series of articles to be used as guidelines, perhaps incorporating illustrative examples of what "good" has been done and including some "poor" examples for contrast.

ACTION: On motion, seconded and carried, the Council authorized further review by staff of this segment of the Association's efforts and the development of a more specific proposal for consideration at a later meeting of the Council."

* * * * *

Subsequently a general outline of a study plan has been evolved, and discussed respectively with the Steering Committee of the Division of Operational Studies of the Association of American Medical Colleges, with members of the staff of The Commonwealth Fund, with representatives of the Division of Health Manpower, Public Health Service, and with the Executive Council of the Association of American Medical Colleges.

As a result, an exploratory conference to discuss and respond to three basic questions has been scheduled. The conference will be restricted to approximately thirty persons and will be multidisciplinary including representatives of architecture, planning, systems analysis and operations research, medical school administrations and faculty, federal health agencies, Council of Teaching Hospitals of the Association of American Medical Colleges, and staff of the Association.

The questions to which the conference will be asked to respond are:

1. Is there a need for a study of facilities for health education at this time?
2. If such a study were undertaken, what should be its scope over what period of time?
3. If such a study were undertaken, what means and which auspices would be most appropriate and most effective?

Problems in the design of medical education facilities vary from fairly general or somewhat philosophical considerations to very specific issues which confront the administrative officers who are responsible. General considerations include pedagogical problems with regard to the learning environment, opposing demands for flexibility and stability, and the issues raised by developing designs for a much-changing but hidden future.

Specific problems concern management techniques in the establishment of effective planning, the methods of cost control, the specific engineering requirements of the medical educational facility.

The study will need to be organized and directed so that all aspects--general and specific--of the planners' problems may be considered.

The exploratory conference is called for the purpose of considering these issues, some of which are stated in the form of questions below:

1. General

How can the needs of the users of a study of health education facilities be evaluated and identified? How can information be made available, most effectively, without producing a "manual" which resolves issues by formula? How can the varied skills needed in such a study be coordinated for maximum effectiveness? How can individual knowledge and experience be coordinated with the general consensus of multidisciplinary committee values? How can the costs of a study be met? Would a series of coordinated studies of specific problems be more appropriate than a single comprehensive study? Would case studies of particular institutions provide a feasible mechanism for portions of the study? What degree of participation by other health professions is appropriate and necessary?

2. Planning

How is the planning of a health educational facility carried out? What are the basic principles of comprehensive planning and how are these principles modified by the needs of the health educational system? What is the organizational structure of the planning program? What are the costs--real and apparent--of a comprehensive planning program? What are the functions and responsibilities of consultants in planning? How is information collected, assembled, analyzed, and acted upon in the planning program? How are institutional objectives determined, and by whom? How are these objectives used in the determination of planning priorities?

3. Design

Does design affect the educational effectiveness of the medical school? What is the effect of function on design? What is the effect of design on function? How can conflicting needs for permanence and flexibility be compromised? Does aesthetics have tangible value in the function of a building? How can the relative demands of a variety of populations (patients, students, staff, faculty, public) be resolved?

4. Finances

What are the sources of funds for construction of health education facilities? What are the effects of restrictions by the suppliers of funds on design, and general costs? What are the factors in the determination of costs? How can costs be managed so that the most value is received? What is the relationship of capital to operating costs? Are mechanisms available to allow increases in capital costs for economy in operational costs?

5. Site Selection

What are the essential relationships of the medical school to other health and/or educational facilities? What are the factors for consideration in the selection of a site? What are the essential internal institutional relationships which determine the position of components of the educational facilities? What are the factors which determine the placing of a building within an existing complex?

6. Educational Needs

How can space needs of personnel or programs be objectively evaluated? What are the needs of students, including those for informal or unstructured learning experiences? Can space remain unallocated until occupancy? What communications, information retrieval, and audiovisual systems are justifiable? How can these needs be evaluated? Should the medical school completely simulate the health care delivery system for effective teaching? What are the behavior patterns of students, especially medical students, in learning situations? How can facilities design most effectively exploit the positive features of student behavior? What are the educational interphases that need to be considered in the medical teaching/learning environments? How can

priorities for space requests be determined? What makes space a status symbol? Are there reasonable and acceptable substitutes? How can facilities design coordinate with unpredictable changes in the nature of health care? How can design be coordinated with predictable change? What cycles in the development of knowledge, and in fashions in education or health care, can be identified? Should these cycles have effect on design?

7. Communication

What means should be used in presenting the data from the study? Should the report be prepared for publication in a comprehensive manual? Would a series of loose-leaf reports published as they are available be more effective? Should study reports be presented in the form of a series of articles (or chapters) to be published in a journal and bound in a single volume at a later time? Does television or other audiovisual systems present means whereby the information can be made available? What should be the role of annual conferences on the problems of planning, design, and construction? Who should be included in such a conference?

December 11, 1968

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

TO: Executive Council Members

FROM: Robert C. Berson, M.D.

SUBJECT: Conference with Officers of the Kellogg Foundation

On Monday, December 9, Walter Rice and I had a three hour conference with the Chairman of the Board, the President and the Associate for Medicine of the Kellogg Foundation.

In addition to giving them a written progress report on the Cost Allocation Study (as contained in the Executive Council agenda material), we discussed that project at some length. We pointed out that the rate of expenditure from the \$35,000 grant from the Foundation had not been as rapid as we had anticipated and that a balance of about \$17,000 will remain at the end of December, when the period of the grant is over. Because of the importance of the next phase of this study, we suggested it would be useful for the Foundation to extend the period of the grant without additional funds. They expressed keen interest in this project and were receptive to the idea of extending the period.

In discussing the whole program of the Association, I told them of the decision to have the general funds of the Association provide basic support for the Division of Operational Studies at the level of \$72,000 per year, beginning with the current fiscal year, and expressed the hope the Foundation will remain interested in considering specific projects and programs as they become well defined and can be considered on their merits.

We described to them the very active development of the Section of Business Officers and the interest, among the members of that Section, in developing: regional meetings, workshops, a packet or kit of references, guides and procedural manuals for new business officers, and getting individuals from the business offices of institutions to spend periods of time on the staff of the Association to help with special projects. We indicated that financial support for this activity will be needed for a period with decisions later as to what directions the program should take and what sources of financial support are indicated. They expressed considerable interest.

RECOMMENDATION:

It is recommended that the Executive Council approve the programs as outlined and authorize a formal request to the Kellogg Foundation for financial support for a period of two years.



NEW YORK CHAPTER THE AMERICAN INSTITUTE OF ARCHITECTS

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February 28, 1969

Robert R. Cadmus, M. D.

President, New Jersey College of Medicine and Dentistry
Representative of the American Hospital Association

Mark A. Freedman, M. D.

Vice President, New York Blue Cross
Representative of National Blue Cross Association

Mr. Gordon A. Friesen, Hospital Consultant

Chairman, Research Committee

The American Association of Hospital Consultants

Mr. Matthew S. McNulty, Jr.

Director of the Council of Teaching Hospitals

Association of American Medical Colleges

Mr. Maurice Payne, Staff Executive

Committee on Health Environment

The American Institute of Architects

Gerald Renthal, M. D., Staff Member

American Public Health Association

Cheves Smythe, M. D.

Associate Director, Association of American Medical Colleges

Gentlemen:

Pursuant to our meeting at the Harvard Club on June 18, 1968, I am enclosing a revised draft of the proposal for a Health Facilities Laboratory. The delay in accomplishing this task was much greater than anticipated and, unfortunately, the result is not necessarily commensurate with the elapsed time. Nevertheless, the A. I. A. remains enthusiastic about the proposal and hopes that your organization will lend its support or endorsement.

The revisions to the enclosed document consist mainly of correcting the major criticism leveled at our June meeting; namely, that the scope of activity proposed for H. F. L. was not clear. I believe we have now emphasized the point that H. F. L. will concern itself with matters relative to health care facilities only and will not be concerned with the planning of health services.

MARGOT A. HENKEL / EXECUTIVE SECRETARY / TREASURER
20 WEST 40TH STREET
NEW YORK, NEW YORK 10018

RECEIVED
MAR 5 1969
AAMC-WASH., D. C.

Drs. Cadmus, Freedman,
Renthal, Smythe
Messrs. Friesen, McNulty, Payne

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February 28, 1969

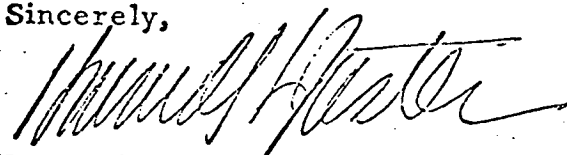
We have elected not to elaborate on the proposed organizational pattern for H. F. L. at this time, since we believe this remains the prerogative of the sponsoring organization. However, if you believe strongly that a more detailed description is advisable, we would welcome your comments.

Our present schedule, if all goes well, calls for the approach to the foundations to start around April 15. It would be most helpful, therefore, if we could have your comments and suggestions by no later than April 7. I would also be glad to meet with any of you to discuss the proposal in more detail, if you wish. It is possible, too, that another general meeting might be desirable to determine how the proposal should be presented to the prospective foundations relative to collective endorsement or support. I imagine this can be determined during the next month.

It is perhaps worth mentioning again that the A. I. A. is merely attempting to act as a catalyst to obtain the support of other concerned professional groups for the broad objectives of H. F. L. With such support, the A. I. A. would seek the interest of one or more foundations. If such an effort is successful, it is contemplated that the A. I. A. and the other concerned professional organizations would serve only in advisory capacities, and only if so requested by the sponsoring foundation(s). It should be emphasized that the A. I. A. does not intend H. F. L. to be an A. I. A. activity, nor does it seek any special or favored relationship with H. F. L. The proposed Health Facilities Laboratory is visualized as a private, independent organization, whose main purpose would be to assist all those organizations and institutions interested and active in health facility planning.

I look forward to hearing from you.

Sincerely,



Howard H. Juster
Chairman, Research Subcommittee
of Hospitals and Health Committee

HHJ:jk
Encl.

cc Mr. Richard Miller
Chairman, Hospitals and Health Committee
Mr. Richard Sonder
Vice Chairman, Hospitals and Health Committee

DRAFT

A PROPOSAL FOR A HEALTH FACILITIES LABORATORY

Hospitals and Health Committee
New York Chapter
American Institute of Architects

Revised:
January 30, 1969

I. SUMMARY

Health care is a primary concern of society and a major consumer of funds. As an element in the health care milieu, health facilities throughout the nation are currently being scrutinized regarding their efficiency in terms of quality and cost. The rapid rate of technotronic developments and the increasing complexity of facility requirements, together with the lack of data on objectives, requirements and methodology for these new developments, have made it extremely difficult for architects and planners to cope effectively with design problems. Thus, the need for an independent, soundly financed research agency to make possible a long range program of study and education in health facility design is becoming critical at this time. This proposal calls for the establishment of such an agency, utilizing foundation funds in part or in entirety. The purpose of this agency, tentatively named, The Health Facilities Laboratory, would be to help health institutions and their communities by encouraging research and experimentation in planning and design, and by disseminating knowledge of such developments in the health field. The investment in the work of this agency would pay handsome dividends in improving the health care system in the United States.

II. BACKGROUND

A. Every citizen in the United States is affected by the availability and quality of health care facilities. Hospitals, which form only part of these facilities, annually care for 28 million inpatients and 125 million outpatients. Every year, about two billion dollars are spent in hospital construction, continually adding to plant assets now worth some \$23 billion. Hospital operating expenses

are rapidly rising; in 1964 they stood at \$12 billion per year, more than tripling the 1950 figure. At the present rate of increase, expenditures on health care will grow from 6% of the gross national product to 10% by the year 2000.

B. As the mainstay of health care facilities, the hospital is under close scrutiny due to concern over the doubling of the daily cost of patient care every seven years since 1945, and the accelerating rate of obsolescence of hospital facilities which is causing a crisis in financing of new hospital construction.

C. The Health Facilities system is under unprecedented pressure to meet new demands and to adjust to fundamental changes:

1. Demands for more care of higher quality are inherent in the growing realization that good health is the fundamental right of every citizen. The role of the federal, state and local government in health care and controlling legislation has ever-increasing impact on facility planning. The urbanization of our population alters the physical pattern of the health care system.
2. Specialization and teamwork are becoming more important. The behavioral and social sciences, as well as biological and physical sciences, are more strongly represented on the health team. These changes are turning medicine away

from the disease-oriented care toward emphasis on health and the life process. The coordinated comprehensive health care system and the related facilities that would provide the essential continuity of care have not yet been created.

3. Technotronic developments are providing better tools for health care, for planning facilities, programs and construction. Technotronic change is occurring faster than can be absorbed by present health care organizations.

III. OBSTACLES

- A. The design of health care facilities should be studied in relation to the entire health care system, but generally is not. As long as facilities are planned with little relation to an overall system of care, and systems of care are devised without regard to the available or planned facilities, progress will continue to be slow.
- B. The fragmented health care system prevailing in most of our communities makes coordinated planning difficult, if not impossible. While regional planning agencies have some effect, they are hampered in their activity by the diversity of the typical community health services, which may include municipal, county, state, federal, V.A., non-profit voluntary, non-profit religious, and private-for-profit agencies. Overlapping methods of financing construction and conflicting regulations on planning and operation of new facilities create further problems.

- C. The process of change is held back by the huge investment in existing durable facilities which are expensive to modify and to enlarge. In New York City alone, some \$1.2 billion would be required to bring existing hospital facilities up to acceptable standards for their current use. These obsolete facilities, old organizational patterns, and personnel trained in outdated methods tend to hold back needed changes.
- D. Guidance of the process of change is inadequate. A fragmented research effort is under way, using both government and private funds, carried out in government offices and universities here and abroad. These efforts are limited in scope, and lack overall coordination. The total amount of money spent on planning research is, without doubt, seriously deficient in view of the enormity of the problem.

IV. NEEDS

There is a growing awareness in the health facility planning field of the need for a catalytic agency which could initiate an attack on the basic planning problems. Such an agency would stimulate, organize, and coordinate efforts to bring about:

- A. Planning approaches that recognize the feedback relationship between facilities and health care systems.

B. Planning techniques that will permit the facility system to change and grow in an orderly way as new demands arise.

C. Coordination of diverse research efforts and methods of financing research for the planning of health facilities.

To establish such an agency, we propose the formation of a Health Facilities Laboratory.

V. PURPOSES OF THE HEALTH FACILITIES LABORATORY (HFL)

A. To encourage the study and development of new ways to manage the planning process of health facilities by promoting the utilization of:

1. Methods for coordinating and correlating physical planning with health service systems.
2. Methods for dealing with redundant community health facilities.
3. Methods for resolving conflicting building codes and regulations.

B. To encourage the study of elements of the health facilities system and the methods of distributing these elements within the community:

1. Developing an increased understanding of the relationship between health facilities and urban development.

2. Promoting the integration of health facility planning within the overall urban planning process.

C. To encourage the study of the process of growth and change, with a view toward developing principles and methods of planning that will help avoid obsolescence by:

1. Developing methods for designing facilities flexible enough to accept changes in operational methods and scope.
2. Developing methods of planning that will help achieve a proper balance between capital cost and operational cost in order to reduce the total cost of health care in the effective manner.

D. To act as an agent of change by:

1. Lending financial assistance for the design, construction and evaluation of facilities suggested by HFL studies and for experimental approaches to facility planning and design.
2. Encouraging manufacture of pertinent products and assemblies not now available.
3. Publishing and disseminating the results of studies conducted under HFL auspices.

4. Publishing and disseminating educational material on significant developments in health facility planning.
5. Encouraging the development of information centers for health facilities planning and research.

VI. METHOD OF OPERATION, HFL

- A. To assure a broad approach, HFL activities should be directed by a group which has available the specialized skills of architecture, engineering and planning, as well as the medical, behavioral and social sciences. The officers of HFL should be sympathetic and capable generalists who will see the planning process in the widest context. Specialized skills may be available either on a full-time staff basis or through outside consultants.
- B. HFL leadership would be responsible for determining coordinated programs of study, not subject to the whim of individual enthusiasm. These programs should be flexible enough to permit adjustment, but sufficiently firm to avoid fragmented studies that do not contribute to the total effort.
- C. HFL would ideally be an independent agency, not associated with a university, government agency, professional organization or health facility. With a relatively small full-time staff, it would make grants for research projects to qualified individuals or groups in universities, health care facilities, and private practice.