COUNCIL OF TEACHING HOSPITALS
EXECUTIVE COMMITTEE MEETING
AAMC BOARD ROOM
9:00 a.m. - 2;30 p.m.
May 7-8, 1970

I. Call to Order - 9:00 a.m.

II. Approval of Minutes Meeting of February 6, 1970 (TAB A)

III. Membership
- A. New Applications (TAB B)
- B. Osteopathic Hospital Membership (TAB C)
- C. Membership Statistics (TAB D)

IV. Budget and Staffing

V. Report of Meetings
- A. AAMC-BCA Liaison Committee (TAB E)
- B. AAMC Ad Hoc Committee on National Health Insurance (TAB F)
- C. AAMC Ad Hoc Committee on Medicare Reimbursement (TAB G)
- D. Regional Meetings

VI. Annual Meeting Discussion (TAB H)

VII. Proposal for a Joint Practice Commission (HANDOUT)

VIII. Deans Seminar

IX. University Hospitals Executive Committee Request for Position Statement (TAB I)

X. Development of the Department of Health Services

IX. Legislative Activities
- A. Health Services Improvement Act of 1970 (S.3443) and (H.R. 15960)
- B. Health Training Improvement Act of 1970 (S.3586)
- C. Amendment to National Housing Act to Increase Ceiling on guaranteed loans to nonprofit hospitals from $25 million to $50 million (TAB J)
- D. Administration Proposal to Amend Social Security Act
- E. Letter to Mr. Ball Concerning Accelerated Depreciation (TAB J)

XII, Review of the AAMC Position on Physician Assistants (TAB K)

XIII. Research Activities (TAB L)
A. COTHIC Report
B. COTHMED Report

XIV. Other Business

XV. Adjournment: 2:30 p.m.

COUNCIL OF TEACHING HOSPITALS
EXECUTIVE COMMITTEE

PRIVATE DINING ROOM 16
PALMER HOUSE
CHICAGO, ILLINOIS
February 6, 1970

Present:

T. Stewart Hamilton, M.D., Chairman
Ernest N. Boettcher, M.D.
Edward J. Conners
George E. Cartmill
Joe S. Greathouse, Jr.
L. H. Gunter
Sidney Lewine
Russell A. Nelson, M.D.
David Odell
Roy S. Rambeck
Irvin G. Wilmot

Staff:

John M. Danielson
Fletcher H. Bingham, Ph.D.
Richard M. Knapp, Ph.D.
Grace W. Beirne
Michael Amrine

AHA Representative:

Merle S. Bacastow, M.D.

I. Call to Order:

The meeting was called to order at 9:00 a.m. with those present noted above.

II. Consideration of Minutes, Meeting 69-5:

On motion, seconded and carried, the minutes of the Executive Committee Meeting #69-5 held on October 30, 1969 in Cincinnati, Ohio were approved as distributed.

III. Membership:

A. New Applications for Membership

St. John's Hospital, Springfield, Illinois

Memorial Hospital, Springfield, Illinois

ACTION #1 Both of these hospitals had been nominated by Dr. Richard Moy, Dean of the Southern Illinois Medical School. Because this medical school had not attained provisional membership in the AAMC, it was agreed that these applications should be tabled and should be submitted to COTH simultaneously with the application of the medical school for provisional membership in the Association.

Hamot Hospital, Erie, Pennsylvania

ACTION #2 Because of the lack of certain necessary information appearing on the application form, the Executive Committee agreed that more information was necessary before a final decision could be made on this hospital.

Harborview Medical Center, Seattle, Washington

It was moved, seconded and carried that this hospital be accepted. Mr. Rambeck abstained.

B. Status of Membership Drive

Action #3 It was agreed that a regionalized breakdown of those hospitals now eligible for membership would be sent to each member of the Executive Committee shortly after the letters of invitation for membership are sent out.

IV. Report of Meetings:

A. AAMC-AHA Liaison Committee

Dr. Hamilton and Mr. Danielson reported on the January 5th meeting of this committee and noted that the items covered included: universal health insurance; organization of house officers; financing of medical education; comprehensive health planning; and education of allied health professionals. They noted that the AHA was to serve as the host for the next meeting.

B. COTH-Association of Canadian Teaching Hospitals

Mr. Wilmot reported on a meeting held between representatives of COTH and ACTH on January 20th in Chicago and indicated that there were substantial problem areas that were shared by American and Canadian teaching hospitals.

ACTION #4 The Executive Committee requested the Director to negotiate the most favorable group rate possible with the ACTH for membership of Canadian teaching hospitals in COTH.

C. Officers Retreat

Dr. Hamilton, Mr. Wilmot and Mr. Danielson reported on the AAMC's Officers Retreat that had been held at Quail Roost in North Carolina.

D. Nursing

Mr. Danielson reported that an initial meeting had been held with several representatives of nursing education and nursing practice, to determine how best nursing might be represented in the AAMC. He noted that substantial agreement had been reached and that this representation might most effectively be accomplished through

appointment of several nurses to the newly established Health Services Advisory Committee. The Executive Committee urged that a fairly specific charge be delineated to guide the activities of this latter committee.

E. Midwest/Great Plains Regional Meeting

Dr. Boettcher and Dr. Bingham reviewed the problems that had developed in this region relating to the establishment of a micro-association. Following discussion the Committee suggested that the item be discussed at the COTH Midwest/Great Plains Regional Meeting.

V. Legislative Activities:

Miss Beirne reviewed the current status of the Hill-Burton legislation, the potential hearings to be conducted by Senator Hart and the 1970 DHEW FY 70 appropriations and administration's budget for FY 71. Following this discussion the committee agreed that:

ACTION #5 The AAMC should continue to maintain effective liaison with the staff of the Health Services and Mental Health Administration in attempts to enhance the legislative programs as well as the appropriations for those programs that are of interest to teaching hospitals.

VI. Recommendations for Special Programs Relating to Teaching Hospitals:

A letter from Leslie R. Smith, Administrator, Harbor General Hospital, was reviewed in which it was requested that COTH serve as an information center for data and materials relating to public teaching hospitals. The Committee agreed that this activity could be best undertaken by the Teaching Hospital Information Center.

VII. Report on Current Negotiations with Medicaid:

It was reported that the number of suspended hospitals had been reduced from 268 to approximately 90. Further staff efforts are being expended to continue to reduce these suspended institutions. A copy of the proposed "Questions and Answers: that had been prepared by S.S.A. to clarify Intermediary Letter #372 was distributed for Committee review and comment.

VIII. G.C.R.C. Space Usage Proposal:

Mr. Wilmot indicated that several representatives of the Council had met on the previous evening with members of the staff of the General Clinical Research Center to discuss the concept of the space usage proposal. The following motion was moved, seconded and carried:

ACTION #6 That the COTH Executive Committee:

(1) Endorses in principle the Space Usage Concept;

(2) Urges continued contact between COTH and the staff of G.C.R.C. in the development of this program and;

(3) Stresses the need to maintain several options for G.C.R.C. reimbursement.

IX. Organization of House Officers:

A snyopsis of negotiations between the Committee of Interns and Residents and the City of New York was presented which showed that the demands of C.I.R. was for $12,000 for interns. Mr. Danielson reported further on the activities of this group as well as others throughout the country.

ACTION #7 The Executive Committee recommended that COTH staff continue to monitor the activities of house staff very closely and also that COTH begin to develop, an an information service, material on the representation opportunities for house staff within the organization of the hospital.

X. Research Activities:

Dr. Knapp reported on the activities of the Teaching Hospital Information Center and also gave a progress report on the COTHMED project. Under the former item, it was urged that the study relating to state appropriations to teaching hospitals be modified to take a more distinct look at sources of income.

XI. It was noted that the next meeting of the Executive Committee was scheduled for May 7 and 8 in Washington. There being no further business, the meeting adjourned at 3:20 p.m.

PLEASE READ INSTRUCTIONS ON REVERSE SIDE

From the Office of:
MATTHEW F. McHUGH, 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: The Crawford W. Long Memorial Hospital of Emory University
Name

35 Linden Avenue, N. E.
Street

Atlanta | Georgia | 30308
City | State | Zip Code

Principal Administrative Officer: Wadley R. Glenn, M. D.
Name

Medical Director and Administrator
Title

Hospital Statistics:

Date Hospital was Established: 1911

Average Daily Census: 404

Annual Outpatient Clinical Visits: 24,811

Approved Internships:

Type	Date Of Initial Approval by CME of AMA*	Total Internships Offered	Total Internships Filled
Rotating	1945	6	0
Mixed	1964	6	0
Straight			

Approved Residencies:

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total Residencies Filled
Medicine	February 14, 1949	9	6
Surgery	August 24, 1949	11	9
OB-Gyn	June 2, 1947	6	2
Pediatrics	-		
Pathology			
~~Psychiatry~~	February 11, 1948	8	2

Information submitted by:

Wadley R. Glenn, M. D.
Name

Medical Director and Administrator
Title

March 27, 1970
Date

Wadley R. Glenn
Signature

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

PLEASE READ INSTRUCTIONS ON REVERSE SIDE

Instructions:

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

Membership in the Council:

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

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

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

and

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

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

If nominated by School of Medicine, complete the following:

Name of School of Medicine Emory University

Name of Parent University Emory University

Name of Dean of School of Medicine Arthur P. Richardson, M. D.

Complete address of School of Medicine Emory University School of Medicine

1380 South Osford Road, N. E.

Atlanta, Georgia 30322

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

FOR AAMC OFFICE USE ONLY:

Date _____ Approved _____ Disapproved _____ Pending _____

Remarks: _____

Invoiced _____ Remittance Received _____

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership
in the
Council of Teaching Hospitals

(Please type)

Hospital: The Jamaica Hospital
Name

Van Wyck Expressway and Jamaica Avenue
City Street

Jamaica, New York 11418
State Zip Code

Principle Administrative Officer: Charles G. Marion
Name

Executive Director
Title

Date Hospital was Established February 18, 1892

Approved Internships:

Type	Date Of Initial Approval by CME of AMA*	Total Internships Offered	Total Internships Filled
Rotating		8	8
Straight		2 Surgical	1

Approved Residencies:

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total ~~Internships~~ Residencies Filled
Medicine	May, 1966	12	12
Surgery	January, 1946	8	8
OB-Gyn	August, 1966	6	4
Pediatrics	January, 1969	4	6
Psychiatry			
Other			
Pathology	July, 1953	8	8

Information Submitted By:

Charles G. Marion
Name

Executive Director
Title of Hospital Chief Executive

April 27, 1970
Date

Signature of Hospital Chief Executive

*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

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership
in the
Council of Teaching Hospitals

(Please type)

Hospital: The Youngstown Hospital Association
Name

North Unit - Gypsy Lane & Goleta Ave.
South Unit - Oak Hill & Francis St.
Street

Youngstown
City

Ohio
State

44501
Zip Code

Principle Administrative Officer: William B. Esson
Name

Executive Director
Title

Date Hospital was Established 1882

Approved Internships:

Type	Date Of Initial Approval by CME of AMA*	Total Internships Offered	Total Internships Filled
Rotating	1914	24	12
Straight Medical	1964	4	0
Straight Surgical	1964	2	2

Approved Residencies:

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total Internships Filled
Medicine	1938	14	14
Surgery	1947	14	14
OB-Gyn			
Pediatrics			
Psychiatry			
Other: Anesthesia	1948	10	8
Other: Radiology	19 40	9	6
Other: Orthopedics	1945	2	2
Other: Pathology	1947	8	8

Information Submitted By:

Robert A. Wiltsie, M. D.
Medical Director Name

April 14, 1970
Date

William B. Esson
Executive Director
Title of Hospital Chief Executive

Signature of Hospital Chief Executive

*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

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership
in the
Council of Teaching Hospitals

(Please type)

Hospital: Veterans Administration Hospital
Name

Martinez — 150 Muir Road
City — Street

California — 94553
State — Zip Code

Principle Administrative Officer: Paul O. Battisti
Name

Hospital Director
Title

Date Hospital was Established: August 1963

Approved Internships:

Type	Date Of Initial Approval by CME of AMA*	Total Internships Offered	Total Internships Filled
Rotating	We participate in the Internship Program of Highland General Hospital, Oakland, California, having four positions in Medicine and one in Neurology for the full academic year on a two-month rotation. The parent program is approved by CME of AMA.		
Straight			

Approved Residencies:

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total ~~Internships~~ Residencies Filled
Medicine	2/28/58	9	
Surgery	6/27/58	10	
OB-Gyn			
Pediatrics			
Psychiatry	6/14/68	4	
Other Neurology	11/7/55	3	
Pathology	5/15/57	6	
Urology	7/7/61	3	

Information Submitted By:

Paul O. Battisti
Name

Hospital Director
Title of Hospital Chief Executive

April 6, 1970
Date

Paul O. Battisti
Signature of Hospital Chief Executive

*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

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership
in the
Council of Teaching Hospitals

(Please type)

Hospital: Bayfront Medical Center, Inc.
Name

St. Petersburg, 701 Sixth Street South
City Street

Florida 33701
State Zip Code

Principle Administrative Officer: William W. Turner
Name

President
Title

Date Hospital was Established 1910

Approved Internships:

Type	Date Of Initial Approval by CME of AMA*	Total Internships Offered	Total Internships Filled
Rotating	March 1953		4
Straight			

Approved Residencies:

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total Internships Filled
Medicine			
Surgery	April 1962	2	
OB-Gyn	June 1963	3	
Pediatrics			
Psychiatry			
Other			
Gen. Prac.	December 1961	4 (2 ea. yr.)	
Pathology	September 1962	4 (1 ea. yr.)	

Information Submitted By:

William W. Turner
Name

President
Title of Hospital Chief Executive

April 7, 1970
Date

Signature of Hospital Chief Executive

*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

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership
in the
Council of Teaching Hospitals

(Please type)
Hospital: Riverside General Hospital - University Medical Center
Name

Riverside — 9851 Magnolia Avenue
City — Street

California — 92503
State — Zip Code

Principle Administrative Officer: Neal D. Asay
Name

Administrator
Title

Date Hospital was Established 1893

Approved Internships:

Type	Date Of Initial Approval by CME of AMA*	Total Internships Offered	Total Internships Filled
Rotating	October 21, 1948	16	16
Straight			

Approved Residencies:

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total Internships Filled
Medicine	1952	8	
Surgery	1953	10	
OB-Gyn	1964	4	
Pediatrics	1966	2	
Psychiatry			
Other	General Practice, 1952	4	Rotating 0,1 - - 16

Information Submitted By:

Donald L. John, M.D.
Name

Acting Chief of Professional Services
Title of Hospital Chief Executive

April 14, 1970
Date

Signature of Hospital Chief Executive

*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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Membership in the Council of Teaching Hospitals:

Teaching Hospital members shall be organizations operated exclusively for educational, scientific, or charitable purposes. Hospitals as institutions will be members of the Council and each institution will be represented by a person designated by the hospital for the purpose of voting at business meetings of the Council. All members will vote at the Annual Meeting for officers and members of the Executive Committee.

Membership to the Council will be determined by the following criteria:

a. those hospitals nominated by a medical school Institutional Member or Provisional Institutional Member of the AAMC from among the major Teaching Hospitals affiliated with the Members and elected by the Council of Teaching Hospitals, or

b. teaching hospitals which have approved internship programs and full, approved residencies in at least 4 recognized specialties including 2 of the following: Medicine, Surgery, Obstetrics-Gynecology, Pediatrics, and Psychiatry, and are elected by the Council of Teaching Hospitals

The voting rights of the Council of Teaching Hospitals in the Assembly of the AAMC shall be as follows: The Council of Teaching Hospitals shall designate 10 percent of its members, up to a maximum of 35, each of whom shall have 1 vote in the Assembly.

If nominated by a School of Medicine, complete the following:

Name of School of Medicine Loma Linda University Medical School

Name of Dean David Hinshaw, M.D.

Address of School of Medicine Loma Linda California 92354

FOR COTH OFFICE USE ONLY

Date_____ Approved_____ Disapproved_____ Pending_____

Remarks_____

Invoiced_____ Remittance Received_____

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership
in the
Council of Teaching Hospitals

(Please type)

Hospital: Oakwood Hospital
Name

Dearborn — 18101 Oakwood Blvd.
City — Street

Michigan — 48124
State — Zip Code

Principle Administrative Officer: Neil McGinniss
Name

Director
Title

Date Hospital was Established _____

Approved Internships:

Type	Date Of Initial Approval by CME of AMA*	Total Internships Offered	Total Internships Filled
Rotating	6/15/55	18	8
Straight			

Approved Residencies:

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total Residencies Filled
Medicine	11/26/69	12	0 (newly approved)
Surgery	9/11/59	6	6
OB-Gyn	12/19/56	8	7
Pediatrics			
Psychiatry			
Other Gen. Prac.	12/28/55	6	3
Other Path.	3/11/57	4	3

Information Submitted By:

Neil McGinniss
Name

Director
Title of Hospital Chief Executive

April 20, 1970
Date

Signature of Hospital Chief Executive

*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

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership
in the
Council of Teaching Hospitals

(Please type)

Hospital: Latter-day Saints Hospital
Name

Salt Lake City — 325 - 8th Avenue
City — Street

Utah — 84103
State — Zip Code

Principle Administrative Officer: Mr. L. Brent Goates
Name

Administrator
Title

Date Hospital was Established January 4, 1905

Approved Internships:

Type	Date Of Initial Approval by CME of AMA*	Total Internships Offered June 23, 1970	Total Internships Filled 1969-1970
Rotating		20	23
Straight	July 18, 1969	8	0

Approved Residencies:

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total Residencies Filled
Medicine	3-12-56	7	5
Surgery	4-1-59	13	13
OB-Gyn	12-16-53	8	5
Pediatrics	None		
Psychiatry	None		
General Practice	8-3-59	2	1
~~Other~~			
Orthopedics	12-2-55	6	6
Pathology	1955	3	1
Plastic Surgery	7-11-57	4	4
Radiology	12-30-55	4	3
Thoracic Surg.	11-14-55	6	5

Information Submitted By:

L. Brent Goates
Name

Administrator
Title of Hospital Chief Executive

14 April 1970
Date

L. Brent Goates
Signature of Hospital Chief Executive

*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

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership
in the
Council of Teaching Hospitals

(Please type)

Hospital: Deaconess Hospital of Buffalo, New York
Name

Buffalo — 1001 Humboldt Parkway
City — Street

New York — 14208
State — Zip Code

Principle Administrative Officer: Bruce J. Baust
Name

Administrator
Title

Date Hospital was Established February 13, 1896

Approved Internships:

Type	Date Of Initial Approval by CME of AMA*	Total Internships Offered	Total Internships Filled as of 9/1/69
Rotating		16	14
1st year Family Practice		8	3
Straight			

Approved Residencies:

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered 1971-72	Total Internships Filled
Medicine	1947	10	5
Surgery	1946	13	9
OB-Gyn	1950	8	5
Pediatrics	none		
Psychiatry	none		
Urology; Head & Neck	in conjunction with SUNYAB		
Colon & Rectal	Pending		
Other			
Ophthalmology	1964	6	5
Pathology	1951	4	0
Family Practice	1968	16	3
Radiology	1950	4	1

Information Submitted By:

VERNON A. REED
Name

EXECUTIVE VICE PRESIDENT
Title of Hospital Chief Executive

April 27 1970
Date

Vernon A. Reed
Signature of Hospital Chief Executive

*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

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership
in the
Council of Teaching Hospitals

0.14

(Please type)
Hospital: St. Francis Hospital
Name

Peoria — 530 N.E. Glen Oak Avenue
City — Street

Illinois — 61603
State — Zip Code

Principle Administrative Officer: Sister M. Canisia
Name

Administrator
Title

Date Hospital was Established 1876

Approved Internships:

Type	Date Of Initial Approval by CME of AMA*	Total Internships Offered	Total Internships Filled
Rotating	1933	28	7
Straight		0	

Approved Residencies:

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total Internships Filled
Medicine	1942	9	5
Surgery	1950	8	6
OB-Gyn	1940	3	3
Pediatrics	1949	4	1
General Practice	1961	4	2
~~Psychiatry~~ Pathology	1953	6	4
~~Other~~			
Orthopedics	1947	4	2
Radiology	1944	3	1

Information Submitted By:

C. D. Branch, M.D. — Director of Medical Education
Name — Title

March 16, 1970 — [signature]
Date — Signature

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

PLEASE READ INSTRUCTIONS ON REVERSE SIDE

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership
in the
Council of Teaching Hospitals

O.K.

(Please type)

Hospital: Fairview General Hospital
Name

Cleveland — 18101 Lorain Avenue
City — Street

Ohio — 44111
State — Zip Code

Principle Administrative Officer: Basil J. Valenti, Administrator
Name

Administrator
Title

Date Hospital was Established 1892

Approved Internships: Planned for 1970-71

Type	Date Of Initial Approval by CME of AMA*	Total Internships Offered	Total Internships Filled
Rotating	1935	25 (70-71)	17 (69-70)
Straight	0	0	0

Approved Residencies:

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total ~~Internships~~ Residencies Filled
Medicine	1955	21	20
Surgery	1957	14	14
OB-Gyn	1955	8	8
Pediatrics	1965	--	--
Psychiatry	--	--	--
Other	General Practice 1957	4	2
	Ophthalmology 1968	3 (Approved but not offered)	
	Anesthesia 1955	11	6
	Pathology 1960	2	1

Information Submitted By:

James Ashe Grauel, M.D. — Director of Medical Education
Name — Title

March 11, 1970 — James A. Grauel
Date — 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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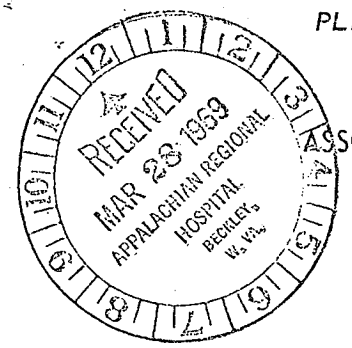

O.K

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
1345 CONNECTICUT AVENUE, N.W.
WASHINGTON, D.C. 20036
202/223-5364

(Please type)

Hospital: Appalachian Regional Hospital
Name

P. O. Box 1149
Street

Beckley, West Virginia 25801
City State Zip Code

Principal Administrative Officer: David C. Schmauss, M.H.A.
Name

Administrator
Title

Hospital Statistics:

Date Hospital was Established: 1956 - Beckley Memorial Hospital
1964 - Appalachian Regional Hospital

Average Daily Census: 184 (10/1/68 through 9/30/69)

Annual Outpatient Clinical Visits: 17,000 - Emergency Room
(Outpatient clinics conducted at Southern West Virginia Clinic located near hospital)

Approved Internships:
NONE

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 as of 7-1-69	Total Residencies Filled as of 3-1-70
Medicine	1958	7	4
Surgery	1958	10	9
~~OB/GYN~~			
Pediatrics	1958	3	1
Pathology ~~Psychiatry~~	1958	2	2

Information submitted by:

David C. Schmauss, M.H.A.
Name

Administrator
Title

February 26, 1970
Date

D C Schmauss
Signature

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

PLEASE READ INSTRUCTIONS ON REVERSE SIDE

Instructions:

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

Membership in the Council:

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

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

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

and

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

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

If nominated by School of Medicine, complete the following:

Name of School of Medicine West Virginia University Medical Center

Name of Parent University West Virginia University

Name of Dean of School of Medicine Clark K. Sleeth, M.D.

Complete address of School of Medicine West Virginia University Medical Center
School of Medicine
Morgantown, West Virginia 26506

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

FOR AAMC OFFICE USE ONLY:

Date _____ Approved _____ Disapproved _____ Pending _____

Remarks: _____

Invoiced _____ Remittance Received _____

#5350-5

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

INTER-OFFICE MEMO

c

C8

Retain – 6 mos.	☐
1 yr.	☐
5 yrs.	☐
	☐
Permanently Follow-up Date	☐

DATE March 23, 1970

TO: John A. D. Cooper, M. D., and Mr. John Danielson

FROM: W. G. Rice, M. D. West

SUBJECT: For the record

As a result of the current negotiations with the Des Moines School of Osteopathy, I would like to request that consideration be given to an invitation to their teaching hospital and the teaching hospitals of other accredited osteopathic schools to joining the Council of Teaching Hospitals without prejudice and, of course, subject to the basic requirements for membership. I believe that they could be accepted on the basis of the category of free-standing teaching institutions not requiring the nomination of the dean of an accredited medical school.

In this regard the timing is critical and the maneuver would be unsuccessful if it were not accomplished with reasonable dispatch.

mbm

COPIES TO:

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

INTER-OFFICE MEMO

Retain – 6 mos.	☐
1 yr.	☐
5 yrs.	☐
	☐
Permanently Follow-up Date	☐

DATE March 27, 1970

TO: Dr. John A. D. Cooper and Mr. John Danielson

FROM: Dr. W. G. Rice

SUBJECT: Des Moines School of Osteopathy

CONFIDENTIAL

The critical timing features of my memo of March 23 have to do with:

a. The relationship of the Des Moines School with the parent AOA and their own Board of Trustees. The status of their June class may be jeopardized. This would seem to be their problem, not ours.

b. The effectiveness of the token recognition of an invitation to apply for membership in COTH. This would provide a mechanism for contact, informal survey, and discussion without entering the area of accreditation of the medical school, or accreditation of the graduates. The meeting of criteria for COTH membership as a teaching osteopathic hospital would not be without risk on the part of the Des Moines Hospital, since they might not be accepted on the basis of failing to meet the definitions for membership. (This is the same risk that any hospital takes. I do not believe there should be a double standard. But the minimum standards already in effect should be applicable.)

I have since discussed the issue of the Des Moines School of Osteopathy with Robert Hardin. He is less than enthusiastic about this development and indicates three possibilities:

a. The Des Moines School is phased out, by denial of support from state or local sources. He suggests he has the political muscle to do this, but may not wish to use it. Graduates of the school now support its operations to the tune of a $1,000 per year assessment. Naturally, they are anxious to have this burden transferred to the tax base or eliminated. (Do you realize that if this system were applied to M. D.'s it would generate 250×10^6 per annum?)

b. The Des Moines School could become a second Iowa-based medical school. A political coalition consists of western rural legislators who believe that this will relieve their doctor shortage (false) and who are also horsetrading for legislative support for a teacher's college, and the Des Moines legislators is supporting this. They have been asked for a 4×10^6 appropriation which will match a Federal construction grant and allow construction of a

COPIES TO:

medical sciences building in a Des Moines suburb. If this is accomplished, the die of state support will have been cast; and the development of a second medical school will be inevitable. The legislators are being told that the single appropriation will be all that is requested. Bob Hardin believes that it is inevitable that the Des Moines osteopathes will request operational support. He also states that Iowa cannot support two medical schools at this time.

c. The third alternative is that the Des Moines school become an arm of the University of Iowa School of Medicine. The University of Iowa already has a faculty in Des Moines. This compromise is not particularly attractive to Hardin and probably would be less attractive to Vigorito. It may, however, be the best solution.

As the result of this discussion, I believe AAMC position should be more conservative. Although the transition of the Des Moines School (and others) to the "mainstream" is inevitable, the problems are in local politics, relationships with AOA, and relationships with AMA and specialty boards. The AAMC primary interest involves membership in the association and participation in accreditation through the LCME. We could allow them a foot in the door by COTH membership but not if this is to be used as a political lever against one of our members (Iowa University).

mbm

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: 368

Nominated by a Dean	239
Qualified by I & R Program	

Canadian Members	3	
Puerto Rican Members	2	
Canal Zone Members	1	
Other Foreign	1	(Beirut, Lebanon)

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

NUMBER OF MILITARY HOSPITALS IN TOTAL MEMBERSHIP: 4

1. Wilford Hall USAF Medical Center, San Antonio, Texas (Southern Region)
2. Fitzsimons General Hospital, Denver, Colorado (Western Region)
3. William Beaumont General Hospital, El Paso, Texas (Southern Region)
4. Brooke General Hospital, Fort Sam Houston, Texas (Southern Region)

STATES WITH NO MEMBER HOSPITALS: 7

Western Region	5	(Alaska, Montana, Nevada, Wyoming, Idaho)
Midwest/Great Plains Region	2	(North Dakota, South Dakota)
Southern Region	0	
Northeastern Region	0	

DISTRIBUTION OF MEMBER HOSPITALS BY REGION:

Western Region	45	(Includes 2 hospitals in 2 providences in Canada)
Midwest/Great Plains Region	96	(Includes 1 hospital in 1 providence in Canada)
Southern Region	75	(Includes 1 hospital in the Canal Zone)
Northeastern Region	153	(Includes 1 hospital in Lebanon and 2 hospitals in Puerto Rico)

March 17, 1970

TO: Members, Board of Governors

FROM: James M. Ensign

SUBJECT: HIGHLIGHTS OF FIRST MEETING, JOINT COMMITTEE, BLUE CROSS ASSOCIATION AND ASSOCIATION OF AMERICAN MEDICAL COLLEGES, MARCH 11, 1970

With representatives from Blue Cross Association and the Association of American Medical Colleges present, Chairman, J. Douglas Colman, called the meeting to order at 10:30 a.m. in the BCA Washington offices:

1. Fiscal implications of the attending physician in the teaching setting (AAMC position).

Dr. Cooper and Mr. Danielson described the background and development of a position paper dealing with the subject of the attending physician in the teaching setting. Dr. Cooper traced the issues in the recent past which have brought the need for such a position statement into clear focus. The complexities of Medicare had made the need for such a document exceedingly important to the AAMC. Mr. Danielson shared with the committee copies of a confidential draft of a position statement which has yet to be approved by the AAMC Executive Committee and Board. The elements of this position statement provided the committee with an opportunity for interchange of views helpful both to BCA and AAMC. The statement will be available to a wider audience upon its adoption by the AAMC.

2. Medicare and the teaching hospital.

Included in the discussion of the AAMC statement above were key references to the current situation under the Medicare Program with the clarification that under current regulations Medicare cannot pay more for hospital-based professional services under Parts A and B than the compensation received by professionals (except where there was a charge schedule established prior to the Medicare Program). The concept of combined billing which was advocated in BCA testimony before the Senate Finance Committee was discussed. AAMC representatives

made it clear that their organization does not seek "double payment" but it does want adequate payment for services rendered. Discussion then focused on other ways of simplification and achievement of greater equity. Developments for the establishment of special funds for professional services came under discussion as well. Concerning the possibility of "forgiveness legislation" to relieve current prospects of overpayment recovery, it was felt that little would be forthcoming.

3. Blue Cross payments in teaching hospitals.

In the past Dr. Cooper had indicated to Mr. McNerney that a significant number of teaching hospitals, deans and faculty members were under the impression that payments for care from commercially insured patients exceeded those from Blue Cross Plans and, therefore, placed Blue Cross in a less than favorable light. Mr. Ensign indicated that careful studies in many Blue Cross Plan areas have shown the reverse to be true. He then described the documentation of payments from several sources (e.g., Medicare, Medicaid, self-pay, commercially insured patients, Blue Cross) in terms of income actually realized. Reference was made to the several "net collection studies" and the GAO study. It was felt by all that it would be helpful to the AAMC if BCA could provide information on this subject to AAMC staff in a form which would be readily understood by their constituents. Mr. Ensign made a commitment to provide this information.

In addition to the above, Mr. Connors indicated that there was a significant number of teaching hospitals which are of the opinion that the Blue Cross national strategy in payment to hospitals is to move in the direction of Medicare ground rules. BCA representatives indicated that such was not the case and pointed to the recent report of the Task Force on Prototype Payment Methods.

4. Role of the teaching hospital in the delivery of health care.

Following a discussion of the relative roles and objectives of teaching hospitals and Blue Cross Plans in moving forward efforts to improve health care delivery and financing, it was agreed that a future meeting of the joint committee should include several deans and teaching hospital administrators and Blue Cross Plan executives representing the same local area for the purpose of stimulating experimentation and development of new models of delivery and financing. Several areas were suggested (e.g., Philadelphia, North Carolina, Michigan, Southern California, Pittsburgh). It was anticipated that these individuals would meet with the joint committee for a period following which they would break up into discussion and problem-solving groups.

5. "National Health Insurance" proposals.

A general discussion of the background of current legislative proposals

and institutional positions took place. The need to tie financing and delivery together when considering future moves was stressed. The need also for a variety of approach rather than "one way" was also emphasized. Mr. Colman felt it important to build public education in health into the consideration of future proposals as well, stressing a need for new ways of reaching school-age children with positive health education programs. The group felt it important to keep this item on the agenda for future meetings.

6. Future meetings.

It was proposed that the next meeting of the Joint Committee take place on the afternoon of May 20. Mr. Danielson will identify several settings for representation with their counterpart Blue Cross Plan executives for inclusion in the list of invitees for the next meeting.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

One Dupont Circle

Washington, D.C. 20036

202/466-5100

DICK KERST
LARRY MARTIN
BERNIE LACHNER

MINUTES

AAMC AD HOC COMMITTEE ON NATIONAL HEALTH INSURANCE

Board Room

One Dupont Circle

February 19, 1970

PRESENT:

Carleton Chapman, M.D., Chairman

Robert B. Howard, M.D.
Mack Lipkin, M.D.
E. Hugh Luckey, M.D.
Milton I. Roemer, M.D.
David E. Rogers, M.D.
Gerald Rosenthal, Ph.D.
Stuart M. Sessoms, M.D.
Cecil G. Sheps, M.D.

EXCUSED:

Robert A. Chase, M.D.
James A. Campbell, M.D.

STAFF:

John A.D. Cooper, M.D.
John M. Danielson
Cheves McC. Smythe, M.D.
Fletcher H. Bingham, Ph.D.
Richard M. Knapp, Ph.D.

I. The Chairman Convened the Meeting Promptly at 10:00 A.M.

II. Introduction and Welcome for Committee Members:

Dr. Chapman, indicating that this was the Committee's first meeting, asked each member of the Committee and staff to introduce himself.

III. Review of Past Association Action and Charge to the Committee:

At its meeting on September 17, 1969, the Executive Council unanimously passed the following resolution:

> The Executive Council approves in principle a universal health insurance for all citizens as a proper and necessary step in having the best possible health care for the people, which is the principal objective of the Association. The Executive Council recommends that the Assembly approves, itself, the same position.

The Federal Health Programs Committee at its September 30, 1969, meeting discussed the issues involved and the appropriate mechanism for the development of an Association position. The Committee agreed that careful consideration must be given in any financing system to both the implications on cost and organization of the health care system.

It was recommended that the following principles be adopted by the Assembly as guidelines for the Association position with regard to the development of programs or legislation for a universal health program:

(1) Emphasis must be placed on redirecting the prevailing patterns of health care from "crisis medicine" to anticipatory care.

(2) The essential role of academic medical centers and teaching hospitals in producing the manpower necessary to meet the expanded demands on the health care system that will inevitably occur must be recognized.

(3) Reimbursement for appropriate costs of the delivery of health care should be provided. The pattern of reimbursement must be compatible with and supportive of the systems of finance for education and training programs conducted in close relationship to the delivery of care in the teaching setting.

(4) The necessity for supporting research, demonstration projects and innovations in systems of health care delivery designed to increase its quantity, quality, and equality should be an integral part of any plan.

It was further proposed that an ad hoc committee should be appointed to develop a more detailed position statement and other documents necessary to further the interests of the Association membership within these guidelines. On Monday, November 3, 1969 the Assembly unanimously approved the resolution.

It was the consensus of the Committee that the charge to the Committee was relatively open-ended, and in need of discussion.

From the ensuing discussion of the charge, three significant issues emerged:

1--the Association position relative to the stance of the AMA, AHA and other health organizations;

2--the question of whether a "participative" or a "leadership" role is appropriate for the AAMC;

3--the determination of the most appropriate mechanism to maximize AAMC influence.

It was pointed out that the medical centers are looking to the AAMC for leadership, rather than the AMA and the AHA in which they are submerged with 250,000 physicians and 7,000 hospitals. It is difficult, if not impossible, for these organizations to provide the medical center viewpoint. Further, the current controversy over the circumstances under which teaching physicians may bill Medicare fees is evidence of the type of development that can occur if the medical education community does not take a position.

At this point in the discussion, there was common agreement by Committee members on the following:

1--the AAMC should take a position independent of other health organizations. This statement should not be interpreted to mean that the AAMC would not cooperate with these organizations, but rather that the AAMC does have a unique constituency, and a responsibility to it;

2--the AAMC should attempt to provide a "leadership" role;

3--this leadership role would best be implemented by the adoption and articulation of a socially responsible position on the issue. This position should be given as widespread distribution as possible.

IV. Discussion of the Issue:

Several members of the Committee pointed out that this is a total university question and that universities have a responsibility which they haven't yet begun to critically examine. It was agreed that resources are available, but the spoken evidence is conspicuously absent.

The point was made repeatedly that there must be a focus on the "system," and the academic medical center's relationship to it. Any other point of view would most likely be unrealistic, and unacceptable to the public. Thus, the educational community should take a leadership role in shaping the system, and preparing people for that system.

The phrase "relationship with the system" prompted some discussion of the need to provide a "buffering" of the academic medical center from a straight line relationship with the rest of the system. The experience of the teaching hospitals in England was cited as an example of the implications of this approach. It was agreed that although the responsibilities of the teaching centers are multiple, their obligations to the system are supplementary rather than different.

There was a consensus that the Medicare and Medicaid programs have highlighted the negative aspects of the contemporary patterns of delivering health services. Therefore, the issue should be stated in the context of: How can national health insurance be a productive force in bringing about change toward given objectives? It was stressed that because national health insurance is the vehicle by which the system will get from one point to another, there is little value in espousing a position on national health insurance merely to be on record. The point is that any design of a national health insurance program must carry with it a concurrent redesign of the health care delivery system.

As a summary to the discussion, the Committee agreed that the following statements are necessary as points of reference to a position statement:

1--there must be an identification of what portions of the present system are desirable, and what changes are desirable;

2--the AAMC commit itself to national health insurance to the extent that the program leads to these changes;

3--there must be recognition of the specific implications of a program of national health insurance on the AAMC constituency--the demands made on our constituents, and the constraints within which they operate.

It was agreed that the remainder of the meeting be spent preparing a brief AAMC position statement. The Chairman appointed Drs. Lucky, Sheps, and Rosenthal to draft a statement over the lunch period. The committee adjourned for lunch at 12:00 P.M.

LUNCH BREAK

V. The Position Statement

The Chairman reconvened the meeting at 1:20 P.M. Dr. Lucky presented the draft statement that the group had prepared. A lengthy discussion ensued which resulted in two subsequent drafts of the statement. There was a consensus of the committee that the final statement was satisfactory and should be publicized at the National Health Forum by Dr. Cooper, and through other appropriate channels.

There was a consensus that the next stage of position development required a more precise exposition of each point in the statement. Individuals volunteered to write sections of particular interest to them. The state-

ment and list of assignments is as follows:

"The Ad Hoc Committee on National Health Insurance of the AAMC supports the principle of National Health Insurance for all citizens as a significant opportunity to improve the health care of the American people. It must be recognized that such improvement in health care will not automatically follow the institution of National Health Insurance. Therefore, to insure improvement in health care, the plan adopted must be structured so as to provide incentives and support for a health care system with the following minimal characteristics:

1. Access to needed care without regard to economic circumstances of the individual. (Dr. Luckey)

2. Planned community programs providing a full range of services with appropriate attention to individual and group preventive measures. (Dr. Cashman)

3. Efficient and effective use of health resources. (Dr. Roemer)

4. Public accountability combined with appropriate balance between professional and consumer participation in program development. (Dr. Sheps)

5. Development and implementation of priorities for achievement of specific health goals established at national, state and local levels. (Dr. Rosenthal, Dr. Rabkin)

6. Provision for systematic evaluation with adequate flexibility to respond to changing opportunities and needs. (Dr. Rogers)

7. Recognition of the dependence of the system on the education of adequate numbers of health professionals and the continuous generation of biomedical knowledge." (Dr. Howard)

It was agreed that these statements would be prepared with sufficient lead time for all statements to be distributed to each member of the Committee. The next meeting was tentatively scheduled for April 23 in Washington, D.C.

The Chairman adjourned the meeting at 3:30 P.M.

PRESIDENT'S AD HOC COMMITTEE
ON MEDICARE AND MEDICAID
AAMC BOARD ROOM
FEBRUARY 18, 1970

Present:

Robert A. Chase, M.D., Chairman
T. Stewart Hamilton, M.D.
Hugh E. Hilliard
William B. Mayer, M.D.
David Odell
Jonathan E. Rhodes, M.D.
Charles E. Sprague, M.D.
Stuart M. Sessoms, M.D.
James V. Warren, M.D.
Irvin G. Wilmot
Charles B. Womer

Staff:

John A.D. Cooper, M.D.
John M. Danielson
Fletcher H. Bingham, Ph.D.
Richard M. Knapp, Ph.D.

Peat, Marwick and Mitchell:

James T. Howell, M.D.
Thomas Bell, M.D.
Richard Stephanson

Call to Order and Review of Charge to Committee:

Dr. Chase called the meeting to order at 10:00 a.m. and indicated that the primary purpose of the meeting was to develop a unified approach, which could be translated into an association-wide agreeable approach, on the issue of Part B payments to attending physicians in teaching settings. It was also noted that this agreement would necessarily be in terms of substantive content only and that the actual final drafts of the document would be completed by staff in consort with Peat, Marwick and Mitchell. Following this action, the document would be circulated to members of the Assembly for review and comment.

Development of Statement:

In the development of the action program for the use of the statement, Dr. Cooper and Mr. Danielson indicated that it was very probable that the Association would be requested to testify by both the House Ways and Means Committee and the Senate Finance Committee. They stressed that this probable activity emphasized the urgency of the problem and the need for a firm and constructive position statement for the Association. Representatives of Peat, Marwick and Mitchell then presented several items which they had prepared relating to the issue under discussion. Included within these materials were: "Organization and Provision of Care In a Teaching Setting: A Statement of Principles"; "Principles for the University Hospital Staff"; and "Models for Organization of Faculty In Teaching Setting".

The Committee spent the remainder of the meeting in discussing primarily the draft document "Organization and Provision of Care In A Teaching Setting: A Statement of Principles". Agreement was reached that the attached document be sent to the members of the Assembly for their review and comment.

The meeting adjourned at 1:30 p.m.

MEMORANDUM

TO: Members of the Assembly of the AAMC

SUBJECT: Amendments to P.L. 89-97

DATE: 24 February 1970

In recent days, the Senate Finance Committee Staff has issued a statement which places the payment for medical services rendered in the teaching hospital in a critical position. The Senate is ready this next week to begin hearings on amendments to P.L. 89-97 (Medicare and Medicaid). If the position of the Senate Finance Committee special staff report becomes law or regulation there will be no legal liability for payment for services in our teaching hospitals on the basis that medical services are not personally rendered.

We have only a few short days to prepare our testimony. Any thought that we can maintain the status quo is to fail to grasp the gravity of the situation.

President John Cooper appointed an advisory committee to guide the development of a statement of principles which will become the basis of our testimony. This working document, prepared under direction of the committee is attached. It should be read carefully and your comments forwarded to me as soon as possible. It is to be emphasized that the principles relate to the teaching hospital and its medical staff and not to the medical school itself, except as the medical school faculty participates in the delivery of medical care.

The document makes two principal changes in existing regulations:

1. That the senior and chief residents become eligible as members of the medical staff of the teaching hospital for the payment for medical services performed. We believe this is consistent with present practices and with the intent of the Congress.

2. That amendments affecting P.L. 89-97 should provide for research and development, innovation and demonstration of new methods of delivery of health care services in the teaching setting as well as for new methods of payment (payment for "units of service", for example).

I would appreciate your reactions by Monday, March 3, 1970.

Cordially,

John M. Danielson,
Director COTH

24 February 1970

ORGANIZATION AND PROVISION OF CARE IN A TEACHING SETTING:

A STATEMENT OF PRINCIPLES

THIS DOCUMENT IS NOT FOR PUBLICATION

ORGANIZATION AND PROVISION OF CARE IN A TEACHING SETTING:

A STATEMENT OF PRINCIPLES

Preamble

This statement of Principles of the Association of American Medical Colleges (AAMC) is structured upon the statement in Section 1802 of P.L. 89-97, where it is stated:

> "Any individual entitled to insurance benefits under this title may obtain health services from any institution, agency, or person qualified to participate under this title if such institution, agency or person undertakes to provide him such services."

Indeed, AAMC extends this guarantee of freedom of choice, and acceptance, to all patients in the nation.

Teaching hospitals have a special role and responsibility in the delivery of health care, for it is to them that the whole medical profession looks for national norms and standards of excellence in the provision of care. The teaching hospital is expected to provide more highly skilled personnel and a broader spectrum of services and scientific research, than other hospitals, in addition to being a significant factor in the education and training of the nation's physicians. This special capacity places unusually heavy financial demands upon the teaching hospital.

The goal of the patient in the teaching hospital is to receive a high level of health and medical services, which frequently are of an unusually complex, scientifically advanced, and costly nature, to satisfy his demands for care. Ultimately, the hospital and the physician are legally and morally responsible for the quality of care which the patient is given, and to provide

for this care, the hospital must obviously have an adequate medical staff. In the teaching hospital this medical staff may be organized from the clinical faculty of the medical school in whole or in part.

The practice of medicine by the medical staff is essential to the education of health personnel, and essential to the hospital in generating income from the provision of hospital services. The medical practice of the staff is also important to the community because the teaching staff is in the forefront of the knowledge of medical sciences. Additionally, it is important to our nation for the development of health manpower.

In the principles which follow, it is emphasized that they pertain to the teaching hospital and its clinical and education requirements. The principles do not relate to the medical school.

To assure proper support for reimbursement and other claims for payment, adequate documentation describing professional services rendered, must be prepared and must specifically identify the responsible physician. Such documentation may be incorporated into the patient's medical record.

STATEMENT OF PRINCIPLES

These principles are written to pertain to those aspects of the teaching hospital which require strengthening of medical staff perspectives, to assist the hospital in securing its financial solvency. The principles seek to define necessary financial relationships of the hospital, its medical staff and associated staff, to support the hospital as an education, as well as a patient service institution.

1. Every patient admitted to the hospital has, at all times, the right to the services of a personal physician of the hospital medical staff, in charge of his diagnosis and therapy.

   The Association of American Medical Colleges concurs that this is necessary to insure the highest quality of care possible for the patient. It is also necessary for fixing the responsibility for the management of the care, and for the professional or the hospital to be eligible for payment of professional fees. This patient-physician relationship should also exist because of medical-legal problems which extend from out-patient, emergency and continuing hospital medical care. Further, it is necessary for the conduct of medical education, which increasingly will involve the private patient-medical staff relationship.

2. In any legislation dealing with health care, it is essential that provision be made for research and development inovation, and demonstration of new methods for the delivery of health care services. At the same time it is important to experiment with and evaluate new methods of payment for such services.

   There exist alternative methods of organizing the teaching hospital medical staff for delivering services which merit exploration. In payment for services, information should be collected and experiments designed for considering such factors as reimbursement and payment for "units of service" rendered and prepaid services.

3. The teaching hospital's medical staff should be organized for, and committed to, providing medical staff direct and personal care at all times.

The Association of American Medical Colleges believes that the functions of the associated staff in education and practice, must bear a closer relationship to the responsible physician, and the institution, than has been done in the past.

4. A charge should be made for all hospital and professional services rendered to patients.

P.L. 89-97 guarantees the right of patients to exercise free choice of his professional practitioner and institution, for the provision of medical care. Improvements in the payment for medical services, while still incomplete, have affected the relationships among patient, doctor, hospital, and the payor. This change in relationships requires development of a greater understanding between hospital and medical staff organizations relative to hospital charges and professional fees. The loss of charitable immunity of hospitals has resulted in increased liability suits against them, augmenting the need for development of these improved relationships.

5. The medical staff should develop organizational methods to receive patients, and perform "on-call," emergency and regular medical services.

A. All patients are guaranteed the right to freedom of choice of their personal physician and institution.

B. Provision should be made for care in the emergency unit.

C. Arrangements for specialty consultations should be made.

D. Senior residents and chief residents may accept patients if they have been elected to the medical staff.

E. A daily roster of responsible physicians for each patient should be prepared.

F. Billings for professional services should be in the name of the responsible physicians.

6. The medical staff and associated staff should be organized for rendering services to patients in a manner which will allow accountability for professional fees submitted.

   A. In some instances, this may require that the active medical staff recognize and accept a new status for the associated staff, to permit billing of third party payors and payment for the professional services provided to the patient.

   B. The Medical staff should be departmentalized, and the associated staff assigned along these departmental lines (either straight or rotating), to work with responsible physicians who have responsibility for patient care.

   C. Members of the medical staff should be prepared to accept and personally perform services for patients.

7. Specific principles on the assignment of the associated staff are required. The appointment of a senior resident and/or chief resident should carry with it eligibility for appointment to the medical staff of the teaching hospital. (In this position the senior residents and chief residents have always carried patient care responsibilities.)

   A. Interns should be assigned to a specific medical department (straight or for each rotation). Within the department they will have direct and continuing relationships with specific staff members and their patients.

   B. Assistant residents and residents should be assigned to a specific medical department or a specialty division within that department. This should also be true in the out-patient department, if out-patient department service is desirable in training. Within the specialty, they will have direct and continuing relationships to specific physicians and their patients.

   C. The senior resident and/or the chief resident should be licensed, and assigned to specific specialties and made eligible to accept responsibility for the medical care of patients, within a scope set by the medical staff. Nonetheless, each senior resident or chief resident should be responsible to specific members of the specialty division and department.

      Senior and chief residents may be assigned responsibility for directly observing, and personally assisting interns and residents with, the care of patients. They may render consultations.

NOTE: In some instances, the institution may not desire to appoint senior and chief residents to the medical staff. This renders them ineligible for payment the professional care provided by them.

8. The teaching hospital must have adequate money resources for current operations, new or expanded programs, and capital uses.

The special nature of the teaching hospitals in their capacity of providing high quality, freqeuntly innovative medical care, in providing an environment for teaching and scientific research, and in setting standards of excellence, have caused the costs of providing care in these hospitals to rise. As the hospitals attempt to meet the increase in public demand for services, and as they meet expanding modern scientific standards, requiring more highly skilled personnel, this trend is expected to continue. At the same time, however, teaching hospitals have a special obligation to improve the management of patient care and to maximize the use of available resources and to minimize the patient's length of stay.

9. The teaching hospital's expansion of scientific competence is in direct response to the growth of the body of medical knowledge. This growth imposes new requirements for space, equipment and personnel, to bring to patients the best in modern medical care.

The teaching hospital is the environment in which medical scientific knowledge and skills are translated into innovations in methods and equipment for the delivery of high quality medical care. Growing specialization in medicine requires greater coordination of patient care management to avoid undue fractionation. However, new or expanded programs or services should be provided only if the need is demonstrated within the community as a whole.

10. As an acceptance of public accountability, the teaching hospitals and the medical staff agree that a professional audit of patient records and other pertinent documents should be continued.

DEFINITION OF TERMS

PERSONALLY RENDERED PROFESSIONAL SERVICES

In the teaching hospital, a single standard of care is rendered to all patients, regardless of their economic status or their point of entry into the health care system. Each has a responsible physician who personally renders care. The responsible physician utilizes the professional services of the associated staff or other staff members, creating a team of physicians approach for patient care. The responsible physician must be present to review and coordinate all physicians' orders carried out by the team approach, in order to assure that the patient has received personal care. Further, during technical procedures, such as surgical operations, the responsible physician must be present even though he may not be the operating surgeon of record. This means that the patient is informed of the team members. It is understood that as a member of the team he may only observe the procedure, being immediately available to perform the surgery if needed. To qualify for billing and collecting the professional fees for such services, the responsible physician will be present to coordinate services. "Personally rendered professional services" also includes those services provided by a member of the hospital medical staff, at the request of the patient's responsible physician, and with the patient's knowledge.

1. MEDICAL STAFF PATIENT - A patient who has chosen a member of the hospital's medical staff, or has accepted a practicing physician assigned by the medical staff of the hospital to personally provide and be responsible for his medical care. Assignment of a physician is accomplished in accordance with established policies and procedures agreed upon by the medical staff and the hospital.

2. ATTENDING PHYSICIAN - A physician who has been appointed by the hospital to the hospital's active medical staff, to personally provide, and be responsible for, the care of patients.

3. RESPONSIBLE PHYSICIAN - A physician who has been appointed to the hospital's active medical staff who assumes the responsibility for providing or observing personally the medical care of his patients. The responsible physician may be a faculty member, a chief resident, senior resident or any other member of the medical staff.

4. ELIGIBLE - Professional fees and hospital charges may be billed for services rendered by the medical staff and associated staff in providing care of patients.

5. ASSOCIATED STAFF - The interns, assistant resident, residents, senior residents and chief resident physicians who are appointed to the hospital's approved teaching programs by the medical school faculty, the hospital's medical staff and the hospital.

6. ASSISTANT RESIDENT - A physician who has been appointed to the hospital's graduate education staff but has not yet attained the final year or two years of specialty qualifications.

7. RESIDENT - A physician who has been appointed to the hospital's graduate education staff and has attained:

   a. Final year of a two- or three-year program, or

   b. The final two years of a four-year or longer program.

8. SENIOR RESIDENT - A physician who has been appointed to a hospital's graduate education staff and has attained the final year of Board required training, or beyond. He may be appointed to the hospital's active medical staff for one year. He has the training chronology of the chief resident on the specialty service, but does not have that designation.

9. CHIEF RESIDENT - A physician who has been appointed to a hospital's graduate education staff and has attained the final year of Board required training, or beyond. He should be appointed to the hospital's active medical staff for one year. He may be reappointed for another year if he continues training. The designation of chief resident and the selection of the chief resident is a function of the medical school faculty, the hospital's medical staff, and the hospital.

CAL PLF

AAMC 1970 ANNUAL MEETING

TENTATIVE SCHEDULE

#4

TIME	10/29 THURSDAY	10/30 FRIDAY	SATURDAY	SUNDAY	11/3 MONDAY
BREAKFAST	Department Chairmen Meetings; BOS Section; COTH Executive Committee				
MORNING	CAS Exec. Committee; GSA Comm.; GSA Comm	Plenary Session	Plenary Session	Plenary Session	Department Chairmen Meetings; Cont. Education; Family Medicine; PR Business; Outside Groups
LUNCH	COTH Luncheon	AD BD COD	CIRME		
AFTERNOON	COTH Business; GSA Program	COD; CAS Prog; GSA Exec Comm.; RME Prog - DIME Liaison; 5 - 6 pm Assembly	COTH Prog. RME; Student Program; JME Editorial Bd.; CAS Bus.& Program	ASSEMBLY	
DINNER	Press Reception; DAA-CAS Reception	COTH Reception	Chairman's Reception	ASSEMBLY	
EVENING	GSA Steering; Outside groups; Department Chairmen Meetings	Open Forum; Outside groups	ANNUAL MEETING	GSA Steering; Outside groups	

Western Union Telegram

RBB053 331P EST APR 23 70 (46)CTB239 MA284 CK136
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JOHN M DANIELSON, DIRECTOR COUNCIL OF TEACHING HOSPITALS ASSN
OF AERICAN MEDICAL COLLEGES
1 DUPONG CIRCLE NORTHWEST WASHDC
BE AT RESOLVED BY THE UNIVERSITY HOSPITAL EXECUTIVE COUNCIL,
MEETING ON APRIL 23RD 1970 THAT FULL CONSIDERATION BE GIVEN
TO A FORMAL POSITION STATEMENT BY THE ASSOCIATION OF AMERICAN
MEDICAL COLLEGES REGARDING EDUCATION AND OR SERVICE
ROLES OF HOUSE
STAFF POSITIONS IN CATEGORIES OF COUNCILLOF
TEACHING HOSPITAL MEMBER INSTITUTIONS
ECONOMICS ELEMENTS OF COMPENSATION ALSO REQUIRE CAREFUL CONSIDERATION
AS AN ELEMENT OF THIS RESOLUTION
F REGIS KANNA UNIV OF CHGO HOSPITALS AND CLINICS ELTON T
DIELEY INDIANA UNIV HOSPITALS DR GERHARD HARTMAN UNIV OF IOWA

GF-1201 (R5-69)

HOSPITALS AND CLINICS ROBERT O CLEVELAND UNIV OF MICHIGAN
HOSPITALS JOHN WESTERMAH UNIV OF MINN HOSPITALS ALLAN
C ANDERSON UNIV OF ROCHESTER STRONG MEMORIAL HOSPITAL JAMES
E VAIL UNIV HOSPITALS OF CLEVELAND OHIO JAMES W BARNUM UNIV
OF WISC HOSPITALS
(145).

Received in person [illegible]

GF-1201 (R5-69)

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

DRAFT

HEARINGS SCHEDULED IN HOUSE STARTING 6/2/70
NOT YET SCHEDULED IN SENATE

Honorable John Sparkman
U. S. Senator
Chairman
Senate Banking and Currency Committee
5300 New Senate Office Building
Washington, D.C. 20510

Honorable Wright Patman
U. S. Representative
Chairman
House Banking and Currency Committee
2129 Rayburn House Office Building
Washington, D.C. 20515

Dear Mr. Chairman:

I am writing to you in my capacity as full-time President of the Association of American Medical Colleges. The Association represents the nation's 105 medical schools, 370 of our leading teaching hospitals, and 34 academic societies of both the basic science and clinical disciplines. Because of this broad representative base, I believe we can speak effectively for the academic medical center which includes the medical school, the faculty and the teaching hospital. The purpose of this letter is to formally convey the support of the Association for Senate Bill 3639, entitled, "Housing and Urban Development Act of 1970."

Specifically, we are interested in Section 503 which would authorize the Secretary to insure mortgages for hospitals, nursing homes, intermediate care facilities, and group practice facilities. The bill as introduced in the Senate would authorize the Secretary to insure hospital mortgages which do not exceed $25 million. In more than a few instances, however, the $25 million principal obligation ceiling has been found to be too low to meet the needs for a comprehensive capital construction program in our large, urban teaching hospitals.

The adoption in the Housing Act of 1968 of a health facilities guaranteed loan program was a landmark provision. Since the program began operation in June of 1969, eleven hospitals have received approval of their applications, and the applications of approximately seventy hospitals are under review for participation.

The teaching hospitals of this country, many of them closely related to medical schools, constitute a significant core of hospital services to sick persons in the communitites they serve. In addition, they provide essential facilities for the education and training of students in medicine and the allied health professions, including extensive and varied graduate programs. They also offer many opportunities for clinical research. This multiple role places upon teaching hospitals a heavy

responsibility to establish and maintain standards of excellence in all three areas of endeavor.

Teaching hospitals often provide the mechanism for managing change in the health care system through the development of strong inter-institutional relationships with community hospitals thereby providing the community hospitals with increased opportunities for patient service, medical education and research. These relationships are designed to strengthen the avenues of accessible health care for all individuals within the community. These developments take on added significance when it is noted that a large portion of the teaching hospitals are located in urban centers with all of the accompanying problems.

The teaching hospital, as a health center, is becoming the single most effective social and technical instrument available to both the medical educator and medical practitioner for the solution of medical problems. We rely on teaching hospitals for the graduate education of physicians and other health manpower, the establishment of standards for the promotion of better health, the best care of the sick and injured, the continued advancement of medical knowledge and the transfer of new technology to the patient's bedside.

These responsibilities which I have outlined often require enormous amounts of capital funds for modernization and construction of medical center facilities. In this regard we have consistently supported the Hill-Burton legislation, including the loan guarantee portion of that legislation. Attached is a copy of the AAMC position statement entitled, "Meeting Society's Expectations for Excellence in Service and Education." 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 legislation affecting modernization and construction funds for teaching hospitals.

The need for capital dollars is critical. The teaching hospitals are large health center institutions located in urban areas. Therefore, the sums of money necessary to adequately finance these capital programs are also large. For this reason, Mr. Chairman, the Council of Teaching Hospitals of the Association of American Medical Colleges wishes to go on record in strong support of the provisions contained in Section 503 of the Housing and Urban Development Act of 1970. We would also respectfully request that favorable consideration be given to an amendment introduced by Senator Thomas J. Dodd which would increase the hospital principal obligation ceiling from $25 to $50 million.

Sincerely,

JOHN A. D. COOPER, M.D.
President

JAD:ddd

March 23, 1970

Mr. Robert Ball
Commissioner
Social Security Administration
6401 Security Boulevard
Baltimore, Maryland 21235

Dear Mr. Ball:

This letter is being written to inform you of our deep concern over the proposed rule which would eliminate the use of accelerated methods of depreciation as a basis of financing long-range capital expansion in our teaching Hospitals.

The Council of Teaching Hospitals of the Association of American Medical Colleges finds itself again in the difficult position of wishing to support the Administration while policy decisions, on the other hand, are made that negate this possibility.

Our understanding has been that the health goals of the Administration are to expand and improve the delivery of health services and to increase the number of health professionals. We are now confronted with a decision that will change the methods of financing of teaching hospitals and will impair the long-grange planning so necessary to achieve these health care delivery and manpower goals.

We respectfully suggest that you take serious pause before taking this action.

Cordially,

John M. Danielson
Director
Council of Teaching Hospitals

JMD:cc

March 30, 1970

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MEMORANDUM

TO: Executive Committee and Executive Council

SUBJECT: Ad Hoc Report of the Task Force on Physician's Assistants Training Programs

At the time of the November, 1969, annual meeting, the Council of Academic Societies was requested to look into the problem of accreditation of training programs for the more highly trained physician's assistants. The Council approved this request, and a task force was appointed, of which Dr. Harvey Estes was chairman. Also on the task force were representatives of the Council of Deans and the Council of Teaching Hospitals. Representatives of the staff of the AMA Councils on Medical Education and on Health Manpower were guests of the task force at its meetings. On February 5, 1970, this group submitted the attached report.

On February 6, 1970, the Executive Committee of the Council of Academic Societies voted to distribute the report to the members of the Council for information only and to refer it to the Executive Committees of the Councils of Deans and of Teaching Hospitals and to the Executive Council of the Association. The Liaison Committee on Medical Education was also informed of these activities and of the content of the report.

It is important to realize that the recommendations of the report relate only to the accreditation of programs for the training of Type A (Level I) Physician's Assistants. These are the most highly trained

physician support personnel who, under a physician's direction, are equipped to carry out many of the functions traditionally assigned to the doctor. Such assistants have also been called health care technologists or Level I assistants.

The report does not concern itself with the education of Type B (Level II or health care technician) assistants, more narrowly trained individuals in a tightly defined specialty area, such as an operating room technician or an orthopedic assistant, nor does it touch upon programs of Type C (Level III or health care aides) in which the great bulk of what are now called allied health physician support personnel fall.

Even with this limited scope the report brings before the Executive Council a major issue which can be divided into four parts:

1. The general question of AAMC support of the physician's assistant concept.
2. The responsibility of AAMC institutions for the education and training of such personnel.
3. AAMC's position in relation to the role of such personnel in the provision of health services in institutions.
4. The role of such personnel in the noninstitutional or private practice of medicine.

The report resolves none of these definitively, and in keeping with its charge, the Task Force addressed itself primarily to the second.

In the meantime, a Physician's Assistants Association has been organized. The National Board of Medical Examiners has been approached about the writing of national-level examinations. The AMA Councils on Medical Education and Health Manpower are increasingly active in the fourth area, that of the potential relation of physician's assistants to practicing physicians. At its last meeting the Liaison Committee voted to invite representatives of the AMA Councils on Medical Education, AMA Council on Health Manpower, and the AAMC to form another task force which would be charged with taking the recommendations of the enclosed report the next step further, sufficient clarification for their presentation to the House of Delegates of the AMA and by inference to the Assembly of the AAMC in November, 1970.

For these reasons it is important that the Executive Council take some position concerning the questions raised by the Task Force and its report at this time.

It is recommended that:

1. The attached report be accepted as information.
2. Individuals be appointed to meet with representatives of AMA Councils.
3. The Executive Council support the position that the accreditation of university-connected programs leading to certification as Type A physician's assistants education programs be undertaken on a joint basis by AAMC and AMA through the Liaison Committee mechanism.

4. The Health Services Advisory Committee be asked to address itself to the problems related to the institutional employment of such personnel.

5. These actions be interpreted as formal endorsement by this Association that the training of Type A physician's assistants in a proper function of academic medical centers.

6. The time tables of the group meeting with the AMA and of the Health Services Advisory Committee be set up to permit formulation of recommendations for adoption by the Assembly in November, 1970.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

March 10, 1970

TO: Representatives, Council of Academic Societies Members

RE: Report of AAMC Task Force on Physician's Assistants Program

At the November, 1969 business meeting of the CAS a task force was appointed and asked to bring a report to the Council recommending the procedure for the training of Physician's Assistants. This task force was chaired by Dr. E. Harvey Estes of Duke University. They have completed this work and submitted the enclosed report and recommendations to the Executive Committee of the Council on February 5, 1970.

Before taking any official action, the Executive Committee would appreciate the reactions of you and the membership of your society both to its general import and its specific recommendations.

The report is also being circulated to the leadership of the Council of Deans, the Council of Teaching Hospitals, and the Executive Council for their suggestions before formal or final action will be taken.

Cheves McC. Smythe, M.D.
Director
Department of Academic Affairs

Enclosure

MHL/jk

REPORT OF AAMC TASK FORCE ON PHYSICIAN'S ASSISTANT PROGRAMS

February 5, 1970

PREAMBLE:

The Task Force was formed by action of the Council of Academic Societies at its November 2, 1969 meeting. It was formed in response to the many questions, both expressed and anticipated, raised by the rapid growth of physician's assistant programs and in recognition of the opportunity for the Council to exert leadership in this new area of medical education. Because of the possible implications for the Council of Deans and the Council of Teaching Hospitals, a representative of each was appointed to the Task Force.

The Task Force was asked to consider the role of these assistants and the need for standards for programs producing them, and to make appropriate recommendations to the council by February 5, 1970.

The Task Force met on two occasions, January 9, 1970, and January 27, 1970, and the following report is a result of these deliberations. Representatives of the American Medical Association were invited to meet with the Task Force, and Mr. Ralph Kuhli and Dr. T. F. Zimmerman were present at and participated in its meetings. Dr. Cheves Smythe of the AAMC and Dr. John Fauser of the AMA also participated in the first meeting.

The group is aware of the great variety of questions raised by this new type of health manpower, many of which were not considered a part of the charge of this particular Task Force and are therefore not addressed in this report. Among the questions are:

(a) The legal aspects of registration and/or control of individual assistants.

(b) The relationship between these categories of assistants and the established, previously defined, health professions (nursing, physical therapy, laboratory technology, etc.).

(c) The relationship between these individuals and physicians and/or medical institutions, such as hospitals, including methods of financial support after the training period and the manner of billing patients for their services.

(d) The need for additional numbers within each of the previously defined, established manpower categories and for still other, yet unspecified, assistants within the broad limits of health care.

I. THE NEED:

A. New types of assistants to the physician are necessary components of the health care team. The current output of medical schools, plus the output of new and expanded schools, will be insufficient to meet the health care needs of those segments of society now being served, while extending equivalent services to those segments now receiving little or no care.

B. Even if sufficient expansion of physician output could be achieved to meet the total need for services, there is doubt that this would be a wise course, since certain tasks do not require the unique talents of the physician and may be more appropriately performed by those with less total training.

C. The existing manpower categories (such as professional nurses and physical therapists) could assume many of these functions with added training but should not be considered as the sole or the

primary entry pathway into these new health professions. There are already shortages in nearly all of the existing health manpower categories, and insistence that new functions be assumed by members of these categories would severely limit the availability of new manpower for these purposes. A new primary pathway into the new category of physician's assistant would tend to open the range of health careers and would enhance the potential for recruitment of male candidates.

II. THE RESPONSIBILITY OF AAMC:

A. While it is possible for assistants to the physician to be trained by an educational institution, such as a junior college, and a group of practicing physicians, it is less likely that an adequate combination of facilities, medical faculty and interest will be found outside the teaching hospitals and medical teaching institutions represented by the AAMC.

B. As a part of its overall concern for the training of the physician, the AAMC should have an interest in any technique or system which will make his work more efficient or more effective. The utilization of well trained assistants is one such technique.

C. As a part of its concern for the provision of high quality health care to all persons, the AAMC must become concerned with the proper training, proper function, and proper utilization of such personnel.

D. As a part of its concern for medical students, the AAMC must promote the concept of an effective health care team as a means of extending the scope of services offered to patients by providing exposure to effective use of assistants at the medical school level.

III. RECOMMENDED ACTION:

A. The AAMC should demonstrate leadership in the definition of the role and function of these new categories of health care personnel, in setting educational standards for programs producing them, and in considering the additional problems raised in the preamble.

B. The AAMC should seek the counsel and the cooperation of other interested organizations and agencies as it moves ahead in the above task.

C. The AAMC should work toward an accrediting agency as a means of effective accreditation and periodic review of programs producing such personnel. A joint liaison committee with the AMA, similar to the Joint Liaison Committee for Medical Education, is one suggested mechanism.

IV. GUIDELINES FOR DEFINITION OF FUNCTIONAL LEVELS OF ASSISTANTS:

A. In view of the great variety of functions which might be assumed by assistants, the variety of circumstances in which these functions might be carried out, and the variety of skills and knowledge necessary to perform these functions, it is necessary to define several categories of assistants. These are defined primarily by their ability for making independent judgmental decisions. This, in turn, rests on breadth of medical knowledge and experience.

1. Type A within this definition of an assistant to the physician is capable of approaching the patient, collecting historical and physical data, organizing the data, and presenting it in such a way that the physician can visualize the medical problem and determine the next appropriate diagnostic or therapeutic step. He is also capable of assisting the physician by performing diagnostic and therapeutic procedures and coordi-

nating the role of other more technical assistants. It is recognized that he functions under the general supervision and responsibility of the physician, though he might, under special circumstances and under defined rules, operate away from the immediate surveillance of the physician. To properly perform at this level, the assistant must possess enough knowledge of medicine to permit a degree of interpretation of findings and a degree of independent action within these defined rules and circumstances.

2. Type B is characterized by a more limited area of knowledge and skill, and a more limited ability for integration and interpretation of findings. He is, as a result, less capable of independent action, but within his area of skill and knowledge he may be equal in ability to the Type A assistant or to the physician himself. Assistants at this level may be trained in a particular specialty without prior exposure to more general areas of medical practice, or may be trained in highly technical skills.
3. Type C is characterized by training which enables him to perform a single defined task or series of such tasks for the physician. These tasks generally require no judgmental decisions and are under direct supervision.

B. All such assistants should function under the general supervision and authority of a physician or a group of physicians and should not establish an independent practice. In addition, the functions performed by such assistants should be within the competence and capability of the responsible physician or physicians. For example, it would be inappropriate for a surgeon's assistant to perform a preoperative cardiac evaluation, unless the surgeon is competent to review his work critically and assume responsibility for its accuracy and completeness.

V. GUIDELINES FOR EDUCATIONAL PROGRAMS FOR TYPE A ASSISTANTS:

This document concerns itself solely with the guidelines for training of Type A assistants. This does not preclude the need for guidelines for other types as described above.

A. General Objectives:

To provide educational guidelines insuring high standards of quality for programs training Type A assistants as specified in Paragraph (IV-A-1) above, while preserving sufficient flexibility to permit innovation, both in content and method of education, all in the interest of protecting the public, the trainees, and those employing graduate assistants; to establish standards for use by various governmental agencies, professional societies, and other organizations having working relationships with such assistants.

B. General Prerequisites:

1. An approved program must be sponsored by a college or university with arrangements appropriate for the clinical training of its students. This will usually be a hospital maintaining a teaching program. There must be evidence that this program has education as its primary orientation and objective.
2. An approved program must provide to the accrediting agency, to be available in turn to other educational institutions, prospective students, physicians, hospitals, and others, information concerning the program including the following:

Name and Location of School
College/University Affiliation
Clinical/Hospital Affiliation

Director
Student Capacity
Academic Calendar
Tuition and Fees

3. An approved program must also provide, for the use of the accrediting agency, sufficient confidential information to establish that the program is in compliance with the specific guidelines which follow.

C. Administration:
1. An approved program may be administered by a medical school, hospital, university, college or other entity, providing it can assure that the educational standards can be maintained and other requirements met.
2. The administration shall be responsible for maintaining adequate facilities and a competent faculty and staff.
3. The administration shall assure the continued operation and adequate financing of the program through regular budgets, which shall be available for review by the accrediting agency. The budget may be derived from gifts, endowments, or other sources in addition to student fees.
4. The administration shall assure that the standards and qualifications for entrance into the program are recorded and available to the accrediting agency, and that these standards are met. Records of entrance qualifications and evaluations for each student shall be recorded and maintained, including transcripts of high school and college credits.
5. The administration shall make available to the accrediting agency yearly summaries of case loads and other educational activities done by clinical affiliates, including volume of outpatient visits, number of inpatients, and the operating budget.

D. Organization of Program:
1. The Program must be under supervision of a qualified director, who has at his disposal the resources of competent personnel adequately trained in the administration and operation of educational programs.
2. It will be the responsibility of the director to maintain a qualified teaching faculty.
3. The director will maintain a satisfactory record system to document all work done by the student. Evaluation and testing techniques and standards shall be stated, and the results available for inspection.
4. The director will maintain records on each student's attendance and performance.
5. The director will maintain on file a complete and detailed curriculum outline, a synopsis of which will be submitted to the accrediting agency. This should include both classroom and clinical instruction.

E. Physical Facilities:
1. Adequate space, light, and modern equipment should be provided for all necessary teaching functions.
2. A library, containing up-to-date textbooks, scientific periodicals, and reference material pertaining to clinical medicine, its underlying scientific disciplines, and its specialties, shall be readily accessible to students and faculty.
3. A hospital or other clinical facility shall be provided and of sufficient size to insure clinical teaching opportunities adequate to meet curriculum requirements.

F. Faculty:
1. An approved program must have a faculty competent to teach the

didactic and clinical material which comprises the curriculum.

2. The faculty should include at least one instructor who is a graduate of medicine, licensed to practice in the location of the school, and whose training and experience enable him to properly supervise progress and teaching in clinical subjects. He shall be in attendance for sufficient time to insure proper exposure of the student to clinical teaching and practice.
3. The program may utilize instructors other than physicians, but sufficient exposure to clinical medicine must be provided to insure understanding of the patient, his problem, and the diagnostic and therapeutic responses to this problem. For this reason attention is specifically directed to provision of adequate exposure of students to physician instructors.

G. Prerequisites for Admission:

1. For proper performance of those functions outlined for Type A assistants as described in Paragraph (IV-A-1) above, the student must possess an ability to use written and spoken language in effective communication with patients, physicians and others. He must also possess quantitative skills to insure proper calculation and interpretation of tests. He must also possess behavioral characteristics of honesty, dependability, and must meet high ethical and moral standards in order to safeguard the interest of patients and others. An approved program will insure that candidates accepted for training are able to meet such standards by means of specified evaluative techniques, which are available for review by the accrediting agency. The above requirements may be met in several ways. The following specific examples could serve the purpose of establishing the necessary qualifications and are provided as guides.
   a. Degree-Granting Programs: The successful completion of the preprofessional courses required by the college or university as a part of its baccalaureate degree.
   b. Non-Degree (Certificate) Programs: A high school diploma or its equivalent, plus previous health related work, preferably including education and experience in direct patient care, plus letters of recommendation from physicians or others competent to evaluate the qualifications cited above.
2. All transcripts, test scores, opinions, or evaluations utilized in selection of trainees should be on file and available to the accrediting agency on request.

H. Curriculum:

1. The curriculum should provide adequate instruction in the basic sciences underlying medical practice to provide the trainee with an understanding of the nature of disease processes and symptoms, abnormal laboratory tests, drug actions, etc. This shall be combined with instruction, observation and participation in history taking, physical examination, therapeutic procedures, etc. This should be in sufficient depth to enable the graduate to integrate and organize historical and physical findings as described in Paragraph (IV-A-1).
2. The didactic instruction should follow a planned and progressive outline and include an appropriate mixture of classroom lectures, textbook assignments, discussions, demonstrations, and similar activities. There should be sufficient evaluative procedures to assure adequate evidence of student competence.
3. Instruction should include practical instruction and clinical experience under qualified supervision sufficient to provide

understanding of and skill in performing those clinical functions required of this type of assistant. Evaluation techniques should be described and results recorded for each student.

4. Though the student may concentrate his effort and his interest in a particular specialty of medicine, he should possess a broad general understanding of medical practice and therapeutic techniques, so as to permit him to function with the degree of judgment previously defined.
5. Though some variation is possible for the individual student, dependent on aptitude, previous education, and experience, the curriculum will usually require two or more academic years for completion.
6. It is urged that the college or university sponsoring the program establish course numbers and course descriptions for all training, and that a transcript be established for each student. Students should receive college credit when this is appropriate, and should receive a suitable degree if sufficient credit is earned. If a degree is not earned, a certificate or similar credential shall be granted to the student on completion of the course of study.

I. Health:

1. Applicants will be required to meet the health standards of the sponsoring institution.
2. As evidence of its concern for imparting the importance of proper health maintenance, the program should provide for the students the same health safeguards provided for employees of affiliated clinical institutions.

J. Accreditation Procedures:

1. Applications for approval of a program for the training of Type A assistants as described above shall be made to the accrediting agency.
2. Forms and instructions will be supplied on request and should be completed by the director of the program requesting approval.
3. Approval of a program may be withdrawn when, in the opinion of the accrediting agency, the program fails to maintain the educational standards described above. When a program has not been in operation for a period of two consecutive years, approval will automatically be withdrawn.
4. Approved programs should notify the accrediting agency in writing of any major changes in the curriculum or a change in the directorship of the program.

H. Robert Cathcart, Vice President
Pennsylvania Hospital
James C. Eckenhoff, Chairman, Dept. of Anesthesia,
Northwestern University Medical Center
Robert W. Ever, Asst. Professor of Medicine,
University of Texas Medical Branch
William D. Mayer, Director, Medical Center,
University of Missouri
Lee Powers, Director, Division of Allied Health
Programs, Bowman Gray School of Medicine
E. Harvey Estes, Jr., Chairman, Department of
Community Health Sciences, Duke University
Medical Center

COTHMED STUDY PROGRESS REPORT

Early this year nine COTH hospitals participated in a pretest of the survey forms to be used in the COTHMED study of the impact of Medicare and Medicaid on teaching hospitals. This study focuses on the teaching hospital, its administrative and its medical staffs, specifically in their roles in the clinical education of medical students, interns and residents.

The study is being accomplished through institutional surveys of 69 teaching hospitals randomly selected from a population of 208 non-federal short term general hospitals with medical school affiliations for undergraduate medical education and approved residency programs in medicine and surgery. Although a few non-COTH members are included in the sample, a majority are members because of the criteria set for the study population.

As a result of the pretest the study design and interview content were reviewed, evaluated and necessary forms revisions completed. The revised survey forms have been submitted to the Bureau of Physician Education and Manpower Training so that necessary clearance by the Bureau of the Budget can be obtained. We expect that the survey itself will begin in mid-June.

Project Director: Jody Williams
Assistant Project Director: Howard R. Viet

Teaching Hospital Information Center
Project Reports

1. House Staff Survey - Preliminary report complete; more comprehensive report will be ready by July 1 at the latest.

2. Community Service Survey - Preliminary report will appear in the Journal of Medical Education June issue under the title "The Role Of The Teaching Hospital In Community Service." This is a reworked portion of the speech delivered by Mr. McNulty at the annual meeting. A final report will be ready by the end of the summer.

3. Survey of Sources of Capital Financing - The data has just come back from computer processing--four tables of interest are included under this Tab. A report to the membership should be available in four to six weeks.

4. State Appropriations to Teaching Hospitals - The results of this study appear as this month's Datagram, and are included in the April issue of the JME. It is tentatively planned to do this study on an annual basis.

5. Administrative Salary Survey - The study is complete. The only question remaining concerns whether the study should be done again; if so, at what point in time?

6. Monitoring Developments in Physician Assistant Programs - The Communication under this Tab was mailed on Monday, May 4.

Negotiations are currently under way with the National Center for Health Services Research & Development for a 12 month extension of the contract to June 30, 1971. We have been informed that our chances are excellent.

Table 1
SOURCES OF CAPITAL CONSTRUCTION - 1968

According to Region
(Shown in Thousands of Dollars)

Sources	NORTHEAST Users #	NORTHEAST Users % *	NORTHEAST Dollars Tot	NORTHEAST Dollars Avg	SOUTH Users #	SOUTH Users %	SOUTH Dollars Tot	SOUTH Dollars Avg	MIDWEST Users #	MIDWEST Users %	MIDWEST Dollars Tot	MIDWEST Dollars Avg	WEST Users #	WEST Users %	WEST Dollars Tot	WEST Dollars Avg
Hill-Burton	17	24	11138	655	4	15	4374	1094	5	12	4873	975	2	13	304	152
NIH	2	3	5086	2543	2	7	1965	983	0	0	0	0	0	0	0	0
State	4	6	1080	270	1	4	12	12	3	7	2296	765	2	13	637	319
Municipal	4	6	9576	2394	2	7	489	245	1	2	115	115	1	6	439	439
Fund Raising	9	13	11188	1243	1	4	275	275	3	7	6830	2277	1	6	157	157
Other Contrib	24	34	11141	464	6	22	8449	1408	6	14	4980	830	3	19	929	310
Hospital Earn	29	41	12498	431	11	41	5410	492	25	58	8052	322	4	25	950	238
Debt	17	24	18758	1103	4	15	2971	743	4	9	12861	3215	2	13	4646	2323
Funded Deprec	1	1	585	585	0	0	0	0	0	0	0	0	0	0	0	0
V.A. Funding	7	10	992	142	7	26	2510	359	5	12	742	148	1	6	180	180
TOTAL	71**		82042	1156	27		26455	980	43		40749	948	16		8242	515

*Signifies hospitals using a particular funding source: Example: 24=% of hospitals in Northeast Region that used Hill-Burton funds as compared to 76% which did not.

**Signifies the number of hospitals in the Northeast Region with Capital Construction monies from one or more funding sources.

Table 2

SOURCES OF CAPITAL CONSTRUCTION - 1968

Sources of Affiliation
(Shown in Thousands of Dollars)

Sources	UNIVERSITY-OWNED Users #	UNIVERSITY-OWNED Users % *	UNIVERSITY-OWNED Dollars Tot	UNIVERSITY-OWNED Dollars Avg	MAJOR Users #	MAJOR Users %	MAJOR Dollars Tot	MAJOR Dollars Avg	LIMITED Users #	LIMITED Users %	LIMITED Dollars Tot	LIMITED Dollars Avg	UNAFFILIATED Users #	UNAFFILIATED Users %	UNAFFILIATED Dollars Tot	UNAFFILIATED Dollars Avg
Hill-Burton	6	29	4196	699	10	14	6973	697	8	21	5151	644	4	15	4369	1092
NIH	0	0	0	0	2	3	1965	983	2	5	5086	2543	0	0	0	0
State	6	29	2945	491	1	1	200	200	3	8	880	293	0	0	0	0
Municipal	0	0	0	0	5	7	4368	874	3	8	6251	2084	0	0	0	0
Fund Raising	0	0	0	0	8	11	12017	1502	2	5	4238	2119	4	15	2195	549
Other Contrib	7	33	1550	221	14	20	15020	1073	12	31	6668	556	6	23	2261	377
Hospital Earn	18	86	7488	416	25	35	8418	337	15	38	4860	324	11	42	6144	559
Debt	2	10	2277	1139	11	15	12997	1182	7	18	10347	1478	7	27	13615	1945
Funded Deprec	0	0	0	0	0	0	0	0	1	3	585	585	0	0	0	0
V.A. Funding	0	0	0	0	16	23	3877	242	4	10	547	137	0	0	0	0
TOTAL	21**		18456	879	71		65835	927	39		44613	1144	26		28584	1099

*Signifies hospitals using a particular funding source: Example: 29= % of university-owned hospitals that used Hill-Burton funds as compared to 71% which did not.

**Signifies the number of university-owned hospitals with Capital Construction monies from one or more funding sources.

Table 3

SOURCES OF CAPITAL CONSTRUCTION - 1968

According to Control
(Shown in Thousands of Dollars)

Sources	STATE				MUNICIPAL				CHURCH				OTHER, N.P.				V.A.			
	Users		Dollars		Users		Dollars		Users		Dollars		Users		Dollars		Users		Dollars	
	#	%*	Tot	Avg	#	%	Tot	Avg	#	%	Tot	Avg	#	%	Tot	Avg	#	%	Tot	Avg
Hill-Burton	3	27	3400	1133	4	44	1977	694	2	8	64	32	18	22	15200	844	1	4	48	48
NIH	0	0	0	0	0	0	0	0	1	4	1950	1950	2	2	5086	2543	0	0	0	0
State	5	45	2433	487	2	22	1258	629	0	0	0	0	3	4	334	111	0	0	0	0
Municipal	0	0	0	0	6	67	4899	817	0	0	0	0	2	2	5720	2860	0	0	0	0
Fund Raising	0	0	0	0	0	0	0	0	0	0	0	0	14	17	18450	1318	0	0	0	0
Other Contrib	2	18	371	186	2	22	607	304	5	19	7758	1552	30	37	16763	559	0	0	0	0
Hospital Earn	10	91	2409	241	0	0	0	0	14	54	4664	333	43	52	19722	459	1	4	58	58
Debt	0	0	0	0	3	33	1861	620	6	23	14041	2340	18	22	23334	1296	0	0	0	0
Funded Deprec	0	0	0	0	0	0	0	0	1	4	585	585	0	0	0	0	0	0	0	0
V.A. Funding	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	20	77	4424	221
TOTAL	11**		8613	783	9		10602	4386	26		29062	1118	82		104609	1276	26		4530	174

*Signifies hospitals using a particular funding source: Example: 27=% of state controlled hospitals that used Hill-Burton funds as compared to 73% which did not.

**Signifies the number of state controlled hospitals with Capital Construction monies from one or more funding sources.

Table 4

SOURCES OF CAPITAL CONSTRUCTION - 1968

According to Bed Size
(Shown in Thousands of Dollars)

Sources	Less than 355 Beds				355-479 Beds				480-659 Beds				660 or more Beds			
	Users		Dollars		Users		Dollars		Users		Dollars		Users		Dollars	
	#	% *	Tot	Avg	#	%	Tot	Avg	#	%	Tot	Avg	#	%	Tot	Avg
Hill-Burton	10	29	10253	1025	4	13	2102	526	8	18	4508	564	6	13	3826	638
NIH	2	6	5086	2543	0	0	0	0	0	0	0	0	2	4	1965	983
State	4	12	1423	356	1	3	746	746	3	7	560	187	2	4	1296	648
Municipal	2	6	5295	2648	1	3	956	956	2	4	1159	580	3	7	3209	1070
Fund Raising	3	9	6518	2173	5	16	2868	574	5	11	7140	1428	1	2	1924	1924
Other Contrib	14	41	4593	328	6	19	3385	564	8	18	5647	706	11	24	11874	1079
Hospital Earn	20	59	9662	483	13	41	4631	356	17	38	3607	212	19	41	9010	474
Debt	10	29	15639	1564	7	22	7078	1011	3	7	4233	1411	7	15	12286	1755
Funded Deprec	0	0	0	0	1	3	585	585	0	0	0	0	0	0	0	0
V.A. Funding	0	0	0	0	2	6	550	275	8	18	2349	294	10	22	1525	153
TOTAL	34**		58469	1720	32		22901	716	45		29203	649	46		46915	1020

*Signifies hospitals using a particular funding source: Example: 29=% of hospitals with small bed size that used Hill-Burton funds as compared to 71% which did not.

**Signifies the number of hospitals with small bed size with Capital Construction monies from one or more funding sources.

Teaching Hospital Information Center
Communication #6
May 4, 1970
Subject: Physician's Assistant Programs

1. Increasing Interest in Training Physician Support Personnel:

There has been throughout the country increasing interest in new educational programs to train physician support personnel. As a result of this, COTH has been receiving numerous requests for information from hospital directors, medical school administrators, potential students and other interested individuals concerning the emerging physician assistant and clinical nurse specialist programs. Accordingly, the Teaching Hospital Information Center staff has attempted to keep pace with current developments in the field.

2. Programs in Development or Operation:

Attachments I and II present a list of individuals responsible for programs and a brief description of each program. We would be pleased to share more complete information on each program in those instances where the information has been made available. If you are aware of other activities which we have excluded, we would appreciate being informed. The attachments make no pretense of being complete, but represent our best knowledge at this point in time.

A recent article in the Wall Street Journal of Thursday, April 23, 1970 entitled, "Many Physicians Hire 'Assistant Doctors' to Help Ease Burden," may be of interest. The Duke Physician's Assistant Program and Colorado Pediatric Nurse Practitioner and Child Health Associate Programs are described in the March issue of the Journal of Medical Education.

3. National Developments:

There is in existence a formally incorporated organization called the American Association of Physicians' Assistants. This organization publishes a quarterly newsletter. Requests for subscriptions should be mailed to Thomas R. Godkins, Editor, Box 2951, W. Durham Station, Durham, North Carolina. The subscription charge is $5.00.

The official position of the American Medical Association is outlined in a document entitled, "Guidelines For Development Of New Health Occupations," approved by the House of Delegates in December, 1969. Copies may be obtained free of charge from the AMA's Department of Health Manpower.

Attachment III is the "Report Of AAMC Task Force On Physician Assistant Programs." This Report does not represent AAMC policy, and has not yet been acted upon by the COTH Executive Committee or the AAMC Executive Council.

Paul J. Sanazaro, M.D., Director, National Center for Health Services Research and Development outlined his agency's position in a speech entitled, "The R & D Approach To Health Manpower In The 1970's." This paper was delivered at the AMA Conference On Physician Support Personnel in the 70's. Copies may be obtained directly from the National Center for Health Services Research and Development, DHEW, Rockville, Maryland 20852.

It would be most helpful if you would keep us informed of any new activity in the development of physician assistant or nurse practitioner educational programs.

RICHARD M. KNAPP, Ph.D.
Project Director
Teaching Hospital Information Center

ARMAND CHECKER
Assistant Project Director
Teaching Hospital Information Center

Attachments: 1-Roster: Physician's Assistant Programs;
2-Physician's Assistant Programs: A Brief Review;
3-Report Of AAMC Task Force On Physician's Assistant Programs.

The project upon which the above results are based has been performed pursuant to Contract No. PH 110-68-41 with the National Center for Health Services Research and Development, Department of Health, Education and Welfare.

FULL-TIME SALARIED PHYSICIANS

Three letters on the following pages from Mr. Reiman, Mr. Hochstadt, and Mr. Carner are indicative of questions which are increasingly being raised. COTH is receiving a growing number of requests, of which these are only the three most recent. The issue is whether the COTH staff, specifically the Teaching Hospital Information Center should undertake an effort to study these types of questions.

RECOMMENDATION: It is recommended that a meeting be scheduled in late May or early June to decide whether a study of this problem should be undertaken. The following persons are recommended to attend the meeting: Cecil G. Sheps, M.D., Chairman, Teaching Hospital Information Center Advisory Committee; Walter Rice, M.D., Director, AAMC Division of Operational Studies; COTH staff; four COTH members who have expressed interest in this problem.

MAINE
MEDICAL
CENTER

OFFICE OF THE DIRECTOR

PORTLAND, MAINE 04102

March 26, 1970

Mr. John M. Danielson, Director
Council of Teaching Hospitals
Association of American Medical Colleges
1 Dupont Circle N.W.
Washington, D.C.

Dear Mr. Danielson:

You will recall I telephoned you last week relative to a problem we are having establishing uniform salaries, job descriptions and fringe benefits for our fulltime salaried physicians. You suggested that I might write you outlining some of the concepts at which time you would see if it would be beneficial for me to come to Washington to spend an hour or so discussing them with you or your people.

Over the last several years we have been slowly adding salaried physicians and currently have nine men who are on a fulltime basis, not including the departments of pathology, radiology, anesthesia or research. With the possible exception of research, we feel the other three departments which are on a formula based upon a percentage of growth, would not be included in a fringe benefit program while they continued on this basis. To wit, they basically have a monopoly and as long as they choose to maintain this status, they should make their own provisions for fringe benefits. However the other men are rightfully raising the question, why not provide fringe benefits for us? I must add that hospital employees are covered by a rather liberal fringe package which goes from pension through disability insurance, life insurance and sick leave. Therefore, one aspect of our concern is, what kind of a fringe package should be put together and how much money does the hospital put into it?

The second question relating to these salaried men is the range of compensation. The hospital has established a ground rule that salaried physicians will be paid between $17,000 and $60,000 per year, but we have not established an equitable manner to help us determine how much a pediatrician gets, how much a pulmonary man gets, etc. And, this is of great concern to us now.

The third question relates to allowing these physicians to maintain some private practice. Currently some of the men do see a few private patients. Some bill these patients for service and retain payments for themselves.

Others bill patients and endorse payments to the Maine Medical Center to be used for continued education purposes.

Listed on the attached sheet are the titles of the salaried men and, where applicable, their salaries from 1965 through the present. Included also are their date of hire and their date of birth.

Perhaps, as you look over this material, you will feel that I have omitted some pertinent information that will be helpful to you, in which case, please let me know so that I can augment the information. If my questions make sense, and you feel someone in your office can offer suggestions and guidance to me, I would be pleased to come to Washington to discuss them.

Sincerely yours,

Philip K. Reiman
Executive Director

PKR/b
Encs.

MAINE MEDICAL CENTER
Portland, Maine

PROFESSIONAL COMPENSATION

1965 - 1969

	1965	1966	1967	1968	1969	BIRTH DATE	EMPLOYMENT DATE
RESEARCH							
Dr. A - Research Investigator	11,960	12,000	18,750	20,000	20,000	11/29/29	7/ 1/61
Dr. J - " "				17,000	17,000	3/25/36	7/ 1/69
Dr. N - " "	20,000	20,000	20,000	25,000	25,000	9/23/15	7/ 1/61
Dr. R - " "	13,500	16,190	20,000	20,000	21,000	10/26/29	2/ 1/67
Dr. R - " "	10,000	10,000	12,500	18,000	20,000	11/ 1/30	7/ 1/66
SALARIED							
Physiatrist, M.D.	19,000	25,000	25,000	26,500	30,000	2/15/16	3/22/65
D.M.E., M.D.	23,500	25,000	30,000	30,000	30,000		
Internal Medicine, M.D.			40,000	40,000	40,000	1/14/13	9/18/67
Pediatrician, M.D.				30,000	30,000	2/ 2/20	3/18/68
Psychiatrist, M.D.		7,502	7,502	7,502	7,502	2/ 8/28	12/19/66
Psychiatrist - Chief, M.D.					35,000	12/20/30	2/ 3/69
Psychiatrist - Assoc. Chief, M.D.					34,000	9/22/30	9/ 2/69
Psychiatrist, M.D. (Hired 3/2/70 at $25,000)						12/13/40	3/ 2/70
Pulmonary, M.D.					25,000	1/15/33	9/ 1/69
Medical Director, M.D. (Starting 9/14/70 at $45,000)						8/ 3/13	9/14/70

Cedars of Lebanon Hospital

Executive Office

3-27

To FMK

March 24, 1970.

Fletcher H. Bingham, Ph.D.
Associate Director
Council of Teaching Hospitals
Association of American Medical Colleges
One DuPont Circle, N.W.
Washington, D.C.

Dear Doctor Bingham:

As you know, Cedars of Lebanon Hospital is formalizing its affiliation with the School of Medicine, University of Miami on a Departmental basis. We have recently concluded a contract with the Department of Obstetrics and Gynecology and within the next few weeks we hope to finalize a contract with the Department of Surgery to be followed shortly thereafter by the Department of Medicine.

Our OB/GYN teaching service got off to a flying start, and it appears as if the Medical School, our OB/GYN attending staff and particularly the Residents are all most pleased with the program to date.

Some many months ago you were kind enough to provide me with sample affiliation agreements, which were used to good advantage in negotiating our present contracts and I wish to again express thanks to you for this help. However, we have need for further assistance in the drawing of contracts for our permanent, full-time Chiefs of Service.

At the present time, we are functioning with temporary Acting Chiefs until such time as we can finalize our plans for the full-time Chiefs.

RECEIVED
MAR 26
WASH., D.C.

1321 N.W. 14TH ST., MIAMI, FLORIDA 33125 TELEPHONE FR 4-9011

Any samples of contracts or agreements for the services of full-time Chiefs of Service would be very much appreciated, particularly if they are from hospitals similar to Cedars of Lebanon Hospital, which is a typical non-governmental community hospital.

Again, please accept our thanks for your previous assistance. It is our hope that you will be able to provide us with material to help us again.

Sincerely,

H. Hochstadt
Vice President
Professional Services

HH:nf

MEMORIAL HOSPITAL

March 26, 1970

Mr. John M. Danielson, Director
Council of Teaching Hospitals
1346 Connecticut Avenue, N.W.
Washington, D.C. 20036

Dear John:

Hope you are enjoying the challenge of your new position and that I'll have an opportunity to see you sometime soon.

I wonder if you would be able to help me by locating an extra copy of the survey of compensation recently compiled from teaching hospital sources. We're negotiating for a full time pediatrician and I let our original copy get away.

Thanks very much.

Best wishes.

Sincerely,

Donald C. Carner
Executive Vice President

DCC:nm

Memorial Hospital of Long Beach | 2801 Atlantic Avenue | Long Beach, California 90801 | 595-2311