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*COTH Representative to the AAMC Executive Council.

ASSOCIATION OF
AMERICAN MEDICAL COLLEGES

✦

COUNCIL OF TEACHING HOSPITALS

SPRING MEETING

1978

✦

6:00 p.m., May 3 -- Noon, May 5
Sheraton St. Louis Hotel
St. Louis, Missouri

COUNCIL OF TEACHING HOSPITALS

SPRING MEETING

✦

May 3-5, 1978
Sheraton St. Louis Hotel
St. Louis, Missouri

✦

Afternoon and Evening, May 3

4:00-6:00 p.m. REGISTRATION
Ballroom Foyer

6:00-7:00 p.m. RECEPTION: OPEN BAR
Ballroom West

7:00 p.m. WELCOME
Ballroom West

David L. Everhart
Chairman
Council of Teaching Hospitals

OVERVIEW OF THE MEETING

Irvin G. Wilmot
Chairman, Planning Committee
COTH Spring Meeting

DINNER

KEYNOTE ADDRESS

"NEW MYTHS OF HEALTH PLANNING"

David M. Kinzer
President
Massachusetts Hospital Association

Morning Session—May 4

Ballroom East

PRESIDING
Robert M. Heyssel, M.D.
Executive Vice President and Director
The Johns Hopkins Hospital

8:30-10:00 a.m. "THE HOSPITAL CHIEF EXECUTIVE LOOKS AT GRADUATE MEDICAL EDUCATION"

Stuart Marylander
Executive Vice President
Cedars-Sinai Medical Center

"THE MEDICAL EDUCATOR'S VIEW"

August G. Swanson, M.D.
Director, Department of Academic Affairs
Association of American Medical Colleges

QUESTIONS AND DISCUSSION

10:00-10:30 a.m. COFFEE

10:30-12:00 Noon "DEALING WITH THE HOUSE STAFF"

Jess Solivan
Vice President for Personnel
New York University Medical Center

"HMO'S AND THE TEACHING HOSPITAL: THE GW EXPERIENCE"

Ronald P. Kaufman, M.D.
Vice President for Medical Affairs
George Washington University Medical Center

QUESTIONS AND DISCUSSION

12:00-1:45 p.m. BUFFET LUNCHEON

Afternoon Session—May 4

Ballroom East

PRESIDING
David L. Everhart
President
Northwestern Memorial Hospital

1:45-4:30 p.m. COTH MEMBERSHIP DISCUSSION AND BUSINESS MEETING

This session is designed to encourage membership discussion and debate on current issues and problems facing teaching hospitals. Based on responses to the COTH Chairman's February 15 request for issue identification, selected individuals have been requested to make brief presentations on these issues to be followed by discussion from those in attendance. Current COTH/AAMC policies and other Council business will also be discussed.

Morning Session—May 5

Ballroom East

PRESIDING
David D. Thompson, M.D.
Director
New York Hospital

8:30-10:00 a.m. "JCAH AND TEACHING HOSPITALS"

John E. Affeldt, M.D.
President, Joint Commission on Accreditation of Hospitals

Moe Katz
Deputy Director for Planning
Montefiore Hospital

QUESTIONS AND DISCUSSION

10:00-10:30 a.m. COFFEE

10:30-11:30 a.m. "A LOOK TO THE FUTURE: MY FIRST YEAR ON THE JOB"

Robert A. Derzon
Administrator
Health Care Financing Administration

11:30 a.m. ADJOURNMENT

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

COTH SPRING MEETING

PROGRAM MATERIALS

MAY 3-5, 1978

SHERATON ST. LOUIS HOTEL

COTH SPRING MEETING
May 3-5, 1978
The Sheraton St. Louis Hotel

TABLE OF CONTENTS

PROGRAM

COTH SPRING MEETING
May 3-5, 1978
St. Louis, Missouri

WEDNESDAY, MAY 3

4:00 - 6:00 p.m.	Registration	Ballroom Foyer
6:00 - 7:00 p.m.	Reception - Open Bar	Ballroom West
7:00 p.m.	Dinner & General Session	Ballroom West

Welcome

David L. Everhart
Chairman
Council of Teaching Hospitals

Overview of the Meeting

Irvin G. Wilmot
Chairman, Planning Committee
COTH Spring Meeting

Keynote Address - "New Myths of Health Planning"

David M. Kinzer
President
Massachusetts Hospital Association

THURSDAY, MAY 4 — MORNING SESSION — Ballroom East

Presiding

Robert M. Heyssel, M.D.
Executive Vice President & Director
The Johns Hopkins Hospital

8:30 - 10:00 a.m. "The Hospital Chief Executive Looks At Graduate Medical Education"

Stuart Marylander
Executive Vice President
Cedars-Sinai Medical Center

"The Medical Educator's View"

August G. Swanson, M.D.
Director, Department of Academic Affairs
Association of American Medical Colleges

Questions and Discussion

THURSDAY, MAY 4 (Cont.)

10:00 - 10:30 a.m. Coffee

10:30 - 12 Noon "Dealing With The House Staff"

Jess Solivan
Vice President for Personnel
New York University Medical Center

"HMO's And The Teaching Hospital"
The GW Experience"

Ronald P. Kaufman, M.D.
Vice President for Medical Affairs
George Washington University
Medical Center

Questions and Discussion

12:00 - 1:45 p.m. Buffet Luncheon

AFTERNOON SESSION Ballroom East

Presiding

David L. Everhart
President
Northwestern Memorial Hospital

1:45 - 4:30 p.m. COTH Membership Discussion and Business Meeting

(Agenda to be handed out at the meeting)

FRIDAY, MAY 5 MORNING SESSION Ballroom East

Presiding

David D. Thompson, M.D.
Director
New York Hospital

8:30 - 10:00 a.m. "JCAH And Teaching Hospitals"

John E. Affeldt, M.D.
President, Joint Commission on
Accreditation of Hospitals

FRIDAY, MAY 5 (Cont.) MORNING SESSION Ballroom East

"JCAH And Teaching Hospitals" (Cont.)

Moe Katz
Deputy Director for Planning
Montefiore Hospital

Questions and Discussion

10:00 - 10:30 a.m. Coffee

10:30 - 11:30 a.m. "A Look To The Future: My First Year on the Job"

Robert A. Derzon
Administrator
Health Care Financing Administration

11:30 a.m. Adjournment

REGISTRANTS *
COTH SPRING MEETING
May 3-5, 1978

Raymond S. Alexander
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Philadelphia, PA

Charles Allen Ashley, M.D.
Director
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Cooperstown, NY

Mr. Allan C. Anderson
Executive Director
Strong Memorial Hospital
Rochester, NY

James L. Ash
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Evanston Hospital
Evanston, IL

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Medical Center
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Dennis Barry
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North Carolina Memorial
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Philip S. Birnbaum
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The George Washington University
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Clarence W. Bushnell
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Bridgeport Hospital
Bridgeport, CT

Daniel W. Capps
Administrator
University Hospital
Tucson, AZ

George Cartmill
President
Harper Grace Hospitals
Detroit, MI

David W. Clark
Administrator
University Hospitals of Cleveland
Cleveland, OH

*Excluding Speakers and Staff.

Thursday Afternoon Session - Additional Material

HEALTH PLANNING, REGIONALIZATION AND THE TEACHING HOSPITAL

I. Introductory Remarks

- Topic is complex, signifcant and timely
- Topic is multi-variant, inter-related and dynamic
- Presentation time limited and therefore
- Issues selected to provoke discussion
  - -- A few among many possibilities
  - -- Generally known to COTH members, not new
  - -- Only context (environment) is, and changing, i.e., increased instability
  - -- Ignorance isn't bliss
  - -- Survival is!

II. Issues

A. Differences of teaching hospital vis-á-vis community hospital

- More than semantics
- What are the features?
- Who understands and perceives?
- Who doesn't and why?
  - -- Recognition by statement (P.L. 93-641)
  - -- But no regs, rules (HSP, AIP)
  - -- Actions follow perceptions
    - Is there an image "message"?
    - A challenge to us?

B. Whole process

- Technical weaknesses -- "us" and "they"
- Process weaknesses -- "us" and "they"

C. Rivalry has become competition

- Overlapping "regions"
- Regions for what?

D. Incentives for "meaningful" change often lacking

- Misfit to plans not enough
- Related to other parts of the "system", e.g., reimbursement, controls, etc.

III. Options

A. Do nothing but wait

B. Educate others by description and get involved in the processes

C. Assess, work with or eliminate competition

D. Develop incentives

-- external and internal

IV. Implications

Trouble

Learn a lot about ourselves, learn a lot about others (needs, demands, people, plans, programs, population served, "quality", quantity, behaviors)

Change in alliances
Change in attitude
Change in data needs

Innovations
Motivations
Analysis (what if .
Risk taking

B-D Work and Time

V. Conclusions

- Issues are not going to go away but become more intense
- Teaching hospitals can direct certain environmental changes, rather than the reverse
- Teaching hospitals can direct mood changes in the general public, but may have to change their image too
- Maintaining academic-clinical services and providing community service balance requires constant effort

Samuel Davis

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Executive Director
Kings County Hospital
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Brooklyn, NY

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Rochester, NY

Stephanie Stumpf
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Pontiac, MI

COTH SPRING MEETING
May 3-5, 1978
St. Louis, Missouri

COTH MEMBERSHIP DISCUSSION AND BUSINESS MEETING
Thursday, May 4, 1:45 p.m. - 4:30 p.m.
Ballroom East

A G E N D A

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VIII. The Voluntary Effort

Gail L. Warden
Executive Vice President
American Hospital Association

IX. Federal or State Rate Regulation 31

Charles B. Womer
President
University Hospitals of Cleveland

X. State-Level Regulation Versus Federal Regulation 33

Robert M. Heyssel, M.D.
Executive Vice President
& Director
The Johns Hopkins Hospital

association of american medical colleges

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

April 14, 1978

202: 466-5175

MEMORANDUM

TO: Council of Teaching Hospitals

FROM: John A. D. Cooper, M.D.

SUBJECT: Agenda Item for the COTH Spring Business Meeting: Report of the Executive Council on Revising the AAMC Dues Structure

The Association's present dues structure has been under careful review by the Finance Committee and Executive Council for over a year.

The Report of the Executive Council, which is attached, chronicles these deliberations and presents a recommendation to the Council of Teaching Hospitals for discussion and action at the spring meeting. Chuck Womer, Chairman of the Finance Committee, and Dave Everhart, COTH Chairman, will present this to the COTH at the Business Meeting Thursday afternoon, May 4. Chuck, Dave, and I and other members of the Executive Council will be available throughout the meeting to respond to any questions or concerns you may have.

The Executive Council plans in June to review the comments and actions of the spring meetings of the COD and COTH, and to develop its final recommendation to go before the AAMC Assembly in October.

Attachment

REPORT OF THE EXECUTIVE COUNCIL ON REVISING THE AAMC DUES STRUCTURE

BACKGROUND

In June of 1976 the Executive Council appointed a Finance Committee under the Chairmanship of Mr. Charles B. Womer, President of the University Hospitals of Cleveland. The Committee was asked to conduct an ongoing review of Association income and expenditures and to present recommendations to the Council when changes in the way the Association financed its programs became necessary.

The first Finance Committee recommendations, approved by the Executive Council in September 1976, were to increase MCAT and AMCAS fees. These increases reflected the increased cost of administering the New MCAT test and the actual cost at which an applicant initially entered the AMCAS system. The dues structure of the Association was discussed by the Finance Committee at that time, and a plan for examining the overall support of the organization was formulated.

In December of 1977, the Finance Committee reported its recommendations on revising the AAMC income structure to the Officers' Retreat. These recommendations included: (1) increasing dues and service fees, effective in fiscal year 1980; (2) imposing an inflator on dues and service fees after the initial increases to keep pace with increasing costs; (3) authorizing the Executive Council to waive or decrease application of this inflator; and (4) anticipating a necessary increase in AMCAS and MCAT fees in fiscal year 1981 and 1983.

The Officers' Retreat also reviewed budget projections prepared by staff, based on what was seen as a minimum Association budget. The officers and later the Executive Council carefully scrutinized the program implications of this minimum budget, agreeing that general funds support of several Association activities be phased out. Staffing levels were adjusted in several other areas where the President felt that tightening of the budget was possible.

At the January 1978 Executive Council meeting, this reduced budget was analyzed in terms of program priorities and the Association's continued ability to meet the primary demands of the membership. By this time it was also clear that the Association's $1.4 million (per year) contract with the Bureau of Health Manpower would not be renewed. Loss of this contract meant that a portion of the data collection and analysis previously supported by BHM would have to be continued on general funds, resulting in substantial added costs.

The Executive Council then looked at the income projected for the next five years under the current schedule of dues, the Finance Committee's recommendation, and a more modest proposal presented by the staff. It was clear that by FY 1980 the current dues structure would not support even the "minimum" level of program activities endorsed by the Executive Council. The Finance Committee recommendation would have produced a moderate surplus of income over expenses in each of the coming years, when calculating expenses from the reduced budget base. The staff proposal would have just barely covered the reduced level of program embodied by the minimum budget each year.

After considerable discussion, the Executive Council asked that the staff develop, in conjunction with the Finance Committee, another alternative. This approach was to provide more income than the current staff proposal, but less than the original Finance Committee recommendation. In requesting this, the Council asked that the staff take into account several concerns.

First, the revised approach should provide income sufficient to allow the Association to respond to new initiatives and priorities as they develop. The Council was particularly concerned that vital task forces or other special projects would be stalled while funding was sought. Some budgetary flexibility should be maintained by planning for modest surpluses.

Second, the revised approach should provide enough flexibility so that an unanticipated jump in the inflation rate would not produce an immediate deficit. All projections of AAMC expenditures had been based on a 6% annual inflation.

Third, the Executive Council reaffirmed its reserve policy by which the officers were directed to maintain unrestricted reserves of at least 50%, and as a goal 100%, of a year's total budget. Since the Association owned no land, building, or other fixed assets of any size, it was considered imperative to the stability of the organization and its ability to attract top notch staff that the constant dollar value of its reserves be maintained.

Finally, the Executive Council expressed concern that the Finance Committee recommendation which would bring all schools up to the dues ceiling within five years might work a hardship on schools with smaller budgets. While it was recognized that the Association attempted to serve all schools equally, it was felt that smaller schools could not be asked to bear the major burden of the dues increase.

At its March meeting the Executive Council considered the recommendations which are presented below. This proposal was developed by staff in conjunction with the Finance Committee, and responds to the Council's concerns with the earlier proposals. These recommendations were discussed at length with the Administrative Board of each Council and the OSR; each of the Boards recommended its approval. The Executive Council also agreed that this approach met the concerns raised previously and recommended its approval to the constituent Councils.

RECOMMENDATION

Table II of the enclosed materials presents the complete schedule of dues which the Executive Council proposes. Table I shows the current dues structure. No change in dues is possible prior to fiscal year 1980.

For the medical schools, whose dues last increased in FY 1969, the recommendation would mean that each school would pay $2,000 more in 1980 than it would have paid under the old schedule. This is because the service fee would now be calculated as a percentage of the school's total budget, rather than as a percentage of the school's budget exceeding the first $2 million. In this way, dues would be paid on an equal basis by each school while only the service fee component would be pro-rated by the size of the school's budget. Since the ceiling on the total of the dues plus service fee would be increased to $12,000, each school would pay exactly $2,000 more than it would have paid under the current schedule.

Both the basic institutional dues and the ceiling will increase slightly each of the next two years, while only the ceiling will be subject to the inflator after FY 1983. The rate applied to determine the service fee will increase by .0001 each year until a rate of .002 is achieved, at which point the rate will plateau.

For provisional institutional members (developing schools who have not enrolled their 3rd year class), the formula would apply in a similar manner with the basic rate of dues being half that of the developed schools. Thus, each developing school would pay up to $2,000 additional service fee in FY 1980, depending on the school's budget.

Members of the Council of Academic Societies, whose dues last increased in FY 1975, would sustain no immediate increase in dues beyond the application of the annual inflator.

Members of the Council of Teaching Hospitals, whose dues last increased in FY 1973, would pay $1,500 in FY 1980; $1,750 in FY 1981; $2,000 in FY 1982; and then become subject to the annual inflator.

The Executive Council recommends building an annual inflator into the Association's dues structure for two principal reasons. The first is to prevent inflation from gradually effecting the reduction in Association programs which would be inevitable if revenues were held constant. The second reason is to avoid the necessity of seeking Assembly approval for minor variations in dues occasioned by inflation. The inflator would be defined as the ratio of the most recent November Revised Consumer Price Index for Urban Wage Earners and Clerical Workers--Washington, D. C. Metropolitan area to that of the previous November. An inseparable part of the proposal to permit use of an annual inflator is the recommendation that the Executive Council be authorized by the Assembly to defer, reduce, or waive the scheduled increases in dues and fees for FY 1981 and all future years if, in its judgment, the full increases were not required to support the Association's authorized programs. Thus, the inflator would represent the outside limit on annual increases permissible without Assembly action.

Tables III - VI show the projected effect of this proposal. Table III compares total income under this proposal and the current schedule, including anticipated increases in AMCAS and MCAT fees. Table IV compares revenues which would be collected just from the medical schools. Tables V and VI show what individual schools would pay in dues and service fees under the current schedule and under this recommendation.

Table VII traces the increases in dues revenue in the 1970's, as compared with increases in Association expenditures. Most of the increase in dues has resulted from the increase in the number of medical schools during this time, an increase which seems unlikely to continue.

The Executive Council recommends to the constituent Councils favorable action on the revised dues structure described above.

CURRENT DUES SCHEDULE

Institutional Members:

$2,000 + service fee of 1/10 of 1% of the total annual operating expenditures of the school in excess of the first $2 million.

Ceiling: $10,000 per school

Provisional Institutional Members:

$1,000 + service fee as above until enrollment of first 3rd-year class; then same as Institutional Members.

Affiliate & Graduate Affiliate Members:

$500

Two-Year Schools:

$1,000

Council of Academic Societies:

less than 300 active members	$ 500
300 - 999	1,000
1,000 - 4,999	2,000
5,000 - more	3,000

Council of Teaching Hospitals:

$1,000

Corresponding Members:

$500

Individual Members:

$30

CURRENT FEE SCHEDULE

COTRANS:

$20 per application

MCAT:

$35

AMCAS:

1 school - $20; increments of $5 to 5th school ($40)

6th and each additional school - $10 per school

Table II

EXECUTIVE COUNCIL RECOMMENDATION - COMPLETE SCHEDULE OF DUES, FEES

DUES SCHEDULE	FY 80	FY 81	FY 82	FY 83
INSTITUTIONAL				
Dues	$ 2,000	$ 2,500	$ 3,000	$ 3,000
Service Fee (Proportion of School Budget)	.001	.0011	.0012	.0013
Ceiling (Dues + Service Fee)	12,000	13,000	14,000	15,000
PROVISIONAL INST.				
Dues	1,000	1,250	1,500	1,500
Service Fee (Proportion of School Budget)	.001	.0011	.0012	.0013
Ceiling (Dues + Service Fee)	12,000	13,000	14,000	15,000
AFFILIATE INSTITUTIONAL	750	1,000	1,000+	1,000+
2-YEAR SCHOOLS	1,250	1,500	1,500+	1,500++
ACADEMIC SOCIETIES	Apply Inflator to Present Schedule Beginning in FY 1980			
TEACHING HOSPITALS	1,500	1,750	2,000	2,000+
CORRESPONDING	500+	Continue to Apply Inflator		
INDIVIDUAL	30	35	35	40
ANTICIPATED FEE SCHEDULE				
MCAT	$ 35	$ 40	$ 40	$ 45
AMCAS BASIC FEE	20	20	30	30
COTRANS	50	50	50	50

+Denotes inflator based on the Revised Consumer Price Index for Urban Wage Earners and Clerical Workers--Washington, D. C. Metropolitan Area.

TOTAL INCOME YIELD

INCOME	FY 79	FY 80	FY 81	FY 82	FY 83
CURRENT SCHEDULE	$6,374,894	$6,338,603	$6,330,676	$6,342,660	$6,372,958
EXECUTIVE COUNCIL RECOMMENDATION	same	6,785,570	7,261,963	7,792,554	8,225,071

Table III

Table IV

INSTITUTIONAL DUES

(Assuming 6% annual growth of school budgets)

		BASIC DUES	SERV. FEE RATE	CEILING (DUES+FEES)	YIELD#
Current Schedule*	FY 80	$2,000	.001	10,000	1,126,397
	81	2,000	.001	10,000	1,133,125
	82	2,000	.001	10,000	1,139,913
					3,399,435
Executive Council Recommendation**	FY 80	2,000	.001	12,000	1,370,292
	81	2,500	.0011	13,000	1,500,427
	82	3,000	.0012	14,000	1,631,339
					4,502,058

#Broken down by school on following pages.

*Rate applies to school budget in excess of $2 million to determine service fee.

**Rate applies to entire school budget to determine service fee.

CURRENT SCHEDULE - YIELD*
(Full-paying Medical Schools Only)

School	FY 80	FY 81	FY 82
100 Schools at Ceiling	1,000,000		
101	9,837		
102	9,731	1,020,000	1,020,000
103	8,565	9,079	9,623
104	8,141	8,629	9,147
105	8,034	8,517	9,028
106	8,014	8,494	9,004
107	7,908	8,382	8,885
108	6,678	7,078	7,503
109	6,137	6,506	6,896
110	6,074	6,438	6,824
111	4,420	4,685	4,967
112	2,809	2,976	3,156
113	2,660	2,820	2,989
114	2,512	2,663	2,823
115	7,459	7,907	8,381
116	5,359	5,681	6,022
117	5,114	5,421	5,746
118	2,343	2,483	2,632
119	3,177	3,367	3,569
120	2,000	2,009	2,129
121	2,571	2,725	2,888
122	6,854	7,265	7,701
TOTAL	$1,126,397	$1,133,125	$1,139,913
TOTAL FY 80, 81, 82 =		$3,399,435	

*Assumes 6% annual growth of school budgets

EXECUTIVE COUNCIL RECOMMENDATION-YIELD*
(Full-paying Medical Schools Only)

School	FY 80 (max = 12,000)	FY 81 (13,000)	FY 82 (14,000)
100 Schools at Ceiling	1,200,000		
101	11,837		
102	11,731	1,326,000	
103	10,565	12,486	1,442,000
104	10,141	11,991	13,976
105	10,034	11,868	13,833
106	10,014	11,843	13,804
107	9,908	11,720	13,662
108	8,678	10,285	12,003
109	8,137	9,656	11,275
110	8,074	9,581	11,188
111	6,420	7,653	8,960
112	4,809	5,773	6,787
113	4,660	5,602	6,586
114	4,512	5,429	6,387
115	9,459	11,197	13,057
116	7,359	8,749	10,226
117	7,114	8,463	9,895
118	4,343	5,231	6,158
119	5,177	6,203	7,282
120	3,895	4,709	5,554
121	4,571	5,497	6,465
122	8,854	10,491	12,241
TOTAL	$1,370,292	$1,500,427	$1,631,339
TOTAL FY 80, 81, 82 =		$4,502,058	

*Assumes 6% annual growth of school budgets

DUES INCOME - EXPENDITURES
1970 - 1978

FY	DUES INCOME	EXPENDITURES	
		GENERAL FUND	TOTAL
1970	$1,063,403	$1,944,149	$2,796,885
1971	1,114,012	2,312,640	3,598,924
1972	1,216,141	3,303,125	4,769,576
1973	1,412,268	3,820,190	5,330,026
1974	1,427,059	4,453,977	6,408,597
1975	1,508,822	4,682,368	7,108,354
1976	1,535,516	5,067,593	7,819,391
1977	1,591,725	5,476,075	8,231,313
1978 (est.)	1,648,250	5,557,500	7,851,634

MEMBERSHIP SUGGESTIONS FOR THURSDAY AFTERNOON SESSION

General Issue Statement	# of Times Suggested
Cost Containment	
• and the teaching hospital	15
• impact on hospital educational programs	7
• voluntary program update (teaching hospital role)	3
• state rate review and teaching hospitals: what's been the experience?	3
• update on federal legislation	2
• how to motivate the faculty on this issue	2
• federal vs. state controls	1
Health Planning	
• impact on teaching hospitals	16
• sharing CT scanners	1
• regionalization	1
Medical Center/Medical School-Teaching Hospital Relationships	
• medical school affiliation relationships (finance, organization, etc.)	9
• medical center organization, governance, mission and accountability	6
• VA hospital/dean's committee relationships	2
Ambulatory Care	
• meeting educational needs, yet being financially feasible	4
• one class service	1
• uniform coding of episodes of care for data base	1
Graduate Medical Education	
• financing graduate medical education	3
• future of free standing residency programs	2
• who's in charge?	2
• institutional distribution of residency positions	1
• implications of foreign medical graduate reduction	1
• changing composition of house staff: more women and minorities	1
• regulation or control of residency positions	1
• house staff productivity studies	1
• relationship between LCGME and residency review committees	1

	# of Times Suggested
Incentive Compensation For Full-Time Clinicians Or Hospital-Based Group Practice	6
National Health Insurance And Teaching Hospitals	4
HMO Implications For Teaching Hospitals	3
JCAH And The Teaching Hospital	3
Shared Services	3
Review of Public General Hospital Commission Report	2
Multi-Institutional Systems	2
Marketing The Teaching Hospital	2

Single Suggestion Items

Age Discrimination Regulations
Medicare Section 223 Ceilings
Proprietary Hospital Competition
COTH Comparative Data Gathering
Implications of Reduced Research Funding on Teaching Hospitals
Will Separation of Education From HEW Have An Effect?
COTH Role In Health Administration Education
Relationship of COTH/AAMC to the Association of Academic Health Centers
Town/Gown Conflicts
Financing Sepcial Care Services
Impact of Clinical Laboratory Improvement Act
Will M.D. Output Continue to Grow? Or Start To Decline?
Emergency Medical Services/ What Is the Academic Realationship in Teaching Hospitals?
Teaching Physician Reimbursement (Section 227)
Quality Assurance Problems
Cost Comparisons Between Teaching And Non-Teaching Hospitals
Studies of Case Mix Relationship to Cost

CHANGING FUNDING PATTERNS FOR FELLOWSHIP PROGRAMS

Support for Advanced Clinical Trainees

I. Statement of the Problem

A. Between 1972 and 1976 Advanced Clinical Trainees[1] increased approximately 35 percent.

B. Federal support for Advanced Clinical Trainees has been decreasing. Indications are that since 1972 Federal support has decreased at least 10 percent.

II. Factors Influencing the Problem

A. Traditional funding sources for Advanced Clinical Trainees include NIH, Federal Research Grants, V.A., Hospital Revenues, Clinical Department Funds, and Private Philanthropy. As Federal funding decreases, pressure is put on Clinical Departments and Hospitals to provide additional support.

B. Approximately 78 percent of University-Owned teaching hospitals have experienced reductions in NIH funding for Advanced Clinical Trainees.

C. Lack of clarity in the definition of the term "clinical fellow" has made data collection difficult.

D. The LCGME will no longer list "Fellowship" programs in their Directory of Accredited Residencies.

E. Cost containment programs which require hospitals to hold down charges will conflict with decreasing Federal funds for Advanced Clinical Trainees if teaching hospitals are required to absorb additional expenses for these trainees.

F. Demand for advanced clinical training positions will increase as medical schools attempt to meet Federal and state mandates for increased output of physicians.

III. Issues

A. Is it appropriate for the Federal Government to withdraw broadly

based tax dollar support for advanced clinical trainees and increase the cost to teaching hospital patients for these educational expenses?

B. If the Federal goal is to increase the number of positions to train primary care physicians, a decrease in funding to Advanced Clinical Trainees is contradictory. Advanced Clinical Trainees provide much of the training for physicians specializing in primary care, and therefore more Advanced Trainees will be necessary to provide the education for increasing numbers of primary care specialists.

C. Advanced Clinical Trainees provide significant amounts of patient care in teaching hospitals at a very low cost. Comparably trained physician manpower, hired as faculty physicians, would cost at least three times as much. Federal incentives to decrease Advanced Clinical Training Positions would therefore increase the cost of patient care significantly.

IV. Report on the April 1978 University of Alabama Hospitals Survey of Funding Sources for Fellowship programs in University-Owned Teaching Hospitals.

V. Alternatives for COTH Members

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[1]An Advanced Clinical Trainee is a physician who, having completed the training requirements for primary specialty certification, continues further training in a related subspecialty.

Management Contracts and the Teaching Hospital

It is important to note that professional hospital management companies do not have all the solutions to the problems facing the teaching hospitals. They do, however, have a legitimate role to play in improving the efficiency and quality of services from the teaching hospital.

The teaching hospital is unique, not only as compared to community hospitals but as compared with one another. Variances can be found in the areas of financial stability, educational and service activities provided, and relationships with their respective medical institutions. While some teaching hospitals are on reasonably sound financial and organizational footing, they still have something to gain from taking advantage of services offered by professional management corporations. Many times a full management contract is not required; an operational audit will clarify for the hospital administration the areas in need of improvement, and a consulting implementation project may be a more appropriate course of action by the teaching hospital.

By definition, the management contract is a contract which defines the obligation of the professional management corporation in the day to day activities of the hospital. The authority of the hospital's governing body remains intact, and the corporation acts as an executive director responsible for the operational management of the hospital. Under no circumstances does the corporation take responsibility for policy; rather, it works with the policy making body in developing and implementing reasonable and attainable goals and objectives for the hospital.

The management companies offer the teaching hospitals an ability to respond to the hospital as a system, a focusing of resources, a committment to implementation, proven knowledge and experience, performance accountability, operational continuity, an analytical pool of talent to perform cost studies, install new systems, acquire capital for new projects and offer a variety of services that no single institution can afford or retain on a hospital staff. They also offer the hospital the same long term concern for profitibility that they have for their own hospitals. Most importantly, they offer the ability of the institution to retain its unique identity while taking advantage of the multi-hospital system.

FEDERAL OR STATE RATE REGULATION?

The AHA, Dr. Heyssel, and others present very persuasive arguments that state regulation of hospital charges and/or budgets under "Federal Guidelines" is preferable to direct Federal regulation. Certainly the experience with state regulation in some states supports their position, but the experience in other states has led many to the opposite conclusion. Obviously, the degree of satisfaction with state regulation on the part of the regulated depends upon the individual experiences in the individual states and varies widely from state to state and even from institution to institution within a state. Based on my experience in Connecticut, I advocated Federal regulation over state regulation, however, when the courts there began to consistently overturn the arbitrary and capricious actions of the Connecticut regulatory agency and Carter and Califano proposed their "caps," I began to vacilate. . . and I continue to do so. At this point I have reached no firm conclusion in my own mind regarding the preferable approach, however, I think that there are significant points which can be made in favor of Federal regulation. These include:

1. In my opinion, state legislatures and the regulatory agencies they legislate are much more susceptible to the pressure of individuals and groups than is the case at the Federal level. This obviously can be an advantage as well as a disadvantage depending on whose viewpoints and pressures prevail. However, largely because of the diversity of the nation, I think that the opportunities for zealots to dictate and administer the regulatory program is significantly greater at the state level.

2. In general, and in full recognition of the dangers of generalities, I think that the quality and expertise of the staffs who administer programs at the Federal level are superior to those at the state level.

3. Inevitably, state regulatory programs will result in many inconsistencies among states unless they are under quite rigid Federal guidelines. This in turn will create special problems for those institutions whose service areas comprise more than one state or for those which are competing with institutions which are located in another state. If rigid Federal guidelines are applied, they could well be tantamount to direct Federal regulation. (Medicaid is a good example of a state administered program under Federal guidelines. I think most would agree that Medicare, despite its weaknesses, is a better and more equitably operated program).

4. I think that we will see significantly increased competition among state regulatory agencies as they try to outperform one another in holding costs down, and this can only be to the detriment of the regulated hospitals.

5. I think that the Federal Government will, over time, accept state regulation in regard to Federally funded programs only if state regulation produces a less costly result than what it thinks Federal regulation would produce.

6. Based on my experience the special nature and problems of teaching-tertiary care hospitals are better understood at the Federal level than they are at the state level.

Obviously, the quality and acceptability to the regulated of state regulation depends upon many considerations. These include the provisions of the enabling legislation, the quality of the staff of the regulatory agency and its level of financing, and the opportunities which are provided for a high degree of direct interaction between the regulator and the regulatees. Perhaps it is this last consideration which has made it appear that state regulation has been most palatable to the hospitals in relatively small, homogenous states with relatively few hospitals and less acceptable in larger, more diverse states.

Charles B. Womer

April 24, 1978

STATE-LEVEL REGULATION VERSUS FEDERAL REGULATION

Accepting the premise that some form of rate regulation is to be used as a means of controlling hospital costs, the question arises: "At what governmental level should regulation be conducted and what methods will be used?"

The central issue in rate regulation for hospitals must be how to set rates in a way that will neither overpay nor underpay, but which will provide incentives to increase the efficiency with which services are rendered. Specific objectives of regulation should include: (1) The establishment of rates that are related to the efficient production of quality services and the disallowance of excess costs that result from duplication of effort and inefficiency both with an individual hospital and between hospitals. (2) The establishment of rates that are set equitably for all classes of purchasers. (3) The recognition of general inflationary pressures on the basis of a meaningful health services-related index. (4) The establishment of rates that provide for the total costs of doing business including an allowance for bad debts and free work and an allowance for replacing plant and equipment at current costs.

Rate setting, however, is not merely the development of objectives and the establishment and application of methodologies but it is by its very nature a political process in which negotiation must be involved. Experience with regulation in other industries supports the notion that no matter how much legal authority is vested in regulatory agencies, a good percentage of important decisions

evolve through a formal hearing and negotiations process. In order to have effective rate regulation, a climate must be created in which healthy negotiations between the regulator and the regulated parties can take place. I would argue that this is doable at the state level, but experience to date would suggest this is not feasible at the federal level. A case in point would be the experience with the economic stabilization program in the early 1970's. Although there was technically a hearing and appeals process built into ESP, in practice, it never worked. Issues could not be negotiated, hardships were created through arbitrary regulations and the end result was a series of lawsuits which surfaced shortly before the demise of the program.

Another case in point is the Medicare caps on routine services which were based on per capita incomes by region. The premise was that per capita income by region should have direct bearing on hospital charges. Therefore, The Johns Hopkins Hospital in Baltimore had a cap established at a level of $70.00 less than university teaching hospitals in Washington, D.C., only 40 miles away. Ironically, the major differences in income between D.C. and Baltimore's SMSAs reflects the very high and stable per capita income of wealthy counties in the D.C. SMSA, populated primarily by federal workers! This represents an example of a case in which HEW could have established more reasonable criteria and more realistic groupings but failed to do so. More importantly, as a practical matter, an appeal had to call in question the methodology.

The regulation of the health care industry must deal with a

large number of institutions with great diversity in location, mission, size, quality of services and case mix, as well as differences in physical plant and equipment, financial reserves and endowments.

One could argue that regulation at the federal level would benefit from the existence of a much broader data base from which comparative methodologies based on reasonable groupings of like institutions could evolve. For example, theoretically from a national perspective it would be easy to deal with all major medical centers as one category in the establishment of reasonable costs for house staff. This might be difficult to do in a small state in which there was only one major medical center. To date certainly, however, no practical example of the advantage of federal regulation over state has been found.

Today some form of rate regulation currently exists in about half of the states although only about one dozen states have statutory programs. It is quite true that the overall success of state-based rate regulation has been marginal. It is no secret that a series of suits have evolved in New York and Connecticut. On the basis of the overall state-based experience, one could argue that the Federal government should step in because some states have failed and others have not taken the initiative to act. There are, however, a couple of very fine state models for rate regulation which have evolved - one of them being the Maryland Program. The Maryland Program which is based on prospective budget review in which hospitals are required to submit revenue and expense budgets

and projections of service volumes and which does provide incentives for efficient management could serve as a model for other states. The track record in Maryland has been good in terms of both the containment of the rate of cost increases and the development of a process that has provided for healthy exchanges of views and facts between the regulator and the regulated hospitals.

There is not adequate evidence from past experience or from proposed legislation to instill enough confidence to support rate regulation at the federal level. The arbitrary approach taken in the Hospital Cost Containment Act of 1977, for example, could place many institutions including university teaching institutions in fiscal jeopardy, with very little opportunity other than through the courts to seek relief.

Robert M. Heyssel

Implications of Academic Medical Centers Taking Responsibility For Graduate Medical Education

Report of the Ad Hoc Committee on Graduate Medical Education
of the Association of American Medical Colleges
October 1971

Implications of Academic Medical Centers Taking Responsibility for Graduate Medical Education

Following is the text of the report by the AAMC Ad Hoc Committee on Graduate Medical Education. The Committee was chaired by Thomas D. Kinney, M.D., Duke University. The members of the Committee are listed at the end of this report. A policy statement based on the report was adopted by the Association of American Medical Colleges Assembly October 30, 1971, during the Annual Meeting at Washington, D.C.

During the years since the end of World War II, the responsibilities of the academic medical center for all forms of clinical education and training have grown. Particularly, education and training programs for postdoctoral clinical students have become a major activity of these centers. Yet the relation of such programs to regulatory agencies independent of academic medical centers remains unchanged. Simultaneously problems of financing these programs have become much more involved. The resulting fragmentation of authority and responsibility has been deplored repeatedly. In 1965 the Association of American Medical Colleges (AAMC), in its report, *Planning for Medical Progress Through Education*, called for broadened university responsibility for graduate medical education (1). The American Medical Association (AMA) has also been deeply concerned with these developments. The two organizations, working in conjunction through the Liaison Committee on Medical Education, have determined to become involved in graduate medical education, initially through careful reexamination of procedures for accreditation of these programs.

In 1969 the AAMC published a report on *The Role of the University in Graduate Medical Education*, advocating less fragmentation of authority in this area and the focusing of responsibility in the university (2). Because of the major responsibility they are taking in graduate medical education, the constituent academic medical centers of the AAMC authorized this study of the implications of their responsibility for graduate medical education.

Definition

The study is directed toward the implications of the assumption by the academic center and its faculty of the total responsibilities and authority of an academic institution for all its students and programs in medical education. This implies that the faculty would collectively assume the responsibility for the education of clinical graduate students (interns, residents, and clinical fellows) in all departments and that the education of these students would no longer be the sole responsibility of groups of faculty oriented to individual departments or single areas of specialty practice.

(The use of the word "student" in this document requires definition. The individuals discussed here have received

their doctorates and are engaged in an intensive postdoctoral program of training to become specialists in one of the areas of medical practice. They basically are students but usually have important commitments to medical care and teaching. They are, therefore, in some sense practicing physicians and faculty members. There is usually no degree goal, but certification by a specialty board or public acceptance of specialty status are the rewards of this training. In view of these considerations, no single word accurately describes persons in this role; with these reservations, the word "student" will be used in this discussion.)

Advantages

Among the advantages inherent in vesting responsibility for graduate medical education in the entire medical center faculty rather than continuing departmental fragmentation are the following:

1. Easier implementation of the continuum concept in medical education.
2. More effective adaptation of programs to individual student's rates of progress through the educational process.
3. Fostering multiple methods for conducting graduate education and thereby enhancing innovation.
4. Enrichment of graduate medical education by bringing to it more of the resources of the university and its faculties.
5. Promoting the introduction of greater efficiency and flexibility in the use of faculty and facilities.
6. Enhancing the principle of determination over educational programs by the individual academic centers.
7. Promotion of a comprehensive pattern of medical training and practice.

Fragmentation of Responsibility

A further significant fact is that, despite often repeated disclaimers, specialty board certification does represent a second degree and is the significant license for almost all American physicians. The evidence for this allegation is all around us but is found most importantly in the attitudes and behavior of the persons in practice and of those who make hospital appointments and decide on professional reward systems, both pecuniary and nonpecuniary.

This state of affairs is a significant departure from the historical precedents for licensure to practice. In the usual formulation, civil government, because of its obligation to protect the people, grants to agencies which it controls the authority and responsibility to decide who shall be admitted to the practice of a profession. Such agencies characteristically have as their primary charge protection of the best interests of the people. In one fashion or another, through either appointment or election, in the United States they are answerable to state governments. This is not true of specialty boards, if they are indeed *de facto* licensing agencies. In current practice they are primarily responsible to their respective colleagues in their specialties. This is far removed from usually accepted concepts of the nature of civil license.

Graduate clinical training or graduate medical education is now carried out in highly variable clinical settings; and since clinical graduate students are frequently licensed physicians who are primarily in a learning role, the status of these students is often ambiguous. Classically, interns and residents are considered employees of hospitals, although medical schools or other professional groups may contribute to their stipends. Their status as hospital employees versus members of the academic medical center student body or staff often leads to ambiguities.

In the majority of instances, house

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officers are pursuing specialty board certification or publicly ascertainable qualification in one of the medical specialties. The duration, content, progress through training, and determination of eligibility for admission to the specialty board examinations are now determined largely by individual boards. Such boards are characteristically private, not-for-profit organizations with substantial autonomy. Academic institutions or hospitals have no direct influence on their policies or actions.

All internships are approved by the Internship Committee of the Council on Medical Education of the AMA. All residency programs are accredited by the residency review committees of the AMA, with the exception of pathology programs, which are examined and accredited by the American Board of Pathology. The residency review committees are made up of representatives appointed by the Council on Medical Education of the AMA from nominations submitted by the appropriate boards and colleges or academies. The residency review committees are autonomous except for matters of policy and do not have to report back to their parent organizations for ratification of their decisions. The graduate education section of the Council on Medical Education of the AMA provides secretarial assistance and administrative support for the operation of all residency review committees.

The concern of the Council on Medical Education for all facets of medical education is a matter of historical record. But in the area of graduate education, the Council has essentially no direct authority over either the boards or the residency review committees since both function independently and autonomously. In practice, however, its influence is significant. It should be noted that the AMA has its roots in the practice of medicine, and its policies will inevitably and properly always be strongly influenced by current conceptions of the interests of practicing physicians, whose direct contact with education has either ended or become a secondary part of their professional activity.

The individual to whom the resident is responsible is his service chief, program director, or departmental head. Such an individual always has a major hospital appointment, and his authority over a clinical service, and hence over its residents, relates to his role in the hospital. He may or may not have a university connection of significance, ranging from major to only ceremonial. This service chief has direct responsibility for the content of the program in accord with the requirements of the specialty boards and the residency review committees. Although service chiefs may work closely with members of their own departments, insofar as content and process of residency education, such chiefs have a considerable autonomy within broad policies.

The medical school or university, through its faculty members and affiliated hospitals, sponsors and influences a large segment of graduate medical education and accordingly should be considered for a more formal role in its design and operation. It has a very real authority, through its influence over hospital policies and the appointments of service chiefs, but it may or may not have real operational responsibility.

In summary, control of graduate medical education is fragmented among the following settings:

1. Hospitals, which employ trainees and provide the classrooms and laboratories for their education.

2. Specialty boards, which determine duration and a portion of the content of training and act as *de facto* licensing agencies.

3. Residency review committees, which accredit on a programmatic basis.

4. Service chiefs, who on a programmatic basis determine the balance of content and all of the process of graduate medical education.

5. Medical schools and universities, which exert considerable authority through the individuals whom they appoint but accept little direct operational responsibility as institutions.

Attributes of Current System

Today's system has consistently and reliably produced specialists well equipped to care for the disease-related problems of their areas of medical practice. In terms of its goals, the system has been an acceptably successful, pragmatic solution, adaptable to the variety of conditions found in so large and diverse a nation as the United States. These are the major strengths of this pluralistic system. If its goal, the replication of highly categorized specialists, were now acceptable in terms of public need, its ambiguities would be tolerable.

The degree of specialization which has been brought about by advancing knowledge has resulted in the evolution of an inordinately complex structure for graduate medical education. It is this complexity which has created demands for considering a more holistic approach to the total duration and content of medical education. Assumption of responsibility for graduate medical education by the entire faculty of the academic medical center could help provide this.

Unification of Responsibility

In many ways the situation in graduate medical education today is not unlike that of undergraduate medical education 70 years ago. It is widely recognized that the medical school and its parent university have assumed responsibility for the total program of undergraduate medical education. This was the significant reform of 1890 to 1925. The issues facing graduate medical education in the 1970s contain many striking parallels, and the solution being explored here has many features of that which worked so well for undergraduate medical education two generations ago.

In the 1960s, medical schools began major undergraduate curricular revisions. These efforts to make undergraduate education more responsive to perceived public needs are generally based on the assumption that the undergraduate educational process is preparing students to enter into a period of postdoctoral training. This combination of predoctoral and postdoctoral education finally produces the polished professional clinician. It now appears that the professional schools have as large a stake in the postdoctoral educational process as they have in the predoctoral.

Academic Center Responsibility

The responsibility which would be assigned to the academic medical center faculties may be enumerated as follows:

1. Determining educational objective and goals.

2. Establishing policies for the allocation of resources and facilities of the entire medical center to permit realization of these goals.

3. Appointment of faculty.

4. Selecting students.

5. Determining content, process, and length of educational program.

6. Evaluating each student's progress.

7. Designating completion of program.

These responsibilities for graduate medical education would be vested in the academic medical center and then would be delegated to its medical faculty and

teaching hospitals which in turn would create a program of educational advancement protecting the rights of students while responding to the requirements of society.

The medical faculty would have a concern for creating an appropriate environment for graduate medical education. Faculties would be responsible for selecting their fellow faculty members and for approving the design of programs in graduate medical education, including concern for the processes used, the duration and content of learning, and the coordination and interrelation between various units of the faculty. As a faculty, the members would have a voice in the selection of students and be concerned for their quality and number. They would also be expected to institute procedures which would allow them to determine their students' achievement of an appropriate educational level and their readiness to take examinations for certification by the appropriate specialty boards.

Implications of Responsibility

So many agencies and people would be affected by pulling today's fragmented responsibilities together and assigning to academic medical centers both the responsibility and authority for the graduate medical education now carried out in their spheres of influence that the only way to analyze implications of these changes is to look at the various forces involved one at a time.

THE UNIVERSITY

Administrative, financial, and organizational relations existing between parent universities and their academic medical centers would not be appreciably altered by this change. Long-range changes could be expected, and these will be touched upon in the following sections.

THE MEDICAL SCHOOL FACULTY

There would need to be relatively little immediate change in the day-to-day climate of the clinical faculties of medical schools. More significant would be the slow but predictable and desirable increase of interaction with other faculties in the medical center and the university at large. There would also be greater coordination of educational activity within the clinical faculty. Presumably, there would be more effective integration of various units of the medical center, both medical and nonmedical; and this integration could be expected to produce different educational and patient care alignments. Possibly, the medical faculty might develop course work, a credit system, and examinations similar to those now operated for undergraduate education.

These organizational patterns would likely precipitate decisions about which aspects of specialty training should precede and which should follow the M.D. degree. These questions must be faced in any event, and the recognition of medical education as a continuum—the responsibility of a single unified faculty—would be a great advantage.

THE GRADUATE SCHOOL

Assignment of responsibility to the academic medical center within a university would raise a consideration regarding the appropriateness of involvement of the graduate school. Although it is conceivable that the graduate school could be the assigned area of such programs, graduate clinical education is so eminently the business of physicians that it makes little sense to locate it in a general university graduate school rather than retaining it in the medical center setting.

DEGREES

The issue of advanced and intermediate degrees in medicine is not trivial. Residents now get unimportant pieces of paper from hospitals (certificates of service) and an important piece of paper from specialty boards (certification of specialty status). The advanced clinical degree has not caught on in this country despite its trial, especially in Minnesota, and despite practices abroad. The envisioned arrangement would probably result in some formal recognition of the end of the graduate educational sequence. A degree pattern of some sort might emerge in time, probably in an uncoordinated fashion from school to school. As an obstacle to a new plan or organization, the degree issue need not be settled early. Any move to imperil the strength of the M.D. degree would be very strenuously resisted. The public has a firm impression of the meaning of the M.D. degree, and any change that might alter its significance should be considered with circumspection.

HOSPITALS

Here truly significant problems may emerge. The major educational program of a hospital would become the responsibility of an agency that in some instances would be external to the hospital and governed by a different board. This is a significant shift, and it can be expected that hospitals everywhere will analyze this implication with their own interests in mind, as is only proper. The realities of getting a group of community hospitals or a community and university hospital to organize a single unified educational program will call for intensive bargaining. It can be predicted that there will be orders of difficulty, from least in a situation in which hospital and medical school are jointly owned and administered by a single board to most where hospital ownership, operation, financing, and location are all separate. As far as financing goes, there would be few differences from today's practices. Organizationally, there might be shifts in the influence of single departments. Operationally, this might emerge as another force toward more comprehensive medical care. In terms of accreditation or approval, the hospital educational program would be approved as a unit. This would mean the number, duration, type of training, and coordination of training offered would be returned to the local control of the joint medical school–hospital faculty.

NONAFFILIATED HOSPITALS

Although the academic medical center initially would assume responsibility for the graduate education of physicians in only its affiliated hospitals, ultimately the need for the center's influence on graduate programs in nonaffiliated hospitals would be necessary for several reasons:

1. A considerable segment of all graduate education is now conducted in nonaffiliated hospitals.

2. Academic medical centers and their affiliated hospitals cannot educate effectively the total number and type of physicians required.

The relationship created might vary from one institution to another depending upon the educational capability of the nonaffiliated hospital, the financial support required, and the desire of the nonaffiliated hospital to participate in an educational program designed and, in large measure, directed by a faculty not totally congruous with its existing medical staff. All such arrangements for cooperative or integrated efforts would be com-

pletely voluntary and obviously to the advantage of both institutions.

THE STUDENT

At first, there would be very few changes for the people in training. However, more ready access to other departments, readier availability of the resources of other units of the medical center and the university, and better coordination of training could be expected to lead to stronger, shorter, and more varied educational programs. These would all eventually work to the advantage of the students, and this must be seen as one of the major benefits expected from the change. Admission to, progress through, and certification of completion of training would become more formal, less casual, and more subject to regular academic procedures.

FINANCING

There is obviously a cost involved in graduate medical education. For years this cost has been absorbed by residents through deferral of earnings, by the clinical faculties through donation of their time, and by the patients through direct charges for hospital services. This system is now challenged by everyone: the residents in their demand for higher salaries, the faculties through the emergence of the full-time system, and the patients who through large third-party payers are challenging the inclusion of any educational costs in charges to patients.

The organization of graduate clinical faculties as a whole rather than solely as departments would have no direct effect on these issues, except for their probable clarification. Expenses should not increase except as academic functions increase. The emerging acceptance of the need to fund service functions by beneficiaries of these services will shortly bring to a head responsibility for funding of the educational component of clinical graduate training. The academic medical center will be unable to assume this burden unless it in turn is financed. The general trend to spread costs of higher education widely through society by any of a number of mechanisms is seen as the only way to handle this issue.

SPECIALTY BOARDS

The role of the specialty boards would change primarily toward their becoming certifying agencies not exercising direct control over duration or content of training. This again also seems to be a change which in one form or another is clearly on us. The boards would continue to have a major role in graduate medical education through the establishment of achievement criteria, the design and provision of examinations, and the certifying of candidates who complete them successfully.

EXTERNAL ACCREDITING AGENCIES

The Liaison Committee on Medical Education, the Council on Medical Education of the AMA, residency review committees, and the Joint Commission on Hospital Accreditation are examples of external accrediting agencies. This function must be carried out in order to protect the public. One of the fundamentals surrounding this proposed assumption of responsibility by academic medical centers is that the centers, in matters pertaining to accreditation, would relate to a single external agency and be accredited by it. The proposed Commission on Medical Education is an effort to create such an agency at this time. Its emergence remains in doubt; but if these changes come about, the academic medical centers would need and would indeed demand the organization of a single,

external accrediting and standard-maintaining body rather than being answerable to many as they are today. The Liaison Committee on Medical Education is already taking some steps to assure greater responsibility for accreditation in graduate medical education through expanding and broadening its membership.

PATIENTS AND CONSUMERS

No immediate effect on patients and consumers can be predicted at this time. However, since the *raison d'etre* of the whole health care and health education system is to serve the people, the vitality of all phases of medical education must eventually provide individuals and services for the people. Public input is desirable and has been proposed at a national level. The degree and the mechanisms for public input should be locally determined by each medical center.

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GUIDELINES FOR ACADEMIC MEDICAL CENTERS PLANNING TO ASSUME INSTITUTIONAL RESPONSIBILITY FOR GRADUATE MEDICAL EDUCATION

A Report From the Graduate Medical Education Committee
Association of American Medical Colleges

1973

GUIDELINES FOR ACADEMIC MEDICAL CENTERS PLANNING TO ASSUME INSTITUTIONAL RESPONSIBILITY FOR GRADUATE MEDICAL EDUCATION

CONTENTS

FOREWORD

The Assembly of the AAMC approved a statement in November of 1971 urging that the academic medical centers assume institutional responsibility for graduate medical education. These guidelines have been developed to assist those faculties that are seeking to develop a plan for institutional assumption of responsibility for the various internship and residency programs in their academic centers.

In developing this document, the Graduate Medical Education Committee and the staff drew heavily upon earlier committee reports. These are mentioned in the Historical Summary and should be referred to by faculties and their planning committees. The Historical Summary also sets forth the rapid and accelerating change in graduate medical education in the United States.

Because the rate of change in graduate medical education has been paralleled by an increasing complexity of academic medical centers, it has been necessary to keep these guidelines broad. Major conceptual ideas for which policies and administrative detail must be developed are set forth. It is not intended that a single best solution be promulgated, or that these guidelines be considered firm requirements.

The value of these guidelines will be enhanced if the specific problems which are met and resolved (or not resolved) by the institutions as they attempt to meet the Assembly's challenge are communicated on a national level. From the aggregate experience plans for specific studies in national policy development can be derived.

I. INTRODUCTION

Graduate medical education is the process that differentiates the multipotential holder of the M.D. degree into a competent, professional physician who has the requisite knowledge, skills and judgement to begin a lifelong career of service and learning in a delimited area of medical practice.

This document sets forth guidelines for the development of overall institutional responsibility for graduate medical education. It is particularly directed towards academic medical centers with medical schools conducting undergraduate programs leading to the M.D. degree, but it has broad applicability to all institutions conducting programs for the graduate education and training of medical specialists.

II. HISTORICAL SUMMARY

Attaining the M.D. degree now signifies that the recipient is prepared for further education rather than for an independent professional career. The degree is a benchmark of transition from the first phase of formal medical education to the second. In the first phase the goal is to educate and train students in the basic and clinical sciences to the point that they are capable of obtaining clinical, social, and cultural data from a variety of patients; are able to assimilate and record these data in a logical and coherent fashion and

correlate this information, to a limited degree, with the existing body of biomedical, scientific knowledge in arriving at diagnostic and therapeutic decisions. As the body of knowledge has grown and the skills for collecting data and providing therapy have become more and more complex, the undergraduate phase of medical education and training has been complemented by a formalized graduate phase.

This phase, largely based upon direct responsibility for patient care, has developed as an apprenticeship system, supervised and controlled by each specialty discipline. National standards for accreditation of graduate programs and for certification of individuals by examination have been evolved by each specialty. Directors for each specialty graduate program are principally guided by these national standards.

In general the system has been successful and has produced highly trained and skilled specialists. However, the reliance on national policies, established solely by specialists in each discipline, for accreditation and certification has not been optimally responsive to societal needs and has produced a relatively inflexible graduate medical educational system which tends to neglect the variations in residents, institutional characteristics, institutional missions and national and regional health service needs.

The nation's medical schools are now providing staff and facilities for the graduate education of 80% of their M.D.

recipients. Therefore, these institutions and their affiliated teaching hospitals should properly assume a larger degree of responsibility for the conceptual development of the graduate phase of medical education and for setting the standards of accomplishment for the students whom they educate and train.

Granting the M.D. degree has been the responsibility of academic institutions for the past fifty years. The assumption of this responsibility terminated the era when medical education was controlled largely by the practicing profession. As a result, new standards derived from the broad perspective of the universities promoted an adherence to excellence in scientific and clinical education and created institutions capable of scientific investigation and the application of new biomedical knowledge to medicine.

Medical schools, as they became components of universities, established their medical educational programs by achieveing a consensus of the entire faculty of the school. This involved both basic scientists and clinicians. Criteria for student selection and standards for promotion and graduation also were considered to be a responsibility of the entire faculty. While constrained to a degree by state licensure laws, accreditation standards, and the "conventional wisdom" of the medical establishment, schools could develop special curricula and instructional techniques peculiarly suited to their students, their resources, and the needs of their communities or regions. Until the mid-50's, few schools made sig-

nificant experiments in modifying the conventional (i.e., 2 basic science years, 2 clinical years) mode of the traditional four-year undergraduate education for the M.D. degree. During the past fifteen years, and particularly during the past five, new approaches to undergraduate education have been common. The forces promoting curricular experimentation are complex, and they vary from one institution to another. The opportunity to depart from tradition is in large measure afforded by the willingness of the accrediting agency (the Liaison Committee on Medical Education), state examining boards and other public agencies to trust that the "corporate wisdom" of the entire faculty of a medical school will assure maintenance of basic and fundamental academic standards. This trust has been enhanced by the emergence of large full-time faculties in both the clinical and basic science departments. These faculties are considered to be of such high quality that they can be permitted a large degree of institutional self-determination for undergraduate medical education.

During the period when undergraduate education was traditional and essentially standardized, and most M.D. recipients entered practice after one year of internship, the purpose of graduate medical education was to produce a few qualified specialists in those clinical areas which required detailed knowledge and skills not ordinarily provided in the formal medical education program. It is not surprising that the first four boards established during the period from 1916

to 1932 were in Ophthalmology, Otolaryngology, Obstetrics and Gynecology, Dermatology and Syphilology. Individuals in these disciplines, concerned with assuring high standards of education and training for those who called themselves specialists, promoted the establishment of Boards to lay down national standards for program length and content and national examinations to assure the competence of those certified as specialists.

Reliance upon rather rigid standards for program characteristics and individual certification was necessitated by the diversity of settings for graduate medical education. Hospitals, both those affiliated with and not affiliated with medical schools, were the institutions for graduate medical education; and in either setting, the program for each specialty discipline was considered the sole responsibility of the specialists involved in that discipline. A broad institutional responsibility for graduate education, similar to that taken by the entire faculty for undergraduate medical education, did not evolve, even as the number of specialty Boards increased and as the setting for graduate medical education moved more and more into the academic environment of the medical schools.

While initially graduate education was largely conducted by full-time practitioner-specialists in the context of their own practice, the development of full-time, clinician-academicians in medical schools gradually moved the major responsibility for graduate medical education into the province

of academic medicine. Students promoted this transition by preferentially choosing programs established in academic settings over those lacking academic affiliations. During the past decade, Board members have been increasingly drawn from physicians in the academic environment.

In 1966 the AMA-sponsored Citizens' Commission on Graduate Medical Education, recognizing the significant engagement of academic medical centers with graduate medical education, recommended that the universities assume full responsibility for all of graduate medical education in the nation.[1] In 1968 the Council of Academic Societies of the AAMC published a report of a major conference on "The Role of the University in Graduate Medical Education." This report pointed out that although the setting for graduate medical education had shifted into the academic medical centers, there was insufficient recognition that these graduate programs were now a major responsibility of these institutions.[2] In 1971 the Assembly of the AAMC approved a statement urging the constituent members of the Association to assume responsibility for graduate medical education in a manner analogous to their assumption of responsibility for undergraduate medical education.[3,4]

The foregoing has related the movement of graduate medical education into the academic environment largely to the development of full-time clinical faculties and to student preference for the academic setting. Several other factors have been operant in this evolution.

The explosion in biomedical knowledge and technology largely is a product of the university-based medical school, and the most comprehensive exposure to this new information can be gained at the university centers. University centers have also commanded more resources for procuring advanced equipment and specialized personnel. While such expenditures have generally been for research purposes, the opportunity to learn the latest methodologies for patient care has been provided to graduate medical students in these settings.

Training programs supported by federal funds have largely gone to university-based medical centers. Thus, direct support for individuals seeking graduate education has been more available in programs directed by full-time, academic clinicians.

The ascendancy of graduate programs in the academic institutions has been significantly related to external forces, particularly those promoting research and increased specialism in medicine. The institutions, either individually or in the aggregate, have only recently realized that they must become concerned with the impact of their large graduate medical education commitments, on their resources and upon the characteristics and quality of medical practice in their communities and the nation.

During the past several years, significant changes have begun to develop in the national approach to accreditation of graduate programs and the certification of specialists.

These changes can provide opportunities for the faculties of graduate medical educational institutions to move toward a broader responsibility.

In the accreditation arena, the formation of the Coordinating Council on Medical Education and the Liaison Committee on Graduate Medical Education has established for the first time an opportunity for five major national organizations to participate in remodeling the accreditation of both undergraduate and graduate medical education. The parent organizations are: the American Medical Association, the Association of American Medical Colleges, the American Board of Medical Specialties, the American Hospital Association and the Council of Medical Specialty Societies. These provide for broad input into both the Coordinating Council and the Liaison Committee on both undergraduate and graduate medical education. It is likely that proposals for innovative improvements in educational programs will receive interested and sympathetic attention by these newly-formed bodies.

During the past decade, the specialty Boards have been seeking to improve their certification procedures for individuals. Increasingly they have turned to the National Board of Medical Examiners for advice and assistance. The National Board, recognizing that rapid changes are occurring in both undergraduate and graduate medical education, is in the process of reorganizing itself so that it can provide more effec-

tive service for certifying that recipients of the M.D. degree are prepared for entering graduate education and also assisting the Boards in developing assessment systems of high quality and validity.

In the discussion and debates which have led to the establishment of a new accrediting system and the reorganization of the National Board of Medical Examiners, it has been repeatedly emphasized by many who participated that the institutions of higher education which conduct programs for the education of physicians must assume greater responsibility for the quality of all programs conducted under their aegis. Further, there is general recognition that in a complex, pluralistic society, national agencies cannot effectively oversee either accreditation or certification without delegating responsibility to institutions which are dedicated to maintaining and improving quality.

At this point in time, the reorganization which has been accomplished on the national scene provides both an opportunity and a challenge to the academic medical centers to assume greater responsibility for and greater authority over graduate medical education.

III. GUIDELINES

A. DEFINITIONS

1. Graduate medical education is that period in the formal education and training of a physician which usually fol-

lows the granting of the M.D. degree and culminates in qualifying for certification in a specific clinical discipline. Certification is obtained by the satisfactory completion of a program of education and training, and passing an examination or examinations conceived and administered by a national body (Board) representing the discipline.

2. Graduate medical students are individuals, usually with an M.D. degree, who are enrolled in a graduate medical institution and are pursuing education and training in a program leading to certification in a clinical discipline. The traditional titles "intern", "resident", "clinical fellow" or "house officer" recognize the hospital-physician role of these individuals. Although such titles do not convey their semi-student status or their role in health care delivery outside the conventional hospital setting, the titles "resident" or "clinical fellow" are widely understood and are preferable to "student" or "trainee".

3. A graduate medical education program is a complete educational and training experience which prepares residents to assume independent responsibility for patient care in a specific clinical discipline.

4. The graduate medical education faculty in an institution ordinarily should include all the full-time and part-time faculty normally responsible for undergraduate medical education. The need to incorporate learning opportunities in the basic sciences into graduate programs will provide a

special challenge to the basic science faculty and their clinical colleagues. Institutions utilizing part-time clinician-teachers are encouraged to provide these individuals with appropriate input into program planning and appropriate recognition.

5. Academic medical centers with institutional responsibility for graduate medical education are institutions or institutional consortia which provide the spectrum of scientific and clinical faculty, the facilities, and the administrative capability necessary to plan, conduct and evaluate graduate education and training based upon policies and goals derived on an institution-wide basis.

B. THE INSTITUTIONAL SETTING

1. Introduction

Graduate medical education requires a special institutional setting. Academic medical centers planning to assume responsibility for graduate medical education must recognize the need for an institutional system capable of delivering health-care services, ranging from primary to tertiary, in a variety of settings.

In developing the health services appropriate for graduate programs, the centers will need to encourage the participation of individuals, institutions and agencies having primarily a service commitment, but willing to make a commitment to the academic mission. The new institutional form

derived from this amalgamation will have both special characteristics and special problems which may require changes in the conventional management and governing policies of either the academic or the health service institution. The academic programs and the service programs must be blended. The faculty must be composed of individuals with a variety of academic and professional capabilities; and as a faculty, must be capable of recognizing the contribution of all its segments to the common goals of education, service, and research.

Financing, although derived from multiple sources, must be apportioned to assure that the various missions of the institution remain in dynamic and effective balance.

2. Governance

a. Role of the Governing Board. The academic medical center which broadens its responsibilities to include graduate medical education must be cognizant of the need for a governing board made up of individuals who can understand its special problems and make policy decisions which range from those related to academic governance to those required in the institutional delivery of health care services. Where the academic center is a consortium of institutions with their own governing boards, a governance mechanism representing all institutions should be established to implement policy decisions related to the overall educational mission of the center and to articulate these policies with the service missions of the several constituent institutions.

The provision of health services to the community is essential for accomplishing the graduate medical education mission, and the board must be sensitive to the needs of the community for health services. There should be provisions made for input to the board from recipients of these services.

b. Role of the Faculty. Faculty should be responsible for policy development and program review of all facets of graduate medical education. Faculty from both basic and clinical academic departments should expect to contribute to the teaching programs of the various disciplines. In most institutions, mechanisms for ensuring that the faculty exercises this responsibility have been well developed for the undergraduate program leading to the M.D. degree. Because of the greater complexity of graduate education, it is particularly important that broad participation of members of the faculty, ranging from basic scientists to practicing clinicians, be engaged in setting standards for student selection, reviewing and approving curriculum plans, assessing the validity of resident evaluation procedures, and ratifying the graduation of residents from various graduate medical programs. This will necessitate establishing a multidisciplinary review system for each graduate program. An overall faculty committee for broad policy development and the adjudication of disagreements will surely be needed.

c. Role of the Residents and Fellows. Because residents and fellows are expected to educate and train those junior to

them and are also expected to share in the supervision of patient care provided by those with lesser experience, they should be provided appropriate involvement in the affairs of the institution. This involvement should be particularly directed toward enhancing their teaching and supervisory skills.

3. Administrative Arrangements

Administrative systems will vary depending upon the size and complexity of the academic medical center. The importance of providing for the following relationships is emphasized:

a. The ultimate responsibility and authority for the educational programs of the academic center should be lodged with an individual who has direct access to, and is also responsible to, the governing board. When the graduate medical institution is a consortium of institutions, the relationship of this administrative officer to each institutional member should be explicitly stated.

b. The undergraduate and graduate medical education programs should be administratively linked.

c. Because of the differential nature of graduate medical education, the specific programs leading to different disciplinary careers should be planned and implemented by faculty members specifically responsible for each program. However, the autonomous discretion of these program directors should be limited. The individual with overall responsibility for the center's educational programs should have administrative authority over each program director and should assure

that the selection of students, appointment of faculty, development of curricula, assessment of residents, evaluation of the educational process and outcomes and the commitment of resources for all programs are commensurate with the polcies for graduate medical education established by the entire faculty.

d. Because administering a health services delivery system is a complex task, it is likely that an individual with particular skills will be delegated this task. It is extremely important that this individual and his staff understand the interdependence of the service and educational programs of the center and that he be a member of the team of individuals responsible for the educational mission.

C. RESIDENT SELECTION, EVALUATION OF PROGRESS AND GRADUATION

1. Selection

Residents selected should ordinarily have achieved the M.D. degree or its equivalent. This is not to be construed to interdict programs which coordinate their curricula with the undergraduate medical school curricula of students who have made early career decisions for a specific discipline. Specific criteria for selection for each program should be developed and approved by the general faculty or a representative body of the faculty.

2. Evaluation of Progress

a. General. Procedures for evaluation and reporting the progress of residents in each program should be developed.

These procedures should include an assessment of knowledge, skills, performance and judgement in the particular discipline pursued and an overall assessment of attitudinal development. No specific examination or rating system is recommended but evaluation should be carried out by faculty members both within and without the resident's discipline. There should be clear evidence that progress is periodically evaluated (at least annually) and reports of these evaluations should be on file in a central office of the institution. Provision should be made for regularly apprising residents of the faculty's evaluation of their progress. This feedback is essential. Evaluation reports should be utilized to verify that residents are ready to graduate and be certified as prepared for Board examinations.

b. Evaluation of Readiness for Increased Patient Care Responsibility. A fundamental educational technique of graduate medical education is caring for patients in a carefully supervised setting. As residents achieve increasing knowledge, skills and judgement, increased responsibility for making decisions and providing services is necessary. Faculty supervision of residents is an important and intricate matter. On one hand, failure to allow residents to grow into increasing responsibility inhibits their professional development, while on the other hand, permitting premature assumption of responsibility endangers patients and may encourage the development of undesirable attitudes and behaviors which will

prove detrimental far beyond the training years. This difficult problem of matching responsibility with achievement cannot be resolved by arbitrarily assuming that after fixed periods of time in a program, all residents are ready for similar levels of responsibility. Verifiable and auditable methods of determining readiness for the next level of patient-care responsibility should be developed. These may include reports of direct observations of residents in the patient-care setting by several faculty members, audits of a resident's patient records, the use of simulation techniques, and written or oral examinations to determine knowledge. Specific and measurable criteria should be determined in advance in order to achieve optimal evaluation.

3. Graduation

Certification that an individual is prepared for independent patient-care responsibility is a dual function shared by the graduate medical institution and the Boards. Graduation should be acknowledged by the awarding of a certificate which signifies that the entire faculty recognizes that the individual awarded the certificate has met all of the requirements set forth by that faculty. The institution should place the same stress on its public accountability for the awarding of such a certificate as do institutions of higher education in awarding advanced degrees.

Examination by the appropriate specialty board completes the certification procedure.

4. Resident Counseling

An advising and counseling service should be available to graduate medical residents.

D. CURRICULUM AND THE LEARNING ENVIRONMENT

1. Curriculum Development

It is recognized that each graduate discipline in medicine has its special body of knowledge and skills. Nevertheless, it is not necessary that all graduate programs in a discipline have either identical content or identical requirements for length of training. Broad guidelines indicating the expectations of achievement for professionals in each discipline are achieved through a national consensus and promulgated by the Boards. Program directors, faculty and residents are encouraged to develop their own curriculum for each discipline taught within the institution and to experiment with the development of new disciplines which can provide patient care more effectively.

In developing curricula, careful attention should be paid to the special distinctions which make each resident unique. These include prior educational background and cognitive, perceptual and manual skills. Opportunities should be provided to residents to plan a significant portion of their programs with the advice and counsel of faculty.

Effective performance in any specialized discipline of medicine is founded upon general knowledge and skills common

to all physicians. Undergraduate medical school curricula are designed to provide students with these basic skills. However, if residents have not had a sufficiently broad experience in the general clinical areas relevant to their specialty, this type of experience should be provided. The timing when residents in various disciplines achieve optimal basic knowledge and clinical skills is of lesser importance than ensuring that these skills are achieved before the residents are certified for graduation.

2. Balancing Service and Education

It has been repeatedly emphasized that graduate medical education is based upon the provision of personal health care services to patients. A willingness to serve patients is an important professional attitude for physicians. The obligation to provide patient services must be a part of the learning experience for all residents. Graduate medical residents are expected to assume increasing service loads as they grow and mature into their full professional roles, and must therefore willingly accept the responsibility of serving the needs of patients in all settings. This emphasis on patient service must not be construed as condoning excessive dependence by institutions upon residents and clinical fellows for the provision of patient services.

3. Continued Intellectual Growth

While learning in the setting of direct patient care is important in graduate medical education, it is essential to

balance the educational strategy with a similar emphasis on continued intellectual growth in biomedical knowledge. Residents should be taught how to continue to expand their fund of knowledge in an organized fashion while fulfilling the demands of accepting increasing responsibility for patient care.

The development of a learning environment which maintains residents' interest in the basic biomedical sciences during the graduate years is both an opportunity and a challenge for the faculties of academic medical centers. Basic scientists and clinicians should work together to maintain and stimulate the intellectual curiosity of these older, now differentiating residents. The instructional techniques for this group must be especially tailored. Adherence to the techniques which are effective for undifferentiated, undergraduate medical students frequently will not succeed.

Centers assuming responsibility for graduate medical education should plan to support enlarged basic science faculties and should seek to recruit basic scientists who can teach effectively in the clinical setting.

E. FINANCING

1. Institutional Financing

Institutions seeking accreditation for graduate medical education must receive sufficient financial resources to support educational programs so that administrators

and faculty with primary responsibility for education can devote their principal energies to conducting the various programs.

Because teaching and practicing clinical medicine are inextricably related, it is expected that faculty having teaching responsibilities will also care for patients. Payment for professional services to patients delivered in the teaching setting by both faculty and residents is appropriate and essential. Funds so generated should be collected and managed in such a fashion that the financial needs of faculty, residents and educational programs are met effectively and fairly. This plan should be formally established, agreed to by the faculty, and its administration should be periodically reviewed by the governing board.

Residents and faculty both contribute to the services provided patients by hospitals. Hospitals providing facilities for graduate medical education must, therefore, contribute to the budget for graduate medical education.

2. Resident Financing

Because the graduate education and training of residents is long and the intensity of their responsibility precludes their earning extra income, the costs cannot be borne solely by most residents.

Residents, as they advance through their training, provide essential services to patients both on behalf of hospitals and their physician-teachers. The financing of resi-

dents should recognize these services, and income derived from both hospital charges and professional fees should be budgeted for their stipends.

F. GUIDELINES CONCERNED WITH RELATED ISSUES

1. Patient Records

Effective learning and effective evaluation of the learner in the clinical setting are dependent upon the excellence of patient record systems. Academic medical centers should make every effort to maintain high quality patient record systems. The goals should be:

a. To make the patient record an effective instrument for ensuring excellence in the provision of care to each individual patient.

b. To make the patient record an effective instrument for learning by displaying all data legibly and in a manner which assures that the rationale for each decision is clearly evident.

c. To make the patient record an effective instrument for evaluating the quality of performance of the resident by making the records auditable. Accomplishing an audit should not require extraordinary investment of time by the reviewer.

An optimal learning environment requires that the learners and their teachers participate directly in patient care and record their observations, opinions and decisions directly in the patient record.

2. Attitudinal Development

Graduate medical education has developed because of the need to provide specialized knowledge and skills to physicians in delimited areas of medical practice. This thrust has placed an emphasis on the attainment of such knowledge and skills, often to the exclusion of cultivating a professional awareness of the emotional needs and cultural characteristics of patients as individuals or as members of specific populations. Graduate medical institutions should be aware that an essential portion of their educational mission is the maintenance and cultivation of helping attitudes in their residents. Many institutions have available to them faculties in the behavioral sciences. These faculties are showing an increasing interest in participating in medical education and they should be encouraged. However, the faculty responsible for graduate medical education must assume primary responsibility for maintaining and cultivating an awareness of the physician's responsibility for encompassing all facets of patients' needs--physical, emotional and cultural.

3. Education With Other Health Professionals

Increasingly, physicians are dependent upon the knowledge and skills of other health professionals. Optimal provision of personal health services to an expanding population with increasing expectations for health care can only be met by the efficient utilization of all available talent. The period of graduate medical education provides special opportu-

nities for training physicians to work with other health professionals. Most academic medical centers are educating several types of health professionals other than physicians. In developing educational policy, curriculum, and instructional plans, members of the faculty responsible for other health professional programs should be consulted; and mechanisms for their meaningful input should be developed. In the graduate setting, differentiating physicians should learn to work with students in other health professions in the real context of patient care. Having residents develop an understanding of the special abilities of other health professionals, coupled with learning how to delegate responsibilities to those colleagues, should be a major goal.

4. Primary Patient Care

An emphasis on specialism in American medicine has resulted in a graduate medical education system focused principally on educating and training physicians for highly specialized roles in the treatment of disease. The generalist, prepared to assume primary responsibility for patients, has not received major attention. Institutions for graduate medical education are encouraged to experiment with the development of delivery systems and educational programs which will encourage a significant proportion of their residents to develop careers as primary care physicians.

5. Manpower Distribution by Specialty and Geographic Location

a. Specialty distribution:

Academic medical centers should plan their program in graduate medical education in accord with specialty manpower needs of both their regions and the nation. In a nation which is undergoing significant changes in its health care delivery system, projecting manpower needs requires complex planning technology. The geographic mobility of physicians further complicates local and regional forecasting. Institutions are urged to utilize resources available locally in developing manpower projections and to cooperate in national efforts to estimate the types of specialists needed in medicine.

b. Geographic distribution:

Solving the problems of getting physicians to settle and work in medically underserved areas is complicated. While there are many financial and cultural factors which influence physicians in their decisions for location, the professional experiences provided during their graduate education may be influential. Learning while caring for patients in well-run ambulatory settings remote from the acute-care teaching hospital may provide insights into the feasibility of establishing a practice in more remote areas. By extending graduate education opportunities into remote settings, academic medical centers will also provide opportunities for continued participation in medical education by physicians who choose to establish their practices in these areas.

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THE ESSENTIALS OF GRADUATE MEDICAL EDUCATION

prepared and submitted by the

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FOREWORD

THE COORDINATING COUNCIL ON MEDICAL EDUCATION AND ITS LIAISON COMMITTEES

The Coordinating Council on Medical Education (CCME)* was established in 1973 through the agreement of five sponsoring professional organizations. These are the Association of American Medical Colleges (AAMC), the American Board of Medical Specialties (ABMS), the American Hospital Association (AHA), the American Medical Association (AMA), and the Council of Medical Specialty Societies (CMSS). Each organization has three seats on the Council.

The Coordinating Council is responsible for coordinating the activities of the three Liaison Committees which have accreditation authority over the undergraduate, graduate, and continuing phases of medical education. The Council also reviews and perfects major policy recommendations and submits agreed-to changes in policy to the five sponsoring organizations, all of which must give approval to policies before they are implemented.

Accreditation of undergraduate medical education is the responsibility of the Liaison Committee on Medical Education (LCME), which was established in 1942. The Association of American Medical Colleges and the American Medical Association each have six seats on the LCME; in addition, there are two public members and a representative of the federal government.

The Liaison Committee on Graduate Medical Education (LCGME) was formally implemented in 1975. The Association of American Medical Colleges, the American Board of Medical Specialties and the American Medical Association each have four seats on the LCGME. The American Hospital Association and the Council of Medical Specialty Societies each have two seats. In addition, there are one public member, one resident physician member, and a representative of the federal government.

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*The address of the Coordinating Council is: Coordinating Council on Medical Education, Office of the Secretary, P.O. Box 7586, Chicago, Illinois 60610

The Liaison Committee on Continuing Medical Education (LCCME) was formally implemented in 1977. The American Medical Association has four seats on the LCCME. The Association of American Medical Colleges, the American Board of Medical Specialties, the American Hospital Association, and the Council of Medical Specialty Societies each have three seats. The Association of Hospital Medical Educators and the Federation of State Medical Boards each have one seat. In addition, there are one public member and a representative of the federal government.

Each Liaison Committee has accreditation policies and procedures germane to the phase of medical education for which it is responsible.

The Liaison Committee on Graduate Medical Education oversees the policies and procedures of the several Residency Review Committees (RRCs) and after review of RRC recommendations issues letters of accreditation to approved programs and their institutions. The LCGME is also responsible for the development of the policies set forth in the General Requirements for Graduate Medical Education and implements those policies after approval by the five sponsoring professional organizations.

The LCGME also reviews and approves the Special Requirements developed by each Residency Review Committee. The RRCs submit these to the LCGME after they have been reviewed and approved by the sponsors of the RRC. The Residency Review Committees and their sponsors are:

RRC	Sponsoring Organization
Allergy & Immunology	AMA Council on Medical Education American Board of Allergy & Immunology
Anesthesiology	AMA Council on Medical Education American Board of Anesthesiology
Colon & Rectal Surgery	AMA Council on Medical Education American Board of Colon & Rectal Surgery American College of Surgeons

RRC	Sponsoring Organization
Dermatology	AMA Council on Medical Education American Board of Dermatology
Family Practice	AMA Council on Medical Education American Board of Family Practice American Academy of Family Practice
General Practice	AMA Council on Medical Education American Academy of Family Practice
Internal Medicine	AMA Council on Medical Education American Board of Internal Medicine American College of Physicians
Neurological Surgery	AMA Council on Medical Education American Board of Neurological Surgery American College of Surgeons
Nuclear Medicine	AMA Council on Medical Education American Board of Nuclear Medicine
Obstetrics-Gynecology	AMA Council on Medical Education American Board of Obstetrics-Gynecology American College of Obstetrics-Gynecology
Ophthalmology	AMA Council on Medical Education American Board of Ophthalmology
Orthopedic Surgery	AMA Council on Medical Education American Board of Orthopedic Surgery American Academy of Orthopedic Surgery
Otolaryngology	AMA Council on Medical Education American Board of Otolaryngology American College of Surgeons
Pathology	AMA Council on Medical Education American Board of Pathology
Pediatrics	AMA Council on Medical Education American Board of Pediatrics American Academy of Pediatrics
Physical Medicine & Rehabilitation	AMA Council on Medical Education American Board of Physical Medicine & Rehabilitation

RRC	Sponsoring Organization
Plastic Surgery	AMA Council on Medical Education American Board of Plastic Surgery American College of Surgeons
Preventive Medicine	AMA Council on Medical Education American Board of Preventive Medicine
Psychiatry & Neurology	AMA Council on Medical Education American Board of Psychiatry & Neurology
Radiology	AMA Council on Medical Education American Board of Radiology
Surgery	AMA Council on Medical Education American Board of Surgery American College of Surgeons
Thoracic Surgery	AMA Council on Medical Education American College of Surgeons American Board of Thoracic Surgery
Urology	AMA Council on Medical Education American Board of Urology American College of Surgeons

ESSENTIALS OF GRADUATE MEDICAL EDUCATION

PREAMBLE

These Essentials of Graduate Medical Education set forth the requirements that institutions and programs sponsoring graduate medical education must meet in order to be accredited by the Liaison Committee on Graduate Medical Education (LCGME)* They are divided into (I) General Requirements, which delineate institutional responsibilities and broad general principles common to all programs in graduate medical education, and (II) the Special Requirements for each specialty. The Special Requirements detail the content and scope of education and training which must be provided by programs to physicians seeking to qualify for certification in a particular specialty.

Accreditation of Graduate Medical Education

Accreditation of institutions sponsoring graduate medical education is a voluntary service conducted by the Liaison Committee on Graduate Medical Education and the Residency Review Committees to ensure that they and the programs they offer meet acceptable standards of quality. The voluntary specialty certifying boards that are members of the American Board of Medical Specialties require that education and training qualifying individuals to seek certification in their specialties be obtained only in programs accredited by the LCGME. Exceptions to this requirement are occasionally granted by certifying boards on a case-by-case basis.

The Continuum of Medical Education

Undergraduate Education:

The education and training of physicians in the United States begins with their entrance into a school of medicine as candidates for the degree of Doctor of Medicine. The undergraduate phase,

*The address of the LCGME is: Liaison Committee on Graduate Medical Education, Office of the Secretary, 6th Floor, 535 North Dearborn Street, Chicago, Illinois 60610

which leads to the M.D. degree, is accredited by the Liaison Committee on Medical Education (LCME) and is preparatory for graduate medical education as indicated in this statement from the LCME's "Structure and Functions of a Medical School":

> *"The undergraduate period of medical education leading to the M.D. degree is no longer sufficient to prepare a student for independent medical practice without supplementation by a graduate training period which will vary in length depending upon the type of practice the student selects."*

During the undergraduate phase, students gain knowledge of the sciences basic to medicine and learn to apply that knowledge to clinical problems. Skills in collecting data are developed by interviewing and examining patients and applying laboratory procedures under the guidance and supervision of the faculty and residents. Students learn to utilize these data to arrive at diagnostic hypotheses and make therapeutic decisions. These basic skills are learned by rotations through a variety of clinical disciplines in both inpatient and outpatient settings. Undergraduate students have limited opportunities to assume personal responsibility for patient care, and do not participate in the care of individual patients for an extended period of time.

Graduate Education:

By the time the M.D. degree is awarded, most graduates have made decisions regarding their further professional development and enter the phase of their education which is termed graduate medical education with the intent to prepare themselves for the practice of medicine in a specialty. For most, this means completing the special educational requirements for certification by a specialty board. A few enter practice before meeting these requirements. Others, after completing the requirements of a primary board, enter into additional training in order to achieve recognition of special competence in a subspecialty.

Physicians who choose to pursue graduate medical education acknowledge their need for education and training beyond the minimum legal standard established by state and territorial laws and regulations, which generally permit physicians to be licensed upon completion of their first year of graduate medical education. The term "resident physicians" has been applied to those in clinical graduate medical education.

In the graduate phase, residents first assume limited, personal responsibility for patient care under the supervision of faculty physicians. The opportunity to learn about the variability of human beings in health and disease, and about their biological, psychological, and social problems is provided through direct and continuing responsibility in caring for many patients. Effective graduate medical education requires that residents gain knowledge, skill, and experience, and a progressive increase in their personal responsibility for patient care in a setting which always provides for systematic supervision by responsible faculty.

Continuing Medical Education:

Postgraduate or continuing medical education is the term applied to the phase of medical education which extends from the completion of formal graduate medical education throughout the professional life of physicians. It is based on a variety of educational strategies ranging from independent study through attendance at formal lectures and participation in seminars to medical audit.

Transition Between Undergraduate and Graduate Medical Education:

The transition from being an undergraduate medical student to the assumption as a resident of an increasing degree of personal responsibility for patient care is a critical period in the professional development of every physician.

This period is made even more critical because most residents are taking their first step toward differentiating into one of the

specialty careers available in the practice of medicine. Throughout the first year of graduate medical education (the G-1 year), special efforts should be made by the teaching staff to determine whether the career aspirations of residents are realistic, and whether they have a sufficient breadth of knowledge and experience to undertake education and training in their chosen field. Career counseling should be provided in order to ensure that residents are guided appropriately.

First year graduate medical (G-1) programs of two types are available to residents at the transition. These are:

Categorical: These G-1 programs are based on the special requirements of a specialty, are principally provided by the teaching staff of a single program, and predominantly provide an educational experience in that specialty. Rotations in other clinical areas may be permitted or expected.

Diversified: These G-1 programs are based on the special requirements of two or more specialties, are provided by the teaching staffs of two or more programs in an institution, and prepare residents to enter at the G-2 level of the specialties sponsoring the diversified program.

I. GENERAL REQUIREMENTS

1. Institutional Responsibility for Graduate Medical Education

The principal institutions which provide programs in graduate medical education are teaching hospitals and the medical schools with which they may be affiliated. Health-related organizations and agencies may also participate. Whatever the institutional form, the LCGME requires that there be a firm institution-wide commitment to medical education. The following policy statement was approved by the sponsoring professional organizations of the CCME in 1974.

> *"Institutions, organizations and agencies offering programs in graduate medical education must assume responsibility for the educational validity of all such programs. This responsibility includes assuring an administrative system which provides for management of resources dedicated to education and providing for involvement of teaching staff in selection of candidates, program planning, program review and evaluation of participants.*
>
> *While educational programs in the several fields of medicine properly differ from one another, as they do from one institution to another, institutions and their teaching staffs must insure that all programs offered are consistent with their goals and meet the standards set forth by them and by voluntary accrediting agencies.*
>
> *The governing boards, the administration, and the teaching staffs must recognize that engagement with graduate medical education creates obligations beyond the provision of safe and timely medical care. Resources and time must be provided for the proper discharge of these obligations. The teaching staff and administration, with review by the governing board, must (a) establish the general objectives of graduate medical education; (b) apportion residency and fellowship positions among the several programs offered; (c) review instructional plans for each specific program; (d) develop criteria for selection of candidates; (e) develop methods for evaluating, on a regular basis, the effectiveness of the programs and the competency of persons who are in the programs. Evaluation should include input from those in training.*

Facilities and teaching staff shall be appropriate and sufficient for effective accomplishment of the educational mission of each program. If outside facilities or staff are needed to fulfill program needs, the primary sponsor must maintain full responsibility for the quality of education provided."

Graduate medical education is conducted in institutional settings wherein there are invariably several missions. Providing clinical services of the highest quality must be the principal mission of hospitals and clinics sponsoring programs in graduate medical education. The range and scope of primary and ancillary clinical services must be sufficient to provide educational opportunities consistent with modern medical practice. All of those who use institutions and their resources for graduate medical education are expected to collaborate to ensure that all institutional missions are achieved, particularly excellence in patient care.

Institutions sponsoring programs in graduate medical education must undertake the educational mission fully aware that the education of resident physicians requires the provision of patient care by residents. However, a commitment to education must supercede any intent to expedite the provision of services. Patient care can be provided in the absence of an educational program, but a sound educational program necessitates involving residents in progressive levels of personal responsibility for patient care under supervision.

Accreditation of graduate medical education programs requires that institutions meet the standards set forth in these general requirements and that each specialty program meet the standards set forth in the special requirements for that specialty*

**Recognizing that the requirements for establishing institutional responsibility will necessitate considerable modification of present policies and procedures in most institutions, the LCGME intends to develop a phased program of implementation which will provide sufficient time to adapt to these new requirements.*

1.1 The LCGME requires that institutions sponsoring programs in graduate medical education provide documentary evidence of a commitment to medical education by:

a) the institutional governing board
b) the institutional administration
c) the teaching staff
d) the organized medical staff

This evidence shall consist of:

1.1.1 A written statement setting forth the purposes for which the institution sponsors graduate medical education. There must be tangible evidence of agreement to this statement by the teaching staff, the organized medical staff, and the administration. The statement must be agreed to and approved by the governing board.

1.1.2 A detailed plan which sets forth how institutional resources are organized and distributed for educational purposes. Such resources include teaching staff, patients, physical facilities and financial support. There must be clear evidence that the plan is agreed to by the administration, program directors, and the organized medical staff, and approved by the governing board. Those responsible for administration of the plan must be identified by name and title in the institution's table of organization.

1.1.3 An operational system, based on institutional policies, established and implemented for graduate medical education programs deemed appropriate for the institution to provide for:

a) the appointment of teaching staff;
b) the selection of residents
c) the apportionment of residents among programs;
d) the evaluation, promotion, and graduation of residents;
e) the development and publication of personnel policies applicable to residents;
f) the termination of residents whose performance is unsatisfactory;
g) the assurance of due process for residents and teaching staff.

These policies must be agreed to by the administration and teaching staff, incorporated in a manual of policies and procedures, and reviewed and approved by the governing board. Further, there must be clear evidence of adherence to these policies and procedures.

1.1.4 An operational system for periodic internal analysis of each sponsored program by the teaching staff, residents, and administration. Such analyses shall include critical appraisal of:

a) the goals and objectives of each program;
b) the instructional plan formulated to achieve these goals;
c) the effectiveness of each program in meeting its goals, including the performance of enrolled residents on examinations.

There must be clear evidence that analyses are effective, and that mechanisms exist to correct identified deficiencies.

Institutions sponsoring more than one program should provide administrative mechanisms for the coordination of the activities of the teaching staffs of all of the programs in the institution.

Documentation of items 1.1.1 through 1.1.4 must be maintained within the institution in some central place ready for periodic review by the LCGME and the RRCs through assigned site visitors. Evidence of failure by a program to comply with established and approved institutional policies will jeopardize the accreditation of that program. Evidence of institutional failure to implement its established policies will jeopardize the accreditation status of all programs.

When significant modifications in institutional policies, programs, or teaching staff occur between LCGME accreditation reviews, institutions must report the nature and magnitude of such changes to the LCGME.

1.2 Interinstitutional agreements: When the resources of two or more institutions are utilized for the conduct of one or more programs, each participating institution must demonstrate a commitment to graduate medical education and will be required to submit the evidence set forth in 1.1.1 through 1.1.4

The following items must be covered in interinstitutional agreements. Documentary evidence of agreements, approved by institutional

governing boards must be available for inspection by assigned site visitors.

1.2.1 Items of agreement:

a) Designation of program director: A single director for each program must be designated. The scope of the director's authority to direct and coordinate the program's activities must be clearly set forth in a written statement.

b) Teaching staff: The teaching staff responsible for providing the educational program and supervising the residents must be designated.

c) Educational contribution: The expected educational experiences to be provided by each institution to each program must be delineated.

d) Assignment of residents: The period of assignment of residents to the segment of a program provided by each institution and any priority of assignment must be set forth.

e) Financial commitment: Each institution's financial commitment to the direct support of each program must be specifically identified. Such commitment should include residents' stipends, reimbursement of teaching staff, and provision of monies for books, teaching equipment, etc. Agreements should provide for an equitable distribution of the financial support for all sponsored programs among the participating institutions.

f) Other: Fringe benefits and special privileges for residents should be as consistent as possible from institution to institution.

1.2.2 When several institutions participate in sponsoring multiple programs, administrative mechanisms should be developed to coordinate the overall educational mission and facilitate the accomplishment of the policies and procedures set forth in subsections 1.1 and 1.2.

1.3 Facilities and Resources: Institutional facilities and resources must be adequate to provide the educational experiences and opportunities set forth in the special requirements for each sponsored program. These include, but are not limited to, an adequate library providing access to standard reference texts and current journals, sufficient space for instructional exercises, adequate facilities for residents to carry out their patient care and personal educational responsibilities, and a patient record system which facilitates both good patient care and education.

1.4 Hospital Accreditation: Hospitals sponsoring or participating in programs of graduate medical education are expected to seek and attain accreditation by the Joint Commission on Accreditation of Hospitals. If a hospital is not so accredited, the reasons why accreditation was not sought or was denied must be explained and justified in the materials submitted for review by the RRCs and the LCGME.

2. *The Teaching Staff*

The individuals who have responsibility for the conduct of graduate medical education programs must be specifically identified. These should include physicians, basic scientists, and other health professionals.

2.1.1 The program director: The director should be recognized as highly skilled in the appropriate medical field, with a clear commitment to education and the advancement of knowledge. The director should have an institutional position which provides the authority and time needed to fulfill administrative and teaching responsibilities, and to achieve the educational goals of the program.

2.1.2 Teaching staff: The teaching staff should consist of members of the medical staff with institutional positions and those who voluntarily participate in the educational programs. They should be selected for their abilities to con-

tribute to the educational goals and objectives of the programs and should have sufficient time to discharge their responsibilities.

2.1.3 Other health professionals: Graduate medical education requires that the activities of all involved health professionals be integrated in the care of patients. The medical teaching staff with the primary responsibility for educational programs should involve other health professionals in its programs.

2.2 Relationships between medical staff and teaching staff: In some institutions the organized medical staff and the teaching staff are differentiated. Where this is the case, the institutional educational plan (1.1.2) must clearly delineate the agreements reached regarding the utilization of institutional resources for education. This must include agreement relating to the contact of residents and teaching staff with the patients of members of the organized medical staff not involved in the teaching program.

3. Resident Physicians

Resident physicians with the following qualifications are eligible to enroll in graduate medical education programs accredited by the LCGME.

3.1 Unrestricted eligibility: Unrestricted eligibility is accorded to those with the following qualifications:

3.1.1 Recipients of the M.D. degree granted by institutions in the U.S. and Canada accredited by the Liaison Committee on Medical Education (LCME).

3.1.2 Recipients of the D.O. degree granted by institutions in the U.S. accredited by the American Osteopathic Association, unless prohibited by Special Requirements.

3.1.3 Recipients of the M.D. degree (or its equivalent) from foreign medical schools not accredited by the LCME who meet the following additional qualifications:

a) Have been granted the privilege to practice medicine in the country of the institution granting the degree, have passed an examination designated as acceptable by the LCGME, and have had their credentials validated by an organization or agency acceptable to the LCGME; or,

b) Have a full and unrestricted license to practice medicine in a U.S. jurisdiction providing such licensure.

3.1.4 In the case of U.S. citizens:

a) Have successfully completed the licensure examination in a jurisdiction in which the law or regulations provide that a full and unrestricted license to practice will be granted after successful completion of a specified period of graduate medical education; or,

b) Have completed in an accredited U.S. college or university undergraduate premedical education of acceptable quality, have successfully completed all of the formal educational requirements of a foreign medical school, but have not been granted the privilege to practice medicine by the country in which the medical school is located by reason of not having completed a period of required service, and have passed an examination designated as acceptable by the LCGME.

3.2 Restricted eligibility: Restricted eligibility for foreign nationals to enroll in LCGME programs is accorded under the following circumstances:

a) When a U.S. medical school and one or more of its affiliated hospitals have a documented bilateral agreement, approved by an agency recognized for that purpose by the LCGME, with an official agency or recognized institution in the resident's country of origin to provide an educational program designed to prepare the resident to make specific contributions in the health field upon return to the country in which the sponsoring agency or institution is located; and,

b) The resident has been accorded the privilege to practice medicine in the country wherein the agency or institution making the agreement referred to in (a) is located; and,

c) The resident has passed examinations designated as acceptable by the LCGME for determination of professional preparedness and fluency in the English language; and,

d) The resident has made a formal commitment to return to the country in which the sponsoring agency or institution is located; and,

e) The credentials of the resident and the existence of a suitable agreement have been validated by an organization or agency acceptable to the LCGME.

Restricted eligibility shall be limited to the time necessary to complete the program agreed to by the parties as referenced in (a), without regard as to whether such agreement fulfills the requirements for certification by a specialty board.

3.3 The enrollment of non-eligibles: The enrollment of non-eligible residents may be cause for withdrawal of accreditation by the LCGME.

3.4 Selection and recruitment: It is expected that institutions and their sponsored programs will select residents with due consideration for their preparedness to enter into the graduate medical education programs that they have selected. Criteria for selection of residents should include personal characteristics as well as academic credentials.

In selecting G-1 residents, institutions are encouraged to participate in The National Intern and Resident Matching Program (NIRMP)*. Participating institutions should ensure that all of their sponsored programs adhere to the principles and policies established by NIRMP.

The NIRMP is a voluntary agency sponsored by: American Hospital Association, American Medical Association, American Protestant Hospital Association, Association of American Medical Colleges, Catholic Hospital Association, American Medical Student Association, and American Board of Medical Specialties.

The recruitment of residents by institutions and programs is premature when it causes students to make career decisions before they or their medical schools have been able to evaluate their interest in, or fitness for, a particular specialty; such early recruitment is strongly discouraged.

4. Relationships Between Institutions and Residents

Resident physicians are expected to have an unreserved commitment to the professional responsibilities expected of all physicians by society. Institutional policies relative to residents' responsibilities must be made available to applicants prior to their making a decision to seek enrollment in a sponsored program.

4.1 Residents' responsibilities: Being an enrolled resident physician in an accredited program of graduate medical education requires the assumption of responsibility for:

a) Participation in the institutional programs and activities involving the medical staff and adherence to established practices and procedures;

b) The provision of medical services, under supervision, to the patients who seek such services from the institution; and,

c) Participation in the formal instructional program presented by the teaching staff; and,

d) The supervision and instruction of medical students and more junior resident physicians; and,

e) The development of a personal program of self-study and professional growth.

4.2 Agreements with enrolled residents: There should be an individual written agreement between the institution and each resident enrolled in its sponsored program. Parties to this agreement should be the program director, the individual designated as having institutional authority, and the resident. The agreement should encompass the following:

4.2.1 Stipend: If a stipend is provided by or administratively managed by the institution, the annual stipend level and other benefits should be stated. The purpose for which the stipend is provided should be stated.

4.2.2 Programmatic requirements: The responsibilities of the resident in the educational program, including independent study, patient care responsibilities, on-call responsibilities, teaching and supervisory responsibilities, and periods of assignment to participating institutions should be detailed.

4.2.3 Evaluation and promotion: The institutional policies and procedures for evaluation and promotion of residents should be clearly stated and the rights of residents to due process in the review and determination of the adequacy of their performance should be delineated.

4.2.4 Other elements: The agreement should clearly state institutional policies for:

a) vacation, professional leave, and sick leave;
b) practice privileges outside the educational program;
c) malpractice coverage.

4.2.5 Individualized programs: Individualized educational plans, such as a reduced schedule or educational opportunities tailored to meet a resident's career development aspirations, must be specified. General agreements arrived at through any collective negotiation between residents and the institution must not inhibit the development of programs to meet the individual needs of residents.

4.3 Due Process: Institutions sponsoring graduate medical education programs must have a written procedure which provides an opportunity for residents to appeal actions by the staff or administration when such actions are perceived to threaten the resident's intended career development. This procedure must be agreed to by the teaching staff and administration and be reviewed and approved by the governing board.

4.4 Reporting requirements: Institutions sponsoring accredited programs in graduate medical education must report annually the names of individuals enrolled in their programs, the institutions from which they received their M.D. degree (or equivalent), the program in which they are currently enrolled, and the program in which they were enrolled for the previous year; in addition, institutions must report those individuals successfully completing their sponsored programs. These reports shall be supplied to the LCGME and to agencies designated by the LCGME as having responsibility for the recording of credit and the collection and analysis of data on physician manpower and development.

5. Relationships Between Teaching Staff and Residents

Medical education requires a collegial atmosphere wherein all who are involved have the common goals of serving the needs of the patients who seek care and advancing the quality of medical practice. The professional development of residents as they advance through the continuum of medical education requires that there be a relationship of mutual respect and understanding between and among them, their teachers, and those whom they themselves teach. Building such a relationship and maintaining such an atmosphere is preeminently the responsibility of the teaching staff. Institutional administrators and governing boards must support these policies and provide the resources needed to promote a harmonious educational environment.

5.1 Supervision: Graduate medical education must be based upon the assignment to residents of increasing levels of personal responsibility for patient care in accordance with their experience and growing competence. On the other hand, there must be continuous supervision of all residents at all levels at all times. The plan for supervision must provide for regular and systematic review of the actions and decisions made by residents through clinical rounds and tutorial sessions. Review of performance and progress must be provided to residents at frequent intervals. Residents who are insecure about their abilities to assume or discharge responsibilities

to patients have a professional obligation to request additional supervisory assistance at any time, and members of the teaching staff are obligated to respond promptly to such requests. The development of a supervisory relationship embodying mutual respect and trust is imperative. Residents who consistently fail to seek assistance when they are faced with problems beyond their abilities must demonstrate that they can respond to corrective action or, if need be, must be terminated from their program.

5.2 Teaching and learning: An environment wherein both the teaching staff and the residents are seeking to improve their knowledge and skills is essential. Senior residents are expected to assume responsibility for teaching junior residents and medical students. The teaching staff is expected to organize formal teaching sessions tailored to meet the special requirements of their sponsored programs. Participation in these sessions by teaching staff from other clinical specialties and by teaching staff from the basic science disciplines is encouraged.

5.3 Formative evaluation: Formative or "in-training" evaluation is encouraged. Evaluation instruments may be prepared by the teaching staff, or the "in-training" examinations developed by certifying boards or specialty societies may be used.

5.4 Evaluation conferences: Periodically, and at least annually, members of the teaching staff must organize conferences to evaluate the performance of each enrolled resident. Participants in these evaluation sessions should include the program's teaching staff, residents with supervisory responsibility for more junior residents, and teaching staff from other programs with which the residents interact. A summary of the evaluation of each resident's performance must be discussed with the resident.

Evaluation summaries must be kept on file by program directors and by the institutional administration. The summaries must be available for inspection by the LCGME through its assigned site visitors and be accessible to the resident.

COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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COTH GENERAL MEMBERSHIP
Memorandum #78-5
June 26, 1978
Subject: Papers Presented at the COTH Spring Meeting

A significant development of the Council of Teaching Hospitals has been a COTH Spring Meeting for chief executive officers. This year's meeting, which was held in early May in St. Louis, was very well received by those who could attend, and many requests were received for copies of those papers which were formally prepared and presented. To accommodate those requests and share this material with those unable to attend the meeting, the enclosed booklet reproduces four papers which stimulated much discussion and debate during the meetings. Hopefully, you'll find them stimulating and useful.

RICHARD M. KNAPP, PH.D.
Director
Department of Teaching Hospitals

Enclosure

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

COTH SPRING MEETING

FORMALLY PREPARED PAPERS

MAY 3-5, 1978 SHERATON ST. LOUIS HOTEL

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"THE HOSPITAL CHIEF EXECUTIVE LOOKS AT GRADUATE MEDICAL EDUCATION"

- Stuart J. Marylander
Executive Vice-President
Cedars-Sinai Medical Center

INTRODUCTION

As I have thought about this morning's topic, it has occurred to me that Dr. Swanson and I could proceed like the fable of the blind men and elephant. First, I would give you my views, then, he would give you his. And, given that each of us is significantly influenced by his previous experiences and institutional positions, you, the audience, might fairly conclude that two papers with similar sounding topics had very little in common. Such an outcome would be self-defeating. Therefore, hopefully Dr. Swanson and I will focus our ideas on a single, oftentimes controversial, aspect of graduate medical education: institutional responsibility for graduate medical education.

BACKGROUND

In preparation for this session, I have reviewed several AAMC documents which advocate institutional responsibility for graduate medical education. I have also reviewed the new draft "Essentials" for approved residencies which are being considered by the LCGME and which were developed by a committee chaired by Dr. Swanson. Two conclusions may be clearly and fairly drawn.

First, while the AAMC has advocated institutional responsibility for graduate medical education, the location of that institutional responsibility has undergone something of a change in the past ten years.

My second conclusion, drawn from reviewing statements and papers on institutional responsibility, is that reorganization of responsibility for graduate medical education has proceeded at a snail's pace in the past decade.

In 1965, Dr. Lowell T. Coggeshall's report, "Planning for Medical Progress Through Education", organized and supported by the AAMC, advocated a broadened university responsibility for graduate medical education. In 1969, the AAMC report on "The Role of the University in Graduate Medical Education" advocated placing the responsibility for graduate medical education in the university. This position was more formally stated in 1971 when the AAMC assembly approved a policy statement urging that academic medical centers assume responsibility for graduate medical education. In the 1973 guidelines developed to support that policy position, the statement is made that "the nation's medical schools are now providing staff and facilities for the graduate education of 80% of their MD recipients. Therefore, these institutions and their affiliated teaching hospitals should properly assume a large degree of responsibility for the conceptual development of the graduate phase of medical education and for setting the standards of accomplishment for the students whom they educate and train."

Clearly, for almost a decade, the emphasis in statements on institutional responsibility focused on making the medical school the responsible institution. The recently proposed LCGME "Essentials" take a somewhat different position. They state that "The principal institutions which provide programs in graduate medical education are teaching hospitals and the medical schools with which they may be affiliated . . . Whatever the institutional form, the LCGME requires that there be a firm institution-wide commitment to medical education". Here, teaching hospitals are placed on an equal footing with medical schools. Thus, it is less clear that those advocating institutional responsibility are simultaneously advocating medical school responsibility for graduate medical education.

Returning to the second conclusion, that our organization of responsibility for graduate medical education has proceeded at a snail's pace in the past decade, I draw on Dr. Swanson's JME "Datagram" of 1975 which reports that at most 62 of 103 responding academic medical centers might probably proceed to assume institutional responsibility for medical education. Frankly, as I look across the nation and speak with my counterparts in other areas, I believe few of even these sixty-two have implemented institutional responsibility organized around the academic medical center. In fact, I suspect that this slow progress underlies the LCGME's perceived need to make a more definitive statement on this matter. With as much written and advocated and so little accomplished, this state of affairs may well be the consequence of institutional tendencies to perpetrate the status quo. Or, it may well be that a change is needed in the concept of institutional responsibility to give it meaning, vibrance, and reality. To better understand this need for change in the concept of institutional responsibility, let's take a look at where we are now and how we got here.

It seems that, until very recently, the positions advocated by Abraham Flexner have dominated virtually all the thinking and discussions on the subject of medical education. For having found undergraduate medical education in a disastrous state, Flexner essentially promoted changing the location of its responsibility from the practicing physician and his proprietary school to the university-affiliated medical schools. Many who advocate that the academic medical center, dominated by its medical school, assume the responsibility for graduate medical education seem to believe that they are bringing the Flexnerian solution to graduate medical education. So was the position taken by the Coggeshall report referred to earlier.

However, with all due deference to Dr. Coggeshall, his concept of even greater return to the Flexner model is probably more idealistic than realistic. Similarly, his exhortation for the medical school to provide the leadership to the entire university may not be greeted with like enthusiasm by other disciplines who may feel that they are at least equal in importance to the overall university as is the medical school.

In response to Dr. Coggeshall, I think it is appropriate to look at a recent review of this subject by Robert H. Ebert, M.D., former Harvard Dean,

who in his article "Medical Education in the United States" (Daedalus 1977), focuses on what he describes as "tension" created by the artificial attempts to give credence to the commitment to the "Flexner Model" in which the medical school and the medical center are totally integrated into the university.

Ebert believes that the three phases of medical education - college, medical school and residency - offer convenient dividing points and that this education can be divided into phases: a university phase - college and medical school, and a non-university or a hospital phase - the residency.

Granted there is a period in the education of a physician when the two phases are integrated; namely, during the clinical portion of medical school; however, this period of integration or overlap does not carry into the internship and residency period to any significant degree. Notwithstanding this, the question remains - isn't the teaching hospital, in fact, a part of the university? Doesn't the presence of full-time staff, quality research, and the commitment to teaching qualify the teaching hospital as an integral part of the university?

Ebert believes - and I quite agree - that the answer is - not necessarily. In order for the successful teaching hospital to be successful, both as a hospital and as a training facility for housestaff, it must have as its primary role the care of the sick and it must carry out this role continuously and consistently irrespective of what the requirements may be for teaching and research. This service role sets the hospital quite apart from the rest of the university and its primary roles.

This point is well recognized in the draft of "The Essentials of Graduate Medical Education" prepared and submitted by the Committee on Essentials of the Liaison Committee on Graduate Medical Education, which, as I indicated previously, is chaired by Dr. Swanson. Quite correctly this document provides that "graduate medical education is conducted in institutional settings wherein there are invariably several missions. Providing clinical services of the highest quality must be the principal mission of hospitals and clinics sponsoring programs in graduate medical education. The range and scope of primary and ancillary clinical services must be sufficient to provide educational opportunities consistent with modern medical practice. All of those who use institutions and their resources for graduate medical education are expected to collaborate to ensure that all institutional missions are achieved, particularly excellence in patient care."

With this in mind, it must be noted that, in contrast to the university where, even if paid by the government, the student is the principal source of income, in the hospital it is the patient served who makes up the primary constituency. The hospital budget is principally for service to patients and, to a very large extent, it is the income from these patients which goes to fund the entire hospital's budget.

As a result of this, graduate medical education also is most often funded through hospitals with patient service dollars. This creates a fiduciary responsibility for the hospital. That trust relationship has been accepted by the community because hospitals have been able to demonstrate that the presence of housestaff contributes to the improvement in the patient care being provided. This trust relationship might well be undermined if the hospital simply became a financial conduit which used money from its patients to support residents identified with a more remote educational institution.

The realities of getting non-university owned hospitals to relinquish total authority for graduate medical education to an external agency, while retaining responsibility for both accountability to the patient and fiscal requirements of the program, is not only unrealistic, but may not be in anyone's best interest given our current health care delivery systems.

A hospital is responsible for the care of its patients. Evolving case law is demonstrating that this responsibility cannot be avoided or delegated: it must be confronted and faced. Given the hospital's responsibility for patient care and the participation in patient diagnosis and treatment essential to the training of residents, it is vital that the hospital must retain its institutional responsibility for graduate medical education.

None of the foregoing is intended to contradict the axiom of the inseparability of teaching and research from quality patient care; no one part of the triad can truly exist without the other two. But rather, it is a matter of emphasis and I doubt that one can argue with any degree of validity that without primary emphasis on quality patient care in the proper institutional setting, it will be extremely difficult indeed to carry on a successful training program for long.

Another factor in the evolution of our concept of institutional responsibility can be drawn from the following: In 1971 the AAMC Ad Hoc Committee on Graduate Medical Education issued a report on the implications of academic medical centers taking responsibility for graduate medical education. In this ad hoc committee's original report, it was pointed out that specialization brought about by advancing knowledge has resulted in a highly complex structure for graduate medical education, resulting in a demand for a more "holistic" approach. The report went on to conclude that the "assumption of responsibility for graduate medical education by the entire faculty of the academic center could help provide this approach."

In response to which I must say that in my limited experience, the academic medical center has been the one largely responsible for the conditions now being decried, and to assume that, now, by giving them total control over all graduate medical education would correct this dilemma is to me being genuinely naive to the function of human nature.

The ad hoc committee went on to discuss the impact of their recommendations on hospitals, and in one of the greatest of understatements of all

times commented that in this area "truly significant problems may emerge."

If, from the foregoing, one is willing to accept an evolution from the concept that the academic medical center is the best agency for controlling graduate medical education to the concept that other institutions may prove to have at least equal responsibility in this area, then one must look at the ability of any of these institutions alone to meet what is traditionally cited as the seven aspects of that responsibility:

(1) Determining educational objective and goals.
(2) Establishing policies for the allocation of resources and facilities of the entire medical center to permit realization of these goals.
(3) Appointment of faculty.
(4) Selecting students.
(5) Determining content, process, and length of educational program.
(6) Evaluating each student's progress.
(7) Designating completion of program.

My response is that no single institution - not even the academic medical center - can fulfill these responsibilities alone without running the risk of producing graduates of even more diverse qualifications and capabilities than is now the case. I believe that hospitals are and will remain the primary institution in graduate medical education, for they have the practicing medical staff and patient resources necessary for participating in and learning from medical practice. In addition, as I have tried to indicate in my comments, hospitals have practical operational characteristics which I believe necessitate that, institutional responsibility for graduate medical education be lodged primarily in the hospital.

I feel the hospital can best accommodate the components of the educational experience, particularly curriculum, faculty and evaluation. The responsibility for maintaining the highest possible quality can appropriately be delegated to the hospital's full-time faculty. Needs and goals can be assessed by the hospital's faculty and integrated into the curriculum; an appropriate balance can be struck between the didactic and the supervised application of medical knowledge to the clinical situation. The faculty can likewise fulfill its responsibility to the external agencies involved - namely, the appropriate specialty boards, the university, and the Liaison Committee for Graduate Medical Education - all from within the hospital setting.

With respect to external agencies, it seems to me that a critical factor which must be safeguarded and maintained is the one that is now currently provided by the specialty boards and the residency review committees - namely, the establishment of standards and criteria through which the accreditation programs help serve to guarantee quality and consistency amongst common programs.

I am well aware of the defects of the current accreditation process and I am sure Dr. Swanson will comment on it in a most significant fashion. However, judgmentally it would appear to me that the best solution is one in which all the interested parties have an opportunity to participate in the decision-making as appropriate partners, a concept which I believe is in concert with the intent of the liaison committees of the Coordinating Council on Medical Education, and rather than abandoning this mechanism by returning to "institutions" much of what is now the responsibility of the liaison committee, I would urge that we build on the strengths of this coordinated approach and endeavor to correct its weaknesses to make it even more effective.

With respect to the role of the academic medical center vis-a-vis the role of the teaching hospital in graduate medical education, I think we must recognize the fact that this cannot be properly examined without also examining the nature of affiliation between medical schools and teaching hospitals, a subject which goes far beyond the purview of this morning's session, but one which is certainly of at least equal importance.

Suffice it to say that the quality of the affiliation in terms of a true partnership between the medical school and the teaching hospital will undoubtedly greatly enhance the quality of the graduate medical education programs, irrespective of where final "institutional responsibility" rests. Personally, I would hope that this Association - the AAMC - will find it possible to further pursue this area. We have an excellent first resource in the AAMC's report on Medical School - Clinical Affiliation Study, but I am sure many of you would agree that much, much more remains to be done in this highly critical and sensitive area.

CONCLUSION

In conclusion, I would like to say that residency training relies on learning by doing, using hospital patients and resources, and because hospitals are responsible for the care of their patients, the development of facilities and programs, and the expenditure of community funds, I believe that institutional responsibility for graduate medical education belongs in the teaching hospital. I agree with the 1966 Millis report recommendation that " . . . each teaching hospital organize its staff, through an education council, a committee on graduate education, or some similar means, so as to make its programs of graduate medical education a corporate responsibility rather than the individual responsibility of particular medical or surgical services or heads of services." This corporate responsibility should not supplant the responsibilities held by medical schools and specialty boards. Rather, it should complement them.

As I survey graduate medical education from the viewpoint of the hospital director, I do not see the need for continued advocacy of the academic medical

center or medical school's institutional responsibility for graduate medical education. I do see the need for teaching hospitals to develop and accept a corporate responsibility for graduate medical education and for teaching hospitals to develop strong institutional arrangements for institutional affiliation and accreditation which supplement the present departmental and specialty relationship and which would enhance the cooperative participation of all elements required for the achievement of this exigent common goal - optimal graduate education.

Thank you.

INSTITUTIONAL RESPONSIBILITY FOR GRADUATE MEDICAL EDUCATION

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You find a phone message to call a banker who is on your Board of Trustees. He is not one of the most supportive members of your board, and you wonder whether the S.O.B. is calling to give you a hard time. To your relief, you find him affable. He asks how things are going, and even inquires about your family. With the pleasantries over, he comes down to business. He has just had a letter from his daughter, the one that has a living arrangement with the fellow who believes that toil stifles creativity. They live 1500 miles away and she believes she may be pregnant. His question -- do you know an obstetrician to whom she can be referred?

You could point out to him that there must be obstetricians in a community of the size she lives in and the yellow pages list physicians by specialty, and all she needs to do is start with A and proceed until she gets an appointment with an obstetrician. You could take down your Directory of Medical Specialists and look up the certified obstetricians in the community and give him three names. But these simple answers never cross your mind; you immediately begin flicking through the grey matter of your biological computer (and also reaching for your Directory of Graduate Medical Education) and say "I don't know a specific obstetrician to recommend to you but the Hospital of Unalloyed Excellence is in Capital City and I'll call Dr. Fecund who is Chairman of the Department of Ob-Gyn. I have confidence that he will be able to recommend whom your daughter should see." Your Board Member thanks you profusely--even hints that he may have been wrong about implying he questioned your competence at the last meeting and hangs up saying that he will be waiting to hear.

Sitting back and staring at the phone you ruminate on the fact that all you know about the Hospital of Unalloyed Excellence is that their program in internal medicine is known for its high quality and you have met the Chief of Medicine. But you know nothing about Dr. Fecund and his obstetrics program. Nevertheless, you pick up the phone and call Dr. Fecund and ask him to identify an obstetrician for your Board Member's daughter. You get a name, call your Board Member, and live happily ever after -- <u>never once thinking that you had placed your complete reliance on institutional responsibility for graduate medical education</u>. You assumed that because the institution had an excellent program in internal medicine, its excellence in Ob-Gyn was equivalent.

I submit that this assumption is unwarranted. All of the national operating policies, and most local operating practices, are based on the principle that graduate medical education programs stand independent of one another and are only tangentially related to the institutions which sponsor them.

Here are some examples from the national level.

(1) There are 23 residency review committees. Each RRC considers its responsibility to be only to judge the quality of the specialty programs for which it is responsible. The RRC in Internal Medicine does not concern itself with whether a program in Ob-Gyn in the same institution is on probation when it reviews and evaluates the internal medicine program. In fact, the presurvey questionnaire for internal medicine does not even ask if there is a program in obstetrics-gynecology.

When the Liaison Committee on Graduate Medical Education found four years ago that the accreditation status of programs was considered confidential, it reversed that policy and further required that RRCs be informed of the accreditation status of the other programs in the institution whose program in their specialty they were reviewing. To date, this policy has only been erratically implemented by RRCs. A major barrier has been that the Secretaries to the RRCs, all of whom are in the AMA's Department of Graduate Education, do not regularly exchange information about the actions of the RRCs they serve. RRCs vary in their perception of the interdependence of programs in their specialty on other programs in the same institution, and RRC Chairmen have not usually placed an emphasis on getting this information.

(2) Each RRC has evolved data collection forms for program directors to fill out in applying for approval and accreditation. Each of the 23 forms asks for certain data about the institution -- each in its own way. Two years ago, the LCGME requested that a common institutional data form be developed which could be filled out by the appropriate institutional administrative office and used by all RRCs for evaluating all sponsored programs in an institution. Despite inquiries at each meeting regarding the progress of this development, only promises have been forthcoming.

(3) AMA field surveyors often visit all or nearly all of the programs sponsored by an institution on one trip. However, each program is visited sequentially and independently -- no institutional recognition to the presence of the field surveyor is given. My own experience is that the surveyor of my program in neurology could just as well have been in San Francisco the previous day even though he may have been in Seattle for two weeks and reviewed six other programs before getting to me.

These examples explain why implementation of institutional responsibility has been so slow. Despite the acceptance four years ago of the policy statement on page nine of the draft revision of the General Requirements, which is in the materials you received on arrival, the LCGME has been unable to mount even the first and simplest procedure to accomplish its implementation.

Institutional responsibility for graduate medical education is perhaps the most misunderstood term in the American lexicon. It is my observation

that most everyone focuses on the word 'institutional' and generally neglects the word 'responsibility'. The question always is "Whose institution is threatened." To the specialty boards, specialty societies and RRCs, it is the institution of having RRCs and their parent bodies set the standards and review programs. They often espouse the belief that even giving the slightest recognition to an institutional base for graduate medical education will mean the instant dissolution of certifying boards and RRCs and the establishment of institutional accreditation of graduate medical education.

To program directors it means that their opportunities to operate as free from institutional constraint as possible will be jeopardized.

To hospital directors it means that medical schools will become the institutions responsible for graduate medical education; and to deans it means that their institutions might have to swallow more than they possibly can at the present time.

The reasons for these misinterpretations and misunderstandings are evident from a perusal of the statements which have been put forth from various sources at various times. Going back to the Coggeshall Report of 1965, there was an emphasis on the need for the university to assume responsibility for graduate medical education. Although the Millis Report did not endorse universities becoming totally responsible, there was a call for greater university involvement. The Council of Academic Societies Conference of 1968 reinforced this thrust. However, the 1974 CCME statement speaks to the responsibility of institutions, organizations and agencies without defining them. Perhaps the first thing that needs to be emphasized, now in 1978, is that institutional responsibility does not necessarily mean university responsibility. It means that institutions (however defined) which sponsor programs in graduate medical education should establish institutional policies and mechanisms which will assure an optimal educational environment and internal mechanisms for quality control. It further means that the importance of the institutional base for graduate medical education must be recognized in policies and procedures for review and accreditation.

I would first like to dispose of the questions surrounding institutional responsibility and the national system for accreditation of graduate medical education programs. When the system for national accreditation of graduate medical education was developed, the impetus came from the specialty boards and specialty societies. In response to the individual concerns of each specialty group, the AMA evolved the technique of establishing residency review committees to develop accreditiation standards and review programs. Each RRC was developed as the service was requested by a specialty board and no thought was given to the interdependence of graduate programs at the insitutional level.

In 1972, the LCGME was established to assume overall responsibility for graduate medical education accreditation. The LCGME membership com-

position acknowledged the need for a wider involvement in graduate medical education because, in addition to the AMA, American Board of Medical Specialties (specialty boards), the American Hospital Association (hospitals), and the AAMC (medical schools) were added. Two years after the establishment of the LCGME, the following policy statement on institutional responsibility was adopted by the LCGME and its five sponsoring organizations.

> "Institutions, organizations and agencies offering programs in graduate medical education must assume responsibiltiy for the educational validity of all such programs. This responsibility includes assuring an administrative system which provides for management of resources dedicated to education and providing for involvement of teaching staff in selection of candidates, program planning, program review and evaluation of participants.
>
> While educational programs in the several fields of medicine properly differ from one another, as they do from one institution to another, institutions and their teaching staffs must insure that all programs offered are consistent with their goals and meet the standards set forth by them and by voluntary accrediting agencies.
>
> The governing boards, the administration, and the teaching staffs must recognize that engagement with graduate medical education creates obligations beyond the provision of safe and timely medical care. Resources and time must be provided for the proper discharge of these obligations. The teaching staff and administration, with review by the governing board, must (A) establish the general objectives of graduate medical education; (B) apportion residency and fellowship positions among the several programs offered; (C) review instructional plans for each specific program; (D) develop criteria for selection of candidates; (E) develop methods for evaluating, on a regular basis, the effectiveness of the programs and the competency of persons who are in the programs. Evaluation should include input from those in training."

The LCGME, as it has supervised the RRCs, has discovered the weaknesses in a system which depends solely on vertical control of quality. By vertical control, I mean sole dependency on the linkages between individual boards, RRCs, and program directors. For example, it is possible, and often found, that all the programs sponsored by an institution are on probation. It is also true that RRCs may invoke requirements on a program director which cannot be met because there are no institutional mechanisms to resolve the policy and management decisions necessary to meet the requirements.

In addition to the vertical linkages, a horizontal, institutional system for resource allocation and quality control is needed. The concerns of some RRCs that institutional responsibility will denigrate their role is simply not true. The effectiveness of the vertical quality control system will be enhanced by a horizontal, institutional system; however, to stimulate the development of institutional mechanisms to provide for responsible management of graduate programs, accreditation policies and

review procedures by the LCGME and the residency review committees must acknowledge the institutional role and stress the need for institutional responsibility.

The proposed revision of the General Requirements for Graduate Medical Education is directed toward that goal. These requirements speak in functional, rather than structural, terms. For many, years, the General Requirements have stated that there should be an educational committee of the staff which is responsible for the organization of the residency program, for the supervision and direction of the residency program, and for correlating the activities of the resident staff in various departments of the hospital. To my knowledge, no RRC even asks whether such a committee exists, let alone whether it is functional. The revised General Requirements would require the implementation of an institutional, as well as program, review and would mean substantial changes in the review process.

The logical direction of change would be to abandon the peripatetic AMA field staff surveyors, most of them would not have to accept early retirement since they are already superannuated, and develop rosters of competent medical educators who would serve voluntarily as site visitors. Instead of surveying each program in isolation, organized site visitor teams with appropriate secretarial support would visit and survey an institution and all of its programs simultaneously on a schedule of every five or more years. The team's report would consist of an overall institutional appraisal and a report on each program. Each RRC would also base its decision on both an appraisal of the institution and the program, and the LCGME would particularly concern itself with an appraisal of the institution. Irv Wilmot is now chairing a new committee of the LCGME charged to review the accreditation process. I hope the committee recommendations will move in this direction.

I will now turn to the problems which institutional responibility raises at the local level. My first premise is that the site for graduate medical education has been, and will continue to be, the hospital; and for most specialties and most residents it has, and will be, the acute care general hospital. However, unlike in the past when a single hospital was able to provide for all of its programs all of the resources needed, we are now seeing, and will see increasingly, a need to enter into inter-institutional arrangements for graduate medical education. The institutions involved are other acute care general hospitals, special hospitals, long-term care facilities, ambulatory clinics, community health agencies, and medical schools. Were the principles of institutional responsibility already operational in existing institutions, the negotiation of inter-institutional agreements would now be simpler, even though they might not be easy.

Basically, institutional responsibility breaks down into two functions:

1) The allocation of resources
2) The control of educational quality

Both are interdependent, for if resources are inadequate quality will

be impaired, but simply providing resources does not guarantee quality. Hospital executives are principally concerned with allocating resources in order to attain the highest quality in both patient care and education. Service chiefs and the medical staff are responsible for utilizing the allocated resources effectively to attain these same goals. Whether resources are beds, clinic space, technical support systems, resident stipends, staff salaries, or fringe benefits, the denominator of the equation is money and the principal source of dollars for graduate education flows from the patient care mission of the hospital and is controlled by the hospital.

Traditionally, the allocation of resources for graduate medical education amongst the programs within institutions has been an entrepeneureal exercise in which the good (or aggressive) get more and the poor (or retiring) get less. The service chiefs and medical staff have shown little interest in establishing a transinstitutional system for the assessment of program quality and program needs. The strong do not wish to lose their prerogatives and the weak are incapable of precipitating such a movement.

When the need for developing interinstitutional agreements arises, resource allocation is the first order of business. Each program director, depending upon his perception of his needs and his bargaining position, demands all the resources he can obtain from the other institution. Obdurate demands for excessive resources, control, or autonomy on the part of a single individual in one of the institutions can stall the efforts of all the others who are working toward a fair and amicable arrangement. Too often, such an individual has an overblown or misconceived perception of his own worth and the quality of his program; but he goes unchallenged by his colleagues, for there is no intrainstitutional system to provide a means for them to assess the merits of his claims to superstatus. Such uncontrolled, arrogant behavior is most likely to flow from chairmen of medical school departments toward the hospitals, and hospitals correctly recognizing that they have the resources the medical school needs, react accordingly. However, the flow is not only in one direction. Directors of previously unaffiliated hospital programs may use their own institutional power base to disrupt negotiations and protect their autonomy even though their programs are faltering.

The effective allocation of resources requires that those responsible have sufficient information to judge whether their allocations are consonant with the institution's mission. This means that the contribution of each graduate medical education program to the mission of a teaching hospital must be assessed periodically by the administration and staff of the institution. That assessment should include an appraisal of the content of the educational program and the balance between supervision, patient care and formal teaching exercises. How a program's faculty evaluates whether their residents are progressing satisfactorily and whether these evaluations bear a meaningful relationship to the goals of the program should be reviewed by faculty from other programs. Where weaknesses are found the program director, the administration, and the other program directors in the institution should work together to achieve solutions -- including either the allocation of additional resources, or withholding resources according to what is judged will benefit the

institution's ability to accomplish its mission. Such internal evaluations of graduate medical education programs will provide far greater information than the brief letters written by AMA staff announcing the decisions and recommendations of residency review committees.

Achieving a workable system within an institution and between institutions to implement the 1974 Coordinating Council policy will not be easy. Graduate medical education presently consists of approximately 4600 programs occupying the facilities of about 1700 hospitals. The national policies and system for accreditation place little emphasis on the institutional base for graduate medical education and yet, at the local level, each institution concerned with the education and training of residents is increasingly faced with the need to allocate more effectively the limited resources available for education, and to negotiate with other institutions, arrangements to maintain or improve the scope and quality of its programs. Arrogance, institutional autonomy, greed, and fear resulting in administrative paralysis is too common. The need for strengthening the institutional base through assuring institutional responsibility for graduate medical education is urgent.

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COTH Spring Meeting
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DEALING WITH THE HOUSE STAFF

To understand more fully the question of dealing with the house staff in a labor relation sense, we should first refer to the current environment in which we are working and those forces which inevitably will affect our dealings with the house staff.

First and foremost, of course, is the labor law changes that are approaching a climax in Congress. H.R. 8410. There is little doubt on either side - management or labor - that the so-called labor reforms to the National Labor Relations Act would have the most far-reaching and - from management's point of view - devastating effects on the labor relations scene - very much including our health organizations, since the 1947 Taft-Hartley amendments.

The facts are that after about 50 years of efforts, labor has been successful in organizing only about 25% of the American work force. Approximately the same proportion is organized in the hospital industry - which should give us little comfort since the preponderance of organization in our industry has taken place at a more accelerated pace - the past 20 years or so. About the same percentage exists for house staff. There were, in round numbers, about 60,000 house staff officers with about 12,000 organized at the point that the Cedars case was decided. George Meany, President of the AFL-CIO, has stated that "Passage of the labor reforms would be no more than simple justice. This bill would do just one thing; translate into fact the promise made 42 years ago when the law was first passed. It would preserve law and order in labor-management relations."

Management opponents of the bill have stated that "It would upset the balance between labor and management built up over the years and would tilt the scale in favor of unions, giving enormous political and economic power to labor leaders." Passage of the amendments would lead to what has been described as "push-button unionism." Business and industry leaders have also warned that the bill's passage would lead to an immediate significant increase in union organization and membership and that, in turn, would result in a sharp rise in new inflationary pressures.

The proposed revisions would set a time limit before which the employers must permit a union election or be ordered to do so by the N.L.R.B.; double back pay for employees illegally dismissed for organizing activities; the barring of employers from Federal contracts for failure to obey a Board order; a little-known section providing that security guards would be allowed to join any union that does not represent employees at the same work location (present law provides that guards must be members of guard unions which in no way are connected with unions representing employees at the work location); the Board's orders would be self-sustaining (presently the Board must take the case to court if the employer refuses to comply); that the Board itself be expanded from five to seven members, ostensibly to help it deal with an expanding workload - but more likely to provide a mechanism for labor to stack the Board in their favor.

As we meet today, this bill is completing its last lap to the floor of the Senate. Indeed, it may already have been introduced before we gathered today. The House of Representatives has already approved the bill. There will undoubtedly be a period of filibustering, parliamentary delays and maneuvers, proposing of amendments, House/Senate conferences and extensive lobbying by both management and labor. The bill is by no means a shoo-in and requires the full support on all our parts to insure its defeat.

Hard on the heels of H.R. 8410 is H.R. 2222 which was reported out of committee to the floor of the House just last week. The bill, as you undoubtedly are aware, attempts to reverse the metamorphosis of the house staff officer by the N.L.R.B. in their incisive and wise Cedars decision that changed HSO's from employee to student. This bill would change them back to employee. These two bills of course present us in the voluntary hospitals with something of a "double-whammy" with regard to house staff. One bill would create the employees which will be more easily organized as a result of the other bill.

Dr. Lawrence Boxt, President of the C.I.R. in New York City, was quoted in the New York Times on March 19, 1978, "The legislation, if approved by Congress, could prevent strikes by house staff physicians." In the C.I.R. Bulletin of the same month - March 1978 - Dr. Boxt's political action committee recommends among other things: "That the C.I.R. actively work with DC 37 and 1199 in areas of common interest. The possibility of strong support of, or even a joint strike when contracts are up, should be openly discussed." DC 37 represents over 100,000 workers in the city's 18 hospitals and District 1199 represents about 50,000 workers in the 44 voluntary hospital and nursing homes in New York City. Combined, these institutions represent virtually 100% of New York City's public and private beds. Dr. Boxt and the union he represents - which purports as its primary objective the improvement of patient care - is recommending a joint strike which would attempt to shut down the entire health system servicing 8 million people.

This diametrically opposed difference between the C.I.R.'s lofty rhetoric and militant action is, of course, not new. In the 1975 New York City strike - billed as the largest doctors' strike in the nation's history - the C.I.R. also carried the banner of the improvement of patient care. The then C.I.R. President, Dr. Richard Knutson, in a TV network interview, made what he referred to later as an "offhand remark":

"Sometime during your career, after you've been up on duty 50 - 55 hours straight and you have an admission, you are going to hope this one doesn't make it." To the credit of many house staff, many of them even at struck institutions, disavowed Dr. Knutson's offhand remark. House staff at NYU Medical Center, which was the only institution where a strike was voted down on two occasions, were quoted, "We will not forsake the patients who convince us that sickness is a 24-hour-a-day job." In one case reported by the New York Times, the resident pushed open the doors for the media of the Emergency Room at Bellevue Hospital, the city hospital affiliated with N.Y.U., and said, "Can you imagine what would happen to them," pointing to the acutely ill patients on stretchers and beds, "if a doctor punched in and out on a time clock?" Another spoke, "It's a shame I'm on 24 hours every other day, I miss 50% of the cases." Regarding Dr. Knutson's reference to "50 - 55 hours straight," the then chief medical resident stated, "Reports of the 55 hour

stretch are a fallacy. You always catnap, a few hours here and there."

You will recall that hours was the major issue leading to impasse in the 1975 strike. In a paper presented at Harvard Business School two years later, Dr. Knutson was quoted as follows:

"Most of the hospitals that went on strike were not affected by the settlement. At most of the hospitals, we already had what we were trying to get in writing."

Another sad commentary on the subject was published by the respected periodical "Prism" some time after the 1975 strike when Dr. Knutson, in an interview, responded as follows to a question as to whether there is a strong feeling among young doctors that the government ought to play a larger role in medicine, akin to what the British have:

"I think many do hold that view, and I don't know whether it stems from pious hopes or from naivete. The average physician now puts in about 62 hours a week. Consider what would happen if the system required him to drop back to 40 hours a week. In effect, medical care would be reduced by one-third."

This, from the leader of the so-called biggest doctors' strike for shorter hours in the nation's history. You may be aware that Dr. Knutson is currently a practicing orthopod in Biloxi, Mississippi, which probably explains his new found conservatism. Although we are all, I am sure, hopeful that H.R. 2222 will ultimately be defeated or die on some committee's shelf (either of which will require all our continued combined efforts), the P.N.H.A., and its local affiliates, are preparing for the organizing phase to follow the bill's anticipated success. In New York City, a questionnaire is being distributed seeking issues to formulate union contract demands. Let me read you some of these:

Patient care issues:
Working conditions:
Training programs:
Wages and fringe benefits:

In case anyone in the industry or government had any illusion that the road ahead was anything but bumpy, the Boxts and Knutsons on the local and the national scene will continue apparently to pursue their cause of patient care improvement through continued introduction of issues into collective bargaining which hospital managements will undoubtedly continue to assert are non-mandatory bargaining issues. Ergo, more impasses, more confrontations, and, tragically, more strikes.

In the meantime, I hope that we - hospital managements - have not been idle since Cedars. That decision provided us with an unprecedented opportunity to shore up our defenses if we lose the H.R. 2222 battle. Whether or not the bill is passed, an appraisal of house staff matters and implementation of necessary changes would hold us in good stead for the future in our internal relations with the house staff.

The following old, time-worn cliche still holds some validity. <u>If you want to avoid a union, act as though you have one</u>. From personal experience, having been through a period of house staff organizations at my own

institution and in an industry-wide basis in multi-employer bargaining, I would strongly advise you that anyone suggesting that house staff unionization can be lived with comfortably should be viewed with, at the minimum, much skepticism.

The head of a nationally recognized major teaching hospital in New York was quoted recently in the New York Times as follows: ".... our hospital had recognized the C.I.R. because we felt that the house staff should have a forum, even though it might be a little uncomfortable for management." That teaching hospital has been one of the first to be struck in each C.I.R. strike and has the distinction of being the only one, to my knowledge, where medical staff picketed in sympathy when 1199 service workers hit the bricks. In the same New York Times article, the head of another major teaching complex whose institution has been minimally affected by C.I.R. strikes and job actions stated that interns and residents were primarily "students" and that their demands "were better handled on a collegial basis."

We, at New York University Medical Center, have attempted to follow the latter course. To translate into reality a collegial basis with HSO's.

We attempted to establish a good faith relationship with the house staff. We recommended as a model a house staff council along the lines of our faculty council to provide an internal forum for house staff input into economic and administrative issues and problems that concerned them. You must remember that at this point we had just notified them that as a result of Cedars we would not recognize the C.I.R. any further as a collective bargaining agent.

The initial reaction to our offer of an internal framework was met, not unexpectedly, with a degree of hostility and suspicion. We were substituting consultation for collective bargaining, internal resolution of grievances for arbitration. At the same time other hospitals were being picketed and struck by the C.I.R. to gain voluntary recognition and the N.Y.U. house staff was being harangued and bombarded with union propaganda stating that N.Y.U.'s refusal to recognize the C.I.R. was the house staff's reward for refusing to strike in 1975.

After much deliberation, discussion and persuasion, the house staff again voted as they did in 1975 against striking and for beginning discussions with administration regarding this so-called collegial model.

Before I progress further regarding the outcome of those discussions, it is crucial that I point out the role played by the chief of service and chairman. Throughout this entire process, they had been kept up-to-date through meetings and memoranda and a number of their suggestions incorporated into the recommendations being made to the house staff. By this time, as a result of much communication, they were up-to-date and sophisticated regarding labor events, processes and alternatives.

Their support of this internal process was crucial. The communication of their support to their house staffs contributed immeasurably to its success.

The final outcome of the deliberations with the house staff resulted in certain economic changes - compensation and benefit - consistent with prevailing practices in the community. In addition, a house staff council was created with representation from each clinical department, and an Executive Committee which would meet periodically with administrative representatives. A grievance procedure was clarified providing for internal resolution of grievances, the house staff officer having the right to be represented by a person of his/her choosing. Another important factor was clarifying the institution's commitment to consult with the house staff council before implementation of new policies and practices. A number of matters regarding appointments and reappointments, individual contracts, etc., were continued from the defunct labor contract and incorporated into these new policies.

The resolutions went through many drafts and were finally distributed to all house staff officers who approved them overwhelmingly.

The existence of the house staff council, its duties and roles, were then incorporated into the institution's Bylaws.

If H.R. 2222 is enacted into law, there certainly will be a renewal wave of organizing nationally.

There is no one best way of assuring that in a union election the house staff officer will vote one way or another. After scores of discussions with deans, chairmen, chiefs, attendings, union officials and house staff officers at a number of institutions in New York and elsewhere, I would point out a number of areas that should receive special attention.

The first and foremost is compensation. Your organization assumes an untenable risk if your rates are not within the prevailing practice in your area. It is realistic to realize that rates at unionized institutions play a dominant role in the determining of prevailing practice. Compensation includes fringe benefits. "Fringe" is probably the most inaccurate word in the management lexicon - there is nothing "fringal" if you will about benefits any longer. They represent a significant chunk of compensation costs. They also, on the other hand, have become well-known and understood by house staff officers. So that here, too, prevailing practice must play an important role. I recall an actual situation a few years ago where a house staff officer was scheduled to rotate on the first of the month from the payroll of a non-union hospital which provided him $10,000 group life insurance to an affiliated institution where the C.I.R. had a contract which, at the time, provided for $100,000 group life insurance coverage. Tragically, the young man died one or two days before the transfer and his beneficiary received $10,000. A unique situation involving disparate benefits?--not so. In other situations of which I am aware, house staff officers with pregnant spouses or pregnant house staff officers moved heaven and earth in order to remain on the affiliated hospital's payroll since its benefit plan provided full coverage for hospitalization and medical maternity coverage. These are situations which are ripe for exploitation by union organizers.

The next area in terms of priority is more complex since it is attitudinal. Simply put, if the HSO feels he/she is a work horse instead of

a professional in training, he/she will be more vulnerable to union promises no matter how unrealistic. Here the chiefs particularly play a decisive role. Whether the teaching hospital is large or small, prestigious or not so well-known, or whether the HSO is a FMG or not, the self-perspective of the individual is probably decisive.

Again, much time should be spent in sophisticating the chiefs in labor relations matters. They should be made aware of the alternatives, particularly the compromising of their prerogatives by collective bargaining agents, arbitrators and other third parties.

I recall one house staff officer who is pursuing a fellowship on the Coast at the moment who, in a very succinct and graphic manner, stated "We will not be shat upon any longer - minorities and the feminists have made their point - we are making our point. If you treat us like disgruntled employees, we will act like disgruntled employees; if you treat us like professionals in training, we will act accordingly."

A word to the wise!

Thank you.

HMOs AND THE TEACHING HOSPITAL
THE G.W. EXPERIENCE

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INTRODUCTION

Before addressing the subject - HMOs and the teaching hospital - I would like to emphatically disclaim any notion that the George Washinton University experience, being located in the nation's capital, offers any significant insight into the legislative logic as expressed by the White House of H.E.W. I can assure you that proximity, at least in my case, does not offer new wisdom; in fact, frequently nearness leads to visual distortions accentuating conflicting federal policies, bureaucratic overload, confusing regulations and the lack of a visible national plan. Rather I would hope that the G.W. experience might be useful to this audience prospectively since many of you may be facing, in the near future, the emergence of prepaid health plans in your community which will have an impact on the health care delivery system and your teaching hospital.

I am fairly confident, although I have not queried the Program Committee explicitly, but I would suspect that if the program had been firmly established six months ago, this subject would not be on the agenda. Most of us recollect that President Richard Nixon in 1971 gave his unqualified endorsement to the health maintenance organization concept as a significant factor toward reconstructing the American medical process. The target was that by 1976 there were to be 40 million people in 1700 HMOs across the country. I would suspect that the failure of this concept to sweep the nation was viewed by a significant proportion of health professional leaders with some sense of relief and that the lack of continued federal support in stimulating these programs, coupled with a high rate of fiscal insolvency was not sincerely mourned; therefore, six months ago, one would have expected that the HMO movement was on the wane. Suddenly, the converse is true and governmental support grows for the HMO program. The logic behind the Carter Administration policy is relatively simplistic; that is, in lieu of a national health insurance program, the Administration is offering as its prime legislative emphasis in health, a control of hospital revenues and an expansion of the role of the HMOs. HMOs, are being promoted on the belief that they provide care cheaper, and have built-in incentives to keep costs down. Also, there is significant bipartisan support in both the Senate and the House for a number of amendments to the current HMO legislation which would increase the funds available to evolving HMOs; remove many of the impediments toward achieving qualification; offer fiscal incentives relative to Medicare and Medicaid and exempting HMOs from a number of the health planning regulations. Coupled with this legislative activity was the Secretary of HEW's pep rally for industry on March 10th of this year, wherein

Mr. Califano invited the presidents of 500 of the largest corporations and 300 other business representatives and more than 200 labor officials to a one-day meeting in the HEW auditorium, espousing the merits of the prepaid group practice to a receptive business community which is expressing increasing concerns over the percentage of the health bill reflected in their product. Whether this renewed enthusiasm and legislative support will result in a more viable prepaid program around the country or not is, of course, problematical. Nonetheless, one can accurately predict that there will be renewed interest in the development and implementation of a significant number of prepaid plans nationwide. (SLIDE) Currently, there are approximately 170 prepaid group practices operating today, serving somewhere around 6 million people; of this 170, only about 50 have met current federal qualification criteria. Putting all this together, I am sure the program committee felt that its membership will be experiencing this resurgence.

The George Washington University Hospital has had the opportunity in the past to deal with two separate prepaid plans: (1) The Group Health Association, a 40 year-old prepaid plan with an enrollment of approximately 110,000, and (2) The George Washington University Health Plan, started in 1972 with a current enrollment of approximately 15,000, a separate corporate entity but very closely linked to the George Washington University and its School of Medicine and Health Sciences. Today I will briefly review (1) the history of the HMO movement, with special emphasis on the Kaiser program since it is the apparent model for the Federal legislation; (2) the HMO Act of 1973 and proposed amendments; (3) the pertinent history relative to G.H.A. and the G.W. Health plan, their salient organizational features, significant policy and fiscal issues; relevant perceptions; and the current situation; and (4) I will then attempt to summarize some of our observations as a result of these relationships, fully recognizing that this is not being presented as a scientific study, full of exhaustive data and standard deviations, but rather two specific case presentations which hopefully might offer some meaningful insights.

A Brief Developmental History of the HMO Concept

How to pay the doctor has been an age old problem, especially for individuals with low or modest income. The concept of pooling small amounts of money for health care began with the sick clubs and friendly societies of Europe in the Middle Ages. The first organized group clinic was the Mayo Clinic in 1914 and the first successful prepaid group practice plan was the Ross Loos in 1929. Both of these attracted some attention, but prior to 1970, HMOs were not numerous enough to be seriously considered as an alternative means of bringing health services to a substantial proportion of the population. In total, prior to February 1971, there were only 33 HMOs in the United States, probably a reflection of organized opposition from a number of sectors to this method of health care delivery. The Supreme Court ruling in 1943 found the AMA and the District of Columbia Medical Society had conspired to restrain trade, excluding Group Health Association doctors from the Medical Society's membership. However, I think all would agree that until the stated Nixon Initiatives in 1971, with the evolution of the HMO Act of 1973, the expansion of HMOs as a meaningful new force in

health care delivery had not been affected.

The undisputed HMO prototype is the Kaiser Medical Care Program. The Kaiser story really began in 1938 when Dr. Sidney R. Garfield was invited by the Kaisers to form a medical group for the workers and their families related to the construction of the Grand Coulee Dam. This program was then transplanted to the Kaiser shipyards and steel mills and flourished during World War II. Its momentum was helped by the court decision relative to Group Health Association of Washington and the 1959 AMA publication of the Larson Report, which stated that there was no definable difference in the quality of care between conventional practice and prepaid plans. Since 1955, the current Kaiser organizational structure has been operative; today, the Kaiser Medical care system is a complex organization, operating in six different geographical regions, each with a high degree of autonomy. The three major common elements are: (1) the Kaiser Foundation Health Plan, Inc., a non-profit corporation that performs most of the administrative and contractual services for the program. (2) Kaiser Foundation Hospitals, a non-profit corporation; and (3) the Permanente Medical Groups, six independent, legally separate entities. In addition to the three elements, there are six associated corporations performing supportive tasks. Despite the appearance of decentralization and multiplicity of organizations, Kaiser is able to operate financially similar to a single unit; that is, the Kaiser Foundation Health Plan and the Kaiser Foundation's Hospitals are non-profit, tax-exempt corporations, governed by two boards of directors which are common membership. The Kaiser Permanente Medical Groups recruit physicians for full-time positions who are salaried until they are accepted as a partner. The partner is paid through a combination of a monthly drawing account and an annual share in the Medical Group's net savings. The Medical Group's income comes from that portion of dues paid by the Health Plan subscribers and allocated to medical services. What have been the elements that have led to the success of the plan and, therefore, the attractiveness of the Kaiser prototype to the federal government?

In my view, the elements can be summarized as follows: (1) The consumer should have a choice so that every member can drop the plan and change to an alternative carrier. (2) The membership should have some voice in the program; for instance, if after labor management bargaining, an employer/employee group should want to cut its payment to Kaiser, Kaiser will arrange to cut the benefits of the group so that the reduced payments will cover the cost. (3) Coverage should be broad. (4) The plan is financed by membership dues paid in advance; the same groups regardless of age and sex and regardless of utilization. (5) Medical care is provided by multi-specialty groups which are based on a partnership rather than a salaried doctor arrangement. (6) Medical care and hospital care should be coordinated. (7) Prepaid dues plus other revenue should cover the financial requirements of the plan; that is, from the hospital's point-of-view, the prepaid dues not only cover operating costs but also funds for construction and new equipment for the medical groups. There should be an excess pool which would be available to distribute to the medical group as incentive compensation and retained by the hospitals and health plan as additional

earnings available for facility development and debt repayment. (8) Marketing success, competitive pricing and efficient use of in-house services has been based on successful identification and capture of a well-defined, sizable service population. (9) Selective utilization of allied health personnel; And (10) Limited involvement in medical education, based on the generally accepted belief that the medical educational environment is not cost-effective for a prepaid health plan. The success of the Kaiser Plan can be measured by (1) membership in the plan has grown steadily and rapidly. In 1950, there were some 154,000 in all the Kaiser plans; 1960, close to a million; 1970, over two million; and at the present time, approximately 3 million.

Surveys seem to show that there is growing satisfaction with the plan. (2) Kaiser Hospital utilization rates are significantly below the rates of comparable populations. (3) The Kaiser Plan has been able to provide health care at a cost competitive with other methods of financing health care services. And, finally, (4) well-established Kaiser Plans are financially self-sufficient.

The HMO Act of 1973 and Proposed Amendments

Viewed from the Kaiser experience, the HMO concept seemed to deal with some of the more visible problems of the fee-for-service system and has therefore become one of the most frequently discussed health policy alternatives. The perceived advantages as viewed by the health policy makers seem to be (1) an HMO promotes many economies since, because of the fixed prepayment, there is an incentive for health care providers to minimize expenses and avoid unnecessary services. (2) Other economies are possible in the realm of manpower utilization, equipment utilization, routine business administration, medical records upkeep, and the distribution of specialists' skills. This is especially true when centralized facilities are used by the HMO. (3) The quality of service is subject to internal peer review; and (4) there is no financial barrier to early preventive care from the patient's point-of-view. Therefore, the HMO concept appears to offer a health care system where wellness, rather than sickness, brings the providers a greater return. Despite these seemingly obivous advantages, there are numerous problems inherent in the concept of HMOs. Theoretically, the prepaid fixed fee nature of an HMO can eliminate the desire to overtreat or overhospitalize. But the logical converse is that the need to avoid a deficit in the HMO may result in a failure to hospitalize or treat when necessary or, in economizing, on the quality of care delivered. How does one, for instance, interpret the following statistics?

Number of Hospital days per thousand persons per year:
HMO: 740 Other: 955

Number of Hospital admissions per one thousand persons per year:
HMO: 70 Other: 88

Hospitalized surgical cases per thousand per year:
HMO: 49 Other: 69

Is this good, conservative medical care or is this a failure to hospitalize or treat when necessary? Nonetheless, citing the success of the

Kaiser Model, the Health Maintenance Organization Act of 1973, signed into law by Richard Nixon on December 29, 1973, committed the Federal Government to support HMOs for a trial period. The law authorized grants and loans to public and/or nonprofit organizations for a number of purposes, such as feasibility studies, planning grants, membership expansion, and projects for initial development of HMOs. One of the major problems of the HMO Act of 1973 was the very stringent requirements for qualification. The organizational requirements were very complex. In addition, the requirement for open enrollment and the scope of mandatory benefits placed HMOs at a severe competitive disadvantage. By far the most controversial of the provisions of the HMO Act is the "dual option" section which, in essence, requires that every employer of 25 persons or more who offers a health benefits plan must offer those employees the option of joining an HMO if a qualified one exists in the area. In summary, the HMO Act of 1973 accomplished what several decades of labor by its advocates had only marginally achieved. It has proven, however, to be a mixed blessing. The law does override restrictive state laws and requires the "dual option." However, requiring this option has triggered a controversy that thus far has hampered rather than helped the development of the HMO. Furthermore, to qualify for federal aid, the organization must meet federal standards which require HMO to provide benefits that are prohibitively expensive and to open its membership to groups with above-average medical costs. In short, the federal government is prescribing an ideal HMO, not an economically feasible one.

All of this has led up to what are to be called "The Health Maintenance Organization Act Amendments of 1978." It is usually ill-advised to be predictive during the legislative process, but this is one of those rare occasions when the Executive Branch, represented by Secretary Califano, H.E.W., Undersecretary Hale Champion, the F.T.C. and the G.A.O., seem to be in general agreement with the Senate represented by Senators Schweiker and Kennedy and the House, represented by Mr. Rogers, that the HMO concept is ready for a rebirth and that some of the generally agreed-upon elements of the amendments might be as follows: (1) convert from a pilot project to a long-term program; (2) increase flexibility and provide adequate funding to encourage development of new HMOs and expand enrollment in existing HMOs; (3) strengthen federal monitoring procedures to prevent HMO fraud and abuse; (4) create a five-year program for field training of HMO managers; (5) exempt HMOs from the Certificate of Need process and the need to obtain HSA approval in the ambulatory sphere; (6) provide $40 million in a revolving loan and loan guarantee fund for construction of ambulatory care facilities for HMOs; (7) remove impediments to use of HMOs by Medicare and Medicaid. On the Medicare/Medicaid issue, it is being suggested that HMOs be paid prospectively by Medicare and Medicaid at 95% of the estimated amount that other health providers received from furnishing similar services; and (8) relax some of the administrative and organizational requirements that were in the prior Act. All of this has led to the following kinds of quotes: HEW Secretary Joseph Califano, "We intend this to be primarily the private sector's effort. I need not tell you that this may be one of the last chances for American free enterprise to tackle the task." Hale Champion said, "The HMO concept has come of age." He accused past administrations of fumbling policy decisions but said, "We have begun

to move and move vigorously to bring this program to life." And, finally, Senator Schweiker stated, "HMOs are certainly not the ultimate answer to all our health care problems. But the health care debate in this country has convinced more and more people that we need structural reform of the health care system through the kind of positive incentives HMOs offer." The Senator also contends that HMOs have proven that they can save money and are "just the kind of incentive base reform that will make the system more self-regulating with a minimum of government oversight. They offer a real hope for badly needed competition in the health care field." Couple all this with industry's expressed interest and their good attendance at the Califano pep rally and I think one would be ill-advised to bet against a resurgence of the HMO concept with emerging new plans and expanding current plans, especially in the urban areas.

The Teaching Hospital and Especially the University Teaching Hospital Cost Issue

Before moving into the G.W. experience, I would like to suggest that we agree that the teaching, tertiary-care hospital, whether community-based or university-controlled, is a more costly inpatient facility than a community hospital not involved in referral care and/or educational endeavors. Some of the elements that cause patient care costs in a major teaching hospital to be greater than patient care costs in hospitals of comparable size which do not have significant educational programs are as follows: (1) The costs directly related to the teaching function, such as housestaff and employed physicians; (2) the patient mix, encompassing both severity of illness and the proportion of medically indigent ; (3) a greater diversity of services; (4) a significantly great utilization of ancillary services, specifically the patterns of ordering laboratory tests and diagnostic radiologic examinations; and (5) a number of other, more subtle, indirect costs, related to space utilization, medical records support, etc.; all of which are necessary for a high quality teaching mission. Therefore, recognizing the enunciated goals of the HMO movement and the general acceptance that a teaching hospital is more costly, can these two porcupines mate? Perhaps the G.W. experience can shed some light on this question.

The George Washington University Hospital

The George Washington University Hospital is a thirty year-old, acute medical/surgical unit, located in downtown Washington, on Pennsylvania Avenue. It is a non-profit, University-owned hospital of some 530 beds, offering the usual array of services with the exception of Pediatrics; the Pediatrics Department and Pediatric Services being housed in the Children's Hospital National Medical Center, a separate entity. The fiscal mix is 70% third-party carrier, 20% self-pay and 10% bad debts and allowances. Within the Hospital cost base are the Graduate Education Programs - 350+ housestaff - and the partial support of a significant number of clinical faculty. The University Hospital has had a balanced budget for the last five years, based on approximately 150,000+ patient days or between 80-85% occupancy. Although its charge structure is one

of the highest in the area, this being necessitated by 20% of the full-pay patients picking up the unpaid costs of 10%, its per kiem costs are comparable to the other teaching hospitals in the city. The University Hospital has always operated on a one class "open staff concept." The Medical and Dental Staff consists of two subsets: One, the geographical full-time faculty of the School of Medicine and Health Sciences and, two, the part-time or clinical faculty made up of practitioners from the Washington, D.C. community. This arrangement between part-time and full-time people has not always been amicable; however, during the past five years or so, most of the differences have been settled so that the Chairmen of the Academic Departments/Chiefs of Service set the policies for the institution in the arena of education with the predictable impact on patient care, in that all patients are available for teaching purposes and the voluntary, part-time faculty are treated with respect. In this environment, there are the usual rounding physicians, house-staff order-writing, and hallway consultations that one would observe at most university hospitals. Parenthetically, Washington, D.C. is the most overbedded community in the nation - 7.3 bed/1000 population - with very little effective metropolitan-wide health planning. Therefore, compatible arrangements between voluntary faculty and full-time faculty within the University Hospital is important for its fiscal viability.

The Group Health Association

The Group Health Association was founded in Washington, D.C. approximately 40 years ago by 2000 employees of the Federal Homeowners Loan Corporation. As noted earlier, it was this organization that, after its conflict with the Medical Society of the District of Columbia pressed for the Supreme Court decision in 1943. However, despite this victory, it has only grown to a current enrollment of slightly over 100,000. The organization of Group Health Association is quite dissimilar from Kaiser. It is governed by a Board of Directors elected from the enrollee membership. The Board employes an executive director who is responsible for all operations of Group Health Association. One of these is the hiring of physician providers. The physicians in Group Health Association have traditionally been, therefore, employees of the consumer Board, working through an executive director on a fixed salary. In the past few years, this arrangement has been changed because of physician dissatisfaction. First, the physicians organized into a medical council which had the authority to hire, fire and fix salaries for physicians within a prospectively negotiated budget. However, after an examination by the National Labor Relations Board it was ruled improper and has now been replaced by a formal union structure. The physician union is recognized by the NLRB and does negotiate directly in collective bargaining with GHA. In fact, this past April, the physician union was on strike for 11 days. Another significant factor is that GHA sub-contracts hospitalization coverage to Blue Cross and is therefore not self-insured.

Group Health Association operates four ambulatory units; however, the major ambulatory structure is on Pennsylvania Avenue, directly across

from the George Washington University Hospital. While on this site since 1962, the Group Health Association had an on-going relationship with the University Hospital until 1976. This relationship took two forms. Most significant was that the physicians hired and employed by the Group Health Association were awarded clinical faculty appointments in their respective departments of the Medical School and appropriate Hospital staff admitting privileges. These physicians then elected to admit almost exclusively to the University Hospital. A small subset arrangement was established between the Group Health Association, Inc. and the Department of Surgery of the Medical School wherein, on a capitation basis, the Department of Surgery provided all surgical services to Group Health Association patients.

The fourteen-year relationship between Group Health Association and the George Washington University Hospital was not always smooth but appeared to be mutually beneficial. Maintenance required a series of accommodations and diplomacy on both sides. It was understood that each new physician to be hired by GHA would be interviewed and screened by the appropriate departmental chairman at the School so that, if hired, he or she would be offered a part-time academic appointment and, subsequently, hospital admitting privileges. Although this courtesy was almost uniformly acted out, there were some occasions when it was neglected and the issue of academic appointment and admitting privileges precipitated a crisis. This issue of hospital privilege was especially sensitive when medical staff disciplinary action against any specific group practice physician was necessary. Over the years, the GHA physician tended to use the Hospital Emergency Room as an after-hours out-patient facility, a habit which caused concern, expressed not only by the full-time faculty and housestaff at the University Hospital but also amongst the enrollees at Group Health Association. More recently, the issue of required pre-operative laboratory test was frequently debated and accommodation was made to Group Health Association and other large group practices in that standard pre-admission tests performed in their facilities, such as EKGs, chest x-rays and blood screens, would be accepted in lieu of repeating these studies at the University Hospital, if the chest film and EKG accompanied the patient on admission and if the laboratories were evaluated by the University Hospital Clinical Laboratories Division. Group Health, understandably, frequently suggested that other laboratory studies should be acceptable when done at Group Health facilities and even that in-patients could have their blood tests performed by GHA rather than by the University Hospital Clinical Laboratories. These requests were denied. Nonetheless, although occasionally stormy, the vast majority of the time, the relationship was relatively smooth and GHA saw the University Hospital as a convenient, high-quality in-patient facility which was helpful to them in recruiting their physicians and a positive marketing factor; and the University Hospital viewed the GHA as an important volume client contributing a spectrum of patients to the medical education mission.

However, in 1976, with inflation and rapidly escalating hospital costs, GHA decided to review its position. As I mentioned, the hospitalization portion of the GHA contract is subcontracted through Blue Cross of Washinton, D.C., which means that the GHA cost at the University Hospital was the same as that of non-GHA Blue Cross recipients. In February 1976,

I was informed by Group Health Association that (1) the Surgical contract would be terminated and the penalties for early termination paid and (2) the physician group at GHA would be instructed to admit the vast majority of their patients to Doctors Hospital, an investor-owned, for-profit, 284 bed facility. I do not have the comparable cost data for any other institution but since there is some, although not always linear relationship between costs and charges; allow me to share with you the charge for the most prevalent semi-private room at George Washinton University Hospital at that time which was $165.00 per day, while Doctors Hospital was $123.00 per day. GHA physicians were still authorized to admit obstetrical cases to GW Hospital and those tertiary care cases that they felt would require our expertise. GHA believed that the move would save it over 1 million dollars per year. Conversely, GW estimated that the GHA patient days constituted approximately 20% of the total revenues of the GW Hospital ($35 million) and 18% of the total admissions. The reactions to this rather unexpected announcement were predictable. The GW faculty were enraged; however Administration could not afford that luxury and had to focus our concern on the fiscal impact of this precipitous decision on the University Hospital. The data in February 1976, when this announcement was made, was that the GHA annual patient days were as follows: in Surgery - 18,353; Medicine-9,580; OB - 4, 492. During the next 20 months, there were marked census shifts and a general fall in occupancy. By November, 1977, GHA utilization had stabilized and has since remained constant; that is, Medical/Surgical annual bed days have stabilized at 8,322 or a decrease of 70%. On the other hand, OB annual bed days have increased to 5,147 or an increase of 15%. It is significant to note that the University Hospital would have experienced, if Group Health Association admissions were the only factor, a total decrease of some 27,000 bed days. However, it experienced only a third of that decrease, or a decrease of 9,000 bed days. This occurred as a result of other physicians - voluntary, part-time - outside of GHA, admitting increasing numbers of their patients to the University Hospital at an incremental rate of some 5-7% per year so that some 9,000 new bed days have been added to the Hospital and this positive trend is continuing. The other factor was that GHA did not remove all of its Medical/Surgical patients and continues to utilize the University Hospital for tertiary care, specifically in the surgical arena. Currently, Group Health Association is petitioning the District health planners for a Certificate of Need to build its own facility within the District of Columbia, since Doctors Hospital is to be demolished as part of urban renewal. This is currently a very complicated and extremely hot issue since, at 7.3 beds per 1000 population, from a health planning point of view, no new beds should be added in the District of Columbia at this time. However, for political reasons, some accommodation will probably be made to the Doctors Hospital Medical and Dental Staff, which may well include GHA's requirements.

The George Washington University Health Plan is a new plan, having been initiated in 1972, jointly under an umbrella organization, with the Georgetown University Health Plan. These two embryo plans agreed to be umbrelled by an organization called the University Affiliated Health Plans, Inc., as a marketing vehicle primarily targeted on the federal employee group. As both of these plans have matured, it was recently

decided to dissolve the umbrella corporate relationship. The Georgetown plan is significantly dissimilar from GW's plan in a number of respects. The two most striking differences are: the Georgetwon plan is manned by part-time faculty who are not employees of Georgetown University but rather employed by the HMO; and it is housed in a number of satellite out-patient facilities which utilize a set of community hospitals for in-patient admissions. The George Washington University Health Plan physicians are all geographic full-time faculty of the George Washington University Medical Center. It has one centralized ambulatory facility and exclusively utilizes the University Hospital and Children's Hospital for admissions. George Washington University Health Plan now has some 15,000 enrollees, is fiscally solvent without any outstanding loans or debts. Its organizational structure is as follows: The George Washington University Health Plan Incorporated is a separate corporation from the University; however, the majority of the Board of Directors are appointees of the President of the George Washington University. The remainder of the Board represents business, Blue Cross and enrollees. The Corporation contracts with Blue Cross for hospitalization coverage as well as for excess reinsurance, and contracts with the George Washington University School of Medicine and Health Sciences, Department of Health Care Sciences for providers - M.D., Nurse Practitioners, and Physician Assistants, as well as administrative staff and contracts, as well with the University for administrative support services. This, therefore, is significantly less than an arm's length relationship with the University. In fact, most of the individuals involved carry major responsibilities either in the University or in the Medical Center. In addition, the Plan contracts, on a capitation basis, with the academic Medical Center departments for specialty, consultative and diagnostic services.

Since its inception, the Plan has grown and is currently considering a satellite in another part of the city which would utilize a different in-patient facility. The Medical Center encouraged and supported the development of the HMO primarily as an educational vehicle to present to medical students, both undergraduate and graduate, as well as Physician Assistant and Nurse Practitioner students, an opportunity to experience in a controlled setting the prepaid practice mode. This primary goal explains the organizational structure. This has been very successful and, in fact, is viewed by the students as a most popular ambulatory experience. In addition, the HMO has enabled the Department of Health Care Sciences to develop a Primary Care Residency Program which is an admixture of Pediatrics and Internal Medicine with a heavy emphasis on office gynecology, ophthalmology, dermatology, orthopaedics, etc., with the graducate being board-eligible in either Pediatrics or Internal Medicine. This program is of growing popularity and offers a reasonable alternative, in our view, to the traditional family practice model for primary care in the urban setting. The presence of the Health Plan has led to the generation of a number of health systems evaluation research programs and publications. Therefore, from the academic point of view, it has been and continues to be successful and growing. From the point of view of the Hospital, the number of admissions to the University Hospital, other than for Obstetrics, is relatively small (4,383 patient days/year). HMO patients are admitted under the control of the HMO

physician who, as I stated, is a full-time member of the faculty. As full-time faculty, they are viewed no differently than full-time faculty in the traditional disciplines and receive the same respect from house-staff and colleagues. As such, they participate in the management of their patients in the same manner as any other primary care physician, admitting to the University Hospital. In this way, they have control not only of admissions but also of length-of-stay and of diagnostic services performed. In our view, this control of hospital utilization coupled with the extensive deployment of physician extenders in the ambulatory sector, has enabled the George Washington University Health Plan to remain competitive with the Georgetown Health Plan, which as I mentioned does not utilize full-time faculty and admits to community hospitals; Group Health Association, which utilizes Doctors Hospital; and Blue Cross/Blue Shield for the marketplace. This competitive relationship from a premium point of view has been well established from marketing comparisons with Blue Cross, Group Health, the Columbia, Maryland Plan and the Georgetown University Health Plan; wherein the high-option, family program premium is almost identical. In speaking with the Administrator of the Health Plan, he believes that there are significant advantages for a centralized plan in having a relationship with the University Hospital, despite the obvious disadvantage of the higher per diem cost. He believes that as a new and growing plan with only 15,000 enrollees, they could not offer the span of specialized services without the University Hospital relationship. In addition, the fact that the practitioners are all full service faculty aids the Plan in recruiting high quality physicians to the HMO, since it offers the opportunity for continued personal academic growth and stature. He also strongly believes that the relationship to the University and its Hospital are positive marketing elements especially for the urban, white-collar federal employee. On the negative side however, there are some concerns as to the conflict of the teaching mission in the prepaid setting with the service mission. There has been some enrollee dissatisfaction related to the presence of students; but, on the other hand, there has been enrollee satisfaction related to the presence of housestaff. Some of the physician faculty have had difficulty in partitioning their time commitments between the patients and precepting the students. Nonetheless, most of the physicians would not give up this preceptor/student relationship even if it required a major extension of their time commitments. On balance, the administrators, the providers and the enrollees, believe that the current arrangement between the George Washington University and its Health Plan has been more positive than negative and, in fact, when options for organizational change are explored,most urge continuation.

In summary, the two disparate experiences have suggested to us the following insights: (1) the reostat on the attitude toward hospital utilization is a greater factor in cost control than the average per diem cost of a hospital day viewed in isolate. Parenthetically, the current charge for the most prevalent semi-private room at the George Washington University Hospital is $175 per day and at Doctors Hospital $163 per day; in other words, in the past two years, George Washington's charge per day has gone up $10 whereas Doctors has gone up $40. (2) Joint involvement

of the hospital with the HMO in the recruitment and selection of HMO staff is an important prophylactic measure in averting conflict and in creating the positive peer relationships. And, (3) open discourse relative to the trade-offs inherent in the relationship is critical, with a special emphasis prospectively not only to the marriage contract but also to the necessary settlements if a divorce were to occur.

Conclusions

I have attempted to review objectively the experience that the George Washington University and, specifically, its University Hospital, has had with two HMOs. One, a mature and large HMO, Group Health Association of Washington, D.C., with which it no longer has any meaningful ongoing relationship and, second, the George Washington University Health Plan, a new, evolving but fiscally-stable plan which is intimately interwoven in both the administrative and faculty organization of George Washington University. As stated earlier, I don't know if these experiences can offer insight into the types of issues which other teaching institutions might face with an HMO, since they may well have been site specific as to time, place and organization, but I would like to share some generalizations we have formulated as a result of the experiences. We, at George Washington, do not try to excuse or argue away the fact that our Hospital is a high-cost, tertiary, medical/surgical unit with one of the highest per diems in the region. We accept the fact that this is due to a combination of patient mix, diagnostic tests, scope of services, the direct costs of personnel and other indirect support costs. We are convinced that the teaching environment has a direct, positive relationship in maintaining high quality patient care. We believe that the physician, if trained and knowledgeable of the prepaid mission is more likely to hospitalize only when required. In addition, when the HMO physician maintains a collegial, peer relationship with the other physicians on the staff of the Hospital, it is easier for them to control the length-of-stay, consultations and orders written on their hospitalized patients. Also, the presence of senior house staff within the teaching hopital environment, contribute significantly to patient care, therefore, enable the HMO to operate with fewer full-time primary care physicians and other health professional personnel.

The problem of admitting privileges, delineation of privileges, bed access, and operating room priority within the teaching hospital is frequently an all or none phenomenon, since it is difficult for the hospital to selectively delete individual HMO physicians, who are practicing together in a group. In my view, prospectively negotiated firm contracts with the HMO are required which specifically delineate the search and selection process for those people who will be expected to have admitting privileges in the teaching hospital; as well as what procedures will be followed if disciplinary actions must be taken by the teaching hospital against an individual physician who belongs to the health maintenance organization. The health maintenance organization may desire to control a set of beds relative to availability and staffing patterns. This has been specifically

highlighted in the George Washington situation wherein Group Health Association wished to utilize nurse midwives in the labor and delivery suite, a situation which the Department of Ob/Gyn felt was in direct conflict with the educational mission. Therefore, bed access and staffing patterns should be prospectively handled in the contract between the HMO and the teaching hospital. Similarly, operating room time and in-and-out surgery is another issue which should be prospectively addressed openly by both parties. Perhaps the major issue that should be seriously considered by both the Plan and the teaching hospital is the uncertainties which surround the development of the prepaid health plan. If the teaching hospital has a direct involvement in an HMO, there is the potential fiscal risk if the Plan fails. However, even if there is no direct involvement, there is a real potential for serious problems caused either by rapid growth or sudden decrements in HMO membership and/or the HMO's utilization of the teaching hospital and its staff. In view of "open-season" requirements and the "dual option", it is unlikely that either party can conrol these potential swings early on in the life of the HMO. Having a significant percentage of a teaching hospital's occupancy dependent on an organized and cost-conscious practice is a potential trouble spot, depending on the number of options a prepaid plan has in its choice of hospitals. It is obvious that the sudden withdrawal of a significant percentage of a teaching hospital's admissions could be a major concern. Also, as HMOs enlarge, they are usually capable of developing their own specialty staff and services. This capacity might strain the relationship between the HMO and the hospital-related fee-for-service physicians.

I have not attempted to be exhaustive in my compilation of issues but rather focused on those situations which impacted on us. Also, I'm convinced that many issues are time-and-place specific. Nonetheless, from our two experiences, I would like to suggest that a prepaid medical plan can cohabit with the teaching hospital if the trade-offs are clearly understood, accepted and explicitly enunciated in the contractual arrangements. The teaching hospital, in return for the opportunity to educate students and/or housestaff in primary care ambulatory and in-patient settings, may well wish to offer the HMO access and some selected priorities. The HMO, in accepting the probability of a high per diem, may appreciate the advantage in provider recruitment, the prestige of the teaching hospital in marketing, and that housestaff availability in both in-patient and ambulatory services may decrease the number of fully employed physicians necessary for the plan.

To return to the porcupine, this is indeed a difficult mating, but it has become clear that the HMO movement with increased federal support will survive and will become a new force in more and more areas of the country; if the mating is unsuccessful, a separate hospital and teaching system will be required to sustain the HMO movement and such a duplication of effort cannot be condoned by the planning agencies. Such a confrontation would not serve us well and might lead to the consideration of decertification of beds in teaching hospitals. In addition, if prepayment is to become a significant element in the health system of this nation, the medical centers and the teaching hospitals must continue

their well-accepted responsibility for the education of medical and allied health personnel and, therefore, must prepare them with experiences in the prepaid system.