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

AGENDA

MEETING OF COTH - COD
COMMITTEE ON FINANCIAL PRINCIPLES
Friday, March 28, 1969
10:00 a.m. - 4:00 p.m.
Plaza Room
Hotel Dupont Plaza
1500 New Hampshire Avenue, N.W.
Washington, D.C. 20036
202/483-6000

I.	Call to Order -- 10:00 a.m.	
II.	Approval of Minutes of Meeting of November 21, 1968	Tab A
III.	Introduction of New Committee Members	Tab B
IV.	Brief Report on February 26th Meeting at the National Institutes of Health on General Clinical Research Centers	Tab C
V.	Report on Correspondence Received from Ernest N. Boettcher, M.D., and William D. Mayer, M.D. -- Possible Action	Tab D
VI.	Discussion of Request to Committee from the AAMC Committee on Federal Health Programs -- Possible Action	Tab E
VII.	Discussion and Recommendations on AAMC Position, Development of Testimony and Selection of Witnesses If There are Hearings by the Senate Committee on Finance -- COTH-COD Questionnaire	Tab F
VIII.	Memorandum of Information Concerning Fees for Professional Services to Medicare Patients in Teaching Hospitals	Tab G
IX.	University of Iowa Program for Supporting Fellowship Training	Tab H
X.	Other Old Business	
XI.	New Business	
XII.	Adjournment -- 4:00 p.m.	

** Luncheon will be served at 12:30 p.m. in the Plaza Room

Chairman to his designate.

COUNCIL OF TEACHING HOSPITALS
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1346 Connecticut Avenue, N.W.
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MEETING OF COMMITTEE ON FINANCIAL PRINCIPLES FOR TEACHING HOSPITALS

O'HARE AIRPORT
CHICAGO, ILLINOIS
NOVEMBER 21, 1968
10:00 a.m. - 4:00 p.m.

Present:

Charles R. Goulet, Chairman
Richard D. Wittrup, Vice Chairman
Vernon L. Harris
Gerhard Hartman, Ph.D.
Arthur J. Klippen, M.D.
Bernard J. Lachner
Roger B. Nelson, M.D.
Francis J. Sweeney, Jr., M.D.
Lawrence E. Martin
Robert C. Linde, AHA Representative
Franklin Denney (Treasurer and Chief Accounting Officer, North Carolina Baptist Hospitals, Inc., Winston-Salem, North Carolina) attended at Reid T. Holmes request because of the latter's inability to be present.

Invited Guest:

Stuart M. Sessoms, M.D.
Director
Duke University Medical Center
Durham, North Carolina

Also Present:

Roger L. Amidon, Ph.D.; Assistant Professor, Graduate Program in Hospital and Health Administration, University of Iowa, Iowa City, Iowa

Staff:

Matthew F. McNulty, Jr., Director , COTH; Associate Director, AAMC
Fletcher H. Bingham, Ph.D., Assistant Director, COTH
Thomas J. Campbell, Assistant Director, Division of Operational Studies, AAMC
Richard M. Knapp, Ph.D., Project Director, Teaching Hospital Information Center, COTH
Armand Checker, Staff Associate, COTH

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

II. Welcome to Invited Guest:

Mr. Goulet, Chairman, welcomed Stuart M. Sessoms, M.D., Director, Duke University Medical Center, Durham, North Carolina as a guest participant in the committee meeting. Mr. McNulty introduced Mr. Checker and Dr. Knapp, and indicated that Dr. Bingham would henceforth maintain staff responsibility for the activities of the committee.

III. Approval of Minutes, Meeting of June 6, 1968:

The minutes of the June 6, 1968 meeting were approved as distributed.

IV. Report on Action Items from June 6th Meeting:

The Chairman reviewed the action items from the June 6th meeting and asked Mr. McNulty to comment on the action taken on the following items:

Action #1 -- The Draft "Statement on Financial Principles" was referred to the Subcommittee for further refinement. Upon completion of this assignment, the revised document will be circulated to the full Committee by mail for further evaluation and comment.

Action #2 -- The Committee should be working to meet a September 5 and 6 deadline, the dates of the next meeting of the COTH Executive Committee. At that time, it is anticipated that a document will be presented for Executive Committee review, comment and disposition.

Mr. McNulty indicated that following further refinement by the subcommittee, final evaluation had been undertaken through Committee comments by mail.

The resulting statement, entitled "Guidelines for Allocating Program Costs in Teaching Hospitals", was subsequently approved by the Executive Committee on September 6th and the Institutional Membership on November 4th in Houston. COTH staff has also requested that the statement be placed on the agenda for the December 17th meeting of the AAMC Executive Council. Dr. Hartman felt that the document needed an additional paragraph to counteract what he believes is an abrupt concluding statement. It was the consensus of the committee that if the staff believed this necessary it could be accomplsiehd without the usual need for approval.

V. Further Charge to Committee on Financial Principles for Teaching Hospitals by COTH Executive Committee, Meeting of September 5 and 6, 1968:

"It was agreed that the Committee on Financial Principles Study the Problems of Payment to House Staff and Attending Physicians, as well as Definition of Includable Costs."

The Chairman introduced the charge from the Executive Committee, and a discussion of house staff financing and faculty and attending staff fees ensued. The following individual approaches to the problem were discussed, indicating that a consistent inter-institutional policy was not in evidence:

1 - Usual and customary fees are being charged by all faculty and attending physicians with the exception of radiology, pathology anesthesiology which are cost related. The issue in this case is one of identifying includables and appropriate expense items;

2 - Faculty on state salary with no limit on collection of fees from private patients;

3 - All house staff paid with hospital funds. Private patients are billed the usual and customary fee which is administered through a Medical Service Plan organizationally located in the College of Medicine.

4 - Supervisory fees under Title XVIII, Part A have been escrowed pending future developments;

5 - Professional fees are not billed through the hospital. The position has been taken that house staff should be reimbursed by the institution, not the professional fee. The rise in house staff stipends has put pressure on this position.

6 - A professional fee is not billed unless supervision is "eyeball to eyeball."

7 - House staff is financed through a medical service plan supported by pooled physician fees.

It was the general consensus of the committee that there have been few approaches built on the unique situation in which the teaching hospital finds itself. Present approaches are based upon the concepts of solo medical practice as it relates to the community hospital. It was further indicated that from the standpoint of the federal government, two basic questions may be asked in the future:

1 - Were the funds used for the purpose for which they were intended?

2 - Was there evidence that something had been reimbursed twice?

The Chairman called the question, and it was decided that the Committee should address itself to this problem. It was also the consensus of the Committee that selected members of the Council of Deans and Council of Academic Societies be requested to become involved. The Chairman suggested the first priority should be one of ascertaining current practices. It was therefore agreed that staff would prepare a questionnaire to be sent to selected institutions and covering the following items:

1 - definition of supervision;

2 - house staff financing;

3 - house staff salaries;

4 - fee for service billing by supervisory physicians not engaged in private practice;

a. Title XVIII, Part B

b. Title XIX

5 - changes in practice following Medicare;

6 - usual and customary fee versus cost relationships as a basis computing remuneration for full-time faculty clinical services;

7 - bases on which to judge the number of house staff positions which should be offered.

It was further decided that data presently available should be summarized demonstrating the rapid growth of full-time faculty, increased length of medical training and differential financing for the delivery of service to low income patients.

ACTION #1 THE COMMITTEE DIRECTED THE STAFF TO PREPARE A QUESTIONNAIRE TO BE SENT TO SELECTED INSTITUTIONS FOR THE PURPOSE OF ASSESSING THE CURRENT SITUATION WITH REGARD TO HOUSE STAFF FINANCING AND THE FINANCIAL PATTERNS OF PART-TIME AND FULL-TIME CLINICAL FACULTY MEDICAL PRACTICE. THE STAFF WILL SOLICIT EVALUATIONS OF THE PROPOSED QUESTIONNAIRE FROM MEMBERS OF THE COMMITTEE. OTHER DATA RELEVANT TO THIS ISSUE WILL ALSO BE SUMMARIZED IN A MANNER MEANINGFULLY RELATED TO THE DIMENSIONS OF THE QUESTIONNAIRE.

ACTION #2 THE COMMITTEE DIRECTED THE STAFF TO PREPARE A GENERAL MEMBERSHIP MEMORANDUM INDICATING THE PRESENT AND FUTURE IMPLICATIONS OF THE ISSUE OF "DUAL PAYMENT." MEMBER INSTITUTIONS SHOULD BE ENCOURAGED TO EXAMINE THEIR ACCOUNTING SYSTEMS TO ENSURE AN AVOIDANCE OF DUPLICATE PAYMENTS.

ACTION #3 THE COMMITTEE DIRECTED ITS CHAIRMAN TO WORK WITH STAFF TO EVOLVE STAGGERED MEMBERSHIP TERMS IN ORDER TO PROVIDE AN ORDERLY OPPORTUNITY FOR COMMITTEE PARTICIPATION BY ALL INTERESTED INDIVIDUALS.

VI. Report - Design Review Committee Meeting (Seven Medical Centers):

Mr. Campbell stated that the Steering Committee had accepted and endorsed the report at a meeting on November 20th. The following efforts will be undertaken during the coming year related to the study:

1 - publication of the report;

2 - jointly sponsored workshops on program costs;

3 - encouragement of additional medical centers to review the possibilities offered by program cost studies;

4 - possible changes in federal requirements;

5 - revision of the guidelines.

Mr. Campbell stated that the University of Iowa had implemented a unique approach to time and effort reporting. Dr. Hartman indicated his willingness to share the approach with those who are interested.

VII . Correspondence from Stuart M. Sessoms, M.D., William G. Anlyan,M.D. and Reid T. Holmes concerning financial support for the medically indigent:

The Chairman called attention to the correspondence from Drs. Sessoms and Anlyan and Mr. Holmes. These letters are attached and made a permenent part of these minutes.

Following lengthy discussion of the issue, Committee members cited local and regional experiences toward resolution of the problem. It was agreed that the problem is not one which is subject to resolution at the national level. However, it was suggested that the "Guidelines for Allocating Program Costs in Teaching Hospitals" would be appropriate documentation for use at the state and local level. Additionally, it was agreed that the problem of adequate working capital is one that requires constant attention at the national level.

ACTION #4 — BECAUSE THE CHARGE TO REVIEW THIS ISSUE (FINANCIAL SUPPORT FOR THE MEDICALLY INDIGENT) ORIGINANTED WITH THE AAMC EXECUTIVE COUNCIL AND THE COTH EXECUTIVE COMMITTEE, THE STAFF WAS DIRECTED TO PREPARE AN APPROPRIATE RESPONSE TO THESE TWO BODIES.

ACTION #5 — THIS ISSUE (FINANCIAL SUPPORT FOR THE MEDICALLY INDIGENT) WAS RECOMMENDED FOR FURTHER REVIEW AT THE COTH SOUTHERN REGIONAL MEETING IN ATLANTA ON APRIL 30, 1969.

VIII. Report - Upcoming Meeting of Teaching Hospital Administrators with Representatives of Clinical Research Centers Branch and Other NIH Personnel:

The Chairman directed attention to an October 1, 1968 Memorandum from William R. DeCesare, M.D., Chief, GCRC Branch, Division of Research Facilities, NIH which is attached as a permenent part of these minutes. The Committee noted that a meeting of selected COTH members and pertinent NIH staff would be held to discuss the implications of this Memorandum.

IX. New Indirect Cost Payment:

Mr. Lawrence E. Martin, a member of the Grants Administration Policy Advisory Committee, made a thorough presentation of the proposed new indirect cost

payment system. Mr. Martin indicated that the objective of the system is to allow NIH to settle indirect cotst at any institution for all research projects at one time.

X. AHA Statement on Financial Requirements for Health Care Institutions:

Mr. Linde briefly described the substantive changes as reflected in the "Exposure Draft". These changes were noted by the Committee.

XI. Future Meeting Dates:

It was indicated that the next meeting of the Committee will be held in the Spring of 1969 at the call of the Chairman.

XII. There being no further business, the meeting was adjourned at 3:40 p.m.

COUNCIL OF TEACHING HOSPITALS
COUNCIL OF DEANS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
1346 Connecticut Avenue, N.W.
Washington, D.C. 20036

COMMITTEE ON FINANCIAL PRINCIPLES
1968 - 1969

Chairman	Charles R. Goulet * Director University of Chicago Hospitals and Clinics 950 East 59th Street Chicago, Illinois 60637
Vice-Chairman	Richard D. Wittrup** Assistant Executive Vice President Affiliated Hospitals Center 641 Huntington Avenue Boston, Massachusetts 02115
COTH Representative Three-Year Term (1968-1971)	Bernard J. Lachner Administrator Ohio State University Hospitals 410 West Tenth Avenue Columbus, Ohio 43210
	Lawrence E. Martin Associate Director and Comptroller Massachusetts General Hospital Fruit Street Boston, Massachusetts 02114
	Francis J. Sweeney, Jr., M.D. Hospital Director Jefferson Medical College Hospital 11th and Walnut Streets Philadelphia, Pennsylvania 19107
	Irvin G. Wilmot Associate Director for Hospitals and Health Services New York University Medical Center 560 First Avenue New York, New York 10016
Two-Year Term (1968-1970)	Gerhard Hartman, Ph.D. Superintendent University of Iowa Hospitals Iowa City, Iowa 52240

Committee on Financial Principles
1968-1969

Two-Year Term (Continued)	Reid T. Holmes Administrator North Carolina Baptist Hospitals, Inc. 300 South Hawthorne Road Winston-Salem, North Carolina 27103
	Roger B. Nelson, M.D. Senior Associate Director University Hospital University of Michigan 1405 East Ann Street Ann Arbor, Michigan 48104
One-Year Term (1968-1969)	Vernon L. Harris Administrator University of Utah Hospital 50 North Medical Drive Salt Lake City, Utah 84112
	Arthur J. Klippen, M.D. Hospital Director Veterans Administration Hospital 48th Avenue and 54th Street Minneapolis, Minnesota 55417
COD Representatives	Robert H. Felix, M.D. Dean School of Medicine Saint Louis University 1402 S. Grand Boulevard St. Louis, Missouri 63104
	Leon O. Jacobson, M.D. Dean Division of Biological Sciences The University of Chicago School of Medicine 950 East 59th Street Chicago, Illinois 60637
	William D. Mayer, M.D. Dean School of Medicine University of Missouri Columbia, Missouri 65201
	Charles C. Sprague, M.D. Dean Southwestern Medical School The University of Texas 5323 Harry Hines Boulevard Dallas, Texas 75235

Committee on Financial Principles
1968-1969

AHA Representative

Robert C. Linde
Director
Division of Finance
Department of Research and Education
American Hospital Association
840 North Lake Shore Drive
Chicago, Illinois 60611

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

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

March, 1969

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE

NATIONAL INSTITUTES OF HEALTH
BETHESDA, MD. 20014
AREA CODE 301 TEL: 656-4000

February 18, 1969

Fletcher Bingham, M.D.
Assistant Director
Council of Teaching Hospitals
Association of American Medical Colleges
1346 Connecticut Avenue
Washington, D.C. 20036

Dear Doctor Bingham:

The General Clinical Research Centers Branch of the Division of Research Resources would appreciate your participation in a meeting to discuss policy for payment of hospital service charges for patients admitted to clinical research centers. The meeting will be held on February 26 in Building 1, Room 114, on the main campus of the National Institutes of Health from 10 a.m. to 4 p.m. Specific items for consideration are identified on the enclosed agenda.

The General Clinical Research Centers program currently supports approximately 90 discrete bed units which until recently have been available exclusively for the hospitalization of research patients. On October 1, 1968, because of budgetary constraints, program policy was altered to allow centers the option of admitting a limited number of "service" patients for routine hospital care. Implementation of this policy has raised a number of questions which require discussion and clarification.

A number of centers have indicated that at least some "service" patients admitted for routine care are suitable for study on previously approved research protocols. In such cases, investigators have asked: 1) whether the clinical research center may be charged if research procedures are undertaken, though not required for routine care; and 2) whether the grant may be charged for that portion of routine nonresearch care services not covered by the patient's insurance carrier?

Another area of concern in "service" patient policy has been the development of appropriate reimbursement methods to compensate the center grant for directly funded operating expenses such as nursing. Some centers have elected to reimburse the grant at a rate calculated as the average per diem rate for bedside nursing in the entire hospital. Other hospitals have proposed that the center grant be reimbursed for "service" patient nursing on the basis of a pro rata share of the nurses assigned to the Center.

Fundamental to the current budgetary constraints on the program is the question whether the admission of "service" patients to clinical centers to help offset operating expenses results in any real benefit to the conduct of research. Clearly, significant clinical research can be accomplished in certain patients hospitalized and charged for routine hospital care. However, the fraction of patients that meet the criteria for both research and service is limited as is the monetary gain from these admissions. If an attempt to perform research on otherwise "service" patients results in selection of financially suitable patients, then the autonomy and integrity of research may be compromised.

Your willingness to participate in a discussion of these important issues is appreciated.

Sincerely yours,

William R. DeCesare, M.D.
Chief, General Clinical Research
Centers Branch
Division of Research Resources

DRAFT
12/26/69

Definitions for Meeting on Policy of Admission of Service Patients to General Clinical Research Centers

1. Research Patients

   Patients admitted to a discrete research center for the purposes of participation in an approved clinical research project in accordance with a research protocol.

2. "Service" Patients

   Patients admitted to a discrete research unit who require hospital care for their condition and who are able to pay for hospital care either directly or through third party insurance carriers.

3. Research "Service" Patients

   "Service" patients admitted to a discrete research center who require hospital care and who meet the criteria of an approved research protocol.

4. Research Hospitalization Care

   Hospital care over and above normal hospital care received by a study patient as a result of his inclusion in a clinical research study.

5. Discrete Beds

   A group of beds geographically separated and reserved exclusively as a clinical research unit.

6. Scatter Beds

   Any hospital beds utilized for clinical research other than those in geographically discrete units.

AGENDA

General Clinical Research Centers Meeting
National Institutes of Health
February 26, 1969
10 a.m. - 4 p.m.
Bldg. 1, Rm. 114

I. Introductory Remarks

Dr. Ronald Lamont-Havers, Associate Director, Extramural Research and Training, NIH
Dr. Thomas Bowery, Acting Director, Division of Research Resources, NIH

II. Remarks by Dr. Fletcher Bingham, Assistant Director, Council of Teaching Hospitals

III. Background of the Meeting

Dr. William R. DeCesare, Chief, GCRC Branch, DRR

IV. General Discussion

A. Admission of service patients to General Clinical Research Centers.

1) Reimbursement of the center grant for directly funded operating expenses
2) Research charges on "service" patients

B. Charges to patients and/or their insurance carriers for hospitalization on discrete bed units.

List of Participants

Mr. W. Thomas Barnes
Associate Administrator of Finance
Johns Hopkins University
Baltimore, Maryland

Dr. Fletcher Bingham
Assistant Director
Council of Teaching Hospitals
Association of American Medical Colleges
1346 Connecticut Avenue
Washington, D.C. 20036

Dr. Truman Blocker, Jr.
President
University of Texas Medical Branch
Galveston, Texas 77550

Mr. Charles Goulet
Superintendent
University of Chicago Hospitals and Clinics
950 E. 59th Street
Chicago, Illinois 60637

ARTHUR FRENCH
PROGRAM DIRECTOR
ON. OF MICHIGAN

Mr. Harold H. Hixson
Administrator
University of California Hospitals
Parnassus and Third Avenues
San Francisco, California 94122

Dr. David M. Kipnis
School of Medicine
Washington University
St. Louis, Missouri 63110

Dr. Elliot V. Newman
Professor of Experimental Medicine
Vanderbilt University School of Medicine
Nashville, Tennessee 37603

Mr. Irvin G. Wilmot
Associate Director for Hospital and Health Services
New York University Medical Center
550 First Avenue
New York, New York 10016

ABSENT

NIH Staff

Dr. Ronald Lamont-Havers
Associate Director
Extramural Research and Training
National Institutes of Health
Bethesda, Maryland 20014

Mr. Richard I. Seggel
Associate Director, Administration
National Institutes of Health
Bethesda, Maryland 20014

Dr. Roger Black
Associate Director
Clinical Center
National Institutes of Health
Bethesda, Maryland 20014

Mr. Bruce Carson
Legislative Analysis Office
National Institutes of Health
Bethesda, Maryland 20014

Mr. Kenneth Miller
Grants Management Branch
Division of Research Grants
National Institutes of Health
Bethesda, Maryland 20014

DRR Staff

Dr. Thomas Bowery
Acting Director
Division of Research Resources
National Institutes of Health
Bethesda, Maryland 20014

Dr. Carl Douglass
Associate Director for Program Planning
Division of Research Resources
National Institutes of Health
Bethesda, Maryland 20014

Dr. William R. DeCesare
Chief, General Clinical Research Centers Branch
Division of Research Resources
National Institutes of Health
Bethesda, Maryland

Mr. Kenneth Anderson
Grants Management Officer
Division of Research Resources
National Institutes of Health
Bethesda, Maryland 20014

Mr. Robert Dickenson
Grants Management Officer
General Clinical Research
Centers Branch, DRR
Bethesda, Maryland 20014

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
NATIONAL INSTITUTES OF HEALTH
DIVISION OF RESEARCH FACILITIES AND RESOURCES
BETHESDA, MARYLAND 20014

Date: October 1, 1968

To: Principal Investigators, General Clinical Research Centers

From: Chief, General Clinical Research Centers Branch, Division of Research Facilities and Resources, NIH

Subject: Policy of Admission of Service Patients to General Clinical Research Centers

Since its inception in 1960 the General Clinical Research Centers program of the National Institutes of Health has maintained each unit as a discrete center, available exclusively for the hospitalization of research patients. All justified costs of center operations have been reimbursed within the limits provided in the annual statement of award. During the coming grant year funds available to the program will be insufficient to maintain effective operation at the level recommended by the National Advisory Research Resources Council. In order to permit effective operations at a reduced funding level while maintaining the discrete character of the unit, centers may elect the option of hospitalizing a limited number of "service" patients.

Centers wishing to exercise this option during the period October 1, 1968 to September 30, 1969 should submit a written proposal in accordance with the following guidelines.

1. To achieve optimal utilization of the Clinical Research Center, the Director of the Clinical Research Center and the hospital administration may agree to admit "service" patients to the Clinical Research Center. Such service patients who require treatment and hospital care and who are able to pay for hospital care either directly or through third parties may be billed by the hospital at its standard rate. Hospitalization for "service" patients shall not be chargeable by the hospital to the grant.

2. Admission of all patients to the Clinical Research Center will continue to be at the discretion of the Program Director of the Clinical Research Center. Patients, such as dialysis and intensive care patients who require an extraordinary share of directly funded operating services, shall not be admitted except on an approved research protocol.

3. The hospital will reimburse the grant for each patient day a "service" patient is housed in the Clinical Research Center at the then current rate of offset for bedside nursing salaries and fringe benefits provided in the approved rate agreement.

4. The number of patient days allocated to "service" patients shall not exceed one-fourth of the total patient days on the center in any one month period except by prior written agreement with the General Clinical Research Centers Branch.

5. Utilization of center beds for service patients should be accounted for on a monthly basis and included in the Annual Report. In addition, a tabulation of the annual number of patient bed days by patient diagnosis should be included for each admitting physician.

However, indigent & medically indigent patients provided a patient day (or days) of service will be what?

William R. DeCesare, M.D.

cc:
Program Directors
Financial Officers
Hospital Administrators
General Clinical Research Center Committee Members

Fixed. Variable.
Pink Book.
Average cost
Cost to charges.

AIR MAIL

SAINT LOUIS UNIVERSITY HOSPITALS
1325 South Grand Boulevard
Saint Louis, Missouri 63104
PR 1-7600

Firmin Desloge Hospital
David P. Wohl Memorial Mental Health Institute

Ernest N. Boettcher, M.D.
Director

February 4, 1969

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

Dear Mr. McNulty:

I am enclosing a copy of a letter just received from our Medicare Part B intermediary which brings to the fore the concerns that we have discussed previously about collecting professional fees for clinic patients.

Apparently the added attention on this subject was precipitated by governmental hospitals that were collecting these fees and placing them in general funds so that, conceivably, they could end up paying for the construction of highways. Our first concern should be to provide teaching hospitals with some guidance as to proper practices in this area.

The second concern is the implication in paragraph 4 that fees should be related to salaries. The author of the letter did assure me that the paragraph was intended to apply only to clinic patients but I feel that the distinctions between clinic and private patients will be increasingly difficult to make. Any move toward setting professional fees at a level relating to salaries could seriously jeopardize a major source of revenue of most of our medical schools.

You may wish to pass this information on to the Committee on Financial Principles. It would be of interest to know whether other teaching hospitals have heard from their local carrier as a result of the meeting referred to in the letter.

Sincerely,

Ernest N. Boettcher, M.D.
Director

ENB:ms
Encl.

GENERAL AMERICAN LIFE
INSURANCE COMPANY • ST. LOUIS, MO. 63166

AREA CODE 314
231-1700

E. H. BORMAN, Director
Professional Relations
Group Insurance Division

January 31, 1969

Title XVIII - Medicare

Ernest N. Boettcher, M.D.
St. Louis University
1325 S. Grand
St. Louis, Missouri 63104

RECEIVED
FEB 3 1969
DIRECTOR'S OFFICE

Dear Dr. Boettcher:

You will recall that we have had some discussion previously of the various aspects of the coverage under Part B Medicare of charges made by teaching physicians who supervise medical services rendered to clinic patients. Recently, in a meeting of Part B carriers in Baltimore, Social Security officials clarified the regulations with respect to the coverage and administration of claims on these charges.

The points covered in this discussion were as follows:

1. Carriers were reminded that coverage is provided under Part B only with respect to services rendered by teaching physicians. Services rendered by interns and residents in training are not covered even though the resident is fully licensed to practice. If such a physician is involved in securing additional training or experience in a particular specialty, etc., then, under the law, coverage is only provided on a cost basis through the Part A intermediary.

2. It was recognized that teaching physicians would have both private and clinic patients and that, depending upon local practice, interns and residents may be involved with both types of patients.

3. The extent of involvement of an intern or resident with a patient is not a factor in determining the coverage or amount of reasonable fee which might be charged by a supervising physician or school. However, for coverage to be provided under the Medicare program, the supervising or teaching physician must be physically present and provide immediate personal supervision of the treatment being rendered.

   Examples given of covered services included actual calls made to the patient's room; actual examination of the patient to check out the resident's or intern's findings; and physical presence in the operating suite at the time a procedure was being performed. Mere presence on the hospital premises or endorsement of orders made by interns or residents would not qualify the fee charged for coverage under the program.

4. Carriers were informed that reasonable charge determinations on fees charged by teaching physicians must be related to the compensation paid to the teaching physician by the medical school, and may not be based solely on prevailing fees for similar services in the area.

5. Indication must be given on claims to identify clinic patients from the teaching physician's private patients; and where clinic patients are involved, some method must be evolved with the medical school to assure that only covered teaching physician services are reimbursed.

Up to the present time, General American has been administering claims on the basis of our previous discussions and understanding that claims submitted would involve only services of teaching physicians and that benefits would be based upon prevailing and customary determinations for the area. It is obvious, however, that the Social Security Administration desires a more precise system.

We would like to discuss this with you at your earliest convenience so that an appropriate administrative arrangement for Medicare claims can be devised. Your reply would be appreciated.

Sincerely yours,

E. H. Porman

EHB:lsm

March 13, 1969

William D. Mayer, M.D.
Dean
The University of Missouri
School of Medicine
Medical Center
Columbia, Missouri 65201

Dear Dr. Mayer:

Through recent correspondence we know of your very vital interest in problems relating to third party payments for services of house staff and supervisory faculty. The Council of Teaching Hospitals, through its Committee on Financial Principles, has for the last year and one-half been directing its attention to selected problems of a fiscal nature that have some effect on the organization of the teaching hospitals. Additionally, this Committee has been developing a position statement on "Guidelines for Allocating Program Costs in Teaching Hospitals". That statement is now complete and a copy is attached for your review and information.

With this statement completed, the Committee (list of membership of the Committee attached) believed it important that we further refine the broad guidelines presented in this statement. Two particular areas that the Committee believed needed attention were:

1. An identification of the costs that should be included within these program areas; and

2. The problem of payments to the house staff, fees for faculty and attending physicians.

At the most recent Committee meeting on November 21, 1968, the various individual institutional approaches to the problem were discussed. It was concluded that a consistent inter-institutional policy was not in evidence.

Because of the relationship of this question to the medical school, the COTH Executive Committee, upon advice of the Chairman and members of the Financial Principles Committee, indicated the desirability of inviting several members of the Council of Deans to serve as members of the COTH Committee, participate in its deliberations and join in realizing conclusions. In order to implement such opportunity, I have discussed this matter with Bill Anlyan (William G. Anlyan, M.D., Chairman, Council of Deans, AAMC, and Associate Provost for Medical Affairs, Duke University).

Because of your knowledge and interest in this area, we were interested in your being one of several deans who would be willing to join this Committee.

As you may know there are several possible imminent events during this 1st Session of the 91st Congress that may require rather immediate response from the AAMC. The AAMC's Committee on Federal Health Programs has charged the COTH Committee on Financial Principles with the responsibility of recommending alternative recommendations in this regard and has also urged that this Committee convene as quickly as possible. We have therefore, scheduled a meeting for Friday, March 28th at 10:00 a.m., in the Plaza Room (second floor) of the Dupont Plaza Hotel, 1500 New Hampshire Avenue, N.W., Washington, D.C. The meeting is scheduled to adjourn by 4:00 p.m.

We would appreciate a note from you indicating whether you can accept this Committee assignment and if so if you can attend the March 28th meeting. Additionally, if you need accommodations we will be pleased to make the necessary reservations.

We do look forward to hearing from you concerning this proposal.

Until then, best regards.

Cordially,

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

MM:car

Attachments: "Guidelines for Allocating Program Costs in Teaching Hospitals"
Membership List, COTH Committee on Financial Principles for Teaching Hospitals

cc: William G. Anlyan, M.D., Chairman, Council of Deans
Roy S. Rambeck, Chairman, Council of Teaching Hospitals
Charles R. Goulet, Chairman, Committee on Financial Principles for Teaching Hospitals

bcc: J. Barton Boyle, Associate Director, University of Missouri Medical Center

University of Missouri - Columbia

228 Medical Science Building
Columbia, Mo. 65201

SCHOOL OF MEDICINE
Office of the Dean

Telephone
314 442-5111 Ext. 611

February 17, 1969

Jonathan E. Rhoads, M.D.
Professor and Chairman
Department of Surgery
The University of Pennsylvania School of Medicine
36 and Hamilton Walk
Philadelphia, Pennsylvania 19104

Dear Dr. Rhoads:

I am writing you concerning an issue I consider to be of great national importance to the university medical centers of this country. It is my understanding that as one of its tasks, the Council of Academic Societies of the AAMC is looking at the area of graduate medical education (housestaff and residency programs).

Within the last month this institution has received letters from and has been in discussion with the fiscal intermediaries on both the Title XVIII (General American Life) and Title XIX (Division of Welfare, State of Missouri) programs. In both instances the focus of discussion has been in the general area of the role of housestaff and of faculty in these programs.

Up until the present time, we have been functioning under the following principle: professional fee billing for professional services is made only in those instances where an attending physician provides personal and identifiable direction to the interns or residents who are participating in the care of his patient, and where the attending physician's services to the patient are the same character and responsibility to the patient as rendered to his patients where an intern or resident is not participating in the care.

It now appears that two questions are evidently being raised:

(1) Further clarification of the requirements for "identifiable direction" or "personal supervision" provided by attending physicians.

(2) The possibility of linking charges of teaching physicians to the source and level of their salary rather than the usual and customary fees for similar services in a given geographic area.

We have been attempting to resolve some of these issues at the local level. However, the recent letter which is attached suggests that these are being discussed at a national level by the Social Security Administration with the Part B carriers. Accordingly, I would like to suggest that the Association of American Medical Colleges move rapidly to attempt to formulate an official position on these issues. Inappropriate regulations in this area could be quite detrimental to the graduate medical educational training programs as well as the financial fiber of the university medical centers in this country.

I have a feeling of great urgency about this which is related not only to the importance of the issue, but to the feeling that we rapidly may be running out of time in order to have any meaningful influence on the decision-making process.

I would obviously be glad to provide any additional information which you might desire. Please feel free to write or call if you feel further discussion would be helpful.

Sincerely yours,

William D. Mayer, M.D.
Dean and Director

WDM:kp

cc: Dr. John A. D. Cooper
Dr. Robert C. Berson
Dr. Cheves Smythe
Mr. Matthew McNulty
Dr. William Anlyan

Enclosure

GENERAL AMERICAN LIFE
INSURANCE COMPANY • ST. LOUIS, MO. 63166

AREA CODE 314
231-1700

E. H. BORMAN, Director
Professional Relations
Group Insurance Division

February 7, 1969

Title XVIII - Medicare

William C. Allen, M.D.
Assistant Medical Director
University of Missouri Medical Center
807 Stadium Rd.
Columbia, Missouri

Dear Dr. Allen:

As you know, coverage is provided under Part B of Medicare (Title XVIII) with respect to the professional services rendered by teaching physicians. Recently, in a meeting of Part B carriers in Baltimore, Social Security officials clarified the regulations with respect to the coverage and administration of claims on these charges. The points covered in this discussion were as follows:

1. Carriers were reminded that coverage is provided under Part B only with respect to services rendered by teaching physicians. Services rendered by interns and residents in training are not covered even though the resident is fully licensed to practice. If such a physician is involved in securing additional training or experience in a particular specialty, etc., then, under the law, coverage is only provided on a cost basis through the Part A intermediary.

2. The extent of involvement of an intern or resident with a patient is not a factor in determining the coverage or amount of reasonable fee which might be charged by a supervising physician or school. However, for coverage to be provided under the Medicare program, the supervising or teaching physician must be physically present and provide immediate personal supervision of the treatment being rendered.

   Examples given of covered services included actual calls made to the patient's room; actual examination of the patient to check out the resident's or intern's findings; and physical presence in the operating suite at the time a procedure was being performed. Mere presence on the hospital premises or endorsement of orders made by interns or residents would not qualify the fee charged for coverage under the program.

3. Carriers were informed that reasonable charge determinations on fees charged by teaching physicians must be related to the compensation paid to the teaching physician by the medical school, and may not be based solely on prevailing fees for similar services in the area.

William C. Allen, M.D. February 7, 1969

As I understand the arrangement for physician compensation at the University of Missouri Medical Center the teaching physicians are paid a stipend by the University for teaching activities and are permitted to retain fees collected for professional services rendered to patients at the University Hospital. To the extent that the compensation paid to the teaching physician by the University includes no portion of the personal supervision given to residents and interns who are rendering services to patients, no change need be made with respect to Part B payments. If the teaching responsibilities of physicians, however, include direct patient care and supervision of residents and interns who are providing patient care, then the professional fee covered under Part B which the teaching physician is authorized to charge to patients by the school will be affected.

Up to the present time, General American has been administering claims on the basis of our previous discussions and understanding that claims submitted would involve only services of teaching physicians and that benefits would be based upon prevailing and customary determinations for the area. It is obvious, however, that the Social Security Administration desires a more precise system.

We would like to discuss this with you at your earliest convenience so that an appropriate administrative arrangement for Medicare claims can be devised. Your reply would be appreciated.

Sincerely yours,

E. H. Borman

EHB:lsm

cc: Mr. Paul Tipton, Supervisor
Accounts Receivable
University of Missouri Medical Center

It is the Committee's opinion that AAMC should make a ringing declaration of the importance to the medical manpower output problem of the maintenance of these programs which provide both essential faculty and clinicians. We shall include such a statement in our presentation to the appropriations committees. The Council of Academic Societies should be requested promptly to provide the Executive Council and this Committee with a statement regarding numbers needed and size of stipends needed, together with a well-reasoned justification therefore, drafted with an awareness of current congressional and BoB attitudes as regards research and clinical manpower.

B. Reimbursement for Supervisory Services of M.D.'s

Staff advised Committee members of the reasons for anticipating the probability of headline-making hearings conducted by Senator Long's Finance Committee ostensibly to expose and correct illegal or improper diversion of Medicare and Medicaid funds. It is to be hoped that a way will be found to persuade the Senator and his staff to separate out and handle separately such problems as might involve teaching hospitals and faculties. The COTH Committee on Financial Principles (which now will include three deans) will be asked to pursue this. Whether or not this might succeed, it will be important that this Committee alert the membership as to what may happen; impress upon it the need to get our houses in order; formulate alternative solutions which might prove acceptable to the Congress either as new regulations or new legislation; attempt to have them adopted.

C. Modification of Berry Plan

Dr. Berson explained the status (which will remain quo). For information only.

D. H.R. 1159 - Assistant Secretary of Defense for Health Affairs

The Committee sees no need for formal AAMC action at this time. Dr. Berson will phone Dr. Rousselot and let him know of our support for the idea and our willingness to help when and if it might prove effective.

Agenda Item III
Pending Legislation

A. H.R. 35

The Committee agrees with the staff recommendation that no action be taken as regards this bill at this time.

B. H.R. 6536 - Reid/Brademas Bill

It was agreed that we have immediate need to learn from the schools just what this bill would do for them, what problems it might solve and what problems it will not solve. After discussing alternative approaches,

C. It is recommended that the House of Delegates concur with the following interpretations of the intent of the House in making the two 1961 recommendations.

1. The statement, "The graduate physician serving as intern or resident should receive financial support commensurate with his professional responsibilities and with due recognition of his educational opportunities," is taken to mean that the level of remuneration in all hospitals should be sufficient to support house officers adequately.
2. The statement that, "The medical profession must assume an increasing responsibility for the development of appropriate methods of financial support of the intern and resident, so as to accomplish the above objective," is taken to mean that the medical profession should establish basic principles by which hospital attending staffs could be guided in the development of additional funds to supplement, if necessary, those derived from hospital sources.

D. The Councils recommend the following statement to guide medical staffs in the development of additional funds to supplement, if necessary, those from hospital sources:

> When it is the desire of a hospital professional staff that a special fund be established for the adequate support of house officer training programs, the fund may be developed from a variety of sources, such as endowment income, grants, voluntary contributions, donations, and fund-raising activities.

E. The published provisions for payment under the Medicare Program for services rendered to to beneficiaries by interns and residents and by attending physicians supervising interns and residents are compatible with the organization and administration of programs of graduate medical education according to the standards of the American Medical Association. These same principles should apply to regulations governing other third party medical care plans.

F. It is recommended that sources and amount of compensation for house officers should be determined by local agreement and implemented in accordance with state laws and the ethical principles and policy positions of the American Medical Association.

G. The above principles should be widely publicized so that they may be understood and implemented in good faith by all concerned.

H. The broad and complex nature of the problems in the financial area is recognized, and continued studies and reports thereon by the Council on Medical Service are encouraged. These should include staff compensation, methods of fund collection, control and disposition, and other pertinent and related matters.

JOINT REPORT
Council on Medical Education and Council on Medical Service
AMERICAN MEDICAL ASSOCIATION

Subject: Graduate Medical Education and Remuneration of House Officers

Presented by: W. Clarke Wescoe, MD, *Chairman* Council on Medical Education

George W. Slagle, MD, *Chairman* Council on Medical Service

Referred to: Reference Committee C (J. M. Stickney, M.D., *Chairman*)

This is the second special report submitted jointly by the Council on Medical Service and the Council on Medical Education in response to recommendations of the House of Delegates in June, 1961, that:

> "1. The graduate physician serving as intern or resident should receive financial support commensurate with his professional responsibilities, and with due recognition of his educational opportunities, and that,
>
> "2. The medical profession must assume an increasing responsibility for the development of appropriate methods of financial support of the intern and resident so as to accomplish the above objective."

The first special report of the two Councils entitled "Compensation of House Officers" was submitted at the June, 1963 Annual Convention in Atlantic City. Although the House of Delegates disapproved that report, it did not rescind its 1961 instructions stating:

> "It is urged that the Council on Medical Education and the Council on Medical Service continue their joint study of the best mechanisms by which these recommendations may be accomplished."

The social legislation identified as Medicare (PL 89-97) carries many implications for the future conduct and financial support of graduate programs in medical education. Because of the speed with which this legislation was enacted, the delay in development of all the necessary guidelines and regulations, and the possibility of further modifications of the legislation, the two Councils believe that while a report at this time is appropriate, it must not be regarded as definitive and final. The recommendations in this report may, in part, provide guidelines for resolving several problems identified in Resolutions 59 and 106 (A-66), but future developments may well lead to modifications of these recommendations.

Review of Action on Previous Report

The 1963 report recognized that the increasing cost of medical education was becoming a deterring influence, particularly during the financially lean years of the internship and residency, while at the same time the majority of house officer training programs had come to depend to a variable degree upon the participation of paying patients.

The recommendations of the Councils included a statement of five principles to govern the assignment of professional responsibility of house officers for patients and the disposition of funds resulting from this relationship. The final recommendation stated the conviction of the two Councils that the sources and amount of compensation for house officers should be determined locally.

The Reference Committee recommendation for disapproval of the Councils' report stated that it represented a well-intentioned effort to find a solution to a most difficult, if not impossible, problem. The House of Delegates then approved, by a vote of 98 to 87, a recommendation from the floor of the House for an amendment to the Reference Committee report, which stated:

> "The AMA record itself as opposed to any system or program by which any part of an intern's or resident's salary is paid out of fees collected by the attending physician or out of fees collected under any type of medical-surgical insurance coverage."

The Reference Committee's final recommendation was that any future proposal pertaining to this matter be thoroughly studied by the Law Department and Judicial Council before submission to the House.

Further policy in this area was established at the Annual Convention in 1964, when a Resolution to rescind the above June, 1963 action was not adopted, but the House stated that current American Medical Association policy permits the physician to dispose of his income as he sees fit, and further stated:

"It is the policy of the American Medical Association that each physician shall be the sole arbiter of the ways in which he shall dispose of his professional income, consistent with the laws of the land and the principles of ethics of this Association."

At the 1965 Clinical Convention, the House of Delegates accepted the following opinion which had been adopted jointly by the Council on Medical Service and the Judicial Council on the subject "Payment of Physician for Services Performed by Intern under his Direction or Supervision."

"The Councils [Judicial Council and Council on Medical Service] jointly agreed that when a physician assumes responsibility for the services rendered to a patient by a resident or an intern, the physician may ethically bill the patient for services which were performed under the physician's personal observation, direction, and supervision."

Continued Studies of Liaison Committee

The Liaison Committee of the Council on Medical Service and the Council on Medical Education has continued its joint studies in this area. In June 1965, the Liaison Committee elected to perform a second national survey, as a five-year follow-up on the survey conducted in 1960 on Administrative Support of Gradu- Training Programs. The questionnaire was sent to 1,185 non-federal hospitals, and responses were received from 736, or 62%.

Summary of Replies to 1965 Questionnaire

The proportion of hospitals utilizing third-party medical care funds for support of graduate programs increased from 20% in 1960 to 31% in 1965. The practice of supplementing house staff incomes has become widespread and varies from lump-sum payment for intramural "moonlighting" in the hospital's own emergency room during normal off-duty hours to actual hourly overtime pay for work beyond a standard number of shifts per week. The questionnaire did not provide a measure of the extent of extramural "moonlighting" by house officers.

The 1965 questionnaire confirmed the previously observed wide variations in practice and policy among the various states, regarding the manner in which third-party medical care funds were made available to support educational programs. In 15 hospitals from 12 different states, certain licensed residents were given concurrent appointments on the attending staffs to facilitate billing and collecting third-party medical care funds. In 25 hospitals from 16 states, house staff salaries were paid by the medical staff or a partnership of the medical staff. For 15 of these hospitals in 11 states, the hospital also paid part of the house officers' salary.

Blue Shield funds were used to support the educational programs in 86 (16%) of 530 hospitals in 28 different states. There were 66 hospitals in 28 states in which the attending staffs collected fees and turned them over to a special fund for the house staff program. There were 28 hospitals in 16 states in which these collections were made by the hospitals for the attending staff; there were 21 hospitals in which collections were made for the licensed intern or resident by the hospital; and there were 15 in which residents themselves collected the money and turned it over to the special fund.

It was also apparent from the questionnaire replies that those residency programs which were supervised by members of a clinic or other similarly organized group of physicians experienced little difficulty in compensating residents out of funds received for professional medical care. The statement was made that, in such situations, the pay for the residents came from the same source as the pay of the other members of the clinic. This could mean that if the interns and residents were licensed they might be classified as junior members of the group; or if not licensed, they could be designated as employees of the group.

Medicare and Graduate Medical Education

The Social Security Amendments of 1965 (Public Law 89-97), permits re-classification of many formerly indigent patients to private patients, thus threatening serious curtailment of the degree to which such patients might participate in educational programs. Furthermore, funds for the professional care of such patients have now become available and can be paid to physicians on the attending staff, but are specifically prohibited from being paid directly to physicians who are appointed as interns and residents.

Although salaries of interns and residents can be paid as a hospital cost under Part A of the Act, there is no assurance this source alone will assure a generally satisfactory income level for the trainees.

In the promulgation of regulations for the administration of that portion of the Medicare Act relating to reimbursement for the services of interns, residents, and supervising physicians, the Department of Health, Education, and Welfare issued a "leaflet" in early July, 1966, which "deals with the provisions for payment under the Medicare program for services rendered to beneficiaries by interns and residents and by attending physicians supervising interns and residents." The key paragraphs in this leaflet read as follows:

"Physicians' services, rendered to beneficiaries, are covered under the supplementary medical insurance program, and the payment for such services is on the basis of reasonable charges.

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

Discussion

The language of Public Law 89-97 refers specifically to "an intern or a resident in training under a teaching program approved by the Council on Medical Education of the American Medical Association." Thus, the Federal Government intends that the participation of interns and residents in the care of Medicare beneficiaries will be compatible with the standards of graduate medical education of the AMA.

The two Councils believe that the 1965 questionnaire has pointed up two inescapable facts relating to remuneration of house officers from third-party funds:

1. Local policies and philosophies differ from state to state, from community to community, and from hospital to hospital; but utilization of third-party medical care funds for the support of programs in graduate medical education has increased generally in spite of official policy statements of the AMA House of Delegates to the contrary.

2. Those institutions in which the attending staffs are organized on a group basis have considerably less difficulty in obtaining and utilizing third-party medical care funds for the support of house officer programs. (The two Councils have been advised by the AMA Law Division that it is legal for hospital attending staffs to form partnerships for the purposes of compensating house officers as employees of the partnerships.)

Recommendations

The 1953 report of the Advisory Committee on Internships, as approved by the House of Delegates, contains significant guidelines on utilization of private patients in teaching programs which the Councils wish to modify and restate in the context of today's socioeconomic developments, since private patients have become and will remain an integral part of house officer education programs.

A. It is recommended that the House of Delegates approve the following policy on utilization of private patients in teaching programs: "It makes no difference whatever whether the patients are private or non-private if all of the following provisions are met:
   - "1. That the patients on private services present the same range of disease as those on public wards and that comparable opportunity exists for responsible participation by the house officer in diagnosis, management, and followup.
   - "2. That the attending staff value breadth of viewpoint that comes from time spent in teaching and do not treat teaching as an unwelcome burden inherent in staff privileges.
   - "3. That the teaching attending staff are sufficiently secure in the private doctor-patient relationship to permit house staff responsibility comparable to public wards and understand in practice the distinction between indoctrination and true learning.
   - "4. That the same critical standards of diagnosis and treatment apply on private and public ward patients."

B. The Councils recommend the following principles to govern the assignment of professional responsibility of house officers for the care of paying patients.
   1. Assignment of responsibility to house officers for the care of patients shall be based on their competence to assume this responsibility.
   2. The number of patients assigned to house officers shall be limited by the educational needs of the training program.
   3. The care of such patients shall continue to be under the supervision of the attending staff physician, and ultimate responsibility for their care shall remain in his hands.

AMERICAN MEDICAL ASSOCIATION

535 NORTH DEARBORN STREET • CHICAGO, ILLINOIS 60610 • PHONE (312) 527-1500 • TWX 910-221-0300

MEMORANDUM

TO: Deans of Medical Schools
Administrators of Teaching Hospitals
Directors of Residency Programs
Chairmen of Internship Committees

FROM: W. Clarke Wescoe, M.D., Chairman
Council on Medical Education

George W. Slagle, M.D., Chairman
Council on Medical Service

SUBJECT: Graduate Medical Education and Remuneration of House Officers

DATE: February 3, 1967

At the 1966 Clinical Session of the House of Delegates of the American Medical Association, a Joint Report on the above subject was submitted by the Council on Medical Education and the Council on Medical Service.

As is detailed in the attached copy of the Report, the two Councils have had this subject under study since 1961 and had submitted their first joint report at the June 1963 Annual Convention.

The present report was approved by the House of Delegates after the Reference Committee had revised paragraphs E,F,G, & H of the recommendations, for purposes of clarification.

The Report is forwarded for your study and consideration as a guide to the organization of teaching programs involving private patients as well as a guide to the establishment of policy and the development of methods for providing adequate financial support for interns and residents.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF TEACHING HOSPITALS

Survey of House Staff and Supervisory Physicians for Medical Education/Patient Service Under Title XVIII and Title XIX

Note: All Information will be Strictly Confidential

1. Has your local legislature made any ruling or is it contemplating one in regard to Title XVIII reimbursement for patient care associated with medical education? /____/ Yes /____/ No. If yes, what is the substance of the ruling?_____

_____

_____

_____

2. Does your hospital staff include faculty members not involved in private practice? /____/ Yes /____/ No. If yes, through which method do they bill and receive reimbursement for services to Title XVIII and XIX patients?_____

_____

_____

_____

3. What method does your institution use to bill and obtain reimbursement for house officers who care for Title XVIII and Title XIX patients?

_____

_____

_____

4. What method does your institution use to bill and obtain reimbursement for fulltime faculty who care for Title XVIII and Title XIX patients?_____

_____

_____

_____

5. How is "Supervision" defined at your institution?_____

_____

_____

_____

6. Does both the medical school and hospital contribute to the financing of house staff? /___/ Yes /___/ No. If yes, what is the percentage of each contribution. _____ Medical School %

_____ Teaching Hospital %

7. On what basis is a judgment made to support the number of house staff officers by each service and discipline?_____

_____

_____

_____
(signed)

_____
(name of institution)

_____
(location)

THE UNIVERSITY OF IOWA
IOWA CITY, IOWA 52240

University Hospitals
Office of the Director
Area 319: 338-0525

December 3, 1968

Mr. Charles R. Goulet, Chairman
Committee on Financial Principles for Teaching Hospitals
University of Chicago Hospitals and Clinics
590 East 59th Street
Chicago, Illinois

Dear Charles:

In accord with the request of members of the Committee on Financial Principles for Teaching Hospitals expressed at our recent meeting in Chicago, I am transmitting herewith copies of the University of Iowa Hospitals new program for supporting fellowship training. As was indicated, the program was formulated by Mr. John Colloton of my staff and a group of senior faculty members and, as set forth on the final page of the report, was subsequently endorsed and unanimously approved by the Hospital Advisory Committee in May of this year.

We feel the innovative features of the program will not only permit the continuing enhancement of our patient care programs through qualitative and quantitative enrichment of our house staff physician input during this time of federal withdrawal (see enclosed chart), but will also facilitate a viable evolvement of our increasingly important subspecialty training programs.

I am enclosing an adequate supply of copies of the report to cover the committee's membership as well as to provide the Council on Teaching Hospital headquarters office with a reserve for distribution as they see fit.

I am hopeful and confident that our concept will be of benefit to other COTH members.

Cordially,

Gerhard Hartman, Ph. D.
Member, Committee on Financial
Principles for Teaching Hospitals

GH:pc
Enclosures

THE UNIVERSITY OF IOWA
IOWA CITY, IOWA 52240

University Hospital
Area 319: 338-0525

April 8, 1968

Mr. Glen E. Clasen, Chairman
Hospital Advisory Committee

Dear Mr. Clasen:

The following report is submitted by the Ad Hoc Committee charged with recommending policy regarding support of resident physicians who remain in training beyond the period of time required to become "board eligible."

Preface

The regional center concept will increase the need for strong sub-specialty sections within the various clinical departments of the College of Medicine and University Hospitals and Clinics. This has been anticipated in the planning of the ambulatory care facility and must now be considered from the standpoint of providing adequate staffing of these sub-specialty divisions. Such faculty members as are now available in our hospital will not be adequate to handle the increased service demands in these areas and therefore we must recruit elsewhere or must establish adequate local training programs from which to recruit staff. The latter idea is the more appealing since with such training programs service can be improved, teaching at all levels can be improved and the opportunity for clinical research

will expand. In some sub-specialty areas, there exist sub-specialty boards and certification while in others, of equal importance, no such formal structure exists. It is the feeling of this committee that both types of training programs need be considered in order for the College and Hospital to advance in all areas. The following recommendations regarding support of sub-specialty trainees are predicated upon the objective of meeting this challenge. It should be emphasized that to the extent "outside" support is available for support of such training, it should continue to be utilized to the maximum.

In formulating our recommendations, the committee identified three categories of trainees who have completed requirements for primary boards. The definition of each and our recommendations relating to the support of each category follow. The support recommendations relate exclusively to training which takes place within the confines of the University Hospitals and Clinics.

CATEGORY I

Definition: Those residents (or fellows) engaged in sub-specialty training leading to certification by an established sub-specialty board. Such training programs now approved at the University of Iowa Hospitals are:

Training Program	Duration of Training	Individuals in Training 7/1/68
a) Allergy	2 years	1
b) Cardiovascular Disease	2 years	4
c) Gastroenterology Disease	2 years	2
d) Pulmonary Disease	2 years	0

Other such training programs now having qualifying boards for which the establishment of University Hospital training programs can be foreseen:

a) Pediatric Allergy
b) Pediatric Cardiology
c) Pediatric Neurology (Possibly by 7/1/68)

Recommendations

a) Principle - These programs are hospital-sponsored training programs and should be viewed in same context as residency training programs leading to certification in the primary specialty. This principle is based upon the fact that any institution having training program approval in a primary specialty and having a physician competent, preferably certified, in a sub-specialty field may conduct sub-specialty training. While the program approval mechanism varies from one sub-specialty to another, the training programs are perpetuated in accord with varying procedures of each respective sub-specialty review board.

b) Stipend Support - The Ad Hoc committee recommends that one year of support for clinically oriented training be shared by the hospital and department (department utilizing multiple income sources) on a 50%-50% matching basis; and that any additional training be underwritten completely from non-hospital sources. This recommendation is predicated upon the following rationale:

1) The service benefit derived from such trainees is, to some degree, shared by the care-cure structures of the institution.

2) The total amount of funds available for support of such trainees can best be maximized through collective efforts.

3) The sub-specialty trainee's teaching-academic-service value to the department during training beyond one year after achieving primary board eligibility is of such value as to justify full departmental support (department utilizing multiple income sources).

CATEGORY II

Definition: Those residents (or fellows) training in sub-specialty areas which have no national certifying board. While such sub-specialties are likely to proliferate in all specialty areas, examples of some such programs at the University of Iowa Hospitals and Clinics are listed below.

a) Pediatric Surgery
b) Gynecological Oncology
c) Hematology
d) Gynecologic Endocrinology
e) Mental Retardation
f) Nutrition

Recommendations

To develop extremely well-trained residents knowledgeable regarding the complex diagnostic and therapeutic modalities today commonplace in medicine and to bring a sophistication of care to patients not now possible, we recommend the establishment of a University Hospital "Patient Care Enrichment Fund." This fund would be utilized to match clinical departmental funds (departments

utilizing multiple income sources) on a dollar-for-dollar matching basis in the payment of residents training within this framework. The rationale for sharing of stipend expense cited in our Category I support recommendation applies equally to this recommendation.

To administer the Enrichment Fund, we recommend the establishment of a Sub-Committee by the Hospital Advisory Committee charged with the responsibility of reviewing annual departmental requests for support from the fund. Fund support would, of course, be limited to those trainees engaged in clinical activities and the stipend level would not exceed that being paid to other individuals in comparable years of formal post-internship training. It would appear that a hospital expenditure capability of $50,000 in fiscal year 1969-70 would be a reasonable starting base for the program envisioned. If individual circumstances warrant, we recommend that departments be free to augment their 50% stipend portion to the extent required to be competitive. It is your subcommittee's projection that 35 to 40 physicians will be training in Categories I and II within a five-year period.

CATEGORY III

Definition: Residency training beyond years required for specialty board certification, which does not fall into Categories I and II. For example, in those circumstances where a primary residency program, on the basis of a "local ground rule," routinely

requires more years of training than is required to become board eligible.

Policy Recommendation Regarding Stipend Support: We recommend that the stipend for such additional years of training be supported entirely from non-hospital sources, unless an equivalent period of training has been supported from non-hospital sources earlier in the residency at University Hospitals.

Respectfully Submitted,

J. W. Colloton
R. D. Gauchat, M. D.
C. P. Goplerud, M. D.
P. M. Seebohm, M. D.
R. T. Soper, M. D.

HOSPITAL ADVISORY COMMITTEE ENDORSED AND APPROVED MAY 15, 1968

Committee Membership:

Dr. W. B. Bean, Chief, Internal Medicine
Dr. F. C. Blodi, Chief, Ophthalmology
Dr. M. Bonfiglio, Professor, Orthopedics
Dr. J. Christie, Chief, Radiology
Mr. G. Clasen, Associate Director
Dr. D. L. Dunphy, Chief, Pediatrics
Dr. R. H. Flocks, Chief, Urology
Dr. M. L. Hale, Chief, Oral Surgery
Dr. R. Hardin, Vice President
Dr. G. Hartman, Director
Dr. L. E. January, Professor, Medicine
Dr. W. C. Keettel, Chief, Obstetrics & Gynecology
Dr. W. M. Kirkendall, Professor, Medicine
Dr. B. F. McCabe, Chief, Otolaryngology
Dr. J. Moyers, Chief, Anesthesiology
Dr. C. E. Radcliffe, Professor, Dermatology
Dr. A. L. Sahs, Chief, Neurology
Dr. D. B. Stone, Executive Associate Dean
Dr. R. T. Tidrick, Chief Surgery
Dr. E. D. Warner, Chief, Pathology
Dr. S. E. Ziffren, Professor, Surgery

UNIVERSITY OF IOWA HOSPITALS AND CLINICS

MEDICAL INTERN AND RESIDENT PERSONNEL AND SALARY EXPENSE GROWTH
1945-47 — 1967-68