

AGENDA

COMMITTEE ON HOUSE STAFF RELATIONSHIPS
TO THE HOSPITAL AND THE AAMC

AAMC Headquarters
One Dupont Circle
Wednesday, June 2, 1971
10:00 a.m. - 3:00 p.m.

- I. Call to Order: 10:00 a.m.
- II. Introduction of Committee Members TAB A
- III. Review of Background events leading to the formation of the Committee TAB B
- IV. Review of the Current Organization of the AAMC: Student and Faculty Participation TAB C
- V. Initial Discussion of Alternative Courses of Action
- LUNCH
- VI. Discussion of Current House Staff Relationships to Hospitals:
- a) Services Rendered to the Hospital TAB D & E
 - b) Services Rendered to the Physician TAB F & G
 - 1. Commissioner Denenberg's Recommendation (#5 on page 10)
 - c) Educational Aspects: Teaching & Learning TAB H, I & J
 - 1. AAMC Cost Allocation Study Presentation by Mr. Tom Campbell
- VII. Determination of Future Course of Committee Action
- VIII. Date of Next Meeting and Adjournment

COMMITTEE ON HOUSE STAFF RELATIONSHIPS TO THE HOSPITAL
AND TO THE AAMC

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To THE COUNCIL OF TEACHING HOSPITALS: *F. J. [Signature]*

THE DISSIDENT VOICES, CURRENTLY THREATENING MANY INSTITUTIONS WITHIN OUR NATION, ARE NOW BEING ECHOED WITHIN THE WALLS OF MANY TEACHING HOSPITALS. NEVERTHELESS - THE OPPORTUNITY AND THE PRECEDENT EXIST FOR A JOINT EFFORT OF ALL HEALTH PROFESSIONALS TO COOPERATE AND TO WORK TOGETHER TO MEET THE CHALLENGE OF HEALTH CARE AND EDUCATION.

WE RECOGNIZE THE CONTRIBUTIONS THAT CAN AND HAVE BEEN MADE BY THE COUNCIL OF TEACHING HOSPITALS OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES. WE CALL UPON YOU TO ACTIVELY INITIATE AND SOLICIT ADDITIONAL REPRESENTATIVES FROM YOUR INSTITUTIONAL MEMBERSHIP - OTHER THAN FROM THE ACADEMIC FACULTY AND ADMINISTRATION. THESE ADDITIONAL REPRESENTATIVES SHALL COME FROM THE CORPS OF INTERNS, RESIDENTS AND NURSING PROFESSIONALS AT THE TEACHING HOSPITALS YOU REPRESENT.

THROUGH THIS THE COUNCIL WILL REASSERT ITS PROGRESSIVE STAND AND LEADERSHIP TO EFFECT A RAPPROCHEMENT OF THE DIVERSE ELEMENTS THAT COMPRISE THE HEALTH PROFESSIONALS - THE NECESSARY FIRST STEP FOR THE PROMULGATION OF BETTER HEALTH CARE AND HEALTH SCIENCES EDUCATION FOR OUR NATION.

ANTHONY BOTTONE, M.D.

UNIVERSITY OF CALIFORNIA ASSOCIATION OF INTERNS AND RESIDENTS

BERNHARD VOTTERI, M.D.

WADSWORTH RESIDENTS AND INTERNS ASSOCIATION

J. ANTHONY SMITH, M.D.

DAVID S. GANS, M.D.

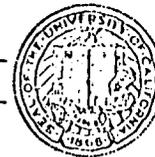
LOS ANGELES COUNTY HOSPITAL INTERNS AND RESIDENTS ASSOCIATION

JIM SKOW, M.D.

UNIVERSITY OF CALIFORNIA LOS ANGELES HOUSE STAFF ORGANIZATION

LOS ANGELES

OCTOBER 30, 1970



DEPARTMENT OF
THE HISTORY OF HEALTH SCIENCES

SAN FRANCISCO, CALIFORNIA 94122

February 10, 1971

Irving Wilmot
Director
COTH-AAMC
One Dupont Circle N.W.
Washington, D.C.

Dear Mister Wilmot:

I am addressing this letter to the question of representation on the part of interns and residents in the AAMC. At the time that I had submitted the petition to the COTH, I left many questions unanswered.

Recently we had a strike by the interns at San Francisco General Hospital. This only served to strengthen my belief that house officers must be brought closer to their former colleagues, the faculty, and also be made intimately aware of the diverse problems facing the hospital in this society. The frustration and hostility that is often generated by isolation and by the propagation of a strongly biased myth among the house staff is hard to estimate. From my studies of different house staff organizations, it has become apparent that the problem of identity with their former colleagues, the attendings, has been one source of trouble. Furthermore, the hospital is viewed as some variety of recalcitrant cow, refusing the milk of health to the needy. Energies are often channeled into attacking the administration or the faculty, at the expense of the hospital and even their own medical education.

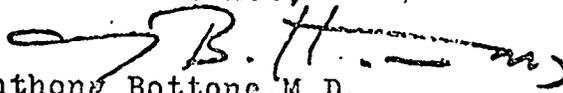
I strongly feel that participation, particularly on the administrative level, would effect a change in opinion. But how should this be done? As you know, there will shortly be a National Conference of House Staffs - at which time matters such as this could be discussed. Personally, I feel that representation in the AAMC would provide one means of creating participation by house staffs. Hospitals could send one house officer to the convention, where they could board in student rooms at reasonable rates. Travel fare to the AAMC convention could come from the house staffs own funds - the important thing, is that it would bring all of the diverse elements of the medical school and hospitals together under one roof. The atmosphere would generate mature debate.

What sort of representation? This could be worked out at the AAMC convention - perhaps one member of the house staff could sit on the Executive Board of the COTH. Furthermore, having official sanction may encourage more active participation by

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house officers on various hospital committees.

I have left open the question of the nursing staff, since I feel it is their obligation to press forward, on their own, at this time.

With best wishes,



Anthony Bottone, M.D.

Chairman

University of California

Association of Interns and Residents

ACTION OF THE COTH EXECUTIVE COMMITTEE MEETING OF
FEBRUARY 12, 1971

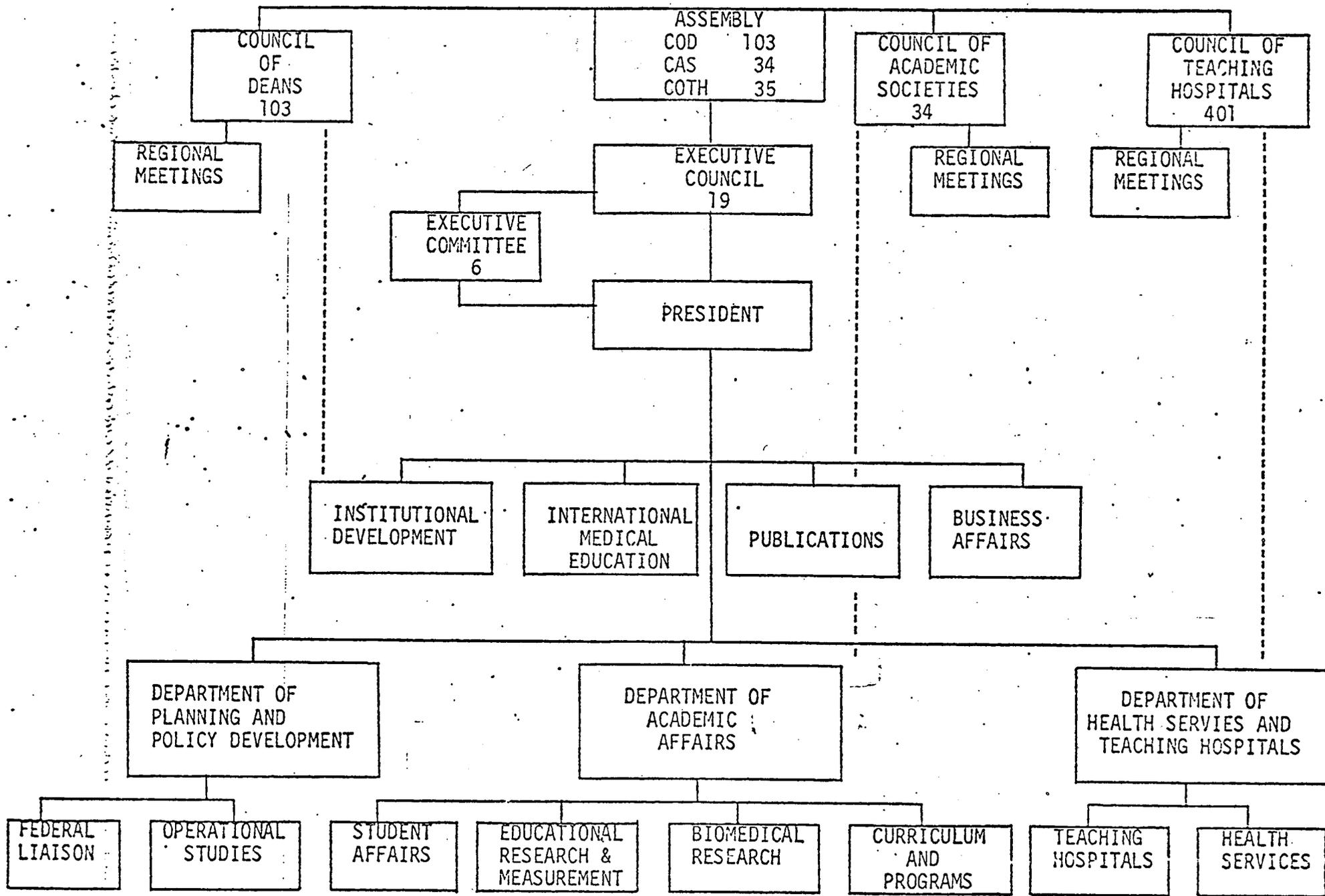
IT WAS MOVED, SECONDED AND CARRIED THAT
THE CHAIRMAN, IN CONSULTATION WITH
STAFF, APPOINT MEMBERS TO A JOINT COTH-
CAS-COD AD HOC COMMITTEE CHARGED WITH
THE RESPONSIBILITY OF STUDYING THE
MATTER AND MAKE RECOMMENDATIONS CONCERNING
APPROPRIATE PARTICIPATION OF HOUSE STAFF
IN AAMC ACTIVITIES

RESOLUTION ADOPTED AT THE FEBRUARY 13, 1971 MEETING

OF THE AAMC ASSEMBLY

BE IT RESOLVED by the Assembly of the AAMC that there be an organization of the faculties of the member institutions represented in the governance of the Association. THEREFORE, the Assembly direct the Chairman and the President of the AAMC, together with such other officers of the Association as the Chairman may designate, to meet with appropriate faculty representatives as well as the Executive Committees of the COD, CAS and the COTH to work out a proposed organizational arrangement for this purpose to be presented to the Executive Council at its next meeting and to be incorporated in ByLaw Revisions for presentation to the AAMC Assembly at the Annual Meeting in November, 1971.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES



Higher Costs of Graduate Medical Education

Based on the results of the AAMC Council of Teaching Hospitals' *Survey of House Staff Policy—1970*, it is estimated that hospitals in the United States will spend more than \$450,000,000 on house officers this academic year. Of 316 members of the Council of Teaching Hospitals who responded to a February,

American Medical Association Directory for the period 1968-69, plus a ten percent estimate for fringe benefits. (Table 1).

The COTH Survey revealed that for 1970-71 three out of every four respondents up-graded their stipend scales for interns (Table 2). Comparable data, which are not presented

TABLE 1
DIRECT COSTS TO HOSPITALS FOR INTERNS AND RESIDENTS

	Number of Trainees*	Average Stipend†	Average Fringe Benefits	Total
<i>Interns</i>	10,464	\$8,115	\$812	\$93,412,000
<i>Residents</i>				
Year 1	10,348	8,723	872	99,289,000
Year 2	9,940	9,274	927	101,398,000
Year 3	9,820	9,824	982	106,105,000
Year 4	3,726	10,419	1,042	42,794,000
Year 5	960	\$11,008	\$1,100	11,624,000
TOTAL				\$454,622,000

* AMA Directory of Approved Internships and Residencies, 1969-70.

† COTH Survey of House Staff Policy—1970.

TABLE 2
COTH SURVEY OF HOUSE STAFF STIPEND POLICY
Stipend Increases For Interns 1970-71 vs. 1969-70

Medical School Affiliation	Hospitals in Which Pay Scales Increased			Total Responding Hospitals	
	Number Responding	Percent of Hospitals in Category	Average Dollar Increase	Number Responding	Average Dollar Increase
University-owned	33	80	\$938	41	\$794
Major	98	86	1,211	114	942
Limited	31	69	1,114	45	567
Unaffiliated	23	61	970	38	623
TOTAL	185	77	\$1,116	238*	\$790

* Five hospitals are omitted because they reported no internship programs.

1970, questionnaire, 243 of them were able to report actual or estimated intern and resident cash stipends for the 1970-71 academic year. The projected total amount is based upon the cash remuneration averages for interns and residents by year of training multiplied by the number of total filled positions listed in the

here, indicate the same trend for residency stipends. For those hospitals which increased their stipend schedules, the average increase was \$1,116 for interns. When those hospitals which did not raise their internship stipends are included, the increase averaged just below \$800. For the year beginning July 1, 1970,

Datagrams

TABLE 3
 COTH SURVEY OF HOUSE STAFF STIPEND POLICY—1970
 Average Stipend 1970-71—All Respondents

	University Owned		Major		Limited		Unaffiliated		Total (norm)	
	# Hosp.	Avg. \$	# Hosp.	Avg. \$	# Hosp.	Avg. \$	# Hosp.	Avg. \$	# Hosp.	Avg. \$
<i>Interns</i>	41	7,717	114	8,228	45	8,010	38	8,328	238	8,115
<i>Residents</i>										
Year 1	40	8,306	119	8,868	46	8,730	38	8,701	243	8,723
Year 2	40	8,831	120	9,380	46	9,239	37	9,449	243	9,274
Year 3	40	9,383	119	9,951	46	9,765	37	9,960	242	9,824
Year 4	38	9,965	113	10,581	45	10,340	37	10,489	233	10,419
Year 5	31	10,560	83	11,242	17	10,825	12	10,804	143	11,008
<i>Fellowships</i>										
Fellow 1	8	8,900	28	10,584	18	10,330	12	10,895	66	10,367
Fellow 2	7	9,914	20	11,413	8	10,464	8	11,143	43	10,942

those hospitals with a major affiliation or which are owned by a medical school showed a greater tendency to raise the stipend level than hospitals with a limited or no affiliation with a medical school. However, as seen in Table 3, the highest average stipends were paid by hospitals with either major affiliation or no affiliation. University-owned hospitals' stipend

schedules remain approximately \$400 less than the average.

This survey is one of several initiated under the auspices of the Teaching Hospital Information Center, which is supported by contract PH 110-68-41 with the National Center for Health Services Research and Development of the Department HEW.

COUNCIL OF TEACHING HOSPITALS

Reprinted from the *Journal of Medical Education*

SUMMARY OF PRINCIPAL POINTS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
TESTIMONY ON H.R. 17550
BEFORE THE SENATE FINANCE COMMITTEE
SEPTEMBER 15, 1970

SECTION 226 - Payment for Services of Teaching Physicians Under the Medicare Program

The House Ways and Means Committee in Section 226 addressed proposed legislation to the reimbursement of teaching physicians under the Medicare program. The Association believes that, due to the wide variety of teaching arrangements, that it is imperative that the Secretary be legislatively permitted to develop and implement several optional methods of reimbursing these physicians who simultaneously practice and teach. The Association further believes that certain underlying principals which would, among other things, insure that no institutional double billing is accomplished and that the Medicare beneficiary receives a comparable level of care to that rendered by the physicians to his other patients needs to be legislatively reaffirmed. A set of approaches which, we believe, should be legislatively permitted is included as an attachment to the testimony.

SECTION 222 - Experiments and Demonstrations Projects In Prospective Reimbursement and to Develop Incentives for Economy In the Provision of Health Services

This section of the bill includes authorization for the Secretary to engage in experiments and demonstration projects which includes among other things, "alternate methods of reimbursement with respect to the services of residents, interns, and supervisory physicians in teaching settings."

The Association recommends that because of the very nature of experiments and demonstrations and the fact that they are usually of limited financial outlays that they not be impeded by the proposed requirement that such projects be initiated only after a written report of each project

Definition of Terms

1. Personally Rendered Professional Services

In the teaching hospital, the quality of care rendered to all patients should not be determined by economic status or the method of entry into the health care system. Each has a responsible physician who personally rendered care.

The responsible physician may utilize the professional services of the associated staff or other staff members, creating a team-of-physicians approach to patient care. To qualify for billing and collecting the professional fees for such services, there should be evidence that the responsible physician has personally rendered the care having reviewed and coordinated all care rendered by the team. Further, during technical procedures, such as surgical operations, the responsible physician must be present even though he may not be the operating surgeon of record. This means that the patient is informed of the team members. It is understood that, as a member of the team, the responsible physician may only observe the procedure, being immediately available to perform the surgery if needed.

"Personally rendered professional services" also includes those services provided by a member of the hospital medical staff, at the request of the patient's responsible physician, and with the patient's knowledge. It is necessary that an opportunity be provided to make a unit charge for the total service rendered in the diagnosis, treatment and follow-up of an episode of disease. In the teaching hospital, the unit of service involves the medical care team and the reimbursement should be negotiated to cover appropriate charges for the care rendered.

2. Medical Staff Patient

A patient who has chosen a member of the hospital's medical staff, or has accepted a practicing physician

assigned by the medical staff of the hospital to personally provide and be responsible for his medical care. Assignment of a physician is accomplished in accordance with established policies and procedures agreed upon by the medical staff and the hospital.

3. Attending Physician

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

4. Responsible Physician

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

5. Eligible

Professional fees may be billed for services rendered by the medical staff. Professional fees may be billed for services rendered by the associated staff when a responsible physician is personally present.

6. Associated Staff

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

7. Assistant Resident

A physician who has been appointed to the hospital's graduate education staff but has not yet attained the final year or two years of specialty qualifications (as described in #8 below).

8. Resident

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

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

9. Senior Resident

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

10. Chief Resident

A resident physician who has been appointed to a hospital's graduate education staff and has attained the final year of Board required training, or beyond. He can be appointed to the hospital's active medical staff for an appropriate period according to the policy of the hospital. The designation of chief resident and the selection of the chief resident is a function of the medical school faculty, the hospital's medical staff, and the hospital.

11. Medical Care Team

As referred to in these principles and accompanying documents, the team consists of a responsible physician from the hospital's medical staff working with one or more members of the associated staff. The team in special care situations may also include other members of the hospital's medical staff working with the responsible physician and members of the associated staff.

5. Chief resident by professional department and division.
- c. Medical staff by out-patient professional department and division.
- d. Associated staff by out-patient professional department and division.
 1. Intern by professional department.
 2. Assistant resident by professional department and division.
 3. Resident by professional department and division.
 4. Senior resident by professional department and division.
 5. Chief resident by professional department and division.
- e. Eligible staff.

Generally speaking, third parties will reimburse salaries of hospital, in-patient department staff and will pay professional fees for medical staff services in the in-patient and out-patient hospital departments.

1. Each patient should have clearly identified medical staff physician and associated staff.
2. This indicates the need for each associated staff member to have a clearly identified relationship to the medical staff.
3. Each year the medical staff should consider appointing licensed chief residents and senior residents to the medical staff if they are judged qualified to see patients

independently except for consultation
on difficult medical management problems.

4. Each medical staff member must see the patients he has accepted, and the hospital must have a medical staff method for accepting each patient as a medical staff responsibility, in addition to an associated staff responsibility.
-
12. Define hospital and medical staff organization roles in medical care, education, and finance objectives. To provide a stable base for the hospital to offer medical care to patients and to offer a clinical setting for the education of physicians, the hospital must be able to finance these operations. It must be in a position to bill and collect for all hospital services rendered to patients. If professional staff expenses are borne by the hospital, it must be in a position to bill and collect for professional services rendered.
 - a. In 1970, all patients should be considered as private in the sense that their care should be personally rendered by the medical staff. The associated staff, whose primary objective is education, may assist the medical staff in rendering care.
 - b. Departmentalization of the medical staff should be fully implemented in the hospital's in-patient and out-patient services. All physicians, including the associated staff, should be identified with a department and a specialty division.
 - c. A uniform fee structure should be determined by the medical staff and published within the hospital organization.
 - d. For a medical staff member to render service, be eligible for payment, and satisfy legal

requirements, he must be available to see patients at all hours, except when he has assigned patient responsibility to a medical staff colleague (not a member of associated staff).

INTERNS AND RESIDENTS: THEIR ROLE IN A TEACHING HOSPITAL
AND THEIR EFFECT ON HOSPITAL ECONOMICS*

Introduction

The activities of interns and residents have an important effect on teaching hospitals, particularly on the care of patients, and because of this, on services to both the hospitals and staff doctors. These services provide a framework within which the interns and residents receive an important part of their own education and training and also within which they help teach medical students and other interns and residents. And all of this has an important impact on the economics of the teaching hospital. These several roles of the interns and residents and their relationship to hospital economics are poorly understood. The hospital program cost study drew attention to this and, as a consequence, the Steering Committee decided that the intern-resident portion of the Yale-New Haven Hospital study should receive special consideration. For this purpose a special subcommittee was appointed. The members of this subcommittee were Dr. Darley, Chairman, and Drs. McKittrick and Snoke. Mr. Carroll served as study director.

The subcommittee was assigned two functions:

1. It was to obtain information that would help toward a better understanding of the role of interns and residents in teaching hospitals.
2. It was to suggest criteria for apportioning intern and resident expenses to proper hospital (and medical school) programs.

The subcommittee decided that for a clear understanding of the role of interns and residents and their effect on teaching hospital economics, a realistic appraisal of the value of the medical services that they provide was essential.

This chapter reports the study findings and their interpretations by the subcommittee. The recommendations and related comments cannot be regarded as a statement of the official attitudes and policies of the sponsoring organizations, nor of the overall Steering Committee.

Definitions

For the purposes of this study it was decided that the definition of certain terms was necessary.

* Assembled by Ward Darley from notes and rough drafts prepared by Augustus J. Carroll and from suggestions made by members of the Steering and ad-hoc Committees.

Teaching Hospital - "A hospital offering major educational and training programs for undergraduate medical students, interns, and residents."*

Intern - "A graduate of a medical school serving his first period of hospital training." (1)

Internship - "A period of hospital training, service, and education, usually of one year's duration, following graduation from medical school" (1).

Most states require an internship of at least one year to qualify for the examination for a license to practice medicine. Hospitals that provide this training may or may not be operated by or affiliated with schools of medicine.

Resident - "A physician serving a more advanced period of training in a hospital than an intern" (1).

Residency - "A period of one to five years of special hospital education, training, and service following the internship. The residency is designed to train the physician in a special field" (1).

House Staff or House Officers - These terms are commonly used by medical and hospital personnel when referring collectively to both interns and residents.

Clinical Fellows - Clinical Fellows are doctors who have finished their internships and residencies and who are training for subspecialties. Their objectives may be practice, teaching, research, or any combination of the three. They sometimes function as residents although their work often places great emphasis on clinical research. In this report no effort was made to distinguish between residents and fellows.

Attending Physicians - This term is often used in referring to physicians who hold appointments on the medical staff of a hospital and are primarily responsible for the care of specific hospital patients. These physicians may be in private practice and serve voluntarily as teachers or salaried members of a medical school faculty. Ordinarily they are certified specialists in one or more fields of medicine. Their patients may be their own or may be assigned to them by the hospital.

Approval of Internships and Residencies - The American Medical Association (AMA) Council on Medical Education is responsible for recommending new standards and modifications of existing standards for the organization and conduct of internships and residencies to the AMA House of Delegates for official approval and publication. The Council is assisted in developing standards and in reviewing individual programs through the organization of special Review Committees which provide for the collaborative action of Council representatives, as well as representatives of each of the specialty boards, and in some cases representatives of national specialty organizations.

Clinical Services - The clinical services of most hospitals are organized according to the various clinical specialties. Among the most common of these

* See page 4.

are Anesthesiology, Internal Medicine, Neurology, Obstetrics-Gynecology, Pathology, Pediatrics, Psychiatry, Radiology, Surgery, and Urology. Depending on the size of the hospital these services may be combined with, subdivided into, or augmented by related services in various subspecialties. Some clinical services may not offer internships or residencies. In addition, hospitals usually operate emergency and outpatient services or clinics. Interns and residents are usually involved in these services.

The length of the internship is usually one year. The length of the residency programs varies from one to five years, depending on the requirements of the AMA Council on Medical Education and the appropriate Residency Review Committees. Each service has a senior or advanced resident who serves as chief. This physician is usually in his last year of residency. He has achieved a high level of competence and is largely responsible for the performance of the interns and residents on his service. Residents other than the chief residents are usually called assistant residents. Many services also have clinical fellows.

As indicated in the definitions, interns and residents are graduates of medical schools and, therefore, can be called physicians. The interns have been, or soon will be, licensed to practice medicine. Residents are almost always licensed but even so have elected to continue in the hospital for additional study.

Methodology

In order to plan and conduct this study the members of the subcommittee decided to construct a questionnaire to be filled in by the members of the house staff and that this would then be followed by an interview of selected interns, residents, members of the hospital medical staff, and senior medical students.

The Questionnaire

The subcommittee members, study director, hospital administrative personnel, and chief residents in the Yale-New Haven Hospital cooperated in designing the questionnaire and in determining the procedures for soliciting other information.

The questionnaire was designed to obtain a time inventory from each intern and resident for a specific week in February, 1966. To insure responses that were as thoughtful and accurate as possible, the questionnaire was reviewed with the chief residents of the various services before it was administered. These residents distributed the questionnaires, explained their use, and collected them after they had been completed. An Assistant Administrator of the Hospital was designated to answer questions that might arise during the report period.

A copy of the Questionnaire that was used appears in the Appendix, pages 143-146.

The information requested included the total number of hours spent in the hospital during the week with this broken down as to time spent in the interests of (a) patient care, (b) professional self-improvement, (c) research activities, (d) teaching M.D. candidates, and (e) other house staff responsibilities.

Only time spent within the hospital was to be reported. The questionnaire recognized that much intern and resident teaching of undergraduate medical students is done simultaneously with the care of patients. Consequently the respondents were instructed that, unless the teaching function required a great deal of extra time, this was to be charged to patient care. As a general guide, only time that directly benefited a patient was to be charged to patient care. Time devoted to teaching other interns or residents, and particularly medical students, which produced no recognizable direct or immediate benefit to specific patients was to be charged to teaching.

Of 210 interns and residents who might have participated in this study, 147, or 70 per cent, actually took part. This includes responses from 140 questionnaire returns and 7 who volunteered to be interviewed but who were not available to complete the questionnaire.

During the week reported, the interns and residents in the study averaged 79.4 hours in time spent at the hospital. Almost three-fourths of this 79.4 hours was devoted to direct patient care activities. The data reported are summarized in the following tables. Additional data appear on pages 148 and 149.

Intern/Resident Report of Time
Expenditure for the One-Week Period

<u>Physicians</u>	<u>(N)</u>	<u>Hours per Week</u>	
		<u>Average</u>	<u>Range</u>
Interns	34		51-133
Residents	106		38-123
Total	140	79.4	

Distribution of Time
for the One-Week Period

<u>Activity</u>	<u>Average Hours/Week Spent by Interns and Residents (N = 140)</u>
Patient Care	58.8
Professional Development (including Study)	12.7
Teaching	3.8
Research	3.0
Unallocated Time	1.1
Total	79.4

Patient Care Given by Interns and Residents

The members of the subcommittee felt that even though the methods used were not particularly precise (such as would have resulted from a "scientific" time-motion study), the results still provided information that would permit valid observation.

The interns and residents who participated in the study reported that they spent almost twice (79.4 hours on an average) what can be considered as a normal work week. Most of this time was spent in patient care. As a consequence the following questions were raised:

What manner of patient care do the interns and residents provide?

Why is this care provided by them instead of by the patient's regular physicians?

Is the care that they provide necessary or beneficial to the patients?

Do the educational and training aspects of internships and residencies detract from or add to the quality of patient care?

To supplement the questionnaire returns, interviews were arranged with 30 interns and residents from representative services, three physicians who were active members of the hospital staff, three senior medical students who had rotated through all of the major services, and several hospital and medical school administrators. The following analysis of the patient care delivered by interns and residents is based on a combination of the information obtained from the questionnaires, the follow-up interviews, and the judgments of the subcommittee.

Since each internship and residency program is approved separately by the appropriate Residency Review Committee, each has its own characteristics. The Yale-New Haven Hospital offers only straight internships in medicine, pathology, pediatrics, and surgery.* Residencies are offered in practically all of the specialty and subspecialty fields of medicine.

Interns and residents always serve under the supervision (not necessarily constant) of physicians who have had more training and experience than they themselves. Many factors can affect the quality of training that an intern or resident receives: (a) the availability of advanced residents and attending physicians to provide training, supervision, and professional advice when

* At the time of the study there were three types of AMA approved internships: rotating, mixed, and straight. In the rotating internship, the year was divided between medicine, obstetrics and gynecology, pediatrics, and surgery. While the straight internships were left unchanged, beginning with the summer of 1966, the rotating internships were redefined to permit the flexibility formerly permissive with the mixed internships, so that beyond the mandatory requirement for four months of internal medicine, a rotation of not less than one, nor more than four additional services could be arranged. The resulting combination of services has been such that there has been a great increase in the total number of internship programs offered and depending upon the clinical resources of the hospital, the interns and program directors can make up a total internship program that is mutually agreeable. This more flexible type of internship is a logical corollary to the elective aspects of the undergraduate curricula that are now appearing in most schools of medicine. It is generally believed that this "new look" is enhancing the educational value of the internship.

needed; (b) the availability of patients; and (c) the extent to which a training and educational program is organized to give the interns and residents patient care responsibilities commensurate with the level of their professional development.

In the interviews each intern and resident was asked whether he was satisfied with the training he was getting, with the level of responsibility given to him, with the supervision he was receiving, and with the opportunities for obtaining emergency advice and help. There were some minor criticisms and suggestions for improvement. In general the majority of the 30 who were interviewed were enthusiastic.

The patient care that interns and residents provide is similar to the care that a patient would receive from a practicing physician of his choice. The resident does all of the things that any other physician would do except that where he has not been thoroughly trained, he performs under close supervision. As one would expect, interns cannot be extended these levels of independence. They take medical histories, perform physical examinations, write up medical records and charts, develop plans for care, report and discuss selected patient problems with the residents and senior staff members, write orders, investigate or study specific problems, assist in surgical procedures, and go to the X-ray Department and the laboratory on behalf of individual patients. They also attend service rounds with the resident. During these rounds, plans are made for the care of all patients that will usually be under the jurisdiction of the residents.

In pathology and clinical pathology internships and residencies, and in the diagnostic portion of radiology residencies, the interns and residents act, for the most part, as if they were consultants to other physicians. Here the patient care service is less direct than the type of service given in other disciplines.

A patient who is receiving care from an intern, a resident, his private physician, and possibly others might wonder: Wouldn't it be better if I received all of my medical care from my own doctor? Is all this extra medical attention from interns and residents necessary? Do I benefit from it, and if so, how?

To understand that interns and residents are important to him, a patient should be reminded of the reasons why he is in the hospital. He is hospitalized so that competent medical care and supervision and needed facilities and equipment will be continuously available. If he has a private physician, he should remember that he will have to share the limited time of this physician with other patients and that this physician cannot be available to him constantly or at all times. Yet the hospitalized patient can receive competent medical care regularly, routinely, or in emergencies as often as he may need it. This would not be possible without either an adequate number of interns and residents or a very large staff of full-time physicians.

The present intern and resident system provides a way of training physicians and future medical specialists; it also gives hospitals and attending physicians a way to maintain constant stand-by physician services for all hospital patients. And the overall costs of this stand-by care are considerably lower than would otherwise be possible.

A patient who has been informed that the intern and resident physicians who care for him work hand in hand with his own private physician and carry out his orders in all important matters will recognize these house staff services as an essential part of the care he receives while in the hospital.

Allocation of Time Reported by Interns and Residents

On-Call - To provide full physician coverage during some low work load periods, interns and residents are required to be on-call or immediately available for duty for several hours each week. The amount of actual work performed during on-call periods varies in the different services. At night the on-call men get as much sleep as possible between calls. Some sleep in on-call rooms in the hospital, but others who live near the hospital may remain at home.

No special instructions were given for reporting on-call time on the questionnaire. Many of those who spent the time in the hospital reported it as patient care time or listed it separately. Since house staff remain on-call so that they will be available for patient care when needed, it is proper to report this time in the patient care category. The interviews revealed that those who spent on-call time in their quarters near the hospital did not include this time in their questionnaire returns. Also those who were on-call within the hospital did not report the time they spent sleeping, eating, or studying. Therefore, the estimate of total hours spent in patient care should be regarded as conservative, probably 5 to 10 per cent below the actual totals.

Performing Autopsies and Reading Electrocardiograms - The hours spent on autopsy work by the pathology interns and the time spent reading EKGs by internal medicine residents was difficult for these respondents to classify. Therefore, they listed this time separately. In this study this was counted as unallocated time which averaged out at 1.1 hours for each intern and resident. Since this amount of time is too small to have a significant effect on the overall picture, adjustments were not necessary. Even so the subcommittee felt that the following comments were warranted:*

One of the principal pathologists of the Yale-New Haven Hospital staff thought that autopsies added indirectly to the quality of patient care. Even though a particular autopsy could seldom, if ever, be identified as beneficial to one particular patient, he compared this service with other hospital activities that benefit all patients. Because of this, he suggested that no portion of autopsy costs should be charged to patient care. In his opinion autopsies contribute to the self-improvement of the men that perform them, to the education of medical students, and to the professional development of the entire professional staff. And because of the investigative aspects of autopsies he recommended that part of the time spent on them be charged to research. He suggested that house staff autopsy time be allocated 50 per cent to research, 25 per cent to self-improvement, and 25 per cent to teaching.

* The Commission on Hospital Accreditation believes that autopsies contribute importantly to the effectiveness of hospital-based patient care. The AMA Council on Medical Education requires an autopsy rate of at least 25 per cent of hospital deaths for approval of an intern training program (2).

On the other hand, the subcommittee members agreed (a) that autopsies are generally regarded as essential to consistently high quality patient care in a hospital, (b) that the autopsy work of house staff doctors on the pathology service was important to their self-improvement, and (c) that autopsies provided valuable teaching materials and experiences for medical students, interns and residents, attending physicians, but (d) that ordinarily neither the design nor the results of autopsies would justify their classification as true medical research. They decided, therefore, that time spent in performing autopsies should be allocated as follows:

Patient Care	50%
Self-Improvement	25%
Teaching	25%

The chief cardiologist on the Yale-New Haven Hospital staff pointed out that all EKG readings by interns or residents must be verified by a full-time cardiologist. Insofar as patient care is concerned, and the time devoted to this should be charged to self-improvement. The members of the subcommittee concurred with this recommendation.

Patient Care
The interviews were used to elicit descriptions of the patient care provided by interns, residents, and members of the full-time staff. They provided an opportunity to discuss the necessity and value of the care that interns and residents gave to the patients. It was also possible to ask the interns and residents whether they thought the training aspects of their work either detracted from or added to the quality of this care.

All of the interns and residents interviewed thought that their teaching or self-improvement activities were distinctly beneficial to all patients.

It is routine practice for an intern to take a patient's history and perform a physical examination. A resident and perhaps a clinical fellow may do the same. No one agreed that this repetition was contrary to patient welfare.

Some said that each of those who become intimately familiar with a patient will usually care for him better. It was emphasized that everyone has different ways of asking questions and that one history may bring out information that another may miss. A patient may be more relaxed and better prepared to respond to the second set of history-taking questions than to the first. And the second physical examination may reveal things not discernible during the first. It was pointed out that when several physicians have first-hand knowledge about the same patient, the result cannot be help but be of benefit--benefit to both the patient and the physicians.

Self-Improvement
In the questionnaires this item accounted for 12.7 hours of the week in conferences and consultations with faculty and other physicians; and medical rounds, surgical, or other grand rounds made with large groups. These rounds are conducted to discuss the problems of selected patients for the professional improvement of the participating physicians (house staff as well as the attending staff) as much as for the benefit of the patients.

Teaching - The Interns and residents felt that their responsibility for teaching and supervising medical students did not interfere with the course of patient care. Rather they believed that students' comments and questions worked to the benefit of the patients.

The teaching time reported included time for individual or group conferences that were primarily for the instruction of students; for example, the presentation of patients when the primary purpose is to display, explain, and discuss etiology, diagnosis, treatment, and prognosis.

The interviews with senior medical students showed their belief that the interns and residents performed very importantly as teachers.

Some services, such as radiology, did not have interns. On the surgical service the interns were so involved in patient care that they had difficulty finding time for teaching.* On the other services, the students regarded the intern as the closest personal link between themselves and the patients. The teaching done by interns, however, is limited in scope. They teach routine things and the manual skills required for the medical care of patients. This leaves the more advanced and more sophisticated aspects of teaching for residents and faculty.

On the whole, however, the students were satisfied with the teaching performed by the interns. At the Yale-New Haven Hospital one student works with two interns on each service. If one proves unsatisfactory as a teacher, the other intern, or the residents, nearly always make up for the deficiency. None of the students seriously criticized the teaching done by residents.

Differences Between Clinical Services

So far this discussion has been limited to the patient care and learning and teaching activities of interns and residents. As between the different services, the elements that made up this combination of activities revealed considerable variation.

Medicine and Pediatrics - By and large the interns spent more total hours during the week in question in the hospital than the residents. Excluding pathology, the respective averages were 104.5 hours as opposed to 76.6 hours.

For the interns the average total time spent in medicine and pediatrics averaged 97 hours whereas for the residents it was considerably less--only 75 hours. The interns spent more time than the residents in patient care (an average of 81 hours as opposed to 56 hours). Both interns and residents spent about the same amount of time in self-improvement (10.3 hours as opposed to 11.4 hours) but less time in teaching (4.9 hours as opposed to 6.7 hours).

As between the medical and pediatric services, the distribution of time between patient care, self-improvement, and teaching was the same for both the interns and residents.

* Also the interns spent so much of their time assisting with the technical aspects of surgery that they considered their personal relationships with patients to be of little consequence.

Surgery - In surgery, during the week in question, the interns averaged 116 hours in the hospital as contrasted with 88 hours for the residents. With 105 of these hours going to patient care, it is surprising that the interns were still able to find over 10 hours for self-improvement and teaching.

Of the 88 hours the resident spent in the hospital, nearly 72 hours went for patient care; nearly 16 hours for self-improvement and teaching.

Obstetrics-Gynecology - The Yale-New Haven Hospital did not offer an internship in obstetrics and gynecology. Its residents are most entirely responsible for prepartum and postpartum maternity care and for preoperative and postoperative gynecological care. They also play a responsible role in the operating rooms. The residents found considerable time for self-improvement and teaching, but even for the week in question, 61 of their hours were involved in patient care.

Pathology - House staff on this service have less direct contact with patients than any of the other clinical services. The first year in pathology is an internship which is primarily an autopsy assignment. Learning to perform an autopsy takes a few weeks. In the early part of his internship, an intern may require all day for performing a single autopsy. The required time for this function is reduced eventually to three hours or less. In addition to this three hours, a day or two is required for preparing slides and a final report. Three times a week these reports are presented to staffs of the different clinical departments. In addition, more formal weekly clinical pathological conferences are presented by the Pathology Department.

The pathologist who was interviewed believed that some persons might think that the department was overstaffed with interns. He explained, however, that it was necessary to train enough men for the next year when they would switch from autopsies to surgical pathology, which is oriented toward direct patient service.

In the two years of residency following the internship, the residents spend some time learning to prepare slides for microscopic examination of tissues and to perform other techniques ordinarily performed by technicians. A pathologist must know how to do these things, but histology technicians will ordinarily perform this function. Frozen tissue sections and the preparation of slides requiring special staining techniques are exceptions. These slides must be prepared during a very short period time--often while the patient is still in surgery. Therefore, a pathologist must become highly skilled in these techniques. In the opinion of the members of the subcommittee, time spent in learning these procedures is a proper charge to patient care.

The questionnaire analysis showed that the house officers in pathology spent much less time in the medical center than those in other departments. And the apportionment of this time to patient care, self-improvement, and other designated activities, follows a much different pattern than was the case in the other departments: more time is devoted to self-improvement and research and less time to patient care. This reduces the average number of hours spent on patient care by the combined house staffs of all departments.

Clinical Pathology - In clinical pathology the residents averaged less time in the hospital than for any other service. And over 80 per cent of this time was spent in research. Self-improvement took nearly 6 hours, direct patient care only 2.7 hours, and teaching practically none. As compared with the other services, this pattern was probably the reflection of the mechanization of the services largely under the supervision of technicians. The members of the subcommittee would have insisted that the residency costs in clinical pathology be charged to research rather than patient care but with only three residents involved, the charge to patient care, as with the other house officers, was permitted to stand.

Radiology - The Yale-New Haven Hospital did not offer internships in radiology but, as in other services that have no internships, a completed internship in another service or services is a requirement for a residency appointment. The residencies are for three years.

A first-year resident must be taught to read X-ray films in the early months of the year. During this time he is not very productive in terms of patient care. He gradually learns to read film, but all readings must be reviewed by a staff radiologist. In the latter part of the first year and throughout the remainder of the residency, this film reading continues. Also the reviews by the staff radiologists continue. However, as the residents gain knowledge and experience, the time required for rechecking decreases, and the residents assume more responsibility. In the third year only the problem cases take much of the staff radiologists' time.

An interview with a staff radiologist showed that the film reading of the residents contributes to patient care even though the readings have to be rechecked. The resident sets up the films for reading and does all of the required clerical work. The staff doctor simply looks at the film and confirms or corrects the residents' interpretation. If there is a correction, this is explained to the resident. Because of what the resident does, film reading may cut the staff radiologists' time in half, or even less. Nevertheless, the proportion of the residents' time reported for patient care was somewhat higher than this radiologist would have expected.

This same radiologist thought that patient care would be just as good if there were no house staff and all films had to be read by the regular staff. To provide the additional staff necessary to compensate for the lack of residents would probably be just as costly for the hospital and the patients. In the opinion of the members of the subcommittee, this does away with the case for no residents for a teaching hospital. To avoid training personnel that is already in short supply would be to neglect one of the most important of its missions. This same line of reasoning can be applied to all areas of residency training.

Radiology residents are assigned to different staff members and at various times they concentrate on certain services: the surgical service, the medical service, orthopedic service, and so forth. In addition to this, the picture is complicated because of the rapidly increasing importance of radiotherapy. This means that the residency programs in radiology must provide for service, research, and teaching in both diagnosis and therapy.

At the Yale-New Haven Hospital, radiotherapy training is provided in the second year of the residency. This year is divided into four quarters.

During the first quarter, the resident studies physics under the tutelage of a staff radiologist and draws up precise plans for the radiotherapy treatments to be given to individual patients. This requires much study and detailed work. The plans developed by the resident must be verified and approved by a staff member.

During the second quarter, the resident begins to take more responsibility. With every new patient the resident takes a medical history and does an examination. This is followed by another history and examination by a staff radiologist. The resident and the staff doctors then discuss the patient and his problems and develop the specifications for therapy. This involves consideration of the kinds of radioactive materials to be used, the parts of the anatomy to be treated, and the best way of providing this treatment without exposing other parts of the body to unnecessary radiation. After the therapeutic plan has been developed, unless there is some question, the resident takes over all of the responsibility for the patient. During this quarter the resident is responsible for 60 to 70 patients at a time. This continues during the third quarter and, in addition, the resident attends clinics on the various services, especially those that are concerned with possible uses of radiotherapy.

During the final quarter of the year, the resident serves as the chief resident on the therapeutic service. He sees every new patient when he is admitted and works on the wards with other residents. He plans work conferences which are held twice a week for the house staff, the regular staff, and the technicians, dietitians, psychiatrists, and social workers who are involved with particular patients. During this period he is also in charge of teaching conferences which are held twice a week, conferences with pathologists, surgeons, and the staffs of other major services. He also attends conferences held in the diagnostic division of the radiology service.

At the conclusion of this year of the residency, if a resident should decide to confine his activities to the radiotherapy, he is expected to seek a fellowship to support the continuation of this training.

Controversy About Diagnostic Tests

To the fullest possible extent, hospital diagnoses and treatments are based on determinable facts about the patient. Thoroughness is mandatory in good patient care.

The early physical examinations of a hospital patient by medical students, interns, residents, and attending physicians are followed by repeated check-ups so as to keep the record of the patient's condition up to date. In addition, in order to pinpoint a diagnosis and to maintain a constant check on the effectiveness of the treatment, a variety of laboratory tests are used. When a hospital is well staffed with interns and residents they order most of these tests. Usually more tests are ordered for each patient than would be the case if all of the orders were issued by attending physicians. The result is a larger patient bill.

Patients and some of those responsible for the payment of patient bills have claimed that some of the X-rays and laboratory tests are ordered to satisfy the training needs of the house staff rather than the needs of the patients and because such tests produce no direct patient benefits they, therefore, should not be included in the charges made for patient care.

To check such claims, the opinions of several attending physicians, including faculty members, 30 house staff physicians, and hospital administrative personnel, were sought in interviews and informal talks.

Most attending physicians and faculty members admitted that some excess use of the laboratories, both by the house and attending staff, was unavoidable. But there was agreement that this would be a difficult matter to control. Although some experienced physicians may consider certain tests unnecessary, others would fully support house staff judgments. Faculty members emphasized that any tests that removed an area of doubt about a patient's physical condition were good for that patient and contributed to the total quality of patient care provided by the hospital.

The 30 interns and residents who were interviewed were reluctant to admit any waste in this area of patient care. They thought that all diagnostic tests ordered for a particular patient helped him either directly or indirectly. Many were problem cases which had been referred to the hospital by physicians who expected the tests in question to be made. The house staff did not believe that they were ordering more tests than attending physicians were ordering for their private patients.

The interns and residents stated that they were taught to be thorough and to avoid the chance of missing diagnoses. They said that house officers on emergency room assignments are pressed for time. They have less opportunity to discuss special problems and the desirability of certain tests. They are on their own and, if there seems to be a possibility that a certain test would help a patient, they went ahead with the necessary orders. All had seen such tests turn up unexpected information that had been vitally important to individual patients. They felt that for the quality of medical care they were being trained to provide, they could not arbitrarily cut down on their orders for diagnostic tests without doing their patients a disservice.

Some services were taking positive steps to minimize the dangers of excessive house staff orders and the resultant waste. House staff who placed non-routine orders were called upon to explain why. Among the house staff this created more of an awareness of the need to exercise judgment and prudence in writing laboratory orders. But even so there was the belief that this had no appreciable effect upon the work load of the laboratory or the overall costs of patient care.

In the opinion of members of the subcommittee all of these questions are rapidly becoming academic. This is because hospital laboratories are increasing their involvement in the multiprocedure screening of every hospital admission, and as a consequence the questions of unnecessary and costly use of the laboratory are rapidly disappearing. Instead, the need for the proper interpretation of complicated profiles of laboratory results is introducing a new dimension to the judgmental skills necessary to the care of patients and the education of physicians.

The Effect of Interns and Residents on Hospital Economics

In the opinion of members of the subcommittee the study of internships and residencies shows that, although the trainees may be legally qualified physicians, their service output is not equal to that which might be expected of physicians who are fully trained and experienced. Still the study shows that the members of the house staff provide essential physician coverage for patients around the clock, that their medical service productivity and the value of their services increases steadily as the residency progresses, and that in the advanced years of their residencies the quality of their service reaches a very high level. The members of the subcommittee believe that this study, through its questionnaires and interviews, shows that factual information can be brought together that will facilitate a broad understanding, including the economic impact, of the total role of interns and residents in teaching hospitals.

To begin with the costs of internships and residencies comprise a significant part of the total costs of operating the Yale-New Haven Hospital. For the fiscal year ending September 30, 1964, for 210 interns and residents (not just the 140 who filled in the questionnaire) this amounted to \$560,380, about 4 per cent of its total costs, or \$2.30 a patient day. This included salaries and all other hospital expenditures related directly or indirectly to internships and residencies. The kinds of internship and residency expenses paid by the hospital are listed on page 147.

Any hospital involved in intern and resident programs should be able to develop this kind of information. Some hospitals compute their total intern and resident costs routinely while others do not. But in either case, the costs filter through the accounting system and are finally reflected in patient costs and rates. These costs borne by the hospital are passed on to patients or to those who pay patient bills.

In addition to the investment that teaching hospitals make in intern and resident training programs, because of the time and effort their faculties put into these enterprises, medical schools also make a significant contribution. For example, a study performed in 1959-1960 found that after deducting related income, each of 12 medical schools averaged \$218,290 as its contribution to intern and resident education (3). Part of this expenditure may seem justified because of the extent to which interns and residents teach medical students. In fact, in deference to this, some medical schools pay part of the residents' stipends--particularly the stipends of the senior residents.

A program cost study performed by the Yale University School of Medicine for the year 1963-1964 revealed that the total salaried faculty time and effort devoted to teaching all interns and residents averaged out at 15 per cent and that this amounted to \$230,273. Therefore, at the Yale-New Haven Medical Center, assuming that the October 1, 1963-September 30, 1964 fiscal year of the hospital can be equated with the 1963-1964 academic year of the medical school, as between the hospital and the school of medicine, the total cost of intern and resident programs for the year was nearly \$800,000. Many different functions involving interns and residents are reflected in such a figure.

For one thing, during the week in question, each of the 140 participating house staff worked in the hospital for an average of 80 hours, twice the 40-hour week that applies to most hospital employees. Of this week, each

individual's time averaged out as follows: 3.8 hours in teaching medical students, 3 hours in research, 12.7 hours in self-improvement, and 58.8 hours in patient care. Even though the week of this study (February, 1966) was two years later than either of the hospital or medical school fiscal years, if it is assumed that all of the years in question are in step, significant relationships between house officer participation in teaching, research, self-improvement, and patient care can be discussed.

Teaching - Again bearing the above assumptions in mind, during the week in question, 140 members of the house staff together spent 532 hours teaching medical students. Obviously 532 hours of teaching medical students by 140 out of 210 interns and residents are not the data that can be compared with 15 per cent of faculty time and energy in teaching interns and residents. But such data could have been obtained and such a comparison could have been made. The extrapolation of the incomplete house officer data for one week to complete data for one year makes it possible to show that this is so. An average of 3.8 teaching hours per intern and resident is 4.8 per cent of the average work week of 79.4 hours and 4.8 per cent of \$560,380 is \$26,899, approximately 10 per cent of the total hospital-intern-resident cost for one year. While it is improbable that all of the above information will be worked into the ledger sheets, the ledger sheets plus program cost studies can supply the information that cannot help but be of importance to the judgments necessary to good hospital and medical school planning and administration. This is of importance even though opposing judgments may be the result. For example, there could be disagreement over the significance of the small figure of \$26,000. Some could say that the full-time faculty needed to do the amount and kind of teaching done by interns and residents would not have been this costly. Others could say that the kind of teaching done by interns and residents was of such value that this service was at least worth this amount if not more. But be this as it may, since the average intern-resident work week was nearly twice the work week applied to most other hospital employees--and interns and residents are hospital employees!--it was the opinion of the subcommittee that the time spent teaching medical students should be considered as contributed time and that since this time was spent to the collective advantage of the hospital, the medical school, the medical students, the patients, and the house staff themselves, any "book" or "cash transfer" adjustment or any other consideration of relative value was not worth the trouble.

Research and Self-Improvement - For the purposes of this discussion, research and self-improvement can be considered together. It is true that the time spent in these two enterprises increased the capacity of the house officers to be more effective in both teaching and patient care. But when the 15.7 hours (15.7 hours equals 19.6 per cent of a work week of 80 hours and 19.6 per cent of \$560,380 is \$109,835) devoted to these activities plus 3.8 hours of teaching are subtracted from the week's work of 80 hours, the remaining 58.5 hours are so far in excess of a normal work week, again the members of the subcommittee decided that this time should be considered as contributed time and need not be accounted for in terms of dollars.

Patient Care - There are two principal ways in which house officers contribute to patient care. First, they give direct care to patients as physicians and second, they free the members of their supervising staff so that they can take the responsibility for more patients than would otherwise be the case. Unless some way can be found to compute the value of the house officer's

contribution to patient care in terms of the output of experienced full-time staff physicians, there is no way of comparing these two kinds of service in terms of dollars. But since, during the week in question, each house officer averaged more than 60 hours of direct patient care, and since this was in excess of the usual work week by 50 per cent, it was the opinion of the members of the subcommittee that the need to make such a comparison was unnecessary and that the total hospital house officer cost of \$560,000 was a just charge against patient care.

But it was also the opinion of the members of the subcommittee that the contributions of these house officers to patient care was largely in the professional sphere and, therefore, the extent to which this \$560,000 should be passed on to patients as a hospital cost rather than a professional charge was open to question.

In raising this question, the members of the subcommittee were not unmindful of the fact that third-party payers, including medicare (4), consider house officer expense as a hospital rather than a professional cost.

At the Yale-New Haven Hospital, the house staff stipends for the year ending June 30, 1966 were as follows:

Interns	\$3,000
First-year residents	\$3,900
Second-year residents	\$4,100
Third-year residents	\$4,300
Fourth-year residents	\$4,500
Chief residents	\$6,000

While these figures can be considered as close to the 1966 average (5), it must be realized that the stipends of house officers are steadily increasing. For the year 1968-1969 the hospitals of ten cities will pay stipends for interns that will vary from \$4,200 to \$7,500 and for fourth-year residents from \$6,000 to \$10,000. Varying combinations of costly living allowances and fringe benefits will also be provided (6). In the opinion of the members of the subcommittee, while one reason for these increases is the need for a livable wage (of the 140 house officers who participated in the Yale-New Haven Hospital study, the ages ranged from 23 to 46 years and, of these, 109 were supporting families), once this condition has been satisfied, a more compelling reason will be the nature and extent to which the interns and residents are responsible for the professional care of patients. And it is further the opinion of the members of the subcommittee, that as this gains in emphasis, there will have to be a limit in the extent to which this can be justified in terms of the usual hospital costs.

The Yale-New Haven Hospital study provided further data in support of this view when it was shown that during the week in question, the interns and residents devoted an average of 29.9 hours to the care of private patients of the attending staff. This information was not included in the summary on pages 148 and 149 because too many of the house staff could not differentiate between those patients that were private and those that were not. However, there was the feeling among the interns and residents who were interviewed that at least one-half of their patient care time involved the private patients of attending physicians.

In concluding this report of the subcommittee, it is believed that while this study had many imperfections, it still can stand as an important pilot effort that shows the importance of teaching hospitals attempting to estimate their program costs. It is recognized that program cost estimating can only consider dollars that are actually spent or that are involved in actual costs. In developing such data, the consideration of relative value cannot be involved. But the study also shows that once the data have been developed, they can still be of use in the better understanding of institutional operations and in the formulation of judgments that may be concerned with questions of relative value and with decisions that can have to do with who should pay how much for what.

In short, it is the opinion of the members of the subcommittee that program cost estimating is a procedure that can be of tremendous help with the understanding of the internal administration and planning of a teaching hospital and in explaining the complicated mosaic of its many functions, in this instance those functions that revolve around the activities of interns and residents. And with program cost figures in hand and also the facts that explain the figures, it is possible to do a better job of explaining the teaching hospital, both to those who think they are informed as well as to those who know that they are not.

As a final conclusion, the members of the subcommittee agree with the recommendation of the National Commission on Community Health Services that "... research be undertaken to provide a basis for calculating and financing the net cost of educating interns and residents" (this is a portion of Recommendation 11) (7), but only if this is done in terms of the reevaluation of educational content and methods, the extent to which services to the hospital, attending physicians, and patients are necessary as educational frames of reference and the extent to which they are not, and the length of time (number of years) that should be involved.

The members of the subcommittee suspect that portions of the internship and residency that are primarily educational, that are in-service or on-the-job training, and that are primarily professional care can be separated out in terms of time and effort and also in terms of costs and that these costs can be distributed accordingly. Once these costs are understood, the sources and the amounts of the necessary income can be better understood. All three of the agencies sponsoring the Yale-New Haven Hospital program cost study have these questions under intensive study. The program cost study of seven university medical centers that is mentioned in Chapter 8 will undoubtedly cast further light upon these questions.

It would be folly to expect that these studies will yield formulas that can be used in common by all teaching hospitals. No two teaching hospitals and the relative emphases of their house officer programs on education, training, and various types of service are necessarily alike. Consequently each hospital must conduct its own analysis of the costs of its manifold programs and operations. Then as the data from hospital to hospital may vary and as hospitals are to be compared and understood, the facts that explain the data and their variations will be readily at hand.

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**TOUR EUROPE
THE N.A.R.I. WAY!
SCHEDULE ANNOUNCED**

An extensive schedule of charter flights, some combined with special medical seminars, has been arranged for members of the National Association of Residents and Interns.

Under the 1970 tour schedule, commencing in May, members will be able to visit some of the most desirable cities and vacation resorts in Europe.

Early Reservations Urged

Medical meetings and seminars are being arranged in conjunction with the tours that are over two weeks in length, thereby enabling members to make the tours tax deductible. Wives of members are, of course, eligible for the charter tours and special arrangements are being completed so that in all probability your spouse's expenses will be tax deductible too.

(Continued on page 6)

**N.A.R.I. Steps Up Drive for Tax Justice,
Joins in New Senate Bid for Change in La**

In its efforts to win tax justice for house staffers, the National Association of Residents and Interns is mounting a new campaign to win legislative relief for doctors in training.

It is hoped that the impetus from N.A.R.I. efforts may set off a nationwide effort to encourage Congress to specifically clarify the law and allow fellowship exemptions for house staffers.

Proposed Modification

N.A.R.I., through its counsel, Bernard Fuchs, has been consulting with the office of Sen. Warren G. Magnuson (D. of Washington) who has introduced a bill (S 3073) which would amend Section 117 of the Internal Revenue Code to exclude from gross income up to \$300 per month of scholarship and fellowship grants for which the performance of service is required.

Mr. Fuchs has submitted a proposed modification to the legislation which

would, if enacted, require the IRS treat interns and resident physicians as recipients of a fellowship grant.

In introducing his legislation, Sen. Magnuson described his amendment being offered in the hope of correcting a misunderstanding that has existed since the original enactment of Section 117 in 1954.

Financial Hardship

He stated that he believes Congress intended a relatively broad interpretation of "scholastic" and "fellowship" grants as used in Section 117 so as to encourage a well-educated citizenry, excluding from ordinary income amounts which were within the meaning of these words.

Instead, he declared, the IRS has given the words a narrow interpretation and hence many graduate students who are required to perform teaching research, or other services as a condition of receiving financial assistance

(Continued on page 5)

**Should Trainees Collect Fees for Services?
N.A.R.I. Supports California Proposal**

An editorial in the October, 1969, issue of "California Medicine" raises important issues concerning the status of residents and interns. The editorial — A Problem and a Proposal — was so important that we felt compelled to reprint it so that all our members could read it.

The editorial notes that "if charity medicine is really to be a thing of the past, professional groups, which would include licensed interns and residents, should be permitted and encouraged to collect reasonable fees for services rendered in a teaching situation just as is done in practice."

It proposes that house staffers be recognized as practicing physicians and members of the professional staff.

Your Association, long a fighter for improvements in the economic and professional status of the house staffer, heartily endorses the proposal.

N.A.R.I. pledges its full support and recommends that appropriate medical organizations take immediate action to implement programs to make residents and interns true professionals in every sense of the word — including remuneration equitable for the services they perform and professional status appropriate to their ability and training. The editorial follows:

A serious problem is developing which is no doubt a predictable outgrowth of the traditional employment status of interns and residents, a status which has too often resulted in their exploitation by both hospital administration and medical staff.

For a number of years, it has been evident that the status of house staff, particularly their pay and fringe benefits, needed substantial improvement, but the response has been slow, and it now appears that it was too slow.

A new determination by interns and residents to improve their status, compensation and working conditions is now apparent. This new determination

(Continued on page 3)

**Residents, Students Favor
Government Partnership**

A survey of students and residents in California indicates that three-quarters of those questioned feel that "the struggle against socialized medicine in the United States should now be channeled into other activities."

These activities, it was noted, included "cooperation with government to form a meaningful partnership for the betterment of the health of the American people."

Slightly more than half of the residents conceded that the government has some role in establishing standards or criteria to assess the quality of care provided to patients by physicians. Among students, 60 per cent of the seniors and 75 per cent of the freshmen favored a government role in this area.

(Continued on page 5)

REMEMBER YOUR MEMBERSHIP IN N.A.R.I. CAN CONTINUE FOR LIFE — AS LONG AS YOU REMAIN ACTIVE IN PRIVATE PRACTICE OR ACADEMIC MEDICINE

Should Trainees Be Paid Fees? N.A.R.I. Endorses Proposal

(Continued from page 1)

is tough-minded and oriented to one kind of action which will very likely produce results. The new tough approach may be said to have started with the imaginative "heal-in" staged by the house staff at the Boston City Hospital a few years ago. This was successful and bore results which were satisfactory to the house staff of that time.

"Sophisticated Service"

We are now informed that after a year or more of negotiations initiated by the Committee of Interns and Residents of New York City, a contract of labor union type has been entered into in New York City. A national association of interns and residents has come into being and in California a University of California Association of Interns and Residents has been formed and at the time of this writing is in negotiations with the five medical schools in the University of California system.

It is easy to react with pious indignation to all of this, particularly if one is old enough to compose an editorial for a distinguished medical journal such as this. But the facts are that things are different than they were 30, 20 or even 10 years ago.

The majority of house staff is now married; often with one or more children. The length of their post-doctoral training has increased. They call attention to the fact that the income of most interns and residents is considerably below what is now held to be the level of poverty. They believe that they render service, sometimes very sophisticated service, and that they should be compensated with a living wage. They argue that specialized training in business, industry and even in other fields of graduate education is usually compensated more nearly adequately even though little service may be rendered.

Some Questions Raised

The issues raised by all this extend far beyond the problem of reasonable pay and working conditions for interns and residents. Perhaps most basic is the question whether house staff should be considered hired help of the hospital, or are they actually professional people rendering the same professional services on the same patients as is the medical staff?

On a broader scale, to what extent is it desirable to encourage the concept of hospital-based physicians who are employed by the hospital and paid from funds generated through the hospital daily rate for patient care?

Is a very expensive hospital educational program a proper charge against a patient who is in the hospital for the care of his illness or repair of his injury? Can this all be justified on the basis of a better quality of care in a teaching hospital? And perhaps most important of all, what are the probabilities that this trend toward unionization among house officers may spread throughout the whole of the medical profession, as it has already begun to do in nursing, and will this be for the ultimate good or ill of the patient and the public?

These are not easily answered questions, but must they not be faced and dealt with by the medical profession right now? The alternative may be to permit a situation to develop which will not benefit the patient, the profession or the public.

In seeking a solution it is suggested that a number of factors which pertain to the problem be considered. The era of charity medicine is drawing to a close; in fact, the concept is probably no longer even viable. This end of an era was brought about by the enactment of Titles XVIII and XIX of the Social Security Act. However, these new titles and the regulations which administer them have not yet been able to resolve the inconsistency of trying to provide access to a single high standard of health care for all on the one hand and filling the needs for clinical "material" in teaching hospitals on the other.

The difficulty is easily understood if it is recognized that "teaching patients" have traditionally been charity patients

and this now conflicts with the aim to do away with charity in medicine. To reconcile this inconsistency it therefore seems only reasonable that if charity is to be phased out of the service of practicing physicians it should also be phased out of the services provided by licensed interns and residents in teaching hospitals.

It is proposed that a logical solution would be to recognize interns and residents as practicing physicians, members of the professional association which, in teaching hospitals, would be organized as a group for the combined purposes of practice and teaching. Such a group would have appropriate internal arrangements with respect to privileges, responsibilities, working arrangements and compensations in much as is the case with group practice on the side of teaching institutions.

If this were done, yet another step would be taken to remove "demagogic" charity from medical care. In a teaching situation would more closely parallel actual practice, the house staff would actually move into the mainstream of patient care, and the funds needed for support of the physicians involved would generate largely, perhaps entirely from the services to be rendered. The arrangements would be on a professional basis among professional people.

Departure from the Past

This proposal is a clear departure from the past. It would probably require changes in the Social Security law and certainly in the regulations. It would require revision of the wording but not necessarily the substance of the requirements of a number of specialty boards and would cause practice groups to come into being in teaching hospitals.

But it all seems logical. It is almost certain that the legitimate demands of interns and residents will somehow have to be met, not only in California but across the nation. The necessary funding will be substantial and will have to come from somewhere.

If charity medicine is really to be a thing of the past, professional groups which would include licensed interns and residents, should be permitted and encouraged to collect reasonable fees for services rendered in a teaching situation just as is done in practice. I do hope that it will do so promptly.

It is suggested that the American Medical Association is the appropriate body to assume the leadership needed to unravel this complex problem.

Physicians Wanted in Ohio Community

Your Association has received an appeal for young physicians who would like to set up practice in Ohio. The physicians who answer the invitation will get their chance to practice medicine in a proposed medical center between two villages — Minster and Bremen, Ohio.

James A. Eiting, who is chairman of the Physicians Committee, said it offers a perfect balance between metropolitan and rural living and is an area that is progressive and growing.

Any interested physician can contact Mr. Eiting at DE Industries, 115 Ohio Street, Minster, Ohio or call collect.

HIGHLIGHTS FROM AND
COMMENTS ON PUBLIC HEARINGS ON FILING
OF PHILADELPHIA BLUE CROSS FOR SUBSCRIBER RATE INCREASE

March 17 to 20 and 22, 1971

by

Leon A. Korin, Assistant Director

With kudos from his admirers and unflattering barbs from his adversaries - and sometimes both from each of these groups - Pennsylvania Insurance Commissioner, Dr. Herbert S. Denenberg, ended 5 days of gruelling public hearings on the premium rate increase of 50% requested by Philadelphia Blue Cross.

The hearings started on Wednesday, March 17, 1971 at 9:00 a.m. and ran for 4 consecutive days - (including Saturday) and were completed on the fifth day, Monday evening, March 22, 1971 at 7:30 p.m. - but not until more than 40 hours of actual testimony had been presented and 132 witnesses had appeared, spoke and were interrogated, to fill more than 2,000 pages for the record! Klieg lights, television and movie cameras were the order of the day. One TV station carried the full proceedings for the first 3 days - live and in color. Philadelphia newspaper, radio and TV reporters were evident throughout the five days and the "New York Times" sent a reporter to cover the story.

"Flamboyant," "brilliant," "indefatigable," "dynamic," "consumer-protector," "clever," "expert," "challenging," and "witty" - and the like, are adjectives which his admirers and supporters might use in describing Dr. Denenberg. His opponents might call him "caustic," "naive," "abrasive," "disruptive," "impetuous," "superficial," "bombastic," "clowning," and the like. But no one will deny that his words and actions are meant to shake up the hospitals, Blue Cross, physicians and the consuming public, as well - for Dr. Denenberg used all communications media to invite the consumers to come to the hearings for their "days in court" - to tell their experiences - good and bad - with doctors, hospitals, Blue Cross, and commercial health and hospital insurance carriers.

In prior public hearings before Insurance Department Commissioners some consumers were "ruled out of order" if they started to tell their complaints about Blue Cross, hospitals and doctors. Not so before Dr. Denenberg. Although this was purported to be a public hearing on the applications by Philadelphia Blue Cross for a \$37 million hike in premiums to be effective on April 1, 1971 and another boost of \$37 million - a total of \$74 million - to become effective August 1, 1971 - "all was fair game" and the presentations at times were not only about the rate increase - but more significantly - the entire health delivery system was under scrutiny and attack for "betraying the public trust."

To put the hearings in proper perspective, one should realize that in addition to Blue Cross Plan representatives, individual hospital administrators, organized hospital regional and state associations, physicians - individually - regional and state organizations, providers of health care services such as multiphasic screening corporations, labor groups, consumers - individually and through organizations - representatives of government, local and State and national were much in evidence. In fact, for the first time in the 13 year history of public hearings on Blue Cross Plans' applications for rate adjustment, the Governor of the Commonwealth appeared in person for a 13 minute presentation on the first day of the hearing. In addition to the Governor, other government personages appeared, including cabinet level State officials - the Auditor General, the Secretary of Community Affairs and the Secretary of the Commonwealth, plus representatives of the Secretaries of Public Welfare and Health. Not to be forgotten were appearances of the Mayor of Philadelphia, U.S. Representative Joshua Eilberg, the State Director of the Consumer Protection Bureau, Bette J. Clemens (in the Attorney General's Office), State Representatives Eugene Gelfand and John Renninger, both interested in health affairs and consumer protection, plus a city councilman (Bellis) and a city mayoralty candidate (Cohen).

Commissioner Denenberg, flanked on his right by chief counsel for the Insurance Department Robert A. Miller (although the Commissioner himself holds a Masters of Law degree from Harvard Law School) and his special assistant for long range planning Rodney Pyfer, and on his left by John Sheehy, Bureau Director, Regulation of Rates and Policies and Actuary Paul H. Henning, conducted the 5-day of hearings, asking almost all the questions himself and commenting again on his own. He started each day's hearings with a synopsis of the previous day's activities including his orders to the Plan, hospitals and doctors. He announced on the second day of the hearings that he had approved a Blue Shield proposal for paying participating physicians for treatment of patients in nursing homes and E.C.F.'s. This was seen as a measure to induce physicians to keep their patients from remaining longer than medically necessary in expensive, acute care hospital beds, if they could be treated in E.C.F.'s.

The official statements for Blue Cross of Philadelphia were made by its Board Chairman, Donaldson Creswell, and Bruce Taylor, Executive Vice President, with the latter carrying almost all of "the ball" during the 5 days. Many Blue Cross officials and Board members were present throughout the hearings, and President Thomas Manley also participated.

Blue Cross stated that unless it received "sufficient money to continue its operation" it faced bankruptcy and would run out of ready cash by April 1. It attributed the drain to increased benefits forced on it by the previous Insurance Commissioner who mandated a co-pay preferred comprehensive contract for Blue Cross and its subscribers. Secondly, the Blue Cross subscribers have used these "substantially expanded benefits" so that the request for "emergency relief rests exclusively in this rise in incidence" of use of services during 1970, according to Bruce Taylor. The Plan also called for involuntary (governmental) control of hospital costs, because, alleged Blue Cross, it had taken "all steps toencourage voluntary control of hospital costs...."

The Commissioner dropped his first bombshell three hours after the hearings started by ordering Philadelphia Blue Cross to cancel its contracts with member participating hospitals and to renegotiate the contract. This edict came after nine months of hassling between Blue Cross and the Delaware Valley Hospital Council, representing member hospitals to negotiate the current contract, which was made retroactive to July 1, 1970. Either party may cancel the contract 90

days after written notice of intent to do so is given, and the Commissioner gave his verbal directive and then, upon request for the order "in writing" a hand written order (a piece of note pad paper saying: "3-17-71, Blue Cross of Greater Philadelphia - Please move to renegotiate in writing - signed, H. S. Denenberg").

Blue Cross had also recommended legislation or other controls which would (1) eliminate educational costs (of physicians) from Blue Cross reimbursable items; (2) eliminate unsuitable hospital beds which it felt would decrease stays; and (3) establish norms for numbers of hospital employees for staffing purposes in patient care and research, (4) refuse to reimburse hospitals on an accelerated depreciation basis.

Dr. Denenberg hit hard against reimbursing hospitals for patients placed in what he called "unsafe" beds - meaning "non-conforming" according to Hill-Burton standards. He also expressed his astonishment that hospitals in the Philadelphia area moved so slowly to take advantage of what he called "free management and industrial engineering services" offered by Blue Cross. It was noted that these services have only been available a brief period of time.

As in most governmental hearings of this type someone brings up "unreasonable" charges or "expenditures beyond prudence" - such as "50 cent aspirin charge." The hearings produced a witness who said she could buy stainless steel surgical scissors in a department store for \$2.50, whereas a hospital she knew paid a surgical supply house \$7.50 for comparable scissors! She alleged that medical equipment was marked up in price between 400-2,500%! The Commissioner also referred to \$10 tape measures which could be bought for 50 cents in the 5 and 10 cent stores.

One of the facts that became evident to this observer in the hearings was that each witness did not have to be qualified as to his expertise - statements could be made without authority, reasonableness or validity - and they most frequently went unchallenged. /"Don't confuse me with facts; my mind is made up" - could be an apt description/.

Owner-operators of proprietary extended care facilities - with economic motives that could be questioned - urged patients be assigned to their facilities costing "\$23.50 per day compared with \$103 per day at a university hospital." Approving the Blue Shield payment for physicians' services at E.C.F's, the Commissioner felt, should ease this situation.

Governor Milton J. Shapp's appearance the first afternoon was highlighted by his announcement of the appointment of a cabinet level TASK FORCE ON HEALTH CARE including the Secretaries of: Community Affairs, Health, Public Welfare and the Insurance Commissioner "plus top level staff men." He also indicated the consumer advisory health care groups would be appointed. The Governor supported Certificate of Need legislation and hoped that use could be made of his branch offices for consumer health programs.

Later, at a press conference in Harrisburg, Governor Shapp warned of possible governmental action to reduce physician and hospital costs. Said he, "If a way can't be found to get the cost of medical care within reasonable boundaries, then the State will have to find a way to set priorities, eliminate duplication and hold costs down."

(Reliable sources in the Governor's office reported to HAP staff on March 25 that Insurance Commissioner Denenberg will be Chairman of the Governor's Task Force aforementioned, and that a meeting of the Task Force is scheduled for the week of March 29, 1971.)

Describing the financial plight of the southeastern Pennsylvania area hospitals was Daniel E. Gay, President of the Delaware Valley Hospital Council. He stressed: (1) need for all purchasers of hospital care - including government to pay reasonable costs for in-and out-patients; (2) higher costs are due, in a great part, to increases in salaries which account for about 2/3 of total costs; (3) he called for an indemnity insurance program and a uniform benefits package for all insurance underwriters; (4) reasonable cost reimbursement for E.C.F. care; (5) rejection of Blue Shield payments to doctors if a Blue Cross case is rejected for hospital payment; (6) protection from excessive costs of malpractice and liability insurance; (7) adequate State reimbursement for educating student nurses; (8) discourage further licensing or certification of paramedical personnel; (9) prompt payments to hospitals for services rendered (to preclude borrowing for operating needs at high interest rates); (10) single audits annually for all hospital jurisdictional agencies; (11) accelerated depreciation and (12) a "no-fault" insurance program.

The Commissioner was caustic in his questioning of Mr. Gay, alleging hospitals want to tell everyone else what to do - Blue Cross, government and the public - but he felt hospitals were slow moving or reluctant "to do things themselves to set their houses in order."

After Jay E. Helme, Executive Director of the Hospital Survey Committee, the facilities (only) planning agency for the area, testified about how their group has saved the community millions of dollars which might have been expended for unneeded new beds and other facilities (replacements or expansions), Commissioner Denenberg asked the Survey Committee to make determination which the hospitals and Blue Cross would abide by in deciding which beds are to be removed from the "suitable" list or to decide which facilities and services - such as open heart surgery, cobalt and other expensive procedures are to be curtailed or established - and at what institutions in accordance with "proven need."

Dropping his second bombshell - after hearing about varying hospital costs, Commissioner Denenberg ordered Blue Cross to furnish him with the per diem costs at each Blue Cross member hospital so that he could publish a "shopper's guide" for consumers, listing all the hospitals and their costs. Realizing subsequently that even with this "guide" consumers could only be admitted to the hospitals where their physicians have staff privileges, the Commissioner hit the "country club like" procedures hospitals use in appointing medical staffs and directed that hospitals examine staff appointment procedures and extend staff privileges to more doctors which "would be one way of introducing a more competitive aspect into the hospital operation."

The position statement of the Hospital Association of Pennsylvania was presented by Executive Vice President John F. Worman. The statement, a copy of which was sent to each member hospital, included, among other items: (1) disallowing physicians' Blue Shield payments when hospital payments are disallowed under Medicare, Medical Assistance or Blue Cross; (2) a suggestion to merge the five Pennsylvania Blue Cross Plans and Blue Shield into one state-wide, single plan; (3) better communications and disclosure to Blue Cross subscribers so they will know exactly what Blue Cross pays the hospital for care rendered - not the vague statement appearing on some hospital bills - that the Blue Cross "allowance" is equivalent to billed charges and hence the subscriber may think Blue Cross pays billings.

Alleging that there were problems in our health delivery system, Mr. Worman took the Commissioner to task for referring to our health care delivery

system as "a Frankenstein monster built on Rube Goldberg principles." Mr. Worman reminded the Commissioner of the health strides made by the system. Subsequently, the Commissioner apologized for referring to the system as a "Frankenstein monster."

Mr. Worman also felt that: (1) research and educational costs - now generally added on to the patient's cost - should be borne by the entire community; (2) costs will rise under the pressure of employee unionization; (3) Unemployment Compensation coverage for employees could increase operating costs by as much as \$12.5 million; (4) malpractice insurance could increase a hospital's cost by as much as \$1.00 per patient day - or more - and the practice of "defensive medicine" by physicians also contributes to higher costs.

He indicated what hospitals are doing to strive for economies and hopefully to "contain" costs and reduce the acceleration of the rate of increases, such as, shared laundries, group purchasing, shared computers, shared industrial engineering, group insurance, educational and training sessions and manpower recruitment campaigns.

Stressing the essentiality for Certificate of Need State legislation and the creation of a new qualified Pennsylvania Health Care Commission, Mr. Worman also asked the Commissioner's help and support in obtaining reasonable cost reimbursement for outpatient and extended care facility services from the State.

One State official (Dr. Alfred Kraft, Commissioner of the Office of Medical Services and Facilities) ended his remarks, after he had indicated that the system needed revamping, but that hospitals were doing a good job under the circumstances, with "there is no problem which we are unable to solve, except the one of the pocketbook." But the whole subject of the hearings was a question of money for Blue Cross to continue to operate - if at all!

Even though only Philadelphia Blue Cross' filing was the reason for the public hearings, Pennsylvania Blue Shield, Inter-County Hospitalization Plan and the other four Blue Cross Plans in Pennsylvania were "invited" ("directed" might be more accurate) to appear and make statements or to respond to 54 questions enunciated by the Commissioner when he announced the public hearings through a press release. He advised the Blue Cross Plans' (outside of Philadelphia) chief executives they would have their public hearings, too, when they next filed for rate adjustments.

Floods of consumer complaints about their bills, their inability to get through to Blue Cross when they tried to phone their offices, alleged cancellation of coverage after 20 years of coverage and getting little consideration concerning representation on the Blue Cross Board brought expressions of concern from the Commissioner.

He opened the third day of the hearings by saying, "We are not anti-hospitals; not anti-Blue Cross; not anti-doctors. We are pro-consumer and pro-Blue Cross subscriber!"

He continued, "this is the beginning, not the end of our investigations." He cited the on-the-spot agreement of Blue Shield to stop paying doctors, if their patients' hospital stay is not a reimbursable Blue Cross hospital stay; Blue Shield to research how physicians could be paid for home visits; he wanted to have hospitals move about 30% of the patients "who don't belong there" to less costly E.C.F.'s. He wanted more definitive consideration for health maintenance organizations and multiphasic screening outpatient work done as preventive health

care measures. He cautioned against misleading advertising of prepayment hospitalization plans and said he was disappointed that some hospital and physician "establishment" representatives were "intellectually sterile" for not coming up with "a single new idea" - and that the Medical Care Foundation described by Pennsylvania Medical Society representatives was something "long in the future." He continued his concern for poor communications between Blue Cross and its subscribers.

He directed the Delaware Valley Hospital Council to furnish him with data relating to their member institutions as to:

- (1) Composition and frequency of meetings of Budget Committees.
- (2) Amounts spent for non-patient care activities such as education and research.
- (3) Amounts spent on dues to the Delaware Valley Hospital Council, HAP and AHA and "other organizations engaged in lobbying, collective bargaining and public relations activities."
- (4) Travel expenses of hospital personnel to attend meetings of aforementioned groups.
- (5) Salaries paid to hospital executive employees.
- (6) Extent of and expenditures for public relations activities.
- (7) Copies of hospital annual budgets.

The Commissioner indicated he may also want similar data for the rest of the hospitals in Pennsylvania in the near future.

Organized labor had several persons testify for it, but its prime spokesman was Harry Boyer, President, Pennsylvania AFL-CIO speaking for more than 1.5 million members in the Commonwealth. He also was offering his testimony on behalf of the Pennsylvania League for Consumer Protection, of which he is a Board member.

He opposed educational and research costs and all non-patient care related costs being part of Blue Cross and hospital charges - suggesting that "Blue Cross and other carriers of hospitalization insurance refuse to pay such charges." Secondly, he felt Blue Cross should not be permitted to recognize charges for "inadequately utilized services" such as costly and complicated radiological therapeutic services or underutilized obstetrical beds. Next, he called for full services being available at hospitals on a seven-day week basis. He called for Blue Shield to pay physicians for other than hospital inpatient physician services, and the greater use of outpatient diagnostic and therapeutic services and extended care facilities.

Mr. Boyer supported legislation introduced by Representative Gelfand last year to form a Hospital Control Commission (H-2183 of the 1970 session)!

He, too, called for a merger of Blue Cross with Blue Shield into one Plan. He wanted private insurance carriers which write hospitalization coverage on a highly selective basis to be compelled...."to have to cover all groups if they are permitted to cover any."

Also, Mr. Boyer called for consumer representation on the Blue Cross Board of Directors.

(Labor representatives consistently and uniformly oppose deductibles and co-insurance features and have supported the service type subscriber contracts with Blue Cross.) But opposing this viewpoint was the former chief actuary for the Social Security Administration, Robert J. Myers, now a Professor of Actuarial Science at Temple University. Mr. Myers called for "cost-sharing by the consumer" a euphemism for deductibles and co-insurance. How to reconcile labor's opposition to deductibles with the actuarial expert's suggestions (which the Commissioner also seemed to look favorably upon - as in auto insurance, despite criticisms of comparing human lives with automobiles!), are opposite viewpoints which must ultimately be decided upon by the Commissioner.

National health legislation also came in for its fair share of references, but its imminence was not expected and all agreed in this Blue Cross hearing, no one dared wait for a national program - if it should come at all! Some felt a more inclusive national health program (for the under 65 years of age group) might be two or more years away - and Blue Cross, the hospitals and the consumer needed action and relief now!

Philadelphia Blue Cross was asked to give the Commissioner details on its refusal to reimburse six member hospitals for certain elements of cost. He wanted to know in what way the charges made by these hospitals were "excessive."

U.S. Representative Joshua Eilberg (D-Phila.) called for a consumer's ombudsman whose authority should "originate outside the power structures of the health and medical professions" and who, "most importantly, should have the authority to say no. If a proposed contract is too expensive, he should be able to veto it."

The Commissioner was urged to "flex his legal muscle" to provide consumer protection. This from an attorney, previously with State government in the Consumer Protection Bureau.

The Assistant City Solicitor for the City of Pittsburgh, Mrs. Marion Finkelhor, reminded the Commissioner that he "inherited" a suit against the Insurance Department (now in Commonwealth Court) brought by the City of Pittsburgh, for failure by the former Insurance Commissioner George F. Reed to allow Mrs. Finkelhor to cross-examine witnesses at the public hearings of a rate adjustment requested last year by Blue Cross of Western Pennsylvania (Pittsburgh based Plan).

The Commissioner indicated he wished to keep the hearings informal and expressed fear that cross-examinations might mean the hearings would bog down on technical and legal matters and drag on for months like some public utilities' rate hearings before the PUC.

The poor, the blacks and the senior citizen consumers were adequately represented even though the Blue Cross filing did not involve its "over 65" coverage. The Young Great Society, the Germantown Community Council for Improved Health Care, the Senior Citizens Action Council, and representatives of the Health Information Project - a student centered group - among others, made lengthy presentations on their suggested remedies to change the health care delivery system. Commissioner Denenberg always manifested courtesy to these persons, with a "thanks a lot; thanks a million for coming in to give us your ideas" at the end of their presentations.

Dr. H. Newton Spencer, President of the Health Service Plan of Pennsylvania (HSP), sometimes referred to as the "Kaiser - Permanente Plan of the East" testified for that health maintenance organization - which has a long way to go before it is really operational as a capitation payment plan for comprehensive health care services.

Paul Guest, Esq., President of Methodist Hospital, the last witness in one long day of the hearing's proceedings, ran out of time (the City Hall Court Room had to be vacated by 6:00 p.m.) in his question and answer period with the Commissioner. His suggestions of why the elements of cost have increased in the past several years and the discount given to Blue Cross by hospitals ("If all hospital patients were Blue Cross subscribers, hospitals would not be able to continue in operation") and his proposals for remedying the situation were precise analyses of the problem. The Commissioner asked Mr. Guest to give him detailed proposals in writing for his study and consideration.

On the fourth day (Saturday, March 20, 1971) of the hearings, several hospital administrators came forward to present their testimony, including Edwin L. Taylor, Director, Graduate Hospital (and President of HAP), who presented a statement on behalf of the Graduate Hospital and as representative of Dr. Luther L. Terry, Vice President for Medical Affairs for the University of Pennsylvania and its hospitals. Mr. Taylor's excellent presentation and the way in which he fielded the questions put to him by the Insurance Commissioner were most masterful. He pointed out that the full financial requirements of provider health institutions must be met, if they are to remain available to the consumer to provide the health care he desires. Indicating that at Graduate Hospital very few doctors have not had their applications for staff appointments approved and that there was "no country club atmosphere, to his knowledge" at the Graduate Hospital medical staff. Other questions put before Mr. Taylor by the Insurance Commissioner pertained to statistical and financial data, occupancy figures, budget committee composition, and the like.

Mr. H. Robert Cathcart, President of Pennsylvania Hospital, spoke on behalf of the Group Health Planning Association of Greater Philadelphia, of which he is Vice President. This organization might be referred to as a health maintenance organization for a geographic unit in the center-city core area of Philadelphia.

Executive Vice President of Hahnemann Medical College and Hospital, Charles S. Paxson, presented his statement as to the methods of determining reimbursable costs for health care providers and the questionable proposals to disallow such items as depreciation, the cost of education for physicians, nurses and related hospital technical personnel. He also recommended coordination or merger of Blue Cross and Blue Shield. He referred to the "shameful way in which the State of Pennsylvania is responsible for not reducing hospital stay dramatically" in that it allows only \$11 a day for care of a DPA patient for skilled nursing services in an E.C.F., when the costs for same are much higher, running over \$20 a day. He also reiterated the fact, as did Mr. Taylor before him, that the increased emergency adjustment of 20.25% requested by Blue Cross was due to the consumer utilization of new benefits, directed by the former Insurance Commissioner and not related to hospital operating cost estimates.

On the last day of the hearings Norman W. Skillman, Administrator, Chester County Hospital, gave his suggestions for reducing hospital expenditures, similar to the testimony he gave last year before the Senate Finance Committee when it was reviewing questions pertaining to extension or contraction of benefits under the Medicare and Medicaid Programs. One of his major thrusts was to reduce the average length of stay of patients and thus reduce the cost of medical care.

If the stay could be reduced by two days in the Philadelphia area it would save millions of dollars.

A representative of Employers Mutuals Insurance Company of Wausau, Wisconsin (the HAP endorsed carrier for Comprehensive General Malpractice and Professional Liability Insurance), presented information to the Insurance Commissioner on the safety education and loss prevention programs conducted by that company in Pennsylvania.

Accusing Blue Cross representatives, Board Chairman Donaldson Creswell, and Executive Vice President Bruce Taylor, of including "half truths, self serving conclusions, and even mis-statements" in their testimony was Barnett Lieberman, Esq., former Philadelphia Commissioner of Licenses and Inspections, who was recently appointed as an unpaid special consultant by Commissioner Denenberg. Supporting Mrs. Marion K. Finkelhor, Mr. Lieberman also called for Blue Cross representatives to be subjected to oath and cross-examination when they present their statements because "public money is at stake."

A most comprehensive, scholarly and balanced presentation was made by Charles P. Hall, Jr., Ph.D., Professor of Insurance and Chairman of the Department of Health Administration at Temple University. Dr. Hall wished to make it "clear at the outset that the public would be making a serious mistake to expect any reduction in the total expenditures for health care in the foreseeable future. At best, we can hope for a decline in the rate of increase in expenditures." He spoke of many problems at the root of the question of health care delivery and indicated that the problem was both complex and many faceted, requiring solutions to be coordinated on many fronts. He gave each element involved in the health care delivery service its fair share of both accolades and criticisms, calling for an end to looking for any one scapegoat to shoulder all of the blame.

The Philadelphia Chapter of the Hospital Financial Management Association, in its testimony, questioned Blue Cross' request for an immediate emergency increase of 20.25% and the additional 30% requested to become effective on August 1, 1971 (on top of the 25% received last year). It was noted that hospital costs did not increase 25% last year and certainly not 50% so far this year. "Approximately 14% to 15% would be more like it." Furthermore, they questioned the Blue Cross Annual Financial Report which does not include the certification of an independent certified public accountant, suggesting that the Commissioner request the Auditor General to perform an audit of Blue Cross. In the area of recommendations, they suggested a method of prospective reimbursement be authorized and pledged their availability to develop a workable solution in this budgeted prospective reimbursement method. They also recommended that "Blue Cross not be permitted to extend benefits to subscribers unless included in the rate filings with the Insurance Department."

The last day of hearings saw three of the five Blue Cross Plan chief executives (Ralph Smith, President, Blue Cross of Northeastern Pennsylvania; Earl G. Wray, Jr., Executive Director, Blue Cross of Lehigh Valley; and Richard D. Rife, President of Capital Blue Cross) present their statements for the Commissioner's consideration. President of the Blue Cross Plan of Western Pennsylvania had testified on the previous Friday.

The Commissioner also listened to testimony about the American Hospital Association's "Ameriplan" presented by the Chairman of the AHA Committee, Mr. Earl Perloff, Chairman of the Boards of the Albert Einstein Medical Center and Philadelphia General Hospital. The HCC's (Health Care Corporations) as a means of restructuring the American health care delivery system were discussed in brief by Mr. Perloff, since a copy of the full Perloff Committee report had been presented to the Commissioner in advance.

Shining forth as the consumers' advocate (one might almost think that the Insurance Commissioner had organized his "Denenberg's Devils" to compete with Nader's Raiders) the Insurance Commissioner during the five days of hearings on the Blue Cross rate increase had the following seven major demands or recommendations to make:

(1) Reorganization - He ordered Blue Cross to reorganize its 36 member Board of Directors within two weeks to reflect greater consumer interest and employer representation. He asked for the elimination of hospital and physician members from the Board, and questioned affiliation of the Board's 21 "public representatives" with Blue Cross subscribers.

(2) Costs - Acknowledging that Blue Cross would probably get an increase or else be put out of business, he questioned and asked for explanations why Blue Cross rejected as "excessive" \$5 million in claims from six Philadelphia area hospitals. He wanted information on non-patient care costs, such as education and research items.

(3) Cost Shoppers' Guide - He stated that his Department, after receiving information from Blue Cross and the Delaware Valley Hospital Council on the average cost per day of care in each of the Blue Cross member hospitals, would publish the per diem cost and also indicate the per diem cost of extended care facilities operating in the area. Also included would be a list of the multi-phasic screening corporations in the Delaware Valley area. Along these lines he demanded more liberal policies for admitting doctors to staffs of hospitals to prevent patients from being turned away from hospitals of their choice, where costs might be lower, because their physicians are not staff members.

(4) Meetings - He called for widespread publicity of Blue Cross meetings and asked for the elimination of three year waiting periods before subscribers could get voting privileges.

(5) Costs of Intern and Resident Training - He indicated that the salaries of interns and residents should be paid by physicians who are on a fee-for-service basis since they benefit from the patient care activities of such student interns and residents. He did not feel this was a cost that should be loaded on to the cost of hospital care, to be paid for by the horizontal patients or Blue Cross subscribers.

(6) Nursing Homes - He approved Blue Shield payments of physicians' fees for care in nursing homes to encourage physicians to transfer patients from high cost acute hospital care facilities to E.C.F.'s.

(7) Beds - He ordered Blue Cross not to pay hospitals for unnecessary or "unsafe" beds, charging that some hospitals are "overbedded."

(The aforementioned seven demands are based on a Philadelphia newspaper account, since HAP has not had an opportunity to review the verbatim testimony transcript.)

After five full days of dramatic public hearings the "piece de resistance" came when Insurance Commissioner Denenberg conceded on Sunday, March 21, 1971, in a TV interview that the requested Blue Cross rate increase of up to 50% was probably inevitable. He indicated that everything would be done to minimize the amount of the increase. "But there is really no choice. You either have to give them the rate increase or put them out of business."

Commissioner Herbert S. Denenberg ended the five days of public hearings at 7:30 p.m. on Monday, March 22, 1971, with a statement that his decision with reference to the rate adjustment filing presented by Philadelphia Blue Cross would be announced within a brief period of time, hopefully within the following two weeks.

Health care personnel in the Commonwealth of Pennsylvania have an interesting time ahead of them as long as this administration continues Dr. Denenberg in office as Insurance Commissioner. Significantly, Dr. Denenberg referred to "the next eight years of this administration" as its time span in which to affect major changes in the health care delivery system of the Commonwealth. It should also be pointed out that from the very beginning, when Dr. Denenberg held his first press conference on February 8, 1971, at 10:30 a.m. and announced the public hearings in Philadelphia for the Blue Cross rate increase, his news release "covered" the Commissioner for eventualities by stating the following: "Rate increases for Blue Cross may be inevitable," Dr. Denenberg said, "but a comprehensive effort must be exerted to contain costs." On that same day, he issued another press release stating that, "The Insurance Department of Pennsylvania will no longer grant rate increases without first reviewing the steps being taken by insurance companies to lower costs, to modernize contracts in order to meet changing consumer needs, to offer more adequate amount of coverage, to offer deductibles that can lower premiums, and to stop arbitrary cancellations and nonrenewals." Not only the health care insurance and pre-payment industry is in for its "interesting" times, but the entire insurance industry in all its ramifications may find this Commissioner to be quite different from others with whom they dealt in the past.

3/29/71

10: Council of Deans
Council of Academic Societies
Council of Teaching Hospitals

The Ad Hoc Committee on Corporate Responsibility for Graduate Medical Education submitted a report to the Councils of the Association at the February 1971 meeting. It was recommended by the Executive Council that the title of the report be modified, indicating that the report was a study of the implications of corporate responsibility for graduate medical education rather than a policy statement. The Executive Council also requested that a brief policy statement be derived from the report and submitted to the Councils for study.

This policy statement was developed by the Committee listed below and is respectfully submitted for study by the Councils of the Association.

Thomas D. Kinney, M.D., Council of Academic Societies
John Parks, M.D., Council of Deans
David Thompson, M.D., Council of Teaching Hospitals
Mr. John M. Danielson, Staff
Marjorie P. Wilson, M.D., Staff
August G. Swanson, M.D., Staff

April 13, 1971

The modifications indicated either by deletions or by additions in *italics* were recommended by the COTH Administrative Board and the Executive Committee of the Executive Council.

April 15, 1971

The policy statement set forth below was derived from a report on the "Implications of Corporate Responsibility for Graduate Medical Education". That document should be used for guidance in the development of the assumption of responsibility for graduate medical education by academic medical centers.

POLICY STATEMENT ON THE
CORPORATE RESPONSIBILITY FOR
GRADUATE MEDICAL EDUCATION

The Association of American Medical Colleges endorses the concept that graduate medical education should become

a corporate responsibility of the faculties of the academic medical centers. Through this endorsement the Association urges the faculties of academic medical centers to develop in conjunction with their parent universities and their teaching hospitals, programmatic plans for taking responsibility for graduate medical education in a manner analogous to presently established procedures for undergraduate medical education.

Assumption of this responsibility by *academic* medical center faculties means that the entire faculty will establish mechanisms to: determine the general objectives and goals of its graduate programs and the nature of their teaching environment, review curricula and instructional plans for each specific program, arrange for evaluating graduate student progress periodically, and confirm student readiness to sit for examinations by appropriate specialty boards.

The Association encourages hospitals with extensive, multiple graduate education programs, which are not now affiliated with academic medical centers to develop their own internal procedures for student selection, specific program review and proficiency examinations. The accrediting agency is urged initially to accredit the entire graduate program of these hospitals. Ultimately, these institutions should either develop affiliations with degree-granting academic medical centers or seek academic recognition as free-standing graduate medical schools. Hospitals with limited graduate programs desiring to continue their educational endeavors, should seek affiliation with an accredited academic medical center.

The Association urges that the Liaison Committee on Medical Education, the Residency Review committees of the AMA and the several Specialty Boards continue their efforts toward developing procedures which will provide for accrediting an entire institution's graduate medical education program by one accrediting agency.

The Association further urges that the specialty boards continue to develop test instruments for measuring achievement of individual candidates that avoid superimposing rigid program requirements on the academic medical centers.

The development of graduate education curricula and instructional programs should take cognizance of appropriate financing for both the service and educational components of the graduate experience.

A SPECIAL REPORT AND RECOMMENDATIONS BY
THE CARNEGIE COMMISSION ON HIGHER EDUCATION

OCTOBER, 1970

Recently an HEW task force has called for direct federal aid to medical education and for the shifting of the responsibility for health manpower within the federal structure. On federal aid to medical education, the report said (48, p. 1):

Because of a traditional reluctance to directly involve the federal government in the financing of medical school education, desperately needed financial support has been funneled through research grants to medical schools. While biomedical and clinical research conducted by the medical schools has been of great value and is an important element in attracting outstanding scholars and researchers, it is frequently a counter-productive incentive to improving the efficiency and teaching aspects of medical education. Therefore, support of the educational function should be separate and distinct from support of the research function. A more direct approach, depending on stipends to both the student and the medical school, would help reduce the financial burden of medical education for the student and provide the medical schools with positive financial incentives to increase their productivity.

A particularly urgent problem is the plight of medical schools, chiefly private institutions, which are in grave financial difficulties. A total of 61 medical schools have been awarded Special Projects Grants by the federal government on the basis of some condition of financial distress (49, p. 2), and in July, 1970, a bill authorizing \$100 million in emergency aid to medical and dental schools "in financial distress" was passed by the Senate and sent to the House (50, p. 9).

The types of federal financial support recommended by the Commission include (1) student grants and loans, (2) institutional grants for educational expenses, (3) grants to university health science centers and university-affiliated area health centers for the advanced education of house officers, (4) grants and loans for construction, (5) start-up grants, (6) research grants, and (7) funds for manpower research and regional planning. The recommendations for grants to institutions are carefully designed to stimulate not only expansion of but also needed changes in health science education.

STUDENT
GRANTS

In view of the high cost of medical and dental education, there is a particularly critical need for grants for students from low-income families who wish to undertake such education. The case for providing medical and dental education grants to students from low-income families also rests on the need to provide equal opportunity

period of four years. Moreover, every institution should be expected to increase its average class size to at least 100.

Payment of the supplements would not begin until actual entry of additional students and would be based on the number of such entrants enrolled in a given year. If a university health science center had initiated a significant expansion plan for added student places at any time from 1967 through 1970, the bonuses would be available for the added students for the remainder of the eight-year period. The Commission believes that even though the expansion should be accomplished within a four-year period, higher costs would be incurred for as long as eight years—hence the stipulation that the bonuses should be available for eight years.

The amounts in 1 and 2 above should be adjusted for medical and dental schools with three-year programs to enable those schools to receive the same amount of institutional aid as they would if they were four-year schools. This adjustment should be made until about 1980 but then should be reviewed.

- 3 An amount equal to the total number of house officers in university health science centers and in university-affiliated hospitals or area health education centers, multiplied by \$2,250, provided that no individual house officer shall be counted for more than three years, and provided that a policy is in effect to encourage specialization in fields in which a shortage exists and discourage it in fields in which there is a surplus, such as surgery. These supplements should also be paid under the condition that the institution make an effort to reduce the duration of house officer education and make it more effective. As indicated above, the internship year is being eliminated in medical education, and the Commission believes that it should not be replaced by an *additional* year of residency.
- 4 As an incentive for *major* curriculum reform, additional cost-of-instruction supplements of \$2,000 a year per student enrolled in M.D.- or D.D.S.-candidate programs, in physician's or dentist's associate or assistant programs, and, under specified conditions, in the last year of premedical or predental programs, for up to three years. These bonuses would be available for the following types of changes:
 - a Introducing physician's or dentist's associate or assistant programs, with the bonuses to be available for such programs for a period of three years even if they had been initiated before the

House Staff Attitudes Toward Teaching

Robert S. Brown, M.D., Ph.D.*

According to an appraisal made at the University of Virginia School of Medicine by a recently graduated class, the instruction which medical students received from house staff is a significant aspect of their education. Review of the literature reveals, however, that little attention has been given to training house staff as teachers, despite the responsibility they traditionally assume in medical education. Further, the attitudes of house staff toward their teaching responsibilities have largely been ignored. The purposes of this study are (a) to determine the amount of time house staff devote to teaching, (b) to determine the level of confidence they have in their teaching ability, (c) to determine the manner in which teaching is conducted by house staff, and (d) to determine their interest in teacher training as part of their on-the-job learning experience.

In April 1968, a survey was conducted among the University of Virginia Hospital house staff in an attempt to understand more clearly some of the ramifications of this problem. Fifty-seven residents and seventeen interns, a group representing approximately fifty-three percent of the house staff, participated in the study. Graduates of foreign medical schools and fellows were not included in the sample.

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This paper discusses the results of the survey at a descriptive level; no attempt has been made to interpret the findings, since subsequent investigations are planned, including a seminar series on pedagogical principles for house staff.

Resident House Staff

All residents in the study, representing every department within the University of Virginia Medical Center, consider themselves to be teachers. Of these residents, all had medical students as pupils; fifty percent taught house staff other than interns; and seventy percent taught interns.

The estimated percentage of training received by residents from fellow house staff ranged from ten percent to ninety percent, with forty-one to fifty percent the estimated average. However, approximately two-thirds of the residents stated that more than forty percent of their learning came as a result of stimulation and education from fellow house staff. All residents felt that the training or education they received from fellow house staff was an important element in their learning experience, and more than half the group stated that house staff from services other than their own departments made an important contribution to their learning. Surgery was the service most commonly mentioned in this regard. Medicine was also frequently listed. Further, seventy percent indicated they would wel-

come improved or new inter-service teaching activities. The majority felt that mutual house staff training was considered deserving of serious attention with the view to improving its opportunities and techniques.

Every resident in the study stated that he had supervised the performance of medical students: eighty percent had supervised interns, and about one-third had supervised other residents. While most of the supervision occurs on the wards and in the clinics, some occurs in the emergency room and the operating room. In addition to supervisory duties, seventy percent of the residents have responsibility for evaluating (grading) the performance of the medical students and forty percent for evaluating interns. However, fewer than ten percent of the residents are ever called upon to evaluate other resident house staff. In reply to the question, "Do you feel you are able to satisfactorily supervise and evaluate the performance of medical students," the vast majority (more than ninety percent) answered affirmatively.

Approximately twenty to twenty-five percent of an average work week is spent by the typical resident in supervising, evaluating, or teaching others. The average percentage of a resident's work week spent "rendering service"—excluding supervising, evaluating, or teaching—was estimated to be between fifty to sixty percent. This range reflected variations among the services, with Obstetrics and Gynecology listing the highest percentages. When asked, "What percentage of an average work week do you consider you are being taught by persons other than fellow house staff," forty-seven percent of the residents estimated zero to ten percent, and one-fourth said eleven to twenty percent. In other words, three-fourths of the residents thought that

twenty percent or less of their average work week is spent in being taught by attending staff.

Less than 15 percent of the residents had ever received training in principles of learning or methods of instruction despite the finding that 100 percent of the group identified themselves as teachers and devoted approximately one-fifth of their time to teaching and administration. In general, the source of the residents' knowledge of teaching methods has been their own training and observations of their teachers. Several listed "common sense," and a few gave "off the top of my head" as the extent of their pedagogical experience. Those few residents who had received any formal instruction in educational science had done so either in the military service or in positions held prior to attending medical school.

Two-thirds of the residents indicated they would welcome the opportunity to attend one or more sessions of a course on principles of learning, supervision, and evaluation. They specifically requested training in methods of instruction, public speaking, and "grading."

When asked to identify those activities considered to have the greatest teaching value for medical students, the residents listed grand rounds, clinical pathological conferences, admission physical examinations, and death conferences, in that order. Activities considered to have little or no teaching value for medical students were chart rounds and admission laboratory work, two of the most time-consuming tasks ordinarily performed by the medical student.

Approximately one-half of the residents felt that they had ample time for independent study; forty-four percent felt they did not. Residents felt they were generally too busy to spend sufficient time with students.

Eighty percent of the residents thought that their respective services emphasized their role as teachers; fifteen percent did not think their services did so; and five percent were uncertain. While one-fourth of the residents thought their departments should not emphasize their role as teachers, the great majority thought that this role should be emphasized and that training to improve their effectiveness as teachers should be provided.

Interns

As in the case of the residents, all interns in the study considered themselves to be teachers. One hundred percent indicated that they were teachers of medical students. A few stated they also taught nurses. All interns viewed themselves as having been taught by other house staff, and thirty-five percent estimated that as much as sixty-one to seventy percent of their training came from fellow house staff. Thirty percent of the interns estimated that they received as much as seventy-one to eighty percent of their graduate education from fellow house staff. Fewer than five percent felt that as little as forty percent of their education came from fellow house staff. One hundred percent of the interns would welcome improved or new inter-service teaching activities with house staff other than those of their own department. All interns felt that the mutual house staff education deserved serious attention.

All interns indicated they have some responsibility for supervising the performance of medical students, a task they feel capable of performing satisfactorily. Approximately two-thirds (sixty-four percent) also are required to evaluate (grade) the performance of the medical student, but here the intern has less confidence in his ability.

The average intern spends about ten

percent of his work week supervising, evaluating, or teaching others—or about one-half the amount of time residents devote to these activities.

Three-fourths of the interns spend seventy percent or more of an average work week rendering service, exclusive of supervising, evaluating, or teaching. More than one-half of the interns indicated that ten percent or less of a work week is spent receiving instruction from persons other than the fellow house staff. Both the time spent rendering service and being taught, however, varied with the rotations. A few said "it was hard to determine" and "depends on the person" when estimating how much instruction they received from the attending staff. No attempt was made to separate didactic instruction from learning by doing or learning while rendering service.

More than two-thirds of the interns actually hold teaching sessions for medical students and forty percent conduct classes for nurses as well. Again, however, the great majority (eighty-three percent) had never received training in principles of learning or methods of instruction. Their sources of knowledge of teaching methods, including supervision and evaluation, were listed as "observing others," "personal experience," and "examples of own teachers."

Two-thirds of the interns indicated a desire for assistance with their teaching duties; methods of instruction and principles of evaluation (grading) were the most popular subjects requested.

No intern in the study felt he had adequate time for independent study or reading during the internship year. Only one intern indicated some doubt in answering this item.

Seventy-five percent of the interns did not feel their respective departments valued or emphasized their role as teachers.

House Staff Attitudes/Brown

The great majority of the interns themselves, however, definitely felt that their teaching responsibilities should be valued and emphasized.

Summary

Though little attention has been paid to the house staff's effectiveness as teachers, house staff assume an important teaching responsibility in the education of medical students. Little, if any, training in educational psychology has been provided for house staff at university medical centers. A survey of the house staff at the University of Virginia Hospital revealed that residents and interns considered themselves to be teachers of medical students. Residents as a group feel that one-half their training or education is received from fellow house staff and stated that opportunities for mutual house staff training should be improved. Residents teach, supervise, and grade medical students, a task which takes up approximately twenty percent of their average work week. This figure is somewhat less than the amount of time they consider they are being

taught by persons other than fellow house staff. Fewer than fifteen percent have received any training in pedagogical principles, and this is viewed by them as an inadequacy for which they would like remedial assistance.

The interns also assume responsibility for teaching and supervising medical students, but they spend only one-half as much time as residents. Seventy percent or more of an intern's average work week is spent rendering service, while only ten percent or less of an average work week do interns feel they are being taught by the attending staff. Like the residents, the interns expressed a desire for assistance in their teaching chores. Approximately one-half of the residents felt that they had sufficient time for independent study. This finding distinguishes the residents from the interns in this study, for 100 percent of the latter stated that they did not have time to read or study independently. Both interns and residents agreed, however, that their role as teachers should be valued and emphasized by their departments.