

AGENDA

COMMITTEE ON HOUSE STAFF RELATIONSHIPS
TO THE HOSPITAL AND THE AAMC

AAMC Headquarters
One Dupont Circle
September 23, 1971
10:00 a.m.-3:00 p.m.

- I. Call to Order: 10:00 a.m.
- II. Review of Minutes - Meeting of June 2, 1971 TAB A
- III. Draft Position Statement: Financing Graduate Medical Education TAB B
- IV. House Staff Participation in the AAMC:
 - A) The Role of the Organized Medical Staff In The Council of Teaching Hospitals; TAB C
 - B) Letter of August 16, 1971 from Donald E. Detmer, M.D. TAB D
- V. Determination of Task Force Recommendations To Be Presented At COTH Annual Meeting, October 29, 1971
- VI. Adjournment

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF TEACHING HOSPITALS

MINUTES

COMMITTEE ON HOUSE STAFF RELATIONSHIPS
TO THE HOSPITAL AND AAMC

AAMC Headquarters
One Dupont Circle
June 2, 1971

Present:

Bernard J. Lachner, CHAIRMAN
Administrator
Ohio State University Hospitals
Columbus, Ohio

Malcom Randall
Hospital Director
Veterans Administration Hospital
Gainesville, Florida

David L. Everhart
Executive Director
New England Medical Center Hospitals
Boston, Massachusetts

William L. Wilson
Executive Director
Mary Hitchcock Memorial Hospital
Hanover, New Hampshire

Betty Eberle, Ph.D.
Assistant Professor
Department of Community Medicine
The University of New Mexico
School of Medicine

Maurice A. Mufson, M.D.
Associate Chief of Staff
West Side VA Hospital
Chicago, Illinois

H. Robert Cathcart
President
Pennsylvania Hospital
Philadelphia, Pennsylvania

Richard M. Loughery
Administrator
Washington Hospital Center
Washington, D.C.

Donald E. Detmer, M.D.
Senior Resident in Surgery
Duke University Hospital
Durham, North Carolina

John G. Freymann, M.D.
Director of Education
Hartford Hospital
Hartford, Connecticut

Excused:

S. David Pomrinse, M.D.
Director
The Mount Sinai Hospital
New York, New York

Paul A. Marks, M.D.
Dean, Faculty of Medicine
Vice President for Medical Affairs
Columbia University
New York, New York

Julius R. Krevans, M.D.
Dean, University of California
San Francisco Medical Center
School of Medicine

Earl N. Metz, M.D.
Associate Professor
Department of Medicine
The Ohio State University Hospitals
Columbus, Ohio

Staff:

Grace W. Beirne
Tom Campbell
Armand Checker
Jody Williams

John A.D. Cooper, M.D.
John M. Danielson
Richard M. Knapp, Ph.D.

I. Following the call to order and introduction of members, John A.D. Cooper, M.D., AAMC President, spoke to the committee. He pointed out that the Committee on House Staff Relationships is one of three COTH committees set up to provide guidance to the AAMC on issues relating to the academic medical center and its hospitals.

A number of public and governmental bodies have shown interest in house staff and their role; the Carnegie Commission, the Social Security Administration and the Congress with its concern that current house staff salaries contradict their educational roles as students have all been reviewing the changing role of the intern and resident. This particular committee reflects AAMC concern with the more general problem of financing medical education. In addition to the House Staff Relationship Committee, four other committees are to examine and provide information for policy and guidance germane to the financing of medical education.

The committees are the following:

- 1) Ad Hoc Committee on Biomedical Research Policy
- 2) Task Force on the Cost of Undergraduate Medical Education
- 3) Task Force to Analyze the Higher Costs of Teaching Hospitals
- 4) Task Force on Construction

II. Richard Knapp noted the other COTH Committees are the Task Force on Goals and Objectives of COTH and the Task Force on the Higher Costs of Teaching Hospitals. At this year's AAMC Annual Meeting, the interim reports developed by these Task Forces and Committees will be presented at the COTH Annual Institutional Membership Meeting on Friday, October 29, 1971. Bernie Lachner outlined the charge to this committee to examine:

- 1) The nature of participation of house staff in the AAMC.
- 2) Response to the national house staff organization particularly to the resolution submitted to COTH at the Los Angeles meeting and the letter to Irvin Wilmot requesting participation in the AAMC.
- 3) Reimbursement of house staff costs with particular regard to the Pennsylvania Blue Cross-Insurance Commission or conflict over reimbursement. In essence, what is needed is a position statement on financing graduate medical education.

III. Robert Cathcart outlined the Philadelphia Blue Cross situation. Philadelphia Blue Cross had requested a rate increase and this request led to public hearings by the State Insurance Commissioner, Herbert S. Dennenberg. Dr. Dennenberg is an economist and a former member of the faculty of the Wharton School of the University of Pennsylvania. He has questioned the propriety of house staff reimbursement under Blue Cross and in the light of an avowed concern for protection of the consumer has indicated that educational costs should be subject to public scrutiny.

However, there does not seem to be the immediate prospect of such costs being separated from reimbursement. Commissioner Dennenberg has requested that these costs be separated for "recognition" within about six weeks time. Dr. Dennenberg's contention is that the education costs of academic medical centers are growing faster than their service costs, that house staff are actually working for the attending physicians and that in the academic medical center patients receive service they would not receive or pay for in institutions outside the academic medical center. In the academic medical center, the consumer, the patient, in Dr. Dennenberg's opinion is thus paying twice for services.

Compounding this problem are situations created by a Pennsylvania law passed last October that permits public employees to organize themselves as bargaining units. An organization of house staff, the Philadelphia Association of Interns and Residents (PAIR), has petitioned three hospitals as collective bargaining units under this legislation. Because of the volume of petitions from new public and hospital employee organizations, the Labor Relations Board of the Commonwealth has been delayed in making a decision as to whether or not PAIR constitutes a legitimate collective bargaining unit. Central to the LRB decision will be determining if house staff are students or employees of the hospital.

IV. ACTION

The Committee chairman requested at this point in the meeting that the COTH staff draft a position statement on financing of graduate medical education and that this paper be circulated for comment and to be the subject of a subsequent meeting if necessary. This matter was to be discussed more substantively later in the meeting after John

Danielson joined the committee members.

V. Discussion of an appropriate avenue for house staff participation was introduced by a review of the AAMC reorganization resulting from the Coggeshall Report. Almost from the time the three constituent bodies, the Council of Deans, the Council of Academic Societies and Council of Teaching Hospitals, were established, the problem of appropriate involvement of faculties, ranging from establishment of a separate Council of Faculties to establishment of a separate group under CAS, has been an issue. A resolution from the Assembly in February, 1971 requested reexamination of faculty representation in the AAMC [to date, both the COTH Executive Committee and CAS took no specific immediate action in the faculty participation questioned].

The Council of Deans at their institutional meeting on May 20, 1971 passed the following resolution with regard to faculty participation:

The COD recommends to the Assembly that the Association at this time not consider any further mechanisms of representation of the faculties in the national association and that such existing mechanisms be strengthened and utilized to increase opportunity for the faculty to make (input).

When student participation in AAMC was petitioned and approved, COD was made the avenue of that participation. Now since the Annual Meeting, COTH has itself been confronted by the question of house staff involvement.

There is at present no representative national organization of house staff for COTH to deal with. The National Association of

Residents and Interns (NARI), a group principally concerned with salaries, job security and other employment issues, has stated publicly that house staff are not students. A National Conference of House Staff, spearheaded by Clement Lucus, formerly President of SAMA, and now a physician serving in the Public Health Service, was held this spring with funds granted from HSMHA. This conference was in no way related to the NARI organization. Richard Knapp and Armand Checker along with representatives of the AMA attended the meeting as observers. Broader issues than economic ones were discussed during the meeting although education per se was not a major concern. A committee appointed during the conference was charged with responsibility for putting together a national house staff organization. To date the group has set up an information clearinghouse, begun publishing a newsletter and begun arrangements for a future conference. It does appear that this new organization will come to fruition.

VI. Dr. Knapp mentioned that in selecting a house staff representative for the meeting, no member of the incipient organization was selected because this would have been tacit acceptance of this group as representatives of all house staff.

Donald Detmer, physician and chief resident in surgery at Duke University Hospital, although selected as house staff representative to the committee, emphasized that at the meeting he was speaking only for himself. He pointed out that NARI as a national organization principally represents house staff at the large urban hospitals, frequently municipal and county hospitals, and not the university, VA

or community hospitals used for teaching, and that in university hospitals, in his opinion, house staff have different problems from those staff in the public hospitals. House staff in his view have the following attributes:

- 1) they are not the employees of attending or faculty physicians;
- 2) in a sense they are captives in training programs which they must complete in order to obtain board certification;
- 3) they are not students in the strict sense of the word since they are licensed physicians and can legally practice as fully responsible physicians;
- 4) their primary loyalty is based on their educational endeavors in the hospital;
- 5) as a group, house staff are wary of a national organization speaking for them. There is disagreement within the group as to which direction is most appropriate - to work within the system or to formulate an adversary role. Dr. Detmer personally prefers the former.

VII. A general discussion of house staff participation followed. Some of the points mentioned were as follows:

- Medical education depends on hospitals. As institutions, we cannot represent the individual interests of individual groups within the hospital.

- Student AAMC representation in the AAMC has been provided under the Council of Deans. [This seems proper] because a dean is clearly responsible for students and decisions about their full course of experience in the medical school. It seems less clear as to who is responsible for education of house staff in hospitals. Responsibility is diffuse for interns; and more concentrated in chiefs-of-service for residents with the concentration of responsibility increasing as the resident advances. This is true enough, but there are different house staff arrangements in different types of hospitals-- urban, community, university -- who it represents and for what.

- Another point of view on who house staff relate to is that they relate to specific clinical people at each level - an overall chief at the beginning levels, and a single chief with responsibility at the sub-specialty level. There are problems here because the professional road is determined by another outside group so that the chief in the hospital does not have complete autonomy in setting-up the course of the house officer's experience.

For discussion purposes, one member stated the following proposition: "the student is to the dean as the house officer is to the director of the hospital." In this sense house officers are already represented in the AAMC, but they may not feel this is so. There was not full agreement with the statement or the concept.

House staff are related to different individuals for different purposes -- hospital administration for employee benefits and some aspects of patient care, and to clinical chairmen or chiefs-of-service for education and other patient care responsibilities.

VIII. Resolution of house staff representation question has implications for the total AAMC. Some viewpoints expressed were:

- If there is formal recognition of house staff, what about other groups within the academic medical center and their representation in AAMC? For example, nurses or allied health may be next.
- There is something unsound about jumping ahead to representation within AAMC rather than looking for vehicles within councils of faculties or medical staff in the schools and hospital at the local level.
- The Teaching Hospital Information Center survey showed that there is some house staff involvement at the local level, mainly through participation on committees - utilization, library, and so on. However, representation at the executive or management level is not widespread.

IX. Dr. Freymann described the Hartford Hospital approach to house staff participation. House staff are regarded as a body with a community of interest and a reactivated house staff council has responsibility for administering house staff affairs. When this reactivation was accomplished, house staff were set-up as a component

of the hospital medical staff. They now serve on all medical staff committees except the executive committee.

One problem at Hartford was the question of votes - how they should be distributed among house staff with more seniority and house staff who were rotaters in relation to those based at the hospital for most of the residency. House staff elected to have no vote since house staff council and committee participation had assured them a chance to be heard. Through this arrangement, house staff recognize that they are physicians who relate to the hospital as do other physicians salaried by the hospital.

X . This description initiated a discussion of the advantages of promoting more house staff participation at a local level rather than formally in AAMC.

- One problem is financing. AAMC is supported by dues from medical schools, hospitals and academic and clinical societies. Student participation is now supported from general funds. If house staff do not come in under the umbrella of present groups, they will have to organize and pay dues for their own groups. If this occurs, it may appear the AAMC is forcing organization into the medical schools and hospitals it now represents.

- On a national basis, house staffs are evanescent, temporally and geographically.

- National representation would tend to set policies for individual house staff without their having anything to say about these policies.

- House staff have to establish the role of their group at individual hospitals and once they are integrated in hospital structure locally, then representation nationally.
- Hospital as an environment for teaching and learning is the concern of the AAMC. Teaching and services are not always consonant goals. Recent salary increases suggest that house staff are being paid for service. Representation of house staff within AAMC should be tied to their educational function and this may already be satisfied.

XI . The issue is not solely one of representation. Administrators have not known where to turn for help on house staff and have turned most often to the Council on Medical Education of the AMA. AAMC should become a national resource that hospitals, chiefs-of-staff, and medical faculties could turn to for information on house staff.

This possible function was discussed in relation to the AAMC Policy Statement on "Corporate Responsibility for Graduate Medical Education." (The most recent version under a new title, is attached as Appendix A to these minutes)

XII . This phase of the discussion terminated with some stimulating arguments for positions and some proposals.

- A. A resolution -- "whereas" etc., recommending that AAMC encourage house staff participation at the local level -- including both situations in which representation

can be channeled through the hospital or the medical school depending on the local policy making structure.

- B. If AAMC does have a role in graduate medical education, there is a "good reason" why there should be representation of house staffs, and that such representation should be within COTH:
1. Hospital appoint house staff;
 2. Hospitals pay house staff;
 3. House staff do provide services to a hospital in a management sense;
 4. Hospitals have on occasion collected fees, where available from services of house staff;
 5. Chiefs of services are program directors and programs are approved on behalf of the hospital;
 6. Hospitals according to the JCAH are to provide an environment for teaching and learning;
 7. What happens if the hospital is no longer reimbursed for education?
 8. Hospital's liability for employees.
- C. Some of the "good reasons" for opposing such representation:
1. AAMC should be concerned about graduate and undergraduate medical education, not the problems of individuals which can be more appropriately dealt with on the local level;
 2. Financing of house staff participation is probably not possible without formal house staff organization;

3. Promoting a formal house staff organization is potentially divisive within AAMC constituency;
4. In some instances the medical school, not the hospital, appoints residents;
5. House staff are not like faculty. They are evanescent, temporally and geographically;
6. House staff represent a specific group rather than institutional responsibility;

The following three alternatives were discussed:

- a) House staff involvement could be a total AAMC function and addressed by all three councils as necessary. Specific problems could be dealt with by staff, as directed by Dr. Cooper.
- b) A division of House Staff Affairs could be established and provide a diffuse arrangement for problem solving, not representation.
- c) The precedent already established could be broken by asking for disassociation of student participation

XIII. It was noted that presence of the Committee members who are deans would have afforded more adequate representation of the educational interests and responsibilities of house staff, along with financial aspects of the house staff programs within the academic medical center and would have provided another essential point of view as to if and, if so, where house staff involvement should be focused within the AAMC.

XIV. Following lunch, John Danielson, who had earlier addressed the national meeting of the Group Health Association of America on the subject of HMO's in the academic medical center, joined the committee for a discussion of house staff financing.

Both AAMC as a whole and COTH specifically have an interest in graduate medical education. The issue of financing is not unrelated to the issue of house staff representation since the locus of representation can be used as a definition of the principal function or role of house staff and of the sources from which house staff should be financed. A glance at old copies of the AMA Green Book would show that until the mid 60's low salaries used to be associated with highly desirable residencies and internships and with the hospital success in recruitment.

The first break in this trend came when house staff in city hospitals affiliated with medical schools threatened strikes if the hospitals did not pay house staff for their services as physicians. As the pricing for house staff recruitment increased, other hospitals followed suit. The elements of indentured servitude and tuition had not been priced out nor was this accomplished as salaries continued to increase and Medicare and Medicaid brought the issues to the surface.

The following diagram was used to demonstrate the components of total house staff function and a means of suggesting sources of reimbursement and of locating house staff within the existing AAMC structure:

HOUSE STAFF FUNCTION

	Institutional Service	Professional Relationship to Physician	Education
Group Served	Hospital	Hospital medical staff	a) Teachers of other house staff and students b) students
Financing	Patient care Revenue		a) reimbursement for teaching b) deduction for tuition
Representation in AAMC	COTH	CAS, or in some instances no representation	CAS

Tom Campbell reported that in the AAMC cost allocation studies forty medical centers are now involved. Cost determination of the teaching and research functions of teaching hospitals is being carried out; the costs of specific house staff functions within the teaching hospital are not included in the study. There was some discussion of studies which have attempted to determine how interns and residents spend their time. In view of the controversy over these efforts, there was suggestion that perhaps concentration should be placed upon what "should be" rather than what "is", and develop sources of finance on that basis.

XV. From the point of view of the VA system, house staff programs are regarded as educational programs. Present stipends rates are based on a system of matching the index hospital in the academic medical center with which the VA hospital is affiliated. At the present

time, these stipends are regarded as educational expenditures in the VA budget.

XVI. This was followed by more general discussion of financing:

- Support of house staff salaries from professional fees of faculty has been practiced in only a few institutions, but has been recently suggested as a desirable means of financing by the Pennsylvania Insurance Commissioner.
- Mary Hitchcock Memorial Hospital already has such an arrangement. Other precedents are also available. Partial payment of house staff from the professional side according to one committee member might be acceptable if it were carefully done.
- Another member suggested that there will be an attempt to cut back numbers of interns and residents to fit available dollars.
- A national policy on the number of house staffs slots may be forthcoming and this leads to questions about who should control graduate medical education and who should pay for it, and the proposed federal capitation of \$1,500- \$3,000 suggests that the federal government is prepared to pay for a piece of it (Eagleton amendment to S. 934).
- The termination of federal support for clinical fellows is raising problems about how the services they provided will now be supported.

- Tuition could be regarded as a negative income tax on the doctors for service employment
- This still creates a need for pricing out for graduate education the costs of tuition, teaching and service.

The education phase of graduate education may be a university function in the future, but it is important to remember, too, that without the teaching provided by interns and residents, the medical students environment would be deficient.

XVII. Mr. Danielson pointed out that although the AAMC does not want to be in a position of negotiating contracts for house staff salaries, it is in the unique position of having constituent organizational members with responsibility for all three areas of house staff functions.

AAMC could speak to the issue of division of responsibility and clearly a dollar value can be ascribed to each of these three areas. Whether or not AAMC wants to decide these issues or have it decided for its members by government or someone else is the matter of concern here. The National Association of Residents and Interns and the new, developing house staff organization could see the AAMC position and this would have an influence on their deliberation.

XVIII. Because the committee was not prepared to make a final decision on the matter of house staff representation at this meeting, they were asked by Mr. Danielson to put down on paper their suggestions on how house staff representation should be handled within the context of the cost allocation diagram.

XIX. A distillate of the discussion at this meeting will be circulated to the committee membership.

XX. At the next committee meeting in July, the staff paper on the financing of graduate medical education and the committee statements on house staff financing will be presented and discussed.

APPENDIX A

POLICY STATEMENT ON THE
RESPONSIBILITY OF ACADEMIC MEDICAL CENTERS
FOR GRADUATE MEDICAL EDUCATION

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

The Association urges that the Liaison Committee on Medical Education, the Residency Review Committees and the Specialty Boards establish procedures which will provide for adequate accreditation of 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.

It is essential that all related components (including hospitals) of academic medical centers jointly develop appropriate financing for the program costs of graduate medical education.

6/4/71

DRAFT POSITION STATEMENT:

FINANCING GRADUATE MEDICAL EDUCATION

The following position statement on the responsibility for graduate medical education will be placed before the AAMC Assembly on Saturday, October 31, 1971:

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The Council of Teaching Hospitals recommends the following proposal for the future development of financing graduate medical education:

SINCE:

Analysis indicates education to be approximately one-third of the time and effort expended by graduate medical students; the remaining two-thirds of time and effort are divided as follows:

- a portion is expended providing professional services on behalf of the medical staff;
- a portion is expended on behalf of the hospital for institutional service of stand-by professional coverage and patient care management

There is a definite need for the type of identification of responsibility which more appropriately relates financing to services rendered, so that provision can be made for the control and necessary incentive sought by both the provider of education and patient care as well as the carrier responsible for their support. The following proposal is directed toward future financing of the cash stipend and fringe benefits paid to graduate medical students. Further, the proposal must be viewed in its fullest context. Full 100 percent financing must be insured until each portion of this proposal is implemented.

THEREFORE:

I.

The AAMC supports in principle the Carnegie Commission Report on Higher Education recommendation that there be a capitation subsidy from the Federal government for graduate medical education.

We recommend that a subsidy (Federal, state or a combination) be considered as payment amounting to one-third of the expense incurred to pay cash stipends and fringe benefits to graduate medical students, and that these funds be paid to the institution obligated to compensate the student.

II.

The AAMC advocates the principle that a significant service is rendered for the physician by the graduate medical student in rendering professional care to the patient.

We recommend that a portion of the graduate medical student's compensation be charged to a physicians' fund that is generated from physicians' compensation at reasonable and prevailing rates.

We believe that there should be a single standard of establishing professional fees, and that this standard should be uniformly applied in the teaching and non-teaching setting with recognition of graduate medical student participation. We further recommend that the various departments rendering professional care be considered, for purposes of billing, in the same category as any group practice that guarantees professional service by a total group, rather than a single physician.

III.

The AAMC recognizes the legal and moral responsibility of the hospital to provide stand-by professional service for its patients and to appropriately manage the supportive care for all patients. It further recognizes the responsibility of the teaching hospital to provide a proper environment for patient care and education.

We recommend that the portion of the graduate medical student's compensation remaining (after Part I & II) be considered as a legitimate hospital expense which should be reimbursable out of patient care funds.

THE ROLE OF THE ORGANIZED MEDICAL STAFF
IN THE COUNCIL OF TEACHING HOSPITALS

At the February 13, 1971 meeting of the AAMC Assembly the following resolution was passed:

"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 directs 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"

During the past six months, a variety of proposals have been discussed as a method for implementation of this resolution.

SINCE:

- - the organized medical staff in many instances is identical to the medical school faculty;
- - the organized medical staff is responsible for the quality and quantity of professional care rendered in the academic medical center;

- - the hospital is the clinical environment of the academic medical center;
- - the organized medical staff of the hospital has an ever increasing obligation to influence a change in the delivery of health care in their community;
- - no presently constituted national organization or association (other than the individual hospital) represents the medical staff of our teaching hospitals.

THEREFORE:

We recommend that the Council of Teaching Hospitals sponsor the organization of teaching hospital staffs within the framework of the COTH and the Department of Health Services and Teaching Hospitals.

PURPOSE:

To advance the quality and quantity of health services in the teaching hospital in such a way as to harmonize with the changes in medical education and research.

FUNCTIONS:

To Render Advice and Assistance

- 1) in establishing new and/or improved methods of delivery of health services;
- 2) in the resolution of problems related to government programs effecting health care delivery;

- 3) in developing more effective and useful organizational patterns to improve communication and decision making;
- 4) through expert counsel on regional planning of health services and facilities;
- 5) in effectuating more appropriate, accurate, rational and efficient medical record systems;
- 6) in the development of affiliations between institutions and professionals to insure a greater continuity of care and a broader range of educational opportunities;
- 7) concerning the appropriateness of programs in graduate medical education;
- 8) to the Council of Teaching Hospitals and the Department of Health Services and Teaching Hospitals on matters relevant to their expertise.

IMPLEMENTATION:

Two possible alternatives are available, The first would be the establishment of a Medical Staff Section, the formation of which might be accomplished as follows:

- A) members would be appointed by the medical staff executive committee of the hospitals who are members of the Council of Teaching Hospitals;
- B) the Medical Staff Section of the AAMC would be divided into four regions for purposes of

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communication concerning regional interest
as well as the ease of establishing
discussion and consensus;

- C)) each region would have a chairman and vice-chairman;
- D) regional meetings will be annual or on call;
- E) the elected officers of the various regions shall constitute an executive committee which would serve on call;
- G) a national chairman shall be an ex officio member of the Administrative Board of the Council of Teaching Hospitals.

The second alternative is the possibility of fully integrating this concept into the present COTH organization by establishing two representatives from each teaching hospital - the chief executive officer of the institution, and a physician appointed by a mechanism to be determined by each individual hospital member of COTH. Administrative Board membership and other appointments would be adjusted accordingly.

Note: At the August 17, 1971 meeting of the COTH Administrative Board there was consensus that the second alternative would be the most appropriate method for implementation.