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AGENDA

TASK FORCE TO RECOMMEND GOALS AND OBJECTIVES FOR COTH AS WELL AS FUTURE CRITERIA FOR MEMBERSHIP

AAMC Headquarters
One Dupont Circle
Monday, June 7, 1971
10:00 a.m. - 3:00 p.m.

I. Call to Order - 10:00 a.m.

II. Introduction of Task Force Members — TAB A

III. Review of Events Leading to the Formation of the Committee — TAB B

IV. Present Status of COTH Membership

- a) Analysis of Current Membership — TAB C
- b) Current Criteria for Membership — TAB D
- c) Dues Structure — TAB E

V. Review of Current COTH Programs

- a) Survey of Constituency Preferences — TAB F
- b) Division of Teaching Hospitals
- c) Division of Health Services
- d) Legislative Efforts

VI. Discussion and Evaluation of Possible Changes in Program Emphasis

VII. Determination of Future Course of Committee Affairs

VIII. Date of Next Meeting and Adjournment

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TASK FORCE TO RECOMMEND GOALS AND OBJECTIVES FOR COTH AS WELL AS FUTURE CRITERIA FOR MEMBERSHIP

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V. The Future Development of the Association of American Medical Colleges

Trends and implications set forth in Chapter III make it clear there is a great challenge ahead for the Association of American Medical Colleges and a major need for national leadership in the field of education for medicine and related health sciences. Evaluative judgments set forth in Chapter IV imply that the association has made a great contribution in decades past and that its present status is one of strength—strength that provides a foundation for future development and leadership.

While the need for leadership is clear and the latent strength possessed by the association is apparent, the executive council and officers of the Association of American Medical Colleges are faced by a major decision. Should they make minor adjustments in programs and organization of the association, making the minimum possible change in its traditional character? Or, should they rise to the challenge fully, make bold forward strides in revising the association's philosophy, objectives, programs, and organization, and, thereby, prepare the association to accept the role of national leader in education for health and medical sciences?

This report urges the latter course—that the Association of American Medical Colleges make the major adjustments needed to prepare it for broader leadership. If broader leadership is not provided by the association, further fragmentation of national educational effort seems inevitable. Moreover, the present void in leadership will likely be filled, at least in part, by others less well qualified to make decisions concerning education for health and medical sciences than the members of the Association of American Medical Colleges.

This chapter specifies actions that should be carefully considered and taken by executive council and the entire association. For its own sake and that of others, there is urgent need for the association to restate its philosophy and objectives. It must continue to develop mechanisms for periodic review of existing and new working objectives, to adopt and apply them in a systematic and formal manner, and to revise organization and staffing in keeping with established goals. Programs and services must be developed in a selective fashion and with concentration upon vital priority activities of greatest concern.

Despite change, there should be constancy in the purpose of the Association of American Medical Colleges—to provide the leadership and service needed to further the development and improvement of human health through education for health and medical sciences.

1. PHILOSOPHY AND OBJECTIVES

The scope of responsibility of the Association of American Medical Colleges should be broadened and enlarged because of the implications thrust upon it by emerging trends related to health care. Its educational horizons

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are enlarging and its philosophy and objectives as an organization should be enlarged accordingly.*

It is recommended that the philosophy of the Association of American Medical Colleges be enlarged to commit the association to assume and exercise a greater leadership role. Education for health and medical sciences has already been extended beyond the limits of the pre-doctoral period. It should extend even further. If the association is to achieve its purpose, it should:

- Lead and assist all who are involved with the student from the time he aspires to and prepares for professional education through each phase of his training and continuing education.
- Concern itself with all facilities and environments through which the student passes in each stage of learning.
- Relate itself more closely to other institutions and organizations in ways which will assist its purpose.
- Retain sight of the fact that professional education serves individuals and groups, the community and the public, and has national and even international implications.

The Association of American Medical Colleges, representing principally those who are involved in education for health and medical sciences, exerts its leadership and service role largely through its capacity as a forum and as a center for communication. Primarily a membership of organizations, the chief strength of the association lies in the institutional strength of its members and their subsequent effect on standards and educational progress. It is the forum which permits initiation and development of ideas and programs.

Those responsible for physician education are most qualified to speak about it so that new developments and progress can be shared among themselves and can be relayed to concerned organizations and an interested public. Only by appropriate communication can information be spread, misinformation corrected, and education achieved. Of necessity, if educational objectives are enlarged, then the functions of the association as a forum and as a means of effecting communication must also be enlarged.

It is recommended that the philosophy and objectives of the Association of American Medical Colleges not be restricted to emphasis on the medical school, but that it be more broadly conceived in terms of service to the nation and community as well as to members. The association should make plain that it regards its role as one of serving the national and public interest through institutions that compose it, thus reflecting the aims of its member institutions to serve the public interest. This broad interest should include service to education generally, and to faculties and students engaged in education for health and medical sciences.

It is recommended that a broader and more precise philosophy be adopted with respect to bonds between the Association of American Medical Colleges and universities. Although it has long been said that medical colleges should be parts of universities, many new reasons have appeared for

*To assist in communicating the recommendations of this report, terms and definitions have been developed to express, as clearly as possible, certain of the key aspects of the subject. They are indicated in the appendix to this report.

strengthening these relationships. The lines between pre-doctoral and post-doctoral education have become less sharp. A greater share of clinical, post-doctoral, and continuing education is being placed in the hands of university faculty members. The more comprehensive term and obvious reality of "education for health and medical sciences" implies education for new allied health professions and occupations.

No medical college, other than one affiliated closely with a university, can achieve as high standards in its educational mission or be stimulated to as high a degree. Physician education, no matter whether in the classroom, in the laboratory or at the bedside, is consistent with and part of university education. Universities—especially the tax-supported ones—are moving in the direction of increased awareness of their obligations to society as well as to individuals. For these reasons and many others, the professional aspects of education for health and medical sciences should be regarded as an essential function and a fully integrated component of university organization, with decreasing dependence upon or control by organized professions and their related associations.

As a corollary to all the above, *it is recommended* that the Association of American Medical Colleges undertake to be a more effective spokesman and that its philosophy and objectives be spread across the land. No other group can educate and inform as well. No other group can speak as authoritatively for the needs and goals of physician education. The universities must know more about the dependence of medical colleges upon them. The public and all of its subsidiary groups, the faculties of medical schools, their alumni, and the practicing profession—all need to be guided and informed. Consideration at the highest levels of national policy formation and program development—including those of the government, states, and related public or private organizations—calls for the wise guidance of those who are most qualified to assist.

The enlarged philosophy must be translated into more than words. *It is recommended* that the broader philosophy be the basis for realistic and concrete objectives that can be the guides to action directed toward agreed ends. The objectives must be specific and viable, related to the needs and implications that can be seen for education and for the Association of American Medical Colleges.

It is recommended that an AD HOC "blue ribbon" committee be established by executive council to work with the executive director to formulate statements of philosophy and objectives for the Association of American Medical Colleges. The committee should include 12 to 15 carefully chosen individuals drawn from member institutions. Committee members should include faculty members, medical school deans, and a few general university administrators.

The committee should prepare draft statements of philosophy and objectives. After the committee has reached tentative agreement on the statements, regional meetings should be held with representatives of member institutions and other interested organizations—related organizations, foundations, government agencies, and so forth. The tentative statements should be distributed to participants prior to the regional meetings. They should be discussed at the meetings. After the meetings, the "blue ribbon"

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committee should meet again to make necessary modifications in the statements. Once agreement is reached on the wording of the statements, they should be presented to executive council for consideration, discussion, and ultimate adoption.

It is recommended that executive council adopt official statements of the association's philosophy and objectives.

It is recommended that the statement of objectives adopted by executive council be used as continuing guides for planning and evaluating the association's programs and actions and for interpretation of the association's work.

It is also recommended that particular effort be made to inform members of the association's philosophy and objectives, once they have been established. Statements of philosophy and objectives should be re-examined and revised periodically to keep the association abreast of changing needs and opportunities.

2. PROGRAMS

If the Association of American Medical Colleges is truly to respond to the implications confronting it from the total field of education for health and medical sciences arising from the emerging trends related to health care, this response must be reflected in its programs. To achieve that, programs of the association need to be re-evaluated in terms of trends and implications, and the association's enlarged philosophy and definite objectives, once they are developed. Then, programs will need to be refined and strengthened so they can achieve the objectives and meet the needs. A detailed review of programs of the scope and detail now needed was beyond the assignment of the present study.

The term "programs" here identifies those activities, other than those providing direct services to members, undertaken by the Association of American Medical Colleges in behalf of its members. Existing programs are considered first; then possible new programs. Supporting services are considered in the next major section of this chapter.

(1) ACCREDITATION

Some present programs are basic to the future development of the Association of American Medical Colleges as well as to its present operations. The function of accreditation, including the establishment of standards and consulting visits to medical schools, is a vital one.

It is recommended that the accreditation program be continued and strengthened. To further this effort, *it is recommended* that enlarged panels of visitors be provided to afford greater flexibility, coverage, and timeliness. Effort should be made to provide limited publication of accreditation reports to assist interested universities.

The considerations involved in accreditation are of overriding importance to medical schools and universities of which they are parts, beyond the interest of all others. The association should lead universities as well as medical schools to undertake a more active and responsible role in the accrediting process.

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(2) STUDIES

Various studies are basic and of widespread usefulness, including those referred to as "operational studies" and other special studies. These studies should be regarded and used as a form of applied research. They should be distinguished from information-gathering as a service to members.

It is recommended that the association continue to make special one-time studies and, occasionally, recurring studies concerned with the general operations of medical schools. The studies of financing medical education, voluntary support, and medical school program costs are excellent examples of these. Wherever possible, such studies should draw upon information gathered through the association or other established channels. They should not duplicate basic information-gathering elsewhere. Whenever data are collected, they should receive some treatment and yield a product of use to those providing information, even if it must be quite general or kept confidential.

Student studies attract wide interest and useful participation as well as providing important findings. They are concerned with the perspective and qualities of students from baccalaureate education through pre-doctoral education. Such studies as those of applicants, the attrition study, and improvements in the Medical College Admission Test provide practical guidance for medical school administrators and will continue to have significance. Furthermore, the findings and discussions related to student matters expand participation in the work of the Association of American Medical Colleges.

(3) INTERNATIONAL ACTIVITIES

International medical education activities are worthwhile and offer productive contacts and *it is recommended* that they be continued.

A useful service is provided in the national interest to assist United States government and private efforts in furthering medical education in other countries, beyond the normal responsibility of the Association of American Medical Colleges. Although it is in this context of service that the program is established and conducted, there should be real attention to deriving mutual benefits from it. There is much to be gained from awareness and exchange concerning the practices of other countries. International contacts should become increasingly useful to American education for health and medical sciences, and such results and benefits should be consciously sought.

(4) CORE RESEARCH PROGRAM

Although the studies are just getting under way, the various aspects of the "core" research program appear potentially to offer the most direct response of all association programs to the emerging trends of health care and their implications for education and the Association of American Medical Colleges. They have taken account of many of the significant trends and are intended to develop findings with direct bearing upon them. *It is recommended* that "core" projects be given more concentrated attention and resources, and that they be expedited.

Such concerns as the nation's need for physicians, application of newer

technology to physician education, research in patient care, criteria of professional competence, and teaching programs in comprehensive medicine are too important to be delayed. They should be moved forward as rapidly as sound research methodology will permit.

Of course, the earlier longitudinal study of a selected sample of medical students is basic to much that will be examined in the "core" projects.

(5) GENERAL PROGRAM REVIEW

To bring all present and future association programs into perspective, it is essential that all programs be reviewed and evaluated in terms of the expanded future role, philosophy, and objectives of the Association of American Medical Colleges. Existing programs should be assessed on the basis of the same criteria upon which new programs are examined. Priority concern should be to meet major needs and objectives related to the implications for the Association of American Medical Colleges and education that arise from the emerging trends related to health care.

It is recommended that a systematic examination of all present programs and needs for new programs be made by the "blue ribbon" committee established to formulate statements of philosophy and objectives. Their study of programs should begin intensively following the adoption of official statements of philosophy and objectives by executive council.

The committee should recommend an over-all "program structure" that will indicate the main areas of program concentration and identify priorities among major programs that should be continued or established. The program structure should be designed to achieve clearly identified association objectives. Priorities should be stated to guide program development and implementation.

Executive council should consider the committee's recommendations and make appropriate approvals. Upon approval of the program structure, the executive director should develop detailed program plans for approval by the executive council. Individual programs should be planned and developed to correspond with the program structure, priorities, and objectives it reflects.

(6) NEW PROGRAMS

While not all new possibilities can be considered immediately as part of the intensive "blue ribbon" committee review, *it is recommended* that important new program fields receive special attention as possible parts of a new program structure. Prime emphasis should be placed on research and experiments in organization and methods of medical care. The very effectiveness of modern health services has led to increased demand and increased costs. Particular attention needs to be given to finding ways in which effectiveness can be further improved, productivity of physicians increased, and cost controlled. Further development of the team approach and the development of new approaches to family practice need to be given priority attention by the association.

(6.1) TEAM APPROACH TO CARE

It is recommended that particular consideration be given to developing improvements in the team approach in both hospital care and medical

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practice. Strong effort should be initiated to clarify the concept and its application, and to improve education for the medical team. Informal discussions should be fostered among medical and allied professional groups to find common understanding about the team. Experiments in application of the medical team idea should be designed and stimulated among member institutions. Improved methods for coordinated education of all professions and occupations allied in the health and medical sciences should be developed.

(6.2) EARLIER DIFFERENTIATION AND FAMILY PRACTICE

It is recommended that the association devote attention to the development of basic educational programs leading to an earlier differentiation into specialties—i.e., group programs preparing the graduate for general service, academic research, and so forth. Related to this, joint or cooperative study should be sought with other organizations to determine the needs for first line medical care, qualifications required to equip a physician to provide first line care, and the best educational approach to prepare physicians for first line medical care. Within this category of activity, *it is recommended* that particular effort be made to provide leadership and aid in the development of improved approaches to family practice.

(6.3) COMPUTER APPLICATIONS

Computer technology is making particularly rapid advances. There appears to be great potential for making computer applications in the fields of research, patient care, and medical education.

It is recommended that serious consideration be given to the association's developing a program to study and exchange information concerning computer applications in the fields of interest to it and to member institutions.

(6.4) CURRICULUM

The medical curriculum currently needs reconsideration, re-evaluation, and revision. The vast accumulation of new knowledge makes it increasingly evident that not all medical information available can be conveyed in four years. There is need to develop a curriculum that provides for later specialization. There is need for re-examination of curriculum to eliminate both duplication and subject matter not essential to subsequent education and practice. There is a particular need to encourage member institutions to give more intensive attention to curriculum evaluation.

It is recommended that more intensified work leading to curriculum improvement be considered. The work undertaken by the association might include (1) further stimulation of experiments in curricula to adapt to new knowledge, new practices, and new technology; (2) further efforts to develop better length and sequence of curricula; (3) comparative analysis of results of different curricula; and (4) increased exchange of information and discussion about new and revised curricula.

Part of this effort might well include development of cooperative study with undergraduate colleges and colleges of arts and sciences to improve requirements, curricula, and programs for baccalaureate education preparing students for the study of medicine.

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(6.4) OTHER PROGRAMS

It is recommended that some existing programs be reviewed with particular attention to their importance and priority for the future. Less important programs should receive less attention and resources and, where appropriate, should be eliminated.

The library of teaching motion pictures should, for example, be re-examined with a view to transferring the function and materials to other organizations. Some research efforts should be reconsidered and continued only if found essential or definitely placed in a lower priority to receive substantial attention only when priority research does not require it.

The association's staff should encourage, assist, and, where possible, coordinate research effort. Staff members should conduct actual research only when immediately related to priority association objectives and when it is not feasible of accomplishment by others.

(7) CONTINUING REVIEW

The process of evaluating and planning programs should be continuous. Hence, *it is recommended* that the association provide for the continuous evaluation of programs by the elected leadership and senior staff members using established objectives as the standard for evaluation.

3. SERVICES

It is important that services of the association be fully effective in supporting programs. They should also be sensitively responsive to service needs. *It is recommended* that services provided to members and others be re-examined and carefully planned to achieve these aims. This review should be made by the "blue ribbon" committee at the time it is reviewing programs.

In reviewing services, concern should be with those activities undertaken to meet key needs of members by providing direct services to them, or to others identified by them, and to support programs of the association.

Services of the association should be closely related to indicated needs of members and programs. The needs and desires of members for services should be re-assessed to determine the services of greatest importance. Services should ordinarily be limited to activities for which members are willing to pay directly, which can be financed from general revenues, or the costs of which can be allocated to programs.

After review, the committee should recommend a definite over-all "structure of services." Existing services should be re-assessed and adjusted in relation to the identified needs of members and programs. Important services should be specified and priorities assigned in relation to established objectives and identified needs. Executive council should consider the recommended structure of services at the same time it considers the over-all program structure and should give appropriate approval. Upon approval, the executive director should develop detailed plans for specific services and submit them to executive council for authorization,

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(1) DATA AND GENERAL INFORMATION

Certain basic data and general information services are essential. *It is recommended* that they be continued and improved. Gathering of data and general information, and their distribution and exchange, is fundamental to effective operation of the association and its members. The scope of information considered should be expanded.

By serving as a central agency for collection and distribution of information about trends and needs in education for health and medical sciences, the association can provide an important resource of objective data for the use of all organizations and agencies concerned with health.

A broad variety of information should be gathered and disseminated on a clearinghouse basis. However, the particular items should be selected with discrimination, so that each is important and useful. Data should be handled that do not duplicate those collected by others. Data should be collected and made available for research, for communication, and for consultation with institutions and organizations.

(2) PUBLICATIONS

The basic publications of the Association of American Medical Colleges also constitute an important and necessary service.

To handle the variety of publications most effectively, *it is recommended* that the editing and production of publications be brought under one individual. It should be his responsibility to assist those preparing publications as parts of programs or services for which they have budget responsibility.

It is recommended that publications be self-sustaining (or yield revenue wherever possible) unless there is outstanding reason for an exception. The publications head should work with program people and other service people to assist in making this possible.

It is recommended that the *Association of American Medical Colleges Directory* and *Medical School Admissions Requirements* be continued as basic publications. They should be on a self-sustaining basis.

The Journal of Medical Education is a publication so essential that it warrants special mention. *It is recommended* that effort to improve it and increase its circulation continue.

(3) MEETINGS

The annual meeting of the Association of American Medical Colleges and most of the cluster of meetings related to it are an essential and productive part of the association's role and service to members. *It is recommended* that continued effort be made to improve the content and organization of meetings to achieve the widest possible extent of participation.

It is recommended that meetings be arranged and conducted on a self-sustaining financial basis, without subsidy from general funds, with only rare and essential exceptions.

To further the relationship and interchange with organizations directly related to education for health and medical sciences, they should be

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encouraged to hold their annual meetings at the same time and place as the association's. Joint sessions of various types should be arranged.

The need for periodic regional meetings is apparent. *It is recommended* that they be provided for. (Suggestions concerning regional organization are set forth on pages 83-4 of this chapter.)

(4) THE MEDICAL COLLEGE ADMISSION TEST AND NATIONAL INTERN MATCHING PROGRAM

Two vital and well-recognized services of the Association of American Medical Colleges are the Medical College Admission Test and the National Intern Matching Program. Having been initiated and substantially refined by the Association of American Medical Colleges, these two efforts now require a minimum of administrative attention and provide significant revenue. They have become virtually indispensable for their users. *It is recommended* they both be continued.

The Medical College Admission Test is an important service to physician education, and the association should continue to sponsor it. The association contracts for administration of the test and receives revenue from its use that covers the costs of staff work on improvement and validation of the test.

The National Intern Matching Program is a useful and helpful adjunct to association services. The association provides facilities for the program and receives benefits from it in revenue, information, and prestige.

(5) OTHER SERVICES

In addition to the basic and essential services, others should be carefully reviewed and evaluated to determine whether they should be continued or modified.

(5.1) PRINTING SERVICES

It is recommended that printing services be provided for association publications and programs only where essential and needed services cannot be obtained elsewhere at equivalent cost. Although this service deserves further review, the committee believes that printing services drain the time and attention of top staff members and use valuable space without considering the full cost of these.

(5.2) PUBLICATIONS

In terms of publications, *Financial Assistance Available for Graduate Study in Medicine* has been useful but may have served its purpose. Any continuation of it should be planned to recover all costs involved. The periodic *Datagrams* have been definitely worthwhile and have called attention to important information. However, it may now be advantageous to incorporate them entirely in *The Journal of Medical Education* where they are already reproduced, although now as a duplication of previous issuances.

(5.3) CONSULTATION AND SEMINARS

Various types of consultation services to individual member institutions are unquestionably useful. They are, however, quite expensive and

consume a high proportion of staff time planned to be used for other responsibilities. Clear determination should be made of the needs and demand for such consultation with individual institutions, the terms on which consultation will be made, and who will pay the cost involved. Staff will need to be provided accordingly, rather than assuming that time can be made available from other responsibilities and assignments.

The intramural seminars, involving considerable association assistance in self-studies in depth of individual medical schools, have attracted noteworthy attention. They are of primary benefit to the institutions involved and afford secondary benefits to the association and other members.

Therefore, *it is recommended* that arrangements be made to assure that costs of consultations and seminars are met by the institutions benefited.

(6) NEW SERVICES

It is recommended that new services be considered that will be in keeping with the enlarged leadership role of the Association of American Medical Colleges. Leadership necessarily involves service. The association should select carefully those services most directly responsive to the implications of emerging trends in health care. The association should examine closely the expanded setting of its services and plan accordingly.

(6.1) COMMUNICATIONS AND LIAISON

The association should serve as an informed focal point of communication and liaison with governmental units, with professional associations related to health outside of the educational setting, and with the national agencies representing all of higher education. The association has responsibility to guide these forces efficiently toward a cohesive complementary effort. The association should take the leadership to set up meetings and workshops with formal agenda and bring appropriate groups together for planning and decision-making sessions.

Quite specifically, *it is recommended* that the Association of American Medical Colleges maintain positive working and informational contacts with all organizations concerned with education for health and medical sciences. It should be active in assisting and drawing upon government agencies on behalf of the entire membership. Also, the appropriate contacts of member institutions with United States government agencies should be facilitated and assisted by the association.

As another important service in direct furtherance of a leadership role, contacts among association members and among and with other organizations concerned with health and medical sciences should be led, fostered, and assisted by the Association of American Medical Colleges. This effort should pervade all association activities and is as much a matter of attitude and approach as of specific arrangements. The association should be out in front with its thinking and should lead the thinking and action of others. It should anticipate needs and bring them to the attention of government, with specific recommendations for action.

(6.2) AID TO SMALLER ORGANIZATIONS

There are specific things that could be done, too, particularly in relation to the smaller organizations with limited staff that are closely con-

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nected to education, such as the associations and societies of faculty members in specialized fields. For example, they could be assisted in working out and conducting arrangements that would make possible coordinated annual meetings, as suggested previously. In time, when office facilities permit, it may be possible to provide office services on a cost basis to organizations that do not desire or are not able to maintain regular offices and office services. Also in time, regional meetings sponsored by the association might be used to bring these smaller organizations' members together.

(6.3) GOVERNMENT AFFAIRS BULLETIN

It is recommended that the association publish a new bulletin providing current information and brief analyses concerning developing aspects of federal government programs of vital concern to medical education. The publication probably should be issued monthly. It might on occasion be confidential. It should be oriented toward serving the special needs of universities and medical schools.

(6.4) TRAINING INSTITUTES FOR ADMINISTRATORS

There is growing need for orientation of new medical school deans, new department heads, and others given new administrative duties. ***It is therefore recommended*** that the association plan and conduct periodic training institutes for new administrators. Specific programs might be provided for individual categories of administrators. The institutes might be developed by the association in cooperation with a university. Foundation support for the institutes might be sought, at least for experimental sessions. The rapid turnover of administrators makes the need for such a service particularly apparent.

4. DEVELOPMENT AND REVIEW OF PROGRAMS AND SERVICES

The first three sections of this chapter have emphasized the need for programs and services of the Association of American Medical Colleges to be consciously and systematically planned in relation to agreed objectives and on the basis of careful analysis of needs. ***It is therefore recommended*** that a sound approach to planning should be developed, adopted, and followed. It might be well to develop a fairly formal "plan for planning" to ensure sound planning in accordance with a desirable schedule and involving appropriate persons.

The association's official statements of philosophy and objectives should guide close examination of needs of association members. The association's program structure should be designed to meet needs and achieve objectives. Priorities among programs should be established to guide program planning and development.

Individual programs should then be planned and developed to meet established priorities and objectives. Services should be planned and provided to support the programs and meet needs of members. The planning and development of programs and services should be a conscious,

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systematic process. When plans for priority programs have been developed, external financial support should be sought to help carry them out.

Following this sequence will call for a more refined and deliberate process of program planning and development than has existed heretofore. The planning process should provide for participation and contributions by all elements of membership and review by appropriate committees or other bodies after staff recommendations are prepared.

Programs should be systematically considered on an annual basis in relation to one another as part of a total budget review. Services should be reviewed at the same time in relation to programs and the needs of members, and with careful regard for benefits and costs. Then the total plan for correlated programs and services and supporting budgets should be formally approved and authorized by executive council.

The implementation of programs and services should be consistent with the established objectives and priorities, approved program plans, and specific budget authorizations. Program plans and budgets should remain stable until deliberately changed at the next periodic review, or earlier if needs and circumstances require.

5. ORGANIZATION

The Association of American Medical Colleges has, throughout its history, been organized in ways that have allowed it to perform its functions effectively. Changes have been made periodically, as objectives, programs, and emphases have changed. Today's plan of organization of the association is not ineffective. However, the current plan has significant limitations in terms of being able to provide the leadership and meet the challenges ahead that have been emphasized throughout this report.

It is recommended, therefore, that the plan of organization of the association be revised to reflect clearly the new philosophy and enlarged leadership role that has been proposed. The organization should provide the structure through which this role can be achieved and made effective. It should be responsive to the implications for medical education and for the association outlined in Chapter III.

Organization of the association should be concerned with the improvement of health in all its aspects, particularly in the comprehensive function of education for health and medical sciences and also in improved care, treatment, research, and other aspects. It should evidence authentic consideration of broad national and public interests and those of universities.

Representation in the association should include all principal elements of the university community involved with education for health and medical sciences. Provision should also be made for participation of other related organizations, expression of their views, and effective working relationships with and among them. It should be mainly an association of institutions and organizations, but both formal and practical provisions should be made for active involvement of responsible and concerned individuals.

It is recognized that there are a number of ways in which the association could be reorganized, and the executive council will probably wish to consider various alternatives. However, to focus discussion and encourage

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action, the outlines of a definite organization proposal are offered in this report.

(1) NAME

In keeping with a broader philosophy and scope, and to evidence increased leadership and responsibilities, it is appropriate to consider a new name for the Association of American Medical Colleges. One way to enlarge concepts, and to indicate that they are enlarged, is to establish a different identification.

It is recommended that a new name such as "American Council on Medical Education" or "Association for the Advancement of Medical Education" be adopted to establish more readily the aims of greater scope, leadership, and participation.

(2) INSTITUTIONAL MEMBERSHIP

It is recommended that the association maintain and enhance its organizational strength by continuing primarily as a membership organization of educational institutions. The principal effect on standards and progress in education for health and medical sciences will be achieved through these institutions. In emphasizing the institution, however, there needs to be an enlarged concept of what the key "institution" really is. Thus, for membership purposes, the medical college should be recognized as a component of the university within which many vital decisions affecting physician education are made outside the college.

Based on this concept, *it is recommended* that the basic class of membership in the association be "institutional membership." This membership should consist of institutions maintaining medical colleges, whether universities or independent medical colleges. These should be the governing members of the association.

Within the class of institutional membership, in addition to the primary members, *it is recommended* that three subordinate categories be recognized. These should be:

- *Graduate institutional members*—These should be United States institutions otherwise qualified for membership but which have formally recognized programs at the graduate, post-doctoral level.
- *Associate institutional members*—These should be non-United States institutions otherwise qualified for membership. They should be received into full association, but without vote.
- *Provisional institutional members*—These should be United States institutions preparing for but not yet ready to assume full institutional membership. They should be received, but without vote.

(3) INDIVIDUAL MEMBERS

The organization should make specific provision for membership and participation by faculty members and other individuals or corporations concerned with education for health and medical sciences. *It is recommended* that a second class of association membership be "individual members." Their membership should consist of recognition and identification with organizations and other individuals in the field and participation on a nonvoting basis in the activities of the association.

It is recommended that three categories of individual members be recognized:

- *Emeritus members*—This should continue to be a largely honorary status which would confer general privileges other than voting upon each individual. Special effort should be made to select individuals who can make particular contributions, including retiring officers of the association.
- *Participating members*—These should be the principal individual members, paying dues and entitled to receive copies of publications and notices. They should also receive invitations to and be accorded privileges of participating in association activities.
- *Sustaining and contributing members*—These should be individual or corporate members whose participation is largely financial. They should be recognized in an honorary way and receive copies of publications, notices, and invitations, but without obligation to take part in activities.

Active participation by individual members in the affairs of the Association of American Medical Colleges should be encouraged in and through their institutions and in regional arrangements according to their specific interests. (Regional arrangements are considered on pages 83-4 of this chapter.)

(4) AFFILIATE MEMBERS

Also within the association's framework of organization, *it is recommended* that provision be made for suitable participation by other organizations concerned with health and medical sciences. Recognizing that there is a broad range of interest among organizations, and varying types of organizations, two different types of relationships should be provided. The difference between them should be identified by the nature and purpose of the organizations involved and by the mutual preference of the relating organization and the association.

The first of these relationships should provide for "affiliate members." Organizations directly and responsibly involved in education for health and medical sciences should be encouraged to become directly affiliated with the association. For this purpose, *it is recommended* that a third class of membership be created, by which such organizations could become affiliate members upon application. Affiliate members should be entitled to representation in the over-all governing body but should not otherwise have decisive voice in affairs of the association. Affiliate members should come largely from among the teaching hospitals and the organizations of teachers and researchers of various scientific and clinical subjects.

(5) RELATED ORGANIZATIONS

In addition to actual members, *it is recommended* that the association recognize as "related organizations" other organizations primarily concerned with education or practice in health and medical sciences. Formal continuing working relations should be established with related organizations, and specific organizational arrangements should be made for their involvement in affairs of the association. Working relations should include such activities as exchange of information and publications, partici-

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pation in meetings and activities, joint studies and experimental or demonstration projects, and limited participation in policy and program considerations of the respective organizations.

The related organizations should be expected to include those (such as the American Medical Association) with which the association has already established cooperative contact, plus other professional or institutional associations, the various professional organizations by medical specialty, voluntary citizen organizations in the health field, and others with common interests.

(6) GOVERNANCE BY MEMBERS

The organization should provide for effective governance of association affairs by its members. To do this, appropriate and representative governing bodies should be established for legislative authority and current direction of the over-all work of the association. The primary governing bodies should consist of (1) a general assembly, representing the members, and (2) an executive council, for current supervision of association affairs. To sustain the basic character of the organization, controlling votes in the two governing bodies should be retained by institutional members.

It is recommended that a "general assembly" be established as the constitutional governing body of the association and represent all members. The principal responsibilities of the general assembly should be to:

- Adopt and amend constitution or charter and bylaws
- Establish membership criteria
- Elect members
- Elect officers
- Elect members of executive council
- Establish standards for accreditation
- Establish major policies
- Approve major programs

It is recommended that general assembly membership comprise the following representation:

- *Institutional representatives*—Each institutional member should be authorized a minimum of three representatives selected by the institution. The three representatives should be expected to consist of (1) the chief university or college executive officer (or the person designated by him as the senior general university officer or college officer responsible for administration of education in the health and medical sciences), (2) the dean of the medical college, and (3) a member of the medical faculty with broad interest in education for health and medical sciences, perhaps selected by the members of the faculty who hold individual memberships in the association. Universities sponsoring more than one medical college should be entitled to select two additional representatives for each college—usually the dean and a member of the medical faculty. Individual members of the association should be represented in the general assembly through their institutions.
- *Affiliate representatives*—Each affiliate member should be authorized two representatives selected by that organization. The representatives should be expected to consist of the organization's presiding officer and principal

executive officer, however determined and titled by that organization. (Such representatives should be limited in total to not more than one-third of the general assembly. If the number of such representatives reaches a point at which it would exceed this proportion, the basis of representation should be revised.)

- *Related organization representatives*—Each related organization should be authorized one nonvoting representative. Such representatives should be entitled to privileges of the floor other than voting.

(7) OFFICERS

The future development and expanding leadership role of the association will be made more effective by changing the titles of key officers.

It is recommended that the senior officer of the association elected annually be designated the "chairman." This title will appropriately reflect his functions and will be in keeping with the practice of many membership organizations, institutions, and enterprises.

It is recommended that the full-time chief executive officer be given the title of "president." This title is in keeping with that used by other important educational organizations. It will facilitate his work as principal representative and spokesman for the Association of American Medical Colleges.

In keeping with these recommendations, the full panel of officers of the Association of American Medical Colleges should be the:

- *Chairman*—Elected annually to preside over the general assembly and executive council and give general legislative leadership. The chairman should be able to succeed himself at least once if desired.
- *Chairman-elect*—Elected to succeed the chairman when he retires from office.
- *Vice chairman*
- *Secretary*
- *Treasurer*
- *President*—Elected for an indefinite period to serve as full-time chief executive officer of the association with suitable compensation.

The officers of the association should be elected by the general assembly.

(8) EXECUTIVE COUNCIL

Under the revised plan of organization, *it is recommended* that the executive council serve as "board of directors" of the association and be responsible for current supervision of affairs within programs and policies established by the general assembly.

The executive council should be elected by the general assembly and should consist of 15 members. The members should include (1) the six elected officers, serving ex officio, (2) the immediate past chairman of the association, (3) six medical school deans, and (4) two other representatives of the institutional members, one of whom should be a general university officer and one a faculty member.

The principal responsibilities assigned to the executive council should be to:

- Elect principal staff members on nomination by the president.
- Approve annual budgets after receiving the recommendation of the president.

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- Approve interim adjustments within major programs established by the general assembly.
- Establish staff organization and administrative policies after receiving recommendations of the president.
- Review and recommend actions requiring the attention of the general assembly.

(9) ADVISORY COUNCILS AND COMMISSIONS

Suitable advisory bodies should be constituted to further participation, discussion, and expression among key institutional representatives and representatives of affiliate members and related organizations. First consideration should be given to establishing bodies directly related to institutional responsibilities and to the organizations affiliated with or related to the association.

Specific provision should be made for "councils" of deans, administrators, and faculty members to meet together as the principal parties directly concerned with the process of physician education and the broad relationships of education for health and medical sciences. "Commissions" should be established as the means of participation for affiliate members and related organizations.

In addition to these directly representative advisory bodies, consideration should be given to establishing a number of "study sections." These should be established for important subject matter areas. They should provide for participation and study by both representatives and individual members on matters of importance. For the present, it appears most feasible to start such groups at regional levels and relate them to program subcommittees of the association (recommended later in this chapter). In providing for such groups, it is important to relate their topics, just as the program of the association should be related, to matters of greatest importance and priority to the association.

(9.1) COUNCILS

Councils should provide forums for each of the major types of institutional representatives in the general assembly. They should offer means by which persons of comparable responsibilities in their institutions can examine both matters of general interest and matters specific to their own institutional responsibilities. *It is recommended* that three councils be established.

- *Council of Deans*—This council should provide for participation of all medical college deans. It should be concerned primarily with educational matters, but also with internal administration of medical colleges and with the relations of medical colleges to other elements of universities.
- *Council of Administrators*—This council should provide for participation of all university presidents (or representatives designated by them as the senior university officers responsible for administration of education for health and medical sciences). It should be concerned primarily with the administration and financing of physician education and education for health and medical sciences as a part of the total university.
- *Council of Faculty*—This council should provide for all participation of faculty representatives, selected for their broad interest in education for

health and medical sciences. It should be concerned primarily with matters of curriculum, educational content, and educational methods.

Proposals and recommendations of the councils should be exchanged with one another for study and comment before they are presented to executive council.

(9.2) COMMISSIONS

Commissions should provide opportunities for direct participation of affiliate members in matters of particular interest to them and related organizations, and should encourage interchange with institutional members. They should be formed by principal types of organizations to provide points of attention and communication about problems or topics of interest common to each type of organization.

Commissions should afford means of communication, discussion, and advice; they should not be legislative in nature; they should not ordinarily take formal actions. The commissions should not be separate organizations. Each should be a part of the association organization through membership ties or by active participation as related organizations.

It is recommended that three commissions be established to consist of approximately equal representation of (1) affiliate members or related organizations and (2) institutional members. The commissions should include:

- *Commission of Related Health Organizations*—This commission should provide for participation of representatives of these organizations on matters of particular interest to them in education for health and medical sciences and interchange with representatives of institutional members.
- *Commission of Teaching Hospitals*—This commission should provide for participation of affiliate member teaching hospitals on matters of particular interest to them and interchange with representatives of institutional members.
- *Commission of Teaching Organizations*—This commission should provide for participation of representatives of affiliate member organizations concerned with various facets of education for health and medical sciences, interchange among them on educational matters, and interchange with representatives of institutional members.

(10) COMMITTEES

Provisions should be made for discussion and exchange of views on major association matters in appropriate committees of members. Committees should be appointed by and, in most instances, report to executive council. Committees should serve as avenues for reviews, screening, and recommendation on matters requiring official action by executive council or general assembly.

It is recommended that "standing committees" be established as general committees representing executive council to maintain cognizance and review of the main over-all aspects of the association's concerns and to bring appropriate recommendations to executive council. Standing committees should ordinarily include at least one executive council member. Other members should be appointed primarily from among institutional

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representatives. There should be minority representation from affiliate members and related organizations, when appropriate.

The number of standing committees should be limited. They should be established only for major subjects of concern to the whole work of the organization and all its membership. Such committees as the following are presently considered to be needed:

- Program committee
- Finance committee
- Accreditation committee
- Public interpretation committee
- Government relations committee
- Research committee

Since executive council is a small group able to meet relatively frequently for over-all coordination of association work, no need is seen for a separate executive committee or administrative committee for coordinating purposes.

"*Ad hoc* committees" should be formed and appointed by executive council when specific important matters requiring review do not fall logically within the purview of one of the standing committees. *Ad hoc* committees should be designated for specific purposes, assigned clear responsibility, established for definite limited periods, and disbanded when their tasks have been completed.

"Program subcommittees" reporting to the program committee should be appointed to review and provide guidance for each major program undertaken by the association. These major programs will ordinarily be those for which major units of staff organization are established.

Program subcommittees should be concerned with program content and approach, and not with day-to-day administration. They should not have direct authority over either the chief executive officer or principal staff members assigned to programs. Program subcommittees should maintain familiarity with programs, review new proposals, and bring appropriate observations and recommendations to the program committee.

(11) STAFF ORGANIZATION

A suitable plan of staff organization should be developed to administer association affairs and carry on programs and services. The staff should be responsible to the governing bodies of the association, under the direction of and through the chief executive officer (who should hold the title of "president").

The plan of staff organization should be carefully re-examined after the program structure and structure of services are decided upon and authorized, as recommended earlier in this chapter. The plan of staff organization and units should be established to parallel the program structure and services authorized. In keeping with this parallel, specific staff units should be designated to provide staff support to standing committees and program subcommittees.

Requirements for numbers and types of persons to staff the organization should be reviewed in relation to the authorized program and service

structure decided upon. Recommendations on staff organization and staffing requirements should be submitted to executive council by the president, together with program and budget recommendations.

(12) REGIONAL ORGANIZATION

It is clear that there are regional differences in interests and problems related to education for health and medical sciences. The five regional meetings of medical school deans held during this study of the future of medical education helped to make this apparent and were extremely worthwhile.

It is recommended that provisions be made, in the revised plan of organization, to extend and encourage participation and communication within regions. Opportunities should be provided for expression of views and recommendation by regional groups to the over-all association. A definite organization plan will be helpful to provide systematic consideration and specific expression on major matters. However, the aim should be to conduct regional affairs as flexibly, informally, and economically as possible.

Interchange among institutions in each region should be furthered by regional arrangements. These arrangements should advance communications, provide forums, and facilitate expression and action. Regional groups should give first attention to matters particular to their regions. They should also provide channels for discussion on major subjects of national scope. Furthermore, regional arrangements should be such as to encourage constructive involvement of faculty members.

To further these aims, *it is recommended* that "regional assemblies" be established by member institutions in designated regions. The assemblies should parallel the composition of the general assembly of the association. They should be formed under association auspices and tied into the total organization.

Similarly, *it is recommended* that regional councils be developed paralleling the association councils and serving similar purposes at regional levels.

For these purposes, *it is recommended* that, at the outset, there be five regions: (1) east, (2) southeast, (3) north central, (4) central and southwest, and (5) west.

Ideas, proposals, or problems generated by regional assemblies or regional councils should be fed into the over-all association organization at appropriate points. Matters considered by regional assemblies should be forwarded to one association standing committee or called to the attention of one of the commissions. Regional councils should relate most closely to their parallel association councils. Reciprocally, the association general assembly, executive council, or councils should call major matters to the attention of regional bodies and solicit their study and comments or recommendations.

Subject matter groups or study sections may be a useful adjunct to regional organization, as noted earlier where advisory bodies are considered. Such subjects as student affairs, continuing education, and baccalaureate programs might fruitfully engage the attention of faculty members and others. Their logical points of contact in the over-all organization would be program subcommittees of the standing program

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committees. Care should be taken, as noted earlier, to focus the attention of regional groups on matters of greatest priority and program importance.

Finally, in terms of regional and local organization, *it is recommended* that study be given to the desirability of encouraging formation of local or institutional chapters of the association. Chapters could bring together the institutional representatives and individual members to foster, at the institutions and locally, the same leadership and scope of concern aimed for by the total association. Chapters should seek the widest possible participation by all those responsible for, related to, or interested in education for health and medical sciences.

By adapting its organization to regional needs and to the development of a forum for all educational associations concerned with health, the Association of American Medical Colleges can initiate an exchange of viewpoints within the broad range of this segment of higher education. Such a forum is deemed essential to mutual understanding and an improved definition of professional roles.

By serving as a central agency for collection and distribution of information about trends and needs in education related to health, the association can be an important source of objective data for use of all agencies concerned with health.

Given these attributes, the Association of American Medical Colleges could serve as an informed focal point of communication and liaison with governmental units, with professional associations related to health outside the educational setting, and with national agencies representing all of higher education. The strength of common purpose and understanding thus achieved could endow the association with a leadership role and the place of national spokesman for health-related higher education.

(13) PLAN OF ORGANIZATION

It is recommended that a definite plan of organization covering the governance, legislative functions, advisory duties, and staff functions be adopted. The primary organization structure and responsibilities should be based on the recommendations of this report or modifications that are worked out.

The recommended organization structure is depicted in two organization charts. Exhibit IX shows the recommended over-all plan of organization of the association. Exhibit X portrays the recommended plan of advisory and regional organization. Definite responsibilities should be assigned within this structure and clear-cut working relationships indicated.

6. RELATIONSHIPS

Much has been said in this report about the need to expand the philosophy and enlarge the scope of work of the association. Emphasis has been placed on the leadership role the association should play in the nation. This new and expanded role will require establishment and maintenance of effective relationships. Thus, it is essential that the association gives specific and positive attention to the nature and effectiveness of its relationships with many groups, organizations, and institutions.

There are a number of important relationships to be recognized. Those

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EXHIBIT IX

RECOMMENDED OVER-ALL PLAN
OF ORGANIZATION FOR
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

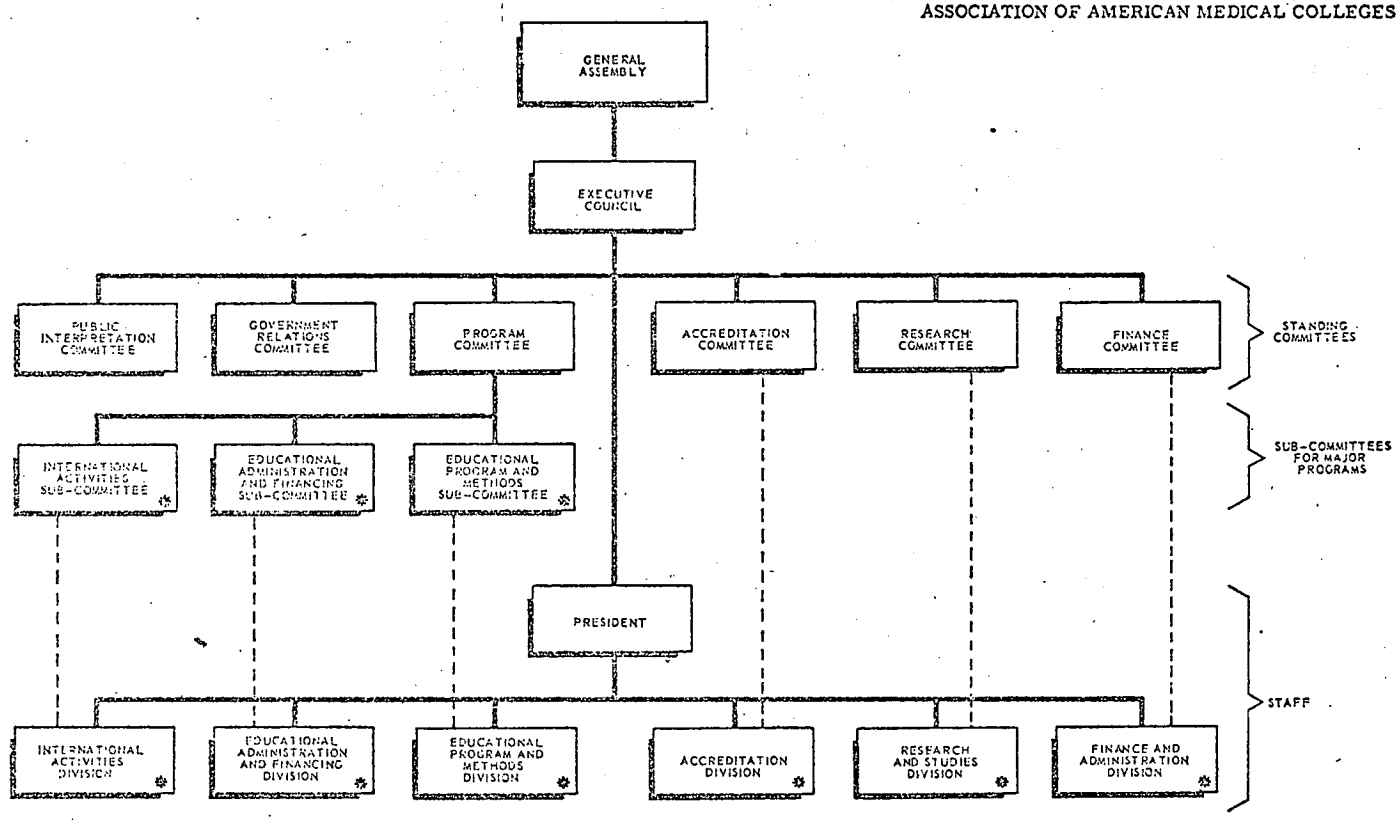

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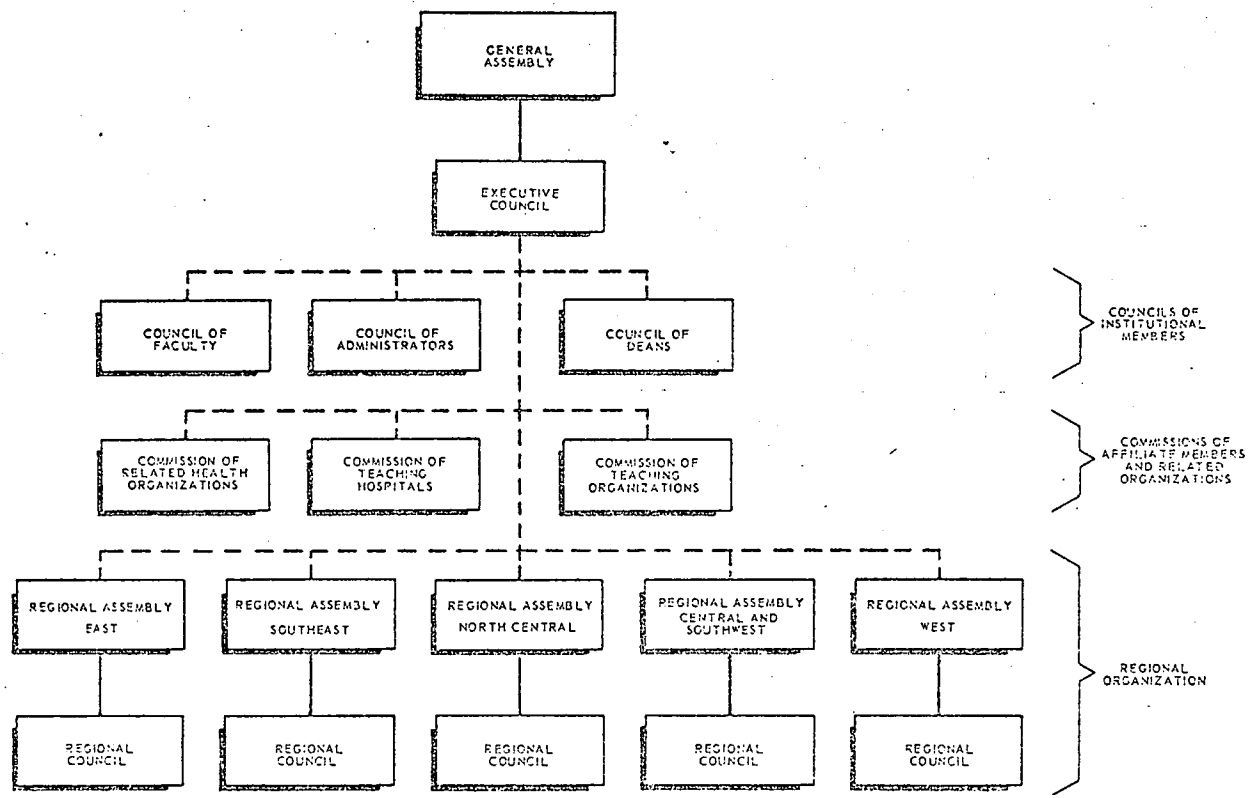
EXHIBIT X

RECOMMENDED PLAN OF ADVISORY
AND REGIONAL ORGANIZATION FOR
ASSOCIATION OF AMERICAN MEDICAL COLLEGES



within the education community are basic and require prime effort. Certainly, relationships within the health and medical field are vital. Key ties with other organizations must be significantly expanded in keeping with the broader concept of the whole of education for health and medical sciences and the leadership role of the association.

Beyond these, there are vital relationships to be enhanced at all levels of government, particularly the United States government. It also should be recognized that understanding and support by the general public is fundamental to the main aim of the association of improving health and health care.

(1) THE UNIVERSITY

As emphasized in earlier chapters, the university must be the focus of educational relationships and should be an object of particular attention by the association. In many states—California is a leading example—the university is the only institution that can bring together all aspects of education in the health field.

It is recommended that strong effort be made to involve university presidents in consideration of health matters and in major association matters. Similarly, university vice presidents responsible for health programs and medical centers should be encouraged to participate in association affairs.

In a practical way, the programs, services, activities, and meetings of the association should, wherever possible, engage the interest of all elements of the university concerned with education for health and medical sciences. These are vital intramural relationships. They include:

- Research units
- Dental schools
- Schools of nursing
- Schools of pharmacy
- Hospitals
- Graduate schools in life sciences
- Undergraduate colleges or colleges of arts and sciences
- Planning offices

(2) RELATED HEALTH ORGANIZATIONS

The role of leadership demands the development of positive and active relationships with other organizations in the field of health and medical sciences. *It is recommended* that the association earnestly seek positive and active relationships with key organizations interested in all aspects of education for health and medical sciences. It should lead organizations interested in this field of education to consider together their mutual interests and significant problems of common concern.

The association should focus its efforts on strengthening education. It should lead and coordinate action of related organizations with respect to education. This can and must be done without any attempt to dominate them or assume responsibility for their affairs. Programs and meetings

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should be designed to facilitate participation by representatives of other organizations. Joint projects, studies, or meetings should be undertaken on matters of common concern with one or more interested organizations.

A special relationship should be cultivated with those organizations most closely involved in education, such as organizations of teachers and researchers in special fields. They should be encouraged to schedule their major meetings at the same time and place as association meetings. In time, provision might be made for a physical as well as symbolic "home" for the smaller organizations of teachers and researchers. As noted earlier, meeting arrangements and office services might be made available on a cost basis. Ultimately, facilities might be provided that would bring the related organization into closer proximity with the association and with one another.

Hopefully, a more active Association of American Medical Colleges, with participation of many more persons—including faculty members—provided for, will make it less necessary for new, smaller organizations to be established.

(3) ROLE AS SPOKESMAN

As a key part of its generally enlarged role, *it is recommended* that the association serve as spokesman for organizations concerned with education for health and medical sciences. In keeping with this leadership role, the association should seek to develop and represent the common views of these organizations.

Because the physician is what he is within the health and medical professions, and because the medical school is what it is within education for health and medical sciences, the association is the proper body to be responsible to speak for this entire educational field. No other organization is in a comparable position to bring together and express a comprehensive view.

Of course, to fulfill this role effectively, the association should significantly expand participation in its affairs by all concerned with the field and substantially enlarge its relationships. It should lead in identifying matters of common concern in education and bring interested groups together to develop and express shared viewpoints. Care should be taken to assure that the views of all properly interested organizations are indeed heard and considered before common views are expressed. Expressions in behalf of the interested organizations should ordinarily be limited to major educational matters of vital concern to all or most organizations in the field. However, the association should feel free to speak more frequently on matters of singular interest to physician education.

Many organizations which alone can make little impact, due to their size or limited specialization, can have meaningful voices through the association. Most organizations understand this and look to the association to speak for education in the health and medical sciences. Other organizations concerned with the field should be led to recognize the common interest and share in the examination of subjects and development of common views for expression in their mutual behalf.

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(4) UNITED STATES GOVERNMENT

It is recommended that the Association of American Medical Colleges take the initiative in developing United States government interest in and support of education for health and medical sciences. The association should determine needs and present specific proposals for legislative and administrative action. The association should not merely respond to requests of the government, but should assume leadership in relationships with government.

Of all the external forces affecting education for health and medical sciences, government has come to be the most important of all. Matters of United States government policy and programs are increasingly important and influential to education for the health and medical sciences. The needs and demands facing education in these related fields are such that government attention and assistance are essential. Conversely, government programs in this country and abroad are placing major demands on educational institutions and the existing supply of health personnel.

High officials of both the executive and legislative branches of the United States government have expressed desire for closer relationships with and assistance from the association. Previous sporadic efforts have provided good response, but have not been consistent or systematic. They have not been fully effective, as a result. Other educational organizations that maintain systematic contact with the government report that it has proved worthwhile, both for the educational interests involved and for government needs and the general public interest.

Along with these relationships, it must be recalled that state governments, through laws, regulations, and appropriations, have significant effect on all aspects of education. Care needs to be taken by the member institutions and organizations, and the association should assist them in every way possible to establish and maintain sound and helpful relations with state governments.

(5) REPRESENTATION IN WASHINGTON

The major recommendations of this report emphasize the need for the Association of American Medical Colleges to provide broader and more forceful leadership and to take the initiative in serving the interest of the field of education for health and medical sciences. This means that closer relationships must be established with the federal government—especially in Washington, D.C. This also means that closer relationships will need to be developed and maintained with other organizations primarily interested in higher education—organizations that are, in most instances, headquartered in Washington.

It is, therefore, recommended that the association establish regular representation in Washington, to fulfill its leadership role and assure effective continuing contacts with the United States government and other organizations primarily concerned with higher education. It should continue and enlarge the steps already taken in anticipation of the recommendations of this report.

Regular representation in Washington should enhance relationships with the United States government and with the many educational and scientific organizations now located in the capital. Regular representation

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will assure much more effective means of gathering information of importance to education for health and medical sciences and of providing information promptly upon request by government agencies or officials and others.

Association representation should emphasize initiative in serving the interests of education for health and medical sciences. It should also extend to gathering information and making it available to members and related organizations, providing information to others upon request, and expressing views when requested.

Initially, a substantial part of the time of the association's chief executive should be spent in Washington. He should establish and maintain key contacts with members and staff of the United States Congress, with executive officials in government agencies, and with other organizations. Key elected officers of the association should work with the chief executive in developing and maintaining Washington relationships.

(6) THE AMERICAN PUBLIC

It is recommended that the association expand its efforts to interpret to the American public the objectives, programs, and needs of education for health and medical sciences. Positive and comprehensive interpretation will be increasingly important to the development of public understanding. Public understanding and support for the field of education for health and medical sciences will be vital in decades immediately ahead.

It was pointed out in Chapter III that the general public is much better informed and much more specifically concerned about health requirements and problems than ever before in history. This is, in large part, the product of persistent effort by those professionally responsible for health matters to draw attention to them and engage the interest of the public in health improvement.

Now that the interest generally exists, conscious and systematic attention needs to be given to improvement of the association's information to and relations with the general public. Greater emphasis should be placed upon national and public health needs and actions being taken or necessary to meet them. This should be evident in deliberations of the association at its meetings, in the statements of association officers, executive council members, and staff, and in association publications.

A basic attitude should be established that public interpretation and public relations are the concern of all officers, leaders, and staff of the association. All actions, statements, or publications of the association and of its officers, leaders, and staff should take account of public information and relations considerations.

It is recommended that serious consideration be given to the development of public interpretation services and that qualified professional assistance be obtained to do so.

Systematic and appropriate effort should be made to establish effective favorable contacts and to provide suitable information to various types of public information media, including the major professional journals, and to organizations interested in education for health and medical sciences.

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7. FACILITIES

Looking to the future, it seems certain that the association's programs, services, and general level of activity will enlarge appreciably, whether as a result of the recommendations of this report or for other reasons. To meet the needs that can be foreseen, the association's facilities should be improved and enlarged to the extent possible. Facilities should reflect and complement the expanded leadership role of the association. They should be adequate to serve program and service requirements and the staff that works to meet them.

(1) RELOCATION TO WASHINGTON

To satisfy most effectively the ultimate aims and goals, it is essential that the association have its principal office in Washington, D.C. ***It is recommended*** that initial steps be taken leading to eventual relocation of association headquarters in Washington. Although a move is not of immediate urgency, a definitive decision to move should be made soon, so that a transition can be effected in an orderly, practical manner.

Recognizing the urgency of having some facilities in Washington immediately, a preliminary recommendation was submitted to executive council during this study to the effect that the association should proceed to establish a Washington office. This has been done.

Location in Washington will bring association offices and staff in closer contact with more organizations with which the association must maintain important and frequent communications. In addition to the many United States government bodies, agencies, educational associations and institutions referred to in earlier sections, an increasing number of professional and other organizations have headquarters in Washington. Nearly all organizations of direct concern to the association already have established representatives there. Furthermore, many university presidents and principal health officers make visits to Washington a relatively routine affair and are easily accessible there.

It is evident that association headquarters will need to be relocated or expanded in any event to meet present and foreseeable space requirements. Therefore, plans for relocation and plans to meet total facilities requirements should be made as part of the same considerations. Plans should be developed carefully, with regard for factors of costs, and could well be implemented gradually over a period of years.

It is recommended that a thorough study be made of future facilities requirements with the intent of relocating headquarters in Washington. An *ad hoc* committee should be appointed by executive council to examine future facilities needs and consider alternative possibilities in Washington. Committee and staff study of facilities requirements should proceed concurrently with and should be governed by findings from the re-evaluation of programs and services recommended earlier and the consequent requirements for facilities to support them.

Various alternative possibilities for providing facilities should be considered, among them:

- Indefinite location with an appropriate educational or scientific organization, if such space is available.

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- Lease of suitable space in an office building.
- Construction of a new building, replacing the present owned property.
- Joining with other organizations in the health and medical field or the field of higher education to lease or construct a facility for joint occupancy.

(2) IMPROVEMENTS IN EVANSTON

Meanwhile, as plans are developed on the premise of relocation to Washington, *it is recommended* that interim improvements be made in the headquarters and other space in Evanston. It is apparent that the establishment of an initial office in Washington will not reduce or relieve the present need for space in Evanston. Steps should be taken to meet these needs. Of course, the extent of improvements and their timing will be affected by the over-all program and facilities plans and the time phasing of future developments, but the present situation should not continue in abeyance indefinitely.

Central program activities should be located in the central building as a matter of priority utilization. Service activities and equipment which do not need to be located in close proximity to executive and program activities in order to meet their requirements should be located elsewhere. Suitable consolidated rental space should be sought at which all or most service activities could be brought together outside the central building.

No permanent or extended commitments should be made for space in Evanston or elsewhere until the study of future facilities has been completed and a plan agreed upon.

8. FINANCING

Although not within the direct assignment of this study, the financing of the association and its programs and services is vital. Some evaluation of the present financing of the association was made earlier. It appears pertinent and may be helpful to offer also a few observations about future financing.

There is little question that expenditures for the operation of the association, the conduct of programs, and the provision of services are going to and should increase. This will unavoidably mean increases in the requirements for funds for the association itself which must be faced and provided for. However, there are means of limiting and channeling expenditures and shaving necessary expenses which need to be considered, too, so that available funds will be used in the most prudent and effective manner possible.

(1) NEED FOR GENERAL AND PROGRAM FUNDS

A vital need of the association is to provide for more and a higher proportion of general funds that will be available for flexible application by the association. Such funds provide the means needed to take advantage of important opportunities and to achieve the greatest creativity.

Membership dues are, of course, a prime source of funds, along with the revenues from some of the general services for which the association charges. In addition, certain types of grants contribute importantly to general and program funds. Positive effort should be made to obtain such grants.

It is important to recognize the relation of a consciously thought out program plan and set of services to the realization of general and program funds. It is increasingly rare that external funds in significant amounts become available unless there is definite indication as to how they will be used. With a well-planned over-all program, it is possible to approach prospective donors to make contributions in terms of definite proposals, intentions, and needs rather than the too frequent alternatives of choosing between vague statements of general purpose or precise, inflexible details within a restricted project.

There is no need to rule out specific and limited contributions. Rather, the emphasis should be to bring such contributions within the framework of the over-all program by seeking them and directing them in terms of the program. Instead of a patchwork of projects developed at the scattered initiative of individual donors, staff members, or other interested parties, the organization can gain flexibility and direction in its effort by assuming the initiative with a program. The program becomes the vehicle to seek out, attract, and apply specific contributions as well as general funds. In this way, the contributions serve the same essential purposes as if they were given without limitation.

Thus, *it is recommended* that the association make positive, systematic, and persistent efforts to develop general financial support and support for major programs. This should be done in terms of a carefully developed, comprehensive, and definite program plan worked out as recommended earlier in this report. When funds are available only for restricted purposes, they should be sought and channeled to the requirements of planned programs. Contributions for specific projects should not ordinarily be accepted unless they meet the needs of planned programs.

The program should come first, and then the financial resources to make it possible. A sound program will attract resources—lack of a program is too likely to produce unrelated resources and scattered efforts.

(2) SOURCE OF FUNDS

The association should seek to obtain maximum financial support from all sources available to it. It should not become too dependent on any one source.

First and basic reliance should be placed on the support of its members in dues, payment for services, and meeting necessary expenses. It is their association and they should sustain it and make it viable. If they are not so strongly interested and involved that they are prepared to do so, it will be difficult to attract external support for broader purposes.

In addition, though the association has the decided benefit from revenues of important, long established, and needed sources which are available to it, the revenues from such key sources as the Medical College Admission Test and National Intern Matching Program should be used to the best and fullest advantage. Necessary amounts should be reinvested in the testing and improvement of the services or for related purposes.

The association makes important broader contributions. Over the years, foundations, corporations, and government have all contributed funds to support undertakings of mutual interest. As in the past, the association

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should continue to look to these more general sources for help in sustaining and improving its work.

The association should increasingly be concerned with the whole of education for health and medical sciences and with national health needs and general public welfare. It is appropriate, therefore, that public and private sources continue to be looked to for support. The association should make its purposes, program, and accomplishments widely known to general and philanthropic sources and endeavor to elicit their interest and support. Charitable foundations, funds and endowments, bequests by individuals, and major current contributions should all be regarded as important potential sources.

The association should exercise care to see that donors are well informed concerning the results achieved with funds they have provided. Carefully prepared acknowledgments and reports should be given to all significant donors, regardless of their requirements.

It is recommended that government support be more actively sought for the association's programs, to the extent and in the form funds may be available. Where the association sees needs in the field of education for health and medical sciences that it or others should meet, the association should take the initiative in seeking government funds for these undertakings. In some instances, it may be desirable to urge the appropriation of funds for major specified purposes.

At present, various forms of contracts provide an important means by which many organizations gain resources to assist their basic efforts. It is important that contracts be considered carefully in relation to the objectives, priorities, and program of the association. If proposed contracts are in accord with the basic guides, they may well provide important and constructive adjuncts to the association's own work. On the other hand, if contracts are not in keeping with the association's program, they are likely to cause diversion of time and effort by top leaders and staff. Such contracts should not ordinarily be undertaken unless there are compelling considerations of public service. The association should continue to provide services to other organizations, but should charge for them.

(3) FINANCIAL MANAGEMENT

As has already been recognized, improved financial management is essential to the most effective functioning of the association. A major step should be to develop clear budgets related to programs. The budgets should be the annual financial expression of the intended programs and services of the association, and should be the product of careful review of all current activities, together with any proposed expansion or additions of new activities.

To meet this need, *it is recommended* that the association adopt a program approach to budgeting. To do so, revised budget procedures, calendar, and format should be developed.

Upon approval of the annual budgets by executive council, it should serve as the working guide for all expenditures or commitments unless changed by executive council. Direction and control of expenditures should be in relation to authorized programs and services. Clear current reports of financial progress and status in terms of programs and services should

be available to principal staff members, the president, and executive council. Some initial steps to achieve this have already been taken.

Effective financial management is important also in developing significant financial support from external sources. Clear evidence of effective productive program and financial management should be provided to past, present, and potential donors, as well as the basic integrity and prudence that is already well known. Each donor should be able to perceive in the association's information a clear-cut relation between programs and expenditures and to determine the disposition of funds and resulting accomplishments in which he is mainly interested.

(4) REDUCING SUBSIDY EXPENDITURES

Demands on the association are great and financial requirements substantial. It has been noted previously that they are quite likely to increase. Therefore, it is essential that the association limit its expenditures and its share of joint expenditures to the fullest extent possible consistent with its objectives. This is important so that funds available from dues, revenues, and contributions can be applied, to the maximum extent, to essential program activities through which objectives can be achieved.

There are only limited reasons why the association should in any way subsidize expenses of other organizations, activities of its members, or services to them. Some subsidies may be essential or serve a useful purpose, but should be undertaken only after careful consideration and conscious decision.

It is recommended that actual or possible subsidy situations be examined and eliminated wherever possible.

The re-examination should extend to:

- *Dues*—The dues charged should be sufficient to meet the proportionate cost of basic overhead and general benefits and services received by all members according to the class of membership, except as these are consciously offset by funds from other sources. Some latitude and adjustment will need to be made in the case of individual memberships, so as to encourage individual participation. In general, members should pay their own way and should not be a net expense to the association.
- *Meetings*—Meetings should, wherever possible, be designed so those attending will meet all or most of the costs involved through fees or other charges. Meetings should be attractive enough and important enough that those attending will be willing to meet necessary expenses. Certain meetings, of course, will be of such general importance to the entire membership that some or all of the costs can properly be met from general funds.
- *Specific services to members*—Services rendered to individual members or small groups of members should ordinarily be paid for by those receiving the benefits, or at least a major portion of the cost should be recovered. The association should consider carefully the establishment of any service that benefits only a limited number of members, although such selective services may serve useful experimental or demonstration purpose or otherwise serve objectives.
- *Contracts*—In no instance should contracts be undertaken without reimbursement of full costs to the association. All contracts should recover both direct expenses and overhead. Negotiations and provisions for all contracts

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or similar arrangements should assure that all costs are fully covered, including ample allowance for overhead. The association should not subsidize the United States government or other organizations for whom contract services are undertaken.

- *Travel of officers and others*—It should be established as general policy that the travel expenses of persons holding offices or taking part in assigned association work should be met by the association. Wherever such costs can appropriately be charged to contracts, this should be done.

Review of these and related financial practices should aid in improving the financial position of the association and do much to ensure the availability of funds needed for priority programs and services.

* * * * *

The specific observations and recommendations set forth in this chapter were considered within the context of a most critical period in medicine. It was also assumed that the educational phase is one of the most important elements of the field of medicine.

As the study developed, it became more and more apparent that the Association of American Medical Colleges is obligated to consider itself as the chosen instrument in leading the way toward many of the most important major adjustments. Minor refinements are not believed to be satisfactory. The report has sought to point directions and chart a broad course for that development.

Some recommendations may appear self-evident and overdue for implementation. Others, although seemingly desirable, will require more elaborate exploration and agreement by the best minds of medicine.

There are important national, educational, and professional interests that must be served, and the association is the proper body to guide the way. There seem to be no convincing reasons why it should not rise to the challenge of the emerging trends in health care and respond effectively to their implication for education for health and medical sciences as it relates to other spheres of medical activity. By so doing, the association will best serve its ultimate purpose of the improvement of health and thereby the welfare of all people.

COTH History

9/11/85

In November of 1965, the Association of American Medical Colleges took one of those bold steps that must occur occasionally in any vital organization which is to survive in a changing world. After a lively debate, the membership of AAMC--which includes all of the nation's medical schools--voted to establish as an integral part of the organization a Council of Teaching Hospitals.

The action amounted to a recognition of the increasingly important role in medical education of the teaching hospital, and more importantly, its Administrator. As with any major change in a long-established organization, some of the Medical school deans present at the meeting had misgivings. After all, some pointed out, a Teaching Hospital Section had existed within AAMC for seven years. Why elevate the hospitals a voting status in an organization that was comprised exclusively of heads of medical schools?

But it quickly became clear that elevation of Teaching hospitals to a major role within the organization was an idea whose time had come. The proposal carried and the Council of Teaching Hospitals, thereafter referred to as COTH, was formed.

Actually, the role of the teaching hospital, where aspiring physicians begin to put classroom theories into practice, had been in a sharp ascendency since the end of World War II. In many

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respects, this growth parallels the role of the Federal government in supporting medical education and reseqrch and in lending massive aid to the construction and equipping of hospitals. Billions of dollars were being pumped into the various facets of health education, research and care, and the public was eager for more and better medical care that the new national prosperity afforded.

No longer was the teaching hospital merely a place where the sick--and more often than not the indigent sick--went for treatment. No longer was the teaching hospital merely a staging area for the practical aspects of medical education. The hospital, particularly the teaching hospital, was a booming and vital institution where exciting new events in the progress of medical care were occurring.

Naturally, this new era was placing greater demands on the teaching hospital administrator. It was to be expected that these harried executives began to consult with each other on common problems. Before long regional groups of teaching hospital administrators had begun to band together to discuss matters of common interest. It was only a matter of time before the idea of organizing teaching hospitals on a national scale would be put forward.

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In March of 1958, Duane E. Johnson, Administrator of the University of Nebraska Hospital, sent several follow teaching hospital administrators an "urgent" memorandum. He had, the memorandum reported, been conferring with Tom Coleman, public information director of the Association of American Medical Colleges, concerning possible participation by University teaching hospitals in the annual program of AAMC. Subsequently, Johnson was notified that Dr. Ward Darley, AAMC's Director, "would like very much to include our hospitals in the umbrella of membership of their parent colleges."

The possibility appeared to Johnson to be a "wonderful opportunity to meet and discuss projects and administrative issues with the leaders in the medical college administration over the United States."

Would the teaching hospital administrators be interested?

A typical answer was one from Dr. Donald J. Caseley, Medical Director of the University of Illinois Research and Educational Hospitals. Although several regional organizations already had been formed, Dr. Caseley replied, "it follows quite logically that a national approach to the unique and common problems would be appropriate."

The ball began to roll quickly. In May of 1958, a meeting was held at the State University of Iowa to plan for a proposed new Teaching Hospital Section of AAMC.

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It was suggested that the principal teaching hospital of each medical school be represented at the meeting. Purpose of the new organization, Dr. Darley informed the AAMC membership, would be "creation of a forum for the study of the role of teaching hospitals in medical education as well as providing an opportunity for this section to participate in the annual AAMC meeting with the medical educators of this country and thus establish a greater understanding between teaching hospitals and medical school administrators."

The Iowa City meeting, to no one's surprise, heartily endorsed the idea and the Medical School-Teaching Hospital Section of AAMC was formed. Gerhard Hartman, Ph.D., Superintendent of the University of Iowa Hospitals, was named Chairman. Dr. Caseley was made Vice-Chairman and Duane Johnson, Secretary.

In the ensuing months, plans were laid for the first meeting of the new section in conjunction with the AAMC's forthcoming annual meeting, Oct. 10-11 at Philadelphia. Hospitals of 80 of the 97 medical schools in the U.S. and Canada were represented at the Philadelphia meeting. Three discussion sessions launched the active phase of the new section. They dealt with "Significance of the Medical School-Teaching Hospital Relationship," "The changing Pattern of Medical Education," and "Private Patients in Teaching."

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The founders of the new Teaching Hospital Section had two specific objectives in mind as they forged the initial shape of the new group. They felt it was imperative to develop a sense of identification on the part of the hospital administrators with the broad field of medical education. And, they wanted to enhance the understanding on the part of the deans of the operational, financial, community relations and patient care problems of the medical school teaching hospitals.

In a [redacted] retrospective letter to Dr. Darley after completion of the initial formative steps, Dr. Caseley [redacted] ticked off a list of subjects that he and the other founders felt could be profitably dealt with. They were:

--Medical School-Teaching Hospital-University relationships.

--Financing of the Medical School-Teaching Hospital.

--Problems relating to the unique position of the Medical School-Teaching Hospital in the community.

--Identification of costs specifically related to teaching and research in the operation of the Medical School-Teaching Hospital.

--Private Patients in the Medical School-Teaching Hospital.

--Who should pay the resident---the Hospital, Medical School, or both?

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--What is the role of the internship in the Medical School-Teaching Hospital?

--The role of the teaching Hospital in postgraduate education.

--Federal Health programs and their influences on the Medical School-Teaching Hospital.

With questions such as these facing both the Deand and the Administrators, the founders felt that "the entire process of medical education would be strengthened by this mutual understanding between deans and administrators," Dr. Darley reported.

Dr. Lowell T. Coggeshall, former _____ and author of the landmark report_____ was an enthusiastic supporter of the new Council. It was obvious, Dr. Coggeshall recollects, that "as research and patient care and teaching became more closely related, the deans and administrators had to work very closely together--the education element and the service element and the teaching hospitals."

In February of 1959, the Hospital Section of AAMC suggested at a meeting formation of a Standing Committee on Medical School-Affiliated Hospital Relationships. This committee, Dr. Darley suggested, would be assigned the responsibility of

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[illegible] setting forth the [illegible] kinds of problems with which the Medical School-Teaching Hospital Section should be concerned.

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Although the teaching hospitals did, indeed, eventually organize under the umbrella of AAMC, there was some discussion in the early stages of affiliating with the American Hospital Association. Some administrators thought this would be a more natural affiliation. There also was some belief that the new group would be more comfortable in AHA, which was willing to co the idea, than in the AAMC, some of whose members were openly hostile to the proposal.

Much of this hostility was soothed by the very active presence of Dr. Darley who constantly stressed the intellectual need for an active role of teaching hospital administrators in AAMC. Dr. Caseley also helped heal the breach through his dual role as a teaching hospital administrator and an associate dean of the University of Illinois Medical School.

By the fall of 1959, the Section on Teaching Hospitals had developed to the point where the new group was ready for a much more active part in the annual meeting of the Association of American Medical Colleges. For two days prior to the AAMC meeting, the Teaching Hospital Administrators held an intensive series of sessions in Chicago.

At this meeting it was proposed that some changes might be made in the initial rule that each member of AAMC designate only one of the teaching hospitals with which the school is affiliated as a member of the teaching hospitals section.

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This proposal alarmed some of the members of AAMC who feared it might result in more administrators belonging to the organization than deans. Finally, it was decided that each dean would designate one teaching hospital administrator as the official, or voting, member of the section. In addition, however, it was decided that each dean would be allowed to appoint as many of his hospital directors as he may choose in addition.

At this point, the nucleus of interested persons who had founded the Teaching Hospital Section began to realize that the initially modest mission of the group would have to be expanded. An intellectual forum is a splendid concept, they realized, but such a forum must be followed up by action. The founding fathers began to concentrate on organizing stimulating programs that, in addition to challenging intellectual quality, would have more substantial meaning for the members. In June of 1960, a committee was appointed to study medical school teaching costs. At the previous meeting of the Teaching Hospital Section, Ray E. Brown, then Administrator of the University of Chicago Clinics, outlined some of the problems relating to the nebulous financial relationship which exists between medical schools and their teaching hospitals. The Executive Committee of the Section decided to inaugurate a study which could

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provide a body of useful and consistent information on the subject.

The next step in further integration of the Teaching Hospitals Section into AAMC was a recognition by the Executive Council that a device was needed to stimulate interest of the deans in the Section's activities. It was suggested in 1961 that at least one plenary session of the annual AAMC meeting be devoted to the common interests of the two groups.

Following the fourth annual meeting of the Teaching Hospital Section in the fall of 1961, Dr. Caseley reported to the membership that "the section seems to have firmly established itself as an integral part of the Association's activities and, to a substantial extent, has achieved the goals expressed by the planning committee in 1958."

Attending the 1961 meeting were representatives of over two-thirds of the medical school teaching hospitals and, in addition, a considerable number of deans attended one or all of the sessions.

The subject matter of the 1961 meeting illustrates the useful quality to which the sessions had evolved. Dr. Richard O. Cannon of the Vanderbilt University Hospital, and chairman-elect of the Section, discussed "The Educational Responsibilities of Medical School

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Teaching Hospitals." Dr. James A. Campbell of the University of Illinois, discussed "Valuation and Evaluation of the Clinical Externship," based on the preliminary and, at that time unpublished, findings by a committee of the Association and the Council on Medical Education. Dr. Campbell stressed the negative value of the unsupervised clinical externship where the student assumes responsibilities which are out of line with his preparation and training.

"Current and Future Problems of Residency Training in the Teaching Hospital," was discussed by Dr. William S. Anlyan, Professor of Surgery at Duke University. Dr. John C. Nunemaker, Associate Secretary of the Council on Medical Education and Hospitals, delivered a paper entitled, "The Responsibilities of the Medical School and Teaching Hospitals for Affiliated Intern and Residency Programs in the Community Hospitals." Other papers at the meeting included one by Dr. Cecil G. Shepps, of the University of Pittsburgh, on "The Responsibilities and Organization of the Medical Center for Medical Care," and one by Dr. John S. Millis, President of Western Reserve University, on "The Medical Center's Role Within the University Structure."

Those who attended the intensive sessions of the 1961 meeting left Montreal with the distinct impression that the Teaching Hospitals Section had arrived.

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The 1962 meeting of the Teaching Hospital Section devoted an entire afternoon session to a subject of growing importance to members---the role of the teaching hospital in research. A number of speakers from the National Institutes of Health took part in the discussions.

(Matt--I am simply unable to determine from all the material when the by-laws were adopted. This should be mentioned. And do you want to print them somewhere here?) (Maybe as an appendix?)

In 1964, the Teaching Hospital Section was presented with an opportunity to take a searching look at where it had gotten in six, fast-moving years and to assess the possibilities of the future. The AAMC charged Dr. Coggeshall and a newly forged committee to "study and make recommendations regarding the future objectives, structure and function of the AAMC..." The executive committee of the Teaching Hospital Section decided to draw up a prospectus of the role, function and objectives it believed appropriate for the section as part of the overall Coggeshall Report.

Moving with deliberate speed, the executive committee held a special meeting in New York early in May under the leadership of Harold Hixson, administrator of the University of California Hospital, and Matthew F.

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McNulty jr., Administrator of the University of Alabama Hospital and Vice Chairman of the Section. McNulty was later to become Chairman of the Section and, later, full-time Director of the Council of Teaching Hospitals.

The committee soon came up with a charter for the future of Teaching Hospitals' role in AAMC that foresaw "an accelerating rate of advance in science and technology and the art of medicine." As a corollary, the committee saw "hospitals playing an increasingly important role in the physician's practice of medicine, through the provision of the skilled human resources and the complex equipment required in modern medical practice. Particularly we see the teaching hospital as playing an even more important part in the clinical teaching of undergraduate students and interns and residents."

Teaching hospitals, through their administrators, should be more effectively organized as a body and should be further integrated into AAMC, the recommendations said. A "Teaching Hospital Assembly" was proposed as a constituent part of AAMC to allow broadening of the definition of the teaching hospital and to include a substantially greater number of institutions. The recommendations also called for a closer, more formalized liaison with the American Hospital Association and the American Medical Association.

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The proposed Teaching Hospital Assembly should have sufficient autonomy and freedom of action to ensure effectiveness of its program, yet should operate under the general umbrella of AAMC policy, the committee concluded. A broadened group of teaching hospitals, more effectively organized and funded could make a significant contribution to the strengthening of AAMC, the members said.

Dr. Coggeshall's report, titled "Planning for Medical Progress Through Education, was issued the following year. Teaching Hospital Section Chairman McNulty noted in a memorandum to institutional representatives that the report was "not too descriptive as to a precise role for the Teaching Hospitals." He expressed concern that the narrative and organizational charts pertaining to the hospitals appeared "to limit the role as envisioned by your Teaching Hospital Section."

But the early misgivings proved to be unfounded. In July of 1965, Dr. Robert C. Berson, executive director of AAMC, wrote Chairman McNulty that in discussing implementation of the Coggeshall report, AAMC's Executive Council was interested in possible establishment of four "councils" within the organization. These would be a council of Faculty, a Council of Vice Presidents, a Council of Deans and a Council of Teaching Hospitals.

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When AAMC met in Philadelphia that fall, the meeting was preceded by the 8th annual meeting of the Teaching Hospital Section. Chairman McNulty read the group a resolution recommending that "the present Teaching Hospital Section be converted into a Council of Teaching Hospitals with its voting membership to be determined in the same way as membership in the Teaching Hospital Section has been, and that the Council designate a person to be elected as a voting member of the Executive Council."

As the resolution later was explained to the membership of AAMC, its force simply was to change the name of the Teaching Hospital Section to Council of Teaching Hospitals, and to provide that the chairman of that group have a voting membership on the Executive Council. But to teaching hospital administrators, the change was highly significant. It meant that they, at last, were on the brink of full-fledged membership in AAMC and, more importantly, A LARGER ROLE IN THE ORGANIZATION the leadership of medical education.

But the action was not automatic. Again, the small group of deans who had viewed formation of the teaching hospital section with some suspicion again voiced their reservations about the move. As the AAMC's official proceedings of the meeting later reported in the Journal of Medical Education "there was active debate on establishment of the Council of Teaching Hospitals."

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"There was some reiteration of the cautious views expressed in earlier discussions," the Journal reported. The "dilution of dean's power" theme was referred to a number of times by AAMC members who feared that the proposal amounted to a power play by teaching hospital administrators. The need, felt by some deans, to recognize local diversity of medical school-teaching hospital relations was brought up several times. Some deans felt the status quo with the teaching hospital section should be maintained---that its potential within AAMC could be further developed without giving hospitals a voting and dues-paying status. Others expressed fear that hospitals which were not properly "teaching hospitals" would be brought into the membership. Some deans (although they) acknowledged that the trend toward increased recognition of teaching hospital administrators was inevitable, but wondered aloud whether AAMC should not accept the realities of the situation with extreme caution.

But the majority of the comments were wholeheartedly in favor of giving formal recognition to what AAMC and the Teaching Hospital Section had in fact been doing. Staff assistance and a vote on the Executive Council of the Association would provide the opportunity for a productive partnership with this essential segment of the medical center, proponents pointed out. Several speakers warned that failure to accept the proposal could discourage teaching hospital administrators sufficiently to push them toward

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formation of their own group.

The essential theme of the debate was the value of communication between deans and administrators and their staffs. One dean said that AAMC had reached the point in history where it was inadequate merely for deans to communicate with one another. Deans and teaching hospital administrators must communicate with each other, and must communicate with government and the public, the argument went. After a few spleens were vented, a vote was taken and the motion passed handily.

The new Council of Teaching Hospitals was granted one voting membership on the AAMC Executive Council---later expanded to three.

The following month, the Executive Committee of COTH met to approve rules and regulations for the organization. Several of the rules give a significant picture of the group:

PURPOSE AND FUNCTION---The council is organized as part of the program of the AAMC special activity relating to teaching hospitals. For this purpose, a teaching hospital is defined as an institution with a major commitment in undergraduate, post-doctoral, or post-graduate education of physicians. In keeping with the action of the AAMC, each medical school will designate a primary teaching hospital and other eligble institutions may be designated by schools or become members by virtue of meeting specific requirements

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in teaching programs as may be set up by the council from time to time. It is expected that the council will hold educational meetings, conduct and publish studies and take group action on various subjects concerning the teaching hospital. The council's program will be subject to the approval of the AAMC.

NATURE OF THE PROGRAM OF THE COUNCIL---As a part of the AAMC, the Teaching Hospital Council would develop, through the appointment of specific study groups, information concerning specific items or problems relating to hospital operation as it relates to the furtherance of education in medicine. The Council would conduct meetings for the presentation of papers and studies relating to education in hospitals and would stimulate, in addition to annual meetings, regional and local meetings of the educational type as seems indicated. The Council could also from time to time recommend group action on items considered of importance for the furtherance of medical teaching in hospitals and upon approval of appropriate bodies take action as indicated to further this objective.

When the Executive Committee of the new Council met the following March the members came to the conclusion that COTH needed a full-time staff member who could work with the Washington office of AAMC in the development of a legislative program affecting the particular interests of the teaching hospitals. This person should, the committee concluded,

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have a thorough understanding of the needs of the teaching hospitals and should be prepared to assist in gathering legislative information. The committee members also wanted a person who would be in a position of being a primary source of information to the legislative and executive branches of the Federal government as to the needs and requirements of the teaching hospitals. This staff member also would work closely with American Hospital Association, which long had maintained an excellent Washington office, the committee decided.

COTH didn't have to look far to find the man for the job. By the time for the annual fall meeting of AAMC--and COTH--Matthew F. McNulty jr. had accepted the new position.

McNulty outlined to the members of COTH an agenda for the future that neatly summed up the mission of the flodgling organization:

--To arrange a partnership of understanding, confidence and mutually sought objectives between deans of medical schools and directors of teaching hospitals---this partnership to be developed within the AAMC so as to produce relationships, beliefs, acceptances, actions and continued dialogue that would benefit teaching hospitals and schools of medicine in the service of the health welfare of the public with emphasis on education and in no way to diffuse the traditional patterns of leadership within the hospital field.

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--To serve as an organizational focus, informational center, and forum of discussion, analysis, policy formation, and prescription recommendation for the member teaching hospitals so that through comprehensive, voluntary, cooperative action, programs could be advanced directly, as well as the continued development of the environment for programs of medical education and education for other health sciences, and for the advancement of patient-care research.

--To provide a central location and a capability for identifying issues or problems of national, regional, and institutional concern through the accumulation of information, the exchange of ideas, the evaluation of such matters and, where appropriate, the recommendation and implementation of basic policy positions.

--To express collective views on particular objectives, in such broad subject areas as health science, health education and patient-care and health-care research, for the information of congress, various Federal agencies, foundations, institutions, associations, and other appropriate bodies, as such views result from the findings, judgments and positions, and projects of concern to the teaching hospitals, medical schools, and the public.

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COTH Director McNulty then outlined the following objectives for exploration by the Council:

--Funding of capital construction for teaching hospital activity, including such questions as how to modernize, expand or replace obsolescent and overcrowded facilities.

--All forms of reimbursement which relate to educational activity, such as federal agency reimbursement, Social Security Title XVIII and Title XIX reimbursement and Blue Cross reimbursement.

--Operational problems, with particular emphasis at this time on ambulatory patient clinics and emergency department activities.

--The role of the teaching hospital in community planning and in participation in extended-care services and home-care, visiting-nurse, and homemaker programs.

--The leadership responsibility of teaching hospitals, in cooperation with medical schools, to encourage merger and consolidation with other hospitals, establishment of satellite hospitals, and similar efforts at more effective and efficient health care which is of benefit to teaching programs.

--The continuance of medical education, including such questions as how and where it should be accomplished and how to improve the facilities and communication resources involved.

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--Funding and administrative operation of clinical research centers with emphasis particularly on the various factors of reimbursement.

--Creative Federalism---Social change has been overwhelming in the last two years. The impact of this change on the educational activities of the teaching hospitals has been considerable. In fact, some of the impact is not yet measurable. Certainly, much of the effect of "Creative Federalism" on teaching hospitals has been to produce reaction rather than leadership. The challenge to the teaching hospitals as a group is to provide creative, voluntary leadership to balance the effective creative federalism leadership. The absence of a balance over a long period of time would introduce distortions into the voluntary system.

It was more than happenstance that Teaching Hospitals were given new stature within AAMC in the year 1965. This was the historic year during which Congress passed more significant health legislation than any single year in the nation's history. Much of this legislation, including Medicare and Medicaid, was bound to have an impact on the postgraduate education of interns and residents in teaching hospitals.

The landmark legislation of 1965 and that of the ensuing years brought to a new peak the massive infusion of Federal funds into teaching hospitals for research and education.

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At the same time, the cost of medical care in the United States began a rapid spiral upward that alarmed the public in general and medical practicioners in particular. To the experts in health economics it became obvious that new methods of delivering health care to Americans at lower cost and higher quality would have to be developed. This amounted to a supreme challenge for the Council on Teaching Hospitals. The logical place for the necessary research and experimentation would be in the teaching hospitals.

As Dr. Coggeshall puts it. "You can't go into county hospitals and charge the counties (for the experimentation), or you can't go into private hospitals and charge the management for expensive research. You can't have such experimentation without the hospital administrator being a key man who understands what the policies are, particularly from the standpoint of cost consciousness."

"My charge to the council, as well as to the AAMC," says Dr. Coggeshall in the manner of a commencement speaker, "is to concentrate their efforts on developing a more effective medical care delivery system. Neither can do it independently. They must do it in complimentary fashion.

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Dr. Coggeshall agrees with many other experts in health care that the United States is working with an outmoded health care delivery system. The nation faces, and likely will face for many years to come, a critical shortage of health professionals, particularly doctors. But more numbers are not adequate to do the job, especially at a more palatable cost than the present price for medical care. The experts are unanimous that improvement of the delivery of h care must go hand-in-glove with training of more doctors and paramedical personnel.

This, the task of the 70's, will be largely borne by the members of the Association of American Medical Colleges and the Council of Teaching Hospitals will share heavily in the burden.

end

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THE NEW YORK HOSPITAL
Chartered 1771
525 EAST 68th STREET, NEW YORK, N.Y. 10021
TRafalgar 9-9000

OFFICE OF THE DIRECTOR

December 23, 1970

John M. Danielson, Director
Council of Teaching Hospitals
& Health Services
One Dupont Circle, N.W.
Washington, D.C. 20036

Dear John:

At the annual meeting of the Council of Teaching Hospitals (Eastern Contingent) on December 4th and 5th the matter of grouping of hospitals was discussed.

The effect of the change in the grouping of teaching hospitals in New York State for calculating Medicaid reimbursement was cited. As you know, the group of hospitals in metropolitan New York was expanded from six "primary" teaching hospitals to twenty-eight. The effect was to lower the average per diem cost and the reimbursement ceilings calculated from the average. Six hospitals were penalized by the new ceilings of which three were in the former "primary" teaching hospital group, or 50 per cent of the previous group.

The State Health Department justifies the change on two scores:

1. All of the twenty-eight hospitals are teaching hospitals as defined by AAMC-COTH.

2. Ceilings were calculated on "routine" hospital costs which should be comparable in all hospitals.

The basis for defining certain costs as "routine" is open to serious question, but it is not the matter of concern discussed at the COTH meeting. However, the first item, grouping of hospitals, was discussed at length and there was a concensus that this is a matter of national concern, one which needs urgently the attention of the national AAMC-COTH organization. We were asked to write to you on this matter in behalf of the group of institutions.

It is suggested that the AAMC-COTH review the membership with the objective of developing groups or categories within the membership. Clearly, not all of the member hospitals are involved to the same degree in undergraduate and graduate education nor are the hospitals comparable in size, complexity and expense of operation.

It would be helpful, we believe, if upon review, the section of the By-Laws relating to Teaching Hospital Members could be revised to delineate the differences and to subdivide the membership appropriately, grouping hospitals of comparable complexity and educational commitment.

Sincerely,

Stanley A. Ferguson
Executive Director
University Hospitals of Cleveland

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

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ASSOCIATION OF AMERICAN MEDICAL COLLEGES

INTER-OFFICE MEMO

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

DATE May 5, 1971

TO: For the Record

FROM: Dick Knapp

SUBJECT: Teaching Hospital Health Services Statistics

According to the most recent copy of the AMA Directory of Internships and Residencies (1969-70), there are 1,449 hospitals in the United States which participate in the graduate education of physicians. According to Table 24A on page 17 of that Directory these hospitals were distributed as follows:

Major Affiliates	376
Limited Affiliates	182
Graduate Affiliates	141
Hospitals without Affiliation	750
Total with Approved Programs	1,449

According to page 84 of the Directory, hospitals have been identified as major affiliates when a medical school has indicated that the hospital is a major unit in the school's teaching program. Hospitals are defined as limited affiliates when a medical school has indicated that the hospital is used to a limited extent in the school's teaching program. Graduate affiliates are used by the school for graduate training programs only. These definitions are somewhat general and lack precision; however, the AMA has informed me that they do not have a definition with any more substance.

Additionally, an actual count of the affiliated hospitals in the Directory reveals a descrepancy with the published table. Thus, the figures have been corrected as follows:

Major Affiliates	350
Limited Affiliates	168
Graduate Affiliates	126

Finally, included in the above group are long-term hospitals, defined as those which have an average length of stay over 30 days. It was felt that these long-term hospitals should be excluded from the analysis. The final grouping is as follows:

Major Affiliates	289
Limited Affiliates	129
Graduate Affiliates	95
TOTAL	513

COPIES TO:

Therefore, the attached tables reflect services provided in short-term general and other special hospitals (federal and non-federal).

Attachments

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SELECTED STATISTICS: 1969[a]

TABLE I

Affiliated vs. All Hospitals
(Federal and nonfederal short-term general and other special)

	Affiliated Hospitals	All Hospitals	% Affil.
Number of Hospitals	513	6,272	8%
Beds	237,408	926,581	25%
Average Daily Census	183,751	732,476	25%
Admissions	6,246,493	29,807,453	20%
Patient Days	67,069,115	267,353,740	25%
Personnel	569,255	1,969,879	28%
Payroll Expense	$ 3,078,007,000	$ 11,003,697,000	27%
Total Expense	$ 5,699,844,000	$ 18,298,654,000	31%

TABLE II

	Major Affiliates	All Hospitals	% Affil.
Number of Hospitals	289	6,272	4%
Beds	150,552	926,581	16%
Average Daily Census	115,591	732,476	15%
Admissions	3,755,556	29,807,453	12%
Patient Days	42,190,715	267,353,740	15%
Personnel	380,009	1,969,879	19%
Payroll Expense	$ 2,106,442,000	$ 11,003,697,000	19%
Total Expense	$ 3,837,794,000	$ 18,298,654,000	20%

TABLE III

	Graduate Affiliates	All Hospitals	% Affil.
Number of Hospitals	95	6,272	1%
Beds	36,768	926,581	3%
Average Daily Census	29,925	732,476	4%
Admissions	1,028,020	29,807,453	3%
Patient Days	10,922,625	267,353,740	4%
Personnel	78,019	1,969,879	3%
Payroll Expense	$ 414,985,000	$ 11,003,697,000	3%
Total Expense	$ 772,130,000	$ 18,298,654,000	4%

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TABLE IV

	Limited Affiliates	All Hospitals	% Affil.
Number of Hospitals	129	6,272	2%
Beds	50,088	926,581	5%
Average Daily Census	38,235	732,476	5%
Admissions	1,462,907	29,807,453	4%
Patient Days	13,955,775	267,353,740	5%
Personnel	111,227	1,969,879	5%
Payroll Expense	555,580,000	$ 11,003,697,000	5%
Total Expense	$ 1,089,870,000	$ 18,298,654,000	5%

TABLE V

	COTH Hospitals	All Hospitals	% COTH
Number of Hospitals	372	6,272	5%
Beds	209,978	926,581	22%
Average Daily Census	167,730	732,476	22%
Admissions	5,624,933	29,807,453	18%
Patient Days	61,221,450	267,353,740	22%
Personnel	561,709	1,969,879	28%
Payroll Expense	$ 3,725,849,000	$ 11,003,697,000	33%
Total Expense	$ 5,593,028,000	$ 18,298,654,000	30%

TABLE VI

COTH Affiliated Hospitals As
A Percentage of All Affiliated Hospitals

	COTH	Total	% COTH
Major Affil.	211	289	73%
Limited Affil.	55	129	42%
Graduate Affil.	38	95	40%
Total	304	513	59%

Total COTH Membership = 401

[a]Affiliations have been taken from the AMA Directory of Approved Internships and Residencies, November, 1969; service statistics are from Hospitals, Guide Issue, August 1, 1970.

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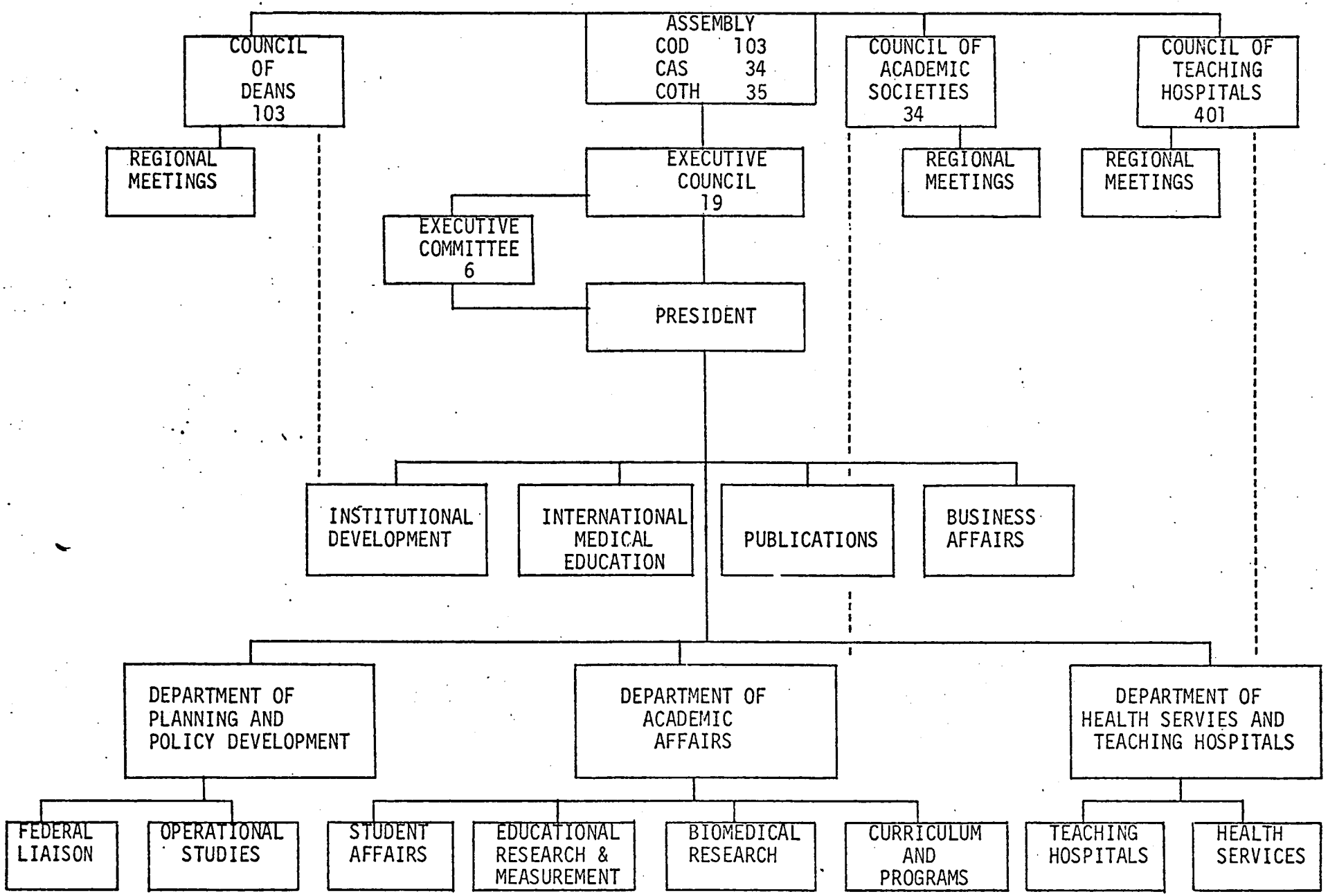
ASSOCIATION OF AMERICAN MEDICAL COLLEGES



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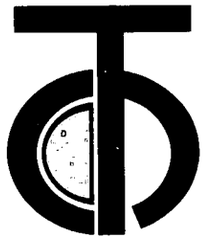
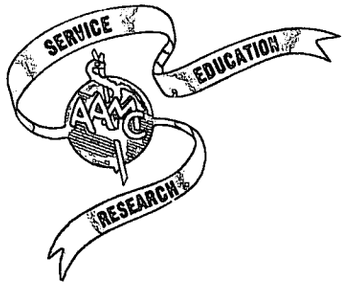


Association of American Medical Colleges

Council of Teaching Hospitals
Rules and Regulations

AS APPROVED
NOVEMBER 3, 1969

ONE DUPONT CIRCLE, N. W.
WASHINGTON, D. C. 20036
(202) 466-5127



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ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Council of Teaching Hospitals
Rules and Regulations

At the meeting of the institutional members of the Association of American Medical Colleges, November 2, 1965, the Association authorized the formation of a Council of Teaching Hospitals.

Purpose and Function. The Council is organized to provide, as a part of the program of the AAMC, special activities and programs relating to teaching hospitals. For this purpose, a teaching hospital is defined as an institution with a major commitment in undergraduate, post-doctoral, or post-graduate education of physicians. Each medical school may nominate and recommend to the Council for membership affiliated teaching hospitals. Other eligible institutions may become members by virtue of meeting specific requirements in teaching programs as may be set up by the Council and approved by the AAMC Assembly. The Council will hold educational meetings, conduct and publish studies, take group action on various issues concerning the teaching hospital and participate in policy making of the Association through its elected officers and representatives.

Nature of the Program of the Council. As a part of the AAMC, the Council of Teaching Hospitals develops, through the appointment of study groups, information concerning specific items or problems of hospital operation as they relate to the goals, purposes and functions of the Academic Medical Center. The Council conducts meetings for the presentation of papers and studies relating to education in hospitals. In addition to the COTH-AAMC Annual Meeting, other educational programs are conducted on a regional basis.

Membership in the Council. Hospitals as institutions are members of the Council and each institution designates a person for the purpose of representation in the Council.

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Eligibility for membership in the Council is determined on the basis of one of the two following criteria:

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

or

b. Those hospitals nominated by an AAMC Medical School Institutional Member or Provisional Institutional Member, from among the major Teaching Hospitals affiliated with the Members and elected by the Council of Teaching Hospitals.

Council of Teaching Hospital members are organizations operated exclusively for educational, scientific, or charitable purposes.

COTH Officers, Executive Committee, and Assembly Members. COTH officers and new executive committee members, and new representatives to the AAMC Assembly are elected annually by all COTH members. Each COTH institutional member is entitled to one vote.

There are nine (9) members of the Executive Committee, serving for three-year terms. Each year three (3) members are elected. In addition, the immediate Past Chairman, the Chairman, the Chairman Elect, and the Council of Teaching Hospitals' representatives on the Executive Council of the AAMC are ex-officio members of the Executive Committee. The Executive Committee meets as deemed necessary by the Chairman. The Executive Committee is authorized to conduct the business of the Council between meetings of the institutional members.

Operation and Relationships. The Council of Teaching Hospitals reports to the Executive Council of the AAMC, and is represented on that Council by three (3) COTH members. Creation of standing committees and any major actions are taken only after recommendation to and approval by the Executive Council of the AAMC.

The voting rights of the Council of Teaching Hospitals members in the Assembly of the AAMC are as follows: COTH is authorized to designate 10 percent of its members, up to a maximum of 35, each of whom shall have one vote in the Assembly. The Assembly is the constituent delegate body to which the AAMC Executive Council is responsible.

Staff, Expenses for Attendance at Meetings, and Dues. The Council of Teaching Hospitals will be provided adequate staff for the conduct of its work. The Executive Committee of COTH appoints standing and ad hoc committees. The committees meet as deemed necessary, with expenses of these meetings paid for by COTH.

The activities of the Council of Teaching Hospitals are financed by its members through appropriate dues established at a current rate of $700.00 per year.

T. Stewart Hamilton, M.D.
Chairman
Executive Committee
Council of Teaching Hospitals

Approved by the Executive Committee of the Council of Teaching Hospitals, the Executive Council of the AAMC, and the COTH Institutional Membership at its Annual Business Meeting, Monday, November 3, 1969.

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AMERICAN HOSPITAL ASSOCIATION

DUES STRUCTURE FOR 1971

Type I-A (short-term hospitals):	
Minimum	$ 357.00
Maximum	5,952.00
Rates based on total expense:	
First $2,500,000	77¢ per M
Second $2,500,000	46¢ per M
Third $2,500,000	31¢ per M
Balance	15¢ per M
Type I-B (long-term hospitals):	
Minimum	357.00
Maximum	1,190.00
Rates based on total expense:	
First $500,000	77¢ per M
Second $500,000	46¢ per M
Third $500,000	31¢ per M
Balance	15¢ per M
Type II (extended care facilities):	
Minimum	221.00
Maximum	736.00
Rates based on total expense:	
First $500,000	77¢ per M
Second $500,000	46¢ per M
Third $500,000	31¢ per M
Balance	15¢ per M
Type III (clinics):	357.00
Type IV-Regular (Blue Cross Plans in United States):	
Minimum	751.00
Maximum	22,560.00
Rate per subscriber certificate	.0466
Type IV-Associate (Canadian Blue Cross):	
Minimum	138.00
Maximum	2,783.00
Rate per subscriber certificate	.0047
Type VII (Areawide Planning Agencies):	357.00
Type VIII (Hospital Schools of Nursing):	300.00
Associate Members:	
Non profit organizations	357.00
Profit-making organizations	714.00
Personal Members:	
Type A	22.50
Type B	357.00
Students	11.25

Temporary Dues Increase:

In addition to regular dues, all members except Type VIII, Associate, and Personal members will pay a temporary dues increase in 1971 equal to 50 per cent of regular dues paid or payable for 1966.

The rules with respect to group members and Contracting Organizations remain the same, except that the new dues rates apply in each instance. These rates apply to members in the states of the United States; special rates are applicable to members in other areas under the jurisdiction of the United States and in Canada.

JES
10/12/70

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AMERICAN HOSPITAL ASSOCIATION

DUES STRUCTURE - 1971
PERSONAL MEMBERSHIPS

Type A - Regular Personal Members	$ 22.50
Type A - Students	11.25
Type B - Regular Personal Members	357.00

Affiliated Societies:

Type A Members:

American Society for Hospital Central Service Personnel	22.50
American Society for Hospital Food Service Personnel	22.50
American Society for Hospital Engineers	30.00
American Society for Hospital Personnel Directors	30.00
American Society for Hospital Public Relations Directors	30.00
American Society for Hospital Purchasing Agents	30.00
American Society for Hospital Nursing Service Administrators	22.50
American Society for Hospital Social Work Directors	37.00
American Society of Directors of Volunteer Services	25.00
Hospital Management Systems Society of the American Hospital Association	30.00
Society of Hospital Attorneys	50.00

Type B Members - All Societies	357.00

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AMERICAN HOSPITAL ASSOCIATION

DUES STRUCTURE FOR 1971

(U.S. POSSESSIONS AND TERRITORIES)

Type I-A (short-term hospitals):	
Minimum	$ 238.00
Maximum	3,968.00
Rates based on total expense:	
First $2,500,000	.51 per M
Second $2,500,000	.31 per M
Third $2,500,000	.20 per M
Balance	.10 per M
Type I-B (long-term hospitals):	
Minimum	$ 238.00
Maximum	793.00
First $500,000	.51 per M
Second $500,000	.31 per M
Third $500,000	.20 per M
Balance	.10 per M
Type II (extended care facilities):	
Minimum	$ 147.00
Maximum	491.00
First $500,000	.51 per M
Second $500,000	.31 per M
Third $500,000	.20 per M
Balance	.10 per M
Type III (clinics):	$ 238.00
Type IV - Regular (Blue Cross Plans in United States):	
Minimum	$ 751.00
Maximum	22,560.00
Rate per subscriber contract	.0466
Type VII (areawide planning agencies):	$ 238.00
Type VIII (hospital schools of nursing):	$ 200.00
Associate:	
Nonprofit	$ 238.00
Profit-making	476.00
Personal:	
Type A	22.50
Type B	357.00
Students	11.25

Temporary Dues Increase:
In addition to regular dues, all members except Type VIII, Associate and Personal members will pay a temporary dues increase in 1971 equal to 50% of regular dues paid or payable for 1966.

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AMERICAN HOSPITAL ASSOCIATION

DUES STRUCTURE - 1971
Institutional and Associate Members
(Canada)

Type I-A (General & special short-term hospitals):	
Amount per bed	$ .50
Minimum	50.00
Maximum	250.00
Type I-B and Type II (Long-term hospitals):	
Amount per bed	.25
Minimum	50.00
Maximum	125.00
Type III (Clinics):	50.00
Type IV (Blue Cross Plans):	
Associate	
Mills per subscriber contract	4.7
Minimum	138.00
Maximum	2,783.00
Type VII (Areawide Planning Agencies):	50.00
ASSOCIATE (Organizations other than inpatient care institutions) Special Associate dues arrangements apply for the Canadian Hospital Association	
Nonprofit	50.00
Profit-making	100.00

JES
10/12/70

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COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

ONE DUPONT CIRCLE, N. W. • WASHINGTON, D. C. 20036 • (202) 466-5123

General Membership Memorandum
No. 71-2G
January 22, 1971
Subject: Project Priorities for the Coming Year and Information Center Evaluation

1. Special Projects to be Considered in Addition to Reported Program Development:

Last year at this time a brief survey was undertaken to determine what issues COTH members felt deserved the most time and attention. As a result of this survey several projects were initiated and completed during the recent administrative year. The survey also served well as an indicator for program planning and Annual Meeting presentations. Your staff is once again undertaking such a survey. Additionally, we are undertaking an evaluation of the publications prepared and sponsored by the Teaching Hospital Information Center, now located in the AAMC's Division of Operational Studies, under the continued direction of Richard M. Knapp, Ph.D. and Armand Checker.

2. A Priority and Evaluation List for Your Consideration:

For these purposes a list of projects most frequently discussed with COTH staff and a list of Information Center publications is attached.

3. Please Complete and Return Attached Forms in Enclosed Envelope:

In order to establish an inventory and a priority, you are requested to rank the three most important issues in order of their relevance to your particular needs and interests. Space is available for additional issues which you may wish to identify as of importance to your institution. In order to evaluate the Information Center publications, you are requested to check the appropriate column for each publication. Suggestions are welcome and would be appreciated.

JOHN M. DANIELSON
Director
Council of Teaching Hospitals
and Health Services

Attachments: Membership Priority and Evaluation Survey
Envelope for Return to COTH Headquarters

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COTH
MEMBERSHIP SURVEY OF SPECIAL
PROJECT PREFERENCES

Please indicate your preference of the three most important issues in order of their importance, e.g. 1, 2, 3. Space for suggested issues is available. The present order of this list is random and in now way reflects the preference of the COTH staff.

RANK	ISSUE
_____	1. Present and future sources to finance the costs of graduate medical education.
_____	2. Responsibilities and terms of employment of full-time salaried clinical chiefs of service.
_____	3. Adjustment by the teaching hospital to the decline of the internship.
_____	4. The legal liabilities peculiar to a teaching hospital.
_____	5. Justifying the higher costs associated with teaching hospitals.
_____	6. Training, utilization, and licensure of the Physician's Assistant.
_____	7. The feasibility of establishing "health maintenance organizations" by teaching hospitals.
_____	8. The role of the teaching hospital and medical school in community medical care problems.
_____	9. The effects of medical school curriculum as they relate to the future of the teaching hospital.
_____	10. The organizational relationship of the teaching hospital to the university medical center.
_____	11. Sources of capital financing for teaching hospitals.
_____	12. The relationship of the teaching hospital and the comprehensive health planning agency.
_____	13. The organizational and operational possibilities for medical faculty and/or staff group practice arrangements.
_____	14. Hospital policy with regard to the payment, training, and employment status of house officers.
_____	15. The teaching hospital's responsibility for broad range ambulatory and extension services.
_____	16. Other: _____

COTH Summary of Responses
Special Project Priority Preferences - 1971

Special Project In Rank Order By Number Of Preferences	Rank Order Of Responses (1)	(2)	(3)	Total
1. Present and future sources to finance the costs of graduate medical education.	63	22	14	99
2. Justifying the higher costs associated with teaching hospitals.	32	31	35	98
3. The feasibility of establishing "health maintenance organizations" by teaching hospitals.	30	24	31	85
4. The organizational relationship of the teaching hospital to the university medical center.	25	22	38	85
5. The role of the teaching hospital and medical school in community medical care problems.	23	27	20	70
6. Responsibilities and terms of employment of full-time salaried clinical chiefs of service.	18	21	26	65
7. The teaching hospital's responsibility for broad range ambulatory and extension services.	14	19	32	65
8. The organizational and operational possibilities for medical faculty and/or staff group practice arrangements.	16	20	21	57
9. Adjustment by the teaching hospital to the decline of the internship.	14	18	14	46
10. Training, utilization, and licensure of the Physician's Assistant.	11	11	21	43
11. Sources of capital financing for teaching hospitals.	9	17	15	41
12. Hospital policy with regard to the payment, training, and employment status of house officers.	3	13	24	40
13. The effects of medical school curriculum as they relate to the future of the teaching hospital.	5	10	13	28
14. The relationship of the teaching hospital and the comprehensive health planning agency.	2	10	13	25
15. The legal liabilities peculiar to a teaching hospital.	4	5	8	17

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