AGENDA

TASK FORCE ON THE COST OF GRADUATE MEDICAL EDUCATION AND FACULTY PRACITCE PLANS

10 a.m. - 3 p.m.
January 16, 1973
AAMC Conference Room
One Dupont Circle
Washington, D.C. 20036

I.	Approval of Minutes, Meeting of September 19, 1972	TAB A
II.	Discussion of Draft Progress Report	TAB B
III.	Review: Survey of Medical Faculty Practice Plans	TAB C
IV.	Possible Legislative Action Concerning Financing of Graduate Medical Education	TAB D
	A) Future Activity of the Coordinating Council On Medical Education	
V.	Discussion of Further Action by the Task Force	

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

TO: TASK FORCE ON COST OF GRADUATE MEDICAL EDUCATION & FACULTY PRACTICE PLANS

FROM: Robert H. Kalinowski, M.D. and Richard M. Knapp, Ph.D.

SUBJECT: Minutes of September 19, 1972 meeting

Present:

Dr. William Anlyan
Dr. Christopher Fordham
Dr. Arnold Relman
Mr. Charles Womer

Guest:

Mr. Ronald Lochbaum

AAMC Staff:

Dr. John Cooper
Dr. Michael Ball
Miss Grace Beirne
Mr. Thomas Campbell
Mr. Charles Fentress
Dr. Robert Kalinowski
Dr. Richard Knapp
Mr. Joseph Rosenthal
Dr. Marjorie Wilson
Mr. Joe Murtaugh

Following approval of the Minutes of the July 19th meeting, Dr. Anlyan requested that Dr. Cooper report on the September 13th meeting of the parent committee. Dr. Cooper stated the purpose of that meeting was to:

1) Obtain the Committee's views of the direction and content of its report to the Assembly, focussing upon a first draft statement of this report, prepared by Mr. Murtaugh (this draft was sent to Committee members on September 8, 1972), and

2) Review the progress of the Task Force on Cost of Medical Education in its detailed study of the cost of undergraduate medical instruction at eight medical schools.

Committee Report

The Committee had made the decision (at earlier meetings) to focus its attention on the problems arising from Federal policy to provide financial support to medical schools on the basis of the enrollment of undergraduate medical students and increases in that enrollment, and the coupled Congressional directive to the Secretary, DHEW to launch a study to establish the methodology for ascertaining the "annual per student educational cost" of the program leading to the M.D. degree, to determine such costs for the 1971-72, 1972-73, and 1973-74 (estimated) school years; to describe national uniform standards for each medical school to use in determining these costs, and to recommend how these cost determinations could be used in fixing the payments to the school through capitation grants.

Congress called for an interim report on March 30, 1973, and a final report by January 1, 1974. The National Academy of Sciences - Institute of Medicine is conducting this study. (Comprehensive Health Manpower Training Act of 1971).

Because of the urgent need for the Association to make known its views on these critical matters, the Committee decided, as shown in the minutes of the July 12th meeting, to provide a report to the Assembly at the November annual meeting which would:

> "establish the view of the Association concerning (1) the complexity of the medical education process -- the interrelatedness of the elements that are integral to that process (instruction, research, services);(2) the indivisibility of that process, beginning with the curriculum leading to the M.D. degree through the years of internship and residency; (3) that only upon the completion of this continuum can the national objective to increase the number of persons capable of performing the functions of physicians in the delivery of health care be satisfied.
>
> The report will therefore stress the essentially arbitrary nature of efforts to establish estimates of the costs of undergraduate medical education, since this is a discrete concept only in the sense that a degree is awarded upon its completion and not in terms of the preparation of an individual for the independent practice of medicine.
>
> However, because of pressures for such estimates, the Association will present a set of preliminary figures, for consideration as a guide to the probable costs of this segment of the continuum - to be followed by more definitive views of the entire medical education process, its costs, and financing, in the context of the broad range of activities of the contemporary medical center complex."

Following the prescriptions outlined in the July 12th directive, Mr. Murtaugh prepared the draft statement, reviewed by the Committee at this meeting. This first draft, however, did not include preliminary findings of the Committee's Task Force groups on the costs of undergraduate medical education process. It is now evident that because of the inherent difficulties in establishing cost estimates for the research and patient care components, and because the group studying the patient care aspect has only recently been organized, cost estimates will not be available in time for the report to the Assembly in November.

In view of this, and as a result of the day's discussion, the Committee decided to:

(1) Provide the Assembly in November with an interim progress report of the Committee's work, leading to

(2) A full report - a more definitive statement of the Association's views - following the July 12th directive, and including prelininary estimates of the costs of undergraduate medical education - to be released, after Executive Council/ Assembly review, early in the spring of 1973. The timing of the release of this report is crucial, in view of the convening of the new Congress, which will be concerned with the extension of the Comprehensive Health Manpower Training Act of 1971, and the scheduled release of the interim report by the Institute of Medicine.

From the standpoint of a time frame for Task Force activity, Dr. Anlyan suggested that the group move forward with overall Committee on the undergraduate effort and then "review the bidding".

At this point, the Task Force discussed the components of the hospital budget which could be specifically ascribed to undergraduate medical education. These are as follows:

-- house staff costs which can be allocated to the function of instructing undergraduate medical students (this would also include teaching physicians who are paid on the hospital budget);

-- the cost of nursing, technician or other staff time as well as the allocation of other hospital cost centers (such as medical records, nursing service or social service) devoted to undergraduate medical education;

-- the cost for hospital space allocated to undergraduate students.

Each of these three components of the hospital budget are included in the medical center cost studies. Mr. Campbell reported that the special eight center study was under way, but specific data on these allocations are not yet available.* Mr. Campbell further elaborated on the methodology used to allocate educational program costs to these three components.

Preliminary data available on the eight center study do indicate that while there are dollars in the hospital budget devoted to undergraduate education; the amount is relatively small when calculated as a percentage of the hospital budget. Following a lengthly discussion, the Task Force agreed on the following general statement.

Given the general attributes of a teaching hospital in terms of the presence of graduate medical educational programs, the character of its patient population, the scope of service provided, and the staffing levels implicit in the discharge of such

*the eight centers involved are as follows:
a) Duke U. Sch. of Med. - Case Western Reserve U. Sch. of Med.
b) Georgetown U. Sch. of Med. - St. Louis U. Sch. of Med.
c) U. of Kansas Sch. of Med.-S.U.N.Y., Upstate Med. Ctr.
d) U. of Iowa Sch. of Med. - Ohio State U. Sch. of Med.

> activities, the conduct of an undergraduate medical educational program in such a setting has only a minor effect (probably not exceeding 1%) on the overall patient care costs of such institutions. The Task Force will review cost study data when it becomes available to determine if there is a need to reconsider its position.

A further matter of concern is the problem of estimating the effect of teaching undergraduate medical students on such items as length of stay of patients, utilization of laboratory and x-ray services, as well as other measures of patient care and hospital service. After full discussion of the matter, the Task Force did not come to full agreement. The following statement characterizes the feeling of the group:

> The current evidence available concerning the additional effect of the presence of medical students on laboratory, x-ray and other service utilization cannot be considered either sufficient or conclusive. Further, if any part of the costs of such increased services are considered educational in nature, they would in large part be attributed to graduate rather than undergraduate medical education.

At this point in the meeting Dr. Anlyan led a general discussion of the costs of graduate medical education and the need for more data and information concerning medical faculty practice plans. The staff was directed to examine the patient care components in the eight center study with specific reference to the cost of graduate medical education and to set forth a plan to:

1) examine institutional policies concerning faculty practice plans;

2) collect these plans from each of the schools;

3) determine the cash flow generated by these practice plans.

The next meeting of the Task Force is to be held on a date yet to be determined in early December.

TASK FORCE ON GRADUATE MEDICAL
EDUCATION AND FACULTY PRACTICE PLANS

Progress Report

The short-run goal of the Task Force was specifically stated as follows: "to determine the patient care cost component of undergraduate medical education". In order to accomplish this task, a discussion paper was drafted which set forth three reductions of the patient care cost component[1] which could be included as educational costs of undergraduate medical education. These three reductions will serve as the framework on which this progress report is based.

I. Teaching Function Costs

The first reduction is relatively straight-forward, and is already included in the AAMC cost allocation methodology. Included here are those activities financed under the teaching hospital budget of an academic medical center which can be appropriately defined as teaching in nature. These costs would include at least the following:

-- house staff time and effort devoted to the function of instructing medical students (this would also include teaching physicians who are paid on the hospital budget);

-- the cost of nursing, technician, or other staff time as well as the allocation of other cost centers (such as medical records or social service) devoted to undergraduate medical education;

-- an appropriate allocation of indirect costs to the function of undergraduate medical education.

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[1] For purposes of this report, The "patient care cost component" refers specifically to the teaching hospital budget.

The Task Force agreed on the following general statement at its meeting on September 19, 1972: Given the general attributes of a teaching hospital in terms of the presence of graduate medical educational programs, the character of its patient population, the scope of service provided, and the staffing levels implicit in the discharge of such activities, the conduct of an undergradute medical educational program in such a setting has only a minor effect (probably not exceeding 1%) on the overall patient care costs of such institutions. The Task Force will review cost study data when it becomes available to determine if there is a need to reconsider its position.

The data derived from the eight center study related to this question is attached as Appendix A of this report.

II. Incremental Hospital Costs Due To Teaching

The second reduction is conceptually a relatively clear matter, but there is at present no agreed upon methodology much less an appropriate body of data to carry out the quantification process. Included here are those increased hospital operating costs resulting from the conduct of teaching functions within the clinical setting. This would include, for example, increased laboratory or radiological studies and a greater patient length of stay which allegedly result from the conduct of medical teaching programs.

There have been numerous evaluations of the varying differences in operating costs between teaching and non-teaching hospitals. The major part of those differences has been considered to be the combined effects of the added costs of teaching functions, the greater expense involved in treating a more seriously ill patient population and the more extensive services provided. Almost nothing has been done in separately measuring these several factors of difference much less making any attempt to distribute these incremental costs due to teaching programs among the several educational programs involved.

Studies and other documented material reviewed by the Task Force include the following:

1) A Comparison of Five Groups of Short-Term General Teaching Hospitals in North and South Carolina;

2) A Comparison of Hartford and Yale-New Haven Hospitals;

3) "Unidentified Educational Costs In A University Teaching Hospital: An Initial Study". (Vol. 47, April, 1972) Journal of Medical Education;

4) "How Much Longer Do Patients Stay In Major Teaching Hospitals?" (Vol. 7, No. 2, February, 1971) PAS Reporter;

5) "Cholecystectomies In University and Nonuniversity Hospitals" (Vol. 9, No. 11, October 1971) PAS Reporter.

New Material Ready for Task Force review is as follows:

1) "Study of Hysterectomies" (Vol. 10, No. 2, September, 1972) PAS Reporter. (attached as Appendix B to this report);

2) A replication of the Kansas study (#1 in above list) completed by the Commission on Professional and Hospital Activities. (attached as Appendix C to this report);

3) A proposed study to compare hospitals which have large graduate medical education programs but very little in the way of undergraduate medical education programs and those which participate significantly in both graduate and undergraduate medical education. (attached as Appendix D to this report).

At its meeting on September 19, 1972, the Task Force adopted the following statement regarding this issue:

> The current evidence available concerning the additional effect of the presence of medical students on laboratory, x-ray and other service utilization cannot be considered either sufficient or conclusive. Further, if any part of the costs of such increased services are considered educational in nature, they would in large part be attributed to graduate rather than undergraduate medical education.

III. The Sharing of Joint Costs

The third reduction of the patient care costs in reaching for the full costs of educational programs is principally a conceptual and policy problem, rather than a methodological one. Described thus far in the preceding steps one and two are those costs encompassed in the patient care expenditures of a teaching hospital which result directly, and to a degree indirectly, from the conduct of teaching activities. Carrying out the reductions of these costs, as proposed in steps one and two, would leave as a remainder, those expenditures for what might be termed regular patient care activity shorn of costs involved in or resulting from teaching activity.

The question that remains is whether any part of this remaining body of patient care costs should be allocated to the cost of medical education. The reason this question arises is the simple fact that the conduct of an undergraduate medical education program requires access to a particular volume of patient care activity. Without it there can be no medical education program. At the same time that patient care activity is being carried out to provide needed hospital care for sick people, this activity also serves another objective; namely, providing the patient care environment for medical education.

Thus, some part or all of the patient care activity of an academic medical center serves more than one objective and therefore may be considered constituting a joint endeavor serving dual purposes. Since this patient care activity is essential to each such purpose, it appears possible to argue that these costs should be distributed to both education and patient care objectives to the extent that they are truly joint. (In many instances, the patient care program of an academic medical center may be of a substantially greater magnitude than that required to provide an adequate teaching program. Such additional patient care activity would be above and beyond that which could be

considered as jointly serving educational programs, and its cost would have to be assigned to other program objectives).

> At its meeting of July 19, 1972, the Task Force submitted this critical issue to intensive examination in order to search out a valid resolution of this apparent dichotomy. As a result, the group concluded that the requisite conditions for treating patient care activity in an academic health center as a joint process did not, in fact, exist. This conclusion was reached in the following manner:

The provision of medical and hospital care to a sick person must be considered as a substantive, essential and primary process, the necessary conditions for which cannot be subordinated or modified because of the concommitant existence of other objectives or intentions. Given a state of illness or disability requiring medical or hospital care, the first and principal action is the provision of that care, the place and setting of which is essentially an accidental or fortuitous aspect. Thus, the medical and hospital care that takes place in an academic health center is an activity that in one form or another would take place regardless of the presence or absence of the particular facility involved.

Thus, the costs of patient care in an academic health center must be primarily attributed to health care objectives and as such constitute a responsibility of whomever bears the burden of an inidividual patient's health services. Any teaching and educational activity associated therewith is derivative of and incremental to this basic patient care function.

This basic division of cost may in certain circumstances be subject to modifications in those circumstances where it may be necessary to bear certain patient care costs as education expense in order to assure that such patient care takes place in a particular setting, rather than any other setting. The acceptance of capital investment burdens involved in providing patient care facilities by a university is an example of this exception. In like manner,

the acceptance of patient care costs for indigent patients or patient costs in excess of reimbursement may in some part be a consequence of this particular situational requirement.

In concluding upon this view, the Task Force emphasized that not all differences between patient care costs in the teaching versus non-teaching setting can be ascribed to teaching differentials. As noted above, significant differences in cost result from the greater illness severity that characterizes the patient population of a teaching institution, the range and extent of technical services provided and frequently substantial qualitative differences in the provision of identical services.

HOSPITAL COST CONTRIBUTIONS TO MEDICAL STUDENT INSTRUCTIONAL COSTS AT SELECTED CENTERS
(Adjusted to 1972 Dollars)

	Hospital F (1969-70)				Hospital E (1969-70)				Hospital G (1970-71)				Hospital H (1971-72)			
	Total $ Expended	$ Alloc'd to M.D. Instr.	$ Per M.D. Stu't	% All'd to MD Instr	Total $ Expended	$ Alloc'd to M.D. Instr.	$ Per M.D. Stu't	% All'd to MD Instr	Total $ Expended	$ Alloc'd to M.D. Instr.	$ Per M.D. Stu't	% All'd to MD Instr	Total $ Expended	$ Alloc'd to M.D. Instr.	$ Per M.D. Stu't	% All'd to MD Stu't
House Staff Salaries/Perquisites	617,000	93,000	191	15.0%	1,107,000	150,000	318	13.6%	2,428,000	140,000 o	357 o	5.8%		498,000	838	&
Nursing Service		---	---		5,562,000	25,000	53	0.4	5,830,000	317,000	808	5.4				
Outpatient Service					344,000	21,000	43	6.0	1,010,000	95,000	243	9.4				
Radiology					529,000	7,000	16	1.4	872,000	22,000	56	2.5				
Anesthesiology						---	---		180,000	5,000	14	3.0				
Laboratories						---	---		2,502,000	22,000	57	0.9				
Medical Records						---	---		632,000	2,000	6	0.4				
Social Service					177,000	19,000	41	10.9	256,000	13,000	33	5.1				
Other (Misc.)	25,000	4,000 #	9 #	16.9		---	---	---	1,406,000	52,000	131	-		1,359,000	2,283	
Administrative Services, etc.					3,131,000	5,000	10	0.2								
Operating Room									969,000	74,000	190	7.7				
General Service & Depreciation									7,945,000	204,000	519	2.6				
Other Hosp. Exp. not Associated with M.D. instruction	9,084,000				4,843,000				4,709,000							
Total	9,726,000	97,000	200	1.0%	15,693,000	228,000	481	1.5%	28,739,000	946,000	2,414	3.3%	&	1,857,000	3,121	&

Notes: This data was compiled by the Division of Operational Studies of the AAMC from program cost allocation studies conducted by the respective health centers for the indicated years. These studies were performed under the guidance of the AAMC.

\# Imputed cost
\+ Negligible amount
& Not available
o Transferred from medical school to hospital

HOSPITAL COST CONTRIBUTIONS TO MEDICAL STUDENT INSTRUCTIONAL COSTS AT SELECTED CENTERS
(Adjusted to 1972 Dollars)

	Hospital A (1968-69)				Hospital B (1969-70)				Hospital C (1968-69)				Hospital D (1969-70)			
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House Staff Salaries/Perquisites	3,354,000	174,000	515°	5.2%		300,000	825	7.5%	1,177,000	210,000	431	17.8%	764,000	38,190 #	95 #	5.0%
Nursing Service	6,557,000	66,000	194	1.0		---	---		4,797,000	46,000	94	1.0		---	---	
Outpatient Service	1,364,000	69,000	203	5.0		---	---			---	---			---	---	
Radiology	1,923,000	82,000	243	4.3		---	---			---	---			---	---	
Anesthesiology	839,000	25,000	74	3.0		---	---			---	---			---	---	
Laboratories	1,247,000	27,000	81	2.2		---	---		1,533,000	13,000	27	0.8		---	---	
Medical Records	269,000	5,000	16	2.0		---	---		381,000	11,000	22	2.9		---	---	
Social Service		---	---	---		---	---		208,000	17,000	35	8.2		---	---	
Other (Misc.)	781,000	26,000	78	3.4		182,000 #	500 #	&		---	---			---	---	
Indirect Costs	3,219,000	41,000	123	1.3												
General Supplies, etc.									1,963,000	53,000	107	2.7				
Other Hospital Expenses not associated with M.D. instruct.	7,132,000								838,000				16,836,000			
Total	26,685,000	515,000	1,527	1.9%	&	482,000	1,325#	&	10,897,000	350,000	716	3.2	17,600,000		95	+

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Commission on Professional and Hospital Activities

Appendix B

William H. Kincaid, editor *Vol. 10, No. 2 1 May 1972*
Revised 11 September 1972

STUDY OF HYSTERECTOMIES

Margaret A. Child, MD, MPH
William J. Ledger, MD

This PAS Reporter *issue is an adaptation of an exhibit first shown at the Twentieth Annual Meeting of the American College of Obstetricians and Gynecologists held in May 1972, in Chicago.*

Hysterectomy is a common operation. It is estimated that 678,000 are performed each year in the United States. Of the major operations only appendectomy is more frequent.[1]

We studied 12,026 hysterectomies recorded as the most important operation. This sample was obtained by systematically selecting every seventh patient of the 5,208,710 discharges from PAS hospitals from January through June 1970.

We compared

- Abdominal and vaginal approaches
- White and nonwhite patients
- Hysterectomies, cholecystectomies, and appendectomies
- Hospitals with obstetrics and gynecology residencies, other teaching hospitals, and nonteaching hospitals
- Patients of different ages

Dr. Child is a biostatistician at CPHA and lecturer in Biostatistics, School of Public Health of the University of Michigan.

Dr. Ledger is associate professor of Obstetrics and Gynecology, University of Michigan Medical School and chief of the Gynecology Outpatient Department at the University Hospital, Ann Arbor.

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The distribution of patients in these categories is shown in the following table.

Table 1

DISTRIBUTION OF PATIENTS

Operative Approach	Number	Percent	Race	Number	Percent
Abdominal	8,462	70	White	9,882	82
Vaginal	3,564	30	Nonwhite	1,070	9
			Not Coded[2]	1,074	9
Total	12,026	100	Total	12,026	100

Teaching Status of Hospital	Number of Patients	Percent	Age Distribution	Number	Percent
With OB-GYN Residency	3,096	26	Under 25 Years	194	2
Other Teaching	3,390	28	25–34	2,267	19
Nonteaching	5,540	46	35–44	4,592	38
Total	12,026	100	Over 44	4,973	41
			Total	12,026	100

Tables 2 through 6 display those differences we found to be statistically significant.

Table 2 shows that a higher percentage of patients having vaginal hysterectomy had a postoperative fever and more were given antibiotics. Patients with abdominal hysterectomies were more often given transfusions.

Table 2

APPROACH: SIGNIFICANT DIFFERENCES ($P<0.001$)

	Abdominal	Vaginal
Percent with postoperative fever[3]	31%	38%
Percent given antibiotics	45%	54%
Percent given transfusions	17%	13%

The most dramatic differences were between whites and nonwhites. Incidence of postoperative fever and use of antibiotics were much higher for nonwhites. There was also a consistently higher transfusion rate for nonwhites. It existed for all final diagnoses explaining admission, all ages, all types hospitals, and both types of hysterecton Furthermore, the average length of stay f nonwhites was almost a day and a half longer.

Table 3

RACE: SIGNIFICANT DIFFERENCES ($P<0.001$)

	White	Nonwhite
Percent with postoperative fever	32%	44%
Percent with antibiotics	46%	61%
Percent with transfusions		
Abdominal hysterectomies	15%	29%
Vaginal hysterectomies	12%	19%
Length of stay	10.3 days	11.6 days

By comparison with two common abdominal operations, hysterectomies were found to have fewer postoperative deaths. Hysterectomy had less than half the mortality of appendectomy and less than one-eighth the mortality of cholecystectomy. Yet transfusions and antibiotics were used significantly more.

Table 4

OTHER OPERATIONS:[4] SIGNIFICANT DIFFERENCES ($P<0.001$)

	Hysterectomy	Appendectomy	Cholecystectomy
Mortality per 10,000 patients	16.4	37.9	141.7
Average length of stay	10.3 days	6.9 days	13.4 days
Percent given transfusions	15%	1%	5%
Percent given antibiotics	48%	45%	43%

Patients treated in hospitals with an OB-GYN residency were less likely to receive antibiotics though they more often had postoperative fever. They were less likely to be given antibiotics without culture. They had more genitourinary X rays, chest X rays, and electrocardiograms. Patients in nonteaching hospitals were more likely to have routine urine and blood studies. They had a shorter average stay.

Table 5

HOSPITAL TYPE: SIGNIFICANT DIFFERENCES ($P<0.025$)

	OB-GYN Residency	Other Teaching	Nonteaching
Percent with postoperative fever	36%	34%	31%
Percent given			
Antibiotics	45%	46%	50%
Antibiotics without culture	55%	63%	73%
Chest X rays	31%	25%	26%
Electrocardiograms	37%	31%	27%
Genitourinary X rays	15%	13%	11%
Urinalysis and hemoglobin or hematocrit not done (per 1,000)	12	17	10
Average length of stay	10.5 days	10.5 days	10.0 days

Age seemed to influence the percent with transfusions and the number of units per transfused patient. Patients 25 to 34 years were less often transfused than any other age group. Patients under 25 appeared to be most often transfused, but because of the small number the difference is not significant. These young patients were given significantly more blood per transfused patient, however. Antibiotic use decreased with age while average hospital stay increased.

Table 6

PATIENT AGE: SIGNIFICANT DIFFERENCES ($P<0.025$)

	Under 25	25-34	35-44	Over 44
Percent with transfusions	19%	13%	16%	16%
Average units per transfused patient[5]	2.8+	2.3+	2.1+	2.2+
Percent given antibiotics	55%	50%	48%	47%
Average length of stay	9.1 days	9.6 days	9.9 days	11.0 days

NOTES

1. This projection for 1971 comes from the Hospital Record Study, a joint study by CPHA and Lea Incorporated, Ambler, Pennsylvania.

2. Some hospitals elect to record race only as white and nonwhite. Others choose to distinguish black and Asiatic from white. Still others use an option to mean some special group with or without racial significance. We have included black, Asiatic, and nonwhite in the nonwhite category. Patients whose race was not recorded are combined with those optionally coded into an unrecorded group.

3. These are patients whose admission temperature was 99.9F or less, but whose peak temperature during the hospitalization was 101.0F or more. In hospitals using the centigrade scale, these limits are 37.4C and 38.0C. (Although the Fahrenheit and Centigrade temperatures do not precicely correspond, they are represented by the same codes in the abstracted data.)

4. Data for the other operations were obtained from a sample of 9,671 cholecystectomies and 7,602 appendectomies by selecting every 7th patient from all patients discharged from PAS hospitals from January through June 1970. The only operations counted were those recorded as the most important. The H-ICDA codes used were:

   71.0 and 71.1 abdominal hysterectomy
   71.3 vaginal hysterectomy
   53.5 cholecystectomy
   49.1 appendectomy

5. The plus sign (+) following the average units of blood per transfused patient reflects the limitation to one digit on the case abstract for the number of units given. Nine or more units is coded as nine. Therefore the possibility remains that the average is higher.

CPHA

Commission on Professional and Hospital Activities

68 Green Road Ann Arbor, Michigan 48105 313-769-6511 Vergil N. Slee, MD, President William H. Kincaid, Exec. Vice-President

AIRMAIL

4 December 1972

Richard M. Knapp, PhD
Director
Division of Teaching Hospitals
Association of American Medical Colleges
Suite 200
One Dupont Circle, N.W.
Washington, D. C. 20036

Dear Dr. Knapp

Enclosed is a study we completed for you on the utilization of diagnostic services for selected diagnoses and operations. We hope you find it useful.

The PAS Reporter issues dealing with comparisons between teaching and non-teaching hospitals are still being composed and we will forward copies to you as soon as they are finished.

If you have any questions or comments about the enclosed study, don't hesitate to call us.

Sincerely

Marjorie S. Greenberg

Marjorie S. Greenberg
Assistant Manager
Information Services

Enclosure: 1. Memorandum Report: "Utilization of Diagnostic Services for Selected Diagnoses and Operations"
2. PAS Case Abstract

jkl-15:10

UTILIZATION OF DIAGNOSTIC SERVICES FOR SELECTED DIAGNOSES AND OPERATIONS: COMPARISON BETWEEN FIVE LARGE TEACHING AND FIVE LARGE NONTEACHING PAS HOSPITALS

Richard M. Knapp, PhD
Association of American Medical Colleges
Washington, D. C.

In a letter dated 5 June 1972, Richard M. Knapp, PhD, Director, Division of Teaching Hospitals, inquired about replicating a study comparing the utilization of diagnostic services in teaching hospitals and nonteaching hospitals. The original study appeared in the April 1972 issue of the Journal of Medical Education.

A similar study has been completed on 9,030 patients discharged during April 1971 through March 1972 from ten large PAS hospitals. The five teaching hospitals have residencies in medicine, surgery, and pediatrics* and the five nonteaching hospitals do not. All of the hospitals belong to the Medical Audit Program (MAP) and all of them utilized SMA-12 multichannel analyzers.

The following six groups of patients were studied: pneumonia and bronchitis (H-ICDA 480-491); diabetes mellitus (H-ICDA 250); acute myocardial infarction (H-ICDA 410); peptic ulcer (H-ICDA 531-534); appendectomy (H-ICDA 49.1); and cholecystectomy (H-ICDA 53.5). All diagnoses were final diagnoses explaining admission and all operations were the most important operations. Pneumonia and bronchitis patients were studied on the pediatric medicine service. Appendectomy patients and cholecystectomy patients were studied on the adult surgery service. All other groups were studied on the adult medicine service.

Enclosed is an illustration displaying data on the patients studied. The first eleven measures through the percent receiving consultations provide for an analysis of the patient mix in each of the two hospital groups. The selection of patients was not based on the requirement that patients have few or no secondary diagnoses and operations because this procedure would require large amounts of computer time to pass through a summary of PAS data and sort out patients with no secondary diagnoses or operations.

*According to the Directory of Approved Internships and Residencies for 1971-1972 published by the AMA.

The number of patients receiving multichannel chemistry analysis is included as a measure of diagnostic service utilization. It also serves as an indicator of the effect multichannel analysis may have on the number of tests performed, and therefore the variety index. If 100% of the patients had multichannel analysis, six items on the PAS Case Abstract (items 46:1-6, Blood Chemistry) would automatically be marked. If no patients had multichannel analysis the only items marked off on the abstract under Blood Chemistry would be those tests performed individually.

Minimum lab not met is included as a quality measure since it signifies that two basic tests (urinalysis and hemoglobin or hematocrit) were not performed in spite of other diagnostic examinations and x-rays. When analyzing the data on minimum lab not met it should be kept in mind that deaths may have a positive effect on this measure, particularly if the deaths occurred soon after admission. The illustration also includes data on the percentage of patients receiving EKG's, repeat EKG's, and x-rays (chest, skeletal, digestive and genitourinary).

A PAS Case Abstract is attached documenting the items included in the variety index measure.

Attachment: Illustration
PAS Case Abstract

jkl-15:8-9

COMMISSION ON PROFESSIONAL AND HOSPITAL ACTIVITIES
1968 Green Road, Ann Arbor, Michigan 48105

AN:
Date: 4 Dec. 1972
By: Miner

COMMISSION ON PROFESSIONAL AND HOSPITAL ACTIVITIES
1968 Green Road, Ann Arbor, Michigan 48105

CPHA

Utilization of Diagnostic Services for Selected Diagnoses and Operations:[1] Comparison Between Five Large Teaching and Five Large Nonteaching PAS Hospitals
April 1971-March 1972

Measures	Pneumonia and Bronchitis[2]		Diabetes[3]		Acute Myocardial Infarction[4]		Peptic Ulcer[5]		Cholecystectomy[6]		Appendectomy[7]	
	A*	B**	A	B	A	B	A	B	A	B	A	B
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
No. of patients	430	852	685	811	1,122	931	492	882	609	1,220	266	730
Rate per 1,000 discharges	5.1	9.6	8.2	9.1	13.4	10.5	5.9	9.9	7.3	13.7	3.2	8.2
Percent Males	61%	58%	42%	37%	67%	71%	60%	59%	26%	24%	56%	51%
Average Stay[8]	7.2	4.8	11.2	8.4	21.9	18.3	9.7	8.8	13.3	11.3	7.9	6.4
Percent Deaths	0.7%	-%	2.8%	2.6%	18.8%	19.3%	0.4%	0.6%	2.1%	1.2%	1.5%	0.4%
Pts. 65 and over	-	-	28.6	29.7	48.8	42.0	22.4	21.8	24.0	18.5	7.5	3.2
WBC 10,000	61.9	55.2	26.3	28.2	40.7	45.3	29.9	30.2	22.5	22.2	72.6	71.2
Temp 100° F	60.2	55.8	6.4	7.3	4.7	3.7	4.5	3.7	9.2	3.7	27.4	20.8
No. of operated pts.	7.7	1.8	11.5	5.9	10.9	4.7	19.1	8.7	100.0	100.0	100.0	100.0
Blood Transfusions	1.2	0.5	1.8	2.1	2.3	1.0	25.4	19.0	7.9	4.3	2.3	1.4
Percent Consultations	14.2%	5.8%	41.5%	21.3%	45.5%	22.7%	35.6%	23.2%	40.4%	48.4%	16.9%	26.9%
Multichannel Chemistry	14.0%	3.5%	68.9%	82.7%	70.4%	73.9%	73.4%	81.5%	61.2%	60.1%	31.2%	26.8%
Min. lab. not met[9]	7.9%	2.7%	6.1%	2.7%	9.9%	9.5%	6.7%	3.1%	3.3%	1.1%	12.4%	5.8%
Variety Index[10]	12	8	18	15	18	15	18	15	17	13	12	9
EKG	7.9%	2.8%	77.7%	61.4%	95.3%	95.3%	66.9%	51.7%	67.7%	44.1%	16.5%	7.8%
Repeat EKG	2.8%	0.1%	16.9%	13.6%	90.5%	87.4%	15.9%	8.7%	17.6%	9.3%	4.1%	2.3%
X-rays:												
Chest	85.8%	83.7%	66.6%	55.7%	87.7%	69.8%	65.7%	46.1%	66.7%	45.2%	35.7%	19.2%
Skeletal	7.4	1.9	25.0	15.3	8.1	5.6	9.3	8.3	9.2	3.7	1.9	0.8
Digestive	3.0	1.1	25.3	25.6	7.8	10.3	89.4	92.0	77.7	57.1	10.2	10.1
Genitourinary	1.4%	0.2%	14.5%	15.0%	2.3%	2.0%	15.9%	11.8%	12.0%	7.0%	9.4%	5.6%

[1] Large hospitals discharge over 15,000 patients annually.
Teaching hospitals have residencies in surgery, medicine, and pediatric medicine.
Nonteaching hospitals do not have residencies in these three specialties.

[2] H-ICDA 480-491 as final diagnosis explaining admission.

[3] H-ICDA 250 as final diagnosis explaining admission.

[4] H-ICDA 410 as final diagnosis explaining admission.

[5] H-ICDA 531-534 as final diagnosis explaining admission.

[6] H-ICDA 53.5 as most important operation.

[7] H-ICDA 49.1 as most important operation.

[8] Excluding deaths.

[9] Minimum laboratory work (urinalysis and hemoglobin or hematocrit) was not done at any time during hospitalization.

[10] The average number of different kinds of laboratory tests, diagnostic X-rays and other tests out of a possible total of seventy.

*A refers to teaching hospitals
**B refers to nonteaching hospitals.

AN
30 November [illegible]
Miner

ATTENDING PHYSICIAN | 6 OPTIONAL a b c

7a HOSPITAL SERVICE | b Teaching services

8 RACE: White | Nonwhite | Black | Asiatic | Special A | c Interservice transfer

Months (thru 23)

9 SEX: Male | Female

10 ADMISSION: Emergency | Urgent | From other hospital

11 DISCHARGE STATUS: a ALIVE With approval | Against advice | TRANSFERRED TO: Other hospital | Extended care facility | Home care program | b DIED Autopsy | No autopsy | c In O R | Post-operative | d Coroner's case

12 EXPECTED PAYMENT: a Medicare or Provincial | b Workmen's Comp. | Medicaid | Govt. agencies (not Medicare, Medicaid or Provincial) | Blue Cross | Commercial insurance | Voluntary charities | Private | Special B

13 PAS HOSPITAL NUMBER

14 EXAMS: Rectal | Pelvic | Fundus (eye) | Tonometry

15 CARE UNITS: Coronary | Intensive | Isolation

16 Selected case

DIAGNOSES

17 FINAL DX EXPLAINING ADMISSION

18 FINAL DIAGNOSES (H-ICDA): a b c d e f g

19 COMPLICATIONS: Hospital infection | Other hospital complication

20 BIRTH WEIGHT: lbs or kg | oz or gm

lbs or kg 21 WEIGHT | inches or cm 22 HEIGHT

THERAPY

23 DRUGS: A: Oral antidiabetics | Insulin | Thyroid; antithyroid | Steroid hormones | Diuretics | Antihypertensives (hypotensives) | ...pressors — B: Vasodilators | Cardiac regulators | Anticoagulants | Sulfas | Antibiotics | Other anti-infectives | Tranquilizers

UNITS OF BLOOD: a Whole blood | b Packed red cells

OTHER THERAPY: Parenteral fluids | ... blood derivatives | ... globulin | Hypothermia | Monitoring device | Oxygen | IPPB | Other inhalation therapy

REMARKS

Also included are the following H-ICDA diagnostic procedure codes:

94.5 Other contrast radiography
94.6 Radioisotope scanning examination
94.7 Other radioistope examination
94.8 Ultrasonic radiography
94.9 Other radiography
97.0 Physical Medicine and rehabilitation
99.7 Spinal puncture

SURGERY

71

L

26 TISSUE OF 29: PATH REPORT IN CHART: Diseased A | Diseased B | No disease | Not coded | NO PATH REPORT | Tissue removed, no report | None removed

27 ANESTHESIA OF 29 (OR DELIVERY): None | Inhalation | Intravenous | Spinal | Saddle block | Epidural, caudal | Nerve or field block | Local | Other

28 SURGEON A

OPERATIONS (H-ICDA) OF SURGEON A: 29 | 30 a b c

31 SURGEON B

32 OPERATIONS (H-ICDA) OF SURGEON B: a b c

33 TIME OF EARLIEST SURGERY (OR DELIVERY if before surgery): a If begun within 6 hours of admission | b If after 6 hours, show day →

52 CONSULTATIONS GIVEN BY: Same service | Medicine | Surgery | OB-Gyn | Pediatrics | Psychiatry | Physical Medicine

53 ADMISSION BLOOD PRESSURE

54 TEMPERATURE a b

55 RESEARCH A B

56 SPECIALS C D E F G

LAB TESTS AND X-RAYS

34 ADMISSION HGB OR HCT: Enter admission hemoglobin in gm/100 ml. Enter whole numbers only—drop tenths

35 ADMISSION WBC: Enter admission white blood cell count in thousands—drop last three digits

36 ADMISSION URINALYSIS: Done | Sugar + | Albumin + | Repeat; or routine done later

37 URINE TESTS: Bile, urobilinogen | Hormones | Calcium, other minerals

38 HISTOLOGY: Cervical Pap | Other Pap | Cell block | Frozen section

39 CULTURE: Throat or nose | Urine | Blood | Other

40 OTHER MICROBIOLOGY: Bacterial smear | Antibiogram | Parasitology

41 FUNCTION: EKG | Repeat EKG | Thyroid | EEG | Kidney | Pulmonary

42 HEMATOLOGY: Hemoglobin | Hematocrit | Red cells, indices | Reticulocytes, nucleated RBC | RBC abnormality tests | White cells | Differential | Sed. rate | Coag. tests, platelets | Prothrombin time

43 SEROLOGY: STS | Spec. human antibodies | Bacterial antibodies | Viral antibodies | Rheumatoid factors | Heterophil | C-reactive protein

44 GASTRIC-STOOL: Stool for blood | Stool analysis | Gastric analysis

BLOOD CHEMISTRY

45 MULTICHANNEL CHEMISTRY | 46 DONE: Nitrogen deriv. | Electrolytes, pH | Liver function | Transaminase, LDH | Proteins, electrophoresis | Cholesterol, lipids | 47 ABNORMAL RESULT | 48 ABNORMAL REPEATED

49 X-RAY: Routine (survey) chest | Diagnostic chest, respiratory | Digestive tract (including GB) | Skeletal | Urogenital | Pleural & perit. cavities NOS | CNS and CNS spaces | Cardiovascular | External soft tissue

50 BLOOD SUGAR: Fasting, random | 2-hour post-prandial | ≥150 mg % found in either of above | Glucose tolerance

51 OTHER TESTS: Amylase, lipase, absorp. tests | Serum iron | Skin tests | Toxicology

OPTIONAL: 57 a b | 58 a b c | 59 a b c | 60 a b c | 61 a b c d | 62 a b c | 63 a b c

December 19, 1972

Marjorie S. Greenberg
Assistant Manager
Information Services
Commission on Professional
and Hospital Activities
1968 Green Road
Ann Arbor, Michigan 48105

Dear Marjorie:

In follow up to my earlier letter of December 4th, I am still very interested in making some comparisons between hospitals which have large graduate medical education programs but very little in the way of undergraduate medical education programs and those which participate significantly in both undergraduate and graduate medical education. My hypothesis would be that the diagnostic testing use rates would not be significantly different. In other words, the presence of undergraduate medical students plays a minor role, if any, in determining diagnostic testing rates. I think the diagnosis used in the study which you recently sent would be appropriate.

I have reviewed the PAS roster and I think the following 20 institutions would be useful in making the comparisons:

List I
Graduate Training Only

1) Iowa Methodist, Des Moines
2) Pacific Medical Center, San Fran.
3) Catholic Medical Center, NYC
4) Grasslands Hospital, Valhalla, NY
5) St. John, Detroit
6) St. John's Mercy, St. Louis, Mo.
7) Aultman, Canton, Ohio
8) St. Elizabeth, Youngstown, Ohio
9) St. Vincent, Worcester, Mass.
10) The Bryn Mawr, Bryn Mawr, Pa.

List II
Undergradaate and Graduate Training

1) Duke, Durham, NC
2) Loma Linda, Loma Linda, Ca.
3) U. of Calif., San Francisco
4) Loyola U., Chicago
5) Ohio State U., Columbus
6) Baylor, Dallas, Texas
7) Vermont Medical Ctr., Burlington
8) Med. College of Va., Richmond
9) Martland, Newark, N.J.
10) Albert Einstein, NYC

Again, I really appreciate your efforts on our behalf. I believe the study comparing teaching and non teaching hospitals will be useful to us. I shall look forward to hearing from you.

Sincerely,

RICHARD M. KNAPP, Ph.D.
Director
Division of Teaching Hospitals

RMK/plf

SURVEY OF MEDICAL FACULTY PRACTICE PLANS, 1973

1) Does your institution have a medical faculty practice plan?

YES _____
YES, but intend to modify it _____
YES, but intend to discontinue it _____
NO _____
NO, but intend to start one _____

2) Do all Clinical Departments have a Medical Faculty Practice Plan?

YES, and all departments are under the same Plan _____
YES, but not all departments have the same Plan _____
NO, but departments which do, all have the same Plan _____
NO, and not all departments have the same Plan _____

3) If reply to #2 above is NO, please list the Clinical Departments with No Plan.

_____ _____ _____

_____ _____ _____

_____ _____ _____

If your school has no faculty practice plan, please describe any restrictions or requirements pertinent to the practice of medicine by members of your clinical faculty in response to question #22 on the final page of this survey.

4) Does the Plan function as :

One or More Partnerships _____
A Separate Corporation _____
A Separate Foundation _____
Agency (of University of Medical School) _____
Other _____

(Please specify)_____

5) Is the full-time faculty member's participation in the plan?

Voluntary _____
Required _____

Other (please specify)_____

6) If participation is voluntary or selective, what percentage of full-time faculty participate?

_____

7) Are there restrictions on the facilities in which Plan members may practice?

YES _____
NO _____

If YES, Please specify, _____

_____

_____

8) Are Plan participants permitted to practice outside the auspices of the Plan?

YES _____
NO _____

If YES, is the faculty member's clinical activity outside the Plan restricted insofar as the number of:

Patients he may bill _____
Hours spent in this activity _____
Dollars collected from this activity _____

Other (please specify)_____

9) Within the Plan, is there a minimum or maximum number of patients which must be seen by members of the Plan?

NO _____
Maximum _____
Minimum _____

10) Within the Plan, is there a minimum or maximum number of hours which must be set aside for seeing patients by members of the Plan?

NO _____
Maximum _____
Minimum _____

11) Is it policy that medical practice under the auspices of the Plan encompasses:

A. All private patients in the medical center _____
B. All service patients in the medical center _____
C. All patients in the medical center _____

12) Is faculty compensation earned through the Plan based upon:

A fixed guaranteed dollar amount decided at the beginning of the year _____
A fixed dollar amount plus percentage of departmental plan income _____
A fixed dollar amount plus percentage of individual plan income _____

Other (please specify)_____

_____

_____

13) Please list by position title, the composition of the policy making board or group which oversees the functioning of the Plan.

_____ _____ _____

_____ _____ _____

14) What component of the medical center organization is responsible for billing patients served by members of the Plan?

Office which administers the Plan _____
Academic Department _____
Hospital _____
Individual Faculty Member _____
Business Office of the College _____

Other (please specify) _____

15) Has the Plan been reviewed and approved by IRS?

YES _____
NO _____

16) a. What was the gross income to the Plan in your most recent fiscal year? $_____ FY_____

b. What portion of this gross income was necessary to administer the Plan? $_____

c. What portion of the remaining income was expended for salaries and fringe benefits of participants in the Plan? _____

d. How much of the net remaining income (after b and c have been deducted) accrued to departmental budgets and the dean's budget as a result of the Plan's operation during the most recent fiscal year?

Dean's budget $_____
Departmental budgets $_____

e. Are there restrictions placed on the use of funds in (d) above?

YES _____
NO _____

If YES, please explain, _____

17) Is the income of the Plan allocated by formula to departmental budgets and the dean's budget?

YES _____
NO _____

If YES, briefly describe the formula, _____

_____

_____

_____

_____

_____

18) What control devices are used to ensure membership conformance to the policies and procedures of the Plan?

External Audit of Billing Records _____
Member Submission of Annual Income Tax Statement _____

Other, please explain, _____

_____

_____

19) Have questions been raised by the parent university or state government concerning the proprietorship of funds generated by members of the Plan?

NO _____
University _____
State _____

If YES, please explain, _____

_____

_____

_____

20) List the two most significant problems in the current operation of the Plan.

A) _____

_____

_____

_____

B) _____

_____

_____

_____

21) If you could make one policy change in the current operation of the Plan, what would that change be?

22) Are there additional comments you wish to make concerning the operation or policies of the Plan at your institution?

PLEASE ENCLOSE A COPY OF YOUR INSTITUTION'S PLAN WITH THIS QUESTIONNAIRE.

MEDICAL SCHOOL

Individual to whom questions should be directed

"GRANTS FOR TRAINING, TRAINEESHIPS, AND FELLOWSHIPS IN FAMILY MEDICINE

"SEC. 767. There are authorized to be appropriated $25,000,000 for the fiscal year ending June 30, 1972, $35,000,000 for the fiscal year ending June 30, 1973, and $40,000,000 for the fiscal year ending June 30, 1974, for grants by the Secretary to any public or nonprofit private hospital—

"(1) to plan, develop, and operate, or participate in, an approved professional training program (including continuing education and approved residency programs in family practice) in the field of family medicine for medical students, interns, residents, or practicing physicians;

"(2) to provide financial assistance (in the form of traineeships and fellowships) to medical students, interns, residents, practicing physicians, or other medical personnel, who are in need thereof, who are participants in any such program, and who plan to specialize or work in the practice of family medicine; and

"(3) to plan, develop, and operate, or participate in, other approved training programs in the field of family medicine.

"GRANTS FOR SUPPORT OF POSTGRADUATE TRAINING PROGRAMS FOR PHYSICIANS AND DENTISTS

Appropriation.

"SEC. 768. (a) There are authorized to be appropriated $7,500,000 for the fiscal year ending June 30, 1973, and $15,000,000 for the fiscal year ending June 30, 1974, for grants under subsection (b).

"(b)(1) The Secretary shall make annual grants in accordance with this section to—

"(A) public or nonprofit private schools of medicine, osteopathy, or dentistry, which are accredited as provided in section 721(b)(1), and which have approved applications, and

77 Stat. 165.
42 USC 293a.

"(B) public or nonprofit private hospitals which are not affiliated with an accredited school of medicine, osteopathy, or dentistry, and which have approved applications,

to assist in meeting the educational costs of the first three years of full-time approved graduate training programs in the area of primary care or in any other area of health care (designated under subsection (c)(3)(B)) in which there is a shortage of qualified physicians or dentists.

"(2) The amount of a grant under this subsection for any fiscal year to any school or hospital shall be equal to $3,000 for each physician or dentist enrolled in a graduate training program (A) described in paragraph (1) of this subsection, and (B) in the case of a grant to a school, conducted in clinical facilities of such schools or with which such school has a written agreement of affiliation, or, in the case of a grant to a hospital, conducted in such hospital; except that if the total of the grants to be made under this subsection for any fiscal year to schools and hospitals with approved applications exceeds the amounts appropriated under subsection (a) for such grants, the amount of the grant for that fiscal year to each such school or hospital shall be an amount which bears the same ratio to the amount determined for the school or hospital for that fiscal year under the preceding sentence as the total of the amounts appropriated under subsection (a) for that year bears to the amount required to make grants to each school in accordance with such sentence.

"(3) For purposes of paragraph (2), the Secretary shall—

"(A) in the case of a grant in the fiscal year ending June 30, 1973, count only the number of first-year physicians and dentists enrolled in graduate training programs described in paragraph (1), and

"(B) in the case of a grant in the fiscal year ending June 30, 1974, count only the number of first- and second-year physicians and dentists enrolled in graduate training programs described in paragraph (1).

"(c)(1) The Secretary may from time to time set dates (not earlier than the fiscal year preceding the year for which a grant is sought) by which applicants for grants under subsection (b) for any fiscal year must be filed.

"(2) A grant under subsection (b) may be made only if the application therefor—

"(A) is approved by the Secretary upon his determination that the applicant meets the eligibility conditions set forth in paragraph (1) of such subsection;

"(B) contains a specific program or programs which such applicant has undertaken to encourage physicians and dentists to enroll

in graduate training programs described in paragraph (1) of this subsection;

"(C) contains or is supported by assurances that such applicant will increase the number of graduate training positions open to physicians and dentists in such graduate training programs;

"(D) provides for such fiscal control and accounting procedures, and access to the records of the applicant, as the Secretary may require to assure proper disbursement of and accounting for any such grant;

"(E) contains a statement in such detail as the Secretary may determine necessary, describing the manner in which any grant made under subsection (b) will be applied to meet the educational costs of the graduate training program for which the grant is made, including any payments from a grant proposed to be made by an applicant which is a school to any clinical facility which participates in such training program under a written agreement of affiliation with the applicant and which shares in the payment of the educational costs of such program; and

"(F) contains such additional information as the Secretary may require to make the determinations required of him under this section, and such assurances as he may find necessary.

"(3) The Secretary—

"(A) shall not approve or disapprove any application for a grant under subsection (b) except after consultation with the National Advisory Council on Health Professions Education;

"(B) shall define in consultation with such Council, those health care fields included within the term 'primary health care' and shall designate any other areas of health care in which there is a shortage of qualified physicians and dentists; and

"Primary health care"

"(C) shall, on an annual basis, establish guidelines specifying such absolute or percentage increases in the numbers of physicians or dentists receiving full-time graduate training which any applicant receiving a grant under subsection (b) as may be required to meet as a condition of such a grant.