AGENDA

COTH ADMINISTRATIVE BOARD MEETING
Parlor A
Palmer House
Chicago, Illinois
February 4, 1972

Call Don Penvene

I. Call to Order - 9:00 a.m.

II. Approval of Minutes, Meeting of October 28, 1971 TAB A

III. Membership TAB B

A) Mail Ballot Confirmation:
- a) The Butler Hospital, Providence, R.I. — no — services available, do outpatient & Brown med. sch. & own evaluation & criteria.
- b) The Hospital for Joint Diseases and Medical Center, N.Y.C. yes
- c) Veterans Administration Hospital, Denver, Colorado yes

Accept

B) St. Joseph Infirmary TAB C — ineligible — Jack Myers - consultation - out moratorium on membership

C) Communication from the Associated Medical Schools of Greater New York TAB D

IV. Items referred from AAMC Executive Council

- a) Eliminating the Freestanding Internship TAB E — approved consensus
- b) Faculty Representation In the AAMC TAB F
- c) Clinical Clerkships for Foreign Medical Graduates TAB G — Memo by COTH report for info

(find out what happened in New Orleans)

V. Progress Report On HMO Grant

VI. Future of Task Forces Reports

1) Task Force to Recommend Goals & Objectives for COTH As Well As Future Criteria for Membership TAB H — accept

2) Committee On House Staff Relationships to the Hospital and the AAMC TAB I — who on task force

3) Task Force to Analyze the Higher Costs of Teaching Hospitals TAB J — ask Rosenthal for yesterday's meeting results

See if we can get copies of VA regional liaison report

VII. VA Sharing Task Force - Mr. Greathouse TAB K — Report on large VA liaison meeting

VIII. Annual Meeting

AAMC Theme: "From Medical School to Academic Health Center" TAB L

evaluate this year's structure

Get list of potential speakers Bart has

IX. Internal AAMC Organization - Mr. Danielson
— Sub-Council activities

X. Legislative Report

A) H.R. 1
B) Price Freeze Regulations

XI. Projects for the Coming Year > affiliation — project preference
what we're doing now
Letter from Hartford Hospital

XII. Information Items:

Composition of COTH Nominating Committee TAB M

XIII. Other Business (Don Fenwirne's suggestion)

XIV. Adjournment

COTH ADMINISTRATIVE BOARD MEETING
October 28, 1971
Washington Hilton Hotel

Present:

Irvin G. Wilmot, Chairman
George E. Cartmill, Chairman-Elect
T. Stewart Hamilton, M.D., Immediate Past Chairman
John H. Westerman, Secretary
Don L. Arnwine
Joe S. Greathouse, Jr.
L.H. Gunter
Bernard J. Lachner
Sidney Lewine
Stuart M. Sessoms, M.D.
Thomas H. Ainsworth, Jr., M.D., AHA Representative

Staff:

John M. Danielson
Richard M. Knapp, Ph.D.
Robert H. Kalinowski, M.D.
Grace W. Beirne
Catharine A. Rivera

I. Call to Order:

Mr. Wilmot called the meeting to order at 3:10 p.m. in the Georgetown East Room of the Washington Hilton Hotel.

II. Presentation by John Mather, M.D. and the Staff of the Institute for the Study of Health and Society:

Mr. Wilmot introduced John Mather, M.D., senior resident in otolaryngology at the University of Maryland Hospital who is Executive Secretary of the Coordinating Committee for a Second National House Staff Conference. Also introduced was Mr. Lou Simmons, Research Coordinator at the Institute for the Study of Health and Society.

Mr. Simmons described the historical development of the Institute as well as some of its current endeavors. He outlined five basic objectives of the Institute as follows: (1) reexamination of the role of health in society; (2) research in health economics; (3) development of a health law center; (4) articulation of the role of consumers in health care issues; (5) full integration of young professionals into the social change process.

In line with objective #5, the Institute has agreed to serve as the contracting or fiscal agent for the Second National House Staff Conference. Dr. Mather outlined the charge to the Coordinating Committee and reported on progress to date. The substance of his remarks appear in a "Position Paper" which is attached as Appendix A to these minutes.

The Conference is to be held on March 2-5 in Atlanta, Georgia. Dr. Mather made two specific requests:

1 - that COTH assist in increasing the awareness of hospital directors, deans, faculty and house staff that the conference is being held;

2 - that COTH use its mailing list to send hospital directors application forms and ask that such applications be routed to the institutional house staff leadership.

Mr. Wilmot thanked Dr. Mather and Mr. Simmons for their presentation, at which point they departed. A discussion of the two specific requests followed.

With regard to the first request, it was pointed out that the anticipated conference had been reported in the COTH REPORT and would be reported in the AAMC BULLETIN and Dr. Cooper's Weekly Activity Report. These actions

happen as a matter of standard operating procedure, and it was agreed that no special action is necessary.

The second request elicited more intensive discussion. A variety of views concerning a proper course of action were presented. Following discussion, there was a consensus that material explaining the conference should be mailed to the membership with a cover letter from Mr. Danielson stating that COTH in no way endorses the conference, but has closely followed the development of this activity.

At this point Dr. Cooper and Mr. Murtaugh joined the meeting to report on the health manpower act and other legislative developments.

III. Consideration of Minutes:

The minutes of the meeting of August 22, 1971 were approved as distributed.

IV. Reconsideration of Action #7, page 17 of the Minutes of the August 22nd Meeting:

Action #7 reads as follows:

> It was moved, seconded and carried with one negative vote cast by Mr. Westerman that the Administrative Board of COTH recommends the dues be increased from $700 to $1,000 annually to become effective July 1, 1972. Further, it was recommended that this recommendation be presented to the membership as part of the report of the Task Force to Recommend Goals and Objectives for COTH.

It was suggested that the Action might be changed to request a dues increase from the membership not to exceed $1,000, but leave the implementation date and final decision to the Administrative Board. The propriety of requesting such powers for the Board was questioned by several members. After brief discussion, there was consensus that the original action should stand as written.

V. Membership:

ACTION #1 — IT WAS MOVED, SECONDED AND CARRIED THAT THE FOLLOWING TWO APPLICATIONS FOR MEMBERSHIP IN COTH BE APPROVED:

1- VETERANS ADMINISTRATION CENTER
BILOXI, MISSISSIPPI

2- VETERANS ADMINISTRATION HOSPITAL
SEPULVEDA, CALIFORNIA

VI. Report of the Nominating Committee:

Members of the Nominating Committee were Dr. Hamilton, Chairman, Mr. Wilmot and Mr. Westerman.

Dr. Hamilton submitted the following report:

Nominations to the AAMC Assembly
Term Expiring 1974

George E. Cartmill
President
Harper Hospital
Detroit, Michigan

Leonard W. Cronkhite, Jr., M.D.
Executive Vice-President
Children's Hospital Medical Center
Boston, Massachusetts

Robert A. Derzon
Director of Hospitals & Clinics
University of California
San Francisco, California

Otto M. Janke
Executive Director & Superintendent
St. Paul-Ramsey Hospital & Medical Center
St. Paul, Minnesota

Arthur J. Klippen, M.D.
Hospital Director
Veterans Administration Hospital
Minneapolis, Minnesota

Sidney Lewine
Director
The Mount Sinai Hospital of Cleveland
Cleveland, Ohio

Herluf V. Olsen, Jr.
President
Medical Center Hospital of Vermont
Burlington, Vermont

Malcom Randall
Hospital Director
Veterans Administration Hospital
Gainesville, Florida

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

Robert M. Sigmond
Executive Vice President & Medical Director
Albert Einstein Medical Center
Philadelphia, Pennsylvania

Irvin G. Wilmot
Director for Hospitals and Health Services
New York University Medical Center
New York, New York

Nominations to the AAMC Assembly
Term Expiring 1972

Don L. Arnwine
Director of Hospitals
University of Colorado Medical Center

Joe S. Greathouse, Jr.
Director
Vanderbilt University Hospital

Nominations to the COTH Administrative Board
Term Expiring 1974

Robert A. Derzon
Director of Hospitals & Clinics
University of California
Hospitals & Clinics
San Francisco, California

Arthur J. Klippen, M.D.
Hospital Director
Veterans Administration Hospital
Minneapolis, Minnesota

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

Term Expiring 1972

Sidney Lewine
Director
The Mount Sinai Hospital of Cleveland

COTH Chairman-Elect

Leonard W. Cronkhite, Jr., M.D.
Executive Vice-President
Children's Hospital Medical Center
Boston, Massachusetts

AAMC Executive Council
Term Expiring 1974

Leonard W. Cronkhite, Jr., M.D.

VII. Task Force Reports:

1 - Task Force to Recommend Goals and Objectives for COTH as well as Future Criteria for Membership

2 - Committee on Hosue Staff Relationships to the Hospital and the AAMC

Dr. Hamilton and Mr. Lachner, chairmem of the respective groups, briefly described the reports they would be presenting at the General Session of the membership the following afternoon.

These two reports as well as Mr. Ferguson's report of the Task Force on the Higher Costs of Teaching Hospitals will be distributed to the COTH membership subsequent to the Annual Meeting.

VIII. Health Services Advisory Committee:

Dr. Kalinowski reported that the first meeting of the Health Services Advisory Committee was held on September 29, 1971, with Chairman Robert M. Heyssel, M.D., Associate Dean for Health Care Programs, The Johns Hopkins University School of Medicine, presiding.

AAMC President John A.D. Cooper, M.D., extended a welcome to the Committee members and described the importance with which he regarded their deliberations in the effort to help the Association in its consideration of all areas of health care delivery. Dr. Heyssel then described the charge to the Committee of exploring initially the feasibility of the involvement of the academic medical centers in the Health Maintenance Organization concept.

The Committee then considered several plans for conducting a study and agreed upon one that would involve a group of consultants and a series of eight regional workshops. A synthesis including recommendations resulting from these workshops would then be considered by the Health Services Advisory Committee and a series of HMO prototype proposed upon this basis. The issue paper setting forth the critical issues was then reviewed. Among those identified for study were (1) Institutional Commitment to the HMO-type

Programs; (2) Organizational Structuring and Governance of the HMO; (3) The Teaching Program and the HMO; (4) Evaluation of HMO Performance; (5) Implications of Identification of the HMO Population Group; and (6) Evaluation. Other members of the Advisory Committee are as follows:

Luther Christman
Dean
School of Nursing
Vanderbilt University
Nashville, Tennessee

Christoper C. Fordham, III, M.D.
Dean
School of Medicine
University of North Carolina

M. Alfred Haynes, M.D.
Associate Dean
Charles R. Drew Postgraduate
Medical School
Los Angeles, California

Robert G. Lindee
Associate Dean for Administration
Stanford University
Palo Alto, California

Richard L. Meiling, M.D.
Vice President for Medical Affairs
The Ohio State University
Columbus, Ohio

Ernest W. Saward, M.D.
Professor of Social Medicine and
Associate Dean for Extramural Affairs
The University of Rochester
School of Medicine and Dentistry
Rochester, New York

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

Anne R. Somers, Ph.D.
Princeton, New Jersey

Robert J. Weiss, M.D.
Associate Dean for Health Care Programs
Harvard Medical School
Boston, Massachusetts

John H. Westerman
Director
University of Minnesota Hospitals
Minneapolis, Minnesota

IX. AAMC-AHA Relationships:

Mr. Wilmot formally introduced Dr. Thomas Ainsworth who will in the future serve as the AHA Representative to the COTH Administrative Board.

X. Other Business:

Mr. Wilmot thanked the members of the Administrative Board and staff for their support during the year. Mr. Danielson, on behalf of the Board, membership and staff extended thanks to Mr. Wilmot for the excellent leadership he had provided over the year.

Dr. Hamilton noted his association with COTH since "the early days" of 1965-66. He cited the satisfaction he had derived and the rewarding relationships which he has enjoyed with his colleagues. The members of the Administrative Board joined in expressing their appreciation of his leadership during these important years.

X. Adjournment:

There being no further business, the meeting adjourned at 5:00 pm. The next meeting of the Administrative Board will be Friday, February 4, 1972 in Chicago at the time of the AMA Congress on Medical Education.

APPENDIX A

2NHSC

SECOND NATIONAL HOUSE STAFF CONFERENCE

SPONSORED BY THE INSTITUTE FOR THE STUDY OF HEALTH AND SOCIETY

JOHN MATHER, M.D.
EXECUTIVE SECRETARY

STEVEN G. McCLOY, M.D.
ADMINISTRATIVE COORDINATOR

PATRICIA H. RAMSEY
CONFERENCE COORDINATOR

1050 POTOMAC ST., N. W.
WASHINGTON, D. C. 20007
(202) 338-7055

POSITION PAPER.

Coordinating Committee for a Second National House Staff Conference.

In March 1971 the First National House Staff Conference was convened in St. Louis, Missouri. The participants included over 200 house officers from this country and Canada, with observers from organized medicine and other fields related to health care delivery.

What happened at the conference?

Extensive reports on this conference have appeared in medical journals including a particularly excellent write-up in the May 1971 issue of HOSPITAL PRACTICE. The majority of the time was taken up with the preparation and approval in plenary session, of Task Force Reports. The areas considered by the participants included racism, community and health worker control of health services, economics, the doctor draft and the question, " What's wrong with the hospital?" Also discussed were international inequality, occupational hazards, house officer training, sexism, new modes of health care, and the foreign medical graduate.

Are these reports available?

The Proceedings of the First National House Staff Conference have been printed by the Government Printing Office. Although they are in limited supply, copies may be obtained from Mrs. Patricia Ramsey, Conference Coordinator, at the above address.

Was a National Association formed at the conference?

No, an association of house officers was not formed at the meeting mainly because the participants felt they did not broadly represent the country's house officers. However, they did establish a Coordinating Committee which is charged with, among other things, the realization of a Second National House Staff Conference. Most observers believe that a national organization of interns and residents will probably be formed at the second conference.

Who is on the Coordinating Committee?

Twelve of the conference participants were elected to this committee which is composed of representatives from seven regions, the women, minority groups, foreign medical graduates, the uniformed services and one from the Ad Hoc committee that recommended its formation. Some of its members, alternates and ex-officio, were members of the steering committee for the first conference and that conference's Ad Hoc committee.

What are the Coordinating Committee's charges?

Briefly stated it is charged with the development of a Second National House Staff Conference, with genuine representation of the country's house officers and fascilitate the formation of a National House Staff Association.

When and where will the Second Conference be held?

The Second Conference will be held in Atlanta, Georgia, March 2nd - 5th, 1972. All doctors and dentists in graduate training programs may attend, as well as those who are serving their two years of military or public health service. The wives of participants and interested observers will be encouraged to attend.

How will the house officers be represented?

The committee has stated as a policy that it will encourage one delegate per 100 house officers or fraction thereof to represent each house staff association or group. Each association or group will be asked to ensure proportionate representation of women, minorities and foreign medical graduates. Nonetheless the committee has developed guidelines to ensure that these smaller groups are adequately represented at the second conference. It is hoped that sufficient funds will be made available for travel expenses and have represented at least one member from each house staff association or group in this country.

How does one participate?

Application forms will be distributed the middle of November and house officers will be expected to participate through their local house staff association or group. Those undertaking training in graduate education programs (MPH, MEd., etc) will be expected to participate through the house staff association or group with which the university is affiliated.

What positions are the Coordinating Committee advocating?

As a group, the committee does not stand for a particular policy or position ... we hold our views only as individuals. Individual members may involve themselves in numerous projects and statements they might make concerning issues only reflect a personnel viewpoint. As a group we stand for a direction and that is, at the expense of repetition, the convening of a Second National House Staff Conference.

Where does the committee stand politically?

Once again, the committee does not have any policy. Presently the committee rejects any notion that it can speak for this country's house officers. As individuals the committee members have various allegiances to many branches of organized medicine (AMA, AWMA, APHA, AAMC etc.) and represent differing geographical and political views.

What function does the committee represent?

The committee is planning a program for the second conference which will focus on issues affecting the future course of training programs for house officers and the delivery of health care in this country. Panelists from all areas of organized medicine and related spheres will be invited to give presentations. The committee is developing a communications network among house officers on a regional basis and in special interest areas. This work is fostered through the distribution of a newsletter entitled "YOUNG DOCTOR'S FORUM".

Is the committee related to national organizations?

No, although individual members may be. The committee is developing a Board of Advisors who are representatives of the divisions in organized medicine. It is hoped that such liaisons as are developed now will be continued and extended following the second conference.

When will a National Association of house officers be formed?

The committee was charged with producing alternate copies of a Constitution and Bylaws for the consideration of the second conference's participants. It is still not known whether such a national association will be created, as this remains the prerogative of the participants of the second conference. Nonetheless many observers feel that it is inevitable. Whether it becomes an integral part of an existing organization in the field of medicine will have to await the deliberations of the second conference's participants.

What might such an association be like?

In as much as it would primarily be an association of house officers it will be responsive to those areas that directly affect their training. Yet, self-serving interests will probably form a small part of its deliberations as it focuses on systems of health care delivery and its organization. It is just this voice of young physicians, who are probably closest to the problems of delivering health care, which has not been heard in the past and should be heard in the future.

Dated. 10/28/71.

Presented to the Administrative Board of the Council of Teaching Hospitals, AAMC.

Prepared and delivered by John H. Mather MD., Executive Secretary CC/SNHSC.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership
in the
Council of Teaching Hospitals

(Please type)

Hospital: Butler Hospital
Name

Providence — 333 Grotto Avenue
City — Street

Rhode Island — 02906
State — Zip Code

Principle Administrative Officer: Ben W. Feather, MD, Ph.D.
Name

Medical Director
Title

Date Hospital was Established 1844

Approved Internships:

Type	Date Of Initial Approval by CME of AMA*	Total Internships Offered	Total Internships Filled
Rotating			
Straight			

Approved Residencies:

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total Residencies Filled
Medicine			
Surgery			
OB-Gyn			
Pediatrics			
Psychiatry			
Other			

Information Submitted By:

Andrew A. DiPrete — President
Name — Title of Hospital Chief Executive

11/15/71 — Andrew A. DiPrete
Date — Signature of Hospital Chief Executive

*Council on Medical Education of the American Medical Association and/or with appropriate A.M.A. Internship and Residency Review Committees.

PLEASE READ INSTRUCTIONS ON REVERSE SIDE

Instructions:

Please complete all copies and return three copies to the Council of Teaching Hospitals, Association of American Medical Colleges, One Dupont Circle, N.W., Washington, D.C. 20036, retaining the Blue Copy for your files.

Membership in the Council of Teaching Hospitals:

Teaching Hospital members shall be organizations operated exclusively for educational, scientific, or charitable purposes. Hospitals as institutions will be members of the Council and each institution will be represented by a person designated by the hospital for the purpose of voting at business meetings of the Council. All members will vote at the Annual Meeting for officers and members of the Executive Committee.

Membership to the Council will be determined by the following criteria:

a. those hospitals nominated by a medical school Institutional Member or Provisional Institutional Member of the AAMC from among the major Teaching Hospitals affiliated with the Members and elected by the Council of Teaching Hospitals, or

b. 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 are elected by the Council of Teaching Hospitals

The voting rights of the Council of Teaching Hospitals in the Assembly of the AAMC shall be as follows: The Council of Teaching Hospitals shall designate 10 percent of its members, up to a maximum of 35, each of whom shall have 1 vote in the Assembly.

If nominated by a School of Medicine, complete the following:

Name of School of Medicine Brown University

Name of Dean Pierre M. Galletti, M.D., Ph.D.

Address of School of Medicine Providence, Rhode Island, 02912

FOR COTH OFFICE USE ONLY

Date_____ Approved_____ Disapproved_____ Pending_____

Remarks_____

Invoiced_____ Remittance Received_____

BROWN UNIVERSITY *Providence, Rhode Island • 02912*
Division of Biological and Medical Sciences

December 23, 1971

John M. Danielson
Director
Department of Health Services and
Teaching Hospitals
Association of American Medical Colleges
One Dupont Circle, N.W.
Washington, D.C. 20036

Dear John:

The Butler Hospital is a private psychiatric institution which has recently joined the group of our affiliated hospitals. As you might have been able to convince yourself during your visit to Providence in early December, the Butler Board of Trustees has made a major commitment toward becoming a teaching hospital. It has appointed a new Medical Director in the person of Dr. Ben Feather, who also holds the title of Professor of Medical Science at Brown University, and serves as Chairman of our Planning Committee for Psychiatry. The Butler Hospital has made financial commitments to additional full-time faculty appointments. It will serve as the focus for a multihospital Psychiatry residency program, covering all our affiliated institutions. I am confident that the Butler Hospital will play a major role in the development of undergraduate and graduate medical education in Rhode Island, and I look forward to its joining the Council of Teaching Hospitals.

Sincerely yours,

Pierre M. Galletti, M.D.,Ph.D.
Chairman

PMG/md

cc: Mr. DiPrete
Mr. Goddard

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership
in the
Council of Teaching Hospitals

(Please type)
Hospital: HOSPITAL FOR JOINT DISEASES & MEDICAL CENTER
Name

1919 MADISON AVENUE, NEW YORK
City Street

NEW YORK 10035
State Zip Code

Principle Administrative Officer: Harvey Machaver
Name

Executive Director
Title

Date Hospital was Established October 11, 1905

Approved Internships:

Type	Date Of Initial Approval by CME of AMA*	Total Internships Offered	Total Internships Filled
Rotating	CME of AMA - 9/70	1 Rotating I 1 Rotating II	1 1
Straight	CME of AMA - 9/70	3 Straight Surgical 2 Straight Medical	3 2

Approved Residencies:

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total Residencies Filled
Medicine	CME of AMA 12/69	6	6
Surgery	CME of AMA 7/67	6	6
~~OB~~-Gyn	Gyn. Res. on rotation from Lenox Hill Hospital		
Pediatrics	---- ----	-----	-----
Psychiatry	---- ----	-----	-----
Other Orth. Surg.	CME of AMA 1/69	30	30
Path.	CME of AMA 9/67	2	2
Anes.	~~Anes Resident on~~ Rotation from Mt. Sinai		

Information Submitted By:

Harvey Machaver
Name

Executive Director
Title of Hospital Chief Executive

10/28/71
Date

Signature of Hospital Chief Executive

*Council on Medical Education of the American Medical Association and/or with appropriate A.M.A. Internship and Residency Review Committees.

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a. those hospitals nominated by a medical school Institutional Member or Provisional Institutional Member of the AAMC from among the major Teaching Hospitals affiliated with the Members and elected by the Council of Teaching Hospitals, or

b. 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 are elected by the Council of Teaching Hospitals

The voting rights of the Council of Teaching Hospitals in the Assembly of the AAMC shall be as follows: The Council of Teaching Hospitals shall designate 10 percent of its members, up to a maximum of 35, each of whom shall have 1 vote in the Assembly.

If nominated by a School of Medicine, complete the following:

Name of School of Medicine Mount Sinai School of Medicine

Name of Dean Dr. George James

Address of School of Medicine 100th Street & Fifth Avenue
New York, New York

FOR COTH OFFICE USE ONLY

Date_____ Approved_____ Disapproved_____ Pending_____

Remarks_____

Invoiced_____ Remittance Received_____

MOUNT SINAI SCHOOL OF MEDICINE
of The City University of New York
FIFTH AVENUE AND 100TH STREET • NEW YORK, N.Y. 10029

Office of the Dean

November 1, 1971

Association of American Medical Colleges
Council of Teaching Hospitals
One DuPont Circle, N. W.
Washington, D. C. 20036

Gentlemen:

Enclosed is an application for membership in the Council of Teaching Hospitals for the Hospital for Joint Diseases & Medical Center. This hospital has been one of our affiliated institutions since the tenth of August, 1970.

I highly recommend that their application for membership be approved.

Sincerely,

George James

George James, M.D.
President and Dean

nb
Enc.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership in the Council of Teaching Hospitals

(Please type)

Hospital: Veterans Administration Hospital
Name

Denver — City
1055 Clermont Street — Street
Colorado — State
80220 — Zip Code

Principle Administrative Officer: James C. Gaskin
Name

Hospital Director
Title

Date Hospital was Established: Hospital previously located at Fort Logan, Colorado (approx. 10 miles from present location) from Oct. 1946 to Aug. 1951, at which time it was relocated to the above address.

Approved Internships:

Type	Date Of Initial Approval by CME of AMA*	Total Internships Offered	Total Internships Filled
Rotating	1947	10	10
Straight	--	--	--

Approved Residencies:

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total Residencies Filled
Medicine	1947	26	26
Surgery	1947	24	24
OB-Gyn	--	--	--
Pediatrics	--	--	--
Psychiatry	1959	12	12
Other(Radiology)	1947	8	8
(Pathology)	1952	5	5

Information Submitted By:
Robert P. Vinall
Assistant Hospital Director
Name

Hospital Director
Title of Hospital Chief Executive

November 30, 1971
Date

Signature of Hospital Chief Executive
JAMES C. GASKIN

*Council on Medical Education of the American Medical Association and/or with appropriate A.M.A. Internship and Residency Review Committees.

PLEASE READ INSTRUCTIONS ON REVERSE SIDE

1/14/72 cw

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a. those hospitals nominated by a medical school Institutional Member or Provisional Institutional Member of the AAMC from among the major Teaching Hospitals affiliated with the Members and elected by the Council of Teaching Hospitals, or

b. 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 are elected by the Council of Teaching Hospitals

The voting rights of the Council of Teaching Hospitals in the Assembly of the AAMC shall be as follows: The Council of Teaching Hospitals shall designate 10 percent of its members, up to a maximum of 35, each of whom shall have 1 vote in the Assembly.

If nominated by a School of Medicine, complete the following:

Name of School of Medicine University of Colorado

Name of Dean (Acting) Gordon Meiklejohn, M. D.

Address of School of Medicine 4200 E. Ninth Avenue

Denver, Colo. 80220

FOR COTH OFFICE USE ONLY

Date_____ Approved_____ Disapproved_____ Pending_____

Remarks_____

Invoiced_____ Remittance Received_____

December 8, 1971

TASK FORCE RECOMMENDED GOALS AND OBJECTIVES
for
COUNCIL OF TEACHING HOSPITALS

The deans of the Associated Medical Schools of New York and New Jersey enthusiastically support the recommendation made by the Task Force to Recommend Goals and Objectives for COTH "that an appropriate affiliation with a school of medicine be required for membership".

Thus far the COTH has been able to accomplish little to improve the standards or quality of the clinical education of students, nor of the training of interns and residents. The Council on Medical Education of the American Medical Association sets minimal standards for an approved internship on the advice of the Internship Review Committee which COTH apparently accepts. Residency program standards accepted by COTH are established by review committees composed of members appointed by the Council on Medical Education and by the specialty boards.

A hospital may be nominated for membership in COTH by a dean or on self nomination, if it has an approved internship program and approved residencies in four (4) specialties, two of which must be in major departments.

The result of these requirements for membership is that forty hospitals in New York City belong to COTH. Thirteen have no definite medical school affiliation. The major educational responsibilities of these latter hospitals is for the training of foreign graduates as interns and residents.

Foreign graduates constituted more than 80% of the house staffs of eleven of these hospitals. We wonder if the quality of these programs is such as to warrant membership in COTH and if the programs were reviewed by a site visit before a membership was granted.

We have not seen the complete report of the COTH Task Force, but would suggest that to become a member a hospital must:

1- Have a definite written agreement with a medical school and is involved in both the education of medical students and the training of house staff.

2- Have its staff appointments approved by the medical school.

3- Have a nucleus of full time staff, (not necessarily fully salaried, but geographical full time with practice limited to hospital facilities).

Hoapitals not meeting such requirements, but having some minor teaching responsibilities for medical students and a recognized internship and residency program might be termed secondary teaching hospitals and given a limited membership in COTH.

We are of the opinion that the Council of Academic Societies is developing in a fashion similar to that of COTH; that is growing in size and numbers without due regard for adacemic standards. Many members of the present societies hold no academic positions and carry no educational responsibilities. We believe the Council of Academic Societies should be limited to associations of faculty members.

ASSOCIATED MEDICAL SCHOOLS OF GREATER NEW YORK

George James, M. D.
President

John E. Deitrick
Director

COTH MEMBER HOSPITALS IN NEW YORK CITY

	NAME	AFFILIATION	# OF RES. PROGRAMS	DATE OF APPLICATION	SELF OR DEAN NOMINATION
1.	Bronx Municipal Hospital Center	M-056	22	10/03/68	Dean
2.	Beth Israel Medical Center	L-108	10	July, 1967	Dean
3.	Bronx Lebanon Hospital Center	--	7	5/11/66	Self
4.	Salvation Army Booth Memorial Hospital	L-060	4	7/15/66	Self
5.	Brookdale Hospital Center	M-060	8	1/03/67	Self
6.	Cumberland Hospital	M-061	8	7/27/66	Self
7.	Catholic Medical Center of Brooklyn & Queens, Inc.	--	7	5/22/70	Self
8.	Harlem Hospital Center	M-057	11	6/21/66	Dean
9.	Hospital for Special Surgery	M-058	5	4/19/66	Dean
10.	The Jamaica Hospital	--	5	4/27/70	Self
11.	Jewish Hospital of Brooklyn	M-061	12	3/11/66	Self
12.	Lenox Hill Hospital	--	11	5/13/66	Self
13.	Long Island College Hospital	M-061	12	3/22/66	Self
14.	Lutheran Medical Center	G-061	6	7/22/66	Self
15.	Memorial Hospital for Cancer and Allied Diseases	M-058 L-082	8	3/28/66	Dean
16.	Methodist Hospital of Brooklyn	L-061	8	5/19/66	Dean
17.	Misericordia-Fordham Hospital	--	8	9/01/66	Self
18.	Montefiore Hospital & Medical Center	M-056	19	5/4/66	Dean
19.	The Mount Sinai Hospital	M-108	20	5/18/66	Dean

NAME	AFFILIATION	# OF RES. PROGRAMS	DATE OF APPLICATION	SELF OR DEAN NOMINATION
New York Hospital	M-058	19	6/20/66	Dean
21. New York Medical College-Flower & Fifth Ave. Hospitals	M-059	17	July, 1966	Dean
22. New York University Medical Center Hosp.	M-060	20	5/09/66	Dean
23. Presbyterian Hospital in the City of N.Y.	M-057	21	5/06/66	Self
24. Roosevelt Hospital	M-057	12	4/20/66	Dean
25. St. Clare's Hospital	--	6	7/05/66	Self
26. St. John's Episcopal Hospital	G-061	6	4/11/66	Self
27. St. Luke's Hospital Center	M-057	16	4/21/66	Dean
28. St. Vincent's Medical Center of Richmond	G-059	8	5/15/70	Self
Veterans Administration Hospital, Bronx	L-108	15	6/16/69	Dean
30. Veterans Administration Hospital, N.Y., N.Y.	L-060	16	8/12/66	Dean
31. City Hospital Center of Elmhurst	L-108	17	July, 1966	Dean
32. State University Hospital of N.Y.-Downstate Medical Center	M-061	20	11/01/67	Self
33. Veterans Administration Hospital, Brooklyn	M-061	9	6/09/66	Dean

NEW YORK CITY HOSPITALS
COTH MEMBERS

# of Residency Programs Offered*	# of Hospitals Offering
22	1
21	2
20	4
19	2
17	2
16	2
15	1
12	4
11	2
10	1
9	1
8	7
7	2
6	3
5	2
4	1
TOTAL	37

*Source: AMA Directory Of Approved Internships And Residencies, 1971-72

NEW YORK STATE HOSPITALS
COTH MEMBERS

# of Residency Programs Offered*	# of Hospitals Offering
22	1
21	2
20	5
19	4
17	2
16	3
15	2
14	2
13	2
12	5
11	2
10	1
9	2
8	11
7	4
6	5
5	4
4	2
TOTAL	64

*Source: AMA Directory Of Approved Internships And Residencies, 1971-72

COTH HOSPITALS	
# of Residency Programs Offered*	# of Hospitals Offering
23	1
22	4
21	8
20	25
19	15
18	13
17	11
16	19
15	15
14	20
13	17
12	19
11	24
9	20
8	33
7	25
6	24
5	21
4	28
3	16
2	6
1	7
TOTAL	371

*Source: AMA Directory Of Approved Internships And Residencies, 1971-72

COTH MEMBERS

AFFILIATION*

Major Affiliation	= 255
Limited Affiliation	= 73
Graduate Affiliation	= 26
Unaffiliated	= 36
TOTAL	390

*Source: AMA Directory Of Approved Internships And Residencies, 1971-72

Not Listed In AMA Directory:

Cedars Sinai Hospital, Miami, Florida
U.S. Public Health Services Hospital, Carville, Louisiana
Good Samaritan Hospital, Baltimore, Maryland
Robert Brigham Hospital, Boston, Massachusetts
Veterans Administration Hospital, Sepulveda, California
University Hospital, University of South Alabama, Mobile, Alabama

Number Nominated By A Dean = 259

Number of Self-Nominated = 145

ELIMINATING THE FREESTANDING INTERNSHIP

At the September 17th Executive Council meeting, the attached material recommending the elimination of the freestanding internship was passed out. At that time, Council members did not have an adequate chance to review the statement and the recommendation of the Ad Hoc committee was subsequently tabled.

One of the major questions raised in discussion was the need for a clearer definintion of a "freestanding" internship. A definition of the meaning of the term may be found in the attached memoranda from the AMA.

In view of the Assembly's recent adoption of the "Statement on the Responsibility of the Academic Medical Centers for Graduate Medical Education," it seems appropriate that the Executive Council reconsider the "Policy Statement on Eliminating the Freestanding Internship."

RECOMMENDATION: that the Executive Council remove from the table and approve the Policy Statement on Eliminating the Freestanding Internship.

POLICY STATEMENT ON ELIMINATING THE FREESTANDING INTERNSHIP

At its December meeting, the House of Delegates of the AMA approved the concept that the freestanding internship should be eliminated. Subsequently, memoranda from the AMA's Council on Medical Education were circularized on December 28, 1970 and March 18, 1971, explaining the implications of this policy (copies of memoranda attached).

The AAMC has made no public statements regarding this development. It is clear that eliminating the freestanding internship is consistent with the development of a more logical continuum of medical education and with the policy statement which will be presented to the Assembly in October regarding the responsibility of academic medical centers for graduate medical education.

A committee consisting of Dr. John Parks (COD), Dr. Tom Kinney (CAS) and Mr. Irvin Wilmot (COTH), Dr. August Swanson (Staff) met on September 3rd and approved the following statement.

> The Association of American Medical Colleges believes that the basic educational philosophy implied in the proposal to eliminate the freestanding internship is sound. Terminating the freestanding internship will encourage the design of well-planned graduate medical education and is consistent with the policy that academic medical centers should take responsibility for graduate medical education. The elimination of the internship as a separate entity is a logical step in establishing a continuum of medical education designed to meet the needs of students from the time of their first decision for medicine until completion of their formal specialty training.

Recommendation:

The committee recommends that the Executive Council approve this statement and forward it to the Assembly for consideration along with the policy statement on the responsibility of academic medical centers for graduate medical education.

AMERICAN MEDICAL ASSOCIATION

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

COUNCIL ON
MEDICAL EDUCATION

MEMORANDUM

TO: All Hospitals with Approved Graduate Programs
All Deans of Medical Schools
All State Boards of Medical Examiners
All Medical Specialty Boards
All Residency Review Committees
All Medical Specialty Societies Represented on Residency Review Committees

FROM: C. H. William Ruhe, M.D.,
Secretary, AMA Council on Medical Education

SUBJECT: Integration of Internship and Residency Training

DATE: December 28, 1970

At the AMA Clinical Session in Boston on December 2, 1970, the AMA House of Delegates approved the third of a series of three actions aimed at integration of the internship and residency years, and emphasizing the continuum of undergraduate and graduate medical education. The first action was taken in December, 1968 with adoption of the statement that "an ultimate goal is unification of the internship and residency years into a coordinated whole."

The second action was in June, 1970, with approval of two statements establishing dates by which integration of internships with residency programs must be completed.

At the December, 1970 meeting, the third action was the adoption of a report entitled "Continuum of Medical Education," which contained ten specific statements recognizing the relation of the previous actions to the requirements of state licensing bodies, the requirements for certification by medical specialty boards, the operation of intern and resident matching programs, the interdependence of undergraduate and graduate programs, and other matters. The complete report is attached.

The actions taken represent further efforts toward implementation of the recommendations of the Citizens Commission on Graduate Medical Education (Millis Commission). They emphasize the necessity for increasing assumption, by the teaching faculty or professional staff of a teaching institution, of corporate responsibility for all of the educational programs offered by that institution.

Full effectiveness in implementation of these actions will depend upon cooperative efforts and complementary actions by teaching institutions, state licensing bodies

and medical specialty boards. The AMA Council on Medical Education hopes that such cooperation and complementary action will lead to shortening of the total time required for medical education and greater emphasis upon the unity and the continuum of medical education.

The Annual Congress on Medical Education, to be held at the Palmer House, Chicago, February 14-15, 1971, will include as a part of its program a discussion of these matters and will provide a forum for the exchange of ideas and opinions, and for explanation of the goals of the unification of the internship and residency years into a coordinated whole.

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COUNCIL ON
MEDICAL EDUCATION

Report of the Council of Medical Education
Approved by the A.M.A. House of Delegates, December 1970

CONTINUUM OF MEDICAL EDUCATION

Report L of the Board of Trustees, presented at the AMA Annual Meeting in June, 1970, stated the results of continuing studies by the Board of Trustees and the Council on Medical Education of the various provisions of the Report of the Citizens Commission on Graduate Medical Education. Two specific recommendations in the Report, aimed at the unification of the internship and residency years into a "coordinated whole," were adopted by the House of Delegates. These were as follows:

1. After July 1, 1971, a new internship program shall be approved only when the application contains convincing evidence that the internship and the related residency years will be organized and conducted as a unified and coordinated whole;

2. After July 1, 1975, no internship program shall be approved which is not integrated with residency training to form a unified program of graduate medical education.

The action of the House of Delegates in adopting these recommendations did not abolish the internship program, but did require that it be made an integral part of a total program of graduate medical education. The advanced deadlines were set to permit institutions to reorganize their programs of graduate medical education to conform to these requirements.

The effective implementation of these recommendations requires that related organizations and agencies, such as the state licensing boards, the examining boards in medical specialties, and the faculties of medical schools, reevaluate the requirements stated in their current policies.

To insure that the desired transition from the undergraduate curriculum to a unified program of graduate medical education can be effected, it is recommended that the following statement on the Continuum of Medical Education be adopted:

1. That the first year of medical education following receipt of the M.D. degree be accredited by an appropriate residency review committee;

2. That all state licensing boards be notified that, effective July 1, 1970, the first year of an approved residency program, including family practice, is acceptable to the Council on Medical Education as an internship approved by the American Medical Association;

3. That it be recommended to the specialty boards that they consider giving credit toward certification for appropriate clinical experience afforded prior to the granting of the M.D. degree;

4. That medical schools be asked to examine the need for four calendar years of undergraduate medical education and to consider the possibility of beginning graduate medical education in the fourth year;

5. That within the area of graduate medical education joint cooperative efforts be encouraged between university faculties and community hospitals in order to produce a larger number of physicians to provide for the delivery of health care;

6. That within university medical centers and their affiliated hospitals university faculties jointly with the faculties of their affiliated hospitals assume greater corporate responsibility for the conduct of graduate education;

7. That the principle of a voluntary matching program be preserved, and that the only point at which this can be preserved is at the time of obtaining the M.D. degree;

8. That the director of a unified program of graduate medical education be responsible to insure that trainees in the program are adequately grounded in such of the broad fields of medicine, surgery, pediatrics, psychiatry, family practice, and pathology as are appropriate to the program and to individual career goals;

9. That all specialty boards requiring three or more years of graduate experience permit the substitution of at least one year of graduate education in medicine, surgery, pediatrics, or family practice for their own stated requirements;

10. That the future design and development of post-M.D. education programs, and curricula leading to qualification for examination by a specialty board, should emphasize:

    a. The educational goal,
    b. The personal motivation,
    c. The learning capabilities,
    d. The individual evaluation,

of each post-M.D. candidate, without reference to calendar perimeters of a fixed or limiting character.

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COUNCIL ON
MEDICAL EDUCATION

MEMORANDUM

TO: All Directors of Approved Graduate Training Programs
All Deans of Medical Schools
All Medical Specialty Boards
All Residency Review Committees
All Medical Specialty Societies Represented on Residency Review Committees

FROM: C. H. William Ruhe, M.D.,
Secretary, AMA Council on Medical Education

SUBJECT: Implications of Recent Actions to Integrate Internship and Residency Programs

DATE: March 18, 1971

On December 28, 1970, a memorandum was sent to all hospitals with approved graduate programs reporting recent actions by the American Medical Association aimed at integration of internship and residency education and emphasizing the continuum of undergraduate and graduate medical education. The present memorandum is intended to amplify and explain that report, and to consider the implications of the unification of graduate training programs.

The Council on Medical Education has approved the following statements for the guidance of program directors:

1. Unification of internship and residency years into a coordinated whole implies that the total program must be directed by one individual. This person must necessarily, therefore, have the responsibility and authority for direction of the residency program in that specialty, and he must be responsible for preparation of the entire application, describing all years and the relationship of each year to the others.

2. The program director should have the option of either requiring or recommending a specific type of "internship year" acceptable as a part of his residency program, depending upon the resources of the institution and the undergraduate experience and career objectives of the candidate.

3. The program director should have the option of designing the internship year as a traditional rotating experience, a rotating experience with a specified

major, or a straight experience limited largely to the specialty field concerned. He should have complete freedom in the design of this internship year and would not need to designate it by any of the above three standard terms. The program director should have the option of including within the internship year specific experiences of particular value to the trainee in his future career, even though the specialty board concerned may have stated that it would not give credit for certain of these experiences toward eligibility for certification.

The institution has the ultimate, corporate responsibility; the program director has the administrative responsibility, but, in order to exercise this responsibility, he should have available the collective judgment of his counterparts in the related specialties.

4. The program director might elect to assign the trainee to an outside hospital for his internship year, would assume responsibility for his educational program for that period of time, and would have to describe in a convincing way those elements of the outside program that assure coordination with the program in the parent hospital. He might also accept trainees who have had experience in other institutions approved for such training.

5. The program director would have to specify the conditions under which a candidate appointed to the first, or internship, year would be eligible for appointment to the subsequent years of the program.

The Future Status of the Internship

When the House of Delegates adopted the statement in Report L of the Board of Trustees, in June, 1970, some program directors interpreted the action on the "free-standing internship" to mean that the rotating internship was being abolished; others interpreted it to mean that any internship in a hospital without a medical school affiliation was being abolished; some simply assumed that all internships were being abolished.

The action of the House of Delegates did not abolish internships, but did require that they be made an integral part of a total program of graduate medical education. Deadlines have been set far enough in advance to permit institutions to reorganize their programs of graduate medical education in order to be able to conform to these requirements if they wish to continue to offer such education.

The term "free-standing internship" has been misinterpreted by a number of program directors. It was intended to indicate those internships not related

to residencies, whether the residencies are in the same hospital as the internship or in other hospitals.

1. Examples of free-standing internships would include:

   (a) an internship offered in a hospital that has no residency programs and that has no relationship to other hospitals for graduate training;

   (b) an internship offered in a hospital that has approved residencies, but that offers the internship as a discrete experience with no indication that it is coordinated with residencies in the same hospital or elsewhere.

2. Examples of an internship, or first year of graduate education, integrated with residencies, would include:

   (a) a rotating internship in one hospital integrated with one or more residencies within that hospital;

   (b) a rotating internship in one hospital integrated with one or more residencies in another hospital;

   (c) a straight internship within one hospital integrated with a residency in that specialty, either solely in that hospital or in a group of hospitals;

   (d) a straight internship structured on the same lines as the residency and integrated in two or more hospitals for the entire training period;

   (e) a straight internship in two or more hospitals integrated with a residency offered in only one of the hospitals.

Critical Mass

In the report adopted at the December, 1970 meeting of the House of Delegates, entitled "Continuum of Medical Education," Item 8 expresses the need for a "critical mass" within any hospital approved for graduate medical education. A successful graduate training program cannot be carried out in a vacuum. However, because the minimum requirements differ from specialty to specialty, the minimum critical mass for good training must be determined for each specialty. In internal medicine, for example, there must be a residency in general surgery. For a residency in family practice, there must be creditable departments of radiology and pathology. The general requirements stated in the "Essentials of Approved Residencies" are applicable to all programs, and provide minimal safeguards.

Memorandum-Implications of Recent Actions to Integrate Internship and Residency Programs

March 18, 1971

The director of a unified program of graduate medical education must be responsible to insure that the trainees in his program are adequately grounded in such of the broad fields of medicine, surgery, pediatrics, psychiatry, family practice, and pathology as are appropriate to the program and to individual career goals. The Council on Medical Education and its Advisory Committee on Graduate Medical Education recognize the value of the concept of a basic two years of graduate education, from the standpoint of facilitating lateral mobility and allowing the candidate to delay committing himself to a premature choice of a specialty. Nevertheless, the Council also recognizes the fact that there is currently a strong trend in students toward early branching within the undergraduate program. Thus there could be a conflict between the desire to shorten the total span of specialty education and the desire to provide breadth of training before the candidate concentrates on narrower specialty training.

Program directors should structure graduate training programs so that they provide not only the requisites acceptable to the specialty boards but also insure that adequate breadth of training is provided without significantly prolonging the total span of training. One step in this direction is the acceptance by most of the examining boards in the surgical specialties of the principle of an examination after a basic two years of surgical training.

Cooperation of Other Organizations and Agencies

Coordination and integration of internships and residencies can be carried out only with the effective cooperation of medical schools, state licensing boards, and the examining boards in the medical specialties. The medical schools in many instances are studying their curricula, and are considering the possibility of concentrating undergraduate medical education in such a manner that at least a portion of the final year can be used to provide graduate education. University faculties, jointly with the faculties of their affiliated hospitals, should assume greater corporate responsibility for the conduct of graduate education, to insure that a meaningful experience is afforded each graduate. In order to produce a greater number of physicians to provide for the delivery of health care, cooperative efforts should be developed and encouraged between university faculties and community hospitals.

Both the December 28, 1970 Memorandum and the present Memorandum have been sent to all state licensing boards so that each of these agencies will be aware of the fact that, as of July 1, 1970, the Council on Medical Education considers the first year of any approved residency program, including that of family practice, as the equivalent of an internship approved by the American Medical Association. This policy should make it possible for trainees to obtain some of the experience normally available in an internship during their fourth year

of medical school, so that, upon graduation, they could be accepted into the first year of a residency program, provided the specialty board in that field does not require an internship, or will give credit for clinical experiences obtained in the final year of medical school.

The American Board of Medical Specialties, which now acts as the coordinating body for the approved examining boards, has also been notified of the adoption of these policies. It is hoped that the specialty boards will give consideration to the possibility of providing credit toward certification for appropriate clinical experience obtained prior to the granting of the M.D. degree, and consider also the possibility, in those specialties requiring three or more years of graduate experience, of permitting substitution of at least one year of graduate education in medicine, surgery, pediatrics, or family practice, for stated requirements of the individual boards.

If the specialty boards find it possible to reorient their requirements for certification so that less emphasis is placed on calendar perimeters, future graduate programs could be designed in such a way that the house officer would be able to achieve his educational goal in as short a time span as possible, based on the program director's individual evaluation of the trainee, which would take into consideration the latter's personal motivation and learning capabilities.

Future Procedures and Evaluations

The effective date of July 1, 1975, was chosen to provide for the orderly implementation of these policies, and to give program directors, medical schools, specialty boards, and licensing boards an opportunity to develop effective implementation of the recommendations.

It seems desirable that, for the present at least, the principle of a voluntary matching program for graduate medical education be preserved. The only point at which this can be preserved is at the time of obtaining the M.D. degree. In the case of a specialty for which the board does not require an internship, there may be developed a matching of the first year of the residency. This is being done on a limited basis in the March, 1971 Matching Program, and a separate matching program has been carried on during the past year for residencies in radiology and in orthopedic surgery, both of which specialties do require an internship.

It has been the policy of the Department of Graduate Medical Education to survey approved programs at intervals of about thirty to thirty-six months. This schedule of surveys will be maintained during the years intervening prior to July 1, 1975, and programs will be evaluated during that time on the basis of previous "Essentials of an Approved Internship" and "Essentials of Approved Residencies."

Memorandum-Implications of Recent Actions to Integrate Internship and Residency Programs

March 18, 1971.

During the past year, as many program directors are aware, straight internships in internal medicine, surgery, obstetrics-gynecology, and pediatrics have been evaluated by the residency review committees in such specialties, and the straight internships in pathology have been evaluated by the American Board of Pathology along with residencies in that specialty. The rotating internships are currently evaluated by the Internship Review Committee, which will continue to carry on this responsibility at least until 1975.

Applications for new, free-standing internships in general will not be accepted for survey unless it can be shown that the program would be implemented as of July 1, 1971. Program directors considering the establishment of a rotating internship at this time should plan an intramural program of internship and residency training or should develop affiliations with other hospitals so that such a coordinated program could be offered. Many hospitals might also be eligible to consider the possibility of offering a three-year family practice program, the first year of which can be credited as an internship.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

JOHN A. D. COOPER, M.D., PH.D.
PRESIDENT

WASHINGTON: 202: 466-5175

December 8, 1971

MEMORANDUM

TO: AAMC Executive Council Members

FROM: Office of the President

SUBJECT: FACULTY REPRESENTATION IN THE AAMC

The enclosed paper on faculty representation in the AAMC was prepared by AAMC staff at the direction of the participants in our December Retreat. The paper summarizes the discussion of the Retreat on this issue, and presents to the Executive Council the recommendations of the Retreat.

This subject will be open to discussion at the December 17th Executive Council meeting.

cc: Dr. Kinney, Mr. Danielson, Mr. Thomas, Dr. Wilson, Dr. Swanson, Mr. Fentress, Mr. Murtaugh

RETREAT DISCUSSION OF FACULTY REPRESENTATION IN THE AAMC

The question of faculty representation served as the focus of discussion at the AAMC's recent Retreat (December 2-4). At issue was the basic justification for such an expansion, the mechanism by which this might best be accomplished, and all long-range implications of such an action on the Association.

Discussion of these questions stimulated a wide range of opinion. While there was general agreement on the value of involvement of the faculties, several questions were raised concerning their role in the governance of the Association. One questioned the possibility of "representation," stating that only the individual delegate would be involved and that nothing would be done to involve or truly represent the whole of the faculty. Another concern was the manageability of the Association: have we reached a critical mass beyond which point proliferation will eventually lead to paralysis.

Extensive debate on these points established a general consensus in favor of formally involving the institutional faculty in both the substance and governance of the Association. As was noted in support of this viewpoint, a primary concern of the AAMC, by definition, is medical education, and this task must eventually be accomplished by the faculty. Seven options for incorporating faculty into the governance of the Association were then solicited:

1) abolish CAS in favor of a Council of Faculties (COF), which would provide for subordinate representation of the professorial societies;

2) retain CAS and establish an Organization of Faculty Representatives (OFR) within the COD--parallel to the OSR;

3) expand CAS to incorporate junior faculty (possible rename COF);

4) establish voluntary compus chapters of the AAMC. Bring a representative of each chapter directly into either CAS or COD. When 50% of the faculties were so organized, they would form a separate council (COF);

5) reorganize regional meetings only, to include COF (Midwest example);

6) retain CAS and establish COF;

Prepared by AAMC for discussion at December 17, 1971 Executive Council meeting.

7) replace COD with a Council of Institutional Representatives (CIR). Each school would have three delegates -- dean, faculty member, student--and one vote.

It was decided that two separate issues had to be resolved: first, how this faculty body is to fit into the AAMC governing structure, and second, how the faculties are to be organized to select a representative.

After much discussion, a consensus was reached on Option #2 above--establishing an Organization of Faculty Representatives under the Council of Deans. An integral part of this consensus was the agreement that this proposal would be presented to and discussed by each of the constituent Councils before going to the Assembly in November. It was also agreed that a moratorium be declared on future expansion of the Association until such time as all the implications of this expansion could be evaluated.

The question of organizing the faculty elicited two different proposals: (1) election of a representative by the whole of the organized faculty (Academic Senate); or (2) establishment of voluntary campus chapters, composed of those faculty members who hold AAMC individual membership and who would elect a representative from their chapter.

While the value of encouraging individual membership was recognized, consensus was reached on the first alternative. The feeling was expressed that the second option would be time-consuming, would leave some schools without faculty representation, and would tend to represent "joiners." It was also described as a "poll tax."

Thus, consensus was reached on an Organization of Faculty Representatives, structurally equivalent to the Organization of Student Representatives, both in its relationship to the governance of the AAMC and in its membership requirements. It was also agreed that AAMC staff would prepare a proposal to transmit this consensus to the December Executive Council meeting for "rigorous debate" and for referral to the February meetings of the CAS, COD, and COTH. A progress report will be presented to the February Assembly meeting, and receipt of the proposal (with amendments and recommendations) from the Councils will be expected at the May 19th meeting of the Executive Council. Final action is aimed at the November Assembly.

This paper and the attached draft Guidelines are therefore submitted to the Executive Council for the review and referral mentioned above.

GUIDELINES FOR THE ORGANIZATION OF FACULTY REPRESENTATIVES

ORGANIZATION

There shall be an Organization of Faculty Representatives which shall be related to the Council of Deans and which shall operate in a manner consistent with Rules and Regulations approved by the Council of Deans.

COMPOSITION

The OFR shall be comprised of one representative form each Institutional Member and Provisional Member of the COD, chosen from the full-time faculty of each such member.

SELECTION

A faculty representative from each participating Institutional Member and Provisional Member of the COD shall be selected by a process which will insure representative faculty input and be appropriate to the governance of the institution. The dean of each participating institution shall file a description of the process of selection with the Chairman of the COD and shall certify to him annually the name of the faculty member so selected.

MEETINGS

Annual Meeting. The OFR shall meet at least once a year at the time and place of the COD Annual Meeting in conjunction with said meeting.

To facilitate the smooth working of the organizational interrelationships, the above shall be interpreted to require that the Annual Meeting of the OFR be held during the period of the Association's Annual Meeting, not simultaneously with the COD meeting. This meeting will be scheduled in advance of the COD meeting at a time which will permit the attendance of interested or designated deans.

ACTIVITIES

The OFR will:

- Elect a Chairman and a Chairman-Elect.
- Recommend to the COD the Organization's representatives to the Assembly. (10% of OFR Membership)
- Consider other matters of particular interest to the faculty of Institutional Members.
- Report all actions taken and recommendations made to the Chairman of the COD.

RELATIONSHIP TO COD

The Chairman and Chairman-Elect of the OFR are invited to attend the COD meetings to make such reports as requested of them by the COD Chairman, to act as resource persons to express the concerns of faculty when invited, and to inform themselves of the concerns of the deans.

RELATIONSHIP TO THE EXECUTIVE COUNCIL

The Chairman of the OFR shall be an ex officio member of the Executive Council with voting rights.

RELATIONSHIP TO THE ASSEMBLY

The Institutional Members and Provisional Institutional Members that have admitted their first class shall be represented in the Assembly by the members of the COD and a number of the OFR equivalent to 10 percent of the members of the Association having representatives in the OFR.

Each such representative (to the Assembly) shall have the privilege of the floor in all discussions and shall be entitled to vote at all meetings.

The Chairman of the Assembly may accept the written statement of the Chairman of the COD reporting the names of individuals who will vote in the Assembly as representatives chosen by the OFR.

COMMITTEES

One representative of the OFR to the Assembly shall be appointed by the Chairman of the Assembly to sit on the Resolutions Committee.

RULES AND REGULATIONS

The OFR shall draw up a set of Rules and Regulations, consistent with these guidelines and the Bylaws of the AAMC, governing its internal organization and procedures. The Rules and Regulations shall be consonant with the goals and objectives of the COD.

FINANCES

- The Association will meet the cost of the travel required for authorized faculty participation in Association committee activities, i.e Executive Council, Administrative Board, and designated committee meetings.

- Staffing expenses will be allocated by the President by administrative action.
- Other costs associated with faculty participation will have to be individually arranged at the institutional level.
- Association funds required to support this organization must be reallocated from currently budgeted funds reducing activities in other areas.

CLINICAL CLERKSHIPS FOR FOREIGN MEDICAL GRADUATES

The AMA Council on Medical Education has proposed a new pathway for U.S. citizens in foreign medical schools to be admitted into AMA approved graduate training programs. This proposal is described in the policy statement adopted June 23, 1971 which is attached. The Executive Council in its action on December 1970 decided to leave the question of participation in this program to the individual schools and establish no general policy.

The attached letter signed by the Deans of the Michigan schools raises questions about the program and requests consideration by the AAMC.

The AMA Council has prepared a statement of guidelines for medical schools that wish to accept foreign medical graduates. This statement has not been widely circulated but has been made available to those requesting information. The AAMC was not consulted in the preparation of the guidelines.

The Council on Medical Education is meeting in New Orleans on November 26-28 and is expected to take further action on this program at that meeting.

Recommendation: Deferred until information is available from the meeting of the Council on Medical Education in New Orleans.

CHAIRMAN'S REPORT [COTH Ad Bd. Agenda 2-4-72 Tab H_7

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

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As you can imagine from the title, the charge to this Task Force was indeed wide ranging, and we ranged rather widely. It was wide enough so that, as I will comment to you, on a couple of issues where we felt rather uncomfortable, we decided that maybe that wasn't our "bag" and so backed off.

All of our group didn't make both meetings, but most of us made at least one, and as you will note, we covered a number of subjects, and we invaded the territory of one or both of the other task forces now and then.

This bothered me until a few minutes ago when Mr. Danielson gave his report, and I found that he had invaded my territory too. So I feel comfortable now and with that, I will fire away:

This Task Force held two all-day meetings -- one in early June and the other in mid-September. We came to four or five major conclusions, which I would like to categorize into three areas:

The first, the role of the AAMC in general

The second, program and dues

And the third, new directions

And I would hope that our Task Force and its thoughts will generate some discussion both now and in the weeks and months ahead, because it may have a profound effect on your Council of Teaching Hospitals and on the Association of American Medical Colleges.

With regard to the AAMC in general, I would like to begin by discussing a little of the history of the role of the AAMC prior to 1965. In those days, as you know, these meetings were really quite small, and the only hospital-oriented person with a long, long history of attending these meetings is here today, I am

glad to say -- Dr. Robin Buerki, who dates back to 1922. And that, I think, beats most of us. But when I first began to come to the meetings, a number of years after that, I was always sure of seeing Robin Buerki -- and often only one or two other people I knew.

It was largely a deans' club. And from this, with the leadership of Al Snoke and others, the hospital group began to get together.

Out of a meeting in Montreal a decade or so ago grew a number of suggestions, many of which were incorporated into the Coggeshall Report, which has really resulted in a major change in the organization of the Association of American Medical Colleges.

One of the key events was the move to Washington, and in the light of what is happening these days it certainly seems to have been a wise one. We all worry about whether being this close -- this deep in the trees we can see the woods -- but on balance I think that this was a very wise thing to have done.

The other important change that resulted from the Coggeshall Report was the expansion of decision making responsibilities, which created the Council of Deans, the Council of Academic Societies, and the Council of Teaching Hospitals. And we have gone along on this basis for a half a dozen years now.

But during this time -- as John Danielson has mentioned -- there have been great changes in the universities with a substantial increase in the numbers of vice-presidents for health affairs whose responsibilities extended beyond those of the medical schools and their affiliated teaching hospitals.

This created problems for the AAMC, because largely the vice president was a person who had been a dean and when be became the chief executive officer of the academic medical center, did he give up his position here?

The "ex-deans-now-vice-presidents", and new vice presidents were in an area of added responsibility, and in our organization of the AAMC we really hadn't

worked out a way to plug them into the integral part of the organization. Because of this and for other reasons they have founded their own organization, which is now known as the Association of Academic Health Centers.

The Task Force viewed this and discussed it at length and took an interim position which I would like to read you and then come to the final position, that:

> "All deliberations and recommendations of this task force are based upon the assumption that the Association of American Medical Colleges is the appropriate organization to represent the 'academic medical center'. Further, the assumption is made that an appropriate method will be established to achieve an effective integration of staff and policy committees that will facilitate coordination of university matters concerning medical schools, teaching hospitals and academic affairs through the AAMC organizational structure".

There were a number of alternative courses of action that seemed available, and even a chart was drawn to show one possible way.

The Vice-Presidents' organization was urged to organize their efforts, to coordinate its efforts with the others working together through their own organization which would be staffed, we hoped, by a joint AAMC-Vice Presidents' organization staff.

Subsequent events did not bring this to fruition, and although the AAMC has its offices in the same building as the AAMC, they do have a separate staff. We felt in our discussions, that in times like this -- and Mr. Danielson said it very well -- that it was very imporatnt nationally that our image be visible and clear in the health field. And our concern was that this might tend to make it fuzzy.

The final action of the Task Force in this area was as follows:

"The next two years will be a period of crucial concern for academic medical centers. The Task Force wishes to reiterate its deep concern that the Association of American Medical Colleges is the appropriate organization to represent the 'academic medical center'. Efforts should be vigorously pursued to achieve an effective integration of staff and policy committees with the Association of Academic Health Centers that will facilitate coordination of university matters concerning medical schools, teaching hospitals and academic affairs through the AAMC organizational structure".

This, of course, is the action of only one Task Force of one part of the AAMC, and will be going with your comments, whatever they may be, to the retreat to which Mr. Danielson referred.

Now let me move into the second area, and this will be very brief. We talked about program and dues. We have already covered the dues, so I don't need to go into that. But as we looked at the program and how it was developed, we felt that it was developed by meetings such as this, by regional meetings, and by submission of questionnaires and tabulation of your comments on these questionnaires -- the very thing that was commented on earlier by Dick Knapp. We looked at it and felt that it might not be ideal, but it seemed to be working pretty well, and until there seemed to be evidence that we ought to change, we should continue on this track. So we picked that stone up and took a good look at it and put it back down again.

Out third area was "new directions" and we hit two points here, and in two areas; I would like to comment on these in a little greater length.

We talked about affiliation, and wondered whether affiliation with an academic medical center should or should not be a prerequisite for a hospital's membership in the Council of Teaching Hospitals.

Under the existing regulations, you may remember that teaching hospitals may become members if they are:

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.

This latter mechanism was originally intended to pick up the institutions such as psychiatric or pediatric institutions, which may not have a full spectrum of graduate programs but did have an integral part in the teaching program of the Univ.

We looked at our membership, which is something over four hundred, and noted that of that group -- and this was a year or so old -- that only sixty-eight COTH members did not have an affiliation of some kind with a medical school.

With the changes that are going on these days, we felt that this number today might be half that. We did not know for sure.

Certainly, as we looked at the trends, it seemed to us more and more that the trend was for any institution which is teaching interns and residents to develop some sort of an affiliation with an academic medical center somewhere.

We reviewed our present criteria and we were in general agreement that some appropriate affiliation with an academic medical center should indeed be a criterion for membership in COTH.

We talked about proposals for determining COTH membership and came to the following:

ELIGIBILITY -- Eligibility for membership in the Council of Teaching Hospitals is determined on the basis that the hospital has an appropriate, documented, affiliation arrangement with a school of medicine for the purpose of undergraduate and/or graduate medical education.

REQUIREMENT --

1. Approval by the COTH Administrative Board.
2. Approval by the AAMC Executive Council.

PROCEDURE FOR APPLICATION --

1. Application by the hospital with an endorsement by the Dean of the affiliated school of medicine;

or

2. Nomination of the hospital by the dean of the school of medicine.

The final action of the Task Force in this matter was as follows:

"The Task Force to recommend Goals and Objectives for COTH as well as future criteria for membership recommends that an appropriate affiliation with a school of medicine be a criterion for COTH membership and that the aforementioned eligibility, requirement and procedure for application be presented for discussion at the Council of Teaching Hospitals Annual Meeting".

We did not get into whether we ought to hang onto the other criteria in addition, and maybe we should have. This is one of these afterthoughts that come to you in brilliant flashes about a week after you adjourn.

We wondered about the institutions that do not meet these requirements, who are presently members. We felt, certainly, that they should continue to be included and be welcomed as long as they would like to be.

We then picked up another aspect of this, because out of New York had come -- and any of you from New York will, I am sure, be prepared to warm to this subject -- the importance of grouping Council of Teaching Hospitals membership in more than one group, because of varying costs, even within the Council of Teaching Hospitals membership, and some of the hospitals with higher costs not being given

an opportunity really to justify these, but being compared directly with other institutions which might be quite distant and quite different and also have much lower costs.

This was a stone that we picked up and took a brief glance at and put back down again quickly! We just felt that we couldn't handle it at this moment in time, and we hoped that one of the other task Forces might be working on that. So I must report that this is one element of undone work by this Task Force, if indeed it was out assignment.

Finally, the second of our "new directions" was to consider the role of the medical staff in the Council of Teaching Hospitals. And here this will touch more than somewhat on what Bernie Lachner will be telling you, because one of the things that came out of his Task Force was the fact that in some hospitals there is a house staff component to the medical staff composition with members of the house staff serving on committees and so forth.

We were facing the problem of what we should do to encourage medical staff participation and also what to do about the house staff who wanted to get some input into the AAMC and thought and wondered whether the Council of Teaching Hospitals might not be an appropriate place.

It seemed to us -- perhaps simplistically -- that if indeed the house staff is a part of the medical staff that by bringing in the medical staff we could perhaps resolve both questions. So we then turned our discussion to how to relate to the medical staff of the teaching hosptials.

Concerning this matter, we agreed that if the AAMC has a major concern for the delivery of health services, a proposal to bring in the organized medical staff is a logical and necessary development following the establishment of the Division of Health Services.

On the other hand -- and this was one of the caveats -- such a proposal could intensify the breach between the clinical and the basic science faculty

because indeed it might theoretically give the clinical faculty an added input into the decision-making mechanisms of the AAMC.

It was stated, however, that the proposal that we were considering should not in any way be viewed as an effort to solve the faculty representation problem. We were looking at it as a method to help with the Council of Teaching Hospitals. A key element for managerial effectiveness is a good working relationship between physicians and administrators. And if we could fold them in, this proposal would be a method of approaching that goal.

The action of the Task Force then, which was unanimous was that the proposal which reads as follows would be presented to the institutional membership at the COTH Annual Meeting and be forwarded for review through proper channels.

The first part of this will concern goals and functions, but I urge you to pay attention to the last paragraph:

"SINCE: -- the organized medical staff is responsible for the quality and quantity of professional care rendered in the academic medical center;

"SINCE: -- the hospital is the clinical environment of the academic medical center;

"SINCE: -- the organized medical staff of the hospital has an ever increasing obligation to influence a change in the delivery of health care in their communnity;

"SINCE: -- no presently constituted national organization or association (other than the individual hospital) represents the medical staff of our teaching hospitals.

"THEREFORE: We recommend that the Council of Teaching Hospitals sponsor the organization of teaching hospital staffs within the framework of the Council of Teaching

Hospitals and the Department of Health Services and Teaching Hospitals."

And the purpose of this is:

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

The functions, as we looked at them were:

To Render Advice and Assistance:

1) In establishing new and/or improved methods of the delivery of health services.

2) In the resolution of problems related to government programs effecting health care delivery.

3) In developing more effective and useful organizational patterns to improve communication and decision making.

4) Through expert counsel on regional planning of health services and facilities.

5) In effectuating more appropriate, accurate, rational and efficient medical record systems.

6) In the development of affiliations between institutions and professionals to insure a greater continuity of care and a broader range of educational opportunities.

7) Concerning the appropriateness of programs in graduate medical education.

8) To the Council of Teaching Hospitals and the Department of Health Services and Teaching Hospitals on matters relevant to their expertise.

And how to do this?

We discussed several ways of hooking on an appendage and then we tried to put ourselves in the seat of the medical staff members and how they would react to this.

We thought also of our regional meetings, and the fact that many of us had medical staff members come, sometimes often -- but more often than not, their feeling was that when they came to the regional meetings, the discussion was largely administrative and that they didn't get a chance to put the questions in that were really of interest to them.

And therefore, after considerable discussion, we agreed on the following method of implementation, which was to fold the medical staffs right in with the existing administrative structure of the Council of Teaching Hospitals, and it is worded as follows:

"This concept should be fully integrated into the present Council of Teaching Hospitals Organization by establishing two representatives from each teaching hospital -- the chief executive officer of the institution, and a physician appointed by a mechanism to be determined by each individual hospital member of COTH. Administrative Board membership and other appointments would be adjusted accordingly."

And then, as I say, by bringing the medical staff in, not only at the administrative board level but more importantly at the regional meetings and thus the setting of our aims and priorities, we believe that such action would help to bring a closer integration between the hospital administrators and the hospital medical staffs all along the line.

POINTS RAISED IN DISCUSSION

1. Are continuing medical education affiliations to be included in the definition of affiliation?

2. "I gather that these recommendations will all go to the retreat that is being made, and therefore be discussed by other parts of the AAMC.

But I have some concern, as I think of the opposition, that a member of the medical staff be appointed to serve the COTH as well as the chief administrative executive officer, because I think, in many of our teaching hospitals -- especially those that are owned and operated and merged in with the medical center -- that the medical staff is not well organized in the traditional sense.

It is heavily departmentalized. The recognition is by faculty and not often by medical staff status. And therefore, I think that it may be difficult, by bringing in one member of the clinical faculty group, to achieve the very good goals that you have set out.

So that I would hope that this would be discussed by the academic societies, which do represent the clinical departments, although there are some problems there because this is heavily specialty oriented and not hospital oriented, and by the Council of Deans, who, I think, have some problems too as to how the clinical faculty relates to them and to the whole institution and to the hospital and not just to the specialty.

But I do see problems in some institutions with staff being heavily full time, heavily departmentalized, and I am not at all sure that one representative is going to accomplish the goal."

3. "But extending this too, I am concerned about size. And it seems to be characteristic of organizations that they grow and they grow and they grow, and then certain groups feel that they are no longer representing them, and then you have spin-offs.

I think that the academic vice-presidents of medical affairs is possibly an example of this and other problems. And I hope that consideration will be given to the size and proliferation problem in all of this.

Also, if I may make a comment on affiliation, I thought -- I think I heard it correctly, Dr. Hamilton; you said affiliation, a criteria, because my concern here is if it becomes the most significant criteria in states such as Connecticut where the eventual goal is to have every hospital affiliated with an academic medical center, you could fold in every hospital."

4. "First I would like to agree with the comment concerning the medical staff representation. In our organization we do have a strong medical staff organization, but, as a matter of fact, they are clinical faculty, so whether one has or does not have a strong organizatio, they are one and the same people.

The other thing is the thing that sort of bothers some of us, perhaps, which is the name of the two organizations that we are talking about -- the Association of American Medical Colleges and the Council of Teaching Hospitals, which are somewhat mutually exclusive in the sense that teaching hospitals teach more than just medical students and post-graduate medicine. Perhaps this is what has caused this other group to come off.

In terms of numbers of students, our pharmacy, dental, nursing, and allied health far outnumber medical students.

So whether these people perhaps could be represented by another fringe group? And I think perhaps back to the original question -- where do you stop?"

5. "I lost track of exactly how this came up or who submitted it, but as a suggestion, I wonder if we get to this point -- I don't object to it except that I had commented here about size.

Would it be possible to take this up with our institutions, with our medical people, and see whether they really are interested in some majority basis of membership. I know many of them are begging us to stop them from going to meetings also, and if we could consider it, I think that we would find a lot of them that, if they knew all of the facts, would probably say, "Well, we prefer to just not be represented at this time".

How do we know they all really want it? All of our institutions?"

6. "I think that at least I feel a need, an operational need, for a much higher degree of medical staff involvement in operation. And it seems to me that we are getting into an era now of alternatives, as opposed to the open-ended horn of plenty.

So that every month I feel much more acutely the need to get doctors tuned in to some of the kinds of problems and help them make the decisions. So I think - am I correct, Stew - that part of the motivation here is to give us a better handle on the operational end?

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

Chairman's Report

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My part in this program is to comment briefly on the activities and deliberations of the Committee on House Staff Relationships to the Hospital and the Association of American Medical Colleges.

The charge to our committee was three fold:

1. We were to examine the nature of the relationship and participation of the House Staff in the activities of the Association of American Medical Colleges.

2. We were to discuss an appropriate response to a resolution from a national House Staff organization submitted to the Council of Teaching Hospitals at the Los Angeles meeting as well as a response to a letter from the same group to Irvin Wilmot requesting participation in the Association of American Medical Colleges.

3. Finally we were asked to review the current status of the costs of House Staff programs with an eye to the development of a position statement on financing graduate medical education.

We had two full day meetings on this subject and, in addition, were provided with a variety of data. As you can imagine we started out on the circular path of whether this subject is education or service or both and ended up back where we started -- talking and talking as everyone else has for many years.

The minutes of our meetings contain significant data to show very clearly that this experience for a young physician is education and should be examined in that vein. There is an equal amount of information that would support a position of being very clearly service. You put it all together and it

supports a mixed education and service experience.

You have personally thought about, read about, written about, and talked about all of these arguments for years, so they will not be repeated here. But suffice it to say, depending on where all of us finally light in defining these issues, this will clearly set our sights and has implications for the participation of the House Staff in the Association of American Medical Colleges.

I can report that there was general agreement that the House Staff does have a role and should be represented in the Association of American Medical Colleges. Their continuing education and patient service responsibilities are very appropriately included in our goals and objectives. At the same time it is very clear that they have no visible organizational avenue, clearly identifiable, separate and exclusive for participation in the activities of the Association of American Medical Colleges at the present time.

If interns and residents are employees, if the hospital collects money from the patient and pays them a salary or stipend, if the hospital is legally liable for their actions, perhaps they belong as a part of the Council of Teaching Hospitals.

If they are students and receive a stipend and are appointed through Medical School affiliations, perhaps they belong as a part of the Council of Deans.

If they are students involved in clinical experiences, selected, trained and certified by a clinical chief of service, then perhaps they belong as a part of the Council of Academic Socieites.

From this you can perceive the committee's dilema in this regard.

And finally, if none of these fits neatly, then perhaps a separate reporting mechanism needs to be identified.

The activities and deliberations of this committee as well as the expectations for direction and some beginnings of a resolution of this matter have implications for all of us. We must certainly at some point in time firmly and resolutely decide as a national policy what is the education content and the clinical experience requirements for a practicing physician. We must decide under whose aegis this education will take place, which clinical facilities are most appropriate, and who is going to pay for it.

We must recognize that at the present time there is a very clear distinction between an internship and residency at a city hospital in New York, Chicago, or Los Angeles, compared to this same avowed experience at a church related hospital in Salt Lake City, Indianapolis, or Dayton. Both of these are separate, distinct, and apart from a University Hospital experience in Iowa City, Gainesville, or Columbus.

The size of the program, the education commitment including the clinical supervised experience, the service component and the economic implications vary in these three settings across the entire spectrum of experience.

One of the things we must consider and review is how much of what kind of supervised education experience is necessary to practice medicine after the awarding of the M.D. degree. At the present time there are very few self-respecting physicians who dare to go into practice without at least two or three years of post M.D. training. If this is so and if there is to be a commonly

accepted period of time and educational experience needed, then perhaps this should be carried out as a regular postgraudate university student, receiving a stipend and paying fees. An integral part of this program must be provision of professional services. This kind of position clearly identifies the primary role of education and sublimates the service component.

It would clearly recognize student status, not employee status, under supervision of responsible staff members.

For those physicians completing this educationally oriented postgraduate medical education experience under supervision, who wanted no further training, they would then be eligible for both practice, peer acceptance, and the necessary redefining of Board eligibility and certification in selected areas.

For those who wished to take further work as fellows, trainees, or postgraduate students, these would be selected opportunities for further work as students.

Another approach is to review the discussion of Dr. Hamilton's committee on goals and objectives for the Association of American Medical Colleges as they relate to a proposed involvement of the medical staff of a teaching hospital in the activities of the Council of Teaching Hospitals. They are important as they might relate to the House Staff. For example, if we could decide that the House Staff should be members of the medical staff, that they very clearly are providing a service as licensed physicians, that as a group they should be involved not only in the practice of medicine, but in the evaluation and peer judgement process, through the organized medical staff of a hospital, we could be approaching a solution to this problem from another

vantage point. If the Council of Teaching Hospitals should look favorably on this type of involvement of practicing physicians, then perhaps a mechanism for inclusion of the House Staff will become more apparent.

In addition to this and in spite of all of this is the recurrent question, of who speaks for the House Staff? If for example, a separate House Staff organization in the Council of Teaching Hospitals were to be set up, how would representatives be selected. If this were to force House Staff organizations in each hospital across the country for the reason of electing from the membership for the Council of Teaching Hospitals, this perhaps might not be appropriate or in the institutions best interest. In addition, if dues were necessary who would ultimately pay them, the House Staff member, his hospital, the medical staff, the medical school or finally the patient or the taxpayer. And for what purpose? This question at the present time still does not have a generally accepted answer. It is a key to final understanding and support.

In getting after the third major assignment we had at the request of our committee, the staff of the Council of Teaching Hospitals undertake the task of developing the beginnings of a working paper that could serve as a guide to the final development of a position statement on the financing of graduate medical education.

This paper develops the position that as a result of various studies the personal educational component for House Staff members on a broad base seems to come out at an average of one third of their total experience. This kind of thoughtful process could lead to a further distribution of the remaining two thirds

of this experience to include patient care services, to include teaching responsibilities, to include research, to include administrative responsibilities and perhaps other areas. This also could have direct implications for the payment of the costs involved in these programs.

Very clearly the various governments involved, Federal, State, or Local, as a National policy could approve and fund capitation grants for the educational component. In like manner, payment for patient care service should come directly from the source for payment of the professional fee for patient care services. This gets directly at the issue of double payment for service and we ultimately, if not right now, must face up to this problem.

Lastly, the teaching and administration services involved should be recognized and paid for by the employing agency, whether it be the hospital or the medical school.

This kind of discussion has ramifications streaking in all directions. It will make many gasp feverishly for fresh air; some will decide that now is not really the time to address this issue of professional fees and their distribution; and others will say that maybe what we have been doing hasn't been all that bad. But all of this leads us to the further realization that a part of this total problem relates to the numbers. How many House Staff positions are available, what types of internships and residencies are needed and where will they be located. It seems very clear to me that we are fast approaching a point in time where we will have legislated from the agency paying the bill just how many of this or that type of graduate medical education experiences there will be.

There will be a limited number of positions for each specialty established and no more. The needs and desires of the graduating student will no longer be considered as important, but will be sublimated to an established public interest policy. This has implications for recruitment, for medical school curricula, licensing bodies, accreditation groups and others.

I don't think we should over react to this possibility. Our very current history shows that in other countries of the world that are having similar manpower and financing problems they have at times gone down the same road of redefining the numbers of specialists needed in the public interest.

There were many other interesting points in the discussion of this intriguing, difficult and emotional problem. I regret that many more interested, dedicated and thoughtful persons did not have the opportunity to participate in these important deliberations.

Finally to review again, this committee had three charges.

1. To examine the nature of the relationship and participation of the House Staff in the activities of the Association of American Medical Colleges.

   Our response specifically to this is the following action: "It was moved and seconded and carried by a vote of six to one, that the Committee on House Staff Relationships to the hospital and the Association of American Medical Colleges recommends that consideration of representation of House Staff in the Association of American Medical Colleges in any determination of the overall

makeup of representation within the Association of American Medical Colleges be discussed at the officers retreat in December, 1971. Further it is the sense of this committee's deliberation that because house officers are involved in and actively participate in education and medical practice it is appropriate that they have representation in the affairs and governance of the Association of American Medical Colleges".

2. To discuss the appropriate responses to both a resolution submitted to the Council of Teaching Hospitals and a letter to the chairman of the Council of Teaching Hospitals, Mr. Wilmot, relative to House Staff participation in the Association of American Medical Colleges. Our response to this was an acknowledgement of receipt of each of these documents and information to the effect that a committee had been formed to review this whole matter, including these requests.

3. Finally the position paper on the financing of graduate medical education.

Several drafts and reviews of this document have taken place. It also will be reviewed at the officers retreat in December of 1971.

We have been addressing a problem and seeking a solution that has eluded us for years. Perhaps we have an appropriate group, the Association of American Medical Colleges looking at it now. I could hope that we will actively participate in these discussions looking to some definitive action.

I have appreciated the opportunity to represent the committee in this regard as well as to participate in their discussions.

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POINTS RAISED FROM THE FLOOR

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1. Mr. Perkins described the Pennsylvania Insurance Commissioner's views on financing graduate medical education, and also made the following point, "The Insurance Commissioner has also raised the question as to how much dues should the patient pay for. And he has specifically said that he thinks that it is completely out of the realm of reasonableness for the patient to be paying for AHA, AAMC, the small Council of Teaching Hospitals -- we don't happen to have any dues -- but the Delaware Valley Hospital Council, the Hospital Association of Pennsylvania, etc.

So one of these days some Insurance Commissioner, I am afraid, is going to be able to make something stick on that, so that probably there will be a question as to where are the dues coming from for the various organizations to which we belong."

2. "Was house staff in on this Task Force study?

The reason I ask is that we all know the house staff opinion changes, and when such distribution of the source of salary is finally determined, there will be a different opinion than perhaps currently exists now. But there is a very strong opinion among house staff that they are primarily in the positions they are in for their education and not always for service to patients.

One hears very commonly, 'I have seen five or six strokes and, therefore, I don't want to take care of any more strokes. I have learned about the care of that kind of patients'. And I think that it is very important that house staff attitudes be included in the Task Force studies, and perhaps if it has to be modified, attempts at education of the current medical students who will be house staff at the time that this distribution of salary source comes so that they know what they are getting into."

3. "I am interested in whether or not the Committee had a chance to take a look at the indirect costs?"

What we are talking about is the direct costs of house staff's salary, and they, in effect, represent, well, no more than half -- fifty per cent of the total costs of an education program. The indirect costs are very important"

4. "I think, perhaps, we have passed over a little too lightly this problem of indirect costs, because it seems to me that there is a potential trap here, as you develop whatever approach is developed -- unless you pretty thoroughly include the indirect costs of education, because the context of this is that the service components will be paid comparatively to other non-teaching institutions.

And unless you have pretty thoroughly identified the teaching costs or the education costs rather thoroughly, you will find yourself still remaining with a higher cost in the service component.

There are a lot of things that were not mentioned here -- faculty, for example, as a major portion, such things as medical libraries, et cetera, ad infinitum, which are direct parts in addition to laboratory and other kinds of costs.

And this is something that needs to be very carefully studied before we begin negotiating on taking out the education costs. And we haven't discussed again, as I mentioned earlier, the other than medical education costs."

5. "What is going to prevent any front end funding for the educational costs from going directly to the pay check of the house officer?"

6. "Although these finances are quite an important issue, and I would not take issue with anything that has been said, I still fail to see what the relationship is exactly between the financing of house officers and why they must be a member of this group, or for that matter, why any other group relating to the teaching hospital must be brought into our fold as part of the discussants and decision-makers."

7. "In these deliberations you must not forget the marketplace either, because we might come up with a nice philosophical split of service versus education and the house staff protective organizations might not agree. And if they disagree enough, they might threaten to strike about it, and they are powerful enough to gain some points.

And as far as Mr. Dennenberg in Pennsylvania goes, if he says that he will pay the house staff only so much, they could pick some critical areas in Pennsylvania and tell Mr. Dennenberg that they are going to strike, and they could make him back water".

8. "Yes, I think this division that is proposed, one-third service, I think it very definitely is subject to what the house officer feels, and this is going to vary in various institutions across the country.

However, as has been mentioned, the one-third deduction from the physician's payroll to cover this expense is going to open up another bag of worms. As has been shown, the amount of time that a physician spends when there is a teaching program in an institution is increased.

If money is taken out of his pocket because of this, he is then going to, in turn, going to demand one-third payment from the house staff for tutition for the amount of time that he is putting in. And I think that we are going to be right back where we started, and I think that this has to be looked at very carefully too."

TASK FORCE TO ANALYZE THE HIGHER COSTS OF TEACHING HOSPITALS

Chairman's Report

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There are no answers to the assignment to our Committee -- at least not at this time. So what I am going to give you is a resume of our activities to date and a progress report; we have no specific recommendations.

I might say that the previous two Task Forces discussed with you some very important principles with an undertone of money. I will talk to you this afternoon about the subject of money with an undertone of philosophy.

The reason for our establishment, I think, has been referred to already. And that was the fact that the Association became aware of the activities in several areas of the country with reference to limitations on the reimbursement to hospitals, because it is pretty obvious that those who pay for the bills, particularly through government auspices, must eventually come to a point of limiting.

The first attempt at this always is to seek some means of uniformity by deciding that everyone is equal. It showed up in New York State under their very ambitious state programs for the development of an overall system of health care for the state and its citizens. It particularly affected several hospitals that are members of COTH and in these instances the state authorities chose to group these hospitals with other hospitals in their areas that, I think all of us would agree, were not compatible.

Therefore, this Committee was asked to see what they might do in helping to resolve this problem. As I say, we have not resolved it; I don't think that there is a single resolution, and we still intend to meet in the future in order to come to futher grips with it.

Let me read briefly from the statement that was given to us as to our anticipated charge:

"It is not anticipated that this Task Force would engage in a major revenue, expenditure and cost analysis of teaching hospitals. It is anticipated, however, that the Committee will review the past and present efforts that have attempted to identify differentials in revenue, expenditures and costs between the teaching hospital and other non-teaching hospitals."

"Further, it is hoped the committee will identify differences in organization, program and type of personnel that might account for the significant variation in costs between teaching hospitals".

By the way, the Committee had before it information that had been collected by the staff that showed a great deal of variation, and no compatibility.

"It seems clear that some rational and reasonable expense accompanies any significant engagement by the hospital in medical, as well as allied health education. What is not clear is the extent to which special programs and their accompanying highly skilled personnel account for major differences in cost between teaching hospitals".

Question:

"Can we determine more practical and effective use of such special programs?"

"Which special programs could or should be financed separately from usual patient care funds?"

"Is there any significance to the method of physician reimbursement in the determination of cost differences?"

"What financial or operating data should be accumulated that is not now available?"

"Is it appropriate to compare, for reimbursement purposes, the range of services and educational programs in teaching hospitals? If so, how?

"What is the significance of intensiveness versus comprehensiveness of [our] service[s]?"

"How does the Task Force view the current popular belief that 'separate sources of funds must be developed for the financing of research and education, and costs related to these functions not be co-mingled with costs of patient care'."

You can see that the concern of our Committee was interrelated with all of the discussion that we have had before.

I might comment that our Committee was made up of a wide representation not only of hospital administrators but deans and physicians from the Council of Academic Societies, so we had an opportunity to have a broad spectrum of opinion and point of view. As you can expect, the one meeting we had was substantially taken up by exploring what the feelings or the beliefs and points of view were of each of the members.

There were many suggestions. A variety of issues were discussed. And the question constantly was:

How do we proceed? How do we look at this problem, and as somebody has called it, how do you massage the numbers so that you can come up perhaps with an approach? How do we review the varied variables which may affect cost?

And here are some of the variables that we set down:

1- The size of the intern and resident staff;

2- The number of fellowship positions;

3- The extent to which the full range of clerkships is offered to undergraduate medical students;

4- The volume of research undertaken;

5- The extent to which the medical faculty is integrated with the hospital medical staff in terms of faculty appointments;

6- The nature of the affiliation arrangement;

7- The appointment or employment of full-time salaried chiefs of service;

8- The number of other full-time salaried physicians;

9- The number of special service programs offered;

10- The level of complexity demonstrated by the diagnostic mix of patients cared for;

11- The staffing pattern and ratios resulting from the distinctive patient mix;

12- The scope and intensity of laboratory services;

13- The financial arrangements and volume of service rendered in outpatient clinics and emergency rooms.

Obviously, each hospital meets each of these characteristics to a varying degree. Ideally, the objective would be to examine the extent to which each hospital meets these, as well as other critical criteria, and classify accordingly.

We looked at several efforts which have been made across the country to research this problem of higher costs:

There is "An examination and Discussion of Factors Influencing Hidden Educational Costs In a University Medical Center Setting" by the University of Kansas, and Mr. James Leming of that staff came and presented his information to us -- a most interesting approach.

There was the "Patient Classification Study", sponsored by the Hospital Research and Educational Trust of the American Hospital Association. The purpose of this study is to relate the characteristics of the patient population to institutional expenditures.

A third study was sent to each member for review. It comes from Pittsburgh, where the hospitals -- all of the hospitals in that area -- working with Blue Cross, developed a model for estimating hospital costs, sponsored by Blue Cross of Western Pennsylvania. Although we see some problems with this effort, it again appears that this might be an approach that the Committee may wish to use as it attempts to set up some sort of a model through which they could examine various variables.

In all such studies we seem to have at least two difficulties:

One is the problem of identifying our product. This afternoon, we have been talking about house officers -- the question of the product of education that we furnish. There is the product of patient care. There is the product of improved care, research, advancement of the science and the practice of health service.

It is clear that the teaching hospital has more than one product, and we have trouble sorting out these products for cost purposes. Additionally, we tend to feel our service product is different from that of a community hospital. However, we have not articulated this very well, and we have only begun to substantiate this feeling with evidence.

I am sure that you can appreciate that our friends in New York, our friends in Pennsylvania, and in other areas, as their questions start to come, are studying this with a great deal of intensity so that they can respond because they have a very practical and difficult problem.

The second difficulty we have is in deciding what is the appropriate unit of cost measurement. We have broadly based yardsticks of patient days and admissions, which many would say are unsatisfactory.

We also have departmental and other specific units such as those provided by HAS -- Hospital Administrative Services -- which also have difficulties associated with them.

The Task Force did make a summary statement which provides us with some direction conceptually. And here we attempted to state that there are three general factors to be considered when we discuss the higher costs of teaching hospitals.

We believe these to be -- and again I point out that we believe these to be because there isn't entirely sufficient strong evidence to indicate that these are all true:

1) The severity of illiness and complexity of diagnosis which patients bring to the teaching hospital;

2) The comprehensiveness and/or intensiveness of services provided by the teaching hospital;

3) The institutional commitment to the incremental costs of providing the environment for undergraduate and graduate medical education.

I would also comment that recently there are some new papers that have been developed that attempt to address this subject. Again, it becomes a little bit confusing because as they attempt to relate these variables to cost, they can't get a clear picture that anyone or any group necessarily can give you a particular answer.

After we had our meeting and had come to a conclusion, I asked that the various members write a note to us concerning their thoughts on our discussion. I think it would be interesting for you to hear the comments from several of them:

1)"We need to define and document what it is that we do in support of medical education. It should be relatively easy to identify those things that teaching hospitals do. They need not be things that no other hospitals do. Each institution can then rate itself with respect to the degree of involvement in the affairs that characterize teaching hospitals."

"This approach, together with the identification of the spectrum of disease and complexity of illness that characterize our individual patient loads, I think will be the foundations of our defense".

2) "[We should] attempt to identify factors in the educational component of costs -- house staff, directors of education, etc."

"I thought one other point was clarified as the meeting moved along. To cloak our higher costs in their entirety as the result of our being an 'educational' institution is not justified. In reality we have higher costs for two reasons -- a commitment to education and a tendency to provide more sophisticated expensive type of procedures. In this day of extreme rigidity in reimbursement formulas and of public concern about high costs, it is critical that we not generalize but rather deal in specific and separate consideration of each segment".

3) "I am not interested in proceeding to specifically identify some of those things which make teaching hospitals differ".

[You see, here comes the point -- are there differences even among teaching hospitals? And again you must realize that the public as yet has not chosen even to indicate that there might be a difference]

"Again, I appreciate the problems for COTH in what [this suggestion has]. However, it is the primary teaching hospitals which are in the most precarious position. It is their continued vitality which demands that their special roles and attributes be clearly identified, quantitatively measured to the extent feasible, and politically and publicly appreciated".

[I would underscore the latter comment because I think that this is the arena in which we are going to be judged -- the political and public arena].

4) "Perhaps the COTH staff could develop data concerning the numbers of medical students, house officers, nurses and other health professional personnel who are educated and trained in the 'primary' teaching hospitals. As to the definition of 'primary', we'll need help from the Committee [which is] dealing with membership criteria.

Now where do we go from here?

I would say that we need to settle on a strategy on how to proceed, and I believe that when we next meet this is going to be the issue that will be before the Committee members.

How do we now feel that we can go ahead and try to grab hold of this problem, and attempt to come up with some ideas and principles that we could then apply in better describing the problem, if not in its solution.

What do we examine? In other words, when we talk about the teaching hospital and its cost -- and if this is higher -- what part of it do we examine in order to indicate the differences?

How do we examine it? In other words, perhaps we have to again watch what is ocurring in a state like New York, because, perhaps, out of practical experience it is much better than something that you might wish to think about and can try.

There might be various approaches:

As I mentioned, the Pittsburgh model is one approach -- and I am sure that we are going to see more models like this, as different areas start to examine it. And also now that we heard from Ralph Perkins in Pennsylvania, it is going to be interesting to see how they examine this.

In all of this, I think that although we are discussing costs, I believe our concern is that we maintain the fiscal viability of teaching hospitals, so that they can continue to do those things which are unique to their purposes, namely, education of physicians as medical students, interns, and residents, and perhaps for postgraduate education and advancing medical care and knowledge.

I wonder if the public has come to accept this, that this is unique to this particular group of hospitals? I doubt it. And I am sure that it is not going to be easy to perhaps develop a sympathetic understanding of the uniqueness of these institutions.

We need to clearly measure the size of our commitments in these areas, and be certain that those who may wish to alter the existing means of financing are aware of the importance of our commitments to national goals for manpower and health care needs.

If our teaching hospitals are not to be adequately supported in these efforts, what institutions or groups are prepared to take over? This, I believe, is the issue which must be addressed, and I hope that we can help in resolving.

I might mention along the way that there came to our attention also a document from our friends in Minnesota. It so happened that they had a "Health of the Nation" series, and as part of that, the teaching hospitals that are members of the Council of Teaching Hospitals in Minnesota drafted a statement which may be a prototype of the type of thing that we may wish to prepare. There are four hospitals represented, and they developed this to indicate what they meant to the State of Minnesota. And when you read it, you get the clear impression that they are pointing out that they are unique, that they have a special role, and that they wish to be understood.

And I would close by commenting on or reading to you the final paragraph of this report.

"The Major affiliates of the Minnesota Council of Teaching Hospitals hope that this brief summary has provided for the public an understanding of their role and function in Minnesota. That the public must be knowledgeable if they are to support, advise, and participate in the future of health care, is recognized by the hospitals. Advice and participation is actively sought for the coming year".

This is not a publicity program, this would be to gain a more sympathetic and a more universal understanding of the particular role that several hundred hospitals - probably in the range of two to four hundred out of a total constellation of seven thousand hospitals in the United States - it is the play in a very important national arena of health manpower, education, research, and patient care.

I believe that this is an important background against which any other explanation we make about what it is, what we cost, et cetera, must be given, so that we can get maximum effective understanding and, hopefully, solutions for the problems that we face."

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POINTS RAISED FROM THE FLOOR

1)

"I believe if we are addressing the question as to how are we going to support the teaching hospital, we are going to have to take a more direct, and pay more direct, attention to what is basically the product of the hospital.

And so far I have heard this afternoon much discussion about the uniqueness of the teaching hospital as a teaching institution, and as an educational institution, and I think that it is going to be difficult to justify it to the public only on that basis alone.

And I wondered if the objective or the definition should be as an institution that provides a certain kind of patient care, and minimize this partitioning of the activity of the hospital between that which is rendered to patients and that which is strictly as an educational facility for individuals who already have a doctorate in medicine or who are still undergraduate students in medical college.

I think that as long as we continue to only look at ourselves as unique institutions, primarily as a teaching activity, and sort of always tag onto the end of our tripod of activities "patient care", we are always going to have difficulty justifying this to the public.

As the medical director of a community-sponsored hospital, I have a board that constantly asks, "Why are we a teaching hospital?" And I think that the only way that I can elicit support from them is to try to convince them that this teaching institution has an effect on the quality of care given to the patients within that hospital. And when I can convince them of that, they are willing to support it. I don't think that they are any different from the public at large."

2)

"I would like to second that observation. I would like to go back about eighteen years to the work that Bob Sigmund did in connection with the work of the old Commission on Financing Hospital Care. Bob demonstrated very simplistically the straight-line relationship between the scope of service of a hospital and the per diem cost.

And it seems to me that what we are talking about is a large scope of service institution which has had per force attached to it -- and for very natural and understandable reasons -- a multiplicity of educational obligations. And the education is taking the licks for the whole kit and caboodle. It is really the scope of the service which that hospital is able to produce for the public at large having superimposed upon it an educational component that is the real cause of the high costs.

And I think, Stan, that your Task Force would be well advised to take the counsel of the gentleman who preceded me here, to go back and really re-study the scope of service of all hospitals and segregate out those who are alluding to themselves as "teaching", and then begin to see where the separation is here between the highest scope of service and the educational component.

And I think that we can get ourselves off of a bit of the defensiveness that has now made the word "education" kind of a "bad-mouth".

MINUTES

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF TEACHING HOSPITALS

VETERANS ADMINISTRATION SHARING
TASK FORCE MEETING

AAMC Headquarters
Washington, D.C.
October 7, 1971

PRESENT:

Joe S. Greathouse, Jr., *CHAIRMAN*
Clyde G. Cox
L. H. Gunter
Kenneth J. O'Brien
Hugh R. Vickerstaff
James W. Varnum

EXCUSED:

John Reinertsen

STAFF:

John M. Danielson
Robert H. Kalinowski
Richard M. Knapp, Ph.D.

GUEST:

Mr. William Freer
Special Assistant to the Assistant Chief Medical Director for Planning and Evaluation

Following the call to order and introduction of members, Mr. Greathouse asked John Danielson to present his views on the role and function of the Task Force.

John Danielson stated that in order to improve communications with Veterans Administration Hospital members of COTH he had been meeting quarterly with an advisory group lead by L. H. Gunter, and composed of the following individuals: John Chase, M.D., Arthur Klippen, M.D., Malcom Randall, John B. Sheehan, M.D. This group does not preempt the AAMC-VA Liaison Committee, but rather its purpose is to draw attention to issues of concern to VA teaching hospitals about which COTH could have a significant impact. This group

recommended that the issue of "sharing" as set forth in P.L. 89-785 as well as a future expansion of this concept is one that deserved special attention. Thus, this ad hoc task force was formed.

The charge to the task force is to make recommendations to speed the implementation of P.L. 89-785. Mr. Danielson also requested each member to review H.R. 10880, "Veterans Medical Care Act of 1971", and submit a critical review which the COTH staff might use in making recommendations when rules and regulations are being drawn for this legislation. He stated that his understanding was that such legislation will probably be passed as set forth in H.R. 10880.

The task force will report to the COTH Administrative Board. However, the possibility of adding a dean and a faculty representative to the task force should be discussed.

At this point, John Danielson presented his personal thoughts concerning national trends as they relate to current changes in the Veterans Administration. He believes much of the current reorganization is a reflection of setting the stage for some form of national health insurance.

The VA has the largest organized system for delivering health services in the country owned by the federal government. The introduction of recent legislation, specifically P.L. 89-785 and H.R. 10880, move this system in a direction which will make the goals and objectives of the VA hospitals more comparable to hospitals in the non-profit voluntary arena. This step puts these institutions in a position which could be used as the basis for standardization and other indicators as the control group.

Further, John Danielson stated that he believes there will be a regional system developed, and that there will be a regional health authority reporting to

a cabinet level Department of Health. The anticipated "freeze" on hospital costs will most likely be permanent, although the allowable percentage will probably change. One of the possible implications of such action may be that the university hospitals may be forced to terminate some of their high cost tertiary care programs and other contract programs for which not nearly full cost is being reimbursed. It is possible that the VA teaching hospitals may be requested to finance a number of these programs.

Bill Freer stated that it is his understanding that the VA policy toward "sharing" is not one of "tokenism", but a leadership attitude of moving forward as rapidly as possible. There are individuals in the system who wish to see the VA system preserved as an entity; but even they now see the need to share and cooperate. Hugh Vickerstaff stated that this latter group does serve as an "intellectual road block". The deans and VA leadership talk one way, but the associate deans and those responsible for university business affairs say that it is very difficult to do business.

Bill Freer officially undertook his new responsibility for "sharing" activities on June 1, 1971. When working with the management audit group, a standard question to hospital directors was (and still is), "What are you doing in the area of sharing ... and why aren't you doing more?" The standard reply was, "Every time we send something into the central office, that's the last we hear of it". This is one of the reasons this new position was established. One procedure he has initiated is that any sharing agreement turned down by general counsel for legal reasons must go through his office for review.

He outlined four major problems which consistently come to his attention:

1) the rigid legislative guidelines, including the problem of interpreting the definition of "specialized medical service";

2) speeding up the "turn-around time" for proposals, and the difficulty of proper communication to all individuals with responsibility for sharing agreements;

3) determining whether or not the institution will "deliver", or would it be more appropriate to contract with individuals for service;

4) the difficulty of instituting effective cost accounting for buying and selling which is acceptable for the purposes of both parties to the agreement.

At this point, Joe Greathouse asked each member of the group to describe local institutional arrangements and identify significant accomplishments and specific problems. During this exchange of ideas, there was some confusion concerning the definition of the various types of agreements. Ken O'Brien submitted the following outline with examples from Little Rock to clarify the matter:

I. Scarce Medical Specialty

The VA cannot recruit and must contract with medical schools and clinics for the specialty. These contracts must provide that the services will be performed at a VA facility.

Authority: 38 USC 4117

Little Rock contracts with UAMC for Radiological and Nuclear Medicine Specialties. (Contract No. V 598P-525)

II. Exchange of Use of Specialized Medical Resources

The VA has resources not available at the hospital in the medical community, and the other hospital has a resource not available at the VA--these hospitals can contract to use each

other's resources.

Authority: 38 USC 5053

Little Rock (Contract No. V598P-557)

Contracts with UAMC for VA to furnish Pulmonary Function testing service and Percutaneous Cordotomy Facilities; and UAMC to furnish Radiotherapy Service and Nuclear Medicine Studies.

III. Mutual Use of Specialized Medical Resources Provided to a VA Hospital

Another hospital (or medical school with hospital facilities) in the medical community has a resource which VA needs and does not have. The VA can make an agreement to obtain that resource when the agreement will obviate the need for a similar resource to be provided in the VAH.

Authority: 38 USC 5053 (a) (1).

Little Rock does not have an agreement of this type.

IV. Mutual Use of Specialized Medical Resources Provided by a VA Hospital

The VA has a resource which has been justified on the basis of Veterans care, but is not utilized to the maximum capacity.

Authority: 38 USC 5053 (b)

Little Rock has three agreements as follows:

Contract No. V 598P-545 -- with Arkansas State Hospital whereby VA furnishes Radio Paging facilities to State Hospital for tie-in with VA paging system.

Contracts V 598P-546 and V 598P-555 with Baptist Medical Center and UA Med Center, respectively, whereby VA furnishes nursing training in Pulmonary Resuscitation and Cardiac Defibrillation.

Bill Freer pointed out that the primary distinction concerns buying and selling. There is flexibility in getting the service into a VAH; but, the flexibility for selling VAH services is not there. The only way to do so is under the "sharing" concept.

Following the descriptions of sharing activities at each institution Hugh Vickerstaff and Joe Greathouse described in depth some of the problems encountered in Nashville. Joe Greathouse made the following points:

-- the physical proximity issue is a key one which is reflected medically as well as in terms of psychological barriers;

-- the transportation problem is a real "hassle";

-- the psychological barriers are very real, and are of no small significance. Birmingham appears, however, to have overcome this difficulty. The problem in Nashville has been fed on both sides by the feelings in "maintaining identities". The VA is viewed by the medical faculty as a separate resource which is professionally isolated.

-- the above problem has been intensified by the administrative inability to implement some shared activities which in fact work, to hold out as examples. This has dampened enthusiasm on both sides of the street.

-- there are two private medical schools in Nashville with vastly different orientation. The VAH could get caught in the middle if sharing is negotiated on an institutional basis.

Hugh Vickerstaff reinforced these points and stated that the matter of self identity is the key to the problem. The attitude of "...we must

protect ourselves from the 'grasping' university" does still prevail. This type of intellectual roadblock does exist, and should be recognized. The new spirit in the VA Central Office needs to be more actively set forth through the VA bureaucracy. Further, there must be imbued in the VA Hospital Directors an attitude of seeking out and initiating these sharing arrangements. Getting that first agreement off the ground is a most important hurdle.

Clyde Cox stated that Birmingham has no contracts and planned none for the future. Joe Greathouse asked if this implied the contract vehicle itself could be a barrier. Clyde Cox agreed. In other words, where the contract mechanism is used extensively, it is a barrier to moving toward the sharing concept. This point is related to the compartmentalized nature of the medical center. The contract allows the compartmentalized units of the center to work out individual arrangements rather than viewing the relationship as a broad institutional commitment.

Bill Freer stated that it's his impression that the Teague Committee is interested in promoting sharing and de-emphasizing contracts.

At this point the Chairman posed the following question: "What can the Task Force do to close the gaps in terms of: (1) the difference between what the deans and hospital directors want, and how faculty and others operate; (2) the difference between what the VA central office wants, and what's happening in the field.

Ken O'Brien suggested:

1) the central office should publish a list of successful ventures, and how they were accomplished;

2) a strongly worded, "let's get going" letter from Dr. Jim Musser's office to the effect that, "we have about three years before it's done for us."

Bill Freer stated that his office is going to publish a quarterly newsletter directed to this issue.

Joe Greathouse asked if case studies might be more helpful outlining how the agreement was developed, its magnitude, problems which were overcome and pitfalls to avoid. He also asked if there might be any merit to asking the AAMC to undertake an information gathering effort from some key institutions. Ken O'Brien suggested that the local Dean's Committees be requested to discuss this matter. Joe Greathouse emphasized the need to know what's going on. Hugh Vickerstaff stated emphatically that what goes to the VAH Directors should be fully communicated to all of Dr. Musser's staff.

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The Chairman suggested that the group should work toward preparation of some type of report. In the meantime, if there are expressions from this group which would be helpful, perhaps they should be initiated.

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The Chairman asked that each task force member:

1) identify issues which should be specified on the Agenda of the next meeting;

2) submit comments on H.R. 10880;

3) talk with others in the field to determine how they see the problems and issues;

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The next meeting of the Task Force will take place in Washington, D.C. some time during the first two weeks in December.

The meeting was adjourned at 2:10 p.m.

MINUTES

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF TEACHING HOSPITALS

VETERANS ADMINISTRATION SHARING
TASK FORCE MEETING

AAMC Headquarters
Washington, D.C.
October 7, 1971

PRESENT:

Joe S. Greathouse, Jr., *CHAIRMAN*
Clyde G. Cox
L. H. Gunter
Kenneth J. O'Brien
Hugh R. Vickerstaff
James W. Varnum

EXCUSED:

John Reinertsen

STAFF:

John M. Danielson
Robert H. Kalinowski
Richard M. Knapp, Ph.D.

GUEST:

Mr. William Freer
Special Assistant to the Assistant Chief Medical Director for Planning and Evaluation

Following the call to order and introduction of members, Mr. Greathouse asked John Danielson to present his views on the role and function of the Task Force.

John Danielson stated that in order to improve communications with Veterans Administration Hospital members of COTH he had been meeting quarterly with an advisory group lead by L. H. Gunter, and composed of the following individuals: John Chase, M.D., Arthur Klippen, M.D., Malcom Randall, John B. Sheehan, M.D. This group does not preempt the AAMC-VA Liaison Committee, but rather its purpose is to draw attention to issues of concern to VA teaching hospitals about which COTH could have a significant impact. This group

recommended that the issue of "sharing" as set forth in P.L. 89-785 as well as a future expansion of this concept is one that deserved special attention. Thus, this ad hoc task force was formed.

The charge to the task force is to make recommendations to speed the implementation of P.L. 89-785. Mr. Danielson also requested each member to review H.R. 10880, "Veterans Medical Care Act of 1971", and submit a critical review which the COTH staff might use in making recommendations when rules and regulations are being drawn for this legislation. He stated that his understanding was that such legislation will probably be passed as set forth in H.R. 10880.

The task force will report to the COTH Administrative Board. However, the possibility of adding a dean and a faculty representative to the task force should be discussed.

At this point, John Danielson presented his personal thoughts concerning national trends as they relate to current changes in the Veterans Administration. He believes much of the current reorganization is a reflection of setting the stage for some form of national health insurance.

The VA has the largest organized system for delivering health services in the country owned by the federal government. The introduction of recent legislation, specifically P.L. 89-785 and H.R. 10880, move this system in a direction which will make the goals and objectives of the VA hospitals more comparable to hospitals in the non-profit voluntary arena. This step puts these institutions in a position which could be used as the basis for standardization and other indicators as the control group.

Further, John Danielson stated that he believes there will be a regional system developed, and that there will be a regional health authority reporting to

a cabinet level Department of Health. The anticipated "freeze" on hospital costs will most likely be permanent, although the allowable percentage will probably change. One of the possible implications of such action may be that the university hospitals may be forced to terminate some of their high cost tertiary care programs and other contract programs for which not nearly full cost is being reimbursed. It is possible that the VA teaching hospitals may be requested to finance a number of these programs.

Bill Freer stated that it is his understanding that the VA policy toward "sharing" is not one of "tokenism", but a leadership attitude of moving forward as rapidly as possible. There are individuals in the system who wish to see the VA system preserved as an entity; but even they now see the need to share and cooperate. Hugh Vickerstaff stated that this latter group does serve as an "intellectual road block". The deans and VA leadership talk one way, but the associate deans and those responsible for university business affairs say that it is very difficult to do business.

Bill Freer officially undertook his new responsibility for "sharing" activities on June 1, 1971. When working with the management audit group, a standard question to hospital directors was (and still is), "What are you doing in the area of sharing ... and why aren't you doing more?" The standard reply was, "Every time we send something into the central office, that's the last we hear of it". This is one of the reasons this new position was established. One procedure he has initiated is that any sharing agreement turned down by general counsel for legal reasons must go through his office for review.

He outlined four major problems which consistently come to his attention:

1) the rigid legislative guidelines, including the problem of interpreting the definition of "specialized medical service";

2) speeding up the "turn-around time" for proposals, and the difficulty of proper communication to all individuals with responsibility for sharing agreements;

3) determining whether or not the institution will "deliver", or would it be more appropriate to contract with individuals for service;

4) the difficulty of instituting effective cost accounting for buying and selling which is acceptable for the purposes of both parties to the agreement.

At this point, Joe Greathouse asked each member of the group to describe local institutional arrangements and identify significant accomplishments and specific problems. During this exchange of ideas, there was some confusion concerning the definition of the various types of agreements. Ken O'Brien submitted the following outline with examples from Little Rock to clarify the matter:

I. Scarce Medical Specialty

The VA cannot recruit and must contract with medical schools and clinics for the specialty. These contracts must provide that the services will be performed at a VA facility.

Authority: 38 USC 4117

Little Rock contracts with UAMC for Radiological and Nuclear Medicine Specialties. (Contract No. V 598P-525)

II. Exchange of Use of Specialized Medical Resources

The VA has resources not available at the hospital in the medical community, and the other hospital has a resource not available at the VA--these hospitals can contract to use each

other's resources.

Authority: 38 USC 5053

Little Rock (Contract No. V598P-557)

Contracts with UAMC for VA to furnish Pulmonary Function testing service and Percutaneous Cordotomy Facilities; and UAMC to furnish Radiotherapy Service and Nuclear Medicine Studies.

III. Mutual Use of Specialized Medical Resources Provided to a VA Hospital

Another hospital (or medical school with hospital facilities) in the medical community has a resource which VA needs and does not have. The VA can make an agreement to obtain that resource when the agreement will obviate the need for a similar resource to be provided in the VAH.

Authority: 38 USC 5053 (a) (1).

Little Rock does not have an agreement of this type.

IV. Mutual Use of Specialized Medical Resources Provided by a VA Hospital

The VA has a resource which has been justified on the basis of Veterans care, but is not utilized to the maximum capacity.

Authority: 38 USC 5053 (b)

Little Rock has three agreements as follows:

Contract No. V 598P-545 -- with Arkansas State Hospital whereby VA furnishes Radio Paging facilities to State Hospital for tie-in with VA paging system.

Contracts V 598P-546 and V 598P-555 with Baptist Medical Center and UA Med Center, respectively, whereby VA furnishes nursing training in Pulmonary Resuscitation and Cardiac Defibrillation.

Bill Freer pointed out that the primary distinction concerns buying and selling. There is flexibility in getting the service into a VAH; but, the flexibility for selling VAH services is not there. The only way to do so is under the "sharing" concept.

Following the descriptions of sharing activities at each institution Hugh Vickerstaff and Joe Greathouse described in depth some of the problems encountered in Nashville. Joe Greathouse made the following points:

-- the physical proximity issue is a key one which is reflected medically as well as in terms of psychological barriers;

-- the transportation problem is a real "hassle";

-- the psychological barriers are very real, and are of no small significance. Birmingham appears, however, to have overcome this difficulty. The problem in Nashville has been fed on both sides by the feelings in "maintaining identities". The VA is viewed by the medical faculty as a separate resource which is professionally isolated.

-- the above problem has been intensified by the administrative inability to implement some shared activities which in fact work, to hold out as examples. This has dampened enthusiasm on both sides of the street.

-- there are two private medical schools in Nashville with vastly different orientation. The VAH could get caught in the middle if sharing is negotiated on an institutional basis.

Hugh Vickerstaff reinforced these points and stated that the matter of self identity is the key to the problem. The attitude of "...we must

protect ourselves from the 'grasping' university" does still prevail. This type of intellectual roadblock does exist, and should be recognized. The new spirit in the VA Central Office needs to be more actively set forth through the VA bureaucracy. Further, there must be imbued in the VA Hospital Directors an attitude of seeking out and initiating these sharing arrangements. Getting that first agreement off the ground is a most important hurdle.

Clyde Cox stated that Birmingham has no contracts and planned none for the future. Joe Greathouse asked if this implied the contract vehicle itself could be a barrier. Clyde Cox agreed. In other words, where the contract mechanism is used extensively, it is a barrier to moving toward the sharing concept. This point is related to the compartmentalized nature of the medical center. The contract allows the compartmentalized units of the center to work out individual arrangements rather than viewing the relationship as a broad institutional commitment.

Bill Freer stated that it's his impression that the Teague Committee is interested in promoting sharing and de-emphasizing contracts.

At this point the Chairman posed the following question: "What can the Task Force do to close the gaps in terms of: (1) the difference between what the deans and hospital directors want, and how faculty and others operate; (2) the difference between what the VA central office wants, and what's happening in the field.

Ken O'Brien suggested:

1) the central office should publish a list of successful ventures, and how they were accomplished;

2) a strongly worded, "let's get going" letter from Dr. Jim Musser's office to the effect that, "we have about three years before it's done for us."

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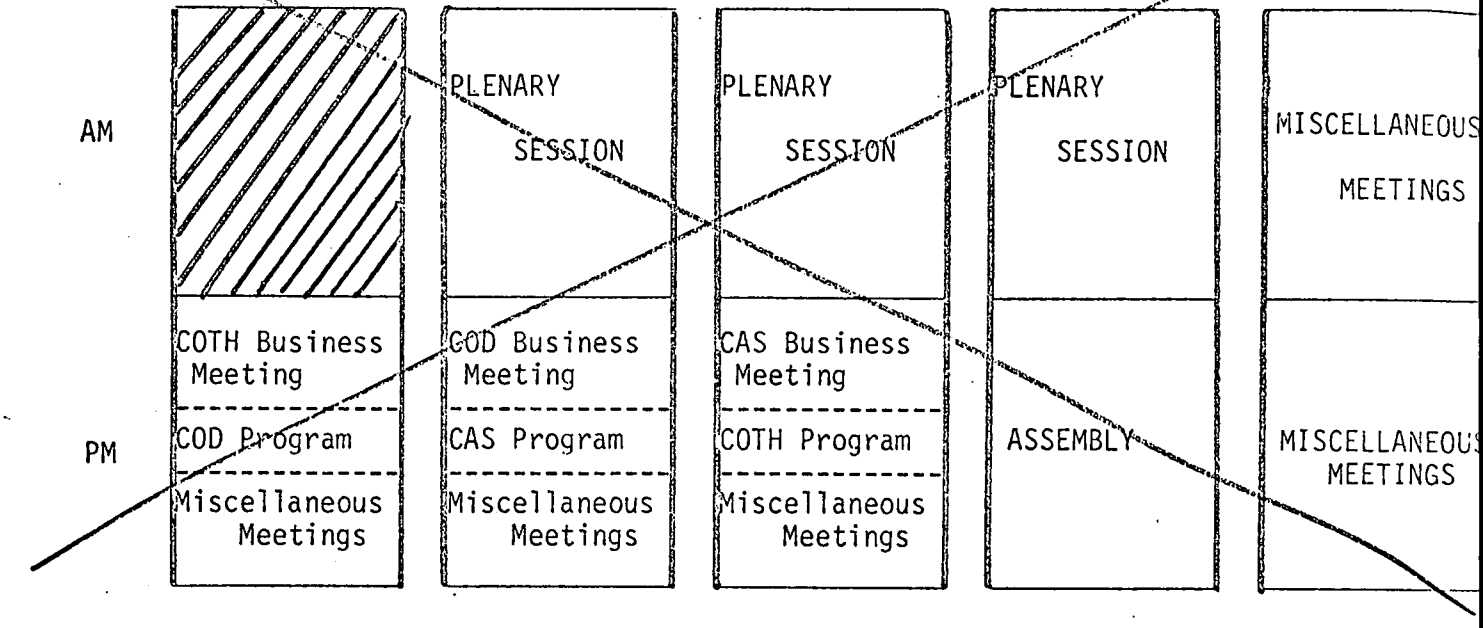
For Discussion:

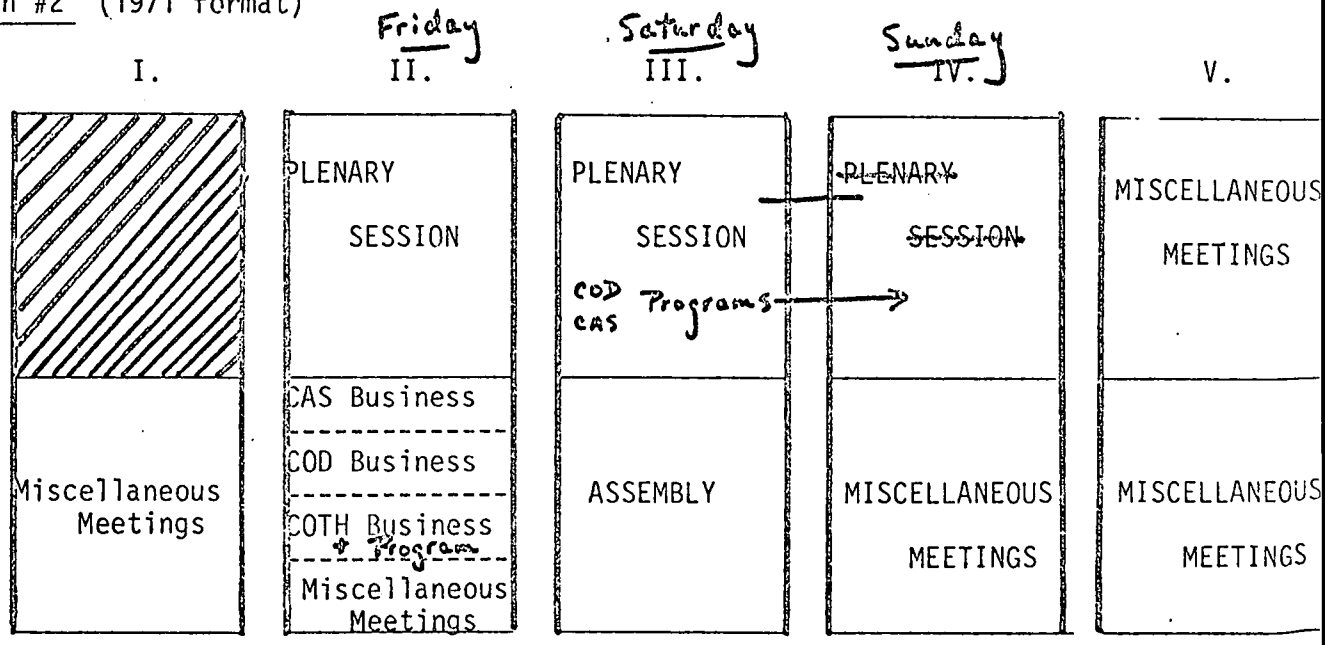
ANNUAL MEETING PROGRAM FORMAT

(5-Day Meeting)

Option #1 (1970 format)



* Option #2 (1971 format)



Council Program meetings could be scheduled at different times, or in conjunction with the Business meetings (as this year).

2 Plenary Sessions

COD CAS Programs either Sat. or Sunday morning

COTH NOMINATING COMMITTEE - 1972

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