



**association of american  
medical colleges**

# AGENDA

FOR

COUNCIL OF TEACHING HOSPITALS

ADMINISTRATIVE BOARD MEETING

September 12, 1985

8:00 a.m.

Shoreham Hotel

Cabinet Room

**one dupont circle, n.w./washington, d.c. 20036**

COTH ADMINISTRATIVE BOARD MEETINGS

October 28, 1985

AAMC Annual Meeting  
Washington Hilton Hotel  
Washington, DC

COTH SPRING MEETING

May 7-9, 1986

Franklin Plaza Hotel  
Philadelphia, PA

May 13-15, 1987

Fairmont Hotel  
Dallas, TX

May 11-13, 1988

New York Hilton Hotel  
New York, NY

AAMC ANNUAL MEETINGS

October 26-31, 1985

Washington Hilton Hotel  
Washington, DC

October 25-30, 1986

The Hilton Hotel  
New Orleans, LA

November 7-12, 1987

Washington Hilton Hotel  
Washington, DC

MEETING SCHEDULE  
COUNCIL OF TEACHING HOSPITALS  
ADMINISTRATIVE BOARD

September 11-12, 1985  
Shoreham Hotel  
Washington, DC

WEDNESDAY, September 11, 1985

6:30pm	COTH ADMINISTRATIVE BOARD MEETING Bruce Steinwald, Prospective Payment Assessment Commission Cabinet Room
7:30pm	COTH ADMINISTRATIVE BOARD RECEPTION Senate Room
8:00pm	COTH ADMINISTRATIVE BOARD DINNER Cabinet Room

THURSDAY, September 12, 1985

8:00am	COTH ADMINISTRATIVE BOARD MEETING Cabinet Room
Noon	JOINT AAMC ADMINISTRATIVE BOARDS LUNCHEON Executive Room
1:00pm	AAMC EXECUTIVE COUNCIL BUSINESS MEETING Congressional Room

ALAN BRUCE STEINWALD

Bruce Steinwald comes to the Prospective Payment Assessment Commission from the Health Policy Office of the Assistant Secretary for Planning and Evaluation, HHS, where he served as Acting Director. While in ASPE, his responsibilities included health budget and legislative oversight as well as economic and policy analysis of health system issues. He also designed and implemented a research agenda oriented to developments in the private sector affecting health care financing and delivery. Mr. Steinwald has conducted research on the economics of the health care system and has written extensively on this subject. He received his M.B.A. in Hospital Administration from the University of Chicago and his B.A. in Business from Johns Hopkins University. He has also completed all the requirements, except his dissertation, for a Ph.D. in Business and Economics at the University of Chicago.

A G E N D A

COUNCIL OF TEACHING HOSPITALS  
ADMINISTRATIVE BOARD MEETING

September 12, 1985  
SHOREHAM HOTEL  
Cabinet Room  
8:00am-Noon

- I. CALL TO ORDER
- II. CONSIDERATION OF MINUTES  
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- III. MEMBERSHIP  
The Naval Hospital  
Bethesda, MD Page 10
- IV. PROPOSED REVISION OF GSA RULES AND  
REGULATIONS Executive Council  
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- V. REVISION OF AAMC POLICIES AND PROCEDURES  
FOR THE TREATMENT OF IRREGULARITIES IN THE  
ADMISSIONS PROCESS Executive Council  
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- VI. INVESTOR OWNED TEACHING HOSPITAL  
PARTICIPATION IN COTH Executive Council  
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- VII. THE INDEPENDENT STUDENT ISSUE Executive Council  
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- VIII. HEALTH PLANNING Executive Council  
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- IX. COMMENTARY ON THE GPEP REPORT Executive Council  
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- X. RESEARCH FACILITIES CONSTRUCTION LEGISLATION Executive Council  
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- XI. REPORT OF THE COMMITTEE FOR THE GOVERNANCE  
AND MANAGEMENT OF INSTITUTIONAL ANIMAL  
RESOURCES Executive Council  
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- XII. TRANSITION TO GRADUATE MEDICAL EDUCATION:  
ISSUES AND SUGGESTIONS Page 22
- XIII. MEDICARE OUTPATIENT SURGERY SAVINGS, ACCESS,  
AND QUALITY ACT Page 32
- XIV. OTHER BUSINESS
- XV. ADJOURNMENT

ASSOCIATION OF AMERICAN MEDICAL COLLEGES  
COTH ADMINISTRATIVE BOARD MEETING  
June 20, 1985

PRESENT

Sheldon King, Chairman  
C. Thomas Smith, Chairman-Elect  
Haynes Rice, Immediate Past Chairman  
Robert J. Baker  
J. Robert Buchanan, MD  
Jeptha W. Dalston, PhD  
Gordon M. Derzon  
Spencer Foreman, MD  
Gary Gambuti  
Glenn R. Mitchell  
Eric B. Munson  
David A. Reed  
Deal Brooks, AHA Representative

ABSENT

James J. Mongan, MD  
Thomas J. Stranova

GUESTS

Robert M. Heyssel, MD  
Richard Janeway, MD  
Lisa St. John

STAFF

James D. Bentley, PhD  
Robert Beran, PhD  
John A. D. Cooper, MD  
James B. Erdmann, PhD  
Robert Jones, PhD  
Thomas J. Kennedy, Jr., MD  
Richard M. Knapp, PhD  
Karen L. Pfordresher  
Nancy E. Seline  
Kathleen Turner  
Melissa H. Wubbold

COTH ADMINISTRATIVE BOARD  
Meeting Minutes  
June 20, 1985

I. CALL TO ORDER

Mr. King called the meeting to order at 8:00am in the Jackson Room of the Washington Hilton Hotel.

II. CONSIDERATION OF THE MINUTES

ACTION: It was moved, seconded, and carried to approve the minutes of the April 4, 1985 COTH Administrative Board Meeting.

Prior to moving to the agenda, Mr. King welcomed Deal Brooks who substituted for Bill Robinson as the AHA representative at the meeting. In addition, he introduced Lisa St. John, an administrative fellow with the Chairman at Stanford University Hospital. The Chairman then made some observations about the Executive Committee visit with William Roper, MD, Special Assistant to the President for Health; and John Cogan, Associate Director of the Office of Management and Budget. He indicated that the meeting went for one and one half hours and while the subjects of student assistance and the National Institutes of Health were discussed, the major portion of the meeting was devoted to the Medicare program with particular reference to cuts in the direct medical education passthrough as well as the indirect medical education adjustment. Both Dr. Roper and Mr. Cogan were extremely knowledgeable. Mr. King indicated there were two observations he would make that had not been previously reported. First, the White House does not favor any of the current bills concerning graduate medical education reimbursement policy changes although it is still very committed to freezing payments under the passthrough for graduate medical education. Second, while Dr. Roper was not in agreement, Mr. Cogan does believe that there is a possibility that the move toward the national DRG rate could be stopped at the 50% federal DRG portion, 50% historical hospital specific base.

At this point, Mr. King called on Dr. Knapp for any additional matters he might have to report to the Board. Dr. Knapp indicated that the Veterans Administration Hospital in Des Moines, IA and Rochester Methodist Hospital in Rochester, MN had written to terminate their membership in the Council of Teaching Hospitals. After brief discussion, there was agreement that the chief executive officer at Rochester Methodist should be called to determine if there were any major matters that might have caused the termination of their membership in COTH. Dr. Knapp then reported that August Swanson, MD had received a telephone call from Illinois Masonic Hospital in Chicago requesting information about any policies the AAMC or COTH may have regarding charging applicants an application fee for residency programs. Dr. Swanson wanted to know whether or not members of the Board were aware of any institutions that had instituted such a policy. No members of the Board were aware of any such institutions. While it is clear that there is no Association policy on the matter, there was general agreement that in all aspects of society, it is becoming increasingly prevalent

that all aspects of any operating activity need to be understood to have a cost associated with them. Therefore, any effort to institute such a policy should not come as a surprise. There was no further discussion of this matter.

### III. MEMBERSHIP

Following discussion and appropriate consideration, the following action was taken:

ACTION: It was moved, seconded, and carried to approve:

- (1) MC LEAN HOSPITAL, Belmont, MA for full membership;
- (2) THE INSTITUTE FOR REHABILITATION AND RESEARCH, Houston, TX for corresponding membership.

### IV. FINANCING GRADUATE MEDICAL EDUCATION

In addition to the items already on the agenda, the Board was asked to consider Medicare's financing of graduate medical education. Several different proposals to alter Medicare's method of financing graduate medical education had been introduced and seriously debated in Congress in the early spring. Since the AAMC had been asked to testify at several hearings regarding these proposals, policy positions had to be taken prior to the issuance of the report of AAMC's Committee on Financing Graduate Medical Education which is chaired by Dr. J. Robert Buchanan. Dr. Janeway had described the Executive Committee's actions in formulating the most significant of these positions, that of being basically supportive of the Dole/Durenberger/Bentsen bill (S. 1158), at the Wednesday evening joint meeting of the COD, COTH, CAS, and OSR administrative boards. Because it was likely that a change in Medicare's financing of GME would be considered as one of the measures to save money to achieve the budget targets, the Board was asked to advise staff of its reactions to the various Congressional proposals. Drs. Janeway and Cooper joined the Board for the discussion. In referring to his remarks of the joint meeting of the Boards of the COD, COTH, CAS, and OSR the previous evening, Dr. Janeway reiterated that the Executive Committee did not intend to undermine the work of the AAMC Committee on Financing Graduate Medical Education by its decision to be supportive of the Dole/Durenberger/Bentsen approach. He indicated that the Committee on Financing Graduate Medical Education was free to formulate its own recommendations, irrespective of the Executive Committee's action on a particular piece of pending legislation. Dr. Knapp reminded the Board that the Buchanan Committee was to address broad financing issues, not just those of Medicare, and then went on to briefly describe the four Medicare and Medicaid proposals under consideration in Congress. (Synopsis of these proposals is included in these minutes as Appendix A.)

The proposals were seen to address two key issues: (1) the methodology for payment for the services of residents in training and (2) the distribution between primary care and non-primary care specialties. The Board appeared to agree that the focus of changes to Medicare and Medicaid expenditures should be on how much money to spend, not on which type of residents should be trained.



Additionally, there seemed to be general agreement that the Buchanan Committee would make general policy recommendations without reference to specific legislative proposals and would need to communicate its decisions and the rationale for those decisions to the constituency to avoid antagonizing a vocal minority of AAMC members who may disagree. Board members raised concern that the AAMC ought to address the need to care for the poor, especially to the extent that FMG's provide a significant portion of this care and the AAMC has taken the position that FMG's should not be funded from patient care revenues. Concerns were raised regarding the decision of the Executive Council that bills should be rendered on behalf of residents who would be ineligible to be funded under Medicare Part A. Some members thought this billing might damage the relationship between the faculty and the residents, or at least change the emphasis of the educational program.

Mr. King closed the discussion by asking that the Buchanan Committee and the Executive Committee be made aware of the COTH Administrative Board's comments and concerns.

#### V. SPRING MEETING REVIEW

The Chairman indicated that he had asked Mr. Gambuti to serve as Chairman of the 1986 Spring Meeting Planning Committee. The meeting is to be held May 7-9 in Philadelphia, PA; Mr. Gambuti had indicated his acceptance. The remaining members of the Committee will be appointed shortly. A brief discussion ensued about the quality of the Spring Meeting in San Francisco. While there was some concern that the program did not appear quite up to the standards of previous years, it was agreed that "autopsies on meetings is not necessarily a productive exercise." The previous year's Planning Committee did an excellent job and the extent to which speakers do or do not reach expectations or whether or not the program appears to "hang together" is not something that can be assured. Thus, the Board wished Mr. Gambuti well and did not have a substantial amount of advice for him.

The staff had suggested that Chicago or New York City be the site for the 1988 COTH SPRING MEETING, or that other cities be considered. After a very brief discussion, it was agreed that New York City should be the site for the 1988 meeting.

#### VI. 1984 NEW CHALLENGES PAPER REVISITED

At its April meeting, the Administrative Board heard discussions on a number of new hospital organizations in which COTH members are involved (VHA, AHS, UHC, and CJH). The implications of these new activities for AAMC/COTH were discussed and staff was asked to prepare a paper summarizing that discussion.

Dr. Bentley began the Board's discussion by providing an overview of the requested staff paper and invited Board members to critically assess both the paper's accuracy in describing the April meeting and the Board's interest in continuing its April emphasis. In a general discussion, Board members (1) agreed the paper accurately reflected the April discussion, (2) asked staff to be prepared to discuss plans which would implement the positions recommended by the

Board, and (3) urged staff to discuss the ideas in the summary paper at the COTH Session of the AAMC Annual Meeting. Finally, Board members encouraged staff to obtain the results of a recent AHA survey of board chairmen and CEO's on the relationship between national hospital associations and other hospital organizations.

#### VII. AAMC FACULTY PRACTICE SURVEY

Dr. Robert Jones of the AAMC Department of Institutional Development opened the discussion by reminding the Board of the survey and requesting Board discussion of the findings. Mr. King encouraged the Board to comment with a special emphasis on identifying issues that should be addressed by the AAMC. Messrs. Rice, Munson, Mitchell, and Derzon all discussed problems with increasing faculty awareness of competitive trends and with developing a practice plan that could commit to arrangements involving risk. They along with Mr. Baker also discussed the need to study and evaluate alternative governance structures. Mr. Munson encouraged an examination of the impact of tenure.

The overall consensus was that the AAMC should develop a series of regional conferences to stimulate an understanding among faculties and deans of current competitive developments, should prepare case studies of approaches which emphasize adapting to competition, and should study models of plan governance. Mr. Rice concluded the discussion by urging the AAMC to involve AAHC members in any seminars or programs.

#### VIII. HEALTH PLANNING

The Board reviewed the Association's position on health planning which was adopted in April of 1982. The statement approved at that time supported the concept of community based health planning on a voluntary basis and mandated state-wide certificate of need review (CON). This CON review authority would pertain to all providers engaged in direct patient care projects that exceeded \$600,000. Discussion of whether or not this position should be modified or reaffirmed followed.

Dr. Foreman, a commissioner for the Maryland State Health Resources Planning Commission, cautioned that CON is the only capital facility regulatory apparatus currently in place, and that its removal could facilitate changes, many of which may assist the teaching hospital's competitors. Agreeing that the tendency in health planning is to overregulate and perhaps become intrusive, Dr. Foreman also agreed that a secondary problem exists in that the current law does not control the capital expenditures of non-institutional providers. Dr. Foreman suggested revisions to the Association's statement to allow for exemptions for some equipment, and to include stronger language requiring all competitors to be under the same restrictions. Another option recently adopted by the Maryland state senate would deregulate the purchase of medical equipment, allowing instead for such equipment to be licensed by the state. Mr. Gambuti concurred that a major problem with current health planning law is that only hospitals are controlled. The intent of health planning should be the control of unnecessary expenditures, and Mr. Gambuti suggested therefore revising the threshold for CON review to \$5-10 million capital projects. Mr. Rice pointed out that the current

encouragement of competition in the health care arena requires administrators to be flexible, whereas the current law, especially in its regional applications, is not flexible. Mr. Reed clarified that Arizona, a state currently without capital expenditure review, has suffered no adverse effects except for proliferation of open-heart surgical activities. Mr. Mitchell suggested that the CON process has become too political. The following action was taken:

- ACTION: It was moved, seconded, and carried to recommend approval of the following position on health planning:
- o That the Association support state-wide CON review of construction projects which result in new bed capacity, or construction projects or new facilities which replace existing beds;
  - o That the Association oppose CON review of major medical equipment or new institutional health services that do not result in increased capacity.

#### IX. REVIEW OF THE AAMC MCAT PROGRAM

Dr. Erdmann, Director, AAMC Division of Educational Measurement and Research, presented for discussion several issues related to the Medical College Admissions Test (MCAT), including (1) whether or not its focus is too directed towards science, and therefore exacerbates the "pre-med syndrome;" (2) its proper role in medical school admissions processes; and (3) the appropriateness of the AAMC sponsorship of this test. Administrative Board members questioned the status of the newly designed essay portion of the test. It was reported that portion of the test is in its second trial year and will be brought forward for discussion and approval before it is included officially as part of the MCAT test.

Discussion focused on the fact that the MCAT is a valid testing device which reflects universal requirements of medical schools. The Administrative Board determined that no further action was necessary in respect to the MCAT program at this time.

#### X. REPORT OF THE AAMC AD HOC COMMITTEE ON THE IOM STUDY OF THE STRUCTURE OF NIH

Dr. Kennedy, Director, AAMC Department of Planning and Policy Development, presented the AAMC AD Hoc Committee's report on the Institute of Medicine (IOM) study of the structure of NIH for the Board's endorsement. Although the IOM study has not had a major impact, its recommendation that there should be a "presumption against" the creation of new institutes within the NIH and the stands it takes on other related subjects are supportive of the AAMC views on the optimal organization and structure of NIH.

- ACTION: It was moved, seconded, and carried to unanimously endorse this report.

XI. PROPOSED CHARGE FOR THE AAMC RESEARCH POLICY COMMITTEE

This agenda item addressed the definition of the proposed charge to the 18 member panel recently appointed by the Committee on Science and Technology of the House of Representatives to undertake a two year study of national science policy. There was no discussion of this informational item.

XII. AAMC POSITION ON THE ADMINISTRATION'S PROPOSED NIH REAUTHORIZATION LEGISLATION

Dr. Kennedy described the Administration's proposal to renew expired NIH authorities for three years. He stated that the proposal contains acceptable reauthorization ceilings and language that would renew authorities only where absolutely necessary for program survival. This proposal is much more acceptable to the AAMC than other suggested initiatives considered by the Senate or proposed by the House (H.R. 2409).

XIII. ADJOURNMENT

There being no further discussion the meeting was adjourned at 12:00noon.

SYNOPSIS OF LEGISLATIVE PROPOSALS TO ALTER PAYMENT FOR  
DIRECT MEDICAL EDUCATION

Dole/Durenberger/Bentsen (S. 1158)

In the initial year of implementation (the hospital's fiscal year beginning on or after October 1, 1985), the proposal would limit each hospital to receiving no more "direct medical education pass-through dollars" than it had in the preceding year. In the succeeding years, the hospital would receive its costs incurred in training residents up to the point at which they become eligible for their initial boards or for five years, whichever is less. Thus, the bill intends to use economic disincentives to reduce the number of subspecialty and lengthy specialty training positions available.

The Senators proposed funding residency training only for U.S. or Canadian citizens or U.S. or Canadian medical school graduates. In other words, there would be no funding for alien FMGs unless they were Canadians or Canadian medical school graduates.

In addition, the bill calls for two studies. The first is an HHS study of nursing and allied health education costs. The second is a General Accounting Office examination of the difference in cost incurred for treating similar patients in a teaching versus a non-teaching setting.

Waxman (H. R. 2699)

This bill would alter the method by which both Medicare and Medicaid pay for graduate medical education. It controls federal outlays by limiting the amount to be paid per resident and would attempt to influence physician specialty mix by weighting the count of residents to favor primary care positions.

Each hospital would be able to claim payment for the Medicare and Medicaid share of the allowable graduate medical education costs calculated by multiplying the hospital's allowable cost per resident times the weighted count of full time equivalent residents. To determine allowable costs per resident, each hospital's most recent cost report would be used to determine the base year direct medical education cost divided by the number of full time equivalent residents. This amount would be inflated to December of 1985 and compared to all other hospitals' cost per resident. Any costs in excess of 200 percent of the average would be disallowed. The base year allowable costs would be inflated forward to the payment year by using the annual change in the Consumer Price Index.

The weighted count of residents would be calculated by first determining the number of full time equivalent residents in patient care activities. Hours spent in HMOs and ambulatory care clinics may be counted, but hours spent in research are to be excluded. These full time equivalent resident counts are then weighted by factors that discourage non-primary care and subspecialty training. When fully implemented, each primary care resident would count as 1.35, each non-primary care resident in training for initial boards or who has not been accepted into a subspecialty training program would count as .65, and each non-primary care resident beyond the initial training would count as .50. Primary care residents are defined as those residents in the first three years of internal medicine, family medicine, or pediatrics, except those who have been accepted into a subspecialty training program or who are receiving this training as part of the initial requirements for specialization in another field. In

addition, residents in preventive medicine and public health and geriatric programs also are considered primary care residents. Since geriatrics is not a recognized subspecialty, Mr. Waxman would give the Secretary the authority to approve geriatrics programs. FMGs could be counted only if they first pass the FMGEMS.

Finally, this bill would also alter the "indirect medical education adjustment." In FY86, the adjustment would drop to 9 percent and if the Secretary develops regulations to address the issue of hospitals with a disproportionate share of indigents, then the adjustment would decrease to 8 percent for FY87 and beyond. The Secretary also is given the authority to develop a sliding scale for resident to bed ratios in excess of .1.

#### Regula/Tauke (H. R. 2501)

The Regula/Tauke bill would establish a separate formula-driven grant mechanism for payment of graduate medical education expenses under Medicare. The bill would cap Medicare total expenditures at the current estimated costs for graduate medical education. This amount would be allowed to increase by the change in the CPI and would form the annual fund from which hospitals would be paid. The amount each hospital would receive would be equal to the ratio of its previous year's actual number of residents times its percent of Medicare days to total days compared to the sum of this calculation for all hospitals. That is, each hospital would calculate the ratio of its residents for which Medicare paid in the previous year, and claim that percentage of the fund. New entrants into the medical education field would be allowed to claim their projected number of residents in the initial year. Hospitals could not increase their number of residents by more than 10 percent in any one year without incurring substantial penalties.

The Secretary would be given the authority to adjust the amount hospitals receive to reflect differences in stipend levels, the type of service area and the mix of specialties. However, all money from the fund must be spent in each year.

#### Quayle (S. 1210)

The Quayle bill alters the Public Health Service Act, not the Social Security Act. As a result, all federal financial assistance for graduate medical education is jeopardized if hospitals fail to comply, but no assurances are given that Medicare will continue to provide adequate funding for residency training.

Senator Quayle seeks to alter the current physician specialty distribution. In his plan, an advisory council to the Secretary would determine a desirable distribution between primary care and other specialties. Primary care, according to the bill, includes pediatrics, internal medicine, family practice, and ob/gyn residents prior to initial board eligibility. The council would reconsider this percentage every four years.

Hospitals would be required to sign agreements with medical schools to work with all other hospitals affiliating with that school to achieve the predetermined percentage distribution. If the hospitals could not achieve such a distribution by cooperating amongst themselves, the dean would be empowered to mediate, and if necessary to arbitrate. If the medical schools and the state so chose, the State could take over the role of achieving the primary care/non-primary care distribution on a statewide basis instead.

Senator Quayle would require that no more than 25 percent of residents in a program or a hospital be FMGs. There is an exception to this for programs with fewer than 8 residents and a provision for the State to obtain a waiver for hospitals heavily dependent on FMGs to provide needed health care services.

COUNCIL OF TEACHING HOSPITALS - ASSOCIATION OF AMERICAN MEDICAL COLLEGES

APPLICATION FOR MEMBERSHIP

Membership in the Council of Teaching Hospitals is limited to not-for-profit IRS 501(C)(3) - - and publicly owned hospitals having a documented affiliation agreement with a medical school accredited by the Liaison Committee on Medical Education.

INSTRUCTION: Complete all Sections (I-V) of this application.

Return the completed application, supplementary information (Section IV), and the supporting documents (Section V) to the:

Association of American Medical Colleges  
Council of Teaching Hospitals  
Suite 200  
One Dupont Circle, N.W.  
Washington, D. C. 20036

I. HOSPITAL IDENTIFICATION

Hospital Name: Naval Hospital, Bethesda

Hospital Address: Naval Hospital, Bethesda, Maryland 20814-5011

Area Code/Telephone Number: (202) 295-2228

Name of Hospital's Chief Executive Officer:

Commanding Officer: CAPT E. S. AMIS, JR., MC, USN

Executive Officer/DME: CAPT JOHN C. BABKA, MC, USN

II. HOSPITAL OPERATING DATA (for the most recently completed fiscal year)

A. Patient Service Data

Licensed Bed Capacity  
(Adult & Pediatric  
excluding newborn): 567

Admissions: 15,562

Average Daily Census: 414.98

Visits: (E.R.): 31,031

Total Live Births: 1,187

Visits: (OP or Clinic): 739,912



B. Financial Data

Total Operating Expenses: \$35,114,000.00

Total Payroll Expenses: \$14,112,800.00

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: Department of Defense - U. S. Navy  
Supervising Faculty: Department of Defense - U. S. Navy

C. Staffing Data

Number of Personnel: Full Time Physicians: 391 Medical Corps Officers  
Part Time: None

Active Medical Staff: 154

Medical Staff with Medical School Faculty Appointments: 140

Clinical Services with Full-Time Salaried Chiefs of Service  
(list services):

Anesthesiology  
Dermatology  
Internal Medicine  
Cardiovascular Diseases  
Endocrinology  
Gastroenterology  
Hematology  
Oncology  
Infectious Diseases  
Pulmonary Disease  
Neurology  
Neurosurgery  
Nuclear Medicine  
OB-GYN  
Ophthalmology  
Orthopaedics  
Otolaryngology  
Pathology  
Hematopathology  
Pediatrics  
Psychiatry  
Imaging  
General Surgery  
Cardiovascular and Thoracic Surgery  
Urology  
Dental  
Radiology  
Critical Care Medicine  
Emergency Medicine  
Oral Surgery

Does the hospital have a full-time salaried Director of Medical Education? The Naval Hospital, Bethesda has a full-time Executive Officer/Director of Medical Education. (salaried - DOD)

III MEDICAL EDUCATION DATA

A. Undergraduate Medical Education

Please complete the following information on your hospital's participation in undergraduate medical education during the most recently completed academic year:

MEDICAL STUDENT ROTATIONS (for the latest one-year period)

ANESTHESIOLOGY	15
C & T SURGERY	24
DERMATOLOGY	19
ENT	18
INTERNAL MEDICINE	108
NUCLEAR MEDICINE	4
NEUROLOGY ****	13
NEUROSURGERY	11
OB-GYN	133
OPHTHALMOLOGY	51
ORTHOPAEDICS	39
PATHOLOGY	31
PEDIATRICS	131
PLASTIC SURGERY	18
PSYCHIATRY	125
RADIOLOGY ****	10
SURGERY	94
UROLOGY	32
CARDIOLOGY	48
INFECTIOUS DISEASES	12
RENAL	12
PULMONARY DISEASE	15
GASTROENTEROLOGY	12
ENDOCRINOLOGY	15
HEMATOLOGY/ONCOLOGY	24
CLINICAL CONSULTS	12
AMBULATORY MEDICINE	12
INTENSIVE CARE UNIT	12
RHEUMATOLOGY	9

1059 ROTATIONS

\*\*\*\* Neurology Uniformed Services University of the Health Sciences rotations arranged by Department; numbers not available.

\*\*\*\* Radiology Uniformed Services University of the Health Sciences rotations arranged by Department; numbers not available.

CLINICAL CLERKSHIPS OFFERED TO NAVY SCHOLARSHIP STUDENTS:

ANESTHESIOLOGY  
CARDIOVASCULAR AND THORACIC SURGERY  
DERMATOLOGY  
OTOLARYNGOLOGY  
INTERNAL MEDICINE  
\*ALLERGY  
\*CARDIOLOGY-WARD  
\*CARDIOLOGY-CLINIC  
\*ENDOCRINOLOGY  
\*GASTROENTEROLOGY  
\*HEMATOLOGY  
\*ONCOLOGY  
\*INFECTIOUS DISEASES  
\*PULMONARY DISEASE  
\*RENAL/NEPHROLOGY  
\*RHEUMATOLOGY  
\*INTENSIVE CARE UNIT  
\*AMBULATORY MEDICINE  
\*CLINICS AND CONSULTS  
NEUROLOGY  
NUCLEAR MEDICINE  
NEUROSURGERY  
\*OB-GYN  
\*MATERNAL-FETAL MEDICINE  
OPHTHALMOLOGY  
ORTHOAEDICS  
PATHOLOGY  
PEDIATRICS  
PLASTIC SURGERY  
PSYCHIATRY  
RADIOLOGY  
SURGERY  
UROLOGY  
\*GYNECOLOGIC ONCOLOGY

\*FOURTH YEAR STUDENTS ONLY

ROTATIONS OFFERED FOR THIRD YEAR UNIFORMED SERVICES UNIVERSITY OF THE  
HEALTH SCIENCES STUDENTS AT NAVAL HOSPITAL, BETHESDA:

INTERNAL MEDICINE  
PSYCHIATRY  
PEDIATRICS  
GENERAL SURGERY  
OB-GYN

ROTATIONS OFFERED FOR FOURTH YEAR UNIFORMED SERVICES UNIVERSITY OF THE  
HEALTH SCIENCES STUDENTS AT NAVAL HOSPITAL, BETHESDA:

ANESTHESIOLOGY  
DERMATOLOGY  
CARDIOLOGY CLINIC  
CARDIOLOGY WARD  
INFECTIOUS DISEASES  
RENAL  
PULMONARY DISEASE  
GASTROENTEROLOGY  
ENDOCRINOLOGY  
HEMATOLOGY  
ONCOLOGY  
ONCOLOGY SUBINTERNSHIP  
CLINICS AND CONSULTS  
AMBULATORY MEDICINE  
INTENSIVE CARE UNIT  
INTENSIVE CARE UNIT RESEARCH  
RHEUMATOLOGY  
ALLERGY  
NEUROLOGY SUBINTERNSHIP  
PEDIATRIC NEUROLOGY  
GYNECOLOGIC ONCOLOGY  
MATERNAL AND FETAL MEDICINE  
OB-GYN SUBINTERNSHIP  
PATHOLOGY  
ADVANCED PEDIATRICS  
NEONATOLOGY  
PEDIATRIC SUBINTERNSHIP  
PEDIATRIC ENDOCRINOLOGY  
PEDIATRIC ACUTE CARE  
NEONATOLOGY SUBINTERNSHIP  
PEDIATRIC CARDIOLOGY  
PSYCHIATRY  
PSYCHIATRY SUBINTERNSHIP  
ALCOHOL REHABILITATION  
CLINICAL CHILD/FAMILY PSYCHIATRY  
CONSULTATION/LIAISON  
ADVANCED SURGERY  
NEUROSURGERY  
OPHTHALMOLOGY  
OTOLARYNGOLOGY  
CARDIOVASCULAR AND THORACIC SURGERY  
ORTHOPAEDICS  
UROLOGY  
SURGERY SUBINTERNSHIP  
PEDIATRIC/ORTHOPAEDIC SUBINTERNSHIP  
HAND SURGERY  
NEUROSURGERY SUBINTERNSHIP  
ORTHOPAEDIC SUBINTERNSHIP  
PLASTIC SURGERY  
OPHTHALMOLOGY SUBINTERNSHIP  
RADIOLOGY  
NEUROLOGY

B. Graduate Medical Education

(1) Date of Initial Accreditation:

Anesthesiology	1949 (2 year program) 1965 (3 year program)
Dermatology	1973
Internal Medicine	1945
Neurology	1950 (Discontinued in 1960) Reaccredited 1971
Neurosurgery	1976
OB-GYN	1949
Ophthalmology	1947
ENT	1949
Orthopaedics	1945
Pathology	1945 (3 year program) 1953 (4 year program)
Hematopathology	1979
Pediatrics	1949
Psychiatry	1949
Radiology	1950
Diagnostic Radiology	1973
Surgery	1945
C & T Surgery	1964
Urology	1948
Nuclear Medicine	1974
Imaging	1984

(2) Residency Programs

Approved Number of Trainees

Anesthesiology	18
Dermatology	6
Internal Medicine	15
Neurology	6
Neurosurgery	6
Nuclear Medicine	4
OB-GYN	9
Ophthalmology	12
Orthopaedic Surgery	8
Otolaryngology	8
Pathology	8
Pediatrics	6
Psychiatry	9
Radiology	16
General Surgery	12
C & T Surgery	2
Urology	4

149

<u>(3) Fellowship Programs</u>	<u>Approved Number of Trainees</u>
Cardiology	4
Endocrinology	4
Gastroenterology	4
Hematology/Oncology	6
Infectious Disease	4
Pulmonary Disease	2
Gynecologic Oncology	2
Maternal-Fetal Medicine	2
Reproductive Endocrinology	2
Hematopathology	1
Imaging	1
	<hr/>
	32

<u>(4) Internship Programs</u>	<u>Approved Number of Trainees</u>
Internal Medicine	18
Surgery	13
OB-GYN	4
Pediatrics	3
Psychiatry	4
Transitional	10
	<hr/>
	52

CATEGORICAL MEDICINE ROTATIONS

Ward Medicine	24 weeks
Neurology	4 weeks
Otolaryngology	4 weeks
Intensive Care Unit	4 weeks
Emergency Room	4 weeks
Anesthesiology	4 weeks
Pediatrics	4 weeks
Orthopaedics	4 weeks

If an intern is NOT going to apply for Internal Medicine Residency, he may delete eight (08) weeks of Internal Medicine and rotate through eight (08) weeks of electives.

CATEGORICAL SURGERY ROTATIONS

Surgery	12 weeks
Orthopaedic Clinic	4 weeks
Otolaryngology	4 weeks
Anesthesiology	4 weeks
Ward Medicine	4 weeks
Pediatrics	4 weeks
Emergency Room	4 weeks
Intensive Care Unit	4 weeks
C & T Surgery	4 weeks
Electives	8 weeks

One elective may be in the medical specialties and one in the surgical specialties, or both in medical specialties.

PSYCHIATRY ROTATIONS

Psychiatry	12 weeks
Ward Medicine	16 weeks
Pediatrics	4 weeks
Neurology	4 weeks
OB-GYN	4 weeks
Emergency Room	4 weeks
Electives	8 weeks

OB-GYN ROTATIONS

OB-GYN	28 weeks
Ward Medicine	8 weeks
Emergency Room	4 weeks
Intensive Care Unit	4 weeks
Neonatology	4 weeks
Anesthesiology	4 weeks

PEDIATRIC ROTATIONS

Pediatrics	36 weeks
OB-GYN	4 weeks
Emergency Room	4 weeks
Trauma (Childrens' Hospital)	4 weeks
Orthopaedics	4 weeks

TRANSITIONAL ROTATIONS

Ward Medicine	12 weeks
Outpatient Medicine	4 weeks
Surgery	4 weeks
Surgery, OB or Surgery subspecialty	4 weeks
Orthopaedics	4 weeks
OB-GYN	4 weeks
Outpatient Pediatrics	4 weeks
Emergency Room	4 weeks
Psychiatry/ARU	4 weeks
Electives	8 weeks

OTHER MEMORANDA OF UNDERSTANDING

<u>INSTITUTION</u>	<u>TRAINING LOCATION</u>	<u>DEPARTMENT</u>
AMERICAN UNIVERSITY	NHBETH	NURSING
CATHOLIC UNIVERSITY	NHBETH	NURSING
CHILDRENS' HOSPITAL NMC	CHNMC	UMBRELLA
COLUMBIA UNION COLLEGE	NHBETH	NURSING
EAST CAROLINA UNIVERSITY	NHBETH	OCCUPATIONAL THERAPY
GALLAUDET COLLEGE	NHBETH	ENT (AUDIOLOGY)
GEORGE WASHINGTON UNIVERSITY	NHBETH/GW	UMBRELLA
AMERICAN RED CROSS BLOOD SERVICES	NHBETH	PATHOLOGY
GEORGETOWN UNIVERSITY	NHBETH/GT	UMBRELLA
HOWARD UNIVERSITY	NHBETH	PHARMACY
J.L. KERNAN'S HOSPITAL	J.L. KERNAN'S HOSPITAL	ORTHOPAEDICS
MEDICAL COLLEGE OF VIRGINIA	NHBETH	OCCUPATIONAL THERAPY
MEDICAL COLLEGE OF VIRGINIA	NHBETH	PHYSICAL THERAPY
MONTGOMERY COMMUNITY COLLEGE	NHBETH	NURSING
MONTGOMERY COUNTY PUBLIC SCHOOLS	NHBETH	UMBRELLA
NATIONAL CATHOLIC SCHOOL OF SOCIAL SERVICES	NHBETH	SOCIAL WORK SERVICE
NICHD, NIH, USUHS	NIH	OB-GYN (MATERNAL-FETAL)
NORTHERN VIRGINIA COMMUNITY	NHBETH	PHYSICAL THERAPY
NICHD, NIH, USUHS	NIH	REPRODUCTIVE ENDO
UNIVERSITY OF MARYLAND	NHBETH	PHYSICAL THERAPY
UNIVERSITY OF MARYLAND	NHBETH	PHARMACY
VETERANS ADMINISTRATION	NHBETH/VA	UMBRELLA
WASHINGTON HOSPITAL CENTER	WHC	ANESTHESIOLOGY
VIRGINIA COMMONWEALTH UNIV	NCU	DENTAL
VIRGINIA COMMONWEALTH UNIV	NHBETH	PHARMACY
NORTHERN VIRGINIA COMMUNITY	NHBETH	NURSING (HEM/ONC)
NORTHERN VIRGINIA MENTAL HEALTH	NVMHI	PSYCHIATRY
SIBLEY MEMORIAL HOSPITAL	SIBLEY	PSYCHIATRY
RUSSELL SAGÉ COLLEGE	NHBETH	PHYSICAL THERAPY
ST. ELIZABETH HOSPITAL	ST. ELIZABETH	PSYCHIATRY
UNIVERSITY OF MARYLAND	U OF M	ORTHOPAEDICS
UNIVERSITY OF MARYLAND	U O M	SURGERY
NCI, NIH, WRAMC, USUHS	NCI, NIH, WRAMC, USUHS	RADIATION THERAPY/ONCOLOG
WASHINGTON HOSPITAL CENTER	WHC	UMBRELLA
UNIVERSITY OF MARYLAND	U OF M/NHBETH	DENTAL
GEORGE WASHINGTON UNIV	NHBETH	SPEECH PATHOLOGY
D.C. GENERAL	NHBETH	UMBRELLA (PENDING)
USUHS, WRAMC, MALCOLM GROW	USU, WRAMC, MAL. GROW	PEDIATRIC ENDO & PED I.D.
NEW ENGLAND BAPTIST	N. ENGLAND BAPTIST	ORTHOPAEDICS
HOWARD UNIVERSITY	NHBETH	HEMATOLOGY/ONCOLOGY
HOWARD UNIVERSITY	NHBETH	UROLOGY
UNIVERSITY OF MARYLAND	U OF M	NEUROSURGERY
USUHS, WRAMC	USUHS, WRAMC, NHBETH	GYN ONCOLOGY
UNIVERSITY OF MARYLAND	U OF M	UROLOGY
UNIVERSITY OF PITTSBURGH	NHBETH	PHYSICAL THERAPY
JOHNS HOPKINS	JOHNS HOPKINS	UROLOGY
HOWARD UNIVERSITY	NHBETH	PATHOLOGY
WASHINGTON HOSPITAL CENTER	WHC	ENT
UNIVERSITY OF DELAWARE	NHBETH	PHYSICAL THERAPY
WASHINGTON HOSPITAL CENTER	WHC	DENTAL (PENDING)

\*WRAMC= WALTER REED ARMY MEDICAL CENTER

\*USUHS= UNIFORMED SERVICES UNIVERSITY OF THE HEALTH SCIENCES



#### IV. SUPPLEMENTARY INFORMATION

To assist the COTH Administrative Board in its evaluation of whether the hospital fulfills present membership criteria, you are invited to submit a brief statement which supplements the data provided in Section I-III of this application. When combined, the supplementary statement and required data should provide a comprehensive summary of the hospital's organized medical education and research programs. Specific reference should be given to unique hospital characteristics and educational program features.

##### SUPPLEMENTARY STATEMENT - RESEARCH

The Clinical Investigation Department of the Naval Hospital Bethesda, is the local governing authority for clinical research conducted at this facility. As such, it is responsible to the Commanding Officer, Naval Hospital, Bethesda and comes under the overall supervision of the Naval Health Sciences Education and Training Command, which has overall responsibility for clinical research conducted in support of our training programs.

Since 1982, the program has been funded at an average level of \$325,000.00 yearly. There have been approximately one hundred and eighty (180) active studies at any one time during that period, involving the participation of some one hundred and twenty (120) staff members as well as forty (40) trainees. Over the past several years, an average of fifty (50) publications, eighty (80) abstracts and eighty (80) presentations have been recorded by this Department. With the addition of the vigorous research efforts of the National Cancer Institute, the program of clinical investigation at this Command has been further strengthened and continues to be quite productive.

##### SUPPLEMENTARY STATEMENT - EDUCATION

The Naval Hospital, Bethesda does not participate in the National Intern/Resident Program. All Navy Program Directors gather in the Washington, D. C. area during the first week in September to select the next year's interns and residents. Notification is forwarded to the selectees/alternates/non-selects by the second week in October. In that the trainees are commissioned Naval officers, we do not encounter salary problems for our trainees.

#### V. SUPPORTING DOCUMENTS

- A. When returning the completed application, please enclose a copy of the hospital's current medical school affiliation agreement. (Appended)

LATEST ACGME ACCREDITATION

ANESTHESIOLOGY	1985
DERMATOLOGY	1983
INTERNAL MEDICINE	1983
NEUROLOGY	1983
NEUROSURGERY	1982 (BEING SURVEYED AUGUST 1985)
NUCLEAR MEDICINE	1985
OB-GYN	1983
MATERNAL FETAL	1984
OPHTHALMOLOGY	1984
ORTHOPAEDICS	1985
ENT	1983
PATHOLOGY	1984
HEMATOPATHOLOGY	1982
PEDIATRICS	1983
PSYCHIATRY	1983
RADIOLOGY	1983
IMAGING	
SURGERY	1982
C & T SURGERY	1982
UROLOGY	1983

ALL PROGRAMS ARE FULLY ACCREDITED


- B. A letter of recommendation from the Dean of the affiliated medical school must accompany the completed membership application. The letter should clearly outline the role and importance of the applicant hospital in the school's educational programs. (See appended information)

Name of Affiliated Medical School: The Uniformed Services University  
of the Health Sciences

Dean of Affiliated Medical School: Jay P. Sanford, M.D.

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Information Submitted by: (Name): Mrs. Barbara B. Smith  
(Title) Graduate Medical Education Coordinator

Signature of Hospital's Chief Executive Officer:

 (Date) 26 July 1985  
CAPT E. S. AMIS, JR., MC, USN  
Commanding Officer



UNIFORMED SERVICES UNIVERSITY OF THE HEALTH SCIENCES  
 F. EDWARD HÉBERT SCHOOL OF MEDICINE  
 4301 JONES BRIDGE ROAD  
 BETHESDA, MARYLAND 20814-4799



OFFICE OF THE PRESIDENT

May 28, 1985

TEACHING HOSPITALS  
 WALTER REED ARMY MEDICAL CENTER  
 NAVAL HOSPITAL, BETHESDA  
 MALCOLM GROW AIR FORCE MEDICAL CENTER  
 WILFORD HALL AIR FORCE MEDICAL CENTER

Dr. Sheldon S. King  
 Chairman, Council of Teaching Hospitals  
 Association of American Medical Colleges  
 One Dupont Circle, N.W., Suite 200  
 Washington, D.C. 20036

Dear Dr. King:

This letter is to strongly support the application for membership in the COTH being submitted by the Naval Hospital, Bethesda (NHB).

USUHS is heavily dependent upon the Naval Hospital, Bethesda for our pre-clinical physical diagnosis, third and fourth year clinical programs, not only in terms of patient access but for faculty members who are at the Naval Hospital yet concurrently carry major teaching and school teaching loads. Of our clinical faculty, 20 percent are Navy physicians, 90 percent of whom are not assigned to the University on a full-time basis but who teach, perform research and serve on all medical school committees on a voluntary additional duty basis. Within the medical school we make no distinctions in terms of their academic responsibilities - promotions, etc. These close relationships are established by agreements which cover both the academic as well as administrative areas. Fortunately, our relationships are such that we have worked together for the past ten years without having to revise the basic academic agreement.

Concomitantly, USUHS contributes to the graduate and continuing medical education, clinical research and patient care at NHB.

There is no question that NHB is one of the major teaching hospitals for USUHS. Naval Hospital, Bethesda has accepted this responsibility with enthusiasm and dedication to our common goals. I strongly support the election to membership of the Naval Hospital, Bethesda.

Sincerely,

Jay P. Sanford, M.D.  
 President/Dean

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TRANSITION TO GRADUATE MEDICAL EDUCATION:  
ISSUES AND SUGGESTIONS

A Report to the  
Administrative Boards  
Association of American Medical Colleges  
September 11-12, 1985

Developed from an Analysis by:  
Norma E. Wagoner, Ph.D.

With the Assistance of:  
Jack C. Gardner, M.D.  
Jon H. Levine, M.D.  
Paula L. Stillman, M.D.

TRANSITION TO GRADUATE MEDICAL EDUCATION:  
ISSUES AND SUGGESTIONS

I. Graduate Medical Education and the Selection Process

A. Issues

A number of recurring questions and concerns center around the selection process and the associated matches:

- o With the limitation in positions, do program directors need to begin to define the population to whom they will give major consideration in the selection process?
- o We have yet to see the impact of the for profit hospital corporations on the recruitment and selection of medical students for positions funded by those corporations in certain medical centers.
- o Does any organization have the right to prevent, restrict or constrain any groups of individuals from establishing their own match process? Will the for profit hospital corporations move in that direction?
- o The NRMP has been in continual evolution since the late 1950's; does the system need further revision to accommodate contemporary needs?

Consideration of these questions and concerns have led to the identification of the following problem list for the graduate medical education selection process:

1. Too much splintering of specialty interest groups into their own match processes: Colenbrander matches, military matches, Urology match, and individual hospital or specialties which operate outside the boundaries of any match process (the no-match group).
2. No uniformity of applications. Some programs use the uniform application, while others use one that has been developed by their own hospitals. This creates enormous pressures on students who may need to submit 30 to 50 applications to one, two, or more specialties.
3. Points of entry into graduate training are many and varied, leading to massive communication problems for all participants.
4. The algorithm and terminology of the NRMP are complex and not easily understood even by the most experienced.

5. In the competitive specialty programs, selection committees are insisting that candidates come for interviews (without any assurances) in order to be given consideration.
6. There is no composite information on available options through all forms of selection processes. This leads to difficulties in communication about entry points for postgraduate training. Each entity administering a match carries out its own form of advertising.

B. Suggestions

Short Term Changes

1. Request that NRMP review and evaluate current information that is being disseminated to program directors and students, including descriptions of the match algorithm and the types of positions offered.
2. There is a definite need for some entity (perhaps the AAMC) to develop comprehensive materials on the residency selection process. A prototype example might be the Medical School Admission Requirements handbook. Explore how this information can or should be communicated.

Long Term Changes

3. Consider a thorough examination and evaluation of the current NRMP process and staffing needs. The NRMP Board of Directors is the group with this responsibility. Perhaps the recently created advisory board could work with the NRMP to provide input from each specialty.
4. Consider development of centralized application service. While there is a uniform application, there is no agreed upon usage. If the program directors could be furnished a reduced administrative workload through such a service (e.g. AMCAS), the system could become sufficiently widely used to furnish a basis for the development of "traffic rules" (e.g. uniform dates).
5. Develop materials by specialty (including details of specific programs within each specialty) which could be sold at cost to students. Such materials should include the following types of information:
  - a. Types of candidates that each program seeks. If possible, a greater specificity about the range of backgrounds sought: LCME graduates only, East coast schools only, AOA, National Board Part I scores of 550 or better, etc. This could reduce the "shot-gun" approach to program selection which currently exists and could markedly reduce the work-load of all parties concerned. If a book of this type is to be developed,

program directors must be convinced that it helps them cut their own costs of communication, and reduces their work load.

- b. Range of stipend. This may become increasingly important as students amass high debts. Students will need to know if they can afford particular programs.
  - c. Range of benefits - malpractice insurance, health benefits, etc.
  - d. Expected background -- "desirable to have electives in....."
  - e. How the interview process is administered.
  - f. Whether they have special programs: primary care track, research track, and other special features of the program.
6. Have teaching hospital directors assume authority over the recruitment and selection procedures of the programs sponsored by their institutions. The diversity of specialties and the sheer number of programs (over 5,000) makes the achievement of uniform policies and procedures almost impossible. In addition, the development of useful information about institutions' programs for students would be simplified if reliable communications were established with the institutions that sponsor programs rather than with each program director. The AAMC has pressed for greater institutional responsibility for graduate medical education since the late 1960s. The assumption of authority over recruitment and selection policies and procedures by the directors of COH member hospitals, which provide more than 60 percent of residency positions, could set a precedent that other hospitals would follow.

## II. Graduate Medical Education and the Clinical Curriculum

### A. Issues

Another major dimension of the transition process is its impact on the clinical education of the medical student, as is evidenced by the following questions and concerns:

- o Do residency directors unduly influence the medical school curriculum now that students are being recruited and selected as early as the third year?
- o Are program directors suggesting (or even stating) to students that unless they take an elective in their hospital, they will not be interviewed or fully considered for a position?
- o Has the use of external examination scores (NBME Parts I and II) become a major selection factor, when it is known that

these scores measure only a small fraction of the attributes necessary for the practice of quality medicine?

A careful review of these and related questions lead us to the following delineation of problems in the clinical education of medical students:

1. Students seeking positions in the very competitive specialties (particularly the surgical specialties, but also, ophthalmology and emergency medicine) are reported to be taking three and four identical electives in the specialty area of choice at various hospitals in the hope of bettering their selection chances. This compromises the general professional education of the physician.
2. A good portion of the fall of the senior year is devoted to completing multiple applications and seeking interviews. There appears to be little interest in assisting the students by grouping interviews for traveling to a particular region of the country. Often times students must make multiple trips back to an area because of the inflexibility of the interview process.
3. The cost of travel associated with the selection process discriminates against less affluent students and, if incorporated in the approved educational costs, increases their indebtedness.
4. The focus on education and learning is being lost in the increasing emphasis on preparing for the residency selection process.
5. Schools are being forced to change their third year curricular structures to accommodate pressures on their students for early exposure to various specialties. Similar pressures in the fourth year are acting to distort elective programs as students undertake earlier specialization.
6. Earlier selection and preparation for selection are forcing premature decisions about career choices upon students.
7. Because low or average NBME scores may preclude a student from being interviewed, schools now need to furnish considerable time for students to prepare for and/or to provide support services to assist them in preparation for these examinations.
8. The pressure upon schools to place their graduates is causing a grade inflation problem, thus lessening the credibility of grades as a measure of competence.

B. Suggestions

Short Term Changes



1. Ask the program directors to work with the AAMC to facilitate communication with medical schools: traffic rules, general guidelines, uniform applications, interview time frames.
2. Undertake research to determine which selection factors provide the best residents. This may increase the quality of selection factors beyond those now currently being used.

#### Long Term Changes

3. Reduce the number of medical students commensurate with the reduction in residency positions.
4. Development of an examination of clinical skills which is both more comprehensive and more oriented to problem solving. Such an examination might well include a "hands on" performance evaluation.
5. Consider a fifth year of medical school. By the fifth year, students would have narrowed their specialty interest to three and would spend three months in each area. The three remaining months of that year would be devoted to a Match process with high quality evaluation techniques being utilized to provide maximum information about the students' skills, abilities and suitability for a particular professional area.
6. Consider extending medical school through four years of clinical education, incorporating residency training into the fourth, fifth, and sixth years of a pre M.D. program.

### III. Graduate Medical Education and the Counseling Process

#### A. Issues

A third series of questions and concerns exemplify another area affected by the transition: the role of Deans of Student Affairs and the problems of counseling in residency selection.

- o In transmitting information to program directors, should Deans of Student Affairs be a student advocate or a factual reporter? Do they have an obligation to see that all medical students have a graduate medical education position?
- o In times of more limited resources, Deans of Student Affairs are being asked to take on greater responsibilities in the residency placement process, including working with graduates who are one, two, or more years out of medical school. How far in time does institutional responsibility extend?
- o What responsibility does an institution have to develop a comprehensive advising system? Should such a system include financial planning and debt counseling since graduates may

have debts which are excessive in relation to residency salaries?

- o Advising is a demanding job and advisors need to have broad knowledge of programs, hospitals, specialties, understanding of selection factors and knowledge of financial matters. Is it realistic to expect our medical schools to expand the staffing for these advising functions?

These questions suggest the following problem areas which might be addressed:

1. In the past, medical students have usually been able to obtain a position in the specialty they wanted. Now, with fewer positions available, Deans of Student Affairs are being placed increasingly in the position of encouraging students to apply for two or three specialties. This emphasis on getting students placed, comes at the expense of the "career fit" counseling process.
2. A related problem with yet to be determined consequences is the possible effect of reduced funding for graduate medical education on the remuneration available and the possibility of significant variation in compensation levels.
3. Early Deans' letters for special matches often require supplemental letters for subsequent matches, compounding the administrative load.
4. Training new and or part-time Deans of Student Affairs in the development of counseling systems and in keeping up with changes in the selection process.
5. Advising the students who find themselves in difficult ethical dilemmas regarding match situations. The ethics of the marketplace appears to be prevailing, and the sense that anything goes is creating major problems with agreements about current procedural guidelines. This is particularly true for the unmatched student who is seeking a competitive specialty. When very few places are available, the temptation to cheat increases.
6. Helping students reduce the anxieties involved in a competitive selection process where their years of work may not achieve a result supportive of their career goals. This may contribute to a loss of idealism about the practice of medicine and about themselves as practicing physicians.

B. Suggestions

1. Offer a national institute where program directors, Student Affairs Deans, and selected students can meet to develop some strategies and goals for increasing the effectiveness of the selection process.

2. Develop a network of Deans of Student Affairs (computer bulletin board?) to provide a means for updating certain kinds of information. Such a network has been proposed by the NRMP for listing unfilled places throughout the year. This type of network might be extended more fully to provide a greater array of services through the NRMP office.

TRANSITION TO GRADUATE MEDICAL EDUCATION  
ISSUES AND SUGGESTIONSA Recent Chronology1983

- A. A presentation by Jack Graettinger (NRMP) at the Northeast GSA, Spring Meeting - 1983, was instrumental in beginning the most recent round of discussions regarding this set of interrelated problems.
- B. Howard Levitin (Yale) took the concerns of the NEGSA to the Thirteen School Consortium who through Dean Robert Berliner (Yale) wrote to Dr. Cooper requesting that the AAMC undertake a major initiative to develop solutions.
- C. The Council of ~~Deans~~ discussed this as an agenda item at their Scottsdale meeting (Spring 1983).
- \*D. The AAMC decided to study the problem from the perspective of the program directors. Dr. Cooper (AAMC) wrote to the clinical societies within CAS asking of each society whether it had an established position on the matter of the selection of applicants into residency training programs.
- \*E. A plan of action was discussed by The Executive Council (June, 1983). The GSA Steering Committee was charged with the preparation of a "White Paper."
- \*F. As requested by ~~the~~ Executive Council, Joe Keyes wrote an analysis of the ~~CAS~~ responses for the Executive Council agenda, September, 1983. The Executive Council concluded that the Executive Committee of the AAMC should meet with officials of those clinical disciplines using early match dates. (See H, Below)
- \*G. This problem area was the major topic of the CAS agenda at the AAMC Annual Meeting, Fall, 1983.
- H. Dec. 7, 1983; AAMC Executive Committee met with specialties operating outside NRMP. Libby Short (AAMC) designed for this special meeting a flow chart showing how the NRMP match could meet all of the objectives of those disciplines currently operating outside the match. Minutes of this meeting were circulated to all participants who were, in turn, asked to comment.

\* Reference documents available

1984

- \*I. The minutes of the Dec. 7, 1983 meeting were adjusted for these comments and were mailed to the Executive Council with the agenda for the January, 1984 meeting.
- J. The proposal developed by the Executive Council (September 1983) for an advisory committee to NRMP was vetoed by the AMA representative to the NRMP board. In late Spring, 1984, the advisory committee was approved, although it did not meet until Spring, 1985.
- K. Spring and Summer of 1984, Dr. Cooper and Dr. Graettinger appeared before the Boards of some of the specialties which operate outside the match with the request that they participate in NRMP; little response.
- \*L. June, 1984, the CAS Administrative Board adopted a resolution supporting the position of a single match.
- \*M. September, 1984, the AAMC Executive Council approved a modified form of that resolution.
- N. At the AAMC Annual Meeting, Fall, 1984, the Council of Academic Societies and the Council of Deans approved the Executive Council resolution.

1985

- O. At the Spring, 1985, CAS meeting, a planned discussion on GPEP developed into a discussion of early match problems.
- P. April, 1985, the Specialty Advisory Committee to the NRMP Board held its first meeting with Dr. Swanson representing the AAMC.
- Q. April, 1985, new LCME guidelines approved; "Functions and Structure of a Medical School" (See R., below).
- \*R. Dean Arnold Brown (Wisconsin) requested further discussion at the Summer Meeting of the COD Administrative Board. The Board requested that AAMC Staff, GME officers, and GSA officers develop an Action Agenda for the September, 1985, meeting.

\* Reference documents available

## MEDICARE OUTPATIENT SURGERY SAVINGS, ACCESS, AND QUALITY ACT

Three basic points summarize Senator Durenberger's proposal:

1. Medicare would pay a fixed prospective rate for outpatient surgeries regardless of delivery settings - outpatient hospital department or ambulatory surgery center;
2. Included in the fixed rate would be all facility costs including prosthetic devices and lab work;
3. No fixed procedure rate would be above the amount paid for the inpatient DRG for the comparable surgery.

The staff believes there is no reason to disagree with items two and three. However, item number one calling for a single rate irrespective of the setting requires attention to the following points:

- o In the July 24 Congressional Record (p. S9966), it's stated that, "The beneficiary who receives his cataract surgery at Yale-New Haven Hospital is paying a copayment of \$900 on a \$4,500 charge." The \$4,500 figure is incorrect by more than 200%. Management at the Yale-New Haven Hospital has indicated that the average charge for ambulatory surgery is \$1,602 (including the lens), and the average inpatient payment for DRG #39 is \$2,075. Based on these errors, There is reason to question the data that's being used and the resulting savings that are being calculated.
- o The bill goes beyond cataract surgery, and includes all procedures on the list for which nonhospital ambulatory surgery centers can be paid a facility fee based on regulations effective September 7, 1982. To generalize from the cataract surgery examples without data is presumptuous. The data for ten procedures provided by the HHS Inspector General's office in a July 18, 1985 letter to Senator Durenberger compare inpatient DRG rates, which include all costs associated with the procedures, with ASC reimbursement, which does not include prostheses, laboratory work or x-ray charges. In addition, the other material provided by the IG suggests some confusion over the difference between costs and charges.
- o Historically Medicare has determined the methodology by which hospital costs are allocated to the outpatient department. It is probably the case that the methodology by which this was done overallocated some costs; e.g., administration and general. Hospitals are now being told to cut back and be competitive. These costs do not disappear, and if they are overallocated, they should have been included in inpatient costs upon which the DRG rates were calculated. One way to recognize this methodological problem is to allow a higher rate for hospital-based programs so that they can compete on a fair price basis.
- o The proposal appears to assume that current overhead that is not fully absorbed by the new rate can be reallocated to the remaining portion of the hospital-based outpatient department. Under current rules this would not be possible.
- o In hospital-based outpatient departments there are substantial amounts of intern and resident allocated expenses. These costs are not present in

ASC rates as currently developed. At the very least, a passthrough for educational costs should be built into whatever rates are put into place for either setting.

- o By regulation, HHS has established the list of surgical procedures which may be performed on an ambulatory basis, and there is a group of patients who are generally in good health for whom surgery in an ambulatory surgical setting is clearly an appropriate alternative. There also is a set of patients for whom these surgeries must be performed on an inpatient basis because they are in such fragile health due to the existence of one or more complicating conditions. In between these two extremes, there is a third group of patients who may be candidates for ambulatory surgery but who have conditions which may complicate this surgery, and thus, the surgeons would want to operate in an outpatient hospital setting which has full capabilities for emergency backup support. There are additional costs for maintaining this backup, and those costs must be borne by all patients using the hospital's ambulatory surgery facilities.

The Durenberger proposal is one example of a more general approach: paying for care in all settings based on the price paid in the least expensive setting. This approach has three major implications for teaching hospitals:

- o Because institutional services carry more overhead and must meet more stringent requirements, services will increasingly move to noninstitutional settings.
- o Patients treated in institutional settings because they present significant risks if treated in a freestanding facility will only pay at a greater-than-freestanding rate if they actually use the backup institutional services.
- o Because few freestanding facilities provide medical education, prices with which teaching hospitals must compete will not include a medical education component.

The Board is requested to discuss:

- o How aggressive the AAMC should be in responding to the Durenberger bill?
- o Whether major teaching hospitals can adapt to or create services which can compete on a price basis with freestanding facilities? and
- o What activities the AAMC could undertake to assist major teaching hospitals in a single price system?