



**association of american
medical colleges**

AGENDA

FOR

COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD MEETING

September 11, 1986

8:00 a.m.

Washington Hilton Hotel

M A P R O O M

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

COTH ADMINISTRATIVE BOARD

Chairman: C. Thomas Smith
Yale New Haven Hospital

Chairman-Elect: Spencer Foreman, MD
Sinai Hospital of Baltimore

Immediate Past Chairman: Sheldon S. King
Stanford University Hospital

Secretary: John E. Ives
Shands Hospital

Robert J. Baker
University of Nebraska Hospital
and Clinics

J. Robert Buchanan, MD
Massachusetts General Hospital

Gordon M. Derzon
Univeristy of Wisconsin Hospital
and Clinics

Gary Gambuti
St. Luke's-Roosevelt Hospital

Larry L. Mathis
The Methodist Hospital

James J. Mongan, MD
Truman Medical Center

Eric B. Munson
North Carolina Memorial Hospital

Charles M. O'Brien, Jr.
Georgetown University Hospital

Raymond G. Schultze, MD
UCLA Hospitals and Clinics

Barabara A. Small
Veterans Administration
Medical Center

William T. Robinson
AHA Representative

COTH MEETING DATES

COTH ADMINISTRATIVE BOARD MEETINGS

September 10-11, 1986	Washington Hilton Hotel Washington, DC
January 21-22, 1987	Same
April 15-16, 1987	Same
June 17-18, 1987	Same
September 9-10, 1987	Same

COTH SPRING MEETINGS

May 13-15, 1987	Fairmont Hotel Dallas, TX
May 11-13, 1988	The New York Hilton Hotel New York, NY

AAMC ANNUAL MEETINGS

October 25-30, 1986	The New Orleans Hilton Hotel New Orleans, LA
November 7-12, 1987	Washington Hilton Hotel Washington, DC
November 12-17, 1988	The Marriott Hotel Chicago, IL

MEETING SCHEDULE
COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD

September 10-11, 1986
Washington Hilton Hotel
Washington, DC

WEDNESDAY, September 10, 1986

- 6:30p COTH ADMINISTRATIVE BOARD MEETING
William L. Roper, MD
Administrator, HCFA
Hemisphere Room
- 7:30pm COTH ADMINISTRATIVE BOARD RECEPTION
AND DINNER
Thoroughbred Room

THURSDAY, September 11, 1986

- 8:00am COTH ADMINISTRATIVE BOARD MEETING
Map Room
- 12:00noon JOINT AAMC ADMINISTRATIVE BOARDS LUNCHEON
Hemisphere Room
- 1:00pm AAMC EXECUTIVE COUNCIL MEETING
Military Room



WILLIAM L. ROPER, M.D.

**Administrator
Health Care Financing Administration
Department of Health and Human Services**

William L. Roper, M.D., was sworn in as the fifth administrator of the Health Care Financing Administration May 12, 1986. He was nominated by President Reagan March 17, 1986, and confirmed by the Senate May 8, 1986.

As administrator of HCFA, Roper is responsible for the overall executive leadership, direction and coordination of all federal health care financing programs under Title XVIII (Medicare), Title XIX (Medicaid) and Title XI (Peer Reviews).

Roper comes to HHS from the White House where since 1983 he had been a special assistant to the President for health policy.

Roper was born in Birmingham, Ala., July 6, 1948. He received an associate of arts degree from Florida College in 1968; bachelor of science degree from the University of Alabama, 1970; his M.D. from the University of Alabama School of Medicine, where he was president of his class all four years, in 1974; and his M.P.H. from that institution's School of Public Health in 1981. He is board certified in pediatrics (1979) and in preventive medicine (1982), and is licenced to practice medicine in Alabama.

A Phi Beta Kappa, he was a State Merit Scholar and president of Alpha of Alabama Chapter, Alpha Omega Alpha.

From 1977 to 1983, Roper was health officer of the Jefferson County Department of Health in Birmingham, serving also from 1981 as assistant state health officer. Between 1979-1982, he served in several positions on the faculty of the University of Alabama at Birmingham in the School of Public Health, Department of Pediatrics, and the Graduate Program in Hospital and Health Administration.

On leave from his Alabama health position, he was a White House Fellow in the White House Office of Policy Development from 1982 to 1983 with responsibility for health policy.

Roper is a member of the Medical Association of the State of Alabama and the American Public Health Association.

He has authored and co-authored articles on medical and health issues.

Roper resides with his wife Maryann Jedziniak Roper, also a pediatrician, in Arlington, Va.

May 12, 1986

A G E N D A

COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD MEETING

September 11, 1986
WASHINGTON HILTON HOTEL
Map Room
8:00am-12:00noon

- | | | |
|-------|--|---|
| I. | CALL TO ORDER | |
| II. | CONSIDERATION OF THE MINUTES | Page 1 |
| III. | DISCUSSION WITH THE AAMC PRESIDENT | Dr. Petersdorf |
| IV. | AMBULATORY CARE TRAINING ACT | Executive Council
Agenda - Page 22 |
| V. | THE MEDICARE DIRECT MEDICAL EDUCATION
PASSTHROUGH AND THE INDIRECT MEDICAL
EDUCATION ADJUSTMENT: FUTURE ISSUES | Page 12 |
| VI. | THE COMMONWEALTH FUND GRANT TO
ANALYZE TEACHING HOSPITAL DATA | Page 19 |
| VII. | REPORT ON ISSUES BEFORE THE ACCREDITATION
COUNCIL ON GRADUATE MEDICAL EDUCATION | Mr. Munson
Dr. Foreman |
| VIII. | NIH CENTENNIAL CELEBRATION | Executive Council
Agenda - Page 19 |
| IX. | CALIFORNIA BALLOT PROPOSAL | Executive Council
Agenda - Page 20 |
| X. | AAMC POSITION ON NBME SCORE REPORTING | Executive Council
Agenda - Page 21
and
Page 24 |
| XI. | MEMBERSHIP | Page 35 |
| | California Medical Center
Los Angeles, California | Page 36 |
| | Newton Wellesley Hospital
Newton, Massachusetts | Page 42 |
| | The Queen's Medical Center
Honolulu, Hawaii | Page 49 |
| XII. | NEW BUSINESS | |
| XIII. | ADJOURNMENT | |

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COTH ADMINISTRATIVE BOARD MEETING
June 19, 1986

PRESENT

C. Thomas Smith, Chairman
Sheldon S. King, Immediate Past Chairman
Spencer Foreman, MD, Chairman-Elect
Robert J. Baker
J. Robert Buchanan, MD
Gary Gambuti
John E. Ives
Larry L. Mathis
James J. Mongan, MD
Eric B. Munson
Raymond G. Schultze, MD
Barbara A. Small
William T. Robinson, AHA Representative

ABSENT

Gordon M. Derzon
Charles M. O'Brien, Jr.

GUESTS

Robert G. Petersdorf, MD
Edward J. Stemmler, MD
Virginia V. Weldon, MD

STAFF

James D. Bentley, PhD
Melissa Brown
Terry Bryll
John A. D. Cooper, MD
Charles Fentress, Jr.
Paul Jolly, PhD
Richard M. Knapp, PhD
Nancy E. Seline
John F. Sherman, PhD
August G. Swanson, MD
Judith L. Teich
Kathleen Turner
Melissa H. Wubbold

COTH ADMINISTRATIVE BOARD MINUTES
Meeting Minutes
June 18-19, 1986

I. CALL TO ORDER

Mr. Smith called the meeting to order at 8:00am in the Farragut 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 10, 1986 COTH Administrative Board meeting.

III. MEMBERSHIP

ACTION: It was moved, seconded, and carried to approve:
VETERANS ADMINISTRATION MEDICAL CENTER, Salem, Virginia
for full membership.

Before moving directly to the agenda, Mr. Smith congratulated COTH Chairman-Elect, Spencer Foreman, MD, on his appointment as President of Montefiore Medical Center in the Bronx, New York. Mr. Smith then asked Dr. Knapp if he had any items to review before considering the formal agenda.

Dr. Knapp indicated that it had become common practice over the past year for any revisions in residency program special requirements for accreditation to be sent to all members of the Council of Deans. There have been seven changes proposed in the past 12 months. Dr. Knapp indicated that he felt it would be wise if such changes were also circulated at least to the COTH Administrative Board members and probably to the the entire COTH membership. He indicated that he believed that the changes in some cases had implications beyond the specific discipline and that hospital chief executives should have the opportunity to comment on any institutional impact of any proposed changes in these special requirements for residency program accreditation. Following brief discussion, it was agreed by the Board that these changes ought to be routinely circulated for comment to COTH members.

IV. DESIGNATION OF FEDERAL LIAISON FUNCTION

Dr. Knapp reported that on occasion the Association must contact responsible officials at member teaching hospitals and medical schools for the purpose of informing them of an urgent legislative matter requiring the institution's attention. Frequently, these individuals are unavailable. In other instances, the institutional organization requires that the dean or hospital director inform another official either directly cognizant or in a decision making line outside the framework of the hospital or the medical school. These situations suggest that it would be both useful and efficient for the Association to develop a list of individuals who have a "federal relations" responsibility to whom the Association could routinely provide background on legislative/regulatory issues on a continuous basis. Dr. Knapp suggested that a survey be accomplished to identify individuals at teaching hospitals who have "federal relations"

responsibilities and also to ask whether or not Washington representation was accomplished by a contract with a Washington law firm or consulting firm. There was consensus that a survey would be useful and that a roster of names should be developed.

V. MEDICARE PHYSICIAN PAYMENT CHARGES UNDER CONSIDERATION

The Board was provided with a brief description of a proposal to change Medicare payments for services to hospital patients provided by radiologists, anesthesiologists, pathologists, and emergency room physicians. The chairman of the House Ways and Means Subcommittee on Health, Rep. Fortney (Pete) Stark, has been contemplating incorporating the payments for these physicians into the hospitals' DRG payments, especially if significant budget savings could be achieved through such a change. The Board was asked to consider what position the AAMC should take on this proposal and how strenuously the AAMC should advocate that position.

ACTION:

It was moved, seconded, and carried to recommend the AAMC oppose the Stark proposal if it comes to fruition in a bill, but that the Association need not take the lead in opposing this provision. Instead, the Association should be supportive of the associations representing the affected physicians.

VI. ORGAN TRANSPLANTATION

Two recommendations from the just released Executive Summary of the National Task Force on Organ Transplantation were brought to the attention of the Administrative Board. The recommendations call upon the Health Care Financing Administration to designate centers to perform major organ transplants and to adopt minimum criteria for transplant centers that address the requirements for facilities and staff, training, volumes of transplants, and survival rates.

The issue of designating centers to perform new and sophisticated medical procedures had been raised in 1984 in the National Organ Transplant Act, which initially contained a provision that would have empowered the Secretary of HHS to designate the physicians and centers that could provide any type of new technology or service, not just organ transplantation. The AAMC objected to granting such broad authority to the Secretary, but concurred that the Secretary should specify minimum criteria for those performing transplants. During debate over the bill, this provision was eliminated.

Given the public and Congressional interest in the issue of transplantation, it appeared likely that the Task Force's recommendations would stimulate legislative or regulatory action to promote designation of centers. The Board was asked to reaffirm the AAMC's earlier position on the issue.

Several members of the Board expressed approval for the concept of establishing minimum medically relevant criteria to be met by those performing vital organ transplantation. However, Mr. Ives and Mr. Mathis voiced concern that political or geographic criteria would be used as well to select designated transplant centers. Drs. Foreman and Buchanan questioned the appropriateness of allowing the Federal government to engage in what was essentially a planning function when such functions traditionally were delegated to the state or local level. After

some discussion, there appeared to be a consensus that the AAMC should support the development of medically relevant standards for transplant centers, that these criteria should come from those who are expert in the field of transplantation and not from the branches of HHS concerned with financing or planning, and that, if necessary, the AAMC, working through the CAS, should stimulate the recognition of existing development of appropriate criteria. Once these medically relevant criteria have been established, the AAMC would not object to the use of these criteria by HCFA or other patient care payors in determining which hospitals and physicians would be paid. Board members suggested contacting several other professional organizations to determine what criteria already exist. These organizations included the American College of Surgeons and the American Society of Transplant Surgeons.

VII. HEALTH CARE INNOVATION ACT OF 1986

Dr. Bentley opened the discussion of this item by summarizing S.2424, the Health Care Innovation Act of 1986, sponsored by Senators Durenberger and Bentsen. As proposed, the bill would provide supplementary payments to hospitals introducing new technologies or procedures. The payment formula would equal 60% of the cost above 110% of the basic DRG price with aggregate payment limits at the institutional and national levels. In exchange for the additional payment, hospitals would be required to submit detailed clinical and financial data.

Mr. Mathis described the favorable impact this bill would have on his hospital which is presently losing \$2 million annually on a new aorta replacement procedure. Dr. Mongan suggested that the act should be designed to address a broader question of how to update rapidly PPS rates and DRG classifications. While most Board members felt the proposed act would result in only a small increase in payments, Mr. Smith summarized the Board's consensus in three points: the AAMC (1) should acknowledge the Senators' recognition of the problems with new technology and express appreciation for the assistance they propose, (2) should focus its efforts to obtain payments for new technologies primarily on rapidly updating the DRG categories and weights, and (3) should support S.2424 for hospitals wishing to use the approach.

VIII. COTH/AAMC AS A VEHICLE TO PROVIDE COMPETITIVE ECONOMIC SERVICES

Mr. King indicated that he had asked this item be placed on the agenda once again to be sure that there was full agreement with the decision reached by the Administrative Board in April. He indicated that he felt it would be wise to open the discussion, and perhaps even consider changing the April decision, and at the very minimum believed it would be wise to call together all the consortia which are developing to determine what role COTH/AAMC could play to be helpful. Mr. Baker cited the forthcoming agenda item entitled, "Role of the AAMC in Promotion of Academic Medical Centers to the Public" as an example of an issue on which a collaborative effort might be useful. Mr. Ives indicated that he felt that the time had passed for direct involvement in service activities by the AAMC. He recommended that every effort be made to find ways to maintain and strengthen relationships between the University Hospital Consortium and the AAMC. Dr. Schultze agreed, indicating that he felt consultative relationships and involvement were probably more desirable than direct business/service relationships.

ACTION:

It was moved, seconded, and carried unanimously to recommend the position taken at the April 10 Administrative Board meeting be

reaffirmed, recognizing a receptivity to initiatives that may be presented as joint activities with consortia and other organizations.

IX. ROLE OF THE AAMC IN PROMOTION OF ACADEMIC MEDICAL CENTERS TO THE PUBLIC

At its April meeting, the Administrative Board considered and recommended the AAMC reject a proposal submitted by the public relations firm, Barton-Gillet, outlining an advertising campaign to enhance the image of academic medical centers. The Executive Council directed AAMC staff to survey members of its Group on Public Affairs to determine the extent to which teaching hospitals and medical schools were advertising. The results of that survey are included in these minutes as Appendix A, and were distributed to Administrative Board members by Mr. Fentress and Dr. Cooper as they joined the Board for further discussion of this issue. Dr. Cooper asked the Board to consider whether there is a role for a national organization in marketing and advertising or whether this function is best performed at a local level, and if there is a role for the AAMC, how it should be structured and funded.

Dr. Buchanan stated there is little understanding of the academic medical center and its role in developing biomedical research and advancing medicine. The AAMC should promote an understanding of the unique and valuable contributions of the academic medical centers, he said. Dr. Weldon agreed with Dr. Buchanan and observed that educational efforts would be particularly useful if they were directed at the business community. Mr. Mathis suggested advertising and marketing should be clearly distinguished and that any national advertising effort be approached with caution.

ACTION:

It was moved, seconded, and carried that the Board urge the AAMC to create a Task Force to consider the proper role for the AAMC in marketing the academic medical center but that careful consideration be given to the wording of the charge to the Task Force to ensure its efforts were not devoted exclusively to advertising.

X. REVIEW OF COTH SPRING MEETING IN PHILADELPHIA

Mr. Smith indicated that Dr. Mongan had agreed to serve as chairman of the Planning Committee for the 1987 COTH Spring Meeting. The other members of the Committee will be appointed shortly. Ms. Small noted the relatively low number of VA medical center directors that attended the 1986 meeting and indicated there were a variety of reasons for that poor attendance. She wished to be sure the Board understood the VA's continuing support, particularly since they would not be having a special VA session at the AAMC Annual Meeting in New Orleans. She felt that there would be much better attendance at the COTH Spring Meeting in the future.

Mr. Smith asked whether there was any interest in changing the length of the meeting. As a suggestion for discussion he asked for a reaction to beginning the meeting with lunch on Thursday and ending with lunch on Friday. Dr. Schultze indicated that he felt one of the purposes of the meeting was to get together with those individuals one would not ordinarily see otherwise. He also indicated he felt the meeting was overly passive with little opportunity for direct

participation by the registrants. Therefore, he felt shortening the meeting would not help in achieving those objectives and suggested the Committee consider more participation and involvement by the attendees. Mr. King indicated that he felt the length of the meeting was about right and that shortening it to a noon Thursday starting time would not really help those coming from the West coast. They would have trouble in attending any of the early meeting functions unless the meeting were to be held in Denver or points west. Dr. Foreman indicated he felt the meeting is primarily "the gathering of our clan," is going well, and ought to be kept in the traditional format. He did indicate that having the meeting in more popular settings would be a healthy course of action.

ACTION: It was therefore moved, seconded, and carried to hold the 1989 COTH Spring Meeting at the Hotel del Coronado in San Diego, California.

XI. GME TRANSITION COMMITTEE REPORT

Dr. Swanson, Director, AAMC Department of Academic Affairs, provided staffing for the Committee and he and Dr. Foreman, committee chairman, presented the report to the Administrative Board. There was much discussion of the date by which deans' letters are required and the fact that there are early matches taking place in a variety of disciplines. Dr. Stemmler indicated that he wasn't so sure that an early match is altogether disadvantageous. There was also general agreement that there is an "institutional responsibility" set of requirements in the General Requirements which has not been well enforced by the accreditation process. It was reported that the deans had recommended the statement on page 5 be changed to read, "That the satisfactory completion of an institution's required clerkship sequence precede the privilege of taking clinical electives elsewhere. (The changes recommended by the deans are underlined.)" It was also suggested that the final recommendation on page 5 include the word encourage rather than insure. As a final matter there were a number of individuals who suggested this report be distributed as embodying guiding principles rather than authoritative literal statements.

ACTION: It was moved, seconded, and carried to recommend that this report be received by the COTH Administrative Board and be recommended for distribution as a discussion document by the AAMC Executive Council.

XII. FOLLOW-UP ON COD SPRING MEETING RESOLUTIONS

The resolutions considered by the deans concerned four topics: 1/ the attractiveness of medicine as a profession; 2/ institutional responsibility for medical education; 3/ institutional responsibility for graduate medical education; and 4/ transition to residency education. Dr. Foreman reported that the Council of Deans had adopted the recommendations in the GME Transition Committee report of the Task Force, including the recommendations on page 52 of the Executive Council agenda book. It was understood that this action should serve as a substitute for the deans resolution under the heading "institutional responsibility for graduate medical education."

Discussion centered on public perception of the attractiveness of medicine as a profession, the decline of numbers in the applicant pool, and the AMA's reports of a glut of students in the "pipeline." Dr. Foreman pointed out that number of applications began to fall before commonly-held perceptions of the medical

profession began to change. In his view this result was prompted by a falling off of public financial support for medical education. Dr. Stemmler brought up the particular problem of states with only one medical school which are also experiencing a falling off of the numbers in the applicant pool. There are states with more applicant spots than the numbers of potential qualified applicants can justify. Thus, an effort needs to be made to balance the applicant pool with educational resources. Some states would rather take applicants who are substantially less qualified than to allow more applicants from out of state.

XIII. TRENDS IN MEDICAL SCHOOL APPLICANTS

Dr. Paul Jolly, Director, AAMC Division of Operational Studies, presented data on trends in applicants to medical schools. He reported that there has been a 23% drop in the number of applicants since 1974, including an 8.5% drop in the past year. There has been no change in the quality of the applicants, however, as measured by MCATs and GPAs. He reported that 56.5% of first-time applicants are accepted. When "repeat" applications are included in the analysis, the chances of acceptance reaches 75%. Dr. Stemmler pointed out that other characteristics -- the "suitability for medicine" criteria -- may be of a lesser quality, although academic qualifications may have remained about the same. Dr. Buchanan stated that this "quality" issue is not likely to stir public policy. Rather, the more prominent issue is that of the alleged "glut of physicians", and students themselves are responding to this; i.e., the decline in the number of applicants.

A survey of students who took the MCAT but did not apply to medical school indicated that 75% said they plan to apply sometime in the future. Very few of those who took the MCAT and did not apply are going to law or business school; most are going to graduate school in the biological sciences. Their reasons for deciding against medicine were:

- o Their scientific interests can best be satisfied in another way;
- o The program of medical education is too long;
- o Physician acquaintances have discouraged them from applying;
- o Practicing physicians have less independence than they did some years ago.

There has been a much greater decrease in the numbers of male applicants than female applicants.

Dr. Schultze pointed out that the Vietnam War had the effect of increasing the number of applicants to medical school, since medicine was perceived as a "safe" profession (although there was a lag time, the peak of applicants was in the late 70's, after the war was ended). Dr. Buchanan stated that the difference between the salaries of PhD's and MD's in university research settings is much less than it used to be. Further, graduate school for PhD's is more often paid for [by outside sources] than is medical school. Dr. Jolly suggested that perhaps the medical school curriculum does not provide sufficient opportunity to become a researcher. Additionally, in research in the basic sciences an MD degree is probably a disadvantage as there is a "cultural" bias against it in that environment.

XIV. REVISION OF GENERAL REQUIREMENTS SECTION OF THE ESSENTIALS OF ACCREDITED RESIDENCIES

Discussion centered around the addition of the sentence, "Further, adequate financial support for residents' stipends is an essential component of graduate medical education," to the General Requirements as set forth on page 18 of the Executive Council agenda book. Dr. Buchanan stated that it is desirable to pay residents and pay them adequately, but that it is inappropriate to argue that the quality of the training program depends on adequate payment. Dr. Foreman stated that graduate medical education decisions should not be made for economic reasons. If graduate medical education is a requirement, not just an option, then we should not set up barriers to it. It was pointed out that one difference between medical school and graduate medical education is that the latter involves "real work," labor, and that the failure to pay for this, on the grounds that you can get away with it, is simply exploitation.

It was reported that the Council of Deans Administrative Board proposed acceptance of the language but without the word "adequate." Following discussion, it was suggested that the sentence be amended to read, "Financial support is important to assure that residents are able to fulfill the requirements of the residency program." If this sentence were accepted, it would obviate the need for the change recommended by staff on page 19; i.e., "The appointment of residents who are not accorded the same benefits generally provided to those in an institution's programs is discouraged and can be condoned only under exceptional circumstances."

ACTION:

It was moved, seconded, and carried unanimously to recommend the following sentence be included as an amendment to "1.3 Facilities and Resources" of the General Requirements Section of the Essentials of Accredited Residencies, "Financial support is important to assure that residents are able to fulfill the requirements of the residency program."

XV. ADJOURNMENT

SURVEY REVEALS A LARGER DEGREE OF ADVERTISING BY AAMC INSTITUTIONS THAN ANTICIPATED

The Executive Council at its April meeting reviewed a proposal submitted by a public relations firm outlining a national advertising campaign designed to enhance the image of the nation's teaching hospitals. The Council took no action on the proposal, but did direct AAMC staff to survey members of the Group on Public Affairs to determine the amount of advertising being conducted by medical schools and teaching hospitals. A questionnaire was circulated to the 500 GPA members in May and by May 30, 184 institutions had responded. A surprisingly large number of institutions are engaged in such activities and have been doing so for at least four years. Here's what the survey tells us:

- 98 teaching hospitals currently have an advertising component of their communications plan
- 18 medical schools are also engaged in advertising
- most of the advertising by both teaching hospitals and medical schools is devoted to print with direct mail coming in second and radio and television third
- advertising conducted by teaching hospitals is concentrated on promoting a product or a service while it appears the medical schools spent slightly more on image enhancement than they do for product or service
- 69 teaching hospitals indicate that marketing research is important to their advertising campaign while only nine medical schools indicated a marketing research capability
- more teaching hospitals, proportionately, are planning an advertisement investment in 1987 than are medical schools
- 73 teaching hospitals indicated a positive outcome from their advertising investment while only 12 medical schools said the campaign was worth the money
- several state medical schools indicated a desire to advertise but stated they were prohibited from doing so by the legislature
- most of the medical schools indicated their advertising campaigns concentrated on the recruitment of subjects for drug testing or clinical trials
- 97 teaching hospitals said they plan to spend a total of \$14,810,000 next year for advertising while 23 medical schools projected a budget of \$345,000

The anticipated 1987 advertising budget for the 97 teaching hospitals responding to the questionnaire compares very favorably with the 1985 advertising budget of the four largest for-profit chains.

	<u>1985 Budget</u>	<u># of Facilities</u>
HCA	\$33M	418
Humana	\$20M*	86
American Medical International	\$18M	133
National Medical Enterprise	\$6.5M	101

*a portion of this budget was used for promoting the corporation's insurance company.

Although the teaching hospitals' advertising projections are close to the money being spent for these purposes by the for-profit chains, further examination would probably show that the corporations are conducting a nationally organized effort with central planning and market research and are able to buy air time and print space at a reduced rate due to mass purchasing.

Recommendation: That a task force be appointed to investigate in-depth whether or not the AAMC should seriously consider mounting an organized enhancement campaign. If the recommendation should be positive, then the task force should make recommendations as to what level and how extensive this effort should be. It is further recommended that the task force membership include representation from the Group on Public Affairs.

GPA QUESTIONNAIRE ON INSTITUTIONAL ADVERTISING

Has your institution done any advertising (purchased, controlled space in either print or electronic)

TEACHING HOSPITAL

In 1985? 88 yes 25 no
In 1984? 53 yes 38 no
Earlier? 37 yes 42 no

MEDICAL SCHOOL

In 1985? 15 yes 61 no
In 1984? 9 yes 60 no
Earlier? 6 yes 58 no

Is advertising a part of your communications plan for 1986?

TEACHING HOSPITAL

98 yes 19 no

MEDICAL SCHOOL

18 yes 50 no

If so, what type?

TEACHING HOSPITAL

95 Print
44 Radio
44 Television
67 Direct Mail
25 Billboard
15 Other

MEDICAL SCHOOL

24 Print
10 Radio
10 Television
14 Direct Mail
2 Billboard
3 Other

If so, please provide an indication of your budget line

TEACHING HOSPITAL

5 Under \$50,000
14 \$50,000-\$100,000
22 \$100,000-\$200,000
20 More than \$200,000

MEDICAL SCHOOL

8 Under \$50,000
5 \$50,000-\$100,000
0 \$100,000-\$200,000
0 More than \$200,000

If you have done advertising before 1986, would you categorize it as

TEACHING HOSPITAL

58 Image

63 Product or Service

MEDICAL SCHOOL

13 Image

10 Product or Service

If you have done advertising, have you done research with it?

TEACHING HOSPITAL

69 yes 26 no

MEDICAL SCHOOL

9 yes 18 no

Are you planning an advertising investment in 1987?

TEACHING HOSPITAL

97 yes 11 no

MEDICAL SCHOOL

23 yes 38 no

Total budget for respondents

\$ 14,810,000

Total budget for respondents

\$ 345,000

If so, will it be for

TEACHING HOSPITAL

59 Image

88 Product or Service

MEDICAL SCHOOL

16 Image

12 Product or Service

If you have advertised, have you found it to be worth the investment?

TEACHING HOSPITAL

73 yes 5 no

MEDICAL SCHOOL

12 yes 1 no

The Medicare Direct Medical Education Passthrough
and the Indirect Medical Education Adjustment:
Future Issues

When the Medicare prospective payment system was enacted in 1983, two provisions were included to meet the special needs and resource requirements of teaching hospitals. The first was a continuation of cost based reimbursement for the direct costs of medical education programs. This has subsequently been modified by the Consolidated Omnibus Budget and Reconciliation Act (COBRA) to provide a per resident payment based on historical costs adjusted for inflation. COBRA retained cost reimbursement for nursing and allied health education. The second special provision was the "indirect medical education adjustment" which uses the individual hospital's resident-to-bed ratio and the results of a national statistical analysis to pay teaching hospitals for their atypical costs.

In the past few years, the President's budget has called for substantial reductions in each of these teaching hospital payments. In response, Congress eliminated open-ended cost reimbursement for graduate medical education and, using a new analysis, reduced the indirect medical education adjustment. The Administration is currently preparing its FY1988 budget proposal, and is expected to seek further reductions in both teaching hospital payments. The balance of this paper reviews the framework within which both adjustments are likely to be viewed. The Board is requested to discuss how the AAMC should respond.

Direct Medical Education Payments

As the COBRA legislation is implemented, Medicare is acquiring up-to-date data on the cost per resident in teaching hospitals. If the data mirror past patterns, HCFA will observe wide variations in the allowable cost per resident.

A spring 1986 questionnaire mailed to all COTH members illustrates the variation that may be forthcoming. The questionnaire asked each hospital to report allowable graduate medical education costs and Medicare's share of costs for (1) resident stipends and benefits, (2) faculty salaries and benefits and (3) overhead costs. Of the 375 questionnaires mailed, only 110 (29%) were returned with useful information of GME costs. In the COTH directory, these 110 hospitals report 20,109 FTE residents. The response rate was substantially better for academic medical center hospitals where 117 members returned 48 (41%) useful questionnaires.

Table 1 uses the resident stipend and benefit data from the special purpose questionnaire and the number of FTE residents at the hospital as reported on the COTH Directory questionnaire to compute stipends (plus benefits) per resident. If the computed amounts from the special survey approximate the amounts reported on the housestaff survey, there would be at least some face validity to the data. While the computed stipends and benefits per resident are generally consistent with the stipend and benefit data from the COTH housestaff survey, the 6 hospitals with stipends and benefits per resident below \$15,000 and the 23 hospitals with stipends above \$30,000 suggest that the data in the special survey or the COTH Directory contain some errors. Thus, caution must be used in considering subsequent results.

Table 2 presents a frequency distribution of the allowable cost per resident with each hospital's number of residents taken from the COTH Directory database and total GME costs taken from the special survey. The table presents both all responding hospitals and responding academic medical center hospitals. Costs per resident ranged from \$14,785 to \$114,395. While some of the observed variation may be due to reporting errors (especially in the number of residents), even if the most extreme twelve hospitals are removed, reported costs would vary from a low of \$23,756 to a high \$96,534. This is a range of 1.00 to 3.98 and undoubtedly exceeds the politically acceptable variation. The median cost reported in academic medical center hospitals is \$41,897 while the median in all responding hospitals is \$48,228. The medians and distributions suggest affiliated community hospitals generally have higher costs per resident than academic medical center hospitals.

Table 3 shows the percentage of total GME costs spent on resident stipends and benefits as reported in the special survey. A hospital with a percentage of 100 reported that the only GME costs it claimed were for the stipends and benefits of residents. A hospital with a percentage below 100 claimed faculty and/or overhead costs in addition to resident stipends and benefits. At the low end, one hospital spent only 19.7% of its GME costs on resident stipends and benefits. At the other extreme, an academic medical center hospital reported that its only GME costs were for resident stipends and benefits. Once again, if the extreme twelve hospitals are removed, the variation in stipends as a percentage of total, 29.4% to 84.5%, remains. It is not possible from questionnaire responses to understand what costs are being claimed beyond resident stipends and benefits. While some responding hospitals clearly separated faculty costs from overhead, other responding hospitals combined them. Therefore, table 3 compares only resident salaries and benefits to GME costs. In those cases where responding hospitals did clearly separate resident, faculty and overhead costs, it is clear that a major source of variation is faculty salary and benefit costs per resident. While some institutions including academic medical center hospitals report little or no faculty salaries for teaching and supervision, others spend as much as \$2.40 on faculty salaries for every \$1.00 spent on resident stipends. Median resident stipends and benefits in responding hospitals are approximately 50% of total GME costs, whether one examines the academic medical center hospitals or all responding hospitals.

Any discussion of these tables must be very tentative. The response rate was low and some of the data look questionable. Nevertheless, the hospitals were asked to report what is shown on their Medicare costs report and someone in the hospital felt comfortable sending these "facts". Thus, it is likely that Medicare will shortly be receiving similar "facts" and using them to develop payment policies. Two options which have been discussed in the past are likely to reappear. The first would limit allowable costs per resident to some ceiling, perhaps the "national average." Even if the ceiling were set at \$50,000 per resident, 46 responding hospitals with an estimated 7,035 residents would be penalized. The second option would be to limit faculty and overhead costs either to the average of 50% or perhaps a smaller amount. The developing FY88 budget for HHS tentatively includes such a limit on faculty and overhead.

Indirect Medical Education Adjustment

When the initial legislation and regulations for prospective payment were being developed, Congress and HCFA worked with the best available data. In most cases, this was 1981 cost report and patient billing data. As more current and refined data have become available, Congress and HCFA have made a number of

corresponding changes. For example, the original indirect adjustment of 11.59% was reduced to 8.7% when better data became available and to 8.1% when the disproportionate share adjustment was added. The AAMC accepted this change because the Association's policy called for setting the adjustment percentage at the correct level based on an empirical statistical analysis.

In its 1986 proposed rule for PPS, HCFA published 1985 case mix indices for all hospitals. The results differed substantially from the original 1981 indices. In some hospitals this represents primarily a change in coding; in other hospitals it represents a real change in type of patient treated. Regardless of the cause, the 1985 data showed more variation in index values than the 1981 data. As a result, the case mix variable in PPS is accounting for more of the variation in hospital costs than it has before, and there is expected to be less variation related to the resident-to-bed ratio. Similarly, better wage index and disproportionate share data are expected to change the percentage for the indirect adjustment. Preliminary data being analyzed by the Congressional Budget Office (CBO) support this expectation. The early CBO results suggest that the indirect medical education adjustment should be reduced from 8.1% per 0.1 resident per bed to approximately 5%. HCFA undoubtedly has similar findings. If these findings hold up when more complete data are available, there will be considerable pressure to reduce the adjustment to achieve budget savings. The reduction, if based on empirical results, would be consistent with present AAMC policy.

Discussion

In the upcoming political debate, the AAMC is in a difficult position. Many members expect the AAMC to behave as a trade association defending current member revenues. The members would have the AAMC defend all of the variation in GME costs and oppose any change in the indirect adjustment. Such positions are difficult to defend analytically. Because the AAMC's hospital advocacy has been based on analytical frameworks rather than simply a defense of revenues, a change in approach would affect how the Association is viewed in Washington.

The Association's present policy on the indirect adjustment states:

THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES SUPPORTS RECOMPUTING THE RESIDENT-TO-BED ADJUSTMENT USING CURRENT HOSPITAL RESIDENT AND BED DATA, UP-TO-DATE CORRECTED HOSPITAL CASE MIX INDICES, CORRECTED WAGE INDICES, AND A REGRESSION EQUATION WHICH INCORPORATES ONLY VARIABLES USED IN DETERMINING HOSPITAL DRG PAYMENTS.

This position seeks to protect the adjustment by making it a technical issue rather than a political one. Moreover, to the extent that more of the payment is reflected in the DRG weight, less difference is available for the indirect adjustment. While this may be logical and technically correct, it does not help the Association with the member who sees Association acceptance of a lowered, but correct, percentage as a failure to defend the teaching hospital.

For the variation in direct cost, there presently is neither a good analytical framework nor adequate data for studying the issue. Nevertheless, the AAMC is in a difficult position because many hospitals claim more than \$75,000 or \$100,000 per resident while others claim substantially less. In this circumstance, the AAMC must attempt to assure reasonable payments to hospitals and yet have politically acceptable variation in costs per resident. The Board

is requested to discuss how the Association should proceed in developing a policy on the variation in costs per resident.

Table 1

Frequency Distribution of Stipends and Benefits per Resident
for COTH Hospitals

<u>Computed Stipend (000's omitted)</u>	<u>Number of Hospitals</u>	
	<u>All Respondents</u>	<u>Academic Medical Center Hospitals</u>
less than 15	6	3
15 - 19.9	15	6
20 - 24.9	26	15
25 - 29.9	24	10
30 - 34.9	12	5
35 - 39.9	7	2
40 - 44.9	2	2
45 - 49.9	<u>2</u>	<u>0</u>
TOTAL	94	43

Table 2

Frequency Distribution of Cost per Resident
in COTH Hospitals

Reported Cost/Resident (in 000's)	Number of Hospitals	
	All Respondents	Academic Medical Center Hospitals
less than 20	4	3
20 - 24	4	3
25 - 29	7	5
30 - 34	11	8
35 - 39	10	4
40 - 44	7	3
45 - 49	16	6
50 - 54	12	4
55 - 59	7	2
60 - 64	4	1
65 - 69	4	2
70 - 74	8	3
75 - 79	2	2
80 - 84	2	1
85 - 89	0	0
90 - 94	1	0
95 - 99	1	0
100 - 104	4	1
105 - 109	0	0
110 - 114	1	0
TOTAL	<u>105</u>	<u>48</u>
Median	48,228	41,897

Table 3

Frequency Distribution of Percentage of GME Costs for
Resident Stipends and Benefits in COTH Hospitals

<u>Percentage of GME Costs for Resident Stipends and Benefits</u>	<u>Number of Hospitals</u>	
	<u>All Respondents</u>	<u>Academic Medical Center Hospitals</u>
less than 20%	1	0
20 - 24.9	2	0
25 - 29.9	5	1
30 - 34.9	6	4
35 - 39.9	10	3
40 - 44.9	9	1
45 - 49.9	15	6
50 - 54.9	10	7
55 - 59.9	8	5
60 - 64.9	8	5
65 - 69.9	6	2
70 - 74.9	6	1
75 - 79.9	4	3
80 - 84.9	4	3
85 - 89.9	2	1
90 - 94.9	1	0
95 - 99.9	1	1
100.0 TOTAL	$\frac{1}{99}$	$\frac{1}{44}$
Median	50.66%	50.30%

The Commonwealth Fund Grant
to Analyze
Teaching Hospital Data

The Commonwealth Fund has approved a \$496,000, three year grant to the AAMC to assemble, analyze and publicly report data on teaching hospitals and the impacts of alternative public policies on them. For the Board's information, this item summarizes the history and plan for the project

The Commonwealth Fund Task Force on Academic Health Centers was formed to help the nation's leading medical institutions find ways to accomplish the changes needed in these times of rising costs; declining public support for medical services, education and research; and a growing supply of medical personnel and facilities. As part of its effort, the Task Force issues reports that examine the effects of public policy decisions on the performance of academic health centers.

The Task Force is presently preparing a report describing an approach for identifying the impacts of policy changes on different groups of teaching hospitals. The report includes six brief pilot studies demonstrating the feasibility of the Task Force's approach. The AAMC project would both launch and institutionalize the analytical approach advocated by the Task Force. A combined AAMC/Johns Hopkins research group would develop the database and initial reports. Subsequently, the AAMC could incorporate the activity into its on-going program of activities.

The Importance of the Project

Most health care analyses examine the impacts of policy changes using only a few subgroupings of hospitals. As a result, many policies are ill-suited to the needs of different hospitals. For example, even the most "enlightened" health policymakers willing to make adjustments for "teaching hospitals" assumed that a single continuous resident-to-bed adjustment applied equitably to all academic health centers. Teaching hospitals and their associations presently do not have the capacity to examine more closely the impact of policy options on different groups of teaching hospitals.

Given the broad reforms being considered, and symbolized by the pending Federal fiscal reductions (with or without Gramm-Rudman), it is essential to recognize the real differences among teaching hospitals and to develop a capacity for differential analysis. With the assistance of Lewin & Associates, the Commonwealth Fund Task Force on Academic Medical Centers developed a general core database and an analytical model of differential analysis and tested it with six pilot studies. These pilot studies have demonstrated the value of assessing the varying impact of health policy on different types or groups of teaching hospitals. Study results showed that proposed policies had varying impacts on different hospitals and that the impact subgroups were different for different issues. Thus, the pilots showed that there is a core of data and analytical techniques that can successfully improve our understanding of the impact of various policy decisions on different groups of teaching hospitals.

There are several important benefits that might result from an understanding of this diversity of effects, and prove important to the future viability of teaching hospitals:

- o Identification of problems and vulnerabilities shared by groups of hospitals.
- o Highlights of the extent of gain or risk involved in a proposed policy.
- o Simulation of the effects produced by a variety of policies and practices, and initiation of changes to alleviate problems caused by existing or proposed policy.
- o Availability of an alternative to the simplistic "industry average" on the one hand, and individual anecdotal data on the other, as a basis for policymaking.
- o Identification of (through this self-diagnosis), and assistance to those groups of hospitals that are currently, or may be under new policies, facing serious difficulties.

This is an especially propitious time to inform the policy process with the kind of analytical results this project would produce. The scramble for federal fiscal restraint will continue to threaten the financial viability of teaching hospitals. A systematic approach and impact analysis capability need to be developed within the community of teaching hospitals in order to improve the knowledge base upon which policy is made.

The Project

The AAMC, through its Department of Teaching Hospitals and a subcontract with The Johns Hopkins University Center for Finance and Management, proposes to establish a comprehensive database on teaching hospitals in order to model and quantitatively evaluate the implications of new policies facing teaching hospitals. The data would be developed at the individual hospital level so that the impacts of a particular policy could be assessed on different types of teaching hospitals (e.g., municipal, university, and community teaching hospitals).

To the greatest degree possible, the project would assemble the database using existing data which are collected by many organizations. For example, it is envisioned that existing data would be obtained from the following:

<u>Organization</u>	<u>Data</u>
American Hospital Association	Annual hospital surveys for 1980-1987
Health Care Financing Admin.	Medicare cost report and case mix data
National Institutes of Health	Federal research awards
Accreditation Council for Graduate Medical Education	Number of residents and types of residency programs
Association of American Medical Colleges	Characteristics of related medical schools

For hospitals belonging to the Council of Teaching Hospitals (COH), the general data would be supplemented by both existing annual surveys on resident stipends and funding sources for graduate medical education, and by special purpose surveys developed to collect information on a particular issue (e.g., hospital debt structure and payment requirements).

The data would be assembled and carefully edited by the subcontracting university research group which has expertise in hospital financial and operating data. For the three year development period, the data would be stored and analyzed on the university's computers with a remote terminal installed at the AAMC to permit on-line use of the data using a microcomputer. During the three year development period, the structure of the data and the programs used to construct and evaluate impact models would be developed to facilitate transferring both data and software to the AAMC's internal computer system.

During the three year development period, three types of project reports would be prepared. The first set of reports would develop alternative typologies of teaching hospitals based on their organizational, patient service, educational, research, and financial characteristics. The second set of reports would use the developed typology to assess the comparative impacts of existing policies/developments on subgroups of teaching hospitals. For example, changes in the number of admissions could be compared across hospital subgroups to identify relationships between hospital characteristics and operational experience. The third set of reports would use the alternative typologies and the assessments of present policies to model the impact of proposed policies. For example, the variation in medical education costs per resident could be examined across hospitals to more fully understand factors contributing to differences in the cost per resident in different types of hospitals.

In year one, it is expected that currently available data will be collected and carefully edited to initiate the database. In addition, a series of initial typologies of teaching hospitals will be constructed and evaluated. In years two and three, available data will be added to permit both longitudinal, lag variable, and more up-to-date analysis. In both years, the impacts of current policies will be described and the consequences of prospective policies will be described.

In order to perform the project, the AAMC would add one professional staff person to its Department of Teaching Hospitals to conduct data analyses and modeling. All other AAMC personnel costs would be contributed to the project by the AAMC. The AAMC would enter into a subcontract with experienced university researchers to assemble the data and provide supporting analysis and modeling. Project costs for year one are \$173,500, for year two are \$164,500, and for year three are \$158,000 for a total of \$496,000.

Project Directors and Advisors

The proposed project will be co-directed by Richard M. Knapp, Ph.D. and James D. Bentley, Ph.D. of the Association's Department of Teaching Hospitals. Drs. Knapp and Bentley have devoted their professional careers to studying the problems and promoting the interests of teaching hospitals. They have been with the Association for 18 and 10 years respectively. Each of them has served on committees and working groups studying teaching hospitals. Both have extensive

personal contacts in teaching hospitals, government agencies, and private sector organizations which will facilitate acquiring the necessary data and identifying appropriate policy developments and options. In 1981 and 1982, Dr. Bentley directed a descriptive study on a sample of 33 teaching hospitals.

Advising Drs. Knapp and Bentley on the project will be a committee comprised of individuals knowledgeable about teaching hospitals and policy analysis. The committee will be chaired by John Dunlop, Ph.D. of Harvard University. Committee membership would include teaching hospital directors, a dean, a university vice president for health affairs, university faculty experienced in public analysis and research methods, and representatives of major health associations. The Advisory Committee would meet twice annually to ensure that the topics selected for analysis are of major interest to public and private policymakers and that the methodologies and findings have credibility as independent research work.

Measures of Project Success

At the completion of the three-year grant period, the project is expected to have resulted in three types of products: (1) a database on teaching hospitals which can be transferred from the university contractor to the AAMC computer center for maintenance and updating, (2) a series of reports presenting alternative ways in which teaching hospitals can be classified using empirical data for policy analysis, and (3) a series of publications analyzing the impacts of policy changes and policy developments on different types of teaching hospitals. Copies of the reports describing different ways to categorize teaching hospitals would be distributed to teaching hospitals, medical school deans, university vice presidents for health affairs, health service and public policy researchers, government agencies, and officials of foundations concerned with health services. Copies of the policy impact publications would be distributed to all of the above groups plus insurance companies and government officials responsible for health financing and policy decisions.

In the longer run, the project will be successful if the analyses stimulate an interest in studying the impacts of policy changes on subgroups of hospitals. For teaching hospitals, the project will be successful if policymakers begin to examine policies in light of the differing impacts on the several different types of teaching hospitals rather than assuming all teaching hospitals have similar characteristics and impacts.

Project Risks

The risks facing this project lie in three areas. First, existing data from presently independent databases must be combined to produce an internally consistent, valid and integrated database. This risk is minimized in two ways: Some university researchers have previously demonstrated that the combining of independent databases is feasible. The use of a university group to develop their initial database under a subcontract will enable the project to benefit from the expertise during the period of time that the AAMC develops a comparable capability. In addition, Drs. Knapp and Bentley have long-term productive working relationships with teaching hospital executives which will facilitate obtaining both any necessary data releases and a high response rate on surveys of supplemented data.

The second project risk is that differential impacts of policies will be observed in data models, but that the adverse impacts will not be concentrated in identifiable subgroups of teaching hospitals. In short, the adverse impacts will

appear to be random. This risk will be minimized by identifying the most useful teaching hospital categories for each policy area. Rather than trying to use the same hospital subgroups to evaluate each change, empirical data will be used to identify the most appropriate analytical subgroups.

The final and most significant risk is that the results of the studies may not change the policymaking process. In a period when legislatures and businesses are primarily concerned with the amount spent, the equity of the distribution of the funds is receiving less attention. Moreover, the current interest in deregulation or minimal regulation may predispose some policymakers to ignore subgroup analysis and impact variation. These risks are real and their consequences can only be demonstrated and argued by having an analysis which demonstrates the inadequacies of assuming teaching hospitals are relatively homogenous.

REPORTING OF NBME SCORES

The original discussion piece which appeared in COD and CAS agenda materials for the June 18-19, 1986 meetings is attached. Since there was some confusion at those meetings about current and proposed NBME score reporting policies, the following additional information is provided.

	<u>Current</u>	<u>Proposal for the Comprehensive Exam</u>
Individual student total scores for Parts I and II	Yes, to students and schools	Yes, to students and schools
Individual student pass-fail status for Parts I and II	Yes, to students and schools	Yes, to students and schools
Individual student discipline scores for Parts I and II	Yes, to students and schools	No, only group mean to schools
Individual student item keyword performance feedback	No	Yes, upon request to students and group performance to schools
Separate subject (shelf) examination program	Yes	Yes

Although there are various new features to the NBME's proposed "comprehensive" examination program, the major score reporting change is the abandonment of discipline scores for individual students. This is apparently a consequence of the content flexibility desired in the new examinations as well as the recommended reduction in number of questions. However, a school mean score by discipline may be derived and reported and item keyword performance feedback is introduced.

The NBME Study Committee for Parts I and II recommended the changes in score reporting for the comprehensive examination. At present the process for developing the comprehensive Parts I and II examinations are just under way. The committees selected to steer the development will meet in September. Thus far, the NBME has not made a firm policy decision on how the results of the examinations will be reported either to the examiners or the medical schools. We are informed that this decision will most likely occur in 1987.

REPORTING OF NBME SCORES

Issue: Should the AAMC take a position favoring the reporting of NBME examination scores solely on a pass-fail basis?

Background

Discussion and debate concerning the effect of NBME examinations on medical student education has centered on the score reporting system, particularly for Part I. The OSR has requested that the Board consider the question proposed above and has submitted the attached background piece for the discussion. The issue has been discussed in various reports (including GPEP) and forums over the past several years and may be well known to Board members. Here we only sketch the basic arguments.

Proponents for a pass-fail only scoring system assert the following:

- 1) The historical purpose and chief value of the NBME examinations is the licensure of physicians. Scale scores make no contribution to this decision.
- 2) The reporting of scale scores tends to have various detrimental effects on medical education.
 - a) It reinforces the tendency for the examination to drive the curriculum. For example, it focuses the faculty's attention on the competencies and skills measured by the exam at the expense of other competencies of equal or greater importance. Also, the examination format tends to promote an emphasis on memorization and information recall.
 - b) The need to make distinctions among a very able group of medical students invariably results in questions focusing on knowledge of minutia having only very indirect clinical implications.
 - c) Internal pressures to produce high scores stifle curriculum innovations.
 - d) It encourages faculties to abrogate their evaluation responsibilities to an external agency.
- 3) Scale scores are too easily abused. By the NBME's own assessment, the examinations evaluate only 25 percent of the competencies expected of graduating students. Yet these scores are viewed by the LCME as evidence of institutional effectiveness. Also, at times political bodies such as state legislatures request score information as a way of evaluating the institutions they support. Under such pressures it is difficult to decrease the emphasis placed on maximizing performance on the examination.

The counter-arguments presented include the following:

- 1) While licensure is the NBME's primary purpose, the examinations can serve other purposes, e.g., student evaluation, program (curriculum) evaluation, and institutional self-study.
- 2) Whatever disagreements exist about the importance of the material tested, the questions are written by medical school faculty members. Thus, it is not an external agency but our own faculties which are making judgments about the relevance of the material.
- 3) If abuses occur in the uses of the scores, the proper remedy is improved education on appropriate and inappropriate uses.
- 4) NBME scores are the single dependable numerical measure of competence and achievement available to program directors who must assess a large number of applicants to residency positions.
- 5) In the final analysis, each medical school faculty has the prerogative to determine institutional policy regarding the use of NBME scores. The information provided by scale scores should not be denied them.

Recently the National Board has embarked on a change in policy regarding the NBME examinations, to improve their value and, no doubt, to respond to the criticisms which have been levelled against them. In the proposed changes, individual discipline scale scores are no longer provided. However, the National Board stopped short of eliminating the reporting of an overall scale score.

Questions for Discussion:

- 1) Does the reporting of an overall scale score on the NBME examinations have such a deleterious effect on medical education that any benefits are outweighed by negative consequences?
- 2) Do internal and external pressures to achieve high NBME scores at the departmental or institutional level substantially undermine faculty freedom to decide the examination's use and value?
- 3) Does the LCME overemphasize institutional mean scores on the NBME examinations in its accreditation review? Is there a perception that it does so?
- 4) Are there alternatives to program directors' reliance on NBME scores to assess applicants to residency positions?
- 5) Is the proposition that NBME scores should be reported only on a pass-fail basis one on which the AAMC can achieve a consensus among its members?
- 6) If AAMC advocacy for eliminating the reporting of scale scores is not advised, are there other steps the AAMC can take to eliminate abuses in the use of the examination, improve its value to students and schools, and mitigate any adverse effects on medical education?

SCORE REPORTING FOR NATIONAL BOARD EXAMINATIONS
OSR ADDENDUM

The Administrative Board of the Council of Deans has requested discussion of Pass/Fail score reporting for National Board Part I and Part II examinations. Interest in exclusive Pass/Fail score reporting was highlighted by a COD Plenary discussion on the National Boards at the 1985 AAMC National Meeting, and by the publication of the Report of the Panel on the General Professional Education of the Physician (GPEP) and College Preparation for Medicine (AAMC, 1984) and new Liaison Committee on Medical Education (LCME) standards for accreditation Functions and Structure of a Medical School (LCME, 1985). The GPEP Report is critical of an overreliance on multiple choice examination techniques in the evaluation of medical student performance, and the new LCME standards were written so as to exclude any direct reference to, or reliance upon, the National Board Examination Scores in the accreditation process.

When founded in 1915, the original purpose of the National Board of Medical Examiners (NBME) was to produce a voluntary certification process of such high quality that an NBME certificate would become acceptable as evidence of proficiency to all state jurisdictions responsible for physician licensure. The NBME achieved that goal initially with the development of comprehensive essay examinations and then with development during the 1950's of multiple choice examinations (Hubbard, 1978). Further refinement and development is currently underway by the NBME towards development of new examinations that are interactively directed towards accessing decision making skills. The NBME has consistently maintained that its examinations are principally for licensure. It has long recognized and facilitated the use of its examinations for other than licensure, but has formally provided recommendations and cautions to medical schools regarding the use of NBME examination scores. Individual schools can and do use the examinations for purposes of individual student evaluation or curriculum evaluation. The responsibility for that use currently rests with each school.

Under the current scoring system for National Board examinations, subscores are provided to the test subjects and their institutions for each discipline covered using a 200-800 scale with five point score intervals. Actual passing standards are referenced to the performance of a selected group of examinees from the previous four years. Under this system it is theoretically possible for all examinees, in any given year, to pass Part I or II, although this has not occurred. Pass/fail rates on Parts I and II have remained relatively constant.

Currently, 47 percent of U.S. medical schools require students to achieve a passing total score on Part I for promotion and/or graduation, while 38 percent require a passing grade on Part II (Table 1). These figures have been stable over the past five years. Only 11-12 percent of medical schools use scores from Parts I or II in the determination of final course grades. This is a significant reduction from the number four years previously for Part I but reflects stability for Part II. Results of the NBME examinations are currently used by half of the medical schools in the U.S. for educational program evaluation, with no substantive change in this frequency of use over the past five years.

Table 1

USE OF NBME EXAMINATIONS BY
U.S. MEDICAL SCHOOLS - 1980-81 to 1984-85

	1980-81*		1981-82		1982-83		1983-84+		1984-85	
	No. (N=125)	Percent	No. (N=126)	Percent	No. (N=126)	Percent	No. (N=127)	Percent	No. (N=127)	Percent
STUDENT EVALUATION										
Use of the NBME exam, Part I										
Exam optional	31	24.8	32	25.4	31	24.6	29	22.8	29	22.8
Student must record score	35	28.0	33	26.2	34	27.0	35	27.6	35	27.6
Student must record total passing score	58	46.4	59	46.8	57	45.2	59	46.5	59	46.5
Student must record passing score in each section			3	2.4	4	3.2	3	2.4	3	2.4
Scores used to determine final course grades	31	24.8	29	23.0	11	8.7	18	14.2	14	11.0
Use of selected sections of NBME exam, Part I, by departments to evaluate students										
Anatomy	12	9.6	10	7.9	8	6.3	8	6.3	4	3.2
Behavioral sciences	7	5.6	5	4.0	5	4.0	2	1.6	2	1.6
Biochemistry	14	11.2	12	9.5	10	7.9	9	7.1	9	7.1
Microbiology	23	18.4	20	15.9	15	11.9	12	9.5	9	7.1
Pathology	21	16.8	17	13.5	12	9.5	11	8.7	10	7.9
Pharmacology	19	15.2	16	12.7	10	7.9	9	7.1	6	4.7
Physiology	18	14.4	15	11.9	11	8.7	8	6.3	4	3.2
Use of NBME exam, Part II										
Exam optional	36	28.8	39	31.0	38	30.2	36	28.4	35	27.6
Student must record score	37	30.4	36	28.6	42	33.3	41	32.3	41	32.3
Student must record passing score to graduate	47	37.6	46	36.5	44	34.9	48	37.8	48	37.8
Scores used to determine final course grades	16	12.8	17	13.5	14	11.1	16	12.6	15	11.8
CURRICULUM EVALUATION										
Based in part on Results of the NBME exams	65	52.0	67	53.2	61	48.4	62	48.8	63	49.6

* This compilation includes 1978-79 data for Louisiana State-Shreveport and 1979-80 data for California-Los Angeles (UCLA)

† This compilation includes 1982-83 data for Georgetown.

Critics argue that these uses by the schools of the NBME examinations have a deleterious effect on medical education in two ways. First, a focus on the competencies assessed by the NBME examinations may devalue other competencies of equal or greater importance. Second, the adoption of the NBME examinations as a national standard for achievement in various disciplines, may induce faculties to abandon their responsibility to exercise independent judgement in the design of the curriculum and the identification and evaluation of important learning objectives.

The first concern can be viewed in the context of the range of competencies that comprise the goal of undergraduate medical education. In the planning and development of enhanced Part I and II examinations, the NBME identified five characteristics important in student evaluation: knowledge and understanding, problem-solving and judgement, technical skills, interpersonal skills, and work habits and attitudes. By applying these five characteristics to ten identified physician tasks, the NBME produced a 50 cell matrix that correlates with competence expected of MD graduates entering graduate medical education (Figure 1). Implicit adoption of this analytical framework by the AAMC is indicated by its appearance in an AAMC position paper on external examinations (AAMC, 1981). Only 12 of these 50 cells represent areas amenable to assessment by current NBME test questions. The argument is made that focus by the school on NBME results tends to overemphasize the areas of competence that NBME examinations cover, at the expense of other competencies. The evaluation method also has a concomitant effect on the teaching methods used. Information recall methods of evaluation tend to promote information transfer methods of teaching. These problems stem in part from the lack of objective measures available to assess the 'other' areas of competence. NBME scores are thought to fill a vacuum created by an absence of other methods of assessment.

Even within the sphere of competencies that the NBME examinations purport to address, a second concern has been expressed about its influence on the content of what is taught in the medical school curriculum. Decisions about the content of the curriculum have always been regarded, within very broad limits, as the prerogative of the medical school faculty. Critics have charged that in seeking the approbation that NBME scores have come to represent, faculties have in effect delegated that authority to the NBME. 'Teaching to the Boards' may have become more commonplace, resulting in a greater emphasis on the transfer of information useful for test performance. This has come at the expense of learning care concepts together with the development of problem-solving and self directed learning skills. The dynamics of test construction itself may, in fact, lead away from core concepts because of the inclusion of more difficult questions designed to produce the desired spread of scores. Medical school proponents of the examinations have countered that the detailed information provided by the NBME on student performance has been useful in identifying gaps in the medical school curriculum. Relatively poor performance by students on one or another segment of the examination may highlight subject matter not learned or inadequately taught.

The use of National Board mean scores and failure rates by the LCME in the accreditation process of U.S. medical schools was actively discussed during the drafting of new accreditation guidelines last year (Jones and Keyes, 1985). By LCME consensus, and in actual fact during the review process, the LCME's principal focus is on a given school's failure rate. A relatively high failure rate signifies a potential problem for a school to produce licensable graduates. It also indicates that a number of students do

FIGURE 1

PROPOSED MATRIX OF PHYSICIAN COMPETENCIES *

ABILITIES TASKS	A Knowledge & Understanding	B Problem-Solving & Judgment	C Technical Skills	D Interpersonal Skills	E Work Habits & Attitudes
1. Taking a History	NBME	NBME			
2. Performing a Physical Examination	NBME	NBME			
3. Using Diagnostic Aids	NBME	NBME			
4. Defining Problems	NBME	NBME			
5. Managing Therapy	NBME	NBME			
6. Keeping Records					
7. Employing Special Sources of Information					
8. Monitoring & Maintaining Health	NBME	NBME			
9. Assuming Community & Professional Responsibilities					
10. Maintaining Professional Competence					

* Cells filled by NBME represent those areas currently assessed by NBME multiple-choice test questions.

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not possess a minimal fund of basic and clinical science information deemed relevant by the community of accredited medical schools. Mean scores on NBME examinations currently receive a secondary focus.

Another use of NBME scores that has drawn the ire of some medical educators is the use by residency program directors in the selection of house officers. The perception that this use is on the rise stems from two factors: a 'buyers' market created by the increasing number of graduates competing for quality residency positions; and, the use of pass/fail grading systems by a number of schools which make it difficult for program directors to discriminate among applicants by some simple measure of academic performance. Concern is expressed that this is contributing to the replication in medical students of a set of behaviors in pre-medical students described as 'pre-med syndrome.' This 'syndrome' is seen as a highly competitive and inappropriate focus on the acquisition of a database of extremely detailed information at the expense of mastery of more fundamental understanding, knowledge, skills and attitudes.

A recent national survey of residency program directors sheds some light on this issue (Wagoner and Suriano, 1984). Preliminary results of this survey are shown in Figure 2. NBME Part I scores are seen to rank eighth in importance in a list of ten academic criteria, with Part II scores ranking fifth, although generally not available in time for the application review process. It is noted that 86 percent of program directors would not rank an applicant who has failed Part I, but 75 percent would rank a candidate who had an Part I score in the 380-450 range, which is the lowest ten percent of passing scores.

State licensure boards require a passing score on NBME Parts I, II and III, but do not look at individual subject or total scores. At the COD Plenary session at the 1985 AAMC national meeting it was noted that the state licensure boards consider the NBME scores only a fraction of the actual criteria for licensure. The principal criteria are the possession of a valid MD degree and the successful completion of an accredited PGY-1 year of clinical training.

The charge that medical education has become a process of information transfer at the expense of skill development should not obscure the fact that medical students need to learn and understand core concepts in biomedical science and bring to patient care a basic fund of clinical information. While no absolute agreement may ever exist on the parameters of this core material, the NBME examination content specifications, designed by test committees composed of medical school faculty members, are presumed to approximate well the topics covered in the curricula of U.S. medical schools. Passing the NBME examinations reflects therefore some minimum level of knowledge of basic and clinical science information and skills in applying this knowledge deemed relevant by U.S. medical schools. In addition, passage of NBME examinations is still a major pathway to licensure.

Against this background, discussion by the Councils within the AAMC is requested by the OSR Administrative Board concerning the implications and feasibility of requesting a change in score reporting by the NBME limited to a PASS/FAIL designation only.

FIGURE 2A

RESIDENT SELECTION: PROCESS AND FACTORS *

Norma E. Wagoner, Ph.D., and J. Robert Suriano, Ph.D.
October 31, 1984

A national survey of residency program directors was conducted in order to determine the degree of importance which cognitive factors, letters of recommendation, and interview criteria played in the selection of candidates by each specialty. A stratified random sample of programs was selected and 405 questionnaires were mailed to program directors. A return rate of 59% was achieved for an N of 237. Some of the results are detailed below:

PERFORMANCE: THE ACADEMIC RECORD

The program directors were asked to select the degree of importance for ten cognitive criteria using a five point rating scale: (1) = unimportant; (2) = some importance; (3) = important; (4) = very important and (5) = critical. The mean ratings are rank ordered below:

	\bar{X}	s.d.
1. Grades in clerkships of program's specialty	3.9	0.9
2. Grades in elective of program's specialty	3.6	0.9
3. Grades in other clerkships	3.5	0.7
4. Rank order in class	3.5	0.9
5. NBME II scores (assuming availability)	3.2	1.0
6. Membership in AOA	3.2	1.2
7. Grades in other electives	3.1	0.8
8. NBME I scores	3.1	1.0
9. Grades in preclinical courses	3.0	0.8
10. Research activities	2.7	0.9

The program directors were also asked to respond in a yes/no manner to a series of questions relating to cognitive criteria. These responses are rank ordered below by magnitude of agreement:

1. 86% give preference in ranking to students who have done well in an elective in the program director's specialty and hospital.
2. 86% would not rank an applicant who has failed NBME I.
3. 75% would rank a candidate with an NBME I score in the 380-450 range.
4. 55% select applicants to interview primarily on academic records.
5. 55% think that HONORS grades in preclinical courses are more important than NBME Part I scores.
6. 54% would favor an applicant who had taken and passed Part II of NBME by the time the candidates are ranked.

*Preliminary results of a survey conducted of program directors in specialties of: Internal Medicine, Surgery, Obstetrics/Gynecology, Pediatrics, Psychiatry, Emergency Medicine, Family Medicine, Otolaryngology, Orthopedic Surgery. Survey date: 9/84

LETTERS OF RECOMMENDATION: DEGREE OF IMPORTANCE OF VARIOUS TYPES OF LETTERS

Program Directors were asked to choose the type of letters which were most often found useful in the selection and ranking of candidates. Using the rating scale listed on the previous page, the choices are listed in rank order:

	\bar{X}	s.d.
1. Chairman's letter	3.9	0.8
2. Clinical letter/your hospital/your specialty	3.9	0.8
3. Clinical letter/your specialty	3.6	0.8
4. Dean's letters	3.6	1.0
5. Clinical letters/other specialties	2.9	0.7

DEAN'S LETTERS: CONTENT AND POLICY/STYLE

Program Directors were asked to rate a number of specifics which could be included in the Dean's letters using the same rating scale listed on the first page. The results are listed in rank order below:

	\bar{X}	s.d.
1. Hints of underlying problems	4.0	0.9
2. Consistency of performance	3.9	0.7
3. Negative comments	3.8	0.9
4. Highly laudatory comments from members of your specialty	3.7	0.9
5. Overall "bottom line" rating based on all students in the class.	3.7	1.0
6. Personal comments about candidate from Dean's letter writer	3.4	0.9
7. Narrative description of academic performance in each clinical rotation	3.4	0.9
8. Delineated rank order of candidate	3.4	1.0
9. Completion of curriculum in prescribed time	3.3	1.0
10. A signed waiver indicating student has not viewed the letter	2.3	1.3

INTERVIEW CRITERIA

Program Directors were asked to rate the importance of a series of individual criterion in the areas of Interpersonal Relationships, Communication Skills, and Work Performance on the one to five scale noted previously. The results are rank ordered below:

	\bar{X}	s.d.
1. Compatability with your program	4.5	0.6
2. Ability to grow in knowledge	4.4	0.6
3. Maturity	4.3	0.6
4. Commitment to hard work	4.3	0.7
5. Fund of Knowledge	4.1	0.6
6. Ability to solve problems well	4.1	0.7
7. Willingness to seek help from others	4.0	0.7
8. Ability to articulate thoughts	4.0	0.7
9. Sensitivity to other's psychosocial needs	3.9	0.8
10. Realistic self appraisal	3.8	0.8
11. Ability to listen	3.8	0.8

REFERENCES

Association of American Medical Colleges. Physicians for the Twenty-first Century: Report of the Panel on the General Professional Education of the Physician and College Preparation for Medicine. Washington, D.C.: AAMC, 1984.

Association of American Medical Colleges. External Examinations for the Evaluation of Medical Education Achievement and for Licensure. Washington, D.C.: AAMC, 1981.

Hubbard, John P., Measuring Medical Education. Lee and Febiger, Philadelphia, Pennsylvania, 1978.

Jones, Robert F. and J.A. Keyes, Jr., The LCME's Use of NBME Examination Results. Draft report for the Association of American Medical Colleges, 1985.

Liaison Committee on Medical Education. Functions and Structure of a Medical School: Standards for Accreditation of Medical Education Programs Leading to the M.D. Degree. LCME, 1985.

Wagoner, Norma E. and J.R. Suriano, Resident Selection: Process and Factors. Preliminary results of a national survey of residency program directors, 1984.

MEMBERSHIP

Three applications for membership in the Council of Teaching Hospitals have been received for review at the September COTH Administrative Board meeting.

Staff recommends the following action:

California Medical Center Los Angeles, CA	CORRESPONDING membership
Newton-Wellesley Hospital Newton, MA	CORRESPONDING membership
The Queen's Medical Center Honolulu, HI*	FULL membership

*The Queen's Medical Center is a former full member who dropped membership in the Council in 1982.



COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES
APPLICATION FOR MEMBERSHIP

Membership in the Council of Teaching Hospitals is limited to organizations having a documented affiliation agreement with a medical school accredited by the Liaison Committee on Medical Education.

INSTRUCTIONS: 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
One Dupont Circle, N.W.
Suite 200
Washington, D.C. 20036

I. HOSPITAL IDENTIFICATION

Hospital Name: California Medical Center-Los Angeles

Hospital Address: (Street) 1414 South Hope Street

(City) Los Angeles (State) California (Zip) 90015

(Area Code)/Telephone Number: (213) 748-2411

Name of Hospital's Chief Executive Officer: Richard A. Norling

Title of Hospital's Chief Executive Officer: President & Executive Director

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

Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn):	<u>327</u>	Admissions:	<u>12,257</u>
Average Daily Census:	<u>185</u>	Visits: Emergency Room:	<u>24,056</u>
Total Live Births:	<u>2,526</u>	Visits: Outpatient or Clinic	<u>47,493</u>

B. Financial Data

Total Operating Expenses: \$ 55,834,000

Total Payroll Expenses: \$ 30,779,000

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: \$ 482,507
 Supervising Faculty: \$ 345,301

C. Staffing Data

Number of Personnel: Full-Time: 900
 Part-Time: 400

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 156
 With Medical School Faculty Appointments: 60

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

Does the hospital have a full-time salaried Director of Medical Education?: Yes

II. MEDICAL EDUCATION DATA

A. Undergraduate Medical Education

None offered during 1985

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

<u>Clinical Services Providing Clerkships</u>	<u>Number of Clerkships Offered</u>	<u>Number of Students Taking Clerkships</u>	<u>Are Clerkships Elective or Required</u>
Medicine	_____	_____	_____
Surgery	_____	_____	_____
Ob-Gyn	_____	_____	_____
Pediatrics	_____	_____	_____
Family Practice	_____	_____	_____
Psychiatry	_____	_____	_____
Other: _____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

B. Graduate Medical Education

Please complete the following information on your hospital's participation in graduate medical education reporting only full-time equivalent positions offered and filled. If the hospital participates in combined programs, indicate only FTE positions and individuals assigned to applicant hospital.

<u>Type of Residency</u> ¹	<u>Positions Offered</u>	<u>Positions Filled by U.S. & Canadian Grads</u>	<u>Positions Filled by Foreign Medical Graduates</u>	<u>Date of Initial Accreditation of the Program</u> ²
First Year Flexible	_____	_____	_____	_____
Medicine	_____	_____	_____	_____
Surgery	_____	_____	_____	_____
Ob-Gyn *	4	4	0	1950
Pediatrics	_____	_____	_____	_____
Family Practice	14	10	4	1984
Psychiatry	_____	_____	_____	_____
Other:	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

¹As defined by the LCGME Directory of Approved Residencies. First Year Flexible = graduate program acceptable to two or more hospital program directors. First year residents in Categorical* and Categorical programs should be reported under the clinical service of the supervising program director.

²As accredited by the Council on Medical Education of the American Medical Association and/or the Liaison Committee on Graduate Medical Education.

* Integrated with LAC-USC residency program in July 1985

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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.

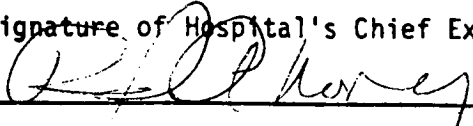
V. SUPPORTING DOCUMENTS

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

Name of Affiliated Medical School: University of Southern California
School of Medicine

Dean of Affiliated Medical School: Joseph P. Van Der Meulen, M.D., Dean

Information Submitted by: (Name) Richard A. Norling
(Title) President

Signature of Hospital's Chief Executive Officer:  (Date) 6-26-86

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SCHOOL OF MEDICINE
OFFICE OF THE DEAN
(213) 224-7001



April 21, 1986

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

Gentlemen:

I am writing to support the application by California Medical Center to become a member of the Council of Teaching Hospitals of the Association of American Medical Colleges.

California Medical Center of Los Angeles, founded in 1887, is a 325 bed, non-profit acute care teaching hospital located in the heart of downtown Los Angeles.

The attending and teaching staff is comprised of board certified specialists in Internal Medicine and Internal Medicine subspecialties, General Surgery and surgical subspecialties, as well as Pathology, Radiology and Gynecology. California Medical Center currently participates in four affiliated teaching programs with the University of Southern California School of Medicine as follows:

1. Family Practice Residency Program - a joint program with the LAC-USC Medical Center since 1984. There are presently 14 residents in this program.
2. Obstetrics and Gynecology Residency Program - currently a joint program with the LAC-USC Medical Center, however, beginning July 1, 1987 all the residents will be from the LAC-USC Medical Center program.
3. Radiation Oncology Residency Program - a four to six month rotation at the Southern California Cancer Center in the California Medical Center, it is an essential component of the residency program in Radiation Oncology at the LAC-USC Medical Center. Medical Oncology Fellows may also arrange for an elective in the Radiation Oncology Department.

Council of Teaching Hospitals

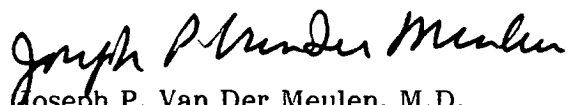
April 21, 1986

Page 2

4. Urology Residency Program - PGY V residents from the LAC-USC Medical Center program rotate to California Medical Center for 4 month periods.

Your approval of their application will be appreciated.

Sincerely,



Joseph P. Van Der Meulen, M.D.
Vice President, Health Affairs
Dean, School of Medicine



COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES
APPLICATION FOR MEMBERSHIP

Membership in the Council of Teaching Hospitals is limited to organizations having a documented affiliation agreement with a medical school accredited by the Liaison Committee on Medical Education.

INSTRUCTIONS: 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
One Dupont Circle, N.W.
Suite 200
Washington, D.C. 20036

I. HOSPITAL IDENTIFICATION

Hospital Name: Newton-Wellesley Hospital
 Hospital Address: (Street) 2014 Washington Street
 (City) Newton (State) Massachusetts (Zip) 02162
 (Area Code)/Telephone Number: (617) 243-6000
 Name of Hospital's Chief Executive Officer: Mr. Barry Spero
 Title of Hospital's Chief Executive Officer: President and C.E.O.

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

Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn):	<u>351</u>	Admissions:	<u>12,065</u>
Average Daily Census:	<u>273</u>	Visits: Emergency Room:	<u>31,249</u>
Total Live Births:	<u>2,040</u>	Visits: Outpatient or Clinic	<u>39,285</u>

B. Financial Data

Total Operating Expenses: \$ 57,080,221

Total Payroll Expenses: \$ 31,563,598

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: \$ 526,596
 Supervising Faculty: \$ 491,087

C. Staffing Data

Number of Personnel: Full-Time: 874
 Part-Time: 1,003

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: _____
 With Medical School Faculty Appointments: _____

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

<u>Medicine</u>	<u>Radiology</u>	<u>Psychiatry</u>	<u>Surgery</u>
<u>Pathology</u>	<u>Emergency</u>	<u>Anesthesia</u>	<u>Pediatrics</u>

Does the hospital have a full-time salaried Director of Medical Education?: _____
 -NO-

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:

<u>Clinical Services Providing Clerkships</u>	<u>Number of Clerkships Offered</u>	<u>Number of Students Taking Clerkships</u>	<u>Are Clerkships Elective or Required</u>
Medicine	_____	_____	_____
Surgery	_____	_____	_____
Ob-Gyn	_____	_____	_____
Pediatrics	_____	_____	_____
Family Practice	_____	_____	_____
Psychiatry	_____	_____	_____
Other: _____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

B. Graduate Medical Education

Please complete the following information on your hospital's participation in graduate medical education reporting only full-time equivalent positions offered and filled. If the hospital participates in combined programs, indicate only FTE positions and individuals assigned to applicant hospital.

<u>Type of Residency</u> ¹	<u>Positions Offered</u>	<u>Positions Filled by U.S. & Canadian Grads</u>	<u>Positions Filled by Foreign Medical Graduates</u>	<u>Date of Initial Accreditation of the Program</u> ²
First Year Flexible	_____	_____	_____	_____
Medicine	24	22	2	Feb. 28, 1950
Surgery	_____	_____	_____	_____
Ob-Gyn	_____	_____	_____	_____
Pediatrics	_____	_____	_____	_____
Family Practice	_____	_____	_____	_____
Psychiatry	_____	_____	_____	_____
Other:	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

¹As defined by the LCGME Directory of Approved Residencies. First Year Flexible = graduate program acceptable to two or more hospital program directors. First year residents in Categorical* and Categorical programs should be reported under the clinical service of the supervising program director.

²As accredited by the Council on Medical Education of the American Medical Association and/or the Liaison Committee on Graduate Medical Education.

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.

V. SUPPORTING DOCUMENTS

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

Name of Affiliated Medical School: Tufts University School of Medicine

Dean of Affiliated Medical School: Henry H. Banks, M.D.

Information Submitted by: (Name) _____

(Title) _____

Signature of Hospital's Chief Executive Officer:

[Signature] (Date) 6/4/86

III. MEDICAL EDUCATION DATA

A. Undergraduate Medical Education

<u>CLINICAL CLERKSHIP</u>	<u># OFFERED</u>	<u>#OF STUDENTS TAKING CLERKSHIP</u>	<u>REQUIRED/ELECTIVE</u>
<i>4th Yr. Medicine</i>	44	32	E
<i>ICU/CCU</i>	10	11	E
<i>ONCOLOGY</i>	11	4	E
<i>Neurology</i>	11	10	E
<i>Hematology</i>	9	8	E
<i>Infectious Disease</i>	11	11	E
<i>Nephrology</i>	8	7	E
<i>Surgery</i>	33	5	E
<i>Emergency Medicine</i>	22	17	E
<i>Radiology</i>	22	11	E
<hr/>			
<i>3rd Year Medicine</i>	16	16	R
<i>3rd Year Surgery</i>	26	26	R
<i>3rd Year Psychiatry</i>	20	20	R



TUFTS UNIVERSITY

School of Medicine

Office of the Dean

May 16, 1986

Mr. Richard M. Knapp
Director
Council of Teaching Hospitals
Association of American Medical Colleges
One Dupont Circle, NW
Washington, DC 20036

Dear Mr. Knapp:

The Tufts University School of Medicine strongly supports the application for corresponding membership in the Council of Teaching Hospitals of the Association of American Medical Colleges being submitted by the Newton-Wellesley Hospital of Newton, Massachusetts.

The Newton-Wellesley Hospital fills an important role in the Tufts educational program. It is a 351 bed general hospital serving the suburban communities of Newton, Weston, and Wellesley. It includes 100 acute-care beds designated for house staff responsibility, coronary and intensive care units with direct and remote monitoring capability, a modern surgical suite, automated clinical laboratory facilities, technologically advanced facilities in radiology, and comprehensive medical library and conference facilities.

All teaching staff members hold teaching appointments with the Tufts University School of Medicine. An extensive teaching program is directed toward all levels of professional education including second-, third-, and fourth-year students, interns, and residents. Tufts medical students take third and fourth year required clerkships in medicine, surgery, and psychiatry. In addition to students taking fourth year elective clerkships in medicine, surgery, and radiology subspecialties are offered in hematology, infectious disease, oncology, neurology, and nephrology. There are regular staff conferences, grand rounds, and specialty rounds.

The hospital offers two categorical internship programs in medicine. One is a straight medical internship; the other is composed of eight months of medicine and four months of surgery and residencies in internal medicine. Residents in general and orthopedic surgery complete rotations in the hospital as part of programs at the New England Medical Center.

136 Harrison Avenue
Boston, Massachusetts 02111
617 956-6565

Mr. Richard M. Knapp
Director
Council of Teaching Hospitals
Association of American Medical Colleges

-2-

May 16, 1986

The Newton-Wellesley Hospital is one of the hospitals in which Tufts medical students receive major required clinical teaching. I strongly support its election to corporate membership.

Sincerely,



Henry H. Banks, M.D.
Dean

HHB:jlm

Enclosure



COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES
APPLICATION FOR MEMBERSHIP

Membership in the Council of Teaching Hospitals is limited to organizations having a documented affiliation agreement with a medical school accredited by the Liaison Committee on Medical Education.

INSTRUCTIONS: 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
One Dupont Circle, N.W.
Suite 200
Washington, D.C. 20036

I. HOSPITAL IDENTIFICATION

Hospital Name: The Queen's Medical Center
Hospital Address: (Street) 1301 Punchbowl Street
(City) Honolulu (State) Hawaii (Zip) 96813
(Area Code)/Telephone Number: (808) 538-9011
Name of Hospital's Chief Executive Officer: Fred A. Pritchard
Title of Hospital's Chief Executive Officer: President

II. HOSPITAL OPERATING DATA (for the most recently completed fiscal year) FY 84-85

Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn):	<u>506</u>	Admissions:	<u>18,272</u>
Average Daily Census:	<u>360</u>	Visits: Emergency Room:	<u>25,115</u>
Total Live Births:	<u>1,389</u>	Visits: Outpatient or Clinic	<u>92,055</u>

B. Financial Data

Total Operating Expenses: \$ 87,953,000

Total Payroll Expenses: \$ 43,211,000

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: \$ 1,501,481
 Supervising Faculty: \$ 153,268

C. Staffing Data

Number of Personnel: Full-Time: 1,614
 Part-Time: 412

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: Physicians: 559
 With Medical School Faculty Appointments: Dentists: 36

Clinical Services with Full-Time Salaried Chiefs of Service (list services): None

Does the hospital have a full-time salaried Director of Medical Education?: No

I. MEDICAL EDUCATION DATA

A. Undergraduate Medical Education N/A -- Queen's does not have any clerkships

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

<u>Clinical Services Providing Clerkships</u>	<u>Number of Clerkships Offered</u>	<u>Number of Students Taking Clerkships</u>	<u>Are Clerkships Elective or Required</u>
Medicine	_____	_____	_____
Surgery	_____	_____	_____
Ob-Gyn	_____	_____	_____
Pediatrics	_____	_____	_____
Family Practice	_____	_____	_____
Psychiatry	_____	_____	_____
Other: _____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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.

V. SUPPORTING DOCUMENTS

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

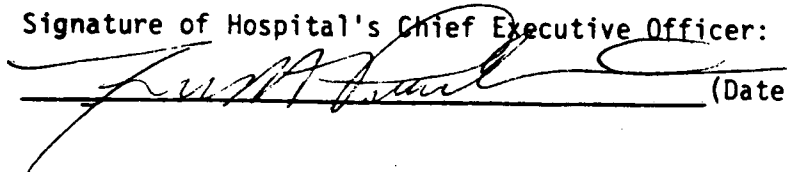
Name of Affiliated Medical School: University of Hawaii John A. Burns School of Medicine

Dean of Affiliated Medical School: Terence Rogers, Ph.D.

Information Submitted by: (Name) Karen K. Muranaka

(Title) Assistant to the President

Signature of Hospital's Chief Executive Officer:

 (Date) July 24, 1986

B. Graduate Medical Education

Please complete the following information on your hospital's participation in graduate medical education reporting only full-time equivalent positions offered and filled. If the hospital participates in combined programs, indicate only FTE positions and individuals assigned to applicant hospital.

<u>Type of Residency</u> ¹	<u>Positions Offered</u>	<u>Positions Filled by U.S. & Canadian Grads</u>	<u>Positions Filled by Foreign Medical Graduates</u>	<u>Date of Initial Accreditation of the Program</u> ²
First Year Flexible	4	4	0	1982
Medicine	16	15	0	1963
Surgery	11	9	1	1961
Ob-Gyn	4	4	0	1962
Pediatrics	1	1	0	1970
Family Practice	N/A			
Psychiatry	9	9	0	1965
Other: Pathology	4	3	1	1947
Orthopedics	4	4	0	1970
Dentistry	2	2	0	1972

¹As defined by the LCGME Directory of Approved Residencies. First Year Flexible = graduate program acceptable to two or more hospital program directors. First year residents in Categorical* and Categorical programs should be reported under the clinical service of the supervising program director.

²As accredited by the Council on Medical Education of the American Medical Association and/or the Liaison Committee on Graduate Medical Education.



THE QUEEN'S MEDICAL CENTER

Founded by King Kamehameha IV and Queen Emma
1301 Punchbowl Street • P.O. Box 861 • Honolulu, Hawaii 96808-0861 • Phone (808) 538-9011

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Chairman

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PRESIDENT

Fred A. Pritchard

July 31, 1986

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

Dear Sirs:

Please find enclosed the completed application for membership in the Council of Teaching Hospitals for The Queen's Medical Center. Also enclosed are the requested supplementary information and supporting documents (affiliation agreement and letter of recommendation).

We would very much appreciate your favorable consideration of our application.

Thank you.

Sincerely,

Karen K. Muranaka
Assistant to the President

skk

enclosures

cc (w/out enclosures): Mr. Fred A. Pritchard, President