COTH ADMINISTRATIVE BOARD
Dupont Plaza Hotel
Washington, D.C.
March 20-21, 1974

AGENDA

Evening Session on Wednesday, March 20 To Convene At 6:00 P.M.
In the Gallery Room of the Dupont Plaza Hotel

I. Call to Order - 6:00 p.m.

II. "The Role of the Organized Medical Staff in the Academic Health Science Center"

John H. Westerman
Director
University of Minnesota Hospitals

Edward J. Connors
Director
University of Michigan Hospitals

III. Cocktails To be Followed by Dinner - 7:00 P.M.

Business Session on Thursday, March 21 to
Convene at 9:00 A.M. in the Dupont Room

COTH Administrative Board
Dupont Plaza Hotel
Washington, D.C.
March 21, 1974
9:00 a.m. - 3:00 p.m.

AGENDA

I.	Call to Order	
II.	Consideration of Minutes	TAB A
III.	Membership	TAB B
	A. Reconsideration of Veterans Administration Hospital Salem, Virginia	
	B. The Faulkner Hospital Corporation Boston, Massachusetts	
	C. Discussion of Membership Criteria Andrew D. Hunt, Jr., Dean Michigan State University College of Human Medicine	
IV.	Setting of AAMC Priorities	TAB C
V.	Resolution on Safeguarding Data Systems	TAB D
VI.	AAMC Response to the IOM Report	TAB E
VII.	Report of AAMC Task Force On Foreign Medical Graduates	TAB F
VIII.	Modification of the Hill-Burton Program	TAB G
IX.	Modification of RMP-CHP Program	TAB H
X.	Relationships of AAHC and AAMC	TAB I
XI.	AAMC-COTH Annual Meeting	TAB J

XII. Information Items

A.	AAMC Institute on Primary Care	TAB K
B.	Legislation Deferring Implementation of Section 227 -- P.L. 92-603	TAB L
C.	AAMC Response to Preadmission Certification	TAB M
D.	Letter Requesting Extension of Comment Period on Health Regulations	TAB N
E.	AAMC Comments on Extension of the Economic Stabilization Act	TAB O
F.	COTH Ad Hoc Committee to Review JCAH Standards	TAB P

XIII. New Business

XIV. Adjournment

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

COTH ADMINISTRATIVE BOARD MEETING
Dupont Plaza Hotel
Washington, D.C.
December 14, 1973

MINUTES

PRESENT:

Robert A. Derzon, Chairman
Sidney Lewine, Chairman-Elect
Leonard W. Cronkhite, Jr., M.D., Immediate Past Chairman
David L. Everhart, Secretary
Daniel W. Capps
David H. Hitt
Arthur J. Klippen, M.D.
J. W. Pinkston, Jr.
S. David Pomrinse, M.D.
John M. Stagl
David D. Thompson, M.D.
Charles B. Womer

STAFF:

Richard M. Knapp, Ph.D.
Dennis D. Pointer, Ph.D.
James I. Hudson, M.D.
Catharine A. Rivera

I. Call to Order:

Mr. Derzon called the meeting to order at 9:00 a.m. in the Dupont Room of the Dupont Plaza Hotel in Washington, D.C.

II. Consideration of Minutes:

The minutes of the Administrative Board meeting of November 4, 1973 were approved as distributed.

III. Membership Applications:

After a brief discussion the following action was taken by the Administrative Board.

ACTION #1

IT WAS MOVED, SECONDED AND CARRIED THAT THE FOLLOWING APPLICATIONS FOR MEMBERSHIP IN THE COUNCIL OF TEACHING HOSPITALS BE REJECTED:

VETERANS ADMINISTRATION HOSPITAL
ALEXANDRIA, LOUISIANA

VETERANS ADMINISTRATION HOSPITAL
SALEM, VIRGINIA

IV. Report: Department of Health Services - Dr. James Hudson:

Dr. Hudson described the major issues that his department has under review and outlined the status of three major grant and contract activities. The HMO Prototype contract terminates at the end of September and a six-month extension of that contract is about to be granted without additional funds. Therefore, the contract is formally scheduled to terminate on June 30, 1974. Continuation of this contract will be reviewed this Spring after the appropriations bill is passed.

A contract is presently being negoiated with the Health Resources Administration which would explore the alternate arrangements providing health science education activities in HMO's. The scope of this contract may extend to other forms of ambulatory care services. Finally, a general resource start-up grant is being proposed to provide the resources for the AAMC to serve as a clearinghouse in the area of PSRO's and utilization review as it applies specifically to the medical-teaching environment. Additionally, the staff is embarking on field visits to explore the number of activities which are, and have been, implemented in this area.

At this point in the agenda, Mr. Derzon pointed out that the AAMC was forming a committee on National Health Insurance and COTH had been requested to provide a list of individuals who might serve on this committee. After a brief discussion, several names were suggested and the chairman was requested to present these names as well as others for consideration. (This committee has since met twice on February 7, and March 14. COTH Representatives on this committee are John Stagl, Baldwin G. Lamson, M.D., and Ray Brown.)

V. AAMC Committee on Health Manpower:

Following an intensive discussion of the report as it appeared in the agenda book, there was general support for the document with two exceptions.

A. It is stated in the report that an additional $1,500 per year for each enrolled student should be provided for schools that initiate programs which provide for a major portion of the clinical education of at least one-half of their students in an ambulatory setting with provisions for longitudinal continuous care of patients. Schools qualifying for primary care capitation should be eligible for additional support not to exceed $400,000 per year for the development of innovative ambulatory educational settings. Questions were raised about the use of a mechanism whereby the criteria for receiving these dollars requires an ambulatory setting which may not be under the auspices or control of the school but rather be a free-standing hospital or other corporate entity. The point to be made is that the medical school would be awarded the funds where program responsibility would be elsewhere. If such an activity had a project grant orientation one could be sure that the dollars were expended in the area which is a precondition of support. However, when the dollars are awarded on a capitation basis they are not necessarily treated this way.

B. It was also stated that the report recommended the deletion of a number of special project and initiative awards which included grants to hospitals for family medicine training. These projects would be folded into a new consolidated program of special initiative awards under which the HEW Secretary could award grants and contracts for carrying out projects in three broad areas: (1) Health professions education development; (2) special national emphasis programs; and, (3) health care practice and the use of health care personnel. Since fifty-two hospitals presently participate in the family medicine grant program, questions were raised regarding the appropriateness of deleting this program from any new health manpower legislation.

There was agreement that COTH members of the Executive Council would raise these points at the council meeting the following day. (A copy of the final document appears as Appendix A to these minutes).

VI. Policy For Release of AAMC Information:

VII. Classification of Salary Study Information:

Since these two items are closely related, it was recommended that the administrative board review them jointly. It was pointed out that the terms "unrestricted" and "Public" are used in both the policy statement and the specific recommendation with regard to classification of salary study information. It was recommended that the nomenclature be made consistant to avoid confusion.

ACTION #2 — IT WAS MOVED, SECONDED AND CARRIED THAT THE COTH ADMINISTRATIVE BOARD APPROVE THE POLICY FOR RELEASE OF AAMC INFORMATION.

Since the second item concerns the matter of releasing faculty salary survey studies, it was recommended that this matter be left to the discretion of the CAS and COD administrative boards and that the present policy of distributing the COTH Executive Salary Survey to the chief executive of each COTH member be retained.

VIII. Report of the AAMC Committee on Graduate Medical Education:

No action was requested of the administrative board on this report; each board was requested to discuss and react to the document. A discussion ensued and the following concerns were raised:

1) A clearer definition of family medicine and primary care needs to be provided.

2) The recommendation that 50 percent of the first year residency positions should be allocated to primary care training and ambulatory settings has very specific implications for the ability of the teaching hospital to maintain and operate its special services at current levels of operations. There are staffing as well as cost implications that need to be considered. Additionally, it was pointed out that at some point it needs to be recognized that service needs of the institution may not be in consonance with the educational needs for the house officers training program.

3) It was recommended that first-year residency positions be limited to 110%-120% of the number of graduates produced by U.S. medical schools. It was stated that before such a

statement were published, the specific implications of that statement need to be carefully assessed. Additionally, it was pointed out that an obligation does exist to make accommodation for foreign trained American citizens.

4) In reference to both of the above points the question was again raised of the institution's ability to maintain and operate the high intensity specialty units which do constitute the achievement of the major objectives of our constituent institutions which is the provision of tertiary care services.

5) While discussing the matter of primary care, the report does not speak to the matter of other specialties which are in short supply, for example anesthesia.

There was a general consensus that the document contained a number of significant recommendations without adequate documentation and without a full discussion of the implications of implementing such recommendations.

IX. Physician Manpower and Distribution Report to the CCME:

This document was prepared under the direction of an ad hoc committee of the Coordinating Council on Medical Education, chaired by Dr. William Holden, Chairman of the Department of Surgery at Case Western Reserve University Medical School. Other members of the committee were: Dr. William Sodeman, Dr. August Swanson, and Dr. David Thompson.

Dr. Thompson outlined the history and rational for preparing the report which contained a variety of types of information which members of the board felt would be extremely useful in addressing the various questions being raised about geographic and specialty distribution of physicians. There was a general consensus of the board members that this was an excellent document which could be used as a basis for supporting policy statements in this area.

X. Report of the Advisory Committee on Academic Radiology:

This report elicited a great deal of discussion and the following specific points were raised:

1) The matter of "conflict of interest" was raised since the Pickering Foundation, which supported the study, is a major manufacturer of radiological equipment and the radiologists who completed the study were major users of radiological equipment.

2) In the calculations set forth in the report there was no credit given to the service contributions of the radiology residents.

3) Educational costs are identified which are being currently reimbursed on a service basis. Such matters need to be carefully reviewed in terms of future sources of financing.

4) The quantative conclusions reached in the report are not supported by the rather subjective conclusions reached in the body of the report.

ACTION #3 — IT WAS MOVED, SECONDED AND CARRIED THAT THE COTH ADMINISTRATIVE BOARD REJECT THE REQUEST THAT THIS REPORT BE ENDORSED BY THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES' EXECUTIVE COUNCIL.

XI. Consideration of Association Priorities - Review of the Officers Retreat:

Mr. Derzon provided a general discussion of the issues that were raised at the retreat; a summary of priorities reached at the retreat is attached as appendix B of these minutes.

XII. FMG Task Force Recommendations:

George Cartmill, President, Harper Hospital of Detroit, was the COTH representative on this task force. Following a brief discussion, the following action was taken.

ACTION #4 — IT WAS MOVED, SECONDED AND CARRIED THAT THE COTH ADMINISTRATIVE BOARD APPROVE THE FMG TASK FORCE RECOMMENDATIONS.

XIII. Adjournment:

There being no further business the meeting was adjourned at 12 noon.

Approved by Executive Council
December 14, 1973

APPENDIX A

AAMC Committee on Health Manpower

Report

Introduction

The Executive Council appointed the AAMC Committee on Health Manpower to develop an Association response in view of the approaching expiration on June 30, 1974, of the various authorities in the Comprehensive Health Manpower Training Act of 1971, the basic legislation dealing with federal support of health professions education.

The members of the committee who participated in its activities were Julius R. Krevans, M.D., Dean, University of California-San Francisco School of Medicine; Merlin K. DuVal, M.D., Vice President for Health Sciences, The University of Arizona College of Medicine; David R. Hawkins, M.D., Chairman, Department of Psychiatry, University of Virginia School of Medicine; Morton D. Bogdonoff, M.D., Chairman, Department of Medicine, The Abraham Lincoln School of Medicine; Sidney Lewine, Director, Mount Sinai Hospital of Cleveland; John C. Bartlett, Ph.D., Associate Dean for Health Affairs and Planning, University of Texas Medical School-Houston; Hugh E. Hilliard, Vice President for Finance and Treasurer, Emory University School of Medicine; and Bernard W. Nelson, M.D., Associate Dean for Medical Education, Stanford University School of Medicine. Dr. Krevans served as Chairman of the committee.

In authorizing appointment of the committee, the Executive Council charged it with reviewing the expiring authorities of the Comprehensive Health Manpower Training Act of 1971 and with recommending to the Executive Council appropriate modifications which the Association should support in working with Executive and Legislative officials on the extension of the expiring authorities. In its work, the committee reviewed the present federal health professions education assistance programs, the progress to date of the AAMC Committee on the Financing of Medical Education, and the provisions of known legislative proposals on health professions education assistance. The committee agreed to certain principles which should underlie the federal role in health professions education and developed a set of recommendations based on those principles.

This report sets out the committee's principles and recommendations and provides some additional explanatory material the committee considered useful in understanding fully its positions.

Principles

The AAMC Committee on Health Manpower believes the following principles should guide the federal role in health professions education.

There should be --

1. Stable, continuing, fiscally responsible federal support for medical

schools' educational activities, special projects and initiatives, student assistance, and capital expenses;

2. First-dollar capitation support of the undergraduate educational activities of the medical schools;

3. Project-grant support for special projects and initiatives reflecting national priorities and special emphasis fields;

4. Direct loans and scholarships to help meet student financial needs, with options for voluntary participation in loan forgiveness programs or service-obligation scholarship programs; and

5. Grants and loan guarantees with interest subsidies to meet physical plant replacement needs and to develop or expand new types of facilities such as ambulatory care facilities.

Recommendations

The AAMC Committee on Health Manpower recommends that legislation embodying those principles should be developed that provides fiscally responsible levels of funding in line with overall national priorities and that encourages prudent institutional planning over a five-year period beginning July 1, 1974.

The committee's specific recommendations follow, grouped under headings of institutional support, special projects, student assistance and capital support:

Institutional support

1. Delete the present capitation formula for schools of medicine, osteopathy, and dentistry and substitute a new formula of $6,000 per student per year, with half of the $6,000 tied to meeting certain conditions: $1,000 per student per year for increasing first-year enrollment by the greater of 5 percent or 10 students; $1,000 per student per year for developing or supporting programs emphasizing the teaching of primary care; $1,000 per student per year for developing or supporting undergraduate educational programs in shortage areas.

2. Provide the capitation support as an entitlement with no separate authorization of appropriations.

3. Delete present provisions on enrollment bonus students.

4. Delete the present enrollment increase requirement.

5. Retain the present maintenance of effort provisions.

6. Delete the present provisions requiring a plan of action in certain areas as a condition of obtaining capitation support.

7. Modify the present programs of start-up and conversion assistance by limiting start-up assistance to educationally underserved areas.

8. Extend unchanged the present program of financial distress grants and authorize appropriations of $10 million per year (fiscal 1974 level).

The Association believes there is an appropriate role for the federal government in helping to meet some of the costs of undergraduate medical education. Undergraduate medical education is composed of interacting elements integral to a unified process leading to the M.D. degree. The elements of this process are the instructional activities covering the imparting of disciplinary and interdisciplinary subject matter through lectures, seminars and laboratory exercise; participation in the care and management of patients; and training in research methods for the solution of problems in health. The cost of the elements is high, and in the past has been shared by the federal government, state and local governments, medical schools themselves through tuition and endowment income, private foundations and others. The federal role has been justified because of the national mobility of physicians and because of an underallocation of resources to medical education by the private sector. In seeking an appropriate federal share, the Association agrees with the report of the Senate Committee on Labor and Public Welfare, accompanying the Comprehensive Health Manpower Training Act of 1971: "The bill ... entitles each educational institution to an award intended to cover approximately one-third of the average per-student educational costs incurred nationally by such institutions .... The costs of research and the costs of patient care are integral to per-student costs of the institution. And ... they shall be included in the calculation of costs for the purpose of applying for their entitlement grant."

Beginning with the White House Conference on Aging during the midyears of the Eisenhower Administration and continuing to the present, there is a growing agreement that access to health care is a right. This is a concept that has been endorsed by important political figures of both parties in both the House and the Senate; it was included as part of President Nixon's health message to Congress in February 1971; and it was a main theme of a White Paper issued by the Department of Health, Education and Welfare in 1971: Towards a Comprehensive Health Policy for the 1970s. This concept carries with it implications which are crucial to understanding the federal role in support of the undergraduate medical education activities of medical schools.

There is no way in which the right of access to adequate health care can be claimed or delivered without training health personnel. Since the public has a claim for access to adequate health care, it must follow then that the public has a legitimate interest in sustaining the production of health personnel. Because of the setting in which education in the health professions is conducted, the educational expense is necessarily a joint product. This fact means that the expenses of the environment of a health professions education are the integrated expenses of instruction, research and medical service. This is so because health professionals are educated in an academic environment, by the research and development arm of the medical profession, some would say, rather than undergoing an apprenticeship process in which they are educated directly by practicing physicians.

Recognizing the issues of joint costs, the federal government in 1971 put in place a program which called for direct support of the education activities

of health professions schools through a capitation grant. Through this device, the government acknowledged the legitimate public interest in the continuity and integrity of health professions educational institutions. The capitation grants have enabled the schools to respond to the need for increased numbers of health professionals. In doing so, the schools have expanded their facilities and have made commitments to new faculty and new programs which new must be sustained if the objectives are to be achieved. In addition, through the device of capitation, the government recognized the value of the establishment of a creative parnership between itself and the academic health centers for the purpose of permitting leverage through which national purposes could be achieved.

The recommendations of the Association that capitation support be extended for five years, that the level of capitation be set at $6,000 per student per year, that capitation be an entitlement, and that half of the capitation be tied to complying with certain conditions are based on the following factors:

1. The $6,000-per-student-per-year capitation level corresponds with approximately one-third of the average of the annual cost per student for the elements of instruction, research and medical service at 12 schools studied by the AAMC Committee on the Financing of Medical Education. While the Association appreciates that its recommended capitation level is well above the presently authorized level of $2,500 per student per year and the present funding level of approximately $1,700 per student per year, it must be emphasized that those levels were set by the Congress and the Executive Branch in developing and administering the 1971 legislation. The Association's 1971 recommended authorization level was $5,000 per student per year, and when that figure is adjusted for an annual 6 percent inflation factor, the resulting increases bring the total to $6,000. Moreover, only those schools which comply with all three conditions of capitation assistance will receive the full $6,000 support. A school which fails to comply with one of three conditions, for example, would lose $1,000 per student per year; its capitation support would fall to $5,000 per student per year.

2. Converting the program to an entitlement and extending it for five years act together to encourage rational institutional planning, based on the program's continuity and predictability of support. With short-lived programs and fluctuating support levels, rational institutional planning is impossible.

3. Coupling a portion of the capitation support to compliance with certain conditions acknowledges the schools' responsibility to contributing to improvements in the nation's health care while recognizing the additional educational costs associated with such projects. The responsibility of the schools goes beyond mere numbers of M.D. graduates; it includes the kinds of training experiences available for medical students and the kinds of health care delivery systems being developed to provide needed health services. In terms of manpower, for example, in the 10 years since federal aid to health professions schools was initiated, the number of schools has increased from 87 to 114; enrollment has increased from 32,001 to 47,259; and graduates have increased from 7,336 to 10,000 per year. The Association is confident that that achievement

can be sustained and that similarly impressive achievements can be recorded under its proposed capitation system in developing new kinds of physicians and improved methods of delivery.

Special projects and initiatives

1. Delete the following present programs: special projects, health manpower education initiative awards, grants to hospitals for family medicine training, capitation grants for graduate training in certain specialties, grants for health professions teacher training, and grants for computer technology health care demonstrations.

2. Substitute for those programs a new, consolidated program of special initiative awards under which the HEW Secretary could award grants and contracts for carrying out projects in three broad areas: (1) health professions education development; (2) special national emphasis programs; and (3) health care practice and the use of health care personnel.

3. Authorize the appropriation of such sums as may be necessary, and provide that appropriated funds are to remain available until expended.

The Association believes there is a useful role for the project-grant approach to financing selected activities in health professions schools. This approach recognizes the incremental cost to the school of such a project and clearly separates the financial support for the project from the general pool of financial support for the basic undergraduate medical education program. Special projects serve as a vehicle for the health professions schools to participate in constructive change in the interest of improving the health and health professions education of the nation. Competitive rather than formula awards strengthen the entire health professions education system by ensuring heterogeneity; homogeneity would produce rigidity and resistance to any change. Competitive awards also allow research and demonstrations without total system involvement.

A problem with the current programs is that they have proliferated over time into an almost unintelligible patchwork of authorities whose complexities pose problems for both applicants and administrators. The Association therefore proposes a simplified program of special initiative awards which would permit the federal government to select its own priority projects, the institutions or combinations of institutions to carry them out, and the levels of funding at which the government wished to support its priority projects. For this reason, the Association did not recommend any specific levels of funding, although the AAMC is prepared to work with others in determining appropriate levels.

Student assistance

1. Increase the present $3,500 loan ceiling to $4,500 per student per year.

2. Delete the present loan forgiveness formula and substitute a new formula providing 100 percent forgiveness for two years' service in a

designated area.

3. Authorize appropriations of $70-$75-$80-$85-$90 million (15,000 students currently aided at $4,500 per year, plus growth of need for loans).

4. Delete the loan program for U.S. students abroad.

5. Increase the present $3,500 health professions scholarship ceiling to $4,500 per student per year.

6. Delete the present entitlement formula and substitute a new formula of $4,000 times the greater of one-tenth the number of full-time students or the number of students from low-income backgrounds.

7. Delete the health professions scholarship program for U.S. students abroad.

8. Increase the present $5,000 physician shortage area scholarship ceiling to $6,000 per student per year.

9. Delete the present shortage-area service requirement and substitute a new service requirement of two years in a designated area regardless of the time support was received.

10. Authorize appropriations of $13.5 million per year (5-percent student participation).

The Association is committed to the goal that there should be equality of opportunity for students wishing to attend medical school. A major barrier denying equal opportunity is the high cost of medical education that must be borne directly by the student. The existing health professions education assistance legislation traces its origin to student aid programs designed specifically to assist the socioeconomically disadvantaged student entering medical school. The health professions loan program and the health professions scholarship program have constituted a major source of student aid for medical students. Since their implementation, the medical profession has been enriched by the addition of students with a greater diversity of socioeconomic backgrounds.

During the past five years, American medical schools have made substantial progress in improving the representation of minority groups in medical school programs. The enrollment of minority groups in the fall of 1973 is 7.4 percent of the first-year enrollment. The AAMC has adopted a goal of 12-percent minority representation in entering classes by September 1975. The AAMC reiterates its belief, as did the AAMC Task Force to the Inter-Association Committee on Expanding Educational Opportunities in Medicine for Blacks and Other Minority Students in 1970, that financial assistance in the form of grants and loans is a critical factor if these goals are to be achieved. Without scholarship support the acutely disadvantaged are forced to borrow sums of money that may exceed the earnings of the entire family. Many are persuaded that the risk of such a debt is too great for them to take -- an assessment frequently reinforced

by the family's experience with past debts.

Equally fundamentally, an emphasis on loans focuses student attention on the future earnings of the physician. Thus it would be predictable that the student's interest in earning large sums of money would be reinforced by his need to borrow large sums as a student. This is not a desirable characteristic to be sought in students; and it is detrimental to the efforts of the country to develop a physician population interested in developing modes of practice that are less costly to the patient and to the nation.

The AAMC believes that the success of continuing efforts to recruit individuals from minority backgrounds into the medical profession will depend on the continuation of federally sponsored scholarship and loan programs for medical students. In particular, scholarship funds are needed to insure the representation of minority groups and the representation of students from socioeconomically disadvantaged backgrounds. These students enter medical school with large debts incurred during their undergraduate years. These debts, coupled with the debts incurred during medical school, make it commonplace for a student to leave medical school with debts of $15,000 or higher.

It has been suggested that educational debts of a medical student could be forgiven in return for practice in designated areas or that scholarships should be made available on condition that the recipient later practice in a designated area. The AAMC has no objection to this approach, provided that it is offered as an alternative to a non-obligatory assistance program and provided further that participation is voluntary.

There is a great diversity of talent and ability among the socioeconomically disadvantaged, and these skills and abilities should be matched with the diversity of opportunity in medicine. The Association does not believe that a loan program that indentures a student to a particular form or area of practice is consistent with the goal of achieving equality of educational opportunity. Many of the proposals for the forgiveness of debt for practice in underserved areas restrict the participant to a fixed professional pathway. Over the long term, the Association does not believe that such an approach will attract to the profession the diversity of talent needed to meet society's needs. The Association believes there is a role for different and multiple approaches to the problem of financing the student costs of medical education.

The debt of students entering medical school is growing rapidly and is commonly underestimated. The Association believes that a limit on the amount of debt assumed by a student to meet the expense of attending college and medical school is reasonable. Excessive debt will reinforce the trend toward higher physician income. The Association believes it is only logical for physicians to focus their attention on higher fees if the government endorses the view that the future earnings of physicians should serve as the source of funds for repayment of educational expenses.

Loan guarantees as a sole source of debt financing of health professions education are unacceptable, although they may be offered in addition to a program of direct loans. A loan guarantee program, subject to the vagaries of the money market, removes from the educational institution all judgment concerning

the individuals to whom laons are made, as well as the amount loaned, and places such judgment in the banks.

The Association recommends increasing the health professions loan and scholarship ceilings in recognition of rising medical student expenses, now estimated at between $4,000 and $5,000 per student per year. The shortage area scholarship ceiling was raised in an effort to make the program more attractive. Service periods were stabilized at two years to equalize the burden of service to participating students and to provide a uniform period of career interruption, intended to facilitate improved career planning.

Capital support

1. Authorize appropriations of $200 million per year for construction grants and provide that appropriated funds are to remain available until expended.

2. Delete the enrollment increase requirement.

3. Extend unchanged the present loan guarantee and interest subsidy program, including the present appropriations limitation for interest subsidies of $24 million.

The Association feels strongly that the appropriateness of a federal role in the construction and maintenance of medical school facilities parallels the federal role in the support of undergraduate medical education. And, as in the case of undergraduate medical education, the cost of capital expansion also is shared by the federal government, state and local governments, the institution itself, and various private and other outside sources. The Association estimates that $300 million are required annually to replace or extensively remodel existing facilities on a 40-year cycle. Assuming an average Federal share of 50 percent, these programs alone would require $150 million a year in grant support before providing money for new construction for facilities required to keep educational programs abreast of new demands and new developments in medicine.

The recommendations of the AAMC include continued grant support because teaching facilities are inherently cost-generating rather than income-producing. As a result, income from the operation of such facilities cannot be used to amortize the cost of the facility. Thus debt financing for such facilities is totally inappropriate. At the same time, other types of facilities, such as ambulatory care centers, are potentially income-generating, and thus could produce funds which could be applied to offset some debt financing. For that reason, the Association also recommended continuing the program of loan guarantees and interest subsidies. The recommended funding levels are based on a professional judgment of an appropriate federal share of the cost of maintaining the existing physical plant of the schools, plus an allowance for new construction of ambulatory care facilities needed for the expanding number of primary care programs being established by academic medical centers.

REPORT OF THE AAMC OFFICERS' RETREAT

December, 1973

The Chairman, Chairman-Elect, and President of the Association along with the Chairman and Chairman-Elect of each Council, the OSR Chairperson, and key AAMC staff met from December 5 - 7 to review the activities of the Association and to discuss the major issues which the AAMC will confront in the coming year.

Foremost among the issues identified for major Association effort are:

1) the development of recommendations on the financing of medical education by the Sprague Committee with the input already put forth by the Krevans Committee on Health Manpower;

2) the development of a more specific AAMC position on national health insurance by a Special Task Force; such a position must lay out legislative specifications on every aspect of national health insurance affecting the medical schools and teaching hospitals;

3) the consideration, by the AAMC Graduate Medical Education Committee with input to the Coordinating Council on Medical Education, of ways to better relate the specialty and geographic distribution of physicians to the needs of the population;

4) the organization of agencies collecting data on medical schools to avoid duplication and provide a more coherent and better utilized information system -- charge to the Data Development Liaison Committee;

5) an examination of the role of the medical schools and teaching hospitals in educating the public about health; this topic would be the theme of the 1974 AAMC Annual Meeting.

Another major consideration was felt to be biomedical research, particularly the issue of assuring adequate research manpower. The Braunwald Committee was asked to evaluate the need for researchers in specialty areas and to recommend an appropriate financing mechanism. This committee was also asked, through the appointment of subcommittees, to consider the peer review system and recommend a mechanism for assuring the appointment of qualified individuals to Advisory Councils and to develop criteria for determining which research areas might benefit from a targeting of federal support (research center approach).

The Retreat participants discussed the Foreign Medical Graduate issue and the overall question of how many physicians are needed. While it was felt impossible to determine the number of M.D.'s needed until problems such as specialty and geographic maldistribution and the disorganization of the health care system are resolved, it was asserted that the number of graduate positions must reflect the needs of the population and all who enter graduate training must demonstrate a high level of competence.

After supporting in concept the use of the health care team to alleviate shortages caused by maldistribution of physicians and recommending that financial incentives to encourage schools in this area be built into Comprehensive Health Manpower legislation, the Retreat considered the accreditation of physician assistants' and allied health educational programs. The newly-formed Commission on Physician Assistants and the proposed Joint Council for the Accreditation of Allied Health Education were discussed, along with the established AAMC position that the LCME should accredit Type A physician assistants programs. The issue of separating the Type A programs from the remainder of the allied health field was left unresolved. If the Association supports this segregation of Type A programs, it may choose to continue to support LCME accreditation or, alternately, may accept the jurisdiction of the CPA and choose to participate on that body. The relationship of the Coordinating Council to the CPA and JCAHE must also be defined.

There is mounting pressure to form a Liaison Committee on Continuing Medical Education under the Coordinating Council. The Retreat recommended that the Association elaborate detailed specifications on the role and function of such a Liaison Committee during the deliberations of a now-appointed CCME ad hoc committee. The stress should be placed upon stimulating continuing education programs which are linked to quality of care appraisal. The Group on Medical Education should be encouraged to include in its membership those individuals in the institutions who are responsible for continuing medical education, and should evolve programs directed toward improving the effectiveness of educational efforts directed toward practicing physicians. Association activities directed at helping the institutions effectively meet the requirements of the PSRO legislation should include the establishment of a central clearinghouse to collect and disseminate information on medical care evaluation studies. This would include developing a network of quality assurance correspondents at each institution.

The Retreat considered pressures being brought to develop national curricula to train medical students in categorical disease areas such as cancer and high blood pressure. It was felt that the Association should encourage these efforts at the level of public and continuing education, but should not support this at the undergraduate level.

The Retreat participants also discussed issues concerning the constituent composition of the AAMC, the responsiveness of the Association to the needs of various segments of the membership, and the AAMC's liaison with other organizations in the health field. As a final item, the format and program of the 1974 Annual Meeting were briefly discussed and referred to the Executive Committee, which serves as the Annual Meeting Program Committee.

UNIVERSITY OF VIRGINIA
SCHOOL OF MEDICINE
CHARLOTTESVILLE, VIRGINIA 22901

OFFICE OF THE DEAN
(703) 924-5118

February 19, 1974

Richard M. Knapp, Ph.D.
Director
Department of Teaching Hospitals
Association of American Medical Colleges
Suite 200
One DuPont Circle, N.W.
Washington, D. C. 20036

Dear Dr. Knapp:

I understand from Mr. H. E. Davis, Director of the Veterans Administration Hospital at Salem, that his Hospital's application for membership in the Council of Teaching Hospitals has recently been rejected. The purpose of this letter is, therefore, to describe the intimate role the Salem Veterans Administration Hospital plays in the educational programs of the University of Virginia.

Over a nine-year period the University has developed an education program in Roanoke which is approximately 120 miles away from the home campus in Charlottesville. This program consists of formal teaching affiliations with three major hospitals. The hospitals interact with each other and with the University, and the Salem Veterans Administration Hospital is a key part of this educational program. I think it best to discuss the relationships between the University and the Salem Veterans Administration Hospital under three headings: Administration, Undergraduate Medical Education, and Graduate Medical Education.

The professional care at the Veterans Hospital is under direction of the committee chaired by the Dean of the School of Medicine. Other members of the Dean's Committee include the Chairmen of Medicine, Surgery, Psychiatry, Urology, Orthopedics and Neurology, and the Associate Dean for Roanoke. The committee meets at regular intervals at the Salem Hospital. In addition to the Dean's Committee, the University of Virginia Associate Dean for the Roanoke area is on the staff of the Salem V.A. Hospital, and actively participates in its activities.

Currently, undergraduate clerkships for medical students are operational in Medicine, Surgery and Psychiatry. In addition, electives are taken by students in a number of other fields.

Residency programs with the University of Virginia are as follows:

1. In Surgery, one third-year resident and three first-year residents are assigned to the Salem Veterans Administration Hospital at all times for three-month periods. The third-year resident functions as chief resident in Surgery.

2. The Internal Medicine residency is the University of Virginia affiliated hospital residency. This is a joint-residency between the Salem Veterans Administration Hospital and the Roanoke Memorial Hospitals with rotations in the University Hospital in Charlottesville.

3. The Orthopedic residency at the University is planned in such a way that the third-year resident in Roanoke functions as the Orthopedic resident at the Veterans Administration Hospital.

4. The Urology residency at the University is organized so that there are two chief resident positions. Each chief resident spends six months of his last year in Charlottesville and six months in Roanoke. During his six months in Roanoke the chief resident has direction of the Urological Service at the Veterans Administration Hospital. In addition, a first-year resident is frequently assigned to Roanoke as scheduling permits.

5. Now that a new, academically-oriented Chief of Psychiatry has come to the Hospital on January 1, the Psychiatry clerkship is being organized and plans are being made for Psychiatry residents from the University to come to the Hospital.

As part of these teaching programs, faculty from Charlottesville come to the Veterans Hospital each week in Medicine, Surgery, and Psychiatry to participate in teaching programs. On the other hand, the full-time professional faculty in Salem actively sit on the University Curriculum Committee and other educational committees and, on occasion, serve as attendings at Charlottesville.

I would hope that this further explanation of the role of the Veterans Administration Hospital at several levels of education will aid in the approval of their membership in the Council of Teaching Hospitals.

If you wish further information, please do not hesitate to contact me.

Sincerely yours,

William Drucker

William R. Drucker, M.D.
Dean

WRD/kac
cc: Dr. H. B. Haley
Mr. H. E. Davis
Dr. F. L. Brochu

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership
in the
Council of Teaching Hospitals

(Please type)

Hospital: Veterans Administration Hospital
Name

Salem
City

Street

Virginia
State

24153
Zip Code

Principle Administrative Officer: Hugh F. Davis
Name

Hospital Director
Title

Date Hospital was Established _____

Approved Internships:

Type	Date Of Initial Approval by CME of AMA*	Total Internships Offered	Total Internships Filled
Rotating	None		
Straight	None		

Approved Residencies:

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total Residencies Filled
Medicine	Sept. 1973	4	2
Surgery (General)	July 1, 1968	4	3
OB-Gyn			
Pediatrics			
Psychiatry			
Other			
Orthopedics	Jan. 1, 1969	1	1
Urology	Jan. 1, 1968	1	1

Information Submitted By:

F. L. BROCHU, M. D., Chief of Staff
Name

H. E. DAVIS, Hospital Director
Title of Hospital Chief Executive

December 5, 1973
Date

Signature of Hospital Chief Executive

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

PLEASE READ INSTRUCTIONS ON REVERSE SIDE

UNIVERSITY OF VIRGINIA
SCHOOL OF MEDICINE

ROANOKE OFFICE
222 WALNUT AVENUE, S.W.
ROANOKE, VIRGINIA, 24016
703-344-8376

23 August 1973

Mr. Hugh Davis
Director
Veterans Administration Hospital
Salem, Virginia 24153

Dear Mr. Davis:

The University of Virginia School of Medicine wishes to make use of the clinical facilities of your hospital for teaching purposes. The intent of this letter is to obtain your official authorization for the faculty and staff of the School of Medicine to use your clinical facilities in this manner.

Under this arrangement, a schedule of our teaching activities will be presented for your approval before the beginning of each major academic interval. It is understood that such teaching programs will not interfere with your primary mission in the care and treatment of veterans. It is further understood that the school recognizes and accepts all responsibility for the planning, scheduling, and conduct of these teaching programs.

I would appreciate your indicating your approval by countersigning this letter, as indicated below, and returning the original to me. A copy is attached for your files.

Sincerely yours,

Harold B. Haley, M.D.
Associate Dean-Roanoke

AGREED:

_____
Director
Veterans Administration Hosp
Salem, Virginia 24153

November 1, 1973

658/00

Harold B. Haley, M.D.
Associate Dean-Roanoke
University of Virginia School of
Medicine
Roanoke Office
222 Walnut Avenue, S. W.
Roanoke, Virginia 24016

Dear Dr. Haley:

This refers to your letter of August 23, 1973, and our later conversation about a written agreement between the VA and the University of Virginia School of Medicine regarding the use of VA facilities for education and training programs.

I had been under the impression that the school and the VA had signed an affiliation agreement when we became a Deans Committee Hospital. After receiving your letter, I have checked and been unable to locate one.

Our Central Office has issued a recent policy statement indicating what should be included in these agreements. I am enclosing a copy of that publication. I am also enclosing a proposed agreement, in triplicate, which I would appreciate your coordinating with Dean Drucker and other concerned parties at the University.

If the agreement is satisfactory, it should be signed by the responsible University official and two copies should be returned to me. After I obtain the approval of the Chief Medical Director, a copy will be returned to the University.

With kind personal regards.

Sincerely,

H. E. DAVIS
Hospital Director

Enclosures

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership
in the
Council of Teaching Hospitals

(Please type)

Hospital: THE FAULKNER HOSPITAL CORPORATION
Name

Boston — City
1153 Centre Street — Street
Massachusetts — State
02130 — Zip Code

Principle Administrative Officer: James V. Kerrigan
Name
Acting Director
Title

Date Hospital was Established December 5, 1900

Approved Internships:

Type	Date Of Initial Approval by CME of AMA*	Total Internships Offered	Total Internships Filled
Rotating	1972	6 (combined- Faulkner & Lemuel Shattuck)	6 (usually 3 at Faulkner Hospital at one time)
Straight	1962	5	5

Approved Residencies:

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total Residencies Filled
Medicine	1949	19 (Combined Faulkner & Lemuel Shattuck)	19 (usually 3 Sr. Res. & 3 Jr. Res. at Faulkner ~~at one time~~)
Surgery	1962	12	12
OB-Gyn			
Pediatrics			
Psychiatry		3	3 *
Other			
Orthopedic	July 1, 1970	1	1
Pathology	1946	1	0

* fall under residency progra of Cambridge Hospital

Information Submitted By:

James V. Kerrigan
Name

Acting Director
Title of Hospital Chief Executive

25 February 1974
Date

James V. Kerrigan
Signature of Hospital Chief Executive

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

PLEASE READ INSTRUCTIONS ON REVERSE SIDE

AGREEMENT

TUFTS UNIVERSITY SCHOOL OF MEDICINE
and
THE FAULKNER HOSPITAL

This Agreement is made between Tufts University School of Medicine, hereinafter referred to as "Tufts" and The Faulkner Hospital, hereinafter referred to as "Faulkner."

Tufts and Faulkner desire to continue their cooperation in the teaching of medical students. Presently Faulkner is involved in teaching Tufts medical students in the following areas:

- 6 students in Physical Diagnosis
- 2 students in Radiology (at any one time)
- 1 student in Gastroenterology (elective)
- 1 student in Headache (elective)
- Brush-up facilities for several Tufts students each summer and fall who need extra experience in order to progress in their program

Faulkner now offers the addition of an elective clinical clerkship in fourth year medicine involving up to two students at any one time. Through this extension of Faulkner's teaching participation Faulkner Hospital also becomes eligible to train, within its approved medical internship program, Tufts medical students who have been selected to spend their fourth year of medical school as an internship.

Specific details of the teaching program for Tufts medical students will be worked out between departments of the same disciplines at Tufts and Faulkner, subject to approval of the Dean of the Medical School and the Director of the Hospital, both of whom will be responsible for the development of financial arrangements in relation to these educational programs.

Tufts is invited to appoint a representative to participate in the activities of appropriate Faulkner Selection Committees whenever matters are under discussion which directly affect the teaching of Tufts medical students at Faulkner.

This agreement recognizes the corporate autonomy of the two institutions. It will not be construed to exclude other agreements for the teaching of medical students and postgraduate students that exist presently between Faulkner and other institutions (i.e., with Harvard Medical School in Surgery, Boston University in Cardiology, and Harvard School of Public Health in Occupational Medicine) or that may be arranged in the future.

This agreement shall continue indefinitely without need for renewal as long as Tufts and Faulkner are accredited institutions. It may be reviewed or terminated by mutual consent at any time. It may be terminated on June 30th of a given year by either party, provided that notice of intent to terminate shall have been given in writing to the other party before January 1st of that year.

For Tufts University School of Medicine

Lauro F. Cavazos, Ph. D.
Acting Dean

Date 2/5/74

For The Faulkner Hospital

William J. Skerry
Director

Date 6 Feb. 1974

CONFERENCE COMMITTEE ON GRADUATE EDUCATION IN SURGERY

REPRESENTING

AMERICAN BOARD OF SURGERY — AMERICAN COLLEGE OF SURGEONS

AMERICAN MEDICAL ASSOCIATION

PAUL A. VAN PERNIS, M.D.
SECRETARY
535 NORTH DEARBORN STREET
CHICAGO, ILLINOIS 60610

August 6, 1973

William V. McDermott, Jr., M.D.
Director, Harvard Surgical Service
New England Deaconess Hospital
185 Pilgrim Road
Boston, Massachusetts 02115

Dear Doctor McDermott:

At its most recent meeting, the Conference Committee on Graduate Education in Surgery, representing the American Board of Surgery, the American College of Surgeons, and the Council on Medical Education, considered the integrated training program in surgery at New England Deaconess Hospital, Cambridge Hospital (Cambridge), Faulkner Hospital, Mount Auburn Hospital (Cambridge), and Veterans Administration Hospital (Manchester, N.H.).

As a result of its deliberations, the Committee granted provisional approval of the surgical internship and the four-year residency program in surgery.

The number of residents appointed to the program should be limited to thirty, with ten at the first-year level, eight at the second-year level, six each at the third and fourth-year levels. However, the Committee will allow modest variations in the number of positions in the first year of the program without prior approval.

In approximately two years, there will be a review by a surgeon representing the Committee in order to obtain information as to the program's effectiveness.

With best wishes for the continued success of your program.

Sincerely,

Paul A. Van Pernis, M.D.
Secretary: Conference Committee on
Graduate Education in Surgery

PAVP/ih

cc: Administrators: New England Deaconess Hospital
Cambridge Hospital
Faulkner Hospital
Mount Auburn Hospital
Veterans Administration Hospital (Manchester, N.H.)
American Board of Surgery
American College of Surgeons
Veterans Administration, Washington, D.C.

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

COUNCIL ON
MEDICAL EDUCATION

COPY April 10, 1972

Frank L. Iber, M.D.
Chief of Medicine
Lemuel Shattuck Hospital
170 Morton Street
Boston, Massachusetts 02130

Dear Dr. Iber:

At its most recent meeting, the Residency Review Committee in Internal Medicine, representing the American Board of Internal Medicine, the American College of Physicians, and the Council on Medical Education, reviewed the straight medical internship and residency programs at Lemuel Shattuck Hospital (to include Faulkner Hospital).

The Committee continued approval of the internship and residency programs without qualification.

With best wishes for the continuing success of your graduate medical education program.

Yours very sincerely,

George Mixter, Jr., M.D.
Secretary
Residency Review Committee
in Internal Medicine

GM/rmd

cc: Administrators of the following hospitals:
Lemuel Shattuck Hospital
✓Faulkner Hospital
American Board of Internal Medicine
NIEMP

THE SETTING OF AAMC PRIORITIES

At the December Executive Council and COD Administrative Board meetings, the process of setting priorities for Association activities was questioned. It was agreed that this would be an agenda item at the March meetings. Of particular concern was the fact that the Report of the Retreat was handed out at the December meetings, and that the Councils were asked to vote on the recommended priorities without any advance consideration.

In recent years, the setting of priorities, or more accurately, the establishment of objectives, has been accomplished by a two-day Officers' Retreat. This conference is attended by the Chairman and Chairman-Elect of the AAMC and each of its constituent Councils, the OSR Chairperson, and the Executive Staff. The agenda is developed by the AAMC Chairman, President and staff in the 2 - 3 weeks immediately following the Annual Meeting. Because the first meeting of the Executive Council is usually held within 4 - 6 weeks after the Annual Meeting, the Executive Council agenda is printed and mailed prior to the Retreat. In 1973, the Retreat was actually held only one week prior to the Executive Council meeting.

The AAMC Bylaws require that "the annual meeting of the Executive Council shall be held within eight (8) weeks after the annual meeting of the Assembly..." Since the Annual Meeting usually falls during the first two weeks of November, and since the Christmas holidays prevent meetings toward the end of December, this eight week time frame is condensed to 4 - 6 weeks.

The Retreat Mechanism

Meeting in a retreat setting for a two-day conference seems to foster closer communications among the participants, particularly during informal discussions. The retreats have generally been successful in providing a total orientation to the Association's activities and, more specifically, to the types of issues which the AAMC must face in meeting the demands of its membership.

RECOMMENDATION: That the AAMC continue the procedure of holding a retreat for the purpose of establishing goals and priorities.

Developing the Retreat Agenda

Historically, the agenda for the retreat has been developed by the staff in conjunction with the Chairman. This has been due, in part, to the severe time constraint of writing, printing and mailing the agenda within 2 - 3 weeks after the Annual Meeting. On one occasion (1971), the Executive Council directed the retreat to consider a specific issue and present a recommendation to the Council.

Increased Executive Council input into developing the retreat agenda is both possible and desirable. Executive Council members should be asked to recommend issues which retreat participants might consider during the discussion of goals and priorities. However, it remains vital to the mission of the retreat that the agenda be coordinated centrally, taking into account the time available for discussion and focusing the agenda to facilitate the efficient consideration of issues.

RECOMMENDATION: That the AAMC Executive Council and Administrative Boards, as part of their September meetings, discuss the agenda of the retreat and suggest items which they feel to be pressing concerns which the Association needs to address in the coming year. The full Councils will also be asked to contribute suggestions at their November meetings. The staff in conjunction with the AAMC Chairman should continue to organize and coordinate the agenda items.

Timing of the Retreat

It is advantageous to continue holding the retreat soon after the Annual Meeting, although the present timetable might be relaxed. This is important since the "governing" year begins at the Annual Meeting with the change of officers and Executive Council members. Since a major function of the retreat is to acquaint these new officers with the staff members, with each other, and with the ongoing programs of the Association, this retreat is most valuable if held before the first meeting of the new Executive Council.

RECOMMENDATION: That the retreat continue to be scheduled between the Annual Meeting and the first Executive Council meeting. The timing between these functions should be relaxed to allow more time for circulation of the retreat agenda and to allow more time for circulation to the Executive Council of the retreat recommendations.

Executive Council Consideration of Priorities

The Executive Council will continue to review and approve the priorities recommended by the Retreat. For this purpose, additional time should be provided between the Retreat and the first Executive Council meeting (3 - 4 weeks). The Executive Council might also be allowed more time to discuss the Retreat recommendations and Association priorities prior to its regular

business meeting.

RECOMMENDATION: That the first meeting of the Executive Council be held in January and be expanded to two days (Thursday and Friday). Administrative Board meetings would then be shifted back to Wednesday. Title VI, Section 4 of the AAMC Bylaws should be amended to read, "The annual meeting of the Executive Council shall be held within 120 days after the annual meeting of the Assembly. . ."

RESOLUTION ON SAFEGUARDING DATA SYSTEMS

The following resolution was approved by the OSR Administrative Board and forwarded for Executive Council action:

> WHEREAS, there are both potential and realized harmful consequences that may and have resulted from the use of automated and nonautomated personal data systems.
>
> RESOLVED that the AAMC urge its member institutions to establish a mechanism with representation of all constituent groups within the academic health center and/or the medical college to develop a set of "safeguard requirements" for automated and nonautomated personal data systems that includes the following points:

a. There must be no personal data record-keeping systems whose existence is secret.

b. There must be a way for an individual to find out what information about him is in a record and how it is used.

c. There must be a way for an individual to be informed when information about him that was obtained for one purpose is being used or made available for other purposes without his consent.

d. There must be a way for an individual to correct or amend a record of identifiable information about him.

e. Any organization creating, maintaining, using or disseminating records of identifiable personal data must assure the reliability of the data for their intended use and must take precautions to prevent misuse of the data.

RECOMMENDATION

That the Executive Council Approve the following statement:

> The AAMC urges its member institutions to establish a mechanism for monitoring automated and nonautomated personal data systems which includes the following points:

a. There should be no personal data record-keeping systems whose existence is secret.

b. There should be a way for an individual to find out what information about him is in a record and how it is used.

c. There should be a way for an individual to be informed when information about him that was obtained for one purpose is being used or made available for other purposes without his consent.

d. There should be a way for an individual to correct or amend a record of identifiable information about him.

e. Any organization creating, maintaining, using or disseminating records of identifiable personal data should assure the reliability of the data for their intended use and should take precautions to prevent misuse of the data.

AAMC RESPONSE TO THE IOM REPORT

The report of the Institute of Medicine study, Costs of Education in the Health Professions, was released on February 26. Due to some printing errors, only a limited number of copies were released at that time. The IOM has promised that the Executive Council would be furnished with copies prior to their March 22 meeting.

It will be necessary for the AAMC to react officially to the IOM report, particularly when discussing renewal of the expiring health manpower authorities.

RECOMMENDATION

That the Executive Council approve the following points as the basis for any AAMC response to the IOM report:

1. The AAMC agrees with the IOM recognition that the federal government has a role in providing ongoing support for health professions education.

2. The AAMC supports the IOM position that the federal role in supporting health professions education may be best administered through first-dollar capitation support, dependent on maintaining the present production of graduates.

3. The level of capitation for medical education recommended by the IOM ($2,450 - 3,900) corresponds to the basic capitation support level recommended by the AAMC Committee on Health Manpower ($3,000).

4. The concept of health professional education as including components of instruction, research, and provision of health services which was utilized by the IOM in allocating costs is similar in principle to the judgments of the AAMC's Sprague Committee.

5. There is remarkable agreement between the IOM cost figures and those determined by the AAMC's Sprague Committee, despite the empirical judgments involved in allocating costs in the highly complex process of educating physicians.

6. The AAMC is attempting to identify the reasons for differences in the costs determined by the two studies.

Association of American Medical Colleges

GRADUATES OF FOREIGN MEDICAL SCHOOLS IN THE UNITED STATES

A CHALLENGE TO MEDICAL EDUCATION

Report to the EXECUTIVE COUNCIL from the

Task Force on Foreign Medical Graduates

February 15, 1974

FOREWORD

In August of 1973 a Task Force on Foreign Medical Graduates was appointed by the Executive Council with the following membership:

Kenneth R. Crispell, M.D.	- Chairman, University of Virginia
Martin S. Begun	- New York University School of Medicine
George E. Cartmill, M.D.	- Administrator, Harper Hospital and Wayne State University
Merlin K. DuVal, M.D.	- University of Arizona
Rolla B. Hill, Jr., M.D.	- State University of New York, Upstate Medical Center
Robert Q. Marston, M.D.	- University of Virginia
Max Michael, Jr., M.D.	- Jacksonville Hospitals Educational Program and University of Florida
Robert J. Weiss, M.D.	- Harvard University
Joseph M. White, M.D.	- University of Missouri at Columbia

The Task Force met on four occasions, namely October 5, November 30, December 27, 1973 and January 28-29, 1974. In its deliberations the Task Force was assisted through the participation of Dr. Emanuel Papper, Chairman of the Council of Deans. It also wishes to thank Dr. Betty Lockett of the Health Resources Administration for her contributions and particularly for providing background documentation for the work of the group. Representatives of AHA (Dr. John G. Freymann), AMA (Dr. Raymond Holden) and HRA (Dr. Harold Margulies) provided helpful comments and criticism at a crucial stage in the deliberations of the Task Force.

Statistical data contained in the text and tables were obtained from the following sources:

- "The Foreign Medical Graduate and Physician Manpower in the United States", BHRD/DMI/OIHMS, Report No. 74 - 47, prepared by Betty A. Lockett and Kathleen N. Williams, Washington, D. C., DHEW - HRA, BHRD, August 1973.
- The American Medical Association and its published statistics.
- Annual reports and other communications of the Educational Council for Foreign Medical Graduates.
- The National Board of Medical Examiners.

As outlined in the terms of reference for the Task Force, the group restricted its concern to those problem areas of the FMG which fall within the sphere of responsibility and authority of the membership of the Association. For this reason the report of the Task Force intentionally is limited to issues of education and quality of medical services, two areas of particular concern to the AAMC.

BACKGROUND AND INTRODUCTION

Throughout the history of the United States immigration has contributed towards the overall development of the work force in the country. The medical profession has been no exception. The arrival of physicians educated abroad, however, and their integration in the United States systems of medical education and service has reached unusual proportions in recent years. Furthermore, many American college graduates have sought medical education abroad and are now beginning to return home with a medical degree earned in a foreign country. These students add a domestic dimension to problems which stem from the rapidly increasing number of foreign medical graduates (FMG)[1] entering the country and being licensed to practice. The complexity of education, accreditation and licensure in medicine further complicates the situation.

The Phenomenon

The basic trend of admitting FMGs into the United States is represented in table 1. It shows that in a little over a decade the number of FMGs in the United States has increased four times more rapidly than has the total physician supply. FMGs are approaching 20 percent of all physicians and one-third of all hospital and residency training posts are filled by them. In 1972 more graduates of foreign medical schools entered the United States than physicians were graduated by our own schools, and 46 percent of all newly licensed physicians in that year were FMGs.

The Immigration and Naturalization Act Amendments of 1965 have had a major impact on the migration of FMGs to the United States. Termination of the national quota system previously in effect opened avenues of entry to the United States for physicians trained in countries where, even in the face of major unmet health needs, the available physician supply appeared to exceed effective economic demand. In addition, preferential immigration status was assigned to professional and occupational skills presumed to be in short supply nationwide, including medicine and other health skills. The result was that physicians from developing countries began to take advantage of the opportunity to immigrate to the United States regardless of their ability to meet licensure requirements in this country.

Foreign-born FMGs are admitted to the United States both as immigrants (permanent residents) and as nonimmigrants (primarily exchange visitors). In the eleven years ending June 1972, over 50,700 physicians entered this country as exchange visitors, the great majority for graduate medical education. Since 1967 about 44 percent of all physicians entering the United States have been immigrants and 52 percent exchange visitors. This has begun to change, however.

---

1) For the purpose of this document a foreign medical graduate is a physician who has completed the requirements for graduation from medical school and for practice in a country outside the United States, Canada, and Puerto Rico.

In 1971 and 1972 more physicians were admitted as immigrants (53 and 63 percent respectively) than as exchange visitors. A major portion of these admitted immigrants, however, were FMGs who converted from nonimmigrant status while residing in this country. Legislation in 1970 facilitated this trend by eliminating the requirement that exchange visitors be absent from the United States for a period of two years after ending their studies, provided they were from countries where their special skills are not in short supply.

There is an emerging group of American-born FMGs who seek medical education abroad after failing to gain admission to a medical school in the United States. They request entry into the American medical education system at various stages of their training. Accurate figures regarding these students are not available, but it is estimated that as many as 6,000 students are currently enrolled in medical schools abroad compared with 50,716 students in American medical schools in September of 1973. According to a recent survey carried out by the Division of Manpower Intelligence of the Bureau of Health Resources Development, in 1971-1972 medical schools of Latin American universities had 2,045 American students enrolled, 91 percent of whom were at the Universidad Autonoma de Guadalajara in Mexico. In 1970 AAMC initiated the Coordinated Transfer Application System (COTRANS) which arranges for qualified American students to take Part I of the National Board Examination and apply for transfer into a United States medical school. As of May 1973 a total of 442 American students had been admitted through this mechanism to domestic medical schools for advanced standing.

Evaluation of FMGs for Admission

Admission to graduate medical education programs and to state licensure examinations generally is predicated on the fact that the graduate has met the education requirements of an accredited medical school in the United States or Canada. Before 1955 the Council on Medical Education of AMA attempted to approximate the system of evaluating medical education in the United States by preparing a list of foreign medical schools considered of sufficient quality for graduates to be admitted into domestic graduate medical education programs. Because this practice proved unsatisfactory, the Educational Council for Foreign Medical Graduates (ECFMG) was established as an independent agency sponsored by AAMC, AHA, AHME, AMA, and FSMB to develop a system of certifying minimal educational accomplishments of FMGs. For certification the ECFMG uses two criteria-proof that the candidate has fulfilled all requirements of a medical school listed in the World Directory of Medical Schools published by the World Health Organization, and a satisfactory score on an examination furnished by the National Board of Medical Examiners. The examination is prepared by a test committee from questions provided by the NBME. Eighty percent of the questions are taken from Part II of the National Board Examination.

Since its inception in 1958 the ECFMG has organized a worldwide network of 178 examination centers in which a cumulative total of 313,885 examinations has been given to 178,325 candidates. The overall pass rate including all repeaters through 1972 is 67 percent. Upon the first try 45 percent obtain a passing score, while a decreasing percentage of those who fail in the first attempt pass in subsequent tries. There is great variation in performance of FMGs from different countries and from different schools within some countries.

Some Characteristics of FMGs

Country of Origin - Until recently the majority of FMGs came from European or other countries with standards of medical education similar to those in this country. As a consequence of the amendments to the Immigration and Naturalization Act passed by Congress in 1965, the number of physician immigrants from Asian and other developing countries increased rapidly. As table 2 shows, 27 and 12 percent of the 2,093 physician immigrants came from Europe and Asia respectively in 1963, while the corresponding figures for 1972 were 13 and 70 percent out of a total 7,143 FMGs. This represents a major shift in nationality of physicians coming to the United States and also in the nature and quality of their medical education because one should not expect medical education offered in developing countries to be the same as that of economically and technically developed nations.

Performance - In objective-type examinations FMGs perform at a lower level than do graduates from American medical schools. Thus, in the past few years the failure rate in the ECFMG examination (score below 75) has varied from 67.4 to 56.9 percent, while students or graduates of American schools have had a failure rate of 14 percent on Part I and 2.5 percent on Part II of the National Board Examination. In FLEX (Federation Licensure Examination) 50 percent of FMGs have passed versus 85 percent of graduates from American schools. In Specialty Board Examinations the failure rate in 1972 was 63 percent for FMGs and 27 percent for domestic graduates. It must be emphasized that there is a much wider spread of performance with FMGs and that some perform as well as domestic graduates. It is generally acknowledged, though not proven, that the medical care rendered by some FMGs is of poorer quality than that rendered by graduates from domestic schools. American FMGs have a similar if not greater failure rate in the ECFMG examination than foreign-born FMGs. This suggests that language difficulties do not significantly influence performance in standardized examinations of this kind.

Specialty and Geographic Distribution - As shown in table 3, FMGs are distributed by specialty in much the same way as physicians educated in the United States. They are concentrated largely in the five major specialties and general practice chosen by United States graduates. Approximately 52 percent of FMGs versus 57 percent of graduates from domestic medical schools select internal medicine, pediatrics, general surgery, obstetrics and gynecology, psychiatry, and general practice.

Proportionally more FMGs are in specialties such as anesthesiology and physical medicine, while fewer FMGs are in dermatology, and orthopedic surgery. In addition, FMGs are disproportionately found in some residency programs. For example, residencies in general practice, physical medicine, colon and rectal surgery, anesthesiology, and pathology are more than 50 percent filled by FMGs. This may imply in the future a smaller supply of physicians born and educated in the United States for these specialties.

Therefore, in the aggregate FMGs are distributed along the same lines as our own graduates, although for certain specialties there is a differential distribution between FMGs and graduates from domestic medical schools. It remains to be seen whether this differential in enrollment in residency programs will have any impact on specialty distribution in practice at a later time.

The participation of FMGs in the practice of medicine has further distorted the geographic distribution of physician manpower in this country. It has been shown that they follow a similar pattern as that of physicians educated in the United States and tend to concentrate in cities.

State Institutions - In many states the demand of public institutions for physicians is accommodated by special licensure provisions for FMGs not fully qualified to practice. The extent to which these FMGs are employed and the impact of their activities on medical care are not known. However, anecdotal evidence suggests that much health care delivery in the public sector depends on physicians not fully qualified but willing to accept working conditions and income levels qualified physicians will not accept.

Academic Medicine - Many FMGs have entered careers in academic medicine in this country. Usually these are physicians who either already have established a reputation in their home country and found the working conditions more attractive in an American institution or have demonstrated unusual capabilities within an American graduate program and entered into an academic career in this country. In 1970 there were 4291[1] FMGs in academic positions (including medical education and research) representing 7.5 percent of all FMGs in the United States at that time. This percentage is slightly greater than that of United States medical graduates (about 5 percent). Today our medical schools have 4,165 FMGs out of a total of 34,658 salaried physicians on their full-time and part-time academic staff. The contribution of FMG scientists to American medical science has been substantial.

Dual Standards

The present policy for certifying FMGs has led to a system of dual standards for admission to graduate medical education in this country. To illustrate, figure 1 gives a graphic representation of the three programs in the continuum of medical education offered in the United States. It shows that the quality of the student's educational experience and performance is ascertained by the following:

- Accreditation on a national or regional basis of the three required education programs offered consecutively by a college or university, a medical school, and a teaching hospital.

- Selection of students for each program on the basis of performance in the previous program, or scores obtained in national entrance examinations, and broader judgement by a selection committee of the institution.

- Internal evaluation of the student by the faculty in a continuing fashion and final certification by the faculty for awarding the degree.

---

1) This figure includes U.S. born FMGs.

- External evaluation of the student by Parts I and II of the National Board Examination (83 of 116 medical schools require the student to take the National Board Examination, while 26 of these schools make a passing score a requirement for promotion or graduation).

- External evaluation for licensure through FLEX (unless the candidate has already received a passing score on the National Board Examination) and for specialty certification by specialty board examination.

The majority of FMGs now applying for admission to graduate medical education has not been screened by equivalent selective internal and external evaluation processes. Furthermore, with notable exceptions, in most countries there is no accreditation system similar to our system. In general, the intensity and quality of the learning experience in the United States is attained by a high faculty student ratio, adequate educational and clinical resources, a competitive situation, and the exposure of the student to the institution's research atmosphere. Finally, by incorporating the student into the medical care programs of the teaching hospital United States medical schools guarantee the American student a participatory role in clinical medicine, while in most schools abroad the clinical student is an onlooker. It may be concluded that while many medical schools abroad are outstanding and excel in many of these same features, the United States medical school provides a more intensive learning experience to the student than those institutions from which a large proportion of the FMGs have graduated. Beginning with the extensive premedical education in colleges, the United States educational continuum results in a physician-graduate of considerable personal maturity and professional sophistication in the art and science of medicine.

The present mechanism by which FMGs are admitted into graduate medical education programs implies that the ECFMG examination is a substitute for assessing the quality of the educational process over a period of four to six years and for selecting and evaluating the student for admission and promotion during this period. In reality, there is no examination available for measuring professional competence. Hence we are faced with dual standards for admission and are condoning the evolution of a dual system of graduate medical education. Currently, a little over one-half of the physicians entering the American system are products of accredited United States medical schools, while the balance for the most part represents products of unaccredited education systems. This double standard results in wide disparity in the quality of the physicians admitted to deliver care in the United States. It undermines the process of quality medical education in this country and ultimately poses a threat to the quality of care delivered to the people.

The FMG's Advocate

The notion that American medical education is rendering a service to foreign doctors by permitting them to enter our system in large numbers must be challenged on several counts. The FMG coming to this country faces difficult and disadvantageous conditions which in many instances offset the potential benefits to be gained from entering the education system. Some of these problem areas are:

- Differences in culture and daily life resulting in isolation.

- Learning of a new language.

- Acceptance into a setting which imposes excessive responsibility for patient care without adequate supervision and educational content.

- General stigma associated with the status of being an FMG and therefore lack of full acceptance on a professional basis.

- Need to accept positions under unfavorable working conditions and with relatively low salary.

- Acceptance of lower performance level.

- Fear and threat of failure.

The present system of accepting FMGs into the United States and incorporating them into our medical education and care systems has created a category of second-class physicians. From an educational and ethical point of view, this is undesirable.

The Task Force's Response

In reviewing the benefits and problems which accompany the admission of FMGs to the United States the Task Force considered many approaches. Although the prohibition of medical practice by FMGs could be considered a possible solution, the long history and ideals of the United States regarding immigration policy make this unacceptable. It was agreed that any recommendations should be in accord with two major considerations, namely that:

- Medical schools in the United States presently are able to identify outstanding candidates for educational programs which prepare physicians, provide programs of quality medical education to students of medicine, and deliver highly qualified physicians in sufficient numbers into the medical care system of this country. With the rapid increase of enrollment by students in our medical schools (15,000 by September 1975), it is anticipated that our basic need for physicians in the 1980's presumably can be satisfied from domestic sources. If the anticipated number of graduates is insufficient to meet our nationally conceived need for physicians, adequately planned and financed programs should be initiated to increase further the class size of domestic medical schools. It seems inappropriate that the United States with its existing resources should depend to any significant degree on physicians supplied by education systems of other countries.

- The dual standards in admission of United States and foreign medical graduates must be reduced in the interest of quality of medical education and care, as well as for the benefit of foreign graduates who come to this country to achieve medical excellence. Ultimately nobody can gain from the continued existence of two classes of physicians.

The Task Force is aware of the consequences that corrective measures may have on the number of FMGs gaining admission to graduate medical education in the United States. Because the implications of the present trend are so vast, it recommends that steps be taken to minimize the difference in admission standards between graduates of domestic and foreign medical schools, in spite of the fact that complete equality cannot be achieved rapidly and that some hospitals will be faced with a shortage of housestaff during an intermediary period of time. The recommendations do not address themselves to the licensing process except for the loopholes which permit unqualified FMGs institutional medical practice without adequate supervision.

The Task Force recognizes the similarity between these recommendations and those made by the National Advisory Commission on Health Manpower in 1967 (pp. 71-81 of volume 2 of the Commission Report). For their implementation close collaboration among concerned government and private agencies is required. The Task Force urges the AAMC to initiate such concerted action.

RECOMMENDATIONS

The Task Force recommends the following policies to the AAMC for adoption and implementation by the constituency in collaboration with related agencies:

1. Physician Manpower - Medical schools of the United States must become the major source for educating physicians to satisfy the need for physician services to the American people. This country should not depend for its supply of physicians to any significant extent on the immigration of FMGs or on the training of its own citizens in foreign medical schools. If the anticipated need for physicians exceeds present or future enrollment in our medical schools, appropriate measures including adequate funding must be taken to enlarge the student body accordingly. Since there is a delay of seven to ten years until a corrective increase in first year medical school admissions first becomes manifest in terms of physician manpower, a continuing analysis of our physician needs is called for.

2. Admission Criteria - The process of certifying FMGs for admission to graduate medical education programs in the United States is inequitable and inadequate. In order to apply the same standards to all medical graduates, it is recommended that a generally acceptable qualifying examination be made a universal requirement for admitting all physicians to approved programs of graduate medical education. Until another such examination may become available, Parts I and II of the National Board Examination should be employed for this purpose. FMGs can register for this examination only after having demonstrated an acceptable command of spoken and written English. Part III of the National Board Examination or some other method for determining clinical competence should be required for continuation beyond the first year of graduate medical studies or for direct admission to advanced standing in graduate medical programs.

3. Approval of Programs of Graduate Medical Education - In order to ensure all medical graduates of a continuing exposure to quality education, regulations for the approval of programs of graduate medical education must be strictly enforced. The regulations should emphasize the educational function of these programs. In addition, the relative number of FMGs permitted in any program should be limited and geared to the educational resources of the program. Effective adaptation and enculturation cannot be expected unless special efforts are made and there is a balance between American and foreign graduates in the program. Since undergraduate and graduate medical education are considered integral parts of an educational continuum, it is also recommended that the number of first year positions in approved programs of graduate medical education be adjusted gradually so as to exceed only slightly the expected number of graduates from domestic medical schools, but provide sufficient opportunities to highly qualified FMGs.

4. Pilot Project - Because examinations to determine the professional competence of the physician are still in a developing stage it is recommended that a pilot project be initiated for the enrollment of a limited number of FMGs as students in modified undergraduate medical education programs in United States institutions. The objectives of this project to be undertaken by AAMC and interested medical schools, are to identify the educational deficiencies of FMGs and provide supervised learning experiences to correct these deficits with the goal of bringing the FMG to a level of professional competence similar to that reached by graduates of domestic schools. In this project preference should be given to United States citizens and may include American students enrolled in foreign medical schools qualified for participation in the COTRANS program.

5. Loopholes - On the basis of temporary licenses or exemptions from licensure provisions, a large but unknown number of FMGs is delivering medical services in institutional settings such as state institutions and other medical service organizations. They are active in this capacity without having qualified either for graduate medical education or licensure. The indefinite continuation of unsupervised medical practice on this basis without minimal involvement in approved graduate medical education should be discontinued. It is recommended that AAMC join with the American Hospital Association, the American Medical Association and other agencies to bring this problem to the attention of the Federation of State Medical Boards in a concerted effort to seek and implement appropriate solutions.

6. Hospital Patient Care Services - These recommendations when implemented undoubtedly will reduce the number of FMGs qualified for appointment to positions in graduate medical education. Therefore, new methods must be developed to ensure patient care services in many hospitals. The Task Force believes that other health care personnel can be trained to provide under physician supervision many of the services now required to be rendered by physicians. Projects to study and demonstrate the engagement of such personnel in institutional care settings should be undertaken immediately. Ultimately, the efficient utilization of such personnel depends on appropriate education of the health care team, particularly physicians, and thus is a conjoint responsibility of medical and other health profession faculties.

7. Special Categories - The Task Force recognizes two groups of FMGs who require special consideration. The first group is represented by those physicians who seek a temporary educational experience with the intent of returning to their home country. These physicians should be admitted to graduate medical education programs without having to pass Parts I and II of the National Board Examination in those instances when the FMG enters with a visitor exchange visa and has a statement describing the proposed program of study. This program should have the concurrence of the American institution accepting the physician, the FMG's home institution, and the governmental or private agency interested in the FMG's education and continuing employment. Furthermore, the American institution should not plan to continue the FMG's engagement beyond the training period, which usually should be limited to two years.

The second group encompasses FMGs who have established reputations as medical academicians and are appointed by medical schools as visiting scholars. Unless the respective state licensing boards prescribe differently, temporary exemptions from the requirement specified under recommendation two should be accorded these FMGs provided they are visiting members of a medical faculty and their involvement in the practice of medicine is limited to patient care related to their teaching obligations. The granting of these exemptions should be based on a policy agreed upon nationally and should cover a delimited period of time. FMGs who serve on medical faculties as teachers and scientists without patient obligations including supervision of those who render patient care do not fall within the purview of these recommendations.

8. Time Table - A realistic time table should be established for implementation of these recommendations.

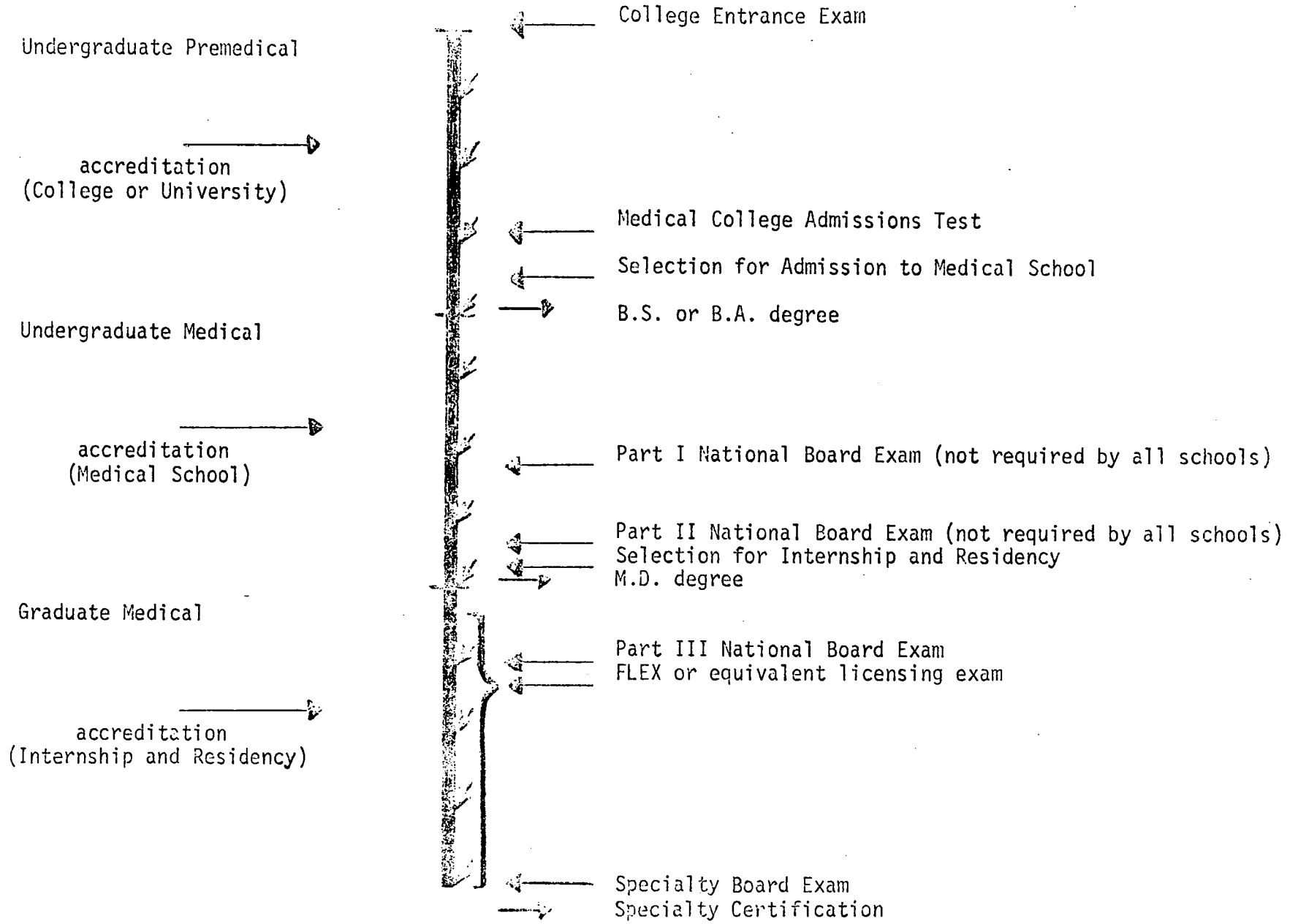


Figure 1: Continuum of medical education - Included are the points at which selection and internal and external evaluation of the student occurs (at right of graph). At the left accreditation of the programs is indicated. (⌐ indicates internal evaluation)

TABLE 1

Ten Years Trend in Admission, Employment and Licensure of FMGs and Graduates of Domestic Medical Schools

	1962	1963	1964	1965	1966	1967	1968	1969	1970	1971	1972	1973
ECFMG												
No. Exams Administered	14,535	19,130	18,511	18,337	18,988	19,188	19,548	22,598	29,950	31,033	32,072	37,083
No. Candidates Passed	6,054	6,043	6,820	7,724	7,842	8,770	7,774	8,127	11,916	9,693	12,837	12,[illegible]
No. FMGs Certified	not available before 1966 --				6,699	5,364	6,142	4,686	5,436	6,886	8,712	6,227
Admission to U.S.												
Exchange Visa	3,970	4,637	4,518	4,160	4,370	5,204	5,701	4,460	5,008	4,784	3,935	4,613
Immigrants	1,297	2,093	2,249	2,012	2,552	3,326	3,128	2,756	3,158	5,756	7,142	7,119
Total*	5,767	6,730	6,767	6,172	6,922	8,897	9,125	7,515	8,523	10,947	11,416	12,285
U.S. Graduates	7,168	7,264	7,336	7,409	7,574	7,743	7,973	8,059	8,367	8,974	9,551	10,391
Graduate Medical Education												
Interns:												
U.S.	6,900	7,136	7,070	7,296	7,309	7,573	7,506	7,194	7,869	8,213	8,120	7,239
FMG	1,273	1,669	2,566	2,821	2,361	2,793	2,913	3,270	2,939	3,339	3,946	3,924
Total	8,173	8,805	9,636	10,097	9,670	10,366	10,419	10,464	10,808	11,552	12,066	11,163
Residents:												
U.S.	21,914	22,177	22,433	22,852	22,765	22,548	23,116	23,816	25,013	26,495	28,970	30,610
FMG	7,723	7,062	7,052	8,153	9,133	9,502	10,627	11,231	12,126	12,968	13,543	14,471
Total	29,637	29,239	29,485	31,005	31,898	32,050	33,743	35,047	37,139	39,463	42,512	45,081
Licensed to Practice												
U.S. Graduates	6,648	6,832	6,605	7,619	7,217	7,267	7,581	7,671	8,016	7,943	7,815	not yet
FMGs	1,357	1,451	1,306	1,528	1,634	2,157	2,185	2,307	3,016	4,314	6,661	avail-
Total	8,005	8,283	7,911	9,147	8,851	9,424	9,766	9,978	11,032	12,257	14,476	able
Physicians in U.S.												
U.S. Graduates		245,550						271,390	276,811	282,[illegible]	[illegible],525	not yet
FMGs		30,925						53,552	57,217	62,214	[illegible],[illegible]	avail-
Total	268,000	276,475	284,224	292,088	303,375	308,630	317,032	324,942	334,028	344,[illegible]	[illegible],[illegible]	able

* Beginning in 1967 the total includes other categories of non-immigrant physicians.

TABLE 2

Country or Region of Emigration of FMGs for 1963 and 1972

Year	Europe		Canada		Latin America *		Asia		Other °		Total
	No.	%	No.	%	No.	%	No.	%	No.	%	No.
1963	575	27.5	467	22.3	580	27.7	260	12.4	211	10.1	2093
1972	911	12.7	439	6.4	372	5.1	4996	69.9	425	5.9	7143

* Includes South America, Mexico and Cuba.
° Includes Africa, Oceania, and selected countries of the Americas.

TABLE 3

Selected Specialty Distribution of FMG's and U.S. Medical Graduates as of 1970

Specialty	All Physicians		Foreign Medical Graduates *		U.S. Medical Graduates	
	Number	Percent	Number	Percent	Number	Percent
Internal Medicine	41,872	12.5	6,894	10.9	34,978	12.9
Pediatrics	17,941	5.4	3,787	6.0	14,154	5.2
General Surgery	29,761	8.9	5,748	9.1	24,013	8.9
Ob-Gyn	18,876	5.6	3,403	5.4	15,473	5.7
Psychiatry	21,146	6.3	5,588	8.7	15,558	5.8
Subtotal 1	129,596	38.8	25,420	40.1	104,176	38.5
General Practice	57,948	17.3	7,512	11.9	50,436	18.6
Subtotal 2	187,544	56.1	32,932	52.0	154,612	57.1
Other	146,484	43.9	30,459	48.0	116,025	42.9
Grand Total	334,028	100.0	63,391	100.0	270,637	100.0

* Including graduates from Canadian medical schools.

Table I-F—State Origin of Medical Education of Interns and Residents, and Distribution of House Officers by State.

STATE	INTERNS					RESIDENTS					INTERNS AND RESIDENTS			
	Interns in State with M.D. from School in State	Nonforeign Grads. with M.D. from Other States, or Canada, U.S.	Can.	Foreign Graduates in Internships in this State	Total Interns in States	Residents in State with M.D. from School in State	Nonforeign Grads. with M.D. from Other States, or Canada, U.S.	Can.	Foreign Graduates in Residencies in this State	Total Residents in State	Total Interns and Residents in State with M.D. from State	Other US & Can. Grads. Interns and Residents in State	Total Foreign Interns, Residents in This State	Total House Officers in the State
Alabama	34	40	..	6	80	143	139	..	40	322	177	179	46	402
Alaska	..	..	..	..	..	..	2	..	..	2	..	2	..	2
Arizona	7	93	..	13	113	16	186	1	85	289	24	279	98	402
Arkansas	36	7	..	..	43	120	41	..	7	168	156	48	7	211
California	419	855	28	41	1,343	1,143	2,851	69	297	4,360	1,562	3,706	338	5,703
Canal Zone	..	14	..	1	15	..	12	..	9	21	..	26	10	36
Colorado	18	151	1	15	185	55	418	4	34	511	73	569	49	696
Connecticut	23	86	..	126	235	76	353	4	397	830	99	439	523	1,065
Delaware	..	18	..	4	22	..	27	1	38	66	..	45	42	88
D. of C.	83	100	..	60	243	177	284	5	283	749	260	384	343	992
Florida	59	174	2	37	272	206	518	10	237	971	265	692	274	1,243
Georgia	41	113	1	23	178	223	290	2	86	601	264	403	109	779
Hawaii	..	17	5	21	43	..	50	7	30	87	..	67	51	130
Idaho	..	..	..	..	..	..	1	..	..	1	..	1	..	1
Illinois	173	120	..	368	661	631	365	14	1,190	2,200	804	485	1,558	2,861
Indiana	108	48	..	4	160	268	109	..	70	447	376	157	74	607
Iowa	19	47	..	13	79	127	167	4	75	373	146	214	88	452
Kansas	45	33	..	..	78	97	119	2	62	280	142	152	62	358
Kentucky	50	36	..	12	98	139	136	2	87	364	189	172	99	462
Louisiana	85	33	..	6	124	362	137	3	93	595	447	170	99	719
Maine	..	14	..	..	14	..	38	1	7	46	..	52	7	60
Maryland	81	143	1	150	375	237	636	14	531	1,418	318	779	681	1,793
Mass.	136	238	..	105	479	455	1,071	56	740	2,322	591	1,309	845	2,801
Michigan	157	135	12	199	503	475	495	37	999	2,006	632	630	1,198	2,509
Minnesota	101	139	6	17	263	294	558	41	162	1,055	395	697	179	1,318
Mississippi	30	25	..	2	57	106	56	..	9	171	136	81	11	228
Missouri	119	87	..	87	293	282	353	6	372	1,013	401	440	459	1,306
Nebraska	63	9	..	4	76	131	30	..	26	187	194	39	30	263
Nevada	..	..	..	..	..	..	4	..	1	5	..	4	1	5
N. Hampshire	..	29	..	..	29	..	74	1	13	88	..	103	13	117
New Jersey	32	28	..	242	302	62	240	2	716	1,020	94	268	958	1,322
New Mexico	3	24	..	..	27	16	133	..	11	160	19	157	11	187
New York	545	376	7	865	1,793	1,637	1,390	55	4,031	7,113	2,182	1,766	4,896	8,906
N. Carolina	40	103	..	15	158	256	452	3	69	780	296	555	84	938
North Dakota	..	8	..	..	8	..	2	..	2	4	..	10	2	12
Ohio	115	216	..	275	606	452	669	24	1,007	2,152	567	885	1,282	2,758
Oklahoma	40	24	..	4	68	120	66	..	28	214	160	90	32	282
Oregon	6	73	1	7	87	73	216	4	26	319	79	289	33	406
Pennsylvania	337	195	..	261	793	999	651	17	1,000	2,667	1,336	846	1,261	3,460
Puerto Rico	43	2	..	17	62	111	6	..	89	206	154	8	106	268
Rhode Island	..	34	..	24	58	..	88	3	111	202	..	122	135	260
S. Carolina	26	21	..	1	48	113	109	1	31	254	139	130	32	302
South Dakota	..	14	..	..	14	..	7	..	1	8	..	21	1	22
Tennessee	75	53	..	8	136	299	205	..	106	610	374	258	114	746
Texas	201	265	..	42	508	641	842	12	351	1,846	842	1,107	393	2,354
Utah	16	48	1	..	65	80	171	5	26	282	96	219	26	347
Vermont	3	24	..	..	27	20	90	1	11	122	23	114	11	149
Virginia	83	124	..	23	230	186	440	2	172	800	269	564	195	1,030
Washington	14	129	1	10	154	78	383	15	50	526	92	512	60	680
West Virginia	15	4	..	11	30	60	28	1	98	187	75	32	109	217
Wisconsin	34	84	1	54	173	213	289	..	159	661	247	373	213	834
TOTALS	**3,515**	**4,653**	**67**	**3,173**	**11,408**	**11,180**	**15,997**	**429**	**14,075**	**41,681**	**14,695**	**20,650**	**17,248**	**53,089**

839 students from one school to a minimum of 597 from the tenth school listed. Among the foreign schools the largest school had 1,243, and the smallest 250, of the students serving as house staff officers.

State Origin of Medical Education of House Staff

Tables I-F and I-G, used together, indicate the relative success of states in retraining for graduate training those physicians who have received their medical education in the state. Studies made some time ago seemed to indicate that physicians tended to practice in the areas in which they received their graduate medical education, and therefore the numbers who remain in the state might serve as one of the predictors of the number of physicians who will be available for patient care in that state.

The relative success of the state can be illustrated, for example, in determining the location of the 75 persons now in internship programs who graduated from the medical school in Alabama; apparently 34 of these accepted internships in the state, and of those who graduated earlier, 143 accepted residencies. A few of these may also be persons who would have been serving an internship, but who went directly into a residency instead. Thus, Alabama retained 177 of its graduates, but it trained 342 who are now serving internships or residencies in the United States, or about 52% of its graduates. The state also attracted 40 U.S. or Canadian graduates from other medical schools outside of Alabama, and 139 residents, for a total of 179. These two groups of U.S. and Canadian graduates gave the state, along with graduates of its own school, a total of 356 house officers, which put it in balance with the number having received their medical education in that state. The 46 foreign graduates serving in the state brought the total number of house officers in Alabama to 402, thus giving it more physicians serving as house officers than it had trained out of the total group available.

For California, 419 interns remained in the state after they have received their M.D. degree from a medical school in that state, and 1,143 residents remained in the state. Medical schools in the state had conferred M.D. degrees on 594 of the physicians currently serving as interns throughout the United States, and on 1,631 residents currently serving in the United States who received an M.D. degree from a medical school in California. The state attracted however, 855 graduates of medical schools in other states or in Canada, who are now serving as interns in California. Likewise, the number of residents who received an M.D. degree from other states or from Canada was a total of 2,851, so that the total number of interns and residents with an M.D. degree from a school in California was 1,562, indicating that 70% of the California graduates remained in that state and 30%

MODIFICATION OF THE HILL-BURTON PROGRAM

Legislative authority for the Hill-Burton hospital construction assistance program is to expire June 30, 1974. The President's fiscal 1975 budget requested no new funds for the program, and the Administration is not currently proposing to request extension or modification of the program. Nevertheless, Congress is almost certain to consider legislation to modify and continue some form of federal assistance in hospital construction.

Because of the importance of the Hill-Burton program in the past to some Association constituents, it is thought the Association may wish to take part through testimony or other means in Congressional action extending and modifying the program. The guidance of the Executive Council is being sought.

Present options available through pending legislative proposals, budget recommendations and past AAMC staff suggestions include the following:

1. Extend the present program without change.

2. Let the program expire, as proposed by the Administration.

3. Extend and modify the program as proposed in a 1972 AAMC staff memorandum: shifting the emphasis from construction of new hospitals to modernization of existing facilities and construction of outpatient facilities; replacing the rural-biased allotment formula with a more equitable formula based on need; increasing the emphasis on assistance for teaching hospitals and outpatient facilities; calling for priority assistance to projects for facilities which will promote the use of innovative and experimental methods of construction and methods of providing hospital and outpatient care.

4. Convert the program from a formula to a project-grant basis, with or without priorities for urban versus rural hospitals or for certain kinds of facilities, as proposed in legislation (S 2983) introduced February 7, 1974, by Senator Javits, and supported by the Council of Urban Health Providers.

5. Convert the program to a DHEW-administered direct loan and loan guarantee program, as proposed in legislation (HR 12053) introduced December 20, 1973, by Congressman Rogers as part of his RMP-CHP proposal.

RECOMMENDATION: The Executive Council select one of the above options or propose an additional option and authorize the AAMC staff to participate appropriately in any legislative process necessary to carry out the designated option.

MODIFICATION OF RMP-CHP PROGRAMS

The legislative authorities for Regional Medical Programs and Comprehensive Health Planning expire June 30, 1974, and there is no discernible interest in Congress to extend these programs in their present form. Both Senator Kennedy and Representative Rogers have introduced proposals which would combine these two programs into a single health planning system. In addition, the fiscal 1975 budget indicates that the Administration is also planning to introduce legislation which would replace RMP and CHP with a single regional planning system. Included in all three proposals are provisions to strengthen governmental efforts to regulate the health industry. Congressional action on the issue is likely in the near future.

In March of 1973, the Association drafted its own legislative proposal for health planning, but this bill may not continue to reflect the Association's position in light of the renewed Congressional interest in planning and regulatory legislation. The Executive Council may wish to reconsider some of the issues basic to the health planning and regulatory processes. The following outline focuses on three key issues in health planning and regulation: the power to develop a health plan, the power to regulate aspects of the health industry, and the power of the planning body to carry out or enforce its health plan. Decisions on each of these problem areas need to be made in order to arrive at a decision on supporting the pending bills.

I. There are many possible areas of government interest in health planning and health industry regulation.

   A. Planning may take place at some level of authority for the following health needs:

      1. Health manpower,

      2. Health care facilities,

      3. Biomedical research,

      4. Health care services delivery, and

      5. Health care services financing.

   B. The authority for the following types of regulation of the health industry may rest at some level of government:

      1. Licensing and certification of health professional manpower,

      2. Licensing and certification of institutional health care providers,

      3. Licensing and certification of health insurers,

      4. Certificate-of-need determination,

      5. Capital expenditure review,

      6. Rate regulation, and

      7. Utilization review and quality control.

II. Once a decision is made to undertake planning or regulation in any of these areas, numerous subsequent decisions must also be made. For each of these functions, the role of the various levels of government must be determined. The following provides a summary of major choices:

A. A federal body should--

1. Perform the planning or regulatory function for the entire nation with or without input from subfederal or other federal bodies;

2. Delegate the planning or regulatory function to subfederal bodies--

a. With or without providing federal financial support for the function,

b. With or without federally-established norms and standards,

c. With or without providing technical assistance; or

3. Do neither.

B. A state body should--

1. Perform the planning or regulatory function for the state--

a. According to federal or its own norms and standards,

b. With or without input from substate or other state bodies,

c. For planning functions, with or without the power to contract with public or private entities to develop plans; or

2. Delegate the planning or regulatory function to substate bodies--

a. With or without providing financial support for the function,

b. With or without state-established norms and standards,

c. With or without providing technical assistance; or

3. Provide comments to a federal body performing the function; or

4. Do none of these.

C. A substate body should--

1. Perform the planning or regulatory function--

a. According to federal, state, or its own norms and standards,

b. With or without input from other planning or regulatory bodies,

c. For planning functions, with or without the power to contract with public or private entities to develop plans; or

2. Provide comments to federal or state planning or regulatory bodies; or

3. Do neither.

III. Once the roles of the various authority levels in health planning and regulation are determined, the relationships among the bodies responsible for planning, regulating, and administering the use of federal health dollars must also be determined. The following provides a summary of major choices:

A. The relationship between planning for health needs and the administration of the expenditure of federal health funds* to meet those needs may take the following forms:

1. The body given the responsibility to develop a plan for a particular health need may also be given the authority to administer a relatively small pool of federal developmental funds to meet that need (implementation power); or

2. The planning body may be given the power to review and approve or disapprove applications to a separate administering body proposing uses of federal health dollars to meet a particular health need (veto power); or

3. The planning body may be given the power to review and comment upon applications to a separate administering body proposing uses of federal health dollars to meet a particular health need (comment power); or

4. The planning body may be given no power in relationship to the administration of federal health funds to meet the need for which it has developed a plan.

B. The relationship of planning bodies to regulatory bodies may take the following forms:

1. A regulatory body may be required to follow the planning body's plan as the basis for its regulatory decisions; or

2. A regulatory body may be required to consider the planning body's plan in its regulatory decisions; or

3. A regulatory body may be allowed to regulate without regard to the planning body's plan.

---

* The federal government expends federal dollars for the following health needs:

1. Health manpower
2. Health care facilities
3. Biomedical research
4. Health care services delivery
5. Health care services financing

Brief summaries of the basically similar health planning bills introduced by Senator Kennedy and Representative Rogers follow. Both bills authorize the federal government to delegate (with federal financial assistance, technical assistance, and norms and standards) the authority to regulate in the areas of certificate-of-need, licensing of health care facilities and manpower, quality control, rate regulation, and capital expenditure review. Both bills also authorize the federal government to delegate (with federal financial assistance, technical assistance, and norms and standards) to substate agencies, the authority to plan for the area's health facilities, manpower, and service needs. These area planning agencies are given the power to administer a relatively small pool of federal developmental funds to implement their health plans. Both bills give area agencies effective veto power over the use in the area of other federal funds authorized under the Public Health Service Act (except for health professions capitation in the Kennedy bill) and the Mental Retardation facilities and Community Mental Health Centers Construction Act of 1963; the Rogers bill in addition includes the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970. Both bills give the area planning agencies comment power to state health commissions over capital expenditures in excess of $100,000. Neither bill includes review by state or area agencies of federal biomedical research support.

In addition, the Rogers (but not the Kennedy) bill establishes a five-member, Presidentially appointed National Council for Health Policy in the Executive Office of the President; and creates a federal health facilities construction loan guarantee and loan fund, with veto power over its use vested in state health commissions and comment power vested in area-level planning agencies.

Differing considerably from the approach of the Kennedy and Rogers proposals, the AAMC draft bill authorizes the federal government to delegate (with federal norms and standards, financial assistance, and technical assistance) to state-level bodies the authority to plan for the state's health needs, except with respect to biomedical research and health professions education. The states would receive varying amounts of federal implementation funds, depending on whether the state has single or separate agencies to develop and implement the plan, and whether or not the state has certificate-of-need legislation. The state agency would have veto power over applications (except those related to biomedical research or health professions education) for all health-related projects in the state to be assisted under the Public Health Service Act, The Social Security Act, and other health laws. The AAMC draft bill does not include other regulatory provisions.

Recommendation: The Executive Council --

supports the organizational structure of the Kennedy and Rogers bills relating to health planning and regulation;

reaffirms past Association support of a Presidential panel of health advisers and independent judicial review of actions taken by health planning and regulatory bodies; and

authorizes the Association staff to work with appropriate legislative and Executive agencies and groups in consideration and development of necessary legislative proposals.

COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

ONE DUPONT CIRCLE, N. W. • WASHINGTON, D. C. 20036 • (202) 466-5123
(202) 466-5127

Administrative Board
Memorandum No. 74-4AB
January 16, 1974

Subject: National Health Policy and Development Act of 1974

The attached legislation was introduced by Representative Rogers for himself, Representative Roy and Representative Hastings on December 20, 1973. The bill is intended to replace the CHP, RMP and Hill-Burton legislation. I believe this bill will be taken very seriously; its contents are most important, and I think warrants your attention. I would be interested in your views on any or all of the sections of the bill. A brief summary of the bill is as follows.

The proposed Act has four principal parts. Part A would establish a National Council for Health Policy. Part B would create a system of Health Service Agencies (HSAs) responsible for areawide health planning and development throughout the country. Part C would assist State governments in the creation of State Health Commissions (SHCs) responsible for State-level health planning and regulatory activities. Part D would create a new Federal program of construction assistance for health facilities based on loans, loan guarantees, and interest subsidies. The new programs would commence during the present fiscal year, thus overlapping with the authorities for CHP, RMP, and Hill-Burton. The Secretary would be responsible for assisting the existing agencies under the latter programs in their transition into the new programs, and then at the end of the present fiscal year the legislative authorities for CHP, RMP, and Hill-Burton would be terminated. The provisions of the new programs are based on the extensive experience now available with the existing programs and combine the most effective and successful features of each of them.

The National Council for Health Policy would be established in the Executive Office of the President. It would have five members appointed by the President with the advice and consent of the Senate, and suitable staff and support for performing its functions. It would be responsible for assessment of the nation's health; assessment of Federal and other health programs; assessment of the need for health resources, services, and financing; developing recommendations for a national health policy; issuing guidelines on the appropriate supply, distribution, and organization of health resources and services; and conducting studies and analyses concerning its recommendations for a national health policy. The Council would be required to submit an annual report to the public on the work it has done. In developing policy the Council would be required to give priority consideration to national health priorities specified in the legislation.

In creating a system of Health Service Agencies (HSAs) the Secretary would first be responsible for dividing the nation into health areas for planning and development purposes. He would then designate in each health area a private nonprofit corporation as the HSA responsible for planning and development in that area. The legislative proposal specifies minimum criteria for the legal structure, staff, governing body, and functioning of the HSAs. They would be broadly responsible for preparing and implementing plans designed to improve the health of the residents of their health areas; increasing the accessibility, acceptability, continuity, and quality of the health care provided the residents; and restraining increases in costs of such care. In performing these functions HSAs would be required to gather suitable data; prepare long-range goal plans and short-term priority plans; provide assistance of either a technical or financial nature to people seeking to implement provisions of the plans; coordinate activities with PSROs, SHCs, and other appropriate planning and regulatory entities; review and approve or disapprove proposed uses of Federal health funds within the area; assist States in the performance of capital expenditure reviews under the Social Security Act; and assist the SHCs in certifying as needed health services offered in the area. Procedures and criteria for use by HSAs and SHCs in their performing of reviews required by the legislation are detailed.

Authority is given to the Secretary for providing assistance to organizations seeking to be designated as HSAs during their development, for providing technical assistance of various kinds to HSAs and SHCs, for making planning grants to designated HSAs to fund part of the cost of their planning programs, and for making development grants for HSA use in implementation of their plans. The Secretary is required to perform annual and triannual reviews of the activities and quality of HSAs to assure that they perform their functions in a satisfactory fashion.

The Secretary would also be required to designate in each State a State Health Commission (SHC) meeting criteria for its composition, staffing, and functions which are specified in the legislation. In order to receive designation, a SHC would need to submit to the Secretary an approvable administrative program

for carrying out its functions. The SHCs would be responsible for annual review and approval or disapproval of the plans of the HSAs, annual review and comment on the budgets of the HSAs, review of applications submitted by HSAs for assistance from the Federal government, commenting on disapproved applications for Federal funds, performance of capital expenditure review functions under the Social Security Act, certification as needed of health services offered within the state, regulation of health care costs within the state, and (if they so desire) licensure and quality activities. Provision is made for the Secretary to provide financial assistance in the development and operating costs of SHCs. In addition the Secretary would be required after the expiration of the fourth fiscal year after enactment of the lesiglation to perform the functions of SHCs in any State in which one was not designated.

Attachment:

EXPLANATION—HEALTH PLANNING ACT OF 1974

HEALTH PLANNING AGENCIES—STRUCTURE AND FUNCTIONS

The National Health Planning Act of 1974 provides for the establishment of health planning agencies throughout the United States. The legislation provides that within 120 days following enactment the Secretary of Health, Education and Welfare, in consultation with the Governor of each State, shall publish proposed boundaries for health areas throughout the United States. Such health areas will include all of the territory of the United States. Each health planning area is to encompass between 600,000 and 3 million people, except that the population of the health area may contain more than 3 million people if the area includes a standard metropolitan statistical area with a population of more than 3 million, and less than 3,600,000 people. If the population of a State is less than 600,000, [illegible]

These areas are not to cross State lines although States may be subdivided into a number of areas. The areas are intended to be medically self-sufficient. They should include provision for all levels of medical care, and are, if possible to include at least one center for highly specialized care and one academic health center. (The center for specialized care and the academic health center may be the same.) The Secretary is required to consult with existing 314(a) and 314(b) agencies, in establishing the boundaries of health planning areas. Boundaries, once established, may be revised by the Secretary. Decisions concerning boundary revisions may be made in consultation with the appropriate State and local officials and agencies involved.

It is hoped that the Secretary, in establishing health planning area boundaries, will take into account problems associated with the generation and analysis of data describing health services and practices in the area. One example would be the importance of integrating, if only on an Administrative level, existing areas designated under the Professional Standards Review Organization provisions of H.R. 1 with the proposed health areas.

The health area is the keystone of this planning bill. It is intended to be the fundamental geographic basis of the planning process. It is intended that each area be medically self-contained, and that information based upon the location of facilities, manpower, and services be gathered by the agency, analyzed and used as the basis for projecting area needs in order to formulate long-range goals, as reflected in a long-range goal plan. Each area is expected to assess existing resources and to project future needs, both in terms of additional resources, and the redistribution of existing resources within the area. [illegible]

For example, in many of our urban areas health care resources are concentrated in affluent sections of the community, while less affluent parts of the community, which may be only a few miles away are virtual health care deserts. It is intended that the health planning agency in the area identify such a maldistribution of resources and incorporate recommendations for improving the equity of the situation in their long-range goal plan.

The legislation also requires that the health planning agency formulate a set of short-term strategies designed to bring about the long-range plan. [illegible]

The structure of the health planning agency is detailed in the proposal. Briefly, it is to be a private nonprofit agency incorporated in the State in which it functions. Its policy-making board is to be composed of representatives, in equal numbers, from consumers of health care services (unrelated to the provision of those services), providers of services (representing health professionals, health insurers, and health institutions), and officials holding public office.

It is hoped, through this mechanism, to achieve a balance of input and interest into the policy-making process.

The legislation provides adequate financing to attract high quality personnel to staff what will be a sophisticated and demanding operation.

Guidelines are set forth in the legislation describing elements which should be taken into consideration during the development of a health plan. The legislation requires that data concerned, (at a minimum) with the health status of residents in the health area, health care facilities, personnel and services functioning in the area, patterns of utilization of health care personnel, facilities and services in the area, and the effect of the area's health care delivery system on the health of the residents in that area be generated and analyzed. This information must result in the promulgation of a long-range goal plan and a short-term priorities plan.

One of the weaknesses of the existing comprehensive health planning agencies is their inability to exert leverage to bring about compliance with a plan. The absence of adequate leverage has resulted to date not only in an inability to implement plans, but, often, in the development of plans which are of inferior quality, do not come to grips with the real problems of the distribution of health care resources within an area, and are frequently concerned only with facilities construction.

The passage of section 1122 of the Social Security Act last year, giving health planning agencies additional authority in the area of capital expenditures, has somewhat improved the situation. The National Health Planning Act of 1974 takes an additional and important step in the same direction. It provides that each health planning agency shall review and approve or disapprove each proposed use within its health area, of Federal funds appropriated for any program under the Public Health Service Act and the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963. Any funds obligated under those two authorities for the development, expansion, or support of health facilities, manpower, or services must be approved or disapproved by the health planning agency. Of those projects approved, the health planning agency is responsible for establishing priorities among those projects.

If an agency disapproves a proposed use of Federal funds under the authorities cited above, the Secretary may not make Federal funds available for that program until he has made, at the initiative of the entity requesting those funds, a review of the agency decision. In making such a review, the Secretary should give the appropriate State health commission (authorized by this legislation) and any other appropriate State health agency an opportunity to consider the agency decision and to submit to the Secretary its comments on the decision. The Secretary may override the decision of the health planning agency, but in so doing must make a detailed public statement concerning his reasons for overriding that decision.

In addition, the health planning agency shall review and make recommendations to planning agencies designated under section 1122 of the Social Security Act for the approval or disapproval of all capital expenditures in excess of $100,000. This requirement is intended to assist the 1122 agencies in those areas in which they exist to perform their functions effectively and in coordination with the health planning agencies authorized under this Title.

The health planning agency is required to review, on a periodic basis, the health services offered or proposed to be offered in a health area and shall make recommendations to each State health commission, authorized by this legislation, for the commission's certification of such health services.

Therefore, this legislation provides that the health planning agency establish criteria, based upon long and short-range plans, for the approval or disapproval of [illegible] Federal funds for the addition or expansion of services, facilities or manpower in the health area.

Control of capital expenditures is a mechanism effecting the distribution of resources in the health area. Patterns of reimbursement for services [illegible]. For that reason, the health planning agency is required to review rates charged by providers in its health area, and [illegible] mendations to the State health commission concerning modification in the [illegible] additional tool for implementing the health plan in an area. Criteria which [illegible] into account in formulating recommendations are listed in the bill.

The legislation provides for substantive review and due process protection, as well as criteria to be taken into account in formulating its recommendations.

HEALTH PLANNING AGENCIES—ASSISTANCE

The legislation provides for a number of forms of assistance to entities designated as health planning agencies.

First of all, the Secretary may provide necessary technical and other assistance to nonprofit private entities which express a desire to be designated as a health planning agency. Only one such entity may be funded in each health area.

In addition, grants are authorized to assist in developing health planning agencies.

The Secretary is required to enter into a designation agreement with one (and only one) entity in each health planning area throughout the United States.

In accepting applications for such designation, the Secretary is directed to give priority to 314(b) agencies and regional medical programs if they are functioning in an area.

The approval of the Governor of each State is required before the Secretary may designate any entity as the health planning agency for a health area.

STATE HEALTH COMMISSIONS—STRUCTURE AND FUNCTIONS

States vary widely in their ability to deal with the problems of equitable distribution of health care resources. This legislation provides the States an opportunity to regulate the health care industry within that State, within Federal guidelines, in order to insure equity in the provision of health services. If, after an adequate trial period, the State does not perform the functions outlined in the legislation to the satisfaction of the Secretary of Health, Education, and Welfare, the Secretary is required to assume responsibility for the performance of those functions.

This legislation requires that the States perform a number of planning and regulatory functions. In addition, it requires that the States vest the responsibility for the performance of those functions in a single agency. However, the selection of a particular agency is left to the discretion of the States, in recognition of the possibility of a variety of satisfactory administrative arrangements fulfilling the requirements of the legislation.

Conditional designation of a State agency as a State health commission may be terminated by either the agency or the Secretary of Health, Education and Welfare upon 90 days notice from either party.

The agency designated as a State health commission must be the sole agency of the State for the performance of the [illegible] functions detailed in the legislation.

The Governor or the legislature of the State involved, (whichever is authorized under the law creating the agency), [illegible]

quired to appoint an advisory council to advise the commission on the performance of its functions. At least ⅔ of the members of such council shall be individuals who are not providers of health care services, shall be representative of the various geographic regions of the State, the health planning agencies within the State, holders of public elective office of the government of the State, and various social, economic and racial populations groups of the State.

In addition, the State is required to have an administrative program capable of carrying out the regulatory functions required by the bill. The administrative program must perform in a manner satisfactory to the Secretary of Health, Education and Welfare.

STATE REGULATORY FUNCTIONS

Each State health commission for which a designation agreement is in effect shall perform the following regulatory functions:

(a) Annual approval or disapproval of long-range goal plans and short-term priority plans of each health planning agency functioning within that State.

(b) Annual review of the budget of each health planning agency.

(c) Review applications by each health planning agency for planning or development grants, and report its comments on such applications to the Secretary.

(d) Serve as the designated planning agency of the State for purposes of section 1122 of the Social Security Act.

(e) Determine which services, after considering the recommendations of the appropriate health planning agency, will be certified within State.

(f) License health care facilities and health care delivery personnel in the State.

(g) Set standards for health care facilities and review the performance of health services within the State, with respect to quality to the extent authorized by State law.

(h) After considering the recommendations of the appropriate health planning agency determine, on a prospective basis, rates to be used for reimbursement for health services and regulate all reimbursements of health care providers which are either on a charge, cost, negotiator or other basis. Review of such rates shall be made at once a year.

Guidelines upon which to base rate regulation are detailed in the legislation.

Rate regulation may be performed, at the option of the State, by another agency of the State government under an agreement with the State health commission satisfactory to the Secretary.

In making regulatory decisions under the authority of this legislation, the State health commission must comply with the goals of the applicable long-range goal plan or short-term priority plan to the extent possible. If a deviation from the goals of these plans exist, the Commission must explain the reasons for the inconsistency to the appropriate health service agency.

ASSISTANCE TO STATE HEALTH COMMISSIONS AND HEALTH PLANNING AGENCIES

Authority for grants for the development and operation of State health commissions is provided in this legislation.

A number of forms of assistance are available to State health commissions and local health planning agencies under the provisions of this bill.

Technical assistance is authorized to be provided by the Secretary of Health, Education, and Welfare when necessary.

In addition, a number of forms of financial assistance are authorized intended to facilitate the development of health plans and the regulatory apparatus necessary to implement them.

1. The Secretary is authorized to make grants to nonprofit private entities to assist them in meeting the costs of fulfilling the organizational and operational requirements of this legislation, in order to become health planning agencies.

For the purpose of making payments pursuant to grants under this legislation, there are authorized to be appropriated $15 million for the fiscal year ending June 30, 1974; $30 million for the fiscal year ending June 30, 1975; $20 million for the fiscal year ending June 30, 1976; and $30 million for the fiscal year ending June 30, 1977.

2. In addition, the Secretary is authorized to make grants annually to each health planning agency with which a designation agreement exists, for the compensation of agency personnel, collection of data, planning and other activities of the agency required to develop a health plan for that area. The amount of such health planning grant shall be 25 cents for each resident of the health area. However, the Secretary may double that grant if the planning agency is able to contribute an amount equal to the difference between 50 cents per person served by the health area and 25 cents per person served by the health area. Local funding must be from non-Federal public sources.

The amount of any grant for planning may not be less than $150,000. For the purpose of making payments pursuant to the grants for planning, there are authorized to be appropriated $60 million for the fiscal year ending June 30, 1975; $100 million for the fiscal year ending June 30, 1976; and $100 million for the fiscal year ending June 30, 1977.

These entitlements may be ratably reduced if authorizations exceed appropriations.

3. In addition to grants for the development of planning agencies and for the formulation of health plans, the legislation authorizes the creation of an area health service development fund. This fund is intended to provide discretionary money to the health planning agencies in order to enable it to sponsor projects which will facilitate achievement of the goals described by the health plans. It is hoped that many of the worthwhile projects currently being undertaken by the regional medical programs can be funded under this authority, providing they contribute to the achievement of the areawide plan. The amount of any grant under this authority may not exceed $1 per capita, based on the population of the health planning area.

For the purpose of making payments pursuant to grants under this authority, there are authorized to be appropriated $100 million for the fiscal year ending June 30, 1975; $125 million for the fiscal year ending June 30, 1976; and $125 million for the fiscal year ending June 30, 1977.

4. Assistance is authorized under this legislation for the development and operation of State health commissions. The Secretary is authorized to make grants to States to assist in meeting the costs of developing a State health commission. Such grants may not exceed 90 percent of the cost of development for a State health commission. The amount of any grant for costs of operating a State health commission for its first year may not exceed 75 percent of such costs. The amount of any subsequent grant for a commission's cost of operation may not exceed the lesser of $500,000 or 50 percent of its cost of operation for a year subsequent to the first year of operation.

For the costs of State health commission development, there are authorized to be appropriated $2 million for the fiscal year ending June 30, 1974; $3 million for the fiscal year ending June 30, 1975; $3 million for the fiscal year ending June 30, 1976; and $3 million for the fiscal year ending June 30, 1977.

For the cost of operating State health commissions, there are authorized to be appropriated $1 million for the fiscal year ending June 30, 1974; $5 million for the fiscal year ending June 30, 1975; $10 million for the fiscal year ending June 30, 1976; and $10 million for the fiscal year ending June 30, 1977.

5. This bill also contains authority for continued funding for regional medical programs and comprehensive health planning agencies, in order to allow their activities to mesh with the authorities contained in this legislation.

FEDERAL GUIDELINES FOR HEALTH PLANNING AGENCIES AND STATE HEALTH COMMISSIONS

Federal health policy has in the past been characterized by a lack of policy. With increasing centralization of the financing of health care services throughout the United States at the Federal level, it has become the responsibility of the Federal Government to establish and encourage adherence to a Federal health policy. As we move toward a broad, comprehensive national health insurance program, it will become increasingly necessary to identify areas of need, as well as areas of surplus with respect to health services throughout the United States. If the Federal Government is responsible for raising and distributing funds in order to purchase health services on behalf of residents of the United States, it is surely responsible for assuring equity in the distribution of those funds, and in assuring that areas of need receive special attention.

This legislation directs the Secretary of Health, Education and Welfare to promulgate guidelines within one year after the enactment of this legislation, concerning national health policy.

In developing these guidelines, the Secretary is directed to give special attention to the following considerations:

1. Guidelines with respect to the appropriate supply, distribution and organization of health resources services.

2. A statement of national health goals, developed with emphasis on the following objectives:

(a) Primary care services for medically underserved populations, especially those which are located in a rural or economically depressed area.

(b) Integration of institutional services within an area.

(c) The development of medical group practices.

(d) The training and increased utilization of physician assistants.

(e) Assuring the availability of support services, particularly costly and sophisticated services, on an areawide or regional basis.

(f) Promotion of activities designed to improve the quality of health services, with particular regard to needs identified by Professional Standards Review Organizations.

(g) The development of institutions capable of providing integrated, multi-level services.

(h) The adoption of simplified and uniform cost accounting, reimbursement, utilization reporting systems, and improved management procedures for health care providers.

(i) The adoption of uniform formulae for relating costs of operation or rates used for reimbursement purposes for health care services.

(j) The adoption of a classification system designed to assure uniform identification of various health care providers, as outlined in the legislation.

The Secretary is required, to the maximum extent possible, to issue guidelines in quantitative terms, in order to facilitate their use by State health commissions and area health planning agencies.

In order to facilitate the implementation of and adherence to the guidelines promulgated by the Secretary, the legislation directs the Secretary to take compliance with those guidelines into consideration in determining whether or not the State is adequately fulfilling its responsibilities with re-

spect to its regulatory functions, and authorizes the Secretary to review and approve area-wide health agency budgets, in order to determine whether or not they are capable of promulgating a plan falling within his guidelines.

Mr. President, this legislation is extremely complex, and has great potential for influencing the distribution of health care resources and the efficiency with which health care funds are expended throughout the United States. I intend to schedule hearings on this legislation in the near future, and am anxious to hear the comments of all interested parties concerning this proposal. Many of the provisions of this legislation will generate controversy. I believe that this is a logical and potentially effective proposal. I believe it will effectively meet the needs of the American people for health planning as I see them. However, I know I speak for other members of the Health Subcommittee as well as myself when I say I will welcome constructive ideas concerning ways to strengthen this proposal. I look forward to receiving such comments during the course of the development of this legislation.

FINANCIAL ASSISTANCE UNDER THE NATIONAL HEALTH PLANNING ACT OF 1974

[In millions]

	Health planning agency development	Health planning agency planning grants	Area health services development funds	State health commission development	State health commission operation
Fiscal year:					
1974	15			2	1
1975	30	60	100	3	5
1976	30	100	125	3	10
1977	30	100	125	3	10
Total	105	260	350	11	26

Note: total authorization, 752,000,000

ECOTH Adm Bd. Mar 20-21-1974
Tab H

RELATIONSHIPS OF AAHC AND AAMC

At the 1973 AAMC Annual Meeting, representatives of the AAMC met with officers of the AAHC (Association for Academic Health Centers) to discuss the appropriate relationship of the two organizations. It was agreed that a paper setting forth this relationship should be prepared and ratified by the AAMC Executive Council and the AAHC Board of Directors.

The draft which follows was prepared by Dr. William G. Anlyan (AAHC Vice Chairman) following that meeting. This document has been reviewed by the AAHC Board, but has not yet received final approval.

RECOMMENDATION

That the Executive Council Approve the document, "Relationships of AAHC and AAMC."

Relationships of AAHC and AAMC

The Coggeshall report in 1966 proposed that the health education professions come under one formal organization and governance structure. Since 1966, both the AAMC and the AAHC have grown and developed.

Under the effective leadership of Dr. John A. D. Cooper, the AAMC has become the national representative of medical schools and teaching hospitals. Its constituents include faculty members, deans and their staff, teaching hospital administrators and students. The continuum of medical education is appropriately represented. The AAMC has developed an interface with both the Executive and Legislative branches of the Federal Government. The AAMC is equally concerned with national common denominator programs and problems affecting the milieu interne of the academic medical center; e.g., accreditation of undergraduate medical education, representation on the LCGME and the CCME, management problems of the academic medical center, etc. A complete review of AAMC activities is not intended.

The AAHC has evolved over a 15 year period as a small organization whose membership is constituted by the senior health sciences administrator in a university, a system of universities or their equivalents. The titles vary from Chancellor, President, Vice Chancellor, Vice-President, etc. The responsibilities of the individuals in their institutions vary from being the chief executive officer in the health sciences to a senior staff position in the office of the University President or Chancellor. There are _____ members and their disciplinary backgrounds vary from medicine and dentistry to other health professions. The AAHC has a single full-time Executive Director and one secretary. The organization has two meetings a year --

the annual meeting in the fall is usually a three day assembly; the spring meeting is a one and one-half day gathering in Washington. In between meetings, the affairs of the Association are overseen by a _____ person Board of Directors. The AAHC does not have day to day operational interface with the federal government; members of the AAHC will participate in discussions with officials of the executive and legislative branches on invitation only -- to provide a coordinated overview of the problems of health professional education. No position would be taken by the AAHC on a specific health professional education program without joint discussion with the leadership of the appropriate organization. The AAHC endeavors to broaden and improve the dialogue and coordination among appropriate health education groups.

Whereas in the present decade the Coggeshall recommendation for unity of organization may not be feasible for a variety of reasons and sensitivities, a major step can be achieved by appropriate coordination and interdigitation of the various organizations.

The AAMC and its sister organizations already have formed the Federation of Associations of Schools of Health Education Professions. Each association, like the AAMC, has developed its own interface with the federal government and its own programs in intra-professional education. The Federation has become the effective spokesman nationally for the common denominator needs of all the schools of health professions. For example, when the Health Professions Educational Assistance Act comes up for renewal, it is anticipated that each Association will speak to the education needs of its profession; there may or may not be a common denominator area for presentation and support by the Federation. The

AAHC would not plan to enter this arena unless invited to testify or unless there appeared to be some gross imbalance that would not be in the national interest.

A more explicit description of the aims, objectives and programs of the AAHC developed by Dr. Wm. Stewart and an ad hoc committee is attached as Appendix I.

Obviously, maximum coordination of the activities of the AAMC and the AAHC during the decade ahead is in the best interests of the nation. Reduplication is expensive and unnecessary with the cost being transmitted to the overlapping constituencies. The identities of the two orgnizations should be maintained and it is conceivable that at times one organization may be in an adversary position with a third party while the other organization maintains a neutral adjudicatory role.

Suggested interlocks:

1. That the Executive Director of the AAHC, the President of the AAHC or his designee, continue to attend the meetings of the Executive Council of the AAMC as visiting participants without vote.

2. That the President of the AAMC and the Chairman of the Assembly of the AAMC, or his designee, continue to attend the meetings of the Board of Directors of the AAHC as visiting participants without vote.

3. At the staff level, the Executive Director of the AAHC and the President of the AAMC continue to develop the most effective working relationships involving attendance of staff meetings, communications as necessary, etc.

4. The newly established category of AAMC membership; viz., Distinguished member - offers another avenue for interlocking the two associations since many of the members in this section are current active members of the AAHC who in the past had served significant roles in the affairs of the AAMC.

5. AAHC members will be invited to attend the annual meeting of the AAMC.

6. The President of the AAMC and the Chairman of the Assembly will be invited to the annual meeting of the AAHC.

7. From time to time and as necessary in the judgment of the officers of the two Associations, combined meetings may be called of the Executive Committee of the AAHC Board of Directors and the AAMC Executive Committee.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

INTER-OFFICE MEMO

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

DATE January 23, 1974

TO: AAMC Department and Division Directors

FROM: Bart Waldman

SUBJECT: DATES AND FORMAT OF THE 1974 ANNUAL MEETING

To facilitate early planning of meetings to be held at the 1974 Annual Meeting, I am providing a tentative schedule of sessions to be held in Chicago. As you undoubtedly have heard, the theme of this year's meeting will be "Educating the Public about Health."

The official dates for the 85th Annual Meeting are November 12 - 16, 1974. This represents a Tuesday - Saturday schedule. All meeting space will be located in the Conrad Hilton Hotel, Chicago, Illinois. All hotel accommodations, barring unforeseen demand, will be located in either the Conrad Hilton or the Palmer House (6 blocks away).

Plenary Sessions will be held on Wednesday and Thursday mornings (13th & 14th). The AAMC Assembly will meet on the afternoon of the 14th. Other large general sessions have not yet been scheduled.

Due to the increased demand for meeting space for outside groups, we have arranged for additional space to be available on a limited basis prior to Tuesday. Hotel accommodations will be available as early as Sunday night. However, AAMC Convention Offices and Registration will not open until Monday evening. Only in exceptional circumstances should meetings be scheduled prior to Tuesday morning.

This information is preliminary, but should be of help in thinking about next fall's schedule. A more detailed schedule and a call for meeting space requests will be circulated around the first of March.

COPIES TO:

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

INSTITUTE ON PRIMARY CARE

Proposed October/November, 1974

Tentative Agenda

First Plenary Session

Issues in Primary Care Education

Presiding: Thomas E. Piemme, M.D., Institute Chairman

Welcome	John A. D. Cooper, M.D.
Issues in Primary Care: The Academic Perspective	Paul B. Beeson, M.D.
Issues in Primary Care: The Policy Perspective	Rashi Fein, Ph.D.

Second Plenary Session

Organization of Model Systems for Primary Care Practice

Presiding: Henry M. Seidel, M.D.

Introduction: Problems and Issues — Henry Seidel, M.D.

Use of Existing Institutional Resources — Thomas DelBanco, M.D.

delineation of examples of conversion of traditional "out-patient" departments to viable instruments and models for primary care practice - issues to be discussed include organization, staffing, recruitment of physician role models, involvement of specialty services, role of the student and graduate trainee, relationship to the medical school and/or hospital, and financing

Respondent — Gerald Perkoff, M.D.

to describe specific example of conversion of OPD to prepaid group practice model

Respondent — Roblieri, M.D.

to describe specific example of university affiliated hospital OPD to primary care practice model complementary to University Clinic

Use of Community/Private Sector Resources — Robert Evans, M.D.

discussion of the spectrum of solutions throughout the U.S. wherein community resources are used - examples to include use of public facility (Montefiore Hospital), use of family practitioner offices (Maryland), use of constellation of community hospitals (Rochester, Medical College of Virginia, Indiana), use of regional divisions (Michigan State), use of regional campuses (Illinois)

Respondent — Edward Kowalewski, M.D.

to describe specific example of use of network of practicing physicians and community hospital ambulatory facilities

Respondent — Harold Wise, M.D.

to describe specific example of use of urban low-income ambulatory facility (Martin Luther King Center)

Third Plenary Session

Graduate Physician Training in Primary Care

Presiding: Joel Alpert, M.D.

Introduction: Problems and Issues — Joel Alpert, M.D.

Training of Generalists in Medicine and Pediatrics — Evan Charney, M.D.

discussion of the development of primary care versus specialty tracks within medicine and pediatrics - description of specific programs developed for this purpose (Rochester) - discussion of implications for specialty boards - discussion of components of such training programs and degree of cross-training in sister specialties - discussion of expectation of behavior of trainee in practice setting

Respondent — Joseph Dorsey, M.D.

to describe specific example of such a training program in the context of prepaid group practice

Respondent — Robert Petersdorf, M.D.

to describe specific example for internal medicine and view of the American Board of Internal Medicine

Training of Family Practitioners — Robert Rakel, M.D.

discussion of the philosophy behind training for family practice - to include history of development since publication of Willard Report - to discuss essentials for training, and mechanisms for residency approval - to discuss component of training, settings in which training may take place, and expected practice behavior of products of such training programs

Respondent — Eugene Farley, M.D.

to describe specific example of training program in affiliated University Hospital

Respondent — Thomas Piemme, M.D.

to describe difficulties in governance and compromise model applicable to medical schools in urban locations

Fourth Plenary Session

Education of New Health Practitioners

Presiding: Alfred M. Sadler, M.D.

Introduction: Problems and Issues — Alfred M. Sadler, M.D.

Training the New Health Practitioner — Charles Lewis, M.D.

discussion of the development of the concept and outline of history of programs training physicians assistants, nurse practitioners, and MEDEX - discussion of issues of certification, accrediation, and legal status - discussion of objectives and components of training programs - discussion of resources necessary for program development - what institutions should/should not be engaged in such efforts - discussion of governance locus within academic health centers - discussion of fiscal implications

Respondent — David Lawrence, M.D.

to describe philosophy and structure of MEDEX model

Respondent — Robert Jewett, M.D.

to describe philosophy and structure of Physician Assistant

Training for Team Practice — David Kindig, M.D.

discussion of congruent training for the health professions - experience with the development of teams in the practice environment - definition of "core" curricula for health practitioners - fiscal implications for academic health centers - experience with teaching medical students and physician assistant students in the same classroom - who heads the team? - institutional governance of training

Respondent — Malcolm Peterson, M.D.

to describe a model (Hopkins) in which multiple resources have been placed in a new school

Respondent — John Ott, M.D.

to discuss development of performance objectives and methods by which skills and performance may be evaluated

Fifth Plenary Session

New Directions in Health Science Education

Presiding: Thomas E. Piemme, M.D., Institute Chairman

Priorities for Health Science Education
in the Next Decade

discussion of current experiments in health science education - results of significant innovations - fiscal incentives and limitations to innovation

Respondent — Hilliard Jason, M.D.

to discuss evaluation of training methodology - methods and preliminary conclusions

Respondent — August Swanson, M.D.

to discuss activities of the AAMC and the commitment of American Medical Colleges to training for primary care

H.R. 11333

(Signed into law January 3, 1974)

PAYMENT FOR SERVICES OF PHYSICIANS RENDERED IN A TEACHING HOSPITAL

SEC. 15. (a)(1) Notwithstanding any other provision of law, the provisions of section 1861(b) of the Social Security Act, shall subject to subsection (b) of this section, for the period with respect to which this paragraph is applicable, be administered as if paragraph (7) of such section read as follows:

"(7) a physician where the hospital has a teaching program approved as specified in paragraph (6), if (A) the hospital elects to receive any payment due under this title for reasonable costs of such services, and (B) all physicians in such hospital agree not to bill charges for professional services rendered in such hospital to individuals covered under the insurance program established by this title.".

(2) Notwithstanding any other provision of law, the provisions of section 1832(a)(2)(B)(i) of the Social Security Act, shall, subject to subsection (b) of this section, for the period with respect to which this paragraph is applicable, be administered as if subclause II of such section read as follows:

"(II) a physician to a patient in a hospital which has a teaching program approved as specified in paragraph (6) of section 1861(b) (including services in conjunction with the teaching programs of such hospital whether or not such patient is an inpatient of such hospital), where the conditions specified in paragraph (7) of such section are met, and".

(b) The provisions of subsection (a) shall not be deemed to render improper any determination of payment under title XVIII of the Social Security Act for any service provided prior to the enactment of this Act.

(c)(1) The Secretary of Health, Education, and Welfare shall arrange for the conduct of a study or studies concerning (A) appropriate and equitable methods of reimbursement for physicians' services under Titles XVIII and XIX of the Social Security Act in hospitals which have a teaching program approved as specified in Section 1861(b)(6) of such Act, (B) the extent to which funds expended under such titles are supporting the training of medical specialties which are in excess supply, (C) how such funds could be expended in ways which support more rational distribution of physician manpower both geographically and by specialty, (D) the extent to which such funds support or encourage teaching programs which tend to disproportionately attract foreign medical graduates, and (E) the existing and appropriate role that part of such funds which are expended to meet in whole or in part the cost of salaries of interns and residents in teaching programs approved as specified in section 1861(b)(6) of such Act.

(2) The studies required by paragraph (1) shall be the subject of an interim report thereon submitted not later than December 1, 1974, and a final report not later than July 1, 1975. Such reports shall be submitted to the Secretary, the Committee on Finance of the Senate, and the Committee on Ways and Means of the House of Representatives, simultaneously.

(3) The Secretary shall request the National Academy of Sciences to conduct such studies under an arrangement under which the actual expenses incurred by such Academy in conducting such studies will be paid by the Secretary. If the National Academy of Sciences is willing to do so, the Secretary shall enter into such an arrangement with such Academy for the conduct of such studies.

(4) If the National Academy of Sciences is unwilling to conduct the studies required under this section, under such an arrangement with the Secretary, then the Secretary shall enter into a similar arrangement with other appropriate non-profit private groups or associations under which such groups or associations shall conduct such studies and prepare and submit the reports thereon as provided in paragraph (2).

(5) The Social Security Administration shall study the interim report called for in paragraph (2) and shall submit its analysis of such interim report to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives not later than March 1, 1975. The Social Security Administration shall study and submit its analysis of the final report to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives by October 1, 1975.

(d) The provisions of subsection (a) shall apply with respect to cost accounting periods beginning after June 30, 1973, and prior to January 1, 1975 except that if the Secretary of Health, Education, and Welfare determines that additional time is required to prepare the report required by subsection (c), he may by regulation, extend the applicability of the provisions of subsection (a) to cost accounting periods beginning after June 30, 1975.

Sec. 227

2

January 15, 1974

Mr. Robert O'Connor
Division of Provider Reimbursement
and Accounting Policy
Bureau of Health Insurance
Room 589, East Building
6401 Security Boulevard
Woodlawn, Maryland 21235

Dear Mr. O'Connor:

For the other members of the Committee and myself I would like to thank you and your staff for taking the time to meet with us last Wednesday. I feel the discussion was particularly helpful with respect to clarifying several ambiguities in the draft regulations. The information obtained will assist us in addressing questions from our constituents if the regulations are published substantially in their draft form.

I would like to re-emphasize that we feel further attention should be accorded to certain sections of the draft regulations. Particularly troublesome is the provision in §405.465(J) that states:

> "The compensation paid by a teaching hospital or a medical school or organization related thereto under arrangement with the hospital, to supervisory physicians in a teaching hospital must be allocated to the full range of services rendered by the physicains to such hospital and/or medical school or organization related thereto for which they are not otherwise compensated."

It appears very unreasonable to require thet payment for certain specific functions or activities should be allocated to other functions or activities if payment was not intended to cover these other activities. This provision produces significant problems in those instances where physicians are paid for a specific range of functions and then engage in other activities "on their own time" on the medical center site for which they are not otherwise compensated. These "other activities" are in every way extramural -- compensation should not be allocated to such function.

Related to the above, §405.465(d) states, in part, that:

> "A physician on the hospital staff or on the medical school staff who receives any compensation from either the hospital or the medical school may not be considered an unpaid voluntary physician for the purpose of this paragraph." (Emphasis added)

As we understand it, a staff physician that is paid a nominal sum to provide the institution a specifically delineated service (e.g., participation on the utilization review committee) cannot be considered a voluntarypphysician with respect to other services he may provide the institution in the absence of any compensation either received or implied. He is, in every sense of the term, "unpaid" with regard to the provision of such other services. The Senate Finance Committee report notes that "the payment represents compensation for contributed medical staff time which, if not contributed, would have to be obtained through employed staff on a reimbursable basis." If a staff physician is paid for certain services and contributes others, the latter, if eliminated, would have to be obtained through alternative means and paid for.

Finally, I urge you to request your cost analysis staff to monitor actual overhead expenditures experienced by institutions operating under the cost provisions for all patients to evaluate the 105 percent rate allowed where the costs for such services are rendered only to health insurance patients. It would be our position that the 105 percent rate is much too low.

Thank you again for considering these comments and the points raised in our Wednesday meeting.

Sincerely,

RICHARD M. KNAPP, PH.D.
Director
Department of Teaching Hospitals

RMK:car

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

WASHINGTON: 202: 466-5175

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

3

February 8, 1974

James B. Cardwell
Commissioner of Social Security
Department of Health, Education and Welfare
Fourth and Independence Avenue
Washington, D.C. 20201

Dear Commissioner Cardwell:

The purpose of this communication is to forward comments of the Association of American Medical Colleges regarding proposed federal regulations altering utilization review standards under the Medicare program. Specifically the material presented here pertains to Federal Health Insurance for the Aged and Disabled: Condition of Participation - Hospitals and Skilled Nursing Facilities, as proposed in the Federal Register, Vol. 39, No. 6 (January 9, 1974) amending 45 CFR 405.

The only advantage that would result from the regulations noted above and those proposing to amend 45 CFR 405 (utilization review standards under the Medicaid program) is elimination of the situation where hospitals are required to operate under differing utilization review standards for both the Medicare and Medicaid programs. The employment of two different sets of standards and procedures causes unnecessary duplication of effort and results in confusion. While coordination of utilization review requirements under Medicare and Medicaid is beneficial, the Association feels that the substance of the proposed regulations and mechanisms they seek to implement, pose severe operational difficulties in the light of rather marginal expected benefits. This is particularly true with regard to the nation's teaching-tertiary care hospitals.

Section 405.1035(f) seeks to establish an admission pre-certification mechanism for the purpose of reducing the unnecessary utilization of inpatient services. The Association shares the objective of the Social Security Administration to make optimal use of scarce health resources but questions whether pre-admission certification is the most cost-effective and cost-efficient manner in which to do so. The cost of implementing such a procedure is extraordinary. Under the proposed regulations the assumption of this cost would be dictated in the absence of any evidence

indicating that there would be any substantial reduction in expenditures. A similar criticism could be made of the length of stay recertification requirements also contained in the proposed regulations. The Association suggests that research be undertaken (one such investigation is already being conducted by the American Hospital Association) to determine the cost-effectiveness and cost-efficiency of pre-admission certification and length of stay recertification before such procedures are implemented on a broad scale.

In addition to potentially high ratio of costs to benefits, the pre-certification mechanism, as proposed, would create serious problems in teaching hospitals. Teaching-tertiary care hospitals are characterized by the fact that they function as referral facilities, providing services to a geographically disperse catchment area. Patients are referred by a local practitioner to a physician faculty member for treatment or further diagnostic workup; often the teaching hospital's outpatient department serves as the inpatient entry point and inter-hospital transfers are commonplace. Pre-admission certification of patients transferred from other hospitals would be of marginal value. Patients referred to the teaching hospital for more sophisticated diagnostic workups would, by definition, not enter the facility with a diagnosis refined enough to serve as a basis for pre-certifying a specific length of stay. The supporting material (medical records, test results, etc.) of referred patients distant from the teaching hospital are generally forwarded immediately prior to admission or are brought by the patient to the hospital. Under such circumstances the pre-certification procedure specified in the proposed regulations is difficult, if not impossible, to execute properly. A time delay caused by the interaction of pre-certification requirements and distance would be particularly troublesome where the admission is medically expedient (much diagnostic work performed by teaching hospitals would fall into this category) although not necessarily emergency in character.

Section 405.1035(e) of the proposed regulations provides that required reviews cannot be conducted by persons who are employed by the hospital (among other stipulations). This provision is contrary to § 1122(e) of P.L. 92-603 (establishing PSRO's) as amended by § 18(v) P.L. 93-233 for hospitals. Many hospitals (especially teaching institutions) pay physicians to conduct utilization review under the Medicare and Medicaid program (or alternatively the review is conducted by salaried physicians on the hospital staff). The regulations, as currently written, would essentially prohibit payment for utilization review activity. If these regulations are finally adopted, the work load associated with utilization review will increase astronomically -- it is unreasonable to assume that physicians would be willing (or should) engage in such activity without compensation. Given the anticipated volume of such work in teaching hospitals, the review function may have to be assumed by several physicians and associated

support personnel on a full-time basis. For example, assuming 35 percent Medicare/Medicaid admissions and 35,000 admissions per year would require approximately 30 pre-certifications per day -- this excludes effort that would have to be expended in re-certifying length of stay. Based upon the aforementioned reasoning, the Association strongly urges that the clause prohibiting employee participation in utilization review be deleted from the regulations.

The Association is particularly concerned about language contained in § 405.1137(b) that grants authority to the Secretary of Health, Education and Welfare to waive published utilization review procedures and substitute a program external to the utilization committee of the individual hospital. At a minimum, the regulations should detail the criteria upon which such authority could be exercised by the Secretary. The Association believes that utilization review is most effective when conducted by the staff of an institution itself. Local staff are most familiar with factors affecting the patient, feedback is facilitated, and acceptance and understanding are greater when corrective action is required.

As currently proposed the regulations would be implemented within four months of final publication. Inadequate lead time is provided to design and install the data management systems and organizational structures necessary to comply with the regulations. Congress has recognized the difficulty in implementing such complex systems under PSRO provision of P.L. 92-603 -- a 24-month lead time was provided in this instance. The Association strongly urges a re-evaluation of the time frame in which such requirements should be implemented.

While commenting upon certain operational difficulties inherent in the proposed regulations, the Association strongly urges that such regulations be withdrawn. There is every reason to believe that the objectives sought in the proposed regulations can be achieved through the development and activation of Professional Standards Review Organizations.

I stand ready to clarify and/or elaborate upon the comments presented here.

Sincerely,

John A. D. Cooper, M.D.

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

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

WASHINGTON: 202: 466-5175

3

February 8, 1974

James S. Dwight, Jr.
Administrator
Social and Rehabilitation Services
Department of Health, Education, and Welfare
P.O. Box 2372
Washington, D.C. 20013

Dear Mr. Dwight:

The purpose of this communication is to forward comments of the Association of American Medical Colleges regarding proposed federal regulations altering utilization review standards under the Medicaid program. Specifically, the material presented here pertains to Medical Assistance Programs; Utilization Review, as proposed in the Federal Register, Vol. 39, No. 6 (January 9, 1974) amending 45 CFR 250.

The only advantage that would result from the regulations noted above and those proposing to amend 45 CFR 405 (utilization review standards under the Medicare program) is eliminiation of the situation where hospitals are required to operate under differing utilization review standards for both the Medicare and Medicaid programs. The employment of two different sets of standards and procedures causes unnecessary duplication of effort and results in confusion. While coordination of utilization review requirement under Medicare and Medicaid is beneficial the Association feels that the substance of the proposed regulations and mechanisms they seek to implement, pose severe operational difficulties in the light of rather marginal expected benefits. This is particularly true with regard to the nation's teaching-tertiary care hospitals.

Section 250.20(a)(4) seeks to establish an admission pre-certification mechanism for the purpose of reducing the unnecessary utilization of inpatient services. The Association shares the objectives of the Social and Rehabilitation Service to make optimal use of scarce health resources but questions whether pre-admission certification is the most cost-effective and cost-efficient manner in which to do so. The cost of implementing such a procedure is extraordinary. Under the proposed regulations the

assumption of this cost would be dictated in the absence of any evidence indicating that there would be any substantial reduction in expenditures. A similar criticism could be made of the length of stay recertification requirements also contained in the proposed regulations. The Association suggests that research be undertaken (one such investigation is already being conducted by the American Hospital Association) to determine the cost-effectiveness and cost-efficiency of pre-admission certification and length of stay recertification before such procedures are implemented on a broad scale.

In addition to potentially high ratio of costs to benefits, the pre-certification mechanism, as proposed, would create serious problems in teaching hospitals. Teaching-tertiary care hospitals are characterized by the fact that they function as referral facilities, providing services to a geographically disperse catchment area. Patients are referred by a local practitioner to a physician faculty member for treatment or further diagnostic workup; often the teaching hospital's outpatient department serves as the inpatient entry point and inter-hospital transfers are commonplace. Pre-admission certification of patients transferred from other hospitals would be of marginal value. Patients referred to the teaching hospital for more sophisticated diagnostic workups would, by definition, not enter the facility with a diagnosis refined enough to serve as a basis for pre-certifying a specific length of stay. The supporting material (medical records, test results, etc.) of referred patients distant from the teaching hospital are generally forwarded immediately prior to admission or are brought by the patient to the hospital. Under such circumstances the pre-certification procedure specified in the proposed regulations is difficult, if not impossible, to execute properly. A time delay caused by the interaction of pre-certification requirements and distance would be particularly troublesome where the admission is medically expedient (much diagnostic work performed by teaching hospitals would fall into this category) although not necessarily emergency in character.

Section 250.20(a)(1) of the proposed regulations provides that required reviews cannot be conducted by persons who are employed by the hospital (among other stipulations). This provision is contrary to § 1122(e) of P.L. 92-603 (establishing PSRO's) as amended by § 18(v) P.L. 92-233 for hospitals. Many hospitals (especially teaching institutions) pay physicians to conduct utilization review under the Medicare and Medicaid program (or alternatively the review is conducted by salaried physicians on the hospital staff). The regulations, as currently written, would essentially prohibit payment for utilization review activity. If the regulations are finally adopted the work load associated with utilization review will increase astronomically -- it is unreasonable to assume that physicians would be willing (or should) engage in such activity

without compensation. Given the anticipated volume of such work in teaching hospitals, the review function may have to be assumed by several physicians and support personnel on a full-time basis. For example, assuming 35 percent Medicare/Medicaid admissions and 35,000 admissions per year would require approximately 30 pre-certifications per day -- this excludes effort that would have to be expended in re-certifying length of stay. Based upon the aforementioned reasoning, the Association strongly urges that the clause prohibiting employee participation in utilization review be deleted from the regulations.

The Association is particularly concerned about language contained in § 250.20(a)(1) that grants authority to the Secretary of Health, Education and Welfare to waive published utilization review procedures and substitute a program external to the utilization committee of the individual hospital. At a minimum, the regulations should detail the criteria upon which such authority could be exercised by the Secretary. The Association believes that utilization review is most effective when conducted by the staff of an institution itself. Local staff are most familiar with factors affecting the patient, feedback is facilitated, and acceptance and understanding are greater when corrective action is required.

As currently proposed the regulations would be implemented within four months of final publication. Inadequate lead time is provided to design and install the data management systems and organizational structures necessary to comply with the regulations. Congress has recognized the difficulty in implementing such complex systems under PSRO provisions of P.L. 92-603 -- a 24-month lead time was provided in this instance. The Association strongly urges a re-evaluation of the time frame in which such requirements should be implemented.

While commenting upon certain operational difficulties inherent in the proposed regulations, the Association strongly urges that such regulations be withdrawn. There is every reason to believe that the objectives sought in the proposed regulations can be achieved through the development and activation of Professional Standards Review Organizations.

I stand ready to clarify and/or elaborate upon the comments presented here.

Sincerely,

John A. D. Cooper, M.D.

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

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

WASHINGTON: 202: 466-5175

February 20, 1974

Honorable Caspar Weinberger
Secretary of Health, Education and Welfare
Washington, D.C. 20201

Dear Mr. Secretary:

The purpose of this letter is to request the Department of Health, Education and Welfare and its agencies to provide at least 60 days for receiving public comments when publishing notices of proposed rule-making relating to hospitals and the health care field generally. The request is made on behalf of the 400 teaching hospitals, all U.S. medical schools and 60 academic societies represented by the Association of American Medical Colleges.

The rules and regulations promulgated to carry out the Medicare and Medicaid programs and other health programs administered by your Department have a direct bearing on both public and private interests. They deal with practically every aspect of the operation of health care providers and they also intimately affect millions of Americans in their daily lives. In most cases when the Department of HEW and its agencies publish proposed regulations in the Federal Register, a 30-day period is specified for receiving public comments. This relatively short period is not adequate to provide the thoughtful and constructive review and comment which such important proposed regulations require and deserve.

The problems hospitals and the health care field have encountered in connection with the customary 30-day period for public comment on proposed regulations are twofold. First, it takes time for notices of proposed regulations published in the Federal Register to reach hospitals and other health care institutions that are located in all parts of the country. Copies of the Federal Register may not reach West Coast subscribers until a week or more after the publication date, and our Association has found that when a proposed regulation is published in the Register, reproducing and mailing it to our members still requires several days.

The second aspect of the problem is the length of time needed to carefully review and analyze proposed regulations and study their implications. The number of federal regulations applicable to hospitals has grown enormously since the inception of the Medicare and Medicaid programs and the complexity of such regulations has also increased extensively. Considerable time and effort are often needed to study proposed regulations, to gather information that will enable determinations to be made as to their effect, and to prepare and forward comments presenting facts and probabilities that can contribute to promulgation of final regulations that are both fair and equitable to all interested parties and that are administratively sound and practicable.

I was pleased to learn the Secretary of HEW in a memorandum dated October 12, 1970, directed all agencies and offices of the Department which issues rules and regulations related to "public property, loans, grants, benefits, and contracts" to utilize for public participation the procedures of the Administrative Procedures Act, 5 U.S.C. 533. This provides for a period of at least 30-days for public comments; it provides the necessary authority and flexibility to establish a 60-day comment period as a usual and customary procedure.

The present customary practice of providing a 30-day period for public comment on proposed regulations relating to government health programs simply does not allow time for meaningful involvement of providers of health care. The Association of American Medical Colleges strongly urges the Department of HEW and its agencies to specify as a general practice at least a 60-day period for public comment on routine proposed regulations.

Sincerely,

John A. D. Cooper, M.D.

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

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

WASHINGTON: 202: 4[illegible] 173

February 15, 1974

Honorable J. Bennett Johnston, Jr.
Chairman
Subcommittee on Production and Stabilization
Senate Committee on Banking, Housing
and Urban Affairs
Senate Office Building, Room 254
Washington, D.C. 20510

Dear Senator Johnston:

The purpose of this letter is to forward comments of the Association of American Medical Colleges regarding extension of the Economic Stabilization Act. The Association represents all United States schools of medicine, four-hundred of the nation's largest teaching-tertiary care hospitals and fifty-two academic societies.

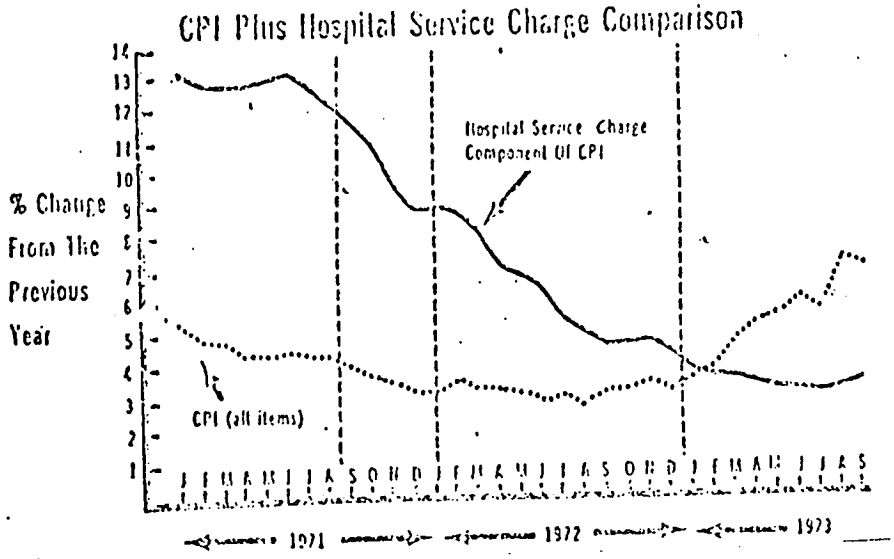
The Association believes that it is inadvisable to retain cost controls on the health sector of the economy. This contention is based upon three arguments: 1) the performance of the health sector in managing the demands placed upon it; 2) the presence of cost control regulations and incentives in existing state and Federal programs, particularly those contained in the Social Security Amendments of 1972; 3) the cost squeeze under which hospitals would operate if they were the only area of the economy to remain under control in a program of a selectively controlled economy.

In previous testimony before the Senate Subcommittee on Production and Stabilization, Dr. John Dunlop listed impressive evidence of the downward trend in prices within the health sector. The evidence, listed in the Appendix (page A-87) of his written testimony stated the following:

> After two years of controls, the indices of inflation show significant improvement. The annualized rate of increase in medical care prices as measured by the CPI came down from 7.3 percent in the pre-Economic Stabilization Program period to 3.7 percent in 1972 and 4.4 percent in 1973.

There were improvements in other price indicators in the health sector as well: hospital semi-private room rates fell from 12.9 percent per year prior to the program to a rate of increase of 6.6 percent in 1972 and 4.7 percent in 1973; increases in average premium increases in commercial health insurance rates slowed to 3.2 percent in 1973 from 7.8 percent in 1972 and 13 percent in 1971; and expense per hospital admission came down to an annual rate of 9.6 percent in fiscal year 1972 and 8.0 percent in 1973 from a rate in excess of 13 percent in fiscal year 1970. This decrease in expense per admission proceeded concurrently with significant increases in the intensity of services provided and improvements in the technology of care. These increases were especially significant in the nation's teaching hospitals.

The performance of the hospital industry, in aggregate, can be seen in the movement of the hospital service charge component of the consumer price index compared with the movement of all items on the CPI. (Chart courtesy of the American Hospital Association.)



It is quite evident from this chart that inflation in the health sector has been brought under control. Some debate has lingered over the reasons for the significant decline in health sector prices. Is the decrease attributable to the effects of the stabilization program or to efforts by those in the health sector to improve efficiency? Support for the former argument is weak. According to the econometric studies quoted in Dr. Dunlop's testimony, the cost controls may have reduced the increase in prices by one or two percentage points by the end of 1972. There is disagreement among econometricians that controls had any impact at all. In fact, two of the five econometric studies reviewed in Dr. Dunlop's written testimony reached the conclusion that controls had no effect.

There are two factors that support the health industry's contention that is has successfully managed to control costs. First the great surge in the demand for medical and hospital services attributable to the impact of Medicare-Medicaid programs have largely been met. This surge of demand put the health industry in disequilibrium. Time was needed to expand facilities and manpower and adjust hospital organization to meet the surge of demand. These adjustments have now been made. Second, professionals in the health sector have become more cost conscious as a result of the increased demands placed upon them as a result of the panpopoly of Medicare and state controls which have been and continue to be implemented. The result of this cost consciousness has been improved efficiency through such programs as shared services, institutional quality assurance activities, utilization review, institutional and community sharing and the improvements in service and administrative techniques. The final accounting of the reasons for the decline in prices will not come for several years. However, based upon these arguments and upon the statistical evidence it is reasonable to believe that the industry was, in large part, responsible for the downturn in prices and can maintain this record of holding down prices without wage and price controls.

However, it will become very difficult for the health industry to keep prices down if it remains as one of the few sectors left under price controls. In order to operate it must purchase goods and services from other sectors of the economy. With controls removed from these other sectors the health industry would be caught in a price-cost squeeze. The prices of its inputs would rise but, if it remained under control, severe limits would be placed upon its ability to absorb these costs. Hence the industry would be placed in chronic financial distress. This situation is intolerable for society. We agree with Dr. Dunlop when he states that:

> Controls may have a small and incremental effect to constrain inflation for short periods...Controls are a special purpose and limited tool to constrain inflation, rather than a general purpose policy. Their potential for adverse effects on output and efficient production needs always to be carefully watched.

The health industry has demonstrated that it can manage cost satisfactorily without controls. It has done this despite the great stresses placed upon it. Continuance of controls, especially in a situation where the health sector would be the only part of the economy to be controlled would be dangerous. Therefore, we feel that controls have outlived their usefulness. They should not be continued.

Sincerely,

John A. D. Cooper

John A. D. Cooper, M.D.

Ad Hoc Committee to Review JCAH Manual

John H. Westerman, Chairman
General Director
University of Minnesota Hospitals
Minneapolis, Minnesota 55455

James E. Cassidy, M.D.
Chief of Staff
Foster G. McGaw Hospital
2160 South First Avenue
Maywood, Illinois 60153

David Dickinson, M.D.
Chief of Staff
University of Michigan Hospitals
Ann Arbor, Michigan

David Jeppson
Director of Hospitals
University of Colorado Medical Center
4200 East 9th Avenue
Denver, Colorado 80220

Malcom Randall
Hospital Director
Veterans Administration Hospital
Archer Road
Gainesville, Florida 32601

C. Thomas Smith, Jr.
Associate Executive Director
Herny Ford Hospital
2799 West Grand Boulevard
Detroit, Michigan 48202

Richard Varco, M.D.
Professor of Surgery
University of Minnesota
College of Medicine
Box 495
University of Minnesota Hospitals
412 Union Street, S.E.
Minneapolis, Minnesota 55455

COTH Ad Hoc Committee to Review the Accreditation Manual for Hospitals (1970)

Association of American Medical Colleges
One Dupont Circle, N.W.
Washington, D.C.
AAMC Conference Room
9:00 a.m.-3:00 p.m.

AGENDA

I. Discussion of Work Program

A. Report to JCAH

B. Report to constituents

C. Reaction to and suggested approach from each committee member

II. Items Relating to JCAH Report

A. Impressions and observations on a sample of teaching hospitals

JCAH Survey findings - Ms. Levin

B. Response to COTH General Membership Memorandum (attached) - Dr. Knapp

C. Reports submitted by other organizations in response to the JCAH request - Dr. Knapp

D. Literature search report - Ms. Levin

E. Identification of potential areas of JCAH - teaching hospital/medical staff common interest

III. Items Relating to Constituent Report

A. Problems of constituents

B. Relation of problems to standards and hospitals

C. Blueprint for institutional adjustment

SUGGESTED WORK PROGRAM TO MEET CHARGE TO THE COMMITTEE

I. Nature of Reports to JCAH

A. Section covering teaching hospital-medical staff reactions regarding existing standards.

1. How are they understood?
2. How are they applied?
3. What is the impact on service-education programs.

B. Section on omissions from standards or what JCAH could do to be more effective for our constituents.

Possible areas

1. House staff organization
2. Responsibility of teaching hospital for house staff
3. Evaluation of performance in community hospitals
4. Research protocols
5. Patient rights and responsibilities
6. Impact of health corporation concept
7. Ambulatory care standards

II. Nature of Report to AAMC-COTH Membership

A. Summary of report to JCAH

B. Analysis of literature search

C. Preparation of Background and Discussion Paper

1. Identification of problems of constituents regarding JCAH standards
   - trustee accountability
   - medical staff regulatory mechanism

Suggested Work Program/2

1. Identification of problems of constituents regarding JCAH standards cont.
   - effectiveness of medical staff and hospital by-laws
   - role of house staff
   - developments in ambulatory care
   - responsibility of specialized teaching center to assure continuity with primary care resource upon patient discharge.

2. Discussion: to what extent are problems related to adjustment of standards and to what extent do problems require adjustment of the institution.

3. Guidelines for teaching hospital adjustment. How to achieve the objectives set forth in item #2.

Response For Request To Review JCAH Standards

Mrs. Lynn Hubschman Director of Social Service Pennsylvania Hospital	-better definition of "social problems" -patient's chart should include psycho-social diagnosis (pg. 169 of the manual)
Robert K. Match, M.D. Executive Vice President and Director Long Island Jewish Hillside Medical Center New Hyde Park, New York	-more emphasis on dentistry; a representative of the Amer. Dental Assoc. should serve on the Board of Commissioners.
Chas. S. Paxson, Jr. Administrative Vice President Temple University Health Science Center	-standards are duly instructive and reasonably acceptable.
Stuart M. Sessoms, M.D. Director Duke University Medical Center	-hosp. dir. reports to V.P. not Bd. of Directors. -composition of Bd. meets university as well as hospital needs (faculty members are not looked upon as candidates).
H. F. Inderlied, M.D. Chairman Committee on Accreditation Saint Luke's Hospital Cleveland, Ohio	-no special standards should be set for teaching hospitals; present standards are reasonably acceptable.
R. D. Linhardt, M.D. Coordinator of Medical Education Wesley Medical Center Wichita, Kansas	-continuing medical education section should be strengthened (pg. 46 of the manual).
John E. Lynch Chief Executive Officer North Carolina Baptist Hospital, Inc.	-summary discussed with surveyors bore little relationship to final written report. -pg. 111 medical records: Internatl. Class. of Dis. is recommended; many hosps. still use the std. nomenclature of diseases & operations.
W. H. Blessing Associate Administrator Professional Services Illinois Masonic Medical Center Chicago, Illinois	-the team should review Res. Rev. Repts. -privilege deliniation for house officers -the team should review inspection reports from those orgs. which spec. in inspecting lab. and rad. services (CAP, AEC, st. dept. of P.H.). -hosp./univ. affiliation arrangements should be reviewed.

John T. Foster
Associate Director
New England Medical Center Hospital

-poor quality of surveyors
-med. sch. affiliation arrangements shd. be reviewed.
-role of med. and dental students & house officers shd. be specified. *suggestion of present policy of Mass. Dept. of Pub. Hlth.

Jeffrey Frerichs
Assistant to Deputy Director
Montefiore Hospital and Medical Center
Bronx, New York

-standards are appropriate & realistic.

LeRoy Deabler
Assistant Director
Rochester General Hospital
Rochester, New York

-require some justification of residency positions offered in terms of manpower needs.

Ralph L. Perkins
Executive Director
Hospital of the University of Pennsylvania

-recommendations attached.

G. L. Warden
Executive Vice President
Rush-Presbyterian St. Luke's Medical Center
Chicago, Illinois

-the process could be upgraded if it took form of peer review including practicing physicians, nurses & administrators. More use should be made of other agency inspection reports.

Daniel W. Capps
Administrator
The University of Arizona
Arizona Medical Center

-univ. owned hosps. have a governing bd. & comm. structure which is different. Med. staff apptment. procedures are also handled differently. The role of chief executive in these institutions varies according to org. arrangements.

Dan W. McAdams
Assistant Director
Church Home and Hospital
Baltimore, Maryland

-more specific def. of privilege delineation. Procedures for house officer privileges.

Alvin M. Goldberg
Director
Mount Sinai Medical Center of Greater Miami

-standards generally satisfactory.

James M. Vaccarino
Administrative Assistant
The Massachusetts General Hospital

-documentation of a long list of meetings etc. is cumbersome. PSRO shd. substitute for medical audit requirements.

*A statement of qualifications, status, clinical duties & responsibilities of those members of the Allied Health Professions, such as doctoral scientists & others, whose patient care activities require that their appointment and authority for specific services be processed through the usual medical staff channels; non-physician practitioners & members of allied health professions shall be individually assigned to an appropriate clinical department & shall carry out their activities subject to departmental policies & procedures.

Rich Grisham
Barnes Hospital

-submitted memo sent to all chiefs of service & dept. heads requesting comments (nothing yet received).

John F. Stapleton, M.D.
Medical Director
Georgetown University Hospital

-diff. for univ. owned hosps. to meet hosp. gov. bd. requirements. Shd. teaching hosps. which engage in constant peer review be required to develop the same med. auditing system as the non-teachin hosp?

William H. Hermann
Administrator
The Mary Imogene Bassett Hospital
Cooperstown, New York

-standards are fine with one exception: the fact tha consumers are entitled to review the findings & may request an audience with JCAH surveyors.

HOSPITAL of the UNIVERSITY of PENNSYLVANIA

PHILADELPHIA 19104

February 11, 1974

RALPH L. PERKINS
EXECUTIVE DIRECTOR

Richard M. Knapp, Ph.D.
Director, Dept. of Teaching Hospitals
Council of Teaching Hospitals
Association of American Medical Colleges
One Dupont Circle, N.W.
Washington, D. C. 20036

Dear Dick,

In response to your letter of January 18th concerning COTH participation in the JCAH Standards Review, we are submitting the following suggestions:

GOVERNING BODY AND MANAGEMENT

Standard I - Interpretation - "....The governing body or advisory board should include a broad representation of the community served by the hospital....."

COMMENT: Unlike community hospitals who can delineate fairly easily the boundaries of the area they serve, teaching and tertiary care hospitals often draw patients from such a large geographic area that it is impossible to define "the community served by the hospital" which makes it difficult to ensure that this undefinable community has true representation.

MEDICAL STAFF

Standard III - ".....the delineation of medical staff pribileges..."

COMMENT: A specialist who is Board Certified has already met the requirements of his peer group or he would not be certified. To ask the medical staff, many of whom are not certified in his specialty, to delineate privileges which have been already set by the Specialty Board seems redundant.

SUGGESTED ALTERNATIVES: A Board Certified physician will automatically be granted clinical privileges in his own specialty. If he desires to practice outside his specialty, then these privileges must be delineated.

MEDICAL RECORD SERVICES

Standard I - Interpretation - ".....Symbols and abbreviations may be used only when they have been approved by the medical staff...."

COMMENT - It is unrealistic to expect someone to review every word in a medical record to see that no abbreviations other than those approved have been used. We agree that extreme care must be taken in using abbreviations while writing drug orders and final diagnoses, but some leeway should be allowed in the body of the record. This is especially true in teaching hospitals with a constant rotation of large numbers of house staff.

RESPIRATORY CARE SERVICES

Standard VI - Interpretation - "The respiratory care service shall be provided ..... Pulmonary function studies and blood gas analysis."

COMMENT - This interpretation assumes that pulmonary function studies and blood gas analysis are the responsibility of the Respiratory Care Service. In some teaching hospitals these are separate areas and do not fall under the control of the Respiratory Care Service.

In general we think they are good and except for the above have very little quarrel.

Sincerely yours,

Ralph L. Perkins
Executive Director

RLP:es

cc: Miss Mildred Barton

Summary of Survey Comments*

Governing Body

There should be bylaws of the governing body for the university teaching hospitals.

The bylaws should be regularly reviewed, revised and dated.

The governing body must meet regularly and have representation from the community.

The governing body must delineate responsibility of chief administrative officer, medical staff and governing body.

The governing body must have procedure for providing due process in medical staff appointments and privileges and for review of procedures of the medical staff for evaluation of quality of care.

Medical Staff

The medical staff must develop clinical criteria for use in medical care evaluation.

Findings of medical care evaluation studies must be reflected in delineation of clinical privileges and in medical staff programs for continuing education.

Minutes of clinical department meetings must document evaluation studies and related decisions for improvement of care.

Medicare staff bylaws must provide due process protection.

Nursing Services

There should be a written nursing care plan for each patient.

There should be a nursing care evaluation program with findings reflected in in-service and continuing education programs.

Nursing notes should document patient and family education.

Emergency Services

There must be a written organizational plan for emergency services.

There must be an official hospital record on every emergency service patient including final disposition and instructions to the patient or family on necessary follow-up care.

*Based on JCAH Survey Report for six university teaching hospitals.

Medical Records

All medical records of discharged patients must be completed within a period of time specified by the medical staff bylaws.

Special Care Units

There must be current written policies and procedures, approved by the medical staff, for management of situations unique to special care units with indication of which personnel perform specific procedures.

JCAH STANDARDS

Annotated Bibliography

1970

Carroll, Walter, "JCAH Standards: Opportunities for Medical Staff Leadership," Hospital Progress, Vol. 51, pp. 63-8, 100. October 1970.

Discussion of privileges and responsibilities of medical staff membership. Need for greater understanding of separate roles and responsibilities of hospital trinity-medical staff, administration, governing board. Reviews JCAH standards from perspective of opportunities for medical staff leadership. Suggests goals for organization of the medical staff.

1971

Stone, J. Martin, "JCAH Standards Emphasize Better Management, Physician Participation," Modern Hospital, Vol. 116, pp. 116, 108-10, February, 1971.

Critique of JCAH effort to assess hospital management through standards. Problems: (1) emphasis is on internal responsibilities of management, while good management must go beyond walls of institution; (2) standards are more minimal than optimal despite rhetoric; reasons; (3) assessment through specification of process may or may not work. Assumption is that if procedures are specified than good management will occur. Preferable to use evaluation through outcomes; (4) roof of hospital management problems is dichotomy between medical staff and the rest of the hospital. JCAH does not speak to this.

Porterfield, John, "JCAH Director Discusses New Standards", Hospitals, JAHA, Vol. 45, pp. 31-35, July 1, 1971, interview.

The need for change in the role of JCAH. Role of JCAH is not to guarantee quality of care but to address matrix within which care is delivered. New standards set "optimal achievable" goals.

McNulty, Elizabeth, "How Survey Mechanism Works," Hospitals, JAHA, Vol. 45, July 1, 1971, pp. 36-40.

Discussion of process of accreditation from computerized questionnaire, through visit of the interdisciplinary survey team, to appeals process.

Carroll, Walter, "Joint Commission Myth (and the Reality)", AORN Journal, Vol. 14, pp. 37-41, September 1971.

History of JCAH. Growth of responsibility with Medicare designation. Context for new approach, the shift from minimum standards to quality goals.

1971 (cont.)

Reinertsen, Jr., "Accreditation-the Administrator's View", AORN Journal, Vol. 14, pp. 47-48, September 1971.

New standards deal with function. Require written departmental organization plan with definition of roles for personnel within the specific service and relationship to other services. Emphasis is on delegation of authority or responsibility to each individual who controls or supervises a function.

Roberts, Bruce, "Accreditation and Legality," AORN Journal, Vol. 14 pp. 49-52, September 1971.

Changes in hospital liability law contributed to change in role for JCAH. Summary of changes: (1) loss of charitable immunity; (2) shift away from local standards to national standards of care; (3) extension of hospital responsibility into patient care arena. Standards reflect liability developments by "placing authority within the hospital organization where the law imposes the responsibility."

1973

Mackert, Mary Ellen, "JCAH Standards Generate Goals," Hospitals JAHA, Vol. 47, pp. 85-89, January,1973.

Implications of new JCAH outlook for central service department. Review of Standard III of environmental services section with requirements for qualified supervisory personnel, written procedures and inservice education.

Bernstein, Arthur, "Staff Privileges and the Hospital's Liability to Patients," Hospitals, JAHA, Vol. 47, pp. 156-170, March, 1973.

Review of recent decisions on hospital liability, Darling v. Charleston Community Memorial Hospital (1965). Nonprofit hospital found liable for error of licensed physician treating private patient in emergency room.

Hull v. North Valley Hospital (Montana, 1972). Found medical staff not an arm of the hospital administration so knowledge of a physician's inadequacy held by the medical staff cannot be attributed to hospital management. Rejected Darling.

Mitchell County Hospital Authority v. Joiner (Georgia, 1972). Found the medical staff is acting on behalf of governing board in assigning privileges. When medical staff knows of a physician's inadequacy and does not act to limit privileges, hospital is liable.

Purcell v. Zimbleman (Arizona, 1972). Found hospital is liable for failure to react to information of prior malpractice claims against a

Purcell v. Zimbleman (cont.)

physician when it has knowledge of them. The court noted JCAH accreditation standards which require governing board to extend privileges only to competent physicians and medical staff bylaws which require medical staff review of physician competence.

Hershey, Nathan, "Some Observations on the JCAH Guidelines," The Hospital Medical Staff, pp. 27-32, June, 1973.

Guidelines present a balance of physician rights and responsibility. The physician receives a grant of responsibility from the governing board and acquires guarantee of objective evaluation and right to due process. New guidelines force standards of medical performance beyond that which is prevalent in many institutions today.

Blaes, Stephen, "Why and How Should Bylaws be Revised," Hospitals, JAHA, Vol. 47 pp. 100-106, December, 1973.

Review of court decisions on hospital liability with attention to use of JCAH standards in Purcell. Recommends restraint in wording of medical staff bylaws so that physicians do not agree to do more than can be reasonably achieved.

COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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

COTH Special Membership Memorandum
74-1S
February 11, 1974
Subject: Elimination of General Research Support Grants

Your teaching hospital is one of forty-seven COTH members awarded a General Research Support Grant for fiscal 1974. The Administration budget proposal for FY 1975, which was submitted to Congress on February 4, proposes to immediately discontinue the General Research Support Program.

As you are aware the GRS program offers special grants to institutions for their use in strengthening medical and health related research. These awards provide support for pilot research projects and young investigators, as well as development of research components of new programs and departments. Although the amounts of the awards are not large, this flexible funding mechanism is extremely useful to start new programs and to provide interim support while institutes and programs are changing direction.

Because of the importance of these flexible dollars, I urge you to write your Congressional delegation outlining the purposes for which these funds are utilized, and strongly recommending the GRS program be continued and fully funded at authorized appropriation levels.

RICHARD M. KNAPP, PH.D.
Director
Department of Teaching Hospitals

GENERAL RESEARCH SUPPORT GRANTS

Cedars-Sinai Medical Center, L.A.
Children's Hospital of Los Angeles
Mount Zion Hospital and Medical Center, San Francisco
Michael Reese Hospital and Medical Center, Chicago
Rush Presbyterian St. Lukes Medical Center, Chicago
Beth Israel Hospital, Boston
Children's Hospital Medical Center, Boston
Massachusetts Eye and Ear Infirmary, Boston
Massachusetts General Hospital,Boston
Peter Bent Brigham Hospital, Boston
Henry Ford Hospital, Detroit
Jewish Hospital of St. Louis
Childrens Hospital of Buffalo
Hospital for Special Surgery, New York
Montefiore Hospital and Medical Center, Bronx
St. Lukes Hospital Center, New York
St. Vincents Hospital and Medical Center of New York
Jewish Hospital and Medical Center of Brooklyn
Albert Einstein Medical Center, Philadelphia
Childrens Hospital of Philadelphia
Childrens Hospital of Pittsburgh
Philadelphia General Hospital
U. Texas, M.D. Anderson Hospital and Tumor Institute, Houston
Baltimore City Hospitals
Magee Womens Hospital, Pittsburgh
St. Josephs Hospital, Phoenix
St. Elizabeth Hospital, Brighton
Hospital for Joint Disease and Medical Center, New York
Pennsylvania Hospital, Philadelphia
New England Deaconess Hospital, Boston
Montefiore Hospital, Assoc. W. Pa., Pittsburgh
New England Medical Center Hospital, Boston
Presbyterian University of Pa. Medical Center, Philadelphia
St. Christophers Hosptial for Children, Philadelphia
St. Lukes Hospital, Cleveland
Childrens Ortho. Hospital and Medical Center, Seattle
Roosevelt Hospital, New York
Robert B. Brigham Hospital, Boston
Allegheny General Hospital, Pittsburgh
Memorial Hospital for Cancer and Allied Diseases

HOSPITALS WHICH ARE ELIGIBLE FOR MEMBERSHIP IN COTH

	Name of Institution	Number of Beds	Residency Programs	Type of Affiliation	Total Residency Positions Offered	
1.	Carraway Methodist Medical Center P.E. Cox, Administrator Birmingham, Alabama	419	GS, IM,OBG, PTH, U	L-010	39[a]	(16)[b]
2.	Lloyd Noland Hospital John W. McLean, Jr., Administrator Fairfield, Alabama	307	AN,D,GS,IM, OBG,ORS,PD	L-010	32	(20)
3.	Pima County General Division Joseph C. Herrick, Administrator Tucson, Arizona	140	GS,IM,OBG,PD	M-100	--	
4.	Kern County General John Canning, Acting Administrator Bakersfield, California	182	GP,GS,IM,OBG, OPH,PTH	L-013	35	(17)
5.	David Grant USAF Medical Center Col. James E. Henry, Administrator Fairfield, California (Travis Air Force Base)	385	DR,GS,IM, OBG,PD,R	M-102	69	(50)
6.	Valley Medical Center of Fresno Manuel Perez, Administrator Fresno, California	583	FP,GS,IM, OBG,OPH,OTO, PD,PS	G-015, 016	61	(37)
7.	Kaiser Foundation James L. Rieder, Administrator Los Angeles, California	465	FP,GS,IM,N, OBG,PTH,PD,R, U	—	71	(50)
8.	White Memorial Medical Center Ronald L. Sackett, Administrator Los Angeles, California	307	AN,GS,IM,NS, OBG,OPH,ORS, OTO,PTH,PD,R, TS,U	M-012, L-014	86	(78)
9.	Highland General Lawrence Hoban, Administrator (Part of Alameda County Health Care Services Agency) Oakland, California	688	GS,IM,OBG, ORS,PTH,P,R, TS,U	G-016	62	(61)
10.	Kaiser Foundation Gordon R. Kirstein, Administrator Oakland, California	262	GS,IM,OBG, ORS,OTO,PD	L-016	47	(43)

[a]=Offered Positions as of July 1, 1974
[b]=Filled Positions as of September 1, 1972

11.	Naval Hospital Capt. E. B. Miller, MSC Administrator Oakland, California	775	AN,GS,IM,OBG, OPH,ORS,OTO, PTH,PD,P,R,U	--	113 (94)
12.	Huntington Memorial Robert S. Lund, Acting Administrator Pasadena, California	482	GS,IM,NS,PS	L-014	29 (21)
13.	San Bernardino County General C.M. Thayer, Administrator San Bernardino, California	306	FP,GS,IM,OBG, ORS,PTH	L-012, G-013	55 (35)
14.	Naval Hospital Capt. A.J. Schwab, MSC,USN Administrative Officer San Diego, California	1,700	AN,DR,D,GS, IM,OBG,OPH,ORS, OTO,PTH,PD,R,TS, TR,U	L-103	197 (155)
15.	Letterman General Brig. Gen. Robert W. Green, MC, Commander San Francisco, California	525	AN,CHP,DR,D,GS, IM,N,OBG,OPH, ORS,PTH,PD,PM,P, TS,U	L-016, 091	137 (138)
16.	St. Mary's Hospital & Medical Center Sister Mary Joanne RN, Administrator San Francisco, California	438	CHP,DR,GS,IM, ORS,PD,P,R,TR	L-016	63 (28)
17.	San Francisco General C. Charles Monedero, Administrator San Francisco, California	653	AN,DR,D,FP,GS, IM,NS,N,OBG,ORS, OTO,PTH,PD,PS,TR, U	M-016	20
18.	U.S. Public Health Service Karl F. Urbach, M.D. Director San Francisco, California	321	GS,IM,OPH,ORS	--	30 (10)
19.	Santa Clara Valley Medical Center Leo G. Smith, Administrator San Jose, California	457	AN,DR,GS,IM, NS,OBG,OPH,ORS, OTO,PTH,PD,PM,TR, U	M-015, G-016	40 (28)
20.	San Joaquin General William Mandel, M.D., Medical Director Stockton, California (French Camp)	462	FP,GS,IM,OBG, OPH,PD	L-102, G-016	44 (22)

21.	Fitzsimons General Maj. Gen. James A. Wier, M.D., Commanding Officer Denver, Colorado	850	D,GS,IM,OBG, OPH,ORS,OTO,PTH, PD,PDA,U	M-017, L-091	90	(89)
22.	St. Joseph Sister Mary Andrew, Administrator Denver, Colorado	554	GP,GS,IM,OBG, ORS,PTH,R	G-017	25	(22)
23.	District of Columbia Frank G. Bossong Administrator Washington, D.C.	816	GS,IM,NS,OBG,OPH, ORS,OTO,PTH,PD, PDA,R,TR,U	M-019, 020, 021	35	(31)
24.	Doctors Hospital Dudley P. Cook Administrator Washington, D.C.	284	GS,IM,PTH	L-019	23	(15)
25.	Walter Reed General Maj. Gen. William H. Moncrief, Jr., M.D. Administrator Washington, D.C.	943	AN,CHP,DR,D,GS, IM,NS,N,OBG,OPH, ORS,OTO,PTH,PD, PS,P,TS,U	M-019, L-021, G-020	201	(223)
26.	Orange Memorial J. Quinn & G. Walker Directors Orlando, Florida	787	GS,OBG,ORS,PTH, PS	--	44	(41)
27.	Tampa General Howard B. Lehwald, Administrator Tampa, Florida	583	CHP,DR,GS,IM,OBG, OPH,OTO,PTH,PD,P, R,U	M-115	27	(17)
28.	Georgia Baptist Edwin B. Peel Administrator Atlanta, Georgia	444	GS,IM,OBG,ORS	--	47	(33)
29.	University Hospital George B. Little, Jr., Administrator Augusta, Georgia	600	D,FP,GS,IM,NS,OBG, OPH,ORS,PTH,PD,TR	M-024	--	
30.	Medical Center of Central Georgia Damon D. King Administrator Macon, Georgia	484	FP,GS,OBG	L-024	31	(10)
31.	Memorial Medical Center R.J. Weinzettel, Executive Director Savannah, Georgia	433	DR,GS,IM,OBG,PTH, R,TS,U	L-024	33	(17)

32.	Tripler General Maj. Gen. C. Hughes, MC, Commanding General Honolulu, Hawaii	750	D,GS,IM,OBG,OPH, ORS,PTH,PD,U	M-105, G-016	91	(100)
33.	Columbus-Cuena Medical Center Joseph J. Rossi, Jr., Administrator Chicago, Illinois	---	GS,IM,OBG	L-027	28	(26)
34.	Louis A. Weiss Memorial Mortimer W. Zimmerman, Executive Director Chicago, Illinois	343	GP,GS,IM,ORS, PTH,R,U	M-030	42	(25)
35.	Naval Hospital Capt. William L. Long, MSC, Administrator Bethesda, Maryland	662	AN,D,GS,IM,N,OBG, OPH,ORS,OTO,PTH, PD,PS,P,R,TS,U	M-019, L-021, G-020	143	(109)
36.	Boston City Leon White, Ph.D., Commander Boston, Massachusetts	809	AN,DR,D,GS,IM,NS, N,OBG,OPH,ORS, OTO,PTH,PD,P,TS,U	M-040, 041, L-042	173	(149)
37.	Cambridge Hospital Leslie N.H. MacLeod, Director Cambridge, Massachusetts	187	AN,GS,IM,PTH,PS,P	M-041	40	(24)
38.	Naval Hospital Capt. S.G. Kramer, MC Commanding Officer Chelsea, Massachusetts	375	PS	M-040	2	(1)
39.	Mount Carmel Mercy Sister Mary Leila, Executive Director Detroit, Michigan	557	GS,IM,OBG,PTH,PD, PS,R	G-043	49	(27)
40.	Sinai Hospital of Detroit Julien Priver, M.D., Executive Vice President Detroit, Michigan	619	AN,DR,GS,IM,OBG, OPH,PTH,PD,PS,P, R,U	M-044	92	(74)
41.	St. Joseph Sister Agnes Breitenbeck, President Flint, Michigan	426	FP,GP,PTH,R	M-098	29	(8)
42.	William Beaumont Kenneth E, Meyers, Director Royal Oak, Michigan	700	DR,GS,IM,OBG,ORS, PTH,PD,PS,R,U	--	114	(101)

43.	Homer G. Phillips John P. Noble, Administrator St. Louis, Missouri	432	GS,OBG,OPH,OTO, PTH,R,U	L-049	70	(55)
44.	Hackensack Lawrence L. Smith, Executive Director Hackensack, New Jersey	471	AN,GS,PTH,P,R	L-053	25	(30)
45.	Jersey City Medical Center Ira C. Clark, Executive Director Jersey City, New Jersey	579	GS,IM,OPH,ORS, PTH,PD,PS,U	M-053	80	(69)
46.	St. Joseph's Sister Jane Frances Brady, Administrator Paterson, New Jersey	507	AN,GS,IN,OBG,ORS, PTH	L-053	59	(45)
47.	St. Peter's Sister Ellen Lawlor, Executive Director Albany, New York	423	GS,OBG,PTH,PD,PS, R	L-054	12	(10)
48.	Bellevue Hospital Center Bernard M. Weinstein, Director New York City, New York	1,572	CHP,DR,D,GS,IM,NS, N,OBG,OPH,ORS,OTO, PTH,PD,PDC,PM,PS,P, R,TR,TS,U	M-060		
49.	Coney Island Frank W. Hays, Executive Director Brooklyn, New York	600	AN,GS,IM,OBG,OPH, ORS,PTH,PD,U	--	46	(45)
50.	Flushing Hospital and Medical Center William F. Moore, Executive Director Flushing, New York	325	GS,IN,OBG,PTH,PD	--	32	(29)
51.	French and Polyclinic Medical School Irwin Shapiro, Executive Director New York City, New York	574	AN,GS,IN,OBG,OPH, ORS,PTH,PD,U	--	67	(59)
52.	Lincoln J. Cesar Galarce, Executive Director Bronx, New York	355	AN,GS,IM,OBG,ORS, OTO,PTH,PD,PDC,PM, PS,P,U	M-056	49	(85)
53.	Maimonides Medical Center Lee W. Schwenn, Executive Vice President Brooklyn, New York	613	AN,CHP,GS,IM,OBG, OPH,ORS,PTH,PD,P, U	M-061	44	(41)

54.	Metropolitan Hospital Center Unit 2 A. Constantine, Executive Director New York City, New York	925	AN,CHP,DR,D,GS, IM,N,OBG,OPH,ORS, OTO,PTH,PD,PDA,PM, P,U	M-059	--	
55.	New York Infirmary Edward Vincent Grant, Administrator New York City, New York	272	GS,OBG,PD	G-060	23	(21)
56.	Queens Hospital Center Robert A. Vitello, Executive Director Jamaica, New York	1,177	AN,CHP,GS,IM,OBG, OPH,ORS,PTH,PD, PDC,PM,P,R,TS,U	M-109	30	(28)
57.	St. Clare's Hospital & Health Center Sister John K, McNulty, Administrator New York City, New York	411	GS,IM,OBG,OPH, PTH,PD	--	64	(61)
58.	Wycoff Heights Allen Podell, Executive Director Brooklyn, New York	375	GS,IM,OBG,PTH,PD	--	56	(53)
59.	Crouse-Irving Memorial David M. Beers, Executive Vice President Syracuse, New York	466	AN,GS,IM,NS,N,OBG, OPH,ORS,OTO,PTH, PD,PDC,PS,TS,U	M-063	--	
60.	St. Joseph's Hospital Health Center Sister Patricia Ann, Executive Vice President Syracuse, New York	386	AN,FP,GS,OBG,ORS, PTH	M-063	13	(9)
61.	Good Samaritan David L. Ford, Administrator Dayton, Ohio	494	FP,GS,IM,OBG	--	36	(16)
62.	Good Samaritan Hospital & Medical Center Chester L. Stocks, Executive Vice President & Administrator Portland, Oregon	520	GS,IM,NS,N,OPH,PTH, PS	G-071	30	(26)
63.	Abington Memorial Morris F. George, President Abington, Pennsylvania	463	GP,GS,IM,OBG,ORS, PTH,R,U	M-074	43	(27)
64.	Lankenau Ralph F. Moriarty, President Philadelphia, Pennsylvania	425	GS,IM,OBG,OPH,ORS, PTH,PS	M-073, L-074	46	(37)

65.	Naval Hospital Capt. G. E. Cruft, Commanding Officer Philadelphia, Pennsylvania	1,000	AN,D,GS,IM,OBG, OPH,ORS,OTO,PD, P,R,U	M-073, L-072	110	(96)
66.	Reading James B. Gronseth, Administrator Reading, Pennsylvania	599	DR,FP,GS,IM,OBG, ORS,PTH,R	L-074, 075	55	(23)
67.	Mayaguez Medical Center Miguel A. Sepulveda, Administrator Mayaguez, Puerto Rico	400	GS,IM,OBG,PD	L-078	36	(31)
68.	Baroness Erlanger Harold L. Peterson, Administrator Chattanooga, Tennessee	652	GS,IM,OBG,OPH,ORS, PTH,PS,R	--	61	(45)
69.	University of Tennessee Memorial Research Center Hospital John H. King, Administrator Knoxville, Tennessee	473	AN,FP,GS,IM,OBG, ORS,PTH,PD,R	M-081	45	(33)
70.	Methodist Harry C. Mobley, Administrator Memphis, Tennessee	915	GS,IM,NS,OBG,OPH, ORS,OTO,PTH,R	G-081	43	(30)
71.	Children's Medical Center James J. Farnsworth, Administrator Dallas, Texas	122	DR,NS,N,OTO,PD,PDC, R,TR,TS	M-084	32	(26)
72.	St. Joseph Sister Mary Agnesita Brosman, Administrator Houston, Texas	768	AN,DR,GS,IM,OBG, OPH,ORS,PTH,PS,R	M-120, L-085	26	(24)
73.	Brooke General Brig. Gen. Edward H. Vogel, Jr., Administrator Fort Sam Houston, Texas	860	AN,DR,D,GS,IM,N, OBG,OPH,ORS,OTO, PTH,PD,PM,PS,TS,U	G-111	167	(141)
74.	Naval Hospital RADM Willard P. Arentzen, MC, Commanding Officer Portsmouth, Virginia	1,102	AN,GS,IM,OBG,ORS, PTH,PD,U	M-122	105	(76)
75.	Roanoke Memorial Hospital William H. Flannagan, Director Roanoke, Virginia	725	DR,FP,GS,ORS,PTH, R	M-089	46	(20)
76.	Virginia Mason Austin Ross, Administrator Seattle, Washington	286	AN,DR,GS,IM,OBG, PTH,R,TR,U	L-091	47	(37)
77.	Madigan General (Army) Tacoma, Washington	1,024	FP,GS,IM,OBG,OTO, PTH,PD,U	L-091	75	(57)

78.	Ohio Valley General Fred E. Blair, Executive Director Wheeling, West Virginia	438	GS,IM,OBG,PTH,R	L-092	30	(17)
79.	St. Joseph's Sister M. Jeanne Gengler, President Milwaukee, Wisconsin	580	DR,GS,OBG,PTH,R,TS	L-094	56	(18)