



association of american medical colleges

MEETING SCHEDULE COUNCIL OF TEACHING HOSPITALS ADMINISTRATIVE BOARD

June 21-22, 1978
Washington Hilton Hotel
Washington, D.C.

Wednesday, June 21

| | | |
|-----------|-----------------------------------|---------------|
| 6:30 P.M. | COTH Administrative Board Meeting | Dupont Room |
| 7:30 P.M. | Cocktails | Kalorama Room |
| 8:30 P.M. | Dinner | Dupont Room |

Thursday, June 22

| | | |
|-----------|--|-------------------|
| 9:00 A.M. | COTH Administrative Board Business Meeting (Coffee and Danish) | Grant Room |
| 1:00 P.M. | Joint COTH/COD/CAS/OSR Administrative Board Luncheon | Conservatory Room |
| 2:30 P.M. | Executive Council Business Meeting | Cabinet Room |

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|--|--------------------------------------|
| IX. AAMC Biomedical and Behavioral Research Policy | Executive Council Agenda Page 28 |
| X. Discharge in Bankruptcy of Student Loans | Executive Council Agenda Page 61 |
| XI. Report of the Task Force on Minority Student Opportunities in Medicine | Executive Council Agenda Page 63 |
| XII. Recent Manpower Reports from GAO, National Academy of Sciences, and CCME | Executive Council Agenda Page 70 |
| XIII. Financial Considerations for Admission to Medical School | Executive Council Agenda Page 80 |
| XIV. Recommendations of the CCME Committee on the Opportunities for Women in Medicine | Executive Council Agenda Page 82 |
| XV. Report of the CCME Committee on the Opportunities for Women in Medicine | Executive Council Agenda Page 88 |
| XVI. Statements Submitted for the Consideration of the Council of Deans at its 1978 Spring Meeting | Executive Council Agenda Page 123 |
| INFORMATION ITEMS | |
| XVII. American Society of Internal Medicine Resolution | Page 129 |
| XVIII. Response to JCAH Manual Revisions | Page 137 |
| XIX. AAMC Testimony on AICPA Exposure Draft | (Separate Handout) |
| XX. Adjournment | |

Association of American Medical Colleges
COTH Administrative Board Meeting

Washington Hilton Hotel
Washington, D.C.
March 23, 1978

MINUTES

PRESENT:

David L. Everhart, Chairman
Robert M. Heyssel, M.D., Chairman-Elect
David D. Thompson, M.D., Immediate Past Chairman
John Reinertsen, Secretary
John W. Colloton
Jerome R. Dolezal
Stuart Marylander
Mitchell T. Rabkin, M.D.
Malcom Randall
William T. Robinson, AHA Representative

ABSENT:

James M. Ensign
Lawrence A. Hill
Stanley R. Nelson
Elliott C. Roberts
Robert E. Toomey

GUESTS:

John F. Finklea, M.D.
Robert G. Petersdorf, M.D.

STAFF:

James D. Bentley, Ph.D.
Armand Checker
John A. D. Cooper, M.D.
Kat Dolan
Gail Gross
James I Hudson, M.D.
Joseph C. Isaacs
Thomas J. Kennedy, Jr., M.D.
Richard M. Knapp, Ph.D.
Thomas E. Morgan, M.D.
J. Trevor Thomas
Bart Waldman

I. Call to Order:

Mr. Everhart called the meeting to order at 9:00 A.M. in the Dupont Room of the Washington Hilton Hotel.

II. Industry-Sponsored Research and Consultation: Responsibilities of the Institution and the Individual

Mr. Everhart explained to the board that a letter written to Dr. Cooper by Rep. Paul Rogers (D-Fla.), Chairman of the House Interstate and Foreign Commerce Health Subcommittee, had prompted staff to develop a position paper addressing several questions raised by the Congressman with regard to industry-sponsored research and consultation. It was agreed at the annual officers retreat that this position paper be recommended for approval as Association policy and transmitted to Rep. Rogers, as well as to the medical schools. Dr. Kennedy provided more background information on the development of the position paper and then introduced Dr. John F. Finklea to the Board. Dr. Finklea, formerly Director of the National Institute for Occupational Safety and Health, was instrumental in developing the position paper as presented in draft form on pages 63-76 in the Executive Council Agenda.

Dr. Kennedy indicated that any comments or recommendations that the board might have regarding the position paper would be welcomed. Dr. Finklea then proceeded to review the position paper for the Board, pointing out recent changes made to it and emphasizing areas of particular concern. He explained that the paper dealt with basically three issues -- propriety, institution safeguards, and individual responsibilities. With regard to individual responsibilities, Dr. Finklea indicated that the major pitfall could be the failure of academic consultants to fully disclose relationships and by doing so, reflect on the institution or university. He concluded that the implementation and monitoring of an effective system of safeguards for expeditious disclosure should be the responsibility of each educational institution. Dr. Thompson asked Dr. Finklea to elaborate on the problem of the industry pressing for results before investigators are ready with findings. Dr. Finklea acknowledged that such pressure exists and agreed that investigators should be cautious about what they report for liability purposes (among others).

ACTION: It was moved, seconded, and carried that the Executive Council be recommended to approve the draft position paper on Industry-Sponsored Research and Consultation as AAMC policy for transmittal to Congressman Rogers and distribution to the medical schools (as proposed on page 62 of the Executive Council Agenda).

III. AAMC Biomedical and Behavioral Research Policy

Dr. Morgan reviewed the AAMC Biomedical and Behavioral Research Policy to date and indicated that there had been no major change in it since 1974. At the suggestion of the Executive Council, an ad hoc committee of constituents was formed in September of last year to review the policy and revise the staff position paper. The committee subsequently developed the position paper that is presented on pages 78-108 of the Executive Council Agenda. At the January 18th meeting of the Council of Academic Societies, a number of problems were noted with the position paper and the committee, thereafter, revised the policy statement to make it appear less self-serving. The considerations in order of priority were (1) goals of scientific effort, (2) mechanisms for achieving research and (3) funding to attain these goals. Dr. Morgan then invited discussion of the six specific goals set forth in the policy statement.

With regard to Goal 3 which advocates public involvement in the decision-making process governing research programs, Mr. Randall felt that this decision-making process would become politicized and wondered how it would bring about public awareness if the goal were achieved. He also expressed concern about public involvement in light of the experience under the health planning law with consumer participation. Mr. Everhart commented that the paper addressed the accountability issue because research can no longer go carte blanche and must regain public support. Mr. Colloton asked how Goal 5 deals with the evaluation of efficacy and safety of new technology and its transfer to patient care. Dr. Morgan explained that the transfer of findings related to the testing of clinical applications and the relaying of them to the public was the last step in the suggested six-step program. He noted that this transfer process needs the most work. The Association's position is that those performing the research function should not be burdened excessively by the safety function which should remain the responsibility of agencies like the Food and Drug Administration and the Center for Disease Control, and should be strengthened.

With regard to the establishment of scientific review panels, Dr. Heyssel felt that it must be made clear that such panels could not be considered technical panels with lay people serving on them. Dr. Heyssel also feared allowing

federal agencies arbitrary decision-making in this area. He believed that the Board should take a position in favor of further study by agencies, not final approval or disapproval of clinical applications of research endeavors. He thought that the best way to settle disagreements on new research products or technology was not to depend on target studies, but rather to put a substantial number of the products out in the market and then observe what happens. Dr. Morgan indicated similar concerns. He stated that the Association's position over the last two years on this subject has been that NIH, while having done a good job at research, should not have primary responsibility for clinical application and development. Dr. Thompson felt that the greatest concern should be on whether the patient feels better. Vigorous scientific data is not or should not be the major criteria, for patients will tell you different things than investigators report. Mr. Everhart reiterated that the recommendation called for approval of this position as set forth in the Executive Council Agenda and wondered to what extent discussion by the Board might modify this recommendation.

Dr. Rabkin indicated that he could not support the policy as recommended on the basis that it lacked clarity and internal consistency with other AAMC positions. He pointed out that the Association had supported keeping HSAs out of manpower and research decision-making, but in this policy statement calls for increased public participation in the decision-making process regarding research. He also noted that the AAMC position statement failed to address the issue of cost effectiveness. Dr. Rabkin wondered if a disservice would be done to the academic community should the paper receive widespread distribution and possibly widespread interpretation. Dr. Morgan assured that this was an internal document to be used to guide the AAMC in developing its policy, and was not intended for general public use. Mr. Marylander felt, however, that even if the document remained internal, it should not remain as written. He believed that calling for an increased role for the public in decision-making would only add to the public's confusion and would bring about the defects that have been seen elsewhere with the growing thrust of consumerism. Dr. Morgan questioned whether the Board objected to the wording of the Goal or the Recommendation or both. Mr. Marylander felt that both should be revised to clarify how public input will be obtained.

Mr. Everhart proposed that the Board's representatives to the Executive Council express the concerns voiced in the foregoing discussion at the Executive Council Meeting and use their discretion with regard to any decisions that would be made.

ACTION: It was moved, seconded, and carried that the COTH Executive Council representatives express the Administrative Board's concerns on this issue at the Executive Council Meeting and use their discretion with regard to any decisions or actions that had to be taken.

IV. Consideration of Minutes:

Mr. Reinertsen requested that the minutes be corrected to reflect that he was not present at the last meeting. As a point of information, Dr. Knapp informed the Board that results of the JCAH-Required Expenditures Survey had not yet been compiled as had been anticipated at the last meeting. He also indicated that the Classification of COTH Members by Non-Routine Service Points had not been disseminated because he felt that it might be misinterpreted by the membership. Mr. Marylander believed that the information should somehow be conveyed to the members. Dr. Knapp then suggested that perhaps it could be presented at the COTH Spring Meeting. Dr. Heyssel felt that it would be appropriate to discuss this at the Spring Meeting and the Board generally agreed.

The minutes of the January 19, 1978 COTH Administrative Board Meeting were unanimously approved as corrected.

V. Membership:

A. Membership Application -- The Sinai Hospital of Detroit, Michigan was considered by the Board for regular membership in COTH. Dr. Bentley reviewed the hospital's application and stated that all requirements for membership had been met and that it was the staff recommendation that it be approved for full membership.

ACTION: It was moved, seconded, and carried to recommend approval of the Sinai Hospital of Detroit for full COTH Membership.

B. Mr. Everhart reviewed the Report on Membership Dues and Terminations and indicated that no action was required.

C. Eligibility for Continuing COTH Membership -- Mr. Everhart asked Dr. Bentley to review the report so that the Board could decide on what should be done with it. Dr. Bentley proceeded, explaining that on page 5 of the report there was a listing of hospitals that had returned questionnaires but had not submitted affiliation agreements. Mr. Everhart pointed out that current membership criteria calls

for all COTH members to have an affiliation agreement on file, in accordance with the guidelines established several years ago. Dr. Bentley reported that some hospitals had submitted a letter from the dean of the affiliated medical school in lieu of a signed affiliation agreement. He added that some of the deans' letters were as strong as some of the affiliation agreements, a number of which were not even signed. It seemed in most cases that the affiliation arrangements constituted whatever the deans stipulated. Mr. Everhart then noted that besides an affiliation agreement, COTH members must have four approved residency programs and two in specialty areas, as well as a commitment to education. Mr. Everhart suggested that if a hospital now having full COTH membership no longer meets all, but at least one, of the criteria, it should be relegated to corresponding membership and receive COTH mailings if it wishes, rather than lose its membership entirely. However, Mr. Everhart said that there was no pressure to do anything with the report at present and that the question was whether or not the Board wanted to do anything with it at all.

Dr. Thompson felt that the hospitals that have an affiliation agreement, but do not fulfill the residency requirements, should fall into the corresponding membership category and that the unaffiliated hospitals in Table 3 of the report posed the more difficult problem. Dr. Bentley observed that all of these institutions were allowed into COTH because most of the hard line issues were not pursued in affiliation agreements. Following more discussion, Dr. Bentley summarized the staff's recommendation. Those institutions that are currently full COTH members should be allowed to remain members if they fulfill the residency requirements and show evidence of a genuine commitment to medical education. Further, NIH should be put into the specialty category as a research institution, and members without four residency programs should be relegated to corresponding membership. Discussion followed, during which Mr. Reinertsen wondered whether the agreements were that necessary at all. Dr. Heyssel felt that the criteria for affiliation agreements should be loosely interpreted. It was generally agreed that staff should prepare, given the time, guidelines for developing affiliation agreements for use by the hospitals. Mr. Reinertsen questioned whether there was a way to get uniformity of affiliation agreements. Mr. Everhart thought that this may really be a legal question, open to the various interpretation of attorneys.

ACTION: It was moved, seconded, and carried that current COTH member institutions be allowed to remain members if they fulfill the residency requirements and show evidence of a genuine commitment to medical education. Further, NIH would be put into the specialty category as a research hospital, and full members without four residency programs would be relegated to corresponding membership. In terms of future membership, the criteria as currently established by the membership committee would be followed. Staff would also be requested to examine affiliation agreement terminology in order to bring together useable items that are in frequent use as guidelines for such agreements.

VI. Report on COTH Spring Meeting Plans

Copies of the printed program for the Spring Meeting were distributed to the Board members. Mr. Everhart reviewed the program and commended the planning committee, chaired by Irv Wilmot, on its efforts. Mr. Randall, a member of the planning committee, commended staff for its efforts in completing a monumental task in such a short time. Mr. Everhart reminded the Board that along with the initial announcement of the Spring Meeting, topic suggestions for the May 4th afternoon session had been requested from the membership. From the responses that this request generated, as presented on pages 36-44 of the Administrative Board Agenda, four major issues evolved: (1) cost containment, (2) health planning, (3) medical school/teaching hospital affiliations and (4) responsibility for graduate medical education. He indicated that these topics would be explored during the afternoon session on Thursday, May 4th. Mr. Everhart queried the Board about how the Meeting would be financed. It was generally agreed that the Meeting should be self-supportive and upon Dr. Knapp's suggestion, that a registration fee of \$50 would be charged.

VII. COTH Executive Salary Survey

Dr. Knapp reminded the Board that at its January meeting it was recommended that questions concerning the usefulness and confidentiality of the Executive Salary Survey be added to this years questionnaire.

Based upon the Survey results, as presented in tables on pages 47-49 of the Administrative Board Agenda, it was the staff's recommendation that the Executive Salary Survey be continued on an annual basis and that the results continue to be distributed to COTH members only.

ACTION: It was moved, seconded, and carried to continue with present policy regarding the publication and confidentiality of the Executive Salary Survey. The Survey would continue to be published on an annual basis and its results would continue to be distributed only to COTH members.

VIII. AHA Multi-Institutional Systems Program: Request to Sponsor a Seminar

Dr. Knapp discussed the AHA's invitation to COTH to jointly sponsor this program. He expressed the belief that it would be appropriate for COTH to co-sponsor this seminar since it focuses on teaching hospitals.

ACTION: It was moved, seconded, and carried that the COTH Board jointly sponsor the AHA Multi-Institutional Systems Program in conjunction with the AHA and Rush-Presbyterian-St. Luke's Medical Center.

IX. AICPA Exposure Draft

Dr. Heyssel expressed concern about the implications of this draft document with regard to disclosure of financial data. He believed that the requirements would inhibit private donors from contributing to hospitals and would mislead the public rather than be informative. He noted that hearings would be held on the 14th of June and that written comments would be accepted until the 15th of June. He strongly believed that COTH should submit testimony to the AICPA in one form or another. Mr. Randall expressed fear as to how this exposure draft might be used by federal agencies. Dr. Rabkin reported that the Massachusetts Rate-Setting Commission is already concerned with this issue. Mr. Colloton asked when the input of the Board would be necessary to assist staff in developing a position statement. Mr. Everhart suggested that perhaps the National Citizens Advisory Committee of the AAMC, as

trustees, or at least a task force named by it, should be involved on this issue. Dr. Thompson agreed that that might be a good idea, but was not sure that the Citizens Advisory Committee would be interested nor that such broad involvement was necessary. Dr. Knapp, responding to Mr. Colloton's earlier question, believed that the Board would have to provide its input by May 1. Mr. Marylander believed that auditors of hospitals should be encouraged to get involved in this issue. He felt that if several of the "Big 8" accounting firms got interested, they could modify the AICPA position. More general discussion ensued.

ACTION: It was moved, seconded, and carried that a task force be created to review the AICPA exposure draft document and develop a position to be submitted as testimony on behalf of the AAMC. Participants on this task force would include members of the National Citizens Advisory Committee. Board members agreed to provide individual responses to the staff by May 1.

X. State Rate Review

Mr. Everhart explained that the COTH Board had waffled on this issue during the past few years because of strong opinions on the Board, as well as actions in varying directions by the AHA House of Delegates. He expressed the belief that it was extremely important that the Board take a position on the issue in order that the AAMC could establish a stance. Mr. Robinson then provided the updated AHA view on the issue. He stated that there were three camps: (1) those who want state rate-setting now (this group is lead by Dave Hitt); (2) those who would agree to state rate-setting if federal "caps" look imminent (it appears that this is the majority position); and (3) those who would agree to state rate-setting only as part of a universal health insurance program. There is almost complete unanimity on state rate-setting being preferable over federal controls. Guidelines for such state rate-setting would be drafted into legislation which has already been developed by an AHA steering committee. The AHA trustees have already called a special meeting to review this draft bill and to plan on how best to get a fair shake in Congress and gain broad industry support. Alex McMahan has argued against introducing a bill now on the basis that it potential success would be diminished if introduced early upon the AHA's request of minority members of Congress.

Mr. Everhart asked the Board members whether staff time should be expended to address this issue in order to develop a firm position or should the board adopt a position of no position, say nothing specific and wear their AHA hats. Dr. Thompson asked where teaching hospitals fit in any of these approaches. He believed, if the Association were to take a position, highest priority should be given to stressing the unique problems of the teaching hospital. He pointed out that this was one reason for the Association's support of the Talmadge bill. Dr. Knapp suggested that maybe he should send a copy of the classification of COTH members by non-routine service points to Jay Constantine and tell him in a letter that sentiments at the AAMC have shifted toward state rate review. Mr. Colloton asked why the Board couldn't support being accountable at the state level under federal guidelines with the understanding that the unique problems of teaching hospitals must be considered. Mr. Marylander said that he would support a position in favor of state rate review without taking a position on when. Mr. Robinson stated that the AHA favors state rate review under federal review, but the problem is also "when?"

Mr. Everhart summarized the various actions that he believed could be taken: (1) endorsement of the AHA position; (2) endorsement of the AHA position, with special consideration of the unique nature of teaching hospitals; (3) reactivate COTH cost containment committee, changing its chairman and possibly reconstituting the membership since most are board members; (4) make this an issue for discussion at the COTH Spring Meeting and hope some consensus opinion as to what action should be taken develops; (5) do nothing and adopt a position of watchful waiting. Mr. Reinertsen pointed out that Dr. Knapp would be getting a copy of the AHA draft bill on April 11 and could review it and provide a summary for future Board discussion. Dr. Knapp expressed support for discussion of the issue at the Spring Meeting. Mr. Reinertsen agreed that after review of the draft bill and isolation of sections that are pertinent, it should be brought up at the Spring Meeting.

Mr. Everhart asked the Board members whether COTH should go on record in support of state rate review under federal guidelines. Dr. Knapp pointed out that this is our current position, though it is not well stated. Dr. Knapp believed that our position should be stated more firmly, with special consideration for teaching hospitals written into the federal guidelines. Dr. Heyssel believed the issue should be pushed as hard as possible on the side of state rate review. Mr. Everhart stated that the Board

will await Dr. Knapp's review of the AHA's draft bill and then place the issue on the agendas of the COTH Spring Meeting and the next Administrative Board Meeting.

XI. Election of Provisional Institutional Members

ACTION: It was moved, seconded, and carried that, subject to a favorable recommendation by the Council of Deans Administrative Board and subsequent ratification by the full Council of Deans, the Executive Council recommend that the Marshal University of Medicine and Catholic University of Puerto Rico School of Medicine be elected to provisional institutional membership in the AAMC by the assembly (as recommended on page 22 of the Executive Council Agenda).

XII. CAS Resolution on the LCGME

ACTION: It was moved, seconded, and carried that the Executive Council be recommended to approve as AAMC policy and transmit to the LCGME the text of the CAS Resolution (as presented on page 23 of the Executive Council Agenda).

XIII. HEW Handicapped Regulations and Medical School Admissions

Dr. Knapp provided background on this issue and noted that the AHA has undertaken a substantial effort to examine the effects of the handicapped regulations on hospitals.

ACTION: It was moved, seconded, and carried that it be recommended that the AAMC chairman be authorized to appoint a task force for the purpose of developing national guidelines on technical standards for schools to use in compliance with the HEW regulations on the handicapped (as set forth on page 25 of the Executive Council Agenda).

XIV. AAHC Statement on Accreditation of Educational Programs in Allied Health

Dr. Knapp provided background on the issue and stated that staff believes that no formal position should be taken at this time.

ACTION: It was moved, seconded, and carried that the Executive Council be recommended to discuss its interest in the issues presented by this statement, but take no formal position on the recommendations (as presented on page 34 of the Executive Council Agenda).

XV. AAMC Recommendations on FY 79 Appropriations for VA Department of Medicine and Surgery Programs

Mr. Randall reviewed the issue for the Board and pointed out some major concerns. As an example of the potential problems that may arise from proposed funding cuts to VA hospitals, Mr. Randall pointed out that the University of Florida medical program could be drastically impacted by the loss of funding to its major teaching hospital affiliate, a VA hospital.

ACTION: It was moved, seconded, and carried that the Executive Council be recommended to approve the recommendations proposed on pages 49-50 of the Executive Council Agenda as a basis for AAMC testimony on the FY 79 budget for the VA Department of Medicine and Surgery programs.

XVI. Emergency Meeting on Medical Manpower Legislation

ACTION: It was moved, seconded, and carried that the Executive Council be recommended to endorse the position that no further amendments should be made to P.L. 94-484 (as proposed on page 52 of the Executive Council Agenda).

XVII. Withholding of Services by Physicians

Mr. Everhart presented background information on this issue and pointed out that the deans strongly support this position paper against strikes. Mr. Marylander held that the position taken was rather wishy-washy. Dr. Bentley pointed out that this position may be contradictory to other AAMC positions.

ACTION: It was moved, seconded, and carried that the Executive Council be recommended not to adopt this statement as recommended to it by the committee (in opposition to the recommendation stated on page 53 of the Executive Council Agenda).

XVIII. AAMC Statement on Involvement with Foreign Medical Schools

ACTION: It was moved, seconded, and carried to recommend that the AAMC statement on involvement with foreign medical schools be approved by the Executive Council and given wide circulation (as recommended on page 57 of the Executive Council Agenda).

XIX. Discharge in Bankruptcy of Student Loans

Dr. Knapp indicated that this topic was to be treated as an informational item and that no formal action was required by the Board. Therefore, no action was taken.

XX. Tentative List of Participants in June MAP Program

Due to the lack of time this information item as listed in the COTH Administrative Board Agenda was not formally reviewed at the meeting.

XXI. New Business

Dr. Rabkin expressed concern with a program policy notice issued February 3rd by the Health Resources Administration which addressed the coverage of CAT Scanners under Section 1122 of the Social Security Act. According to the notice, the Section 1122 statute and regulations should be interpreted so that the purchase of a CAT Scanner by or on behalf of a health care facility or HMO involving a capital expenditure less than \$100,000 is subject to review if it results in the addition of a new diagnostic service. Such a purchase would be considered to be the addition of a new diagnostic service unless the purchase serves to replace an existing scanner of the same type. Dr. Rabkin emphasized that in the past, substantial change in services referred to therapeutic specialty services (e.g., psychiatric services) rather than new diagnostic procedures or technology (especially when they may simply update older techniques). He expressed considerable concern that HEW, in its latest interpretation of what constitutes a new service, has rendered an essentially clinical decision in economic terms without the adequate credentials to make such a clinical judgement. Mr. Colloton noted that the State of Iowa is taking on this question at the local level as a local issue. Dr. Knapp felt that the key to this question was to get at a clear definition of what constitutes "substantial" change. After further discussion, it was decided that a COTH Report story should be written on this issue, advising the COTH Membership to watch carefully how this HEW determination will be applied at their local levels.

XXII. Adjournment

The meeting was adjourned at 12:50 P.M.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF TEACHING HOSPITALS

Application for Membership

INSTRUCTIONS: Type all copies, retain the Pink copy for your files and return two copies to the Association of American Medical Colleges, Council of Teaching Hospitals, One Dupont Circle, N.W., Washington, D.C., 20036. PLEASE ENCLOSE A COPY OF THE HOSPITAL'S AFFILIATION AGREEMENT WITH THE APPLICATION.

MEMBERSHIP CRITERIA:

Eligibility for membership in the Council of Teaching Hospitals is determined by the following criteria:

- (a) The hospital has a documented institutional affiliation agreement with a school of medicine for the purpose of significantly participating in medical education;

AND

- (b) The hospital sponsors or significantly participates in approved, active residencies in at least four recognized specialties including two of the following: Medicine, Surgery, Obstetrics-Gynecology, Pediatrics and Psychiatry.

Membership in the Council is limited to not-for-profit (IRS-501C3) institutions, operated for educational, scientific or charitable purposes and publically-owned institutions.

I. MEMBERSHIP INFORMATION

Charles F. Kettering Memorial Hospital

HOSPITAL NAME
3535 Southern Boulevard Kettering
STREET CITY
Ohio 45429 513 298-4331 Ext. 278
STATE ZIP CODE TELEPHONE NUMBER
Chief Executive Officer **Marlowe Schaffner, M.D.** NAME
President TITLE

Date hospital was established: **March 4, 1964**

APPROVED FIRST POST-GRADUATE YEAR (Figures for fiscal year 1977-78)

| TYPE ² | Date of Initial Approval by CME of AMA** | Total F.T.E. ¹ Positions Offered | Total Positions Filled by U.S. And Canadian Grads | F.T.E. 1 Total Positions Filled by FMG's |
|-------------------|--|---|---|--|
| Flexible | 1965 | 6 | 6 | 0 |
| Categorical -Path | 1966 | 2 | 2 | 0 |
| Categorical* -IM | 1970 | 4 | 4 | 0 |

** Council on Medical Education of the American Medical Association and/or with appropriate AMA Internship and Residency Review Commission.

1. Full-time equivalent positions at applicant institution only. If hospital participates in combined programs indicate only F.T.E. positions and individuals assigned to applicant institution.
2. Type as defined by the AMA Directory of Approved Internships and Residencies. (Flexible-graduate program acceptable to two or more hospital program directors; Categorical-graduate program predominately under supervision of single program director; Categorical*-graduate program under supervision of single program director but content is flexible.)

APPROVED RESIDENCIES

| TYPE | Date of Initial Approval by CME of AMA** | Total F.T.E. ¹ Positions Offered | F.T.E. ¹ | F.T.E. ¹ |
|-----------------|--|---|---|---------------------------------|
| | | | Total Positions Filled by U.S. And Canadian Grads | Total Positions Filled by FMG's |
| Medicine | 1970 | 7 | 7 | 0 |
| Surgery | 1969 | 7 | 7 | 0 |
| Ob-Gyn | | | | |
| Pediatrics | | | | |
| Psychiatry | | | | |
| Family Practice | | | | |
| Other (List): | | | | |
| Pathology | 1966 | 8 | 2 | 3 |
| Plastic Surg | 1972 | 4 | 1 | 2 |

II. PROGRAM DESCRIPTION (Attached)

To supplement the information above and to assist the COTH Administrative Board in evaluating whether or not the institution fulfills the membership criteria, it is requested that you briefly and succinctly describe the extent of the hospital's participation in or sponsorship of educational activities with specific reference to the following questions.

- A. Extent of activity for undergraduate medical education students (e.g., number of clerkships offered; number of students participating; proportion of medical staff time committed to medical students).
- B. Presence of full-time salaried chiefs' of service and/or Director of Medical Education (e.g., departments which have salaried chiefs; hospital chiefs holding joint appointments at medical school).
- C. Dimension of hospital's financial support of medical education costs and nature of financial agreement with medical school (e.g., dollars devoted to house staff salaries and fringe benefits; the percentage of the hospital's budget these dollars represent; hospital's contribution to cost of supervising faculty; portion of service chiefs' costs paid by the hospital).
- D. Degree of affiliated medical school's involvement in and reliance upon hospital's education program (e.g., medical school faculty participation in hospital activities such as in-service education, conferences or medical staff committees).

The above are not meant to be minimum standards or requirements, but reflect the belief that COTH membership indicates a significant commitment and consideration of the items above. The hospital's organized medical education program should be described clearly with specific reference given to unique characteristics and to the institution's medical education objectives.

III. LETTER OF RECOMMENDATION

A letter of recommendation from the dean of the affiliated medical school should be included outlining the importance of the teaching hospital in the school's educational program.

Name and Address of Affiliated School of Medicine: Wright State University School of Medicine, P.O. Box 927, Dayton, Ohio 45401

Name of Dean: John R. Beljan, M.D.

Information Submitted by:

Elvin C. Hedrick, M.D.

NAME

1-19-78

DATE

Director of Medical Education

TITLE OF PERSON SUBMITTING DATA

SIGNATURE OF HOSPITAL CHIEF EXECUTIVE

SECTION II. PROGRAM DESCRIPTION

- A. The Kettering Medical Center is one of four Dayton Area general hospitals which will serve along with an Air Force, a Veteran's Hospital, and a Children's Medical Center as a clinical base for the Wright State University School of Medicine. It is anticipated that when the School of Medicine is fully operational, all medical students will be rotating to Kettering for some clinical assignment in Medicine, Surgery, or Psychiatry. It is estimated that approximately 30 students may be at this hospital at any time.

Approximately 56% of our active staff participates in our Residency Training Program and 65% of our active staff holds a teaching appointment at the Wright State University School of Medicine.

- B. There is a full time director of Medical Education with University appointment in the Department of Medicine and in the Department of Postgraduate and Continuing Education of Wright State University. The director and associate director of the Pathology Residency are geographic full time at the Kettering Medical Center. The director and associate director of the Internal Medicine Residency are both half time paid by the hospital. The associate director of the Surgery Residency is part time salaried. The director of the Surgery Residency is a volunteer. The director of the Wright State University affiliated hospitals, Anesthesiology Residency is geographic full time at the Kettering Medical Center, as is also the associate director.

The Department of Surgery of Wright State University is based at the Kettering Medical Center. The chairman of the department is geographic full time at the center.

- C. In 1978, Medical Education's budget is \$973,006, which amounts to 2.2% of the hospital's budget.

The hospital supplies office space and one secretary and \$10,000 annually to the budget of the Wright State University Department of Surgery. All of the paid individuals referred to in B above, are supported by the hospital from patient revenues, or from income from a one half million dollar endowment held by the Medical Center for use in Medical Education activities with Wright State University.

- D. As indicated above, 65% of our active attending staff have faculty appointments. Therefore, the majority (more than 65%) of our conferences are presented by faculty members. Other segments of the faculty participate freely and frequently including members from the basic Science Department. We receive support and advice from the Professional Educators of the school's Department of Postgraduate and Continuing Education.

The objective of our residency programs, is to produce qualified certifiable specialists for clinical practice, in their respective fields. It is our objective, that at least half of our internal medicine residents will practice general internal medicine. Those who elect to do so, should be able to gain acceptance into elite fellowships in sub-specialties of their choice.

The entire postdoctoral Medical Education program is supervised by an Education Committee, which includes the program directors in it's membership and also includes practicing physicians with an interest in teaching. By policy, not more than one half of the membership of this committee is changed in any one year. In actual practice, the continuity is much greater than this. This committee reports to the Executive Committee as a staff. The director of Medical Education is the permanent secretary of the committee and bears liaison relationship to the medical school. Each program director is responsible to the director of Medical Education and the Medical Education Committee for the organization operation and evaluation of his residency. The somewhat unique characteristics of the Kettering Medical Center programs, has been the development of teaching panels, in which housestaff are assigned to a small group of attendings interested in the education program. This permits a close team relationship between housestaff and attendings and has resulted in effective on-going evaluations of the trainee at all points. It has also permitted effective delegation of responsibility to housestaff permitting an unusual degree of responsibility on private services. In addition to this, both the medicine and surgery services do have the classical, "staff services".

Wright State University Medical Students will be supervised primarily by faculty members on the Kettering Medical Center staff under the direction of the Wright State University Department Chairman with assistance from the director of Medical Education, residency program staff, and residents.

AGREEMENT BETWEEN THE WRIGHT STATE UNIVERSITY
SCHOOL OF MEDICINE AND TRUSTEES OF
KETTERING MEDICAL CENTER

This agreement, made this 18th day of December, 197 5, by the Trustees of Wright State University, hereinafter referred to as the "School of Medicine", and the Trustees of Kettering Medical Center, hereinafter referred to as the "Hospital", is entered into for the mutual benefit of both.

Preamble

The primary concern of the hospital is to provide the best possible care of patients. This care can be enhanced by a superior teaching program for and by the medical staff. This has always been the policy of Kettering Medical Center. We are convinced that an affiliation of the Hospital with the School of Medicine will strengthen further that teaching program and will contribute thereby to the maintenance of the best possible patient care.

The primary concern of the School of Medicine is the education of its medical students. The School of Medicine is convinced that a superior educational program for its students can be obtained only when superior patient care is demonstrated as part of the educational process.

Witnesseth

Whereas, Wright State University has established a School of Medicine and students of said School require clinical experience and the use of clinical facilities, and;

Whereas, the School of Medicine is developing programs of medical education in a number of community facilities and is desirous of including

the Hospital among these facilities, and;

Whereas, the Hospital has the facilities for furnishing clinical experience, and;

Whereas, the Hospital is desirous of enriching its total educational program by direct association with the School of Medicine, and;

Whereas, it is to the mutual benefit of the parties that students of the School of Medicine use said Hospital facilities for clinical training and experience and residents and staff of the Hospital use the resources of the School of Medicine for furtherance of their education, and;

Whereas, it is to the mutual benefit of the parties that qualified members of the School of Medicine be appointed to the Staff of the Hospital, and;

Whereas, it is to the mutual benefit of the parties that qualified members of the Hospital Staff be appointed to the faculty of the School of Medicine, and;

Whereas, both parties recognize the Hospital retains final responsibility for patient care, and;

Whereas, both parties recognize the School of Medicine retains final responsibility for the medical students' education;

THEREFORE, in consideration of their mutual promises herein contained and of their mutual interests, recognizing that the substance of this Agreement of Cooperation shall provide the bases for the working relationship and for decision making, yet it will not attempt to predetermine each decision but permit growth and development of an effective relationship as well as acknowledge the need for regular review due to the changing requirements of the institutions, individually and together, the parties agree to the following.

Joint Responsibilities

1. To assist in establishing policies through which the Hospital and the School of Medicine can carry on the cooperative activities of this agreement a Joint Coordinating Committee shall be established. This Committee shall be composed of six members, three to be appointed by each party. The terms of the initial appointment will be one, two and three years. After that, respective members are subject to annual appointment by the Hospital and the School of Medicine and will, under usual circumstances, serve for three years. The terms of the appointment will be staggered so as to maintain continuity of the Committee. The Committee will elect its own chairman. The chairmanship shall be alternated between the two parties.

2. The Hospital and the School of Medicine agree that it is desirable to permit use of the facilities and resources of the Hospital by the School of Medicine and the facilities and resources of the School of Medicine by the Hospital in order to more fully realize the substance of this association.

Clinical resources of the Hospital shall be made available for teaching purposes for the students of the School of Medicine subject to the rules and regulations of the Hospital. Under these guidelines, the Hospital will afford each student who is designated, in writing, by the School of Medicine, the opportunity for experience in all types of medical practice which may be available at the Hospital and will permit such students and members of the School of Medicine faculty access to appropriate hospital and outpatient department facilities, for such periods of time and for such experience as described by the Medical School Curriculum and in harmony with Hospital policy, necessary to

fulfill obligations of the educational program. The Hospital will permit its Staff, and other personnel, to participate in the clinical experience and teaching of students. Residents, upon the approval of the appropriate Chiefs of Departments of the Hospital and/or Directors of the Residency Program, will be permitted to participate in undergraduate medical education and training programs of the School of Medicine.

3. The Joint Coordinating Committee shall meet annually to determine the operating effectiveness of the agreement and study how, if at all, the agreement might be improved to the satisfaction and mutual benefit of the parties. Such meetings may be called more frequently through a request of any two members of the Joint Coordinating Committee. If necessary and wherever feasible, the Committee shall also serve to mediate any differences which might arise between the parties pursuant to the intent of this agreement. Recommendations of the Joint Coordinating Committee shall be presented to and accepted by both the Dean of the School of Medicine and the Hospital Staff Executive Committee before they become accepted.

4. Both parties agree to work together towards the maintenance of acceptable accreditation status of each other.

5. Both parties agree to abide by Federal and State regulations with respect to discrimination.

6. Where appropriate and consistent with the intent of this agreement, key leadership positions concerned with specific or major undergraduate School of Medicine teaching functions, such as a Chairman of a Clinical Department who is physically based within the Hospital and the Director of Education for the Department in question of the Hospital, normally will be appointed jointly by the School of Medicine and by the Hospital to the School of Medicine Faculty and to the Hospital Staff respectively.

7. It is agreed by both parties that the association agreement, except as noted in item #6 above, does not conflict with the custom of the Hospital to appoint physicians to its Staff. Nor does that appointment require participation of the Staff Physician in the medical student education program, or in any way limit patients of Hospital Staff Physicians to admission into the hospital for care. Staff physicians of the Hospital who are selected and appointed to the Faculty of the School of Medicine will support the educational program of the School and participate, as directed, in its implementation under the terms of the Faculty Appointment.

8. It is agreed by both parties that the association agreement, except as noted in item #6 above, does not conflict with the custom of the School of Medicine to appoint its full-time, part-time and volunteer clinical faculty. Such a physician of the School of Medicine may be selected and appointed to the Hospital Staff, and he/she will support the Hospital's programs under the terms of the Hospital Staff appointment.

9. A member of the Faculty of the School of Medicine can teach medical students based at the Hospital without a Hospital Staff appointment, but, in such cases, the Faculty Member cannot be involved in situations which involve patient care responsibilities.

School of Medicine Responsibility

1. Selected faculty members of the School of Medicine, upon the recommendation of the Dean, shall be referred to the Medical Staff for appointment to the Hospital Staff in accordance with the bylaws of the Hospital to engage in health care delivery at the Hospital.

2. The Faculty of the School of Medicine shall develop, operate, and evaluate a quality undergraduate medical education program.

3. The School of Medicine understands the importance of timely planning and coordination of education goals and programs. Major changes

in the School of Medicine's program emphasis at the Hospital shall be reviewed by Joint Coordinating Committee for their recommendation with respect to the change. It is understood that the purpose of the Joint Coordinating Committee is not to set educational policy or to engage in curriculum planning, but rather to consider the effect of any such change on the general welfare of the Hospital and/or the School as relates to their association agreement.

4. The School of Medicine faculty and students who are participating in this association will be under the responsibility and control of the School of Medicine. The School of Medicine will assure that such participants will comply with all applicable rules, regulations and requirements of the Hospital.

Hospital Responsibility

1. The patient care responsibilities of the staff physicians and residents who participate in the association program are responsible to, and under the control of, the Hospital. The Hospital will assure that such participants will comply with the rules, regulations and requirements of the School of Medicine.

2. The Hospital understands that major changes in its programs may reflect on this association and also understands the importance of timely planning and coordination of its patient care programs. Any such contemplated major changes will be reviewed by the Joint Coordinating Committee for their recommendation with respect to the change. It is understood that the purpose of the Joint Coordinating Committee is not to set patient care standards or initiate patient care programs but rather to consider the effect of such changes on the general welfare of the Hospital and the School of Medicine as related to the association agreement.

3. The Hospital agrees to maintain high standards of patient care.

4. The Hospital agrees to make its facilities and patients available, when possible, for instructional purposes to fulfill the educational needs of the program. Exceptions can be made for specific patients on request of the attending physician, the parents or guardians, or by the individual patient himself.

5. The Hospital will provide emergency first aid and emergency care for the School of Medicine Faculty and students should accident or illness occur while in the Hospital, pursuant to this association agreement. Charges for such care will be at the usual rates. The Hospital's determination of the duration and extent of the first aid or the emergency care shall be conclusive.

6. The Hospital agrees to maintain its present policy regarding liability incurred by its employees and other covered parties.

The agreement supersedes the previous agreement of 19 December, 1972 made between the two parties. The terms of this agreement shall commence upon the signing of this agreement and shall continue until terminated by either party. Such termination shall be preceded by written notification to the other party of the intention to terminate sent by registered mail two years prior to the proposed termination date. However, both parties may mutually agree to terminate this agreement at any time. This agreement is entered into with a spirit of mutual cooperation for the benefit of both parties, with the full realization that this agreement encompasses long-range planning and joint efforts to assure meaningful learning experiences for the students, residents, and the staff-faculty and the highest quality of health care for the patients.

W. B. ...
Chairman, Board of Trustees
Kettering Medical Center

Robert S. ...
Chairman, Board of Trustees
Wright State University

NOTE: See also "Kettering Medical Center Internal Policies" attached.

Wright State University
School of Medicine



Office of the Dean
Dayton, Ohio 45431
513 268-3465

Reply to: Box 927, Dayton, Ohio 45401

March 21, 1978

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

Gentlemen:

This letter is a recommendation on behalf of the Kettering Medical Center of Kettering, Ohio in support of their application for membership to the AAMC Council of Teaching Hospitals. The Kettering Medical Center has been a strong partner in our total medical educational program at Wright State University School of Medicine, and administratively houses our Department of Surgery. In addition, our first endowed Professorship in Medicine is the result of a joint gift to the Kettering Medical Center and the Wright State University School of Medicine to enhance our co-operative educational programs.

The hospital has been exerting a leadership role in assisting the School of Medicine to integrate four independent surgical residency programs (including their own) into a single, unified School-based effort. Their grounds house the Cox Heart Institute of the Wright State University School of Medicine, one of the twelve centers for the multiple risk assessment program, and a key facility for clinical research.

There is a long-term commitment between the School of Medicine and Kettering Medical Center for medical educational programs. We have just received approval to invest \$460,960 from our Ambulatory Teaching Facilities appropriation from the State of Ohio to develop physical improvements at the Kettering Medical Center for the purpose of furthering their joint educational programs with us.

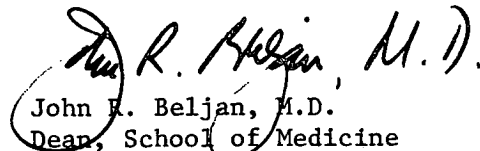
American Association of
Medical Colleges

-2-

March 21, 1978

The Kettering Medical Center is an outstanding example of a major teaching hospital with a demonstrated commitment to medical education. It has evidenced strong support for the School of Medicine, and our relations are cordial and productive. I believe that the Kettering Medical Center meets every criterion for membership in the Council of Teaching Hospitals, and I would strongly recommend its acceptance to membership by the AAMC.

Sincerely,


John R. Beljan, M.D.
Dean, School of Medicine
Vice-Provost

JRB:shw

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF TEACHING HOSPITALS

Application for Membership

INSTRUCTIONS: Type all copies, retain the Pink copy for your files and return two copies to the Association of American Medical Colleges, Council of Teaching Hospitals, One Dupont Circle, N.W., Washington, D.C., 20036. PLEASE ENCLOSE A COPY OF THE HOSPITAL'S AFFILIATION AGREEMENT WITH THE APPLICATION.

MEMBERSHIP CRITERIA:

Eligibility for membership in the Council of Teaching Hospitals is determined by the following criteria:

- (a) The hospital has a documented institutional affiliation agreement with a school of medicine for the purpose of significantly participating in medical education;

AND

- (b) The hospital sponsors or significantly participates in approved, active residencies in at least four recognized specialties including two of the following: Medicine, Surgery, Obstetrics-Gynecology, Pediatrics and Psychiatry.

Membership in the Council is limited to not-for-profit (IRS-501C3) institutions, operated for educational, scientific or charitable purposes and publically-owned institutions.

I. MEMBERSHIP INFORMATION

Good Samaritan Hospital and Health Center

HOSPITAL NAME

2222 Philadelphia Drive,

STREET

Dayton,

CITY

Ohio

STATE

45406

ZIP CODE

(513) 278-2612

TELEPHONE NUMBER

Chief Executive Officer

James P. Fitzgerald

NAME

President

TITLE

Date hospital was established: 1932

APPROVED FIRST POST-GRADUATE YEAR

| <u>TYPE²</u> | <u>Date of Initial Approval by CME of AMA**</u> | <u>Total F.T.E.¹ Positions Offered</u> | <u>F.T.E.¹ Total Positions Filled by U.S. And Canadian Grads</u> | <u>F.T.E.¹ Total Positions Filled by FMG's</u> |
|-------------------------|---|---|---|---|
| Flexible | <u>7/31/75</u> | <u>5</u> | <u>0</u> | <u>2</u> |
| Categorical Med. | <u>7/31/75</u> | <u>3</u> | <u>0</u> | <u>3</u> |
| Categorical* Surg. | <u>7/31/75</u> | <u>3</u> | <u>0</u> | <u>1</u> |
| Family Practice | <u>7/31/75</u> | <u>4</u> | <u>4</u> | <u>0</u> |

** Council on Medical Education of the American Medical Association and/or with appropriate AMA Internship and Residency Review Commission.

1. Full-time equivalent positions at applicant institution only. If hospital participates in combined programs indicate only F.T.E. positions and individuals assigned to applicant institution.
2. Type as defined by the AMA Directory of Approved Internships and Residencies. (Flexible-graduate program acceptable to two or more hospital program directors; Categorical-graduate program predominately under supervision of single program director; Categorical*-graduate program under supervision of single program director but content is flexible.)

APPROVED RESIDENCIES

| TYPE | Date of Initial Approval by CME of AMA** | Total F.T.E. ¹ Positions Offered | F.T.E. ¹ | F.T.E. ¹ |
|-----------------|--|---|---|---------------------------------|
| | | | Total Positions Filled by U.S. And Canadian Grads | Total Positions Filled by FMG's |
| Medicine | 7/31/75 | 9 | 1 | 8 |
| Surgery | 7/31/75 | 10 | 2 | 5 |
| Ob-Gyn | | | | |
| Pediatrics | | | | |
| Psychiatry | | | | |
| Family Practice | | | | |
| Other (List): | | | | |
| Flexible | 7/31/75 | 2 | 0 | 2 |
| Family Practice | 7/31/75 | 10 | 9 | 0 |

II. PROGRAM DESCRIPTION - See Attachment

To supplement the information above and to assist the COTH Administrative Board in evaluating whether or not the institution fulfills the membership criteria, it is requested that you briefly and succinctly describe the extent of the hospital's participation in or sponsorship of educational activities with specific reference to the following questions.

- Extent of activity for undergraduate medical education students (e.g., number of clerkships offered; number of students participating; proportion of medical staff time committed to medical students).
- Presence of full-time salaried chiefs' of service and/or Director of Medical Education (e.g., departments which have salaried chiefs; hospital chiefs holding joint appointments at medical school).
- Dimension of hospital's financial support of medical education costs and nature of financial agreement with medical school (e.g., dollars devoted to house staff salaries and fringe benefits; the percentage of the hospital's budget these dollars represent; hospital's contribution to cost of supervising faculty; portion of service chiefs' costs paid by the hospital).
- Degree of affiliated medical school's involvement in and reliance upon hospital's education program (e.g., medical school faculty participation in hospital activities such as in-service education, conferences or medical staff committees).

The above are not meant to be minimum standards or requirements, but reflect the belief that COTH membership indicates a significant commitment and consideration of the items above. The hospital's organized medical education program should be described clearly with specific reference given to unique characteristics and to the institution's medical education objectives.

III. LETTER OF RECOMMENDATION

A letter of recommendation from the dean of the affiliated medical school should be included outlining the importance of the teaching hospital in the school's educational program.

Name and Address of Affiliated School of Medicine: Wright State University School of Medicine,
Dayton, Ohio 45431

Name of Dean: John R. Beljan, M.D.

Information Submitted by:

James F. Schieve, M.D.

Vice President, Medical Affairs

TITLE OF PERSON SUBMITTING DATA

NAME
2/21/78
DATE

James P. Fitzgerald
SIGNATURE OF HOSPITAL CHIEF EXECUTIVE
James P. Fitzgerald, President

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF TEACHING HOSPITALS

Application for Membership - Attachment

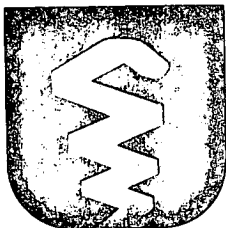
II. Program Description

- A. Extent of activity for undergraduate medical education students (e.g., number of clerkships offered; number of students participating, proportion of medical staff time committed to medical students).
1. Two-week selective opportunities four times a year for first and second year medical students of Wright State University School of Medicine. (Six students have participated thus far.)
 2. Third-year clerkships in Medicine, Surgery, Family Practice and Psychiatry. No students have participated as yet. Planned to begin in the fall of 1978. Third-year clerkships in Ob-Gyn are likely to follow. It is estimated that thirty, third-year students will receive third-year clerkships in one of the above mentioned areas each year.
 3. Fourth-year medical student clerkships will be offered for selective clerkships in all areas of hospital in-patient and out-patient activity.
- B. Presence of full-time salaried chiefs' of service and/or Director of Medical Education (e.g., departments which have salaried chiefs; hospital chiefs holding joint appointments at medical school).
1. Full-time salaried Hospital Chiefs of service and/or Director of Medical Education.
 - a. David P. Nicholson, M.D., Director of Medical Education, Good Samaritan Hospital and Health Center; Professor, Department of Medicine and Director, Pulmonary Disease Group, Wright State University School of Medicine.
 - b. William Stowe, M.D., Director of Family Practice Residency Program, Good Samaritan Hospital and Health Center; Associate Professor of Family Practice, Wright State University School of Medicine.
 - c. James F. Schieve, M.D., Vice President of Medical Affairs, Good Samaritan Hospital and Health Center; Clinical Professor of Medicine, Wright State University School of Medicine.

2. Full-time Hospital salaried physicians who hold Wright State University School of Medicine faculty appointments.
 - a. Ludolph van der Hoeven, M.D., Director, Clinical Laboratories, Good Samaritan Hospital and Health Center; Clinical Professor, Department of Pathology, Wright State University School of Medicine.
 - b. Linda Burton, M.D., Associate Pathologist, Good Samaritan Hospital and Health Center; Clinical Instructor, Department of Pathology, Wright State University School of Medicine.
 - c. Kendall K. Kane, M.D., Pathologist, Good Samaritan Hospital and Health Center; Associate Clinical Professor, Department of Pathology, Wright State University School of Medicine.
 - d. Allan J. LaClave, M.D., Director, Department of Psychiatry and Acting Chairman, Department of Psychiatry and Mental Health, Good Samaritan Hospital and Health Center; Assistant Clinical Professor, Department of Psychiatry, Wright State University School of Medicine.
 - e. Dechamma Alexander, M.D., Staff Psychiatrist, Good Samaritan Hospital and Health Center; Assistant Clinical Professor, Department of Psychiatry, Wright State University School of Medicine.
 - f. Richard Murray, M.D., Staff Psychiatrist, Good Samaritan Hospital and Health Center; Associate Clinical Professor, Department of Psychiatry, Wright State University School of Medicine.
 - g. Clarence deLima, M.D., Staff Psychiatrist, Good Samaritan Hospital and Health Center; appointment pending from Wright State University School of Medicine.
3. There are three full-time Wright State faculty members in the Department of Psychiatry and one full-time member of the Department of Community Medicine of Wright State who have their administrative activity based at Good Samaritan Hospital and Health Center.
 - a. Barry Blackwell, M.D., Chairman and Professor, Department of Psychiatry, Wright State University School of Medicine; Attending Staff member, Good Samaritan Hospital and Health Center.
 - b. Arnold Allen, M.D., Director, Wright State University School of Medicine Psychiatry Residency, Professor of Psychiatry, Wright State University School of Medicine; Attending Staff member, Good Samaritan Hospital and Health Center.

- c. Abraham Heller, M.D., Professor, Department of Psychiatry, Professor, Department of Community Medicine, Wright State University School of Medicine; Attending Staff member, Good Samaritan Hospital and Health Center.
 - d. Joseph Alter, M.D., Chairman and Professor, Department of Community Medicine, Wright State University School of Medicine; Medical Staff appointment for Good Samaritan Hospital and Health Center is pending.
- C. Dimension of Hospital's financial support of medical education costs and nature of financial agreement with medical school (e.g., dollars devoted to house staff salaries and fringe benefits; the percentage of the hospital's budget these dollars represent; hospital's contribution to cost of supervising faculty; portion of service chiefs' costs paid by the Hospital).
1. The Hospital's costs totaled \$37,167,000 for the most recent year. Although it is difficult to separate medical education costs from patient service activity, education costs of the Hospital support the total salary of nine full-time physicians, share support with the Medical School with six other physicians for full-time school faculty members, and support by contract or salary for part-time educational activity of twenty other physicians. The Hospital supports thirty house staff members at a cost of \$384,023, including fringe benefits. The medical education component of the total Hospital's cost based on the most recent Medicare report (this includes indirect costs) is estimated to be \$1,584,900 or 4.3% of our total budget.
- D. Degree of affiliated medical school's involvement in and reliance upon hospital's education program (e.g., medical school faculty participation in hospital activities such as in-service education, conferences or medical staff committees).
1. The Wright State University School of Medicine is based on the concept that the clinical experiences of its students will be obtained through its affiliated community hospitals. Good Samaritan Hospital and Health Center is one of the core fully affiliated hospitals and has a formal agreement with the Medical School to engage in medical student teaching on an ongoing, regularly scheduled basis, that full-time faculty of the School will be geographically based at the Hospital who will become fully active members of the Hospital Staff of Good Samaritan Hospital and Health Center with all the duties and obligations of any active Staff member. It is important to recognize that the Wright State University School of Medicine does not have a University Hospital.

Wright State University
School of Medicine



Office of the Dean
Dayton, Ohio 45431
513 268-3465

Reply to: Box 927, Dayton, Ohio 45401

March 1, 1978

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

Gentlemen:

This letter is in strong recommendation that Good Samaritan Hospital and Health Center of Dayton, Ohio be accepted to the membership of the AAMC Council of Teaching Hospitals. The Good Samaritan Hospital has been a strong partner in our medical educational program at Wright State University School of Medicine, and currently houses our Department of Psychiatry. In addition, the hospital has been instrumental in helping integrate four separate residency programs in surgery (including their own) into a single, integrated Wright State University Surgical Residency. We are currently in the process of locating our Department of Community Medicine at Good Samaritan Hospital, and have been active with it in ambulatory teaching programs and outreach activities.

There is a long-term commitment between the School of Medicine and Good Samaritan Hospital for medical educational programs. We are investing \$1,538,453 from our state ambulatory teaching facilities appropriation to effect physical improvements at the Good Samaritan Hospital for the purpose of furthering their joint educational programs with us.

The Good Samaritan Hospital is an outstanding example of a major teaching hospital with a demonstrated commitment to medical education. It has evidenced strong support for the School of Medicine, and our relations are cordial and productive. I believe that the Good Samaritan Hospital meets every criterion for membership in the Council of Teaching Hospitals, and I would strongly recommend its acceptance to membership by the AAMC.

Sincerely,

John R. Beljan, M.D.
Dean, School of Medicine
Vice-Provost

JRB:shw

AGREEMENT BETWEEN THE WRIGHT STATE UNIVERSITY
SCHOOL OF MEDICINE AND TRUSTEES OF
GOOD SAMARITAN HOSPITAL

This agreement, made this 15th day of December, 1975, by the Trustees of Wright State University, hereinafter referred to as the "School of Medicine", and the Trustees of Good Samaritan Hospital hereinafter referred to as the "Hospital" is entered into for the mutual benefit of both.

Preamble

The primary concern of any hospital should be to provide the best possible care of patients. This can only be obtained under present conditions when a superior teaching program for and by the medical staff is a basic policy of the hospital. Such a policy has always been followed at the Good Samaritan Hospital. We are convinced that an affiliation of the Hospital with the School of Medicine will strengthen further that teaching program and will contribute thereby to the maintenance of the best possible patient care.

The primary concern of the School of Medicine should be the education of its medical students. The School of Medicine is convinced that a superior educational program for its students can only be obtained only when superior patient care is demonstrated as part of the educational process.

Witnesseth

Whereas, Wright State University has established a School of Medicine and students of said School require clinical experience

and the use of clinical facilities, and;

Whereas, the School of Medicine is developing programs of medical education in a number of community facilities and is desirous of including the Hospital among these facilities, and;

Whereas, the Hospital has the facilities for furnishing clinical experience, and;

Whereas, the Hospital is desirous of enriching its total educational program by direct association with the School of Medicine, and;

Whereas, it is to the mutual benefit of the parties that students of the School of Medicine use said Hospital facilities for clinical training and experience and residents and staff of the Hospital use the resources of the School of Medicine for furtherance of their education, and;

Whereas, it is to the mutual benefit of the parties that qualified members of the School of Medicine be appointed to the Staff of the Hospital, and;

Whereas, it is to the mutual benefit of the parties that qualified members of the Hospital Staff be appointed to the staff of the School of Medicine, and;

Whereas, both parties recognize the Hospital retains final responsibility for patient care, and;

Whereas, both parties recognize the School of Medicine retains final responsibility for the medical students education and;

THEREFORE, in consideration of their mutual promises herein contained and of their mutual interests, recognizing that the substance

of this Agreement of Cooperation shall provide the bases for the working relationship and for decision making, yet it will not attempt to predetermine each decision but permit growth and development of an effective relationship as well as acknowledge the need for regular review due to the changing requirements of the institutions, individually and together, the parties agree to the following.

Joint Responsibilities

1. To assist in establishing policies through which the Hospital and the School of Medicine can carry on the cooperative activities of this agreement a Joint Coordinating Committee shall be established. This Committee shall be composed of six members, three to be appointed by each party. The terms of the initial appointment will be one, two and three years. After that respective members are subject to annual appointment by the Hospital and the School of Medicine and will, under usual circumstances, serve for three years. The terms of the appointment will be staggered so as to maintain continuity of the Committee. The Committee shall elect its own Chairman who will serve for one year. The Chairmanship will be alternated between a member from the School of Medicine and the Hospital.

2. The Hospital and the School of Medicine agree that it is desirable to permit use of the facilities and resources of the Hospital by the School of Medicine and the facilities and resources of the School of Medicine by the Hospital in order to more fully realize the substance of this association.

Clinical resources of the Hospital shall be made available for teaching purposes for the students of the School of Medicine subject to the rules

and regulations of the Hospital. Under these guidelines the Hospital will afford each student who is designated, in writing, by the School of Medicine, the opportunity for experience in all types of medical practice which may be available at the Hospital and will permit such students and members of the School of Medicine Faculty access to appropriate hospital and outpatient department facilities, for such periods of time and for such experience as described by the Medical School Curriculum and in harmony with Hospital policy, necessary to fulfill obligations of the educational program. The Hospital will permit its Staff, and other personnel, to participate in the clinical experience and teaching of students. Likewise, residents, upon the approval of the appropriate Chiefs of Service of the Hospital and/or Directors of the Residency Program will be permitted to participate in undergraduate medical education and training programs of the School of Medicine.

3. The Joint Coordinating Committee shall meet annually to determine the operating effectiveness of the agreement and study how, if at all, the agreement might be improved to the satisfaction and mutual benefit of the parties. Such meetings may be called more frequently through a request of any two members of the Joint Coordinating Committee. If necessary and wherever feasible the Committee shall also serve to mediate any differences which might arise between the parties pursuant to the intent of this agreement. Recommendations of the Joint Coordinating Committee shall be presented to both the Dean of the School of Medicine and the Hospital Staff Executive Committee.

4. Both parties agree to work together towards the maintenance of acceptable accreditation status of each other.

5. Both parties agree to maintain a policy in which neither will discriminate against any employee, applicant for employment, or student because of age, sex, race, color, creed, or national origin.

6. Where appropriate and consistent with the intent of this agreement, key leadership positions such as a Chairman of a Clinical Department of the School of Medicine and Chiefs of Professional Services of the Hospital, normally will be appointed jointly by the School of Medicine and by the Hospital to the School of Medicine Faculty and to the Hospital Staff respectively.

7. It is agreed by both parties that this agreement, except as noted in item #6 above, does not conflict with the custom of the Hospital to appoint physicians to its Staff. Nor does that appointment require participation of the Staff Physician in the medical student education program, or in anyway limit the admission policy of the Hospital for patients of its Staff Physicians. Staff physicians of the Hospital may be selected and appointed to the Faculty of the School of Medicine upon recommendation of the Medical School Department Chairman and with the approval of the Dean. In which case they will support the educational program of the School and participate as directed in its implementation under the terms of the Faculty Appointment.

8. It is agreed by both parties that this agreement, except as noted in item #6 above, does not conflict with the custom of the School of Medicine to appoint its full-time, part-time and voluntary clinical faculty. Such a physician of the School of Medicine may be selected and appointed to the Hospital Staff by the usual credentialing procedure of the Hospital. In which case he/she will support the Hospital programs under the terms of the Hospital's Medical Staff By-laws.

9. A member of the Faculty of the School of Medicine can teach medical students based at the Hospital without a Hospital Staff appointment. In such cases the Faculty Member cannot be involved in situations which involve patient care responsibilities.

10. Both parties understand that additional specific agreements will be developed in the future as a result of this association. These areas will include, but are not limited to, financial arrangements in regards to space and personnel, the mutual development of Residency Programs, medical continuation education programs, and a medical student code of conduct.

School of Medicine Responsibility

1. Selected faculty members of the School of Medicine upon the recommendation of the Dean and confirmation of the Hospital Staff shall be appointed to the Hospital Staff in accordance with the bylaws of the Hospital to engage in health care delivery at the Hospital and in the education of undergraduate students and residents.

2. The Faculty of the School of Medicine shall develop, operate, and evaluate a quality undergraduate medical education program.

3. The School of Medicine understands the importance of timely planning and coordination of educational goals and programs. Major changes in the School of Medicine's program emphasis at the Hospital shall be reviewed by Joint Coordinating Committee for their recommendation with respect to the change. It is understood the purpose of the Joint Coordinating Committee is not to set educational policy or to engage in curriculum planning but rather to consider the effect of any such change on the general welfare of the Hospital and/or the School as relates to their association agreement.

4. The School of Medicine faculty and students who are participating in this association will be under the responsibility and control of the School of Medicine. The School of Medicine will assure that such participants will comply with all applicable rules, regulations and requirements of the Hospital.

Hospital Responsibility

1. The patient care responsibilities of the staff physicians and residents who participate in the association program are responsible to, and under the control of the Hospital. The Hospital will assure that such participants will comply with the rules, regulations and requirements of the School of Medicine.

2. The Hospital understands that major changes in its programs may reflect on this association and also understands the importance of timely planning and coordination of its patient care programs. Any such contemplated major changes shall be reviewed by the Joint Coordinating Committee for their recommendation with respect to the change. It is understood that the purpose of the Joint Coordinating Committee is not to set patient care standards or initiate patient care programs but rather to consider the effect of such changes on the general welfare of the Hospital and the School of Medicine as related to the association agreement.

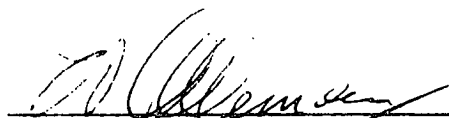
3. The Hospital agrees to maintain high standards of patient care.

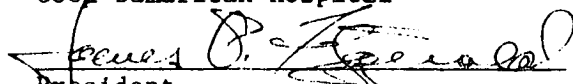
4. The Hospital agrees to make its facilities and patient resources available for instructional purposes to fulfill the educational needs of the program. Exceptions can be made for specific patients on request of the attending physician, the parents or guardians, or by the individual patient himself.


5. The Hospital will provide emergency first aid and emergency care for the School of Medicine Faculty and students should accident or illness occur while in the Hospital pursuant to this association agreement. Charges for such care will be at the usual rates. The Hospital's determination of the duration and extent of the first aid or the emergency care shall be conclusive.

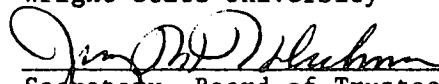
6. The Hospital will only assume the responsibility for liability incurred by its employees or other covered parties.

The terms of this agreement shall commence upon the signing of this agreement and shall continue until terminated by either party. Such termination shall be preceded by written notification to the other party of the intention to terminate sent by registered mail two years prior to the proposed termination date. However, both parties may mutually agree to terminate this agreement at any time. This agreement is entered into with a spirit of mutual cooperation for the benefit of both parties, with the full realization that this agreement encompasses long range planning and joint efforts to assure meaningful learning experiences for the students, residents, and the staff-faculty and the highest quality of health care for the patients.


Chairman, Board of Trustees
Good Samaritan Hospital


President
Good Samaritan Hospital


Chairman, Board of Trustees
Wright State University


Secretary, Board of Trustees
Wright State University

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF TEACHING HOSPITALS

Application for Membership

INSTRUCTIONS: Type all copies, retain the Pink copy for your files and return two copies to the Association of American Medical Colleges, Council of Teaching Hospitals, One Dupont Circle, N.W., Washington, D.C., 20036. PLEASE ENCLOSE A COPY OF THE HOSPITAL'S AFFILIATION AGREEMENT WITH THE APPLICATION.

MEMBERSHIP CRITERIA:

Eligibility for membership in the Council of Teaching Hospitals is determined by the following criteria:

- (a) The hospital has a documented institutional affiliation agreement with a school of medicine for the purpose of significantly participating in medical education;

AND

- (b) The hospital sponsors or significantly participates in approved, active residencies in at least four recognized specialties including two of the following: Medicine, Surgery, Obstetrics-Gynecology, Pediatrics and Psychiatry.

Membership in the Council is limited to not-for-profit (IRS-501C3) institutions, operated for educational, scientific or charitable purposes and publically-owned institutions.

I. MEMBERSHIP INFORMATION

Jerry L. Pettis Memorial Veterans Hospital
HOSPITAL NAME

11201 Benton Street Loma Linda
STREET CITY

California 92357 (714) 825-7084
STATE ZIP CODE TELEPHONE NUMBER

Chief Executive Officer Winton D. Ross
NAME

Hospital Director
TITLE

Date hospital was established: September 25, 1977

APPROVED FIRST POST-GRADUATE YEAR

| TYPE ² | Date of Initial Approval by CME of AMA** | Total F.T.E. ¹ Positions Offered | F.T.E. ¹ | F.T.E. ¹ |
|-------------------|--|---|---|---------------------------------|
| | | | Total Positions Filled by U.S. And Canadian Grads | Total Positions Filled by FMG's |
| Flexible | | | | |
| Categorical | <u>July 1965</u> | <u>31</u> | <u>28</u> | <u>3</u> |
| Categorical* | <u>July 1976</u> | <u>7</u> | <u>7</u> | <u>0</u> |

** Council on Medical Education of the American Medical Association and/or with appropriate AMA Internship and Residency Review Commission.

- Full-time equivalent positions at applicant institution only. If hospital participates in combined programs indicate only F.T.E. positions and individuals assigned to applicant institution.
- Type as defined by the AMA Directory of Approved Internships and Residencies. (Flexible-graduate program acceptable to two or more hospital program directors; Categorical-graduate program predominately under supervision of single program director; Categorical*-graduate program under supervision of single program director but content is flexible.)

APPROVED RESIDENCIES

| TYPE | Date of Initial Approval by CME of AMA** | F.T.E. ¹ | |
|---------------------------|--|---|---|
| | | Total F.T.E. ¹ Positions Offered | Total Positions Filled by U.S. And Canadian Grads |
| Medicine | July 1965 | 13 | 13 |
| | March 1965 | 7 | 7 |
| Surgery | June 1971 | 1 | 1 |
| Orthopedics | July 1957 | 3 | 2 |
| Anesthesiology | Sept 1964 | 4 | 4 |
| Psychiatry | December 1967 | 3 | 2 |
| Radiology | July 1965 | 1 | 1 |
| Pulmonary | July 1965 | 1 | 0 |
| Other (List): | July 1965 | 2 | 2 |
| Gastroenterology | February 1947 | 1 | 1 |
| Pathology | pending | 1 | 1 |
| ENT | December 1977 | 2 | 2 |
| Dental | | | |

II. PROGRAM DESCRIPTION

To supplement the information above and to assist the COTH Administrative Board in evaluating whether or not the institution fulfills the membership criteria, it is requested that you briefly and succinctly describe the extent of the hospital's participation in or sponsorship of educational activities with specific reference to the following questions.

- A. Extent of activity for undergraduate medical education students (e.g., number of clerkships offered; number of students participating; proportion of medical staff time committed to medical students).
- B. Presence of full-time salaried chiefs' of service and/or Director of Medical Education (e.g., departments which have salaried chiefs; hospital chiefs holding joint appointments at medical school).
- C. Dimension of hospital's financial support of medical education costs and nature of financial agreement with medical school (e.g., dollars devoted to house staff salaries and fringe benefits; the percentage of the hospital's budget these dollars represent; hospital's contribution to cost of supervising faculty; portion of service chiefs' costs paid by the hospital).
- D. Degree of affiliated medical school's involvement in and reliance upon hospital's education program (e.g., medical school faculty participation in hospital activities such as in-service education, conferences or medical staff committees).

The above are not meant to be minimum standards or requirements, but reflect the belief that COTH membership indicates a significant commitment and consideration of the items above. The hospital's organized medical education program should be described clearly with specific reference given to unique characteristics and to the institution's medical education objectives.

III. LETTER OF RECOMMENDATION

A letter of recommendation from the dean of the affiliated medical school should be included outlining the importance of the teaching hospital in the school's educational program.

Name and Address of Affiliated School of Medicine: Loma Linda University School of Medicine
Loma Linda, California 92354

Name of Dean: G. Gordon Hadley, M.D.

Information Submitted by:

Richard G. Griffin, M.D. Associate Chief of Staff for Education

NAME

DATE

4/25/78

TITLE OF PERSON SUBMITTING DATA

SIGNATURE OF HOSPITAL CHIEF EXECUTIVE

Winton D. Ross

WINTON D. ROSS



VETERANS ADMINISTRATION
JERRY L. PETTIS MEMORIAL VETERANS HOSPITAL
11201 BENTON STREET
LOMA LINDA, CALIFORNIA 92354

IN REPLY
REFER TO:

II. PROGRAM DESCRIPTION

- A. The Jerry L. Pettis Memorial Veterans Hospital in Loma Linda is a major affiliate of the Loma Linda University Medical Center and it is anticipated that by the time of full activation we will offer clerkships to approximately 160 medical students annually. This will be accomplished by having the entire junior medical class rotate through the hospital. At the present time we have approximately 30 medical students participating in our program at any one time in a clerkship status. It is anticipated that approximately 10% of medical staff time will be committed to medical student teaching when the hospital is fully activated.
- B. There are salaried Chiefs of Service in Medicine, Surgery, Pathology, Radiology, Nuclear Medicine, Psychiatry, Neurology, and Rehabilitation Medicine. In addition, we have full time paid Chiefs of Service in the following ancillary areas: Psychology, Social Work, Nursing, Pharmacy, Audiology and Speech Pathology, and Dental.

All of the hospital service chiefs hold joint appointments with Loma Linda University School of Medicine. There is also a full time paid director of education in the person of the Associate Chief of Staff for Education, together with support through Library, Medical Media, and Patient Education Services.

- C. The hospital has substantial commitment to, and investment in, medical education and has a formalized agreement with Loma Linda University Medical Center for support of medical residents. The salaries of all Service Chiefs are paid by the hospital and the cost of supervising faculty is shared between the hospital and the University through paid employees at the Veterans Administration Hospital and WOC participation by University faculty. In addition, a budget of \$162,610.00 is established for Consulting and Attending staff who will also participate in the teaching program. The salaries and fringe benefits paid to the house staff amount to \$388,841.00.

II. PROGRAM DESCRIPTION

- D. Loma Linda University School of Medicine is completely involved in the educational programs for physicians in the Jerry L. Pettis Memorial Veterans Hospital education program. The programs of this hospital are entirely integrated with the University's programs and medical school faculty participation is an integral part of virtually all of the educational programs provided by the hospital. The program is designed to be one of a fully integrated program with participation of trainee staff by rotation through participating programs in this hospital, at the University Medical Center, and at Riverside General Hospital University Medical Center. The program is designed to provide an integrated but broad-based program which allows for a wider range of experience than could be accomplished by participation in any single program alone. It is fully supported by the University and functions as a major teaching facility with heavy emphasis on both experiential and didactic teaching. The objective is to provide well-trained, highly capable medical personnel upon completion of the integrated program.

LOMA LINDA UNIVERSITY



Loma Linda Campus
LOMA LINDA, CALIFORNIA 92354
La Sierra Campus
RIVERSIDE, CALIFORNIA 92515

SCHOOL OF MEDICINE
OFFICE OF THE DEAN

April 20, 1978

Richard M. Knapp, Ph.D.
Chairman, Council on Teaching Hospitals
Association of American Medical Colleges
One Dupont Circle, N.W.
Suite 200
Washington, D. C. 20036

Dear Dr. Knapp:

I am writing this letter to confirm that the Jerry L. Pettis Memorial Veterans Administration Hospital in Loma Linda is an integral part of our medical school campus educational activities. It is fully integrated in both our undergraduate and graduate programs. We trust this information is of help to you.

Sincerely,

G. Gordon Hadley, M.D.
Dean

GGH:lm



VETERANS ADMINISTRATION
DEPARTMENT OF MEDICINE AND SURGERY
WASHINGTON, D.C. 20420



JAN 27 1977


IN REPLY
REFER TO: 141B

Director (00)
VA Hospital
Loma Linda, California 92354

SUBJ: Memorandum of Agreement (Affiliation) between Veterans Administration Hospital, Loma Linda, California, and the Loma Linda University School of Medicine, Loma Linda, California

1. We are pleased to advise you that the subject Memorandum of Agreement, with the additions described below has been approved by the General Counsel and signed by the Chief Medical Director.
2. We have added a page four to the Memorandum of Agreement to incorporate a reference to the University Affirmative Action Plan, and to include the plan and a statement on University Hiring Practices as a part of our Memorandum of Agreement (Affiliation).
3. If you and the University officials concur, please indicate this by each initialing page four of the agreement and each of the pages in Exhibits A and B, and returning a copy to this office (144).
4. You are to be congratulated on this affiliation with the Loma Linda University School of Medicine. We hope that the quality of health care in your facility will benefit greatly from the development of joint Veterans Administration/University education and training programs. Our office will be pleased to give you assistance in helping to insure that this relationship will be beneficial to both the University and your facility.
5. The signed agreement, modified as described above, is enclosed for your files.

By direction of the ADCMD for Operations,

for 
WILLIAM D. MAYER, M. D.
ACMD for Academic Affairs

Enclosures

MEMORANDUM OF AGREEMENT (AFFILIATION)
BETWEEN
THE VETERANS ADMINISTRATION HOSPITAL, LOMA LINDA, CALIFORNIA
AND
THE LOMA LINDA UNIVERSITY SCHOOL OF MEDICINE, LOMA LINDA, CALIFORNIA

This agreement when approved by the United States Veterans Administration and the Loma Linda University School of Medicine at Loma Linda, California, shall authorize the Veterans Administration Hospital, Loma Linda, and the Loma Linda University School of Medicine, California, to affiliate for the purposes of providing the best possible medical care for the veterans of the region, and providing for expansion and enrichment of the health science professional programs of Loma Linda University.

Responsibilities shall be divided as follows:

- A. The Loma Linda University School of Medicine at Loma Linda, California,
 - 1. will organize a Dean's Committee, composed of senior members of the faculty of the School(s), and other appropriate educational representatives.

- B. The Dean's Committee
 - 1. will nominate to the Veterans Administration Hospital Director candidates for vacant chiefs of professional services positions and candidates for a staff of consulting and attending specialists, annually, in the number and with the qualifications agreed upon by the Dean's Committee and the Veterans Administration.
 - 2. will advise on the development and quality of the education and training programs of the Veterans Administration Hospital, and such programs as are operated jointly by the Veterans Administration and the School(s).
 - 3. will nominate all physicians and dentists for residency or other graduate education and training programs in the numbers and with the qualifications agreed upon by the Dean's Committee and the Veterans Administration.
 - 4. will cooperate with VA personnel in establishing medical residency programs and in determining their scope, organization, standards of performance, and the adequacy of facilities.

5. will collaborate with the chiefs of service in the supervision of their residents and in supervising the activities of the attending and consulting staff.

6. will furnish advice with respect to standards of patient care, education, and bio-medical research.

C. The Veterans Administration:

1. will operate and administer the Veterans Administration Hospital, and retain full responsibility for the care of patients therein.

2. will appoint those qualified physicians and dentists to full-time and regular part-time staff of the hospital, that have been nominated to the Hospital Director by the Dean's Committee unless there are impelling reasons to the contrary.

3. will appoint those attending and consulting staff and the physician trainees as nominated by the Dean's Committee, unless there are impelling reasons to the contrary.

4. will cooperate fully, to the extent authorized, with the Loma Linda University School of Medicine in the conduct of appropriate programs of education, training, and research.

D. The Director, Veterans Administration Hospital, Loma Linda, California:

1. will be fully responsible for the operation of the Veterans Administration Hospital.

2. will cooperate with the Dean's Committee in the conduct of education and training programs.

E. Chiefs of Service:

1. will be responsible to their superiors in the Veterans Administration for the conduct of their services.

2. will, in cooperation with consulting and attending staff, supervise the education and training programs within their respective services.

F. The Attending Staff

1. will be responsible to the respective chiefs of service.

2. will accept appropriate responsibility for the proper care and treatment of patients in their charge upon delegation by the Hospital Director or his designee.
3. will provide adequate training to assigned house staff.
4. will hold faculty appointment in the Loma Linda University School of Medicine, or will be outstanding members of the profession with equivalent professional qualifications acceptable to the Medical School and the Veterans Administration.

G. Consultants:

1. will be members of the faculty in the Loma Linda University School of Medicine, responsible to the respective chief of service.
2. will participate in the education and training programs of the Veterans Administration Hospital.

H. Other Considerations:

1. The Loma Linda University School of Medicine will not discriminate against any employee or applicant for employment or registration in its course of study because of race, color, sex, or national origin.
2. Civil actions arising from alleged negligence or wrongful conduct of house staff while engaged in patient care or related activities at VAH, Loma Linda, California, will be considered and acted upon in accordance with the provisions of 38 U.S.C. 4116.
3. This agreement may be terminated at any time upon the mutual consent of both parties or upon six (6) months notice given by either party. An annual review of policies and procedures will be made.
4. Since Loma Linda University is owned and operated by the Seventh-day Adventist Church, which recognizes the seventh day (Saturday) as the Sabbath, and arranges its activities in harmony therewith, it is understood that the responsibilities accepted by the University under this affiliation agreement will be carried out in such a way as not to compromise their religious beliefs in any way.

5. Loma Linda University executes this agreement in harmony with its Affirmative Action Plan as amended filed May 20, 1976 Office of Civil Rights, HEW, San Francisco. In the event of conflict between the provision of this agreement and said Affirmative Action Plan, the Affirmative Action Plan shall control.

6. The Loma Linda Affirmative Action Plan and Statement on Hiring Practices appended to this memorandum of agreement (Affiliation) as Exhibits A and B are hereby made a part of this agreement.

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AHC

Harrison S. Evans Date 11/30/76
Vice President for Medical Affairs
and
Dean, School of Medicine
Loma Linda University

William S. Ross Date 11/30/76
Hospital Director
Veterans Administration Hospital

John Chase Date 1/18/77
Chief Medical Director
Department of Medicine and Surgery
Veterans Administration

AFFIRMATIVE ACTION PLAN

I. Policy Statement--Non-Discrimination Pledge

As a member of the sisterhood of schools, colleges, and universities operated by the Seventh-day Adventist Church, Loma Linda University subscribes to the official Employment Policy for Seventh-day Adventist Educational Institutions, as stated to include the University teaching hospital. This policy is in accord with Title 41 Section 60-1.5 (see pg. 253) providing-- "for a school, college, university, or other educational institution or institution of learning, to hire and employ employees of a particular religion if such school, college, university, or other educational institution or institution of learning is, in whole or in substantial part, owned, supported, controlled, or managed by a particular religion or by a particular religious corporation, association, or society, or if the curriculum of such school, college, university, or other educational institution of learning is directed toward the propagation of a particular religion. The primary thrust of this provision is directed at religiously oriented church-related colleges and universities and should be so interpreted".

The basic teachings and international nature of the Seventh-day Adventist Church require that its institutions be committed in philosophy and practice to the doctrine of equal human rights. The church insists that all persons should be given full and equal opportunity within the church to develop the knowledge and skills needed for the upbuilding of the church. Positions on all levels of church activity are, therefore, open on the basis of qualifications, without regard to race, color, ethnic background, country of origin, age, or sex. Identification with any of these categories is a matter in which the individual has no choice and cannot alter.

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However, in choosing and following a career, a person acquires a role determined chiefly by himself. It is he who decides his beliefs, creed, and church affiliation,--rights guaranteed each citizen by the Constitution of the United States.

For Seventh-day Adventists, the free exercise of religion includes the right to operate educational institutions that are distinctively Adventist. The creation and maintenance of such institutions requires that they be staffed only by those individuals who are in complete harmony with the beliefs and practices of the church. Hence, in the employment of personnel for its educational institutions one of the occupational qualifications for any position is for the individual to be a Seventh-day Adventist, committed to the program of the church, except as set forth below:

- A. In exceptional cases, within professional areas for which Seventh-day Adventist personnel are not available, the governing board may employ non-Adventists who are sympathetic to the religious concepts and in harmony with the basic philosophy.
- B. In exceptional cases, within areas for which Seventh-day Adventist personnel are not available, the University Hospital may employ non-Adventists who are sympathetic to the religious concepts and in harmony with the basic philosophy of the church.

The governing body of the church in the United States of America has ruled officially, and in practice abides by the following policies:

1. Equal employment opportunities shall be afforded, with no discrimination in recruitment or hiring against any employee or applicant because of race, color, ethnic background, country of origin, age or sex, except where age or sex are bona fide occupational qualifications.
2. Preferential hiring shall be practiced only on the basis of freely chosen adherence to Adventist tenet as an essential to the operation of an Adventist Institution.
3. Compensation and benefits will be administered without regard to race, color, ethnic background, country of origin, creed, age or sex, except where age or sex are bona fide occupational qualifications.
4. Decisions for the promotion of employees will be based upon the qualifications of an individual as related to the requirements of the position for which he is being considered.
5. Inasmuch as the personal life and the professional identity of an individual are inseparable, all employees are expected to conform to the standards of conduct and practices that are peculiarly Adventist.

LOMA LINDA UNIVERSITY'S
STATEMENT ON HIRING PRACTICES

I. STATUS OF LOMA LINDA UNIVERSITY

A. Loma Linda University is a California nonprofit corporation which operates an educational institution which is an integral part of the teaching ministry of the Seventh-day Adventist Church. This is reflected in the Articles of Incorporation of Loma Linda University as amended to January 26, 1971, in the following language:

"I. The name of this Corporation is LOMA LINDA UNIVERSITY.

II. The primary purpose of this Corporation is to establish, maintain, and conduct one or more educational institutions of collegiate and university grade within the State of California, as part of the system of educational institutions established and operated throughout the world by the Seventh-day Adventist Church.

III. This Corporation was organized and exists under the provisions of law now contained in Division 12, Chapter 2, Article 2, of the Education Code of the State of California."

B. Loma Linda University is recognized by the Internal Revenue Service as a tax exempt organization under Internal Revenue Code Section

501(c)(3) which relates to a "Corporation ... organized and operated exclusively for religious, charitable ... or educational purposes ..."

C. Loma Linda University has adopted in principle, by an action of its Board of Trustees on February 23, 1972, the Seventh-day Adventist Philosophy of Higher Education as promulgated by the General Conference of Seventh-day Adventists. The relevant portion of this statement reads as follows:

"Seventh-day Adventists are convinced ... that the church must maintain the privilege and right ... to employ only those who are in complete harmony with the religious concepts and philosophy of the church."

D. In harmony with the foregoing, Loma Linda University retains the right to give preference in hiring to Seventh-day Adventists. Recognition of this right has been given by Federal law in the manner set forth below.

II. FEDERAL LAW

A. Title VII of the Civil Rights Act of 1964 (42 USC Sections 2000e, et seq.), as amended by the Equal Employment Opportunity Act of 1972, precludes discrimination on account of race, color, religion, sex and national origin generally. However, Section 702 of Title VII states the following exemption:

"Section 702. This title shall not apply to an employer with respect to the employment of aliens outside any State, or to a religious corporation, association, educational institution, or society with respect to the employment

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of individuals of a particular religion to perform work connected with the carrying on by such corporation, association, educational institution, or society of its activities." (Emphasis supplied.)

B. Executive Order 11246 (3 CFR 339) as amended by Executive Order 11375 (32 Fed. Reg. 14303) bans discrimination by government contractors on account of race, color, religion, sex, and national origin. This Executive Order is enforced by designated compliance agencies in conjunction with the Office of Federal Contract Compliance under the Secretary of Labor. Effective April 24, 1975, the Department of Labor, in accordance with the aforementioned Executive Orders, amended Title 41, Chapter 60, Section 60-1.5 and Part 60-50 of the Code of Federal Regulations (39 CFR 11555), in order to clarify the employment obligations of religious corporations, associations, educational institutions and societies under the Executive Order, and to establish consistency between the religious exemption provisions of Section 702 of the Civil Rights Act of 1964, as amended, and the rules and regulations of the Office of Federal Contract Compliance. As reported in the Federal Register, Vol. 40, No. 58, the aforementioned Section 60-1.5 has been amended to include the following exemption:

"Section 60-1.5 Exemptions.

(a) * * *

(5) Contracts with certain educational institutions. It shall not be a violation of the equal opportunity clause for a school, college, university, or other educational institution or

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institution of learning to hire and employ employees of a particular religion if such school, college, university, or other educational institution or institution of learning is, in whole or in substantial part, owned, supported, controlled, or managed by a particular religion or by a particular religion or by a particular religious corporation, association, or society, or if the curriculum of such school, college, university, or other educational institution of learning is directed toward the propagation of a particular religion. The primary thrust of this provision is directed at religiously oriented church-related colleges and universities and should be so interpreted." (Emphasis supplied.)

III. CALIFORNIA LAW

A. Section 1411 of the California Fair Employment Practices Act (California Labor Code Section 1410, et seq.) states the public policy of the State of California as follows:

"Section 1411. Legislative Declaration.

It is hereby declared as the public policy of this state that it is necessary to protect and safeguard the right and opportunity of all persons to seek, obtain, and hold

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employment without discrimination or abridgement on account of race, religious creed, color, national origin, ancestry, physical handicap, or sex.

It is recognized that the practice of denying employment opportunity and discriminating in the terms of employment for such reasons foments of domestic strife and unrest, deprives the state of the fullest utilization of its capacities for development and advance, and substantially and adversely affects the interests of employees, employers, and the public in general.

This part shall be deemed an exercise of the police power of the state for the protection of the public welfare, prosperity, health, and peace of the people of the State of California." (Emphasis supplied.)

B. Section 1412 of the California Fair Employment Practices Act declares the opportunity to seek, obtain and hold employment without discrimination to be a civil right, as follows:

"Section 1412. Opportunity to seek, obtain and hold employment without discrimination as civil right. The opportunity to seek, obtain and hold employment without discrimination because of race, religious creed,

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color, national origin, ancestry, physical handicap, or sex is hereby recognized as and declared to be a civil right."

(Emphasis supplied.)

C. Section 1420 of the California Fair Employment Practices Act defines unlawful employment practices to include, inter alia, the following:

"Section 1420. Unlawful employment practices. It shall be an unlawful employment practice, unless based upon a bona fide occupational qualification, or, except where based upon applicable security regulations established by the United States or the State of California:

(a) For an employer, because of the race, religious creed, color, national origin, ancestry, physical handicap, or sex of any person, to refuse to hire or employ him or to refuse to select him for a training program leading to employment, or to bar or to discharge such person from employment or from a training program leading to employment, or to discriminate against such person in compensation or in terms, conditions or privileges of employment ..."

(Emphasis supplied.)

D. However, Section 1413(d) of the California Fair Employment Practices Act by definition exempts certain associations and organizations, as follows:

"(d) 'Employer,' except as hereinafter provided, includes any person regularly employing five or more persons, or any person acting as an agent of an employer, directly or indirectly; the state or any political or civil subdivision thereof and cities. 'Employer' does not include a social club, fraternal, charitable, educational or religious association or corporation not organized for private profit."

(Emphasis supplied.)

IV. SUMMARY

While Loma Linda University makes it a policy and practice not to discriminate with respect to race, color, sex, national origin, ancestry, or physical handicap, it does retain the right under both Federal and State law to give preference in hiring to Seventh-day Adventists.



COUNCIL OF TEACHING HOSPITALS ◦ ASSOCIATION OF AMERICAN MEDICAL COLLEGES

APPLICATION FOR MEMBERSHIP

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

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

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

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

I. HOSPITAL IDENTIFICATION

Southwestern Michigan Area Health Education Center
Hospital Name: (Borgess Hospital and Bronson Methodist Hospital)
Hospital Address: (Street) 252 East Lovell
(City) Kalamazoo, (State) Michigan (Zip) 49007
(Area Code)/Telephone Number: (616) 383-7896 or 383-6360
Name of Hospital's Chief Executive Officer: Robert M. Nicholson, M.D.
Title of Hospital's Chief Executive Officer: Executive Director

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

A. Patient Service Data

| | | | |
|--|--------------|----------------------------------|----------------|
| Licensed Bed Capacity (Adult & Pediatric excluding newborn): | <u>926</u> | Admissions: | <u>39,362</u> |
| Average Daily Census: | <u>755</u> | Visits: Emergency Room: | <u>61,515</u> |
| Total Live Births: | <u>3,863</u> | Visits: Outpatient or Clinic: | <u>104,041</u> |

*All figures given are combined totals for the two member hospitals (Borgess Hospital and Bronson Methodist Hospital).

B. Financial Data

Total Operating Expenses: \$ 68,951,520.00

Total Payroll Expenses: \$ N.A.

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: \$ 1,344,270.00
 Supervising Faculty: \$ 511,930.00

C. Staffing Data

Number of Personnel: Full-Time: 2,930
 Part-Time: 1,067

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 238
 With Medical School Faculty Appointments: 148

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

| <u>Internal Medicine</u> | <u>Pediatrics</u> | <u>Family Practice</u> | <u>Surgery</u> |
|--------------------------|-------------------|------------------------|----------------|
| _____ | _____ | _____ | _____ |

Does the hospital have a full-time salaried Director of Medical Education?: Robert M. Nicholson, M.D.

III. MEDICAL EDUCATION DATA

A. Undergraduate Medical Education

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

| <u>Clinical Services Providing Clerkships</u> | <u>Number of Clerkships Offered</u> | <u>Number of Students Taking Clerkships</u> | <u>Are Clerkships Elective or Required</u> |
|---|-------------------------------------|---|--|
| No. of Subspecialties <u>Medicine</u> | <u>10</u> | <u>73</u> | <u>elective</u> |
| | <u>6</u> | <u>19</u> | <u>required</u> |
| No. of Subspecialties <u>Surgery</u> | <u>8</u> | <u>24</u> | <u>elective</u> |
| | <u>3</u> | <u>18</u> | <u>required</u> |
| | <u>2</u> | <u>12</u> | <u>required</u> |
| <u>Ob-Gyn</u> | <u>12</u> | <u>2</u> | <u>elective</u> |
| No. of Subspecialties <u>Pediatrics</u> | <u>4</u> | <u>6</u> | <u>elective</u> |
| | <u>6</u> | <u>19</u> | <u>required</u> |
| <u>Family Practice</u> | <u>12</u> | <u>4</u> | <u>elective</u> |
| <u>Psychiatry</u> | <u>3</u> | <u>7</u> | <u>required</u> |
| Other: <u>Pathology</u> | <u>12</u> | <u>4</u> | <u>elective</u> |
| <u>Anesthesiology</u> | <u>12</u> | <u>6</u> | <u>elective</u> |
| <u>Radiology</u> | <u>1</u> | <u>1</u> | <u>elective</u> |
| <u>F.P.C.</u> | <u>2</u> | <u>13</u> | <u>required</u> |

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B. Graduate Medical Education

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

| <u>Type of Residency</u> ¹ | <u>Positions Offered</u> | <u>Positions Filled by U.S. & Canadian Grads</u> | <u>Positions Filled by Foreign Medical Graduates</u> | <u>Date of Initial Accreditation of the Program</u> ² |
|---------------------------------------|--------------------------|--|--|--|
| First Year Flexible | 4 | 4 | 0 | 1973 |
| Medicine | 34 | 34 | 0 | 1974 |
| Surgery | 14 | 4 | 0 | 1975 |
| Ob-Gyn | - | - | - | - |
| Pediatrics | 9 | 6 | 0 | 1976 |
| Family Practice | 9 | 9 | 0 | 1977 |
| Psychiatry | - | - | - | - |
| Other: | | | | |
| <u>Pathology</u> | 8 | 2 | 0 | 1974 |
| <u>Ortho.</u> | 8 | 8 | 0 | 1974 |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

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

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

IV. SUPPLEMENTARY INFORMATION

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

V. SUPPORTING DOCUMENTS

- A. When returning the completed application, please enclose a copy of the hospital's current medical school affiliation agreement.
- B. A letter of recommendation from the dean of the affiliated medical school must accompany the completed membership application. The letter should clearly outline the role and importance of the applicant hospital in the school's educational programs.

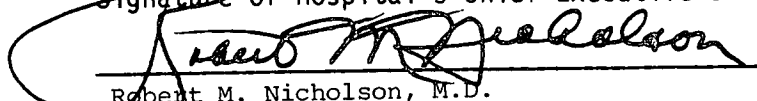
Name of Affiliated Medical School: Michigan State University
College of Human Medicine

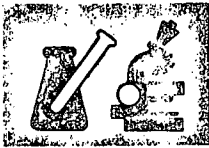
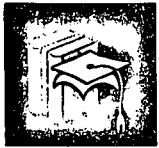
Dean of Affiliated Medical School: W. Donald Weston, M.D.

Information Submitted by: (Name) Robert M. Nicholson, M.D.

(Title) Executive Director

Signature of Hospital's Chief Executive Officer:

 (Date) April 14, 1978
Robert M. Nicholson, M.D.



SOUTHWESTERN MICHIGAN AREA HEALTH EDUCATION CENTER
252 East Lovell Street
Kalamazoo, Michigan 49006

(616) 383-7896

Robert M. Nicholson, M.D.
Executive Director

~ MEDICAL EDUCATION ~

Descriptive Summary Statement

The Southwestern Michigan Area Health Education Center was established as a corporate entity within the state of Michigan in May of 1973. It became operational July 1, 1973, and in the preamble to its constitution and by-laws states, "the scope of participation in medical education activities by the CORPORATION will include all activities relating to the training of professional health personnel". The members of the corporation are Borgess Hospital and Bronson Methodist Hospital, located in the city of Kalamazoo. Each is a general hospital numbering 465 beds. The affairs of the corporation are managed by an independent fifteen person board of directors. Each corporate member is entitled to six seats on the board of directors with two of the six seats occupied by members of the respective board of trustees of each member, one by the chief administrative officer and three by staff physicians. The remaining three full voting members of the board are two non member, affiliated citizens representing the general public, and the executive director. Michigan State University's College of Human Medicine and the University of Michigan Medical School each have a seat on the board of directors, but these individuals are ex-officio without vote. To date, the corporation has been heavily involved in program activities at the undergraduate, graduate and continuing medical education levels for physicians, has had some involvement in the education and training of type A physician's assistants students with Western Michigan University, and may soon embark upon a training program for emergency medical service personnel of the advanced life support variety. Since its inception and to date, corporate members (Borgess and Bronson Hospitals) have provided over seventy-five (75%) percent of the financial support, from local community funds, for the operation of the organization.

The Corporation was conceived, designed and established with the intention of serving an eight county area within southwestern Michigan as suggested by the 1970 Carnegie Commission Report entitled, "Higher Education and the Nation's Health". Thus far, the corporation has remained true in its spirit and methods of operation to the area health education center concept as suggested and outlined in this report. Also contained in the preamble to the constitution is a statement, "each party agrees not to engage in the operation or conducting of health education programs, or activities which are the same or similar to those conducted by the corporation as long as that party is a member of the corporation". Members of the corporation have faithfully adhered to this requirement. Among other things, they do not operate separate graduate (residency) training programs. The corporation, on the other hand, does operate,

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Descriptive Summary Statement
Southwestern Michigan Area
Health Education Center
Page Two

manage, and assume complete responsibility for Liaison Committee on Graduate Medical Education approved programs in the fields of internal medicine, general surgery, pediatrics, pathology, orthopaedics, and family practice. None of the residency programs are autonomous and all are conducted in a cooperative manner under the general supervision of the executive director and his staff within programmatic guidelines established by the administration. At the present time there are sixty-seven (67) individuals, all of whom are graduates of United States medical schools, who are in various stages of residency training in all of the programs conducted under the aegis of the corporation.

In the area of undergraduate educational activities for physicians during the current academic year, 127 medical students will have partaken of an educational clerkship program in Kalamazoo conducted under the auspices of the Southwestern Michigan Area Health Education Center. A great majority of these students are from Michigan State University College of Human Medicine and the University of Michigan Medical School. Michigan State University students are assigned to Kalamazoo for a two (junior and senior) year period, while all other students are on assignment for four, eight, or twelve weeks of rotational experience. Current projections for the academic year 1978-79 are for 154 medical students to participate in educational programs conducted by the corporation.

It is our view that the fertile educational climate and soil of Kalamazoo are ideal for the conduct of a broad range of health educational activities. All specialties and subspecialties are represented in the community, with additional educational resources and research support available from the world's second largest pharmaceutical concern, the Upjohn Company, with world headquarters and base operations located in Kalamazoo.

Southwestern Michigan Area Health Education Center is a federally authorized (I.R.S.) non profit corporation (501 C-3) registered as such with the State of Michigan.



Robert M. Nicholson, M.D.
Executive Director

MICHIGAN STATE UNIVERSITY

COLLEGE OF HUMAN MEDICINE • OFFICE OF THE DEAN

EAST LANSING • MICHIGAN • 48824

April 11, 1978

Robert M. Nicholson, M.D.
Executive Director
Southwestern Michigan Area
Health Education Center
252 East Lovell Street
Kalamazoo, MI 49006

Dear Bob:

We are very pleased to support Southwestern Michigan Area Health Education Center's (SMAHEC) application for membership in the AAMC Council of Teaching Hospitals. Since the Council of Teaching Hospitals normally derives its membership from individual teaching hospitals, we would emphasize that SMAHEC is a nonprofit education corporation under the corporation laws of the State of Michigan and is exempt under section 501(c)(3) of the Internal Revenue Code.

SMAHEC, founded by Borgess Hospital and Bronson Methodist Hospital in 1973 as an organization responsible for the operation and management of undergraduate, graduate and postgraduate medical educational programs, also is the organization through which the College of Human Medicine coordinates and manages the undergraduate medical education clerkships of the twenty-six medical students who are based in Kalamazoo. Its importance in our community-based approach to medical education cannot be overemphasized.

Due to the scope of our combined medical education programs in Kalamazoo, we believe membership in the AAMC Council of Teaching Hospitals is highly appropriate and you have our strong endorsement of your application.

Sincerely,


W. Donald Weston, M.D.
Dean

WDW:pe

MICHIGAN STATE UNIVERSITY

COLLEGE OF HUMAN MEDICINE • OFFICE OF THE DEAN

EAST LANSING • MICHIGAN • 48824

18 May 1978

Richard M. Knapp, Ph.D.
Director
Department of Teaching Hospitals
AAMC
Suite 200
One Dupont Circle, N.W.
Washington, D.C. 20036

Dear Dr. Knapp:

Thank you for sending me a copy of your letter of May 8 to Dr. Robert Nicholson, Executive Director of Southwestern Michigan Area Health Education Center (SMAHEC). You indicated that the COTH Administrative Board will give special consideration to SMAHEC's application for membership in COTH.

I cannot emphasize enough the importance to us of the community medical education corporations, of which we are a voting member, recognized and selected for membership in COTH. We believe that this type of arrangement is a step beyond individual hospital affiliation agreements. The educational corporations bring about a pooling of medical facilities and programs for medical education purposes and this system works remarkably well, not only in Kalamazoo but in our other campus communities as well.

I trust that the COTH Administrative Board will act favorably on SMAHEC's application on June 22. If you need additional supportive information, we will be pleased to cooperate.

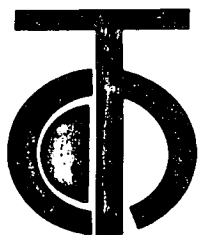
Sincerely,



W. Donald Weston, M.D.
Dean

WDW:smv

cc: Robert M. Nicholson, M.D.



COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

APPLICATION FOR MEMBERSHIP

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

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

I. HOSPITAL IDENTIFICATION

Hospital Name: University of Massachusetts Hospital
Hospital Address: (Street) 55 Lake Avenue North
(City) Worcester (State) Massachusetts (Zip) 01605
(Area Code)/Telephone Number: (617) 856-0011
Name of Hospital's Chief Executive Officer: Micheal O. Bice
Title of Hospital's Chief Executive Officer: Hospital Director

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

A. Patient Service Data

| | | | |
|--|-------------|----------------------------------|---------------|
| Licensed Bed Capacity (Adult & Pediatric excluding newborn): | <u>403</u> | Admissions: | <u>2,827</u> |
| Average Daily Census: | <u>70.1</u> | Visits: Emergency Room: | <u>10,237</u> |
| Total Live Births: | <u>0</u> | Visits: Outpatient or Clinic: | <u>24,481</u> |

B. Financial Data

Total Operating Expenses: \$ 10,335,061

Total Payroll Expenses: \$ 5,543,495

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: \$ 233,441
 Supervising Faculty: \$ 15,269

C. Staffing Data

Number of Personnel: Full-Time: 511
 Part-Time: 56

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 7
 With Medical School Faculty Appointments: 131

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

| | | | |
|------------------------|----------------|----------------------|-------------------|
| <u>Family Practice</u> | <u>Surgery</u> | <u>Orthopedics</u> | <u>Pediatrics</u> |
| <u>Medicine</u> | <u>Ob/Gyn</u> | <u>Ophthalmology</u> | <u></u> |

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

III. MEDICAL EDUCATION DATA

A. Undergraduate Medical Education

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

| <u>Clinical Services Providing Clerkships</u> | <u>Number of Clerkships Offered</u> | <u>Number of Students Taking Clerkships</u> | <u>Are Clerkships Elective or Required</u> |
|---|-------------------------------------|---|--|
| Medicine | <u>1</u> | <u>19</u> | <u>Required</u> |
| Surgery | <u>1</u> | <u>12</u> | <u>Required</u> |
| Ob-Gyn | <u></u> | <u></u> | <u></u> |
| Pediatrics | <u>1</u> | <u>5</u> | <u>Required</u> |
| Family Practice | <u></u> | <u></u> | <u></u> |
| Psychiatry | <u></u> | <u></u> | <u></u> |
| Other: <u></u> | <u></u> | <u></u> | <u></u> |
| <u></u> | <u></u> | <u></u> | <u></u> |
| <u></u> | <u></u> | <u></u> | <u></u> |

B. Graduate Medical Education

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

| <u>Type of Residency</u> ¹ | <u>Positions Offered</u> | <u>Positions Filled by U.S. & Canadian Grads</u> | <u>Positions Filled by Foreign Medical Graduates</u> | <u>Date of Initial Accreditation of the Program</u> ² |
|---------------------------------------|--------------------------|--|--|--|
| First Year Flexible | _____ | _____ | _____ | _____ |
| Medicine | 18 | 18 | 0 | 1977 |
| Surgery | 5 FTE* | _____ | _____ | 1977 |
| Ob-Gyn | 2 FTE** | _____ | _____ | 1977 |
| Pediatrics | 4 FTE+ | _____ | _____ | 1977 |
| Family Practice | _____ | _____ | _____ | _____ |
| Psychiatry | _____ | _____ | _____ | _____ |
| Other: | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

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

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

* 34 in integrated programs rotating through University Hospital so there are 5 FTE at any one time
 ** 16 in integrated programs rotating through University Hospital so there are 2 FTE at any one time
 + 19 in integrated programs rotating through University Hospital so there are 4 FTE at any one time

IV. SUPPLEMENTARY INFORMATION

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

V. SUPPORTING DOCUMENTS

- A. When returning the completed application, please enclose a copy of the hospital's current medical school affiliation agreement.
- B. A letter of recommendation from the dean of the affiliated medical school must accompany the completed membership application. The letter should clearly outline the role and importance of the applicant hospital in the school's educational programs.

Name of Affiliated Medical School: University of Massachusetts Medical School

Dean of Affiliated Medical School: Roger J. Bulger, M.D.

Information Submitted by: (Name) Michael O. Bice
(Title) Hospital Director

Signature of Hospital's Chief Executive Officer:
Michael O. Bice (Date) 4/27/75

IV. SUPPLEMENTARY INFORMATION

Design and Function

The University Hospital and the Medical Science Building have been designed to function as an integrated center for medical education. The two buildings are connected floor-by-floor. Each building is functionally incomplete without the other.

The University Hospital is the only hospital in central Massachusetts specifically designed for medical education. It contains classrooms, faculty offices, student laboratories, and many functional interrelationships especially designed for teaching. Its floor-by-floor connection with the Medical Science Building allows ideal utilization of the entire Medical School faculty for clinical teaching. Interdepartmental teaching programs, particularly those involving the basic science faculty, would be much more difficult if all such teaching had to be conducted in other hospitals in the area.

Primary Care Teaching at the University Hospital

Specialty care is very important in the education of primary care physicians. The University Hospital will provide those specialties which currently are not offered in the affiliated Worcester Hospitals.

However, the University Hospital will not be utilized exclusively for tertiary care. To do so could perpetuate in our school the traditional trend to the production of specialists. Medical educators and health planners are now placing emphasis upon new methods of providing health care in a University setting in order to produce more primary care physicians. It is deemed essential that University hospitals carry on a carefully planned program in primary care. To have no such programs and no faculty "role models" in our University Hospital would say loud and clear to our students that the Medical School did not feel primary care was important enough to emphasize it at the home base.

Primary care is largely concerned with outpatient evaluation and treatment as opposed to inpatient care. A large number of outpatients seeking primary care must be available for the training of students and residents. This kind of education in the University Hospital setting is conducted in scheduled outpatient clinics where the trainees are closely supervised by senior faculty.

Most primary care in the Worcester area is provided in the private offices of individual physicians. A significant amount of primary care is also obtained by "walk-in" visits to emergency rooms of local hospitals. In order to meet most of the educational needs of primary care training programs, it is necessary for the Medical School to provide a primary care unit in its teaching hospital in addition to the five primary health care centers already in existence or being developed as well as others which are likely to be developed in other locations throughout the State. These centers will refer the majority of cases directly to our affiliated hospitals rather than to the University Hospital itself.

The primary care unit at the teaching hospital will be interdepartmental. The staff will come primarily from the major departments involved in primary care (Medicine, Pediatrics, Community and Family Medicine, Ob/Gyn, Psychiatry, and Family Practice). However, specialty departments will also help staff the primary care clinic for both instructional and patient care services. For example, a general surgeon will be assigned to the unit. Other surgical specialists will be available on call, as well as being present at the unit as specified times for the evaluation of problems in their particular specialty area. Primary care residents and medical students will also rotate through the specialty clinics in order to ensure adequate training in the specialty problems they may encounter in office practice. Thus, almost all of the faculty at the University Hospital, including specialists, will participate directly in the education of primary care physicians.

UMMC RESIDENCY PROGRAMS

| <u>GME Specialty</u> | <u>1977-78</u> | <u>1978-79</u> | <u>1979-80</u> | <u>1980-81</u> | <u>1981-82</u> | <u>Full Growth</u> |
|-------------------------|----------------|----------------|----------------|----------------|----------------|--------------------|
| <u>Family Practice:</u> | | | | | | |
| PGY 1 | 12 | 12 | 12 | 12 | 12 | 12 |
| PGY 2 | 12 | 12 | 12 | 12 | 12 | 12 |
| PGY 3 | 7 | 12 | 12 | 12 | 12 | 12 |
| Total | 31 | 36 | 36 | 36 | 36 | 36 |
| <u>Medicine:</u> | | | | | | |
| PGY 1 | 7 | 14 | 24 | 29 | 31 | 31 |
| PGY 2 | 4 | 8 | 13 | 23 | 27 | 31 |
| PGY 3 | 6 | 12 | 14 | 18 | 20 | 31 |
| PGY 4 | 1 | 1 | 1 | 1 | 2 | 2 |
| Total | 18 | 35 | 52 | 71 | 80 | 95 |
| <u>Pediatrics:</u> | | | | | | |
| PGY 1 | 8 | 9 | 10 | 10 | 11 | 11 |
| PGY 2 | 8 | 9 | 10 | 10 | 11 | 11 |
| PGY 3 | 2 | 7 | 9 | 9 | 10 | 10 |
| PGY 4 | | | 2 | 2 | 2 | 2 |
| Total | 18 | 25 | 31 | 31 | 34 | 34 |
| <u>OB/Gyn:</u> | | | | | | |
| PGY 1 | 3 | 4 | 4 | 4 | 4 | 4 |
| PGY 2 | 6 | 4 | 4 | 4 | 4 | 4 |
| PGY 3 | 2 | 4 | 4 | 4 | 4 | 4 |
| PGY 4 | 2 | 4 | 4 | 4 | 4 | 4 |
| Total | 13 | 16 | 16 | 16 | 16 | 16 |

| <u>GME Specialty</u> | <u>1977-78</u> | <u>1978-79</u> | <u>1979-80</u> | <u>1980-81</u> | <u>1981-82</u> | <u>Full Growth</u> |
|-------------------------|----------------|----------------|----------------|----------------|----------------|--------------------|
| <u>Surgery:</u> | | | | | | |
| PGY 1 | 12 | 16 | 16 | 16 | 16 | 16 |
| PGY 2 | 9 | 9 | 9 | 9 | 9 | 9 |
| PGY 3 | 7 | 6 | 6 | 6 | 6 | 6 |
| PGY 4 | 7 | 6 | 6 | 6 | 6 | 6 |
| PGY 5 | 5 | 6 | 6 | 6 | 6 | 6 |
| Total | 40 | 43 | 43 | 43 | 43 | 43 |
| <u>Anaesthesiology:</u> | | | | | | |
| PGY 1 | | 2 | 2 | 3 | 3 | 3 |
| PGY 2 | 2 | 3 | 5 | 6 | 6 | 6 |
| PGY 3 | | 3 | 3 | 5 | 6 | 6 |
| PGY 4 | | 2 | 3 | 3 | 3 | 4 |
| Total | 2 | 10 | 13 | 17 | 18 | 19 |
| <u>Cardiology:</u> | | | | | | |
| PGY 4 | 5 | 5 | 5 | 5 | 5 | 5 |
| PGY 5 | 6 | 5 | 5 | 5 | 5 | 5 |
| PGY 6 | | 1 | 2 | 2 | 2 | 2 |
| Total | 11 | 11 | 12 | 12 | 12 | 12 |
| <u>Orthopedics:</u> | | | | | | |
| PGY 2 | 3 | 4 | 4 | 4 | 4 | 4 |
| PGY 3 | 4 | 4 | 4 | 4 | 4 | 4 |
| PGY 4 | 3 | 4 | 4 | 4 | 4 | 4 |
| PGY 5 | 5 | 4 | 4 | 4 | 4 | 4 |
| Total | 15 | 16 | 16 | 16 | 16 | 16 |
| <u>Pathology:</u> | | | | | | |
| PGY 1 | 0 | 2 | 2 | 2 | 3 | 3 |
| PGY 2 | 0 | 2 | 2 | 2 | 2 | 2 |
| PGY 3 | 0 | | 2 | 2 | 2 | 2 |
| PGY 4 | 0 | | | 2 | 2 | 2 |
| Total | 0 | 4 | 6 | 8 | 9 | 9 |

| <u>GME Specialty</u> | <u>1977-78</u> | <u>1978-79</u> | <u>1979-80</u> | <u>1980-81</u> | <u>1981-82</u> | <u>Full Growth</u> |
|------------------------|----------------|----------------|----------------|----------------|----------------|--------------------|
| <u>Radiology:</u> | | | | | | |
| PGY 2 | 0 | 2 | 2 | 3 | 3 | 3 |
| PGY 3 | 0 | 1 | 2 | 3 | 3 | 3 |
| PGY 4 | 0 | 0 | 2 | 3 | 3 | 3 |
| Total | 0 | 3 | 6 | 9 | 9 | 9 |
| <u>Neurology:</u> | | | | | | |
| PGY 2 | 0 | 1 | 3 | 4 | 4 | 4 |
| PGY 3 | 0 | 1 | 3 | 4 | 4 | 4 |
| PGY 4 | 0 | 1 | 3 | 4 | 4 | 4 |
| Total | 0 | 3 | 9 | 12 | 12 | 12 |
| <u>Gen. Prev. Med.</u> | | | | | | |
| PGY 2 | 0 | 1 | 1 | 1 | 2 | 2 |
| PGY 3 | 0 | 0 | 1 | 1 | 1 | 2 |
| PGY 4 | 0 | 0 | 0 | 1 | 1 | 2 |
| Total | 0 | 1 | 2 | 3 | 4 | 6 |



UNIVERSITY OF MASSACHUSETTS
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CHANCELLOR, UNIVERSITY
OF MASSACHUSETTS AT WORCESTER
DEAN OF THE MEDICAL SCHOOL
55 LAKE AVENUE NORTH
WORCESTER, MASSACHUSETTS 01605

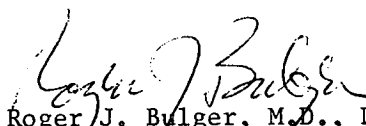
April 6, 1978

MEMORANDUM TO: Council of Teaching Hospitals

FROM: Roger J. Bulger, M.D., Dean
University of Massachusetts Medical School

REGARDING: Application of University of Massachusetts
Hospital for Membership in the Council of
Teaching Hospitals

The University Hospital is wholly owned and operated by the University of Massachusetts and has been planned and built in concert with the Medical School, with floor-by-floor connections to the clinical science building. It's growth and development are fully integrated with that of the Medical School. As Chancellor, I am in direct control of hospital operations and our medical school chairmen are the service chiefs within the hospital. Thus it is important for us to join the ranks of the Council of Teaching Hospitals at this time.


Roger J. Bulger, M.D., Dean
University of Massachusetts,
Medical School

RJB/ked

NON-COTH HOSPITALS WHICH MEET MEMBERSHIP REQUIREMENTS

At the COTH Spring Meeting Dr. William Hejna, Senior Vice President at Rush Presbyterian - St. Luke's Medical Center in Chicago, asked whether or not there was a list available of teaching hospitals which meet the requirements for membership but do not belong to the Council of Teaching Hospitals. On the following pages is a list of hospitals which appear to meet the affiliation and residency program requirements based on information taken from the LCGME Directory of Accredited Residencies 1976-77.

HOSPITALS ELIGIBLE FOR COTH MEMBERSHIP

| <u>Hospital</u> | <u>Former Member</u> | <u>Affiliation</u> |
|---|----------------------|--|
| <u>Baptist Medical Centers, Birmingham, Alabama</u> | No | L- University of Alabama School of Medicine, Birmingham, Alabama |
| <u>Lloyd Noland, Fairfield, Alabama</u> | No | L- University of Alabama School of Medicine, Birmingham, Alabama |
| <u>Pima County General, Tucson, Arizona</u> | No | M- University Of Arizona College of Medicine, Tucson, Arizona |
| <u>David Grant U.S.A.F. Medical Center, Fairfield, California</u> | No | M- University of California, Davis, School of Medicine, Davis, California |
| <u>Valley Medical Center of Fresno, Fresno, California</u> | No | L- University of California School of Medicine, San Francisco, California |
| <u>Glendale Adventist Medical Center, Glendale, California</u> | No | M- Loma Linda University School of Medicine, Loma Linda, California |
| <u>White Memorial Medical Center, Los Angeles, California</u> | No | M- Loma Linda University School of Medicine, Loma Linda, California G- University of Southern California School of Medicine, Los Angeles, California |
| <u>Highland General, Oakland, California</u> | Yes | G- University of California School of Medicine, San Francisco, California |
| <u>Kaiser Foundation, Oakland, California</u> | No | L- University of California School of Medicine, San Francisco, California |
| <u>Kaiser Foundation, Sacramento, California</u> | No | M- University of California, Davis, School of Medicine, Davis, California |
| <u>Mercy Hospital and Medical Center, San Diego, California</u> | No | M- University of California, School of Medicine, San Diego, California |

| <u>Hospital</u> | <u>Former Member</u> | <u>Affiliation</u> |
|---|----------------------|--|
| <u>Letterman Army Medical Center</u> San Francisco, California | No | L- University of California School of Medicine, San Francisco, California |
| <u>St. Mary' Hospital And Medical</u> <u>Center, San Francisco, California</u> | No | L- University of California School of Medicine, San Francisco, California |
| <u>San Francisco General, San</u> <u>Francisco, California</u> | No | M- University of California School of Medicine, San Francisco, California |
| <u>Santa Clara Valley Medical</u> <u>Center, San Jose, California</u> | No | M- Stanford University School of Medicine, Stanford, California G- University of California School of Medicine, San Francisco, California |
| <u>Kaiser Foundation, Santa Clara,</u> <u>California</u> | No | L- Stanford University School of Medicine, Stanford, California |
| <u>San Joaquin General, Stockton,</u> <u>California</u> | Yes | L- University of California, Davis, School of Medicine, Davis, California G- University of California School of Medicine, San Francisco, California |
| <u>Fitzsimmons Army Medical Center,</u> <u>Denver, Colorado</u> | Yes | M- University of Colorado School of Medicine, Denver, Colorado L- University of Washington School of Medicine, Seattle, Washington |
| <u>Veteran's Administration,</u> <u>Wilmington, Delaware</u> | No | G- Jefferson Medical College Of Thomas Jefferson University, Philadelphia, Pennsylvania |
| <u>District of Columbia General,</u> <u>Washington, D.C.</u> | No | M- Georgetown University School of Medicine, Washington, D.C. M- Howard University College of Medicine, Washington, D.C. |
| <u>Walter Reed Army Medical Center,</u> <u>Washington, D.C.</u> | No | M- Georgetown University School of Medicine, Washington, D.C. L- Howard University College of Medicine, Washington, D.C. |

| <u>Hospital</u> | <u>Former Member</u> | <u>Affiliation</u> |
|---|----------------------|---|
| <u>Memorial Medical Center,</u> <u>Savannah, Florida</u> | No | M- Medical College of Georgia School of Medicine, Augusta, Georgia |
| <u>Tripler Army Medical Center</u> <u>Honolulu, Hawaii</u> | No | M- University of Hawaii School of Medicine, Honolulu, Hawaii G- University of California School of Medicine, San Francisco, California |
| <u>Columbus-Cuneo-Cabrini</u> <u>Medical Center, Chicago, Illinois</u> | No | L- Northwestern University Medical School, Chicago , Illinois L- Loyola University of Chicago Stritch School of Medicine, Maywood, Illinois |
| <u>St. Francis, Evanston,</u> <u>Illinois</u> | Yes | M- Loyola University of Chicago Stritch School of Medicine, Maywood, Illinois G- Northwestern University Medical School, Chicago, Illinois |
| <u>Christ, Oaklawn, Illinois</u> | No | L- Rush Medical College, Chicago, Illinois |
| <u>St. Joseph Infirmiry, Louisville,</u> <u>Kentucky</u> | Yes | L- University of Louisville School of Medicine, Louisville, Kentucky |
| <u>Greater Baltimore Medical Center,</u> <u>Baltimore, Maryland</u> | Yes | G- Johns Hopkins University School of Medicine, Baltimore, Maryland |
| <u>Mercy, Baltimore, Maryland</u> | No | M- University of Maryland School of Medicine, Baltimore, Maryland |
| <u>St. Agnes, Baltimore, Maryland</u> | Yes | G- University of Maryland School of Medicine, Baltimore, Maryland |
| <u>South Baltimore General, Baltimore,</u> <u>Maryland</u> | No | G- University of Maryland School of Medicine, Baltimore, Maryland |

| <u>Hospital</u> | <u>Former Member</u> | <u>Affiliation</u> |
|--|----------------------|---|
| <u>National Naval Medical Center,</u> Bethesda, Maryland | No | M- Georgetown University School of Medicine, Washington, D.C. M- George Washington Univer- sity School of Medicine, Washington, D.C. L- Howard University College of Medicine, Washington, D.C. |
| <u>Boston City, Boston,</u> Massachusetts | No | M- Boston University School of Medicine, Boston, Massachusetts L- Harvard Medical School, Boston, Massachusetts |
| <u>Carney, Boston, Massachusetts</u> | Yes | L-Boston University School of Medicine, Boston, Massachusetts G-Tufts University School of Medicine, Boston, Massachusetts |
| <u>St. Elizabeth's Hospital of Boston, No</u> Boston, Massachusetts | No | M-Tufts University School of Medicine, Boston, Massachusetts |
| <u>Cambridge, Cambridge, Massa-</u> chusetts | No | M- Harvard Medical School, Boston, Massachusetts L- Tufts University School of Medicine, Boston, Massachusetts |
| <u>Mount Auburn, Cambridge,</u> Massachusetts | No | M- Harvard Medical School, Boston, Massachusetts |
| <u>Framington Union, Framington,</u> Massachusetts | No | M- Boston University School of Medicine, Boston, Massachusetts |
| <u>Mount Carmel Mercy Hospital</u> <u>and Medical Center, Detroit</u> Michigan | Yes | L- Wayne State University School of Medicine, Detroit, Michigan G- University of Michigan Medical School, Ann Arbor, Michigan |
| <u>St. Mary's, Grand Rapids,</u> Michigan | No | M- University of Michigan Medical School, Ann Arbor, Michigan |
| <u>Bronson Methodist, Kalamazoo,</u> Michigan | No | M- University of Michigan Medical School, Ann Arbor, Michigan |

| <u>Hospital</u> | <u>Former Member</u> | <u>Affiliation</u> |
|--|----------------------|--|
| <u>Bronson (cont.)</u> | | M- Michigan State University College of Human Medicine, East Lansing Michigan |
| <u>St. Lawrence, Lansing, Michigan</u> | No | M- Michigan State University College of Human Medicine, East Lansing, Michigan |
| <u>Pontiac General, Pontiac, Michigan</u> | Yes | G- University of Michigan Medical School, Ann Arbor, Michigan |
| <u>William Beaumont, Royal Oak, Michigan</u> | No | L- Wayne State University School of Medicine, Detroit, Michigan |
| <u>Miller Division (United Hospitals), St. Paul, Minnesota</u> | Yes | L- University of Minnesota Medical School, Minneapolis, Minnesota |
| <u>U.S.A.F. Medical Center, Biloxi, Mississippi</u> | No | L- Tulane University School of Medicine, New Orleans, Louisiana |
| <u>Deaconess, St. Louis, Missouri</u> | No | G- University of Missouri-Columbia School of Medicine, Columbia, Missouri G- St. Louis University School of Medicine, St. Louis, Missouri |
| <u>Firmin Desloge General, St. Louis, Missouri</u> | No | M- St. Louis University School of Medicine, St. Louis, Missouri |
| <u>Homer G. Philips, St. Louis, Missouri</u> | No | L- Washington University School of Medicine, St. Louis, Missouri |
| <u>Atlantic City, Atlantic City, New Jersey</u> | No | M- Hahnemann Medical College and Hospital, Philadelphia, Pennsylvania |
| <u>Hunterdon Medical Center, Flemington, New Jersey</u> | No | M- CMDNJ-Rutgers Medical School, Piscataway, New Jersey |
| <u>Raritan Valley, Greenbrook, New Jersey</u> | No | M- CMDNJ-Rutgers Medical School, Piscataway, New Jersey |

| <u>Hospital</u> | <u>Former Member</u> | <u>Affiliation</u> |
|--|----------------------|--|
| <u>Jersey City Medical Center, Jersey City, New Jersey</u> | Yes | M- CMDNJ-New Jersey Medical School, Newark, New Jersey |
| <u>St. Peter's Medical Center, New Brunswick, New Jersey</u> | No | M- CMDNJ-Rutgers Medical School, Piscataway, New Jersey |
| <u>St. Joseph's Hospital and Medical Center, Patterson, New Jersey</u> | No | M- CMDNJ-New Jersey Medical School, Newark, New Jersey |
| <u>St. Francis Medical Center, Trenton, New Jersey</u> | No | L- CMDNJ-Rutgers Medical School, Piscataway, New Jersey |
| <u>St. Peter's, Albany, New York</u> | No | L- Albany Medical College of Union University, Albany, New York |
| <u>Mount Vernon, Mount Vernon, New York</u> | No | M- New York Medical College Flower and Fifth Avenue Hospitals, New York City, New York |
| <u>Bellevue Hospital Center, New York City, New York</u> | No | M- New York University School of Medicine, New York City, New York |
| <u>Coney Island, New York City, New York</u> | No | L-State University of New York Downstate Medical Center, Brooklyn, New York |
| <u>Lincoln, New York City, New York</u> | No | M- Albert Einstein College of Medicine of Yeshiva University, New York City, New York |
| <u>Maimonides Medical Center, New York City, New York</u> | Yes | M- State University of New York Downstate Medical Center, Brooklyn, New York |
| <u>Mary Immaculate Division, New York City, New York</u> | No | G- New York Medical College Flower and Fifth Avenue Hospitals, New York City, New York |
| <u>Metropolitan Hospital Center, New York City, New York</u> | No | M- New York Medical College Flower and Fifth Avenue Hospitals, New York City, New York |

| <u>Hospital</u> | <u>Former Member</u> | <u>Affiliation</u> |
|--|----------------------|--|
| <u>Morrisania City, New York</u> <u>City, New York</u> | Yes | M- Albert Eistein College of Medicine of Yeshiva University, New York City, New York |
| <u>Ellis, Schenectady, New York</u> | No | L- Albany Medical College of Union University, Albany, New York |
| <u>Crouse-Irving Memorial, Syracuse, New York</u> | Yes | M- State University of New York, Upstate Medical Center, College of Medicine, Syracuse, New York |
| <u>St. Joseph's Hospital Health Center, Syracuse, New York</u> | No | M- State University of New York, Upstate Medical Center, College of Medicine, Syracuse, New York |
| <u>Moses H. Cone Memorial, Greensboro, North Carolina</u> | No | M- University of North Carolina School of Medicine, Chapel Hill, North Carolina L- Bowman Gray School of Medicine of Wake Forest College, Winston-Salem, North Carolina |
| <u>Charles F. Kettering Memorial, Kettering, Ohio</u> | No | M- Wright State University School of Medicine, Dayton, Ohio |
| <u>Mercy, Toledo, Ohio</u> | No | M- Medical College of Ohio at Toledo, Toledo, Ohio |
| <u>St. Vincent Hospital and Medical Center, Toledo, Ohio</u> | No | M- Medical College of Ohio at Toledo, Toledo, Ohio |
| <u>Toledo, Toledo, Ohio</u> | No | M- Medical College of Ohio at Toledo, Toledo, Ohio |
| <u>Jewish, Cincinnati, Ohio</u> | No | L- University of Cincinnati College of Medicine, Cincinnati, Ohio |
| <u>Presbyterian, Oklahoma City, Oklahoma</u> | No | M- University of Oklahoma School of Medicine, Oklahoma City, Oklahoma |
| <u>St. Anthony, Oklahoma City, Oklahoma</u> | No | L- University of Oklahoma School of Medicine, Oklahoma City, Oklahoma |

| <u>Hospital</u> | <u>Former Member</u> | <u>Affiliation</u> |
|--|----------------------|---|
| <u>Hillcrest Medical Center,</u> Tulsa, Oklahoma | No | L- University of Oklahoma School of Medicine, Oklahoma City, Oklahoma |
| <u>St. Francis,</u> Tulsa, Oklahoma | No | L- University of Oklahoma School of Medicine, Oklahoma City, Oklahoma |
| <u>St. John's,</u> Tulsa, Oklahoma | No | L- University of Oklahoma School of Medicine, Oklahoma City, Oklahoma |
| <u>Good Samaritan Hospital and</u> <u>Medical Center,</u> Portland, Oregon | No | L- University of Oregon Medical School, Portland, Oregon |
| <u>St. Vincent Hospital and</u> <u>Medical Center,</u> Portland, Oregon | No | G- University of Oregon Medical School, Portland, Oregon |
| <u>Abington Memorial,</u> Abington, Pennsylvania | No | M- Temple University of the Commonwealth System of Higher Education School of Medicine, Philadelphia, Pennsylvania G- Hahnemann Medical College and Hospital, Philadelphia, Pennsylvania |
| <u>Allentown,</u> Allentown, Pennsylvania | Yes | G- University of Pennsylvania School of Medicine, Philadelphia, Pennsylvania |
| <u>Harrisburg Polyclinic,</u> Harris- burg, Pennsylvania | Yes | M- Pennsylvania State Univer- sity College of Medicine, Milton S. Hershey Medical Center, Hershey, Pennsyl- vania |
| <u>Misericordia Division,</u> Philadelphia, Pennsylvania | No | M- Jefferson Medical College of Thomas Jefferson University, Philadelphia, Pennsylvania |
| <u>Naval Regional Medical Center,</u> Philadelphia, Pennsylvania | No | M- Hahnemann Medical College and Hospital, Philadelphia, Pennsylvania M- Jefferson Medical College of Thomas Jefferson University, Philadelphia, Pennsylvania |

| <u>Hospital</u> | <u>Former Member</u> | <u>Affiliation</u> |
|---|----------------------|--|
| <u>Reading, Reading, Pennsylvania</u> | Yes | L- Temple University of the Commonwealth System of Higher Education School of Medicine, Philadelphia, Pennsylvania L- University of Pennsylvania School of Medicine, Philadelphia, Pennsylvania |
| <u>Robert Packer, Sayre, Pennsylvania</u> | No | M- Hahnemann Medical College and Hospital, Philadelphia, Pennsylvania |
| <u>Caguas Sub-Regional, Caguas, Puerto Rico</u> | No | L- University of Puerto Rico School of Medicine, San Juan, Puerto Rico |
| <u>Ponce District General, Ponce, Puerto Rico</u> | No | L- University of Puerto Rico School of Medicine, San Juan, Puerto Rico |
| <u>Charleston County, Charleston, South Carolina</u> | No | M- Medical University of South Carolina College of Medicine, Charleston, South Carolina |
| <u>Richland Memorial, Columbia, South Carolina</u> | No | L- Medical University of South Carolina College of Medicine, Charleston, South Carolina |
| <u>Baroness Erlanger, Chattanooga, Tennessee</u> | No | M- University of Tennessee College of Medicine, Memphis, Tennessee |
| <u>Methodist, Memphis, Tennessee</u> | No | G- University of Tennessee College of Medicine, Memphis, Tennessee |
| <u>Nashville Metropolitan General, Nashville, Tennessee</u> | No | M- Vanderbilt University School of Medicine, Nashville, Tennessee |
| <u>Brackenridge, Austin, Texas</u> | No | M- University of Texas Medical Branch at Galveston, Galveston, Texas |
| <u>William Beaumont Army Medical Center, El Paso, Texas</u> | Yes | L- University of Texas Medical Branch at Galveston, Galveston, Texas L-University of New Mexico School of Medicine, Albuquerque, New Mexico |

| <u>Hospital</u> | <u>Former Member</u> | <u>Affiliation</u> |
|---|----------------------|--|
| <u>William Beaumont Army Medical Center, (cont.)</u> | | L- Texas Tech University School of Medicine, Lubbock, Texas |
| <u>John Peter Smith, Fort Worth Texas</u> | No | L- University of Texas Southwestern Medical School at Dallas, Dallas, Texas |
| <u>Ben Taub General, Houston, Texas</u> | No | M- Baylor College of Medicine, Houston, Texas |
| <u>Jefferson Davis, Houston, Texas</u> | No | M-Baylor College of Medicine, Houston, Texas |
| <u>St. Joseph, Houston, Texas</u> | No | M- University of Texas Medical School at Houston, Houston, Texas L- University of Texas Medical Branch at Galveston, Galveston, Texas |
| <u>St. Luke's Episcopal, Houston, Texas</u> | No | M- Baylor College of Medicine, Houston, Texas |
| <u>University of Texas M.D. Anderson Hospital and Tumor Institute, Houston, Texas</u> | Yes | M- University of Texas Medical School at Houston, Houston, Texas |
| <u>Brooke Army Medical Center, San Antonio, Texas</u> | No | L- University of Texas Health Sciences Center at San Antonio Medical School, San Antonio, Texas |
| <u>Scott and White Memorial, Temple, Texas</u> | Yes | L- University of Texas Medical Branch at Galveston, Galveston, Texas L- Baylor College of Medicine, Houston, Texas |
| <u>Holy Cross Hospital of Salt Lake City, Salt Lake City, Utah</u> | No | L-University of Utah College of Medicine, Salt Lake City, Utah |
| <u>Riverside, Newport, Virginia</u> | No | L- Medical College of Virginia Health Sciences Division of Virginia Commonwealth University, Richmond, Virginia |

| <u>Hospital</u> | <u>Former Member</u> | <u>Affiliation</u> |
|---|----------------------|--|
| <u>Naval Regional Medical Center, Portsmouth, Virginia</u> | No | M- Eastern Virginia Medical School, Norfolk Area Medical Center Authority, Norfolk, Virginia L- Loyola University of Chicago Stritch School of Medicine, Maywood, Illinois, |
| <u>Roanoke Memorial Hospitals, Roanoke, Virginia</u> | No | M- University of Virginia School of Medicine, Charlottesville, Virginia |
| <u>Veteran's Administration, Salem, Virginia</u> | No | M- University of Virginia School of Medicine, Charlottesville, Virginia |
| <u>Swedish Hospital Medical Center, Seattle, Washington</u> | No | L- University of Washington School of Medicine, Seattle, Washington |
| <u>Virginia Mason, Seattle, Washington</u> | No | L- University of Washington School of Medicine, Seattle, Washington |
| <u>Sacred Heart Medical Center, Spokane, Washington</u> | No | L- University of Washington School of Medicine, Seattle, Washington |
| <u>Madigan Army Medical Center, Takoma, Washington</u> | No | L- University of Washington School of Medicine, Seattle, Washington |
| <u>Ohio Valley Medical Center, Wheeling, West Virginia</u> | No | M- West Virginia University School of Medicine, Morgantown, West Virginia |
| <u>St. Mary's Hospital Medical Center, Madison, Wisconsin</u> | No | M- University of Wisconsin Medical School, Madison, Wisconsin |
| <u>Marshfield Clinic, Marshfield, Wisconsin</u> | No | G- University of Wisconsin Medical School, Madison, Wisconsin |
| <u>St. Joseph's, Milwaukee, Wis- consin</u> | No | L- Medical College of Wisconsin, Milwaukee, Wisconsin |
| <u>St. Luke's, Milwaukee, Wisconsin</u> | No | L- Medical College of Wisconsin, Milwaukee, Wisconsin |

DISTINGUISHED SERVICE MEMBERSHIP

Requirements for Distinguished Service Membership in the AAMC are set forth in Section 2.B. on page 94 of the agenda book. It is recommended that Leonard W. Cronkhite, Jr., M.D., President, The Medical College of Wisconsin, be recommended for Distinguished Service Membership in the AAMC.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

I. MEMBERSHIP

Section 1. There shall be the following classes of membership, each of which that has the right to vote shall be (a) an organization described in Section 501 (c) (3) of the Internal Revenue Code of 1954 (or the corresponding provision of any subsequent Federal tax laws), and (b) an organization described in Section 509 (a) (1) or (2) of the Internal Revenue Code of 1954 (or the corresponding provisions of any subsequent Federal tax laws), and each of which shall also meet (c) the qualifications set forth in the Articles of Incorporation and these Bylaws, and (d) other criteria established by the Executive Council for each class of membership:

- A. Institutional Members - Institutional Members shall be medical schools and colleges of the United States.
- B. Affiliate Institutional Members - Affiliate Institutional Members shall be medical schools and colleges of Canada and other countries.
- C. Graduate Affiliate Institutional Members - Graduate Affiliate Institutional Members shall be those graduate schools in the United States and Canada closely related to one or more medical schools which are institutional members.
- D. Provisional Institutional Members - Provisional Institutional Members shall be newly developing medical schools and colleges of the United States.
- E. Provisional Affiliate Institutional Members - Provisional Affiliate Institutional Members shall be newly developing medical schools and colleges in Canada and other countries.
- F. Provisional Graduate Affiliate Institutional Members - Provisional Graduate Affiliate Institutional Members shall be newly developing graduate schools in the United States and Canada that are closely related to an accredited university that has a medical school.
- G. Academic Society Members - Academic Society Members shall be organizations active in the United States in the professional field of medicine and biomedical sciences.
- H. Teaching Hospital Members - Teaching Hospital Members shall be teaching hospitals in the United States.

11/8/77

- I. Corresponding Members - Corresponding Members shall be hospitals involved in medical education in the United States or Canada which do not meet the criteria established by the Executive Council for any other class of membership listed in this section.

Section 2. There shall also be the following classes of honorary members who shall meet the criteria therefore established by the Executive Council:

- A. Emeritus Members - Emeritus Members shall be those retired individuals who have been active in the affairs of the Association prior to retirement.
- B. Distinguished Service Members - Distinguished Service Members shall be persons who have been actively involved in the affairs of the Association and who no longer serve as AAMC representatives of any members described under Section 1.
- C. Individual Members - Individual Members shall be persons who have demonstrated a serious interest in medical education.
- D. Sustaining and Contributing Members - Sustaining and Contributing Members shall be persons or corporations who have demonstrated over a period of years a serious interest in medical education.

Section 3. Election to Membership:

- A. All classes of members shall be elected by the Assembly by a majority vote on recommendation of the Executive Council.
- B. All Institutional Members will be recommended by the Council of Deans to the Executive Council.
- C. Academic Society Members will be recommended by the Council of Academic Societies to the Executive Council.
- D. Teaching Hospital Members will be recommended by the Council of Teaching Hospitals to the Executive Council.
- E. Distinguished Service Members will be recommended to the Executive Council by either the Council of Deans, Council of Academic Societies or Council of Teaching Hospitals.
- F. Corresponding Members will be recommended to the Executive Council by the Council of Teaching Hospitals.

COTH SPRING MEETING EVALUATION

Responses to the evaluation questionnaire totaled 80 individuals. Tables in the summary don't always add to 80 because not everyone answered all questions.

| <u>Participant Category</u> | <u>Number of Responses</u> |
|-----------------------------------|----------------------------|
| Chief Executive - Other Nonprofit | 30 |
| Other Executive - Other Nonprofit | 12 |
| Chief Executive - University | 14 |
| Other Executive - University | 4 |
| Chief Executive - VA | 15 |
| Other Executive - VA | 1 |
| Chief Executive - Municipal | 4 |

Included on the pages that follow are:

1. Tables setting forth responses to specific questions on the evaluation form; page 96
2. Two pertinent letters and five negative evaluation forms; page 109
3. All comments written into the open-ended question on the evaluation form. page 123

Based upon results of the evaluation effort, the meeting appears to have been very successful, and should be held in the month of May, 1979 at a major city in a central location. Given this year's experience, and more planning time, it is anticipated that the weak portions of this first effort can be strengthened and certain problems can be avoided.

Specific Questions

1. When should the planning committee be appointed?
2. Given the negative comments from certain quarters of the membership, what particular types of individuals should be represented on the planning committee?
3. Based upon the evaluation and this year's experience, are there specific instructions or guidance which the COTH Board wishes to include in the planning committee's charge?

TABLE I
OVERALL EVALUATION - I JUDGE THE MEETING TO HAVE BEEN

| | <u>Excellent</u> | | <u>Good</u> | | <u>Poor**</u> | |
|------------------------------|------------------|------------|-------------|------------|---------------|-----------|
| | # | % | # | % | # | % |
| CEO - Municipal | 4 | (100) | - | - | - | - |
| CEO - University-Owned | 8 | (57) | 5 | (36) | 1 | (7) |
| Other - University-Owned | 1 | (25) | 3 | (75) | - | - |
| Chief - Voluntary Nonprofit* | 14 | (47) | 14 | (47) | 2 | (6) |
| Other - Voluntary Nonprofit | 3 | (27) | 7 | (64) | 1 | (9) |
| Chief - VA | 10 | (67) | 5 | (33) | - | - |
| Other - VA | - | - | 1 | (100) | - | - |
| <hr/> TOTAL | <hr/> 40 | <hr/> (51) | <hr/> 35 | <hr/> (44) | <hr/> 4 | <hr/> (5) |

* Includes Church Related Hospitals

**One individual, a CEO from a voluntary non-profit hospital places a check between good and poor and said the idea needs some work.

TABLE II
LOCATION PREFERENCE

| | <u>Major City</u> | | <u>Resort Hotel</u> | | <u>University Conf. Ctr.</u> | | <u>No Preference</u> | |
|--------------------------|-------------------|------|---------------------|------|----------------------------------|------|----------------------|-------|
| | # | % | # | % | # | % | # | % |
| CEO - Municipal | 2 | (50) | 2 | (50) | - | - | - | - |
| CEO - University-owned | 7 | (50) | 4 | (29) | - | - | 3 | (21) |
| Other - University-owned | 1 | (25) | 3 | (75) | - | - | - | - |
| CEO - Nonprofit & Church | 19 | (61) | 8 | (26) | 3 | (10) | 1 | (3) |
| Other - Nonprofit | 6 | (55) | 4 | (36) | 1 | (9) | - | - |
| CEO - VA | 7 | (47) | 8 | (53) | - | - | - | - |
| Other - VA | - | - | - | - | - | - | 5 | (100) |
| <hr/> Total | 42 | (53) | 29 | (36) | 4 | (5) | 5 | (6) |

TABLE III
TIME FOR A SPRING MEETING

| | <u>March</u> | | <u>April</u> | | <u>May</u> | | <u>June</u> | | <u>No Prefer.</u> | |
|--------------------------|--------------|-----|--------------|------|------------|------|-------------|------|-------------------|-------|
| | # | % | # | % | # | % | # | % | # | % |
| CEO - Municipal | - | - | 1 | (25) | 2 | (50) | 1 | (25) | - | - |
| CEO - University-owned | - | - | 3 | (22) | 7 | (50) | 2 | (14) | 2 | (14) |
| Other - University-owned | - | - | 1 | (25) | - | - | 1 | (25) | 2 | (50) |
| CEO - Nonprofit | 1 | (3) | 5 | (16) | 15 | (48) | 2 | (7) | 8 | (26) |
| Other - Nonprofit | 1 | (9) | 1 | (9) | 9 | (82) | - | - | - | - |
| Chief - VA | 1 | (7) | 3 | (20) | 5 | (33) | 3 | (20) | 3 | (20) |
| Other - VA | - | - | - | - | - | - | - | - | 1 | (100) |
| <hr/> Total | 3 | (4) | 14 | (18) | 38 | (47) | 9 | (11) | 16 | (20) |

Meetings Already Known To Be Scheduled In Spring Of 1979.

| | |
|-----------------------------------|---------------------------|
| Deans' Spring Meeting | April 22-25 |
| Duke Forum | May 10-12 |
| AMA Congress on Medical Education | May 9-13 |
| AHA Board | May 16-18 |
| COTH Board/AAMC Executive Council | March 28-29 June 13-14 |

TABLE IV
OVERALL SPEAKER EVALUATION

| | <u>Very Interest.</u> | | <u>Somewhat Interest.</u> | | <u>Not Interest.</u> | | <u>Very Useful</u> | | <u>Somewhat Useful</u> | | <u>Not Useful</u> | |
|--|-----------------------|-------------|---------------------------|-------------|----------------------|------------|--------------------|-------------|------------------------|-------------|-------------------|-------------|
| | # | % | # | % | # | % | # | % | # | % | # | % |
| Kinzer - Health Planning Myths | 35 | (52) | 28 | (41) | 5 | (7) | 11 | (18) | 39 | (63) | 12 | (19) |
| Marylander - GME | 48 | (63) | 27 | (36) | 1 | (1) | 35 | (47) | 37 | (49) | 3 | (4) |
| Swanson - GME | 58 | (77) | 17 | (22) | 1 | (1) | 42 | (56) | 32 | (43) | 1 | (1) |
| Solivan - House Staff Relations | 53 | (72) | 20 | (27) | 1 | (1) | 39 | (54) | 33 | (41) | 4 | (5) |
| Kaufman - HMO's & G.W. | 31 | (37) | 48 | (57) | 5 | (6) | 22 | (30) | 40 | (56) | 10 | (14) |
| Affeldt - JCAH | 34 | (48) | 34 | (48) | 3 | (4) | 27 | (41) | 29 | (44) | 10 | (15) |
| Katz - JCAH | 38 | (56) | 27 | (40) | 3 | (4) | 16 | (25) | 36 | (56) | 2 | (3) |
| Derzon - Looking Ahead | 54 | (73) | 13 | (19) | 2 | (3) | 33 | (51) | 30 | (46) | 2 | (3) |
| Thursday - Business Session & Discussion | 27 | (40) | 38 | (56) | 3 | (4) | 20 | (30) | 39 | (59) | 7 | (11) |
| Total | 378 | (58) | 252 | (38) | 24 | (4) | 245 | (39) | 315 | (51) | 61 | (10) |

TABLE V
EVALUATION - KINZER - HEALTH PLANNING MYTHS

| | <u>Very Interest.</u> | | <u>Somewhat Interest.</u> | | <u>Not Interest.</u> | | <u>Very Useful</u> | | <u>Somewhat Useful</u> | | <u>Not Useful</u> | |
|--------------------------|-----------------------|------|---------------------------|------|----------------------|------|--------------------|------|------------------------|-------|-------------------|------|
| | # | % | # | % | # | % | # | % | # | % | # | % |
| CEO - Municipal | 1 | (33) | 2 | (67) | - | - | - | - | 3 | (100) | - | - |
| CEO - University-owned | 4 | (36) | 7 | (64) | - | - | 1 | (10) | 7 | (70) | 2 | (20) |
| Other - University-owned | 3 | (75) | - | - | 1 | (25) | 2 | (50) | 1 | (25) | 1 | (25) |
| CEO - Nonprofit | 11 | (42) | 12 | (46) | 3 | (12) | 4 | (19) | 10 | (48) | 7 | (33) |
| Other - Nonprofit | 7 | (78) | 1 | (11) | 1 | (11) | 2 | (22) | 6 | (67) | 1 | (11) |
| Chief - VA | 9 | (60) | 6 | (40) | - | - | 2 | (13) | 12 | (80) | 1 | (7) |
| <hr/> Total | 35 | (52) | 28 | (41) | 5 | (7) | 11 | (18) | 39 | (63) | 12 | (19) |

TABLE VI
EVALUATION - MARYLANDER - GRADUATE MEDICAL EDUCATION

| | <u>Very Interest.</u> | | <u>Somewhat Interest.</u> | | <u>Not Interest.</u> | | <u>Very Useful</u> | | <u>Somewhat Useful</u> | | <u>Not Useful</u> | |
|--------------------------|-----------------------|------------|---------------------------|------------|----------------------|-----------|--------------------|------------|------------------------|------------|-------------------|-----------|
| | # | % | # | % | # | % | # | % | # | % | # | % |
| CEO - Municipal | 3 | (75) | 1 | (25) | - | - | 2 | (50) | 2 | (50) | - | - |
| CEO - University-owned | 5 | (42) | 6 | (50) | 1 | (8) | 4 | (36) | 5 | (46) | 2 | (18) |
| Other - University-owned | 3 | (75) | 1 | (25) | - | - | 3 | (75) | 1 | (25) | - | - |
| CEO - Nonprofit | 20 | (67) | 10 | (33) | - | - | 13 | (43) | 16 | (54) | 1 | (3) |
| Other - Nonprofit | 7 | (64) | 4 | (36) | - | - | 6 | (55) | 5 | (45) | - | - |
| Chief - VA | 10 | (67) | 5 | (33) | - | - | 7 | (47) | 8 | (53) | - | - |
| <hr/> Total | <hr/> 48 | <hr/> (63) | <hr/> 27 | <hr/> (36) | <hr/> 1 | <hr/> (1) | <hr/> 35 | <hr/> (47) | <hr/> 37 | <hr/> (49) | <hr/> 3 | <hr/> (4) |

TABLE VII
EVALUATION - SWANSON - GRADUATE MEDICAL EDUCATION

| | <u>Very Interest.</u> | | <u>Somewhat Interest.</u> | | <u>Not Interest.</u> | | <u>Very Useful</u> | | <u>Somewhat Useful</u> | | <u>Not Useful</u> | |
|--------------------------|-----------------------|-------|---------------------------|------|----------------------|-----|--------------------|-------|------------------------|------|-------------------|-----|
| | # | % | # | % | # | % | # | % | # | % | # | % |
| CEO - Municipal | 3 | (75) | 1 | (25) | - | - | 2 | (50) | 2 | (50) | - | - |
| CEO - University-owned | 8 | (62) | 4 | (31) | 1 | (7) | 6 | (50) | 5 | (42) | 1 | (8) |
| Other - University-owned | 3 | (100) | - | - | - | - | 3 | (100) | - | - | - | - |
| CEO - Nonprofit | 24 | (80) | 6 | (20) | - | - | 16 | (53) | 14 | (47) | - | - |
| Other - Nonprofit | 8 | (73) | 3 | (27) | - | - | 6 | (55) | 5 | (45) | - | - |
| Chief - VA | 12 | (80) | 3 | (20) | - | - | 9 | (60) | 6 | (40) | - | - |
| <hr/> Total | 58 | (77) | 17 | (22) | 1 | (1) | 42 | (56) | 32 | (43) | 1 | (1) |

TABLE VIII
EVALUATION - SOLIVAN - HOUSESTAFF RELATIONS

| | <u>Very Interest.</u> | | <u>Somewhat Interest.</u> | | <u>Not Interest.</u> | | <u>Very Useful</u> | | <u>Somewhat Useful</u> | | <u>Not Useful</u> | |
|--------------------------|-----------------------|-------|---------------------------|------|----------------------|-----|--------------------|-------|------------------------|------|-------------------|-----|
| | # | % | # | % | # | % | # | % | # | % | # | % |
| CEO - Municipal | 3 | (100) | - | - | - | - | 3 | (100) | - | - | - | - |
| CEO - University-owned | 7 | (58) | 5 | (42) | - | - | 5 | (50) | 5 | (50) | - | - |
| Other - University-owned | 4 | (100) | - | - | - | - | 3 | (60) | 2 | (40) | - | - |
| CEO - Nonprofit | 22 | (71) | 8 | (38) | 1 | (1) | 16 | (52) | 13 | (42) | 2 | (6) |
| Other -Nonprofit | 8 | (73) | 3 | (27) | - | - | 6 | (55) | 4 | (36) | 1 | (9) |
| Chief - VA | 9 | (69) | 4 | (31) | - | - | 6 | (38) | 9 | (56) | 1 | (6) |
| <hr/> Total | 53 | (72) | 20 | (27) | 1 | (1) | 39 | (52) | 33 | (43) | 4 | (5) |

TABLE IX
EVALUATION - KAUFMAN - HMO's & G.W.

| | <u>Very Interest.</u> | | <u>Somewhat Interest.</u> | | <u>Not Interst.</u> | | <u>Very Useful</u> | | <u>Somewhat Useful</u> | | <u>Not Useful</u> | |
|--------------------------|-----------------------|------------|---------------------------|------------|---------------------|-----------|--------------------|------------|------------------------|------------|-------------------|------------|
| | # | % | # | % | # | % | # | % | # | % | # | % |
| CEO - Municipal | 2 | (67) | 1 | (33) | - | - | 2 | (67) | 1 | (33) | - | - |
| CEO - University-owned | 8 | (57) | 4 | (29) | 2 | (14) | 3 | (23) | 7 | (54) | 3 | (23) |
| Other - University-owned | 1 | (25) | 3 | (75) | - | - | 3 | (75) | 1 | (25) | - | - |
| CEO - Nonprofit | 13 | (50) | 13 | (50) | - | - | 10 | (38) | 13 | (50) | 3 | (12) |
| Other - Nonprofit | 3 | (27) | 7 | (64) | 1 | (9) | 2 | (18) | 7 | (64) | 2 | (18) |
| Chief - VA | 4 | (27) | 9 | (60) | 2 | (13) | 2 | (14) | 10 | (72) | 2 | (14) |
| <hr/> Total | <hr/> 31 | <hr/> (37) | <hr/> 48 | <hr/> (57) | <hr/> 5 | <hr/> (6) | <hr/> 22 | <hr/> (30) | <hr/> 40 | <hr/> (56) | <hr/> 10 | <hr/> (14) |

TABLE X
EVALUATION - AFFELDT - JCAH

| | <u>Very Interest.</u> | | <u>Somewhat Interest.</u> | | <u>Not Interest.</u> | | <u>Very Useful</u> | | <u>Somewhat Useful</u> | | <u>Not Useful</u> | |
|--------------------------|-----------------------|------|---------------------------|------|----------------------|------|--------------------|------|------------------------|------|-------------------|------|
| | # | % | # | % | # | % | # | % | # | % | # | % |
| CEO - Municipal | 2 | (67) | 1 | (23) | - | - | 2 | (67) | 1 | (23) | - | - |
| CEO - University-owned | 5 | (56) | 3 | (33) | 1 | (11) | 2 | (29) | 4 | (57) | 1 | (14) |
| Other - University-owned | 2 | (50) | 2 | (50) | - | - | 1 | (33) | 1 | (33) | 1 | (33) |
| CEO - Nonprofit | 9 | (31) | 19 | (66) | 1 | (3) | 7 | (26) | 13 | (48) | 7 | (26) |
| Other - Nonprofit | 5 | (45) | 5 | (45) | 1 | (10) | 4 | (36) | 6 | (55) | 1 | (9) |
| Chief - VA | 11 | (73) | 4 | (27) | - | - | 11 | (73) | 4 | (27) | - | - |
| <hr/> Total | 34 | (48) | 34 | (48) | 3 | (4) | 27 | (41) | 29 | (44) | 10 | (15) |

TABLE XI
EVALUATION - KATZ - JCAH

| | <u>Very Interest.</u> | | <u>Somewhat Interest.</u> | | <u>Not Interest.</u> | | <u>Very Useful</u> | | <u>Somewhat Useful</u> | | <u>Not Useful</u> | |
|--------------------------|-----------------------|------|---------------------------|------|----------------------|------|--------------------|------|------------------------|------|-------------------|------|
| | # | % | # | % | # | % | # | % | # | % | # | % |
| CEO - Municipal | 2 | (67) | 1 | (23) | - | - | 1 | (33) | 1 | (33) | 1 | (33) |
| CEO - University-owned | 6 | (60) | 3 | (30) | 1 | (10) | 2 | (22) | 3 | (33) | 4 | (45) |
| Other - University-owned | 2 | (50) | 2 | (50) | - | - | 1 | (50) | 1 | (50) | - | - |
| CEO - Nonprofit | 14 | (52) | 11 | (41) | 2 | (7) | 4 | (16) | 15 | (60) | 6 | (24) |
| Other - Nonprofit | 3 | (30) | 6 | (60) | 1 | (10) | 1 | (10) | 8 | (80) | 1 | (10) |
| Chief - VA | 11 | (73) | 4 | (37) | - | - | 7 | (47) | 8 | (53) | - | - |
| <hr/> Total | 38 | (56) | 27 | (40) | 3 | (4) | 16 | (25) | 36 | (56) | 12 | (19) |

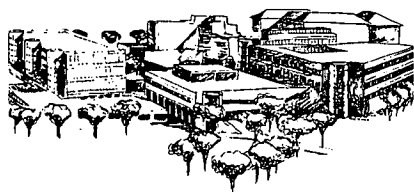
TABLE XII
EVALUATION - DERZON - LOOKING AHEAD

| | <u>Very Interest.</u> | | <u>Somewhat Interest.</u> | | <u>Not Interest.</u> | | <u>Very Useful</u> | | <u>Somewhat Useful</u> | | <u>Not Useful</u> | |
|--------------------------|-----------------------|-------|---------------------------|------|----------------------|-----|--------------------|------|------------------------|------|-------------------|------|
| | # | % | # | % | # | % | # | % | # | % | # | % |
| CEO - Municipal | 2 | (67) | 1 | (23) | - | - | 1 | (23) | 2 | (67) | - | - |
| CEO - University-owned | 9 | (90) | 1 | (10) | - | - | 5 | (56) | 4 | (44) | - | - |
| Other - University-owned | 4 | (100) | - | - | - | - | 1 | (23) | 2 | (67) | - | - |
| CEO - Nonprofit | 24 | (89) | 2 | (7) | 1 | (4) | 18 | (69) | 8 | (31) | - | - |
| Other - Nonprofit | 9 | (82) | 2 | (18) | - | - | 4 | (40) | 5 | (50) | 1 | (10) |
| Chief - VA | 6 | (43) | 7 | (50) | 1 | (7) | 4 | (29) | 9 | (64) | 1 | (7) |
| <hr/> Total | 54 | (78) | 13 | (19) | 2 | (3) | 33 | (51) | 30 | (46) | 2 | (3) |

TABLE XIII

EVALUATION - THURSDAY - BUSINESS & DISCUSSION SESSION

| | <u>Very Interest.</u> | | <u>Somewhat Interest.</u> | | <u>Not Interest.</u> | | <u>Very Useful</u> | | <u>Somewhat Useful</u> | | <u>Not Useful</u> | |
|--------------------------|-----------------------|------|---------------------------|------|----------------------|-----|--------------------|------|------------------------|------|-------------------|------|
| | # | % | # | % | # | % | # | % | # | % | # | % |
| CEO - Municipal | 1 | (23) | 2 | (67) | - | - | 1 | (23) | 2 | (67) | - | - |
| CEO - University-owned | 3 | (25) | 9 | (75) | - | - | 2 | (20) | 8 | (80) | - | - |
| Other - University-owned | 2 | (67) | 1 | (23) | - | - | 2 | (23) | 1 | (67) | - | - |
| CEO - Nonprofit | 9 | (38) | 14 | (58) | 1 | (4) | 8 | (32) | 15 | (60) | 2 | (8) |
| Other - Nonprofit | 3 | (27) | 7 | (64) | 1 | (9) | 1 | (10) | 5 | (50) | 4 | (40) |
| Chief - VA | 9 | (60) | 5 | (33) | 1 | (7) | 6 | (41) | 8 | (54) | 1 | (5) |
| <hr/> Total | 27 | (40) | 38 | (56) | 3 | (4) | 20 | (30) | 39 | (59) | 7 | (11) |



BLODGETT MEMORIAL MEDICAL CENTER

1840 WEALTHY S.E.
GRAND RAPIDS, MICHIGAN 49506 • 616-774-7607

BLODGETT MEMORIAL HOSPITAL
MILTON C. MILLER AMBULATORY CARE CENTER
BLODGETT PROFESSIONAL BUILDING
SCHOOL OF NURSING

May 11, 1978

WILLIAM J. DOWNER, JR., F.A.C.H.A.
President

Mr. David Everhart
Chairman
Council of Teaching Hospitals
Association of American Medical Colleges
One Dupont Circle, N.W. Suite 200
Washington, DC 20036

Dear Dave:

It was good to see you again in St. Louis at the COTH meeting. This note is to explain my meeting evaluation questionnaire which is enclosed.

As I told you Wednesday night, many of us see COTH as a "sleeping giant" which potentially can be a major force in the political arena, with the overall mission of seeing that teaching hospital special needs are adequately protected and advanced. Unfortunately, I got the feeling - and I hope I am wrong - that COTH primarily represents the interests of University owned and controlled hospitals.

Those teaching hospitals, such as Blodgett, which have major affiliations with Universities but are not controlled by them seem under-involved with COTH. I was concerned to see so few such hospitals represented in St. Louis although I suspect there may be at least 100 such hospitals in the COTH membership. Perhaps I am an optimist in thinking that greater involvement by this group of hospitals can help provide a bridge for COTH to community hospitals.

Perhaps some special attention needs to be given to this group of teaching hospitals. One vehicle might be through separate discussion groups at the COTH spring meeting. If COTH can adequately address the issues of all its membership, I will be a lot more comfortable in paying the increased dues in future dues.

I believe this meeting was a good start and should be followed up on at least an annual basis.

Sincerely,

William J. Downer, Jr.
President

/kbt





THE UNIVERSITY HOSPITAL AND CLINICS

800 N.E. 13th STREET — P.O. BOX 25606

OKLAHOMA CITY, OKLAHOMA 73125

Hospital Administration

May 15, 1978

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

Dear Dick:

Attached is the evaluation and comments sheet for the spring meeting. The evaluation I have given the meeting is rather critical, therefore, I felt it only fair to identify who filled it out and to make suggestions for future meetings.

In my opinion a spring meeting is very desirable and can go a long way toward strengthening COTH and its members' involvement and support.

While the CEO limitation may be offensive to some, I would support a continuation of that policy. To me, the most valuable portion of this year's meeting was the opportunity to have meaningful interchange with other CEO's about problem solving.

In the future my recommendation would be that all prepared papers be excluded from the agenda. There are so many meetings we can go to for pontification and philosophy that our spring meeting should be used for something different.

My suggestion would be that a number of topics - say, "4, 5 or 6" which interest the membership be chosen for discussion. The program committee would then assign one person to lead the development of issues related to a particular subject. The registrants would then be divided into small groups, as many as there are numbers of topics. Hopefully, the COTH staff could assign group participants based on a reasonable cross section of not only types of institutions but of geographical locations. One-half day could be spent by the groups carefully to defining the issues; outlining what, if anything, is being done at their institution to cope with the issue, and perhaps developing positions for COTH and/or the AAMC to consider to assist in resolutions of problems.

Letter: Richard M. Knapp, Ph.D.
Director
Department of Teaching Hospitals
May 15, 1978
Page 2

Perhaps, if we are really successful, the meeting outcome would be to recommend courses of action for teaching hospitals to take to help member hospitals improve their ability to meet institutional needs.

The remainder of the session could be used for a short business meeting and reports from the groups could be given by the person the program committee had assigned as a leader for the group.

Now for a different subject: Perhaps it is only a personal perception but it seems to me we keep hearing the same people time after time and that these people mostly come from big schools and teaching hospitals from the Northeast, Chicago, and California. In fact, my perception is that COTH is almost totally dominated by seven states: Massachusetts, New York, Illinois, Michigan, Ohio, California, and Maryland. In my opinion, COTH is still small enough so that there can be a greater representation in membership and that more members can be involved in developing COTH positions and policies. It is further, my opinion that this is not going to happen by itself but will take your leadership for it to happen.

The easiest thing for those elected to leadership positions to do is to make appointments of others with whom they are personally familiar. I think you have to work with them to develop mechanisms to get broader involvement from CEO's as well as from top administrative (Number two) people whose appointment would be an investment in the future of COTH.

Years in the field without a doubt provides a corner of the market in experience but certainly does not corner the market in intelligence, ability or new ideas.

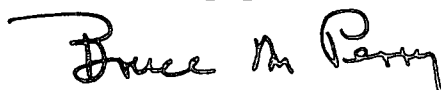
I believe some of the greatest minds in hospital administration are in teaching hospitals and that for the most part these minds are an untapped source which COTH can and should use.

Letter: Richard M. Knapp, Ph.D.
Director
Department of Teaching Hospitals
May 15, 1978
Page 3

I will be in Washington on June 13, 14, and 15, and would look forward to an opportunity to sit down and talk to you about my concerns. If you would like to do this, please call me and we will set up a time to do so.

I agree with Dave Everhart's comment that our COTH dues are the biggest bargain in town. I hope that the added resources of increased membership participation will make it an even bigger bargain.

Sincerely yours,

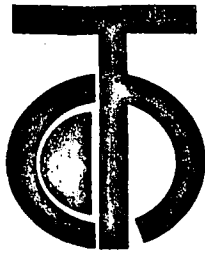


Bruce M. Perry
Executive Director

BMP:rl

1978 SPRING MEETING

Evaluation and Comments



COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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

(202) 466-5127

I. COTH Attendees:

A. At my hospital, I am (check one):

the Chief Executive officer

other: please specify title _____

B. My hospital is owned by (check one):

a university

a municipal or county government (including a hospital district)

a church or church-related corporation

the Veteran's Administration

a non-profit corporation

II. My objectives in attending the 1978 COTH Spring Meeting were to (rank order from most important (#1) to least important):

1 learn from substantive speakers about contemporary issues

2 discuss institutional management with my professional colleagues

3 discuss COTH/AAMC positions on important issues

4 develop or renew acquaintances with COTH executives

other: please specify _____

III. Overall Evaluation - I judge the meeting to have been (check one):

excellent, worth the time and money; should be held annually

good, worth organizing again next year

OK - needs much work

poor, unless meeting is redesigned would not attend again

not worth the time and money

IV. Program Evaluation

A. Please indicate your interest in the topic and evaluation of the usefulness of the following program sessions:

| Session | Interest in Topic (check one) | | | Usefulness of Presentation (check one) | | |
|---|---|-------------------------------------|-------------------------------------|---|-------------------------------------|-------------------------------------|
| | Very Interesting | Somewhat Interesting | Not Interesting | Very Useful | Somewhat Useful | Not Useful |
| Kinzer-Health Planning Myths | _____ | _____ | <input checked="" type="checkbox"/> | <i>Terrible</i> <input checked="" type="checkbox"/> | | |
| Marylander-Graduate Medical Education | <input checked="" type="checkbox"/> | _____ | _____ | <input checked="" type="checkbox"/> | _____ | _____ |
| Swanson-Graduate Medical Education | <input checked="" type="checkbox"/> | _____ | _____ | <input checked="" type="checkbox"/> | _____ | _____ |
| Solivan-Housestaff Relations | _____ | <input checked="" type="checkbox"/> | _____ | _____ | <input checked="" type="checkbox"/> | _____ |
| Kaufman-HMO's & G.W. | _____ | <input checked="" type="checkbox"/> | _____ | _____ | _____ | <input checked="" type="checkbox"/> |
| Affeldt-JCAH | _____ | <input checked="" type="checkbox"/> | _____ | _____ | <input checked="" type="checkbox"/> | _____ |
| Katz-JCAH | <input checked="" type="checkbox"/> | _____ | _____ | _____ | <input checked="" type="checkbox"/> | _____ |
| Derzon-Looking Ahead | <input checked="" type="checkbox"/> | _____ | _____ | <input checked="" type="checkbox"/> | _____ | _____ |
| Thursday-Business & Discussion Session | <i>poorly organized - too much material - not enough time</i> | | | | | |

V. Suggestions

A. Time for a Spring Meeting -- I suggest that future spring meetings be held in (check one):

_____ March April May _____ June _____ no preference

B. Location for a Spring Meeting -- I suggest that future spring meetings be held in (check one):

major city _____ resort hotel _____ university conference center

C. In light of your objectives for this meeting and your evaluation of it, what suggestions would you make for future Spring Meetings?

*More discussion time -
better organization*

1978 SPRING MEETING

Evaluation and Comments



COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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

I. COTH Attendees:

A. At my hospital, I am (check one):

the Chief Executive officer

other: please specify title _____

B. My hospital is owned by (check one):

a university

a municipal or county government (including a hospital district)

a church or church-related corporation

the Veteran's Administration

a non-profit corporation

II. My objectives in attending the 1978 COTH Spring Meeting were to (rank order from most important (#1) to least important):

1 learn from substantive speakers about contemporary issues

4 discuss institutional management with my professional colleagues

3 discuss COTH/AAMC positions on important issues

2 develop or renew acquaintances with COTH executives

other: please specify _____

III. Overall Evaluation - I judge the meeting to have been (check one):

excellent, worth the time and money; should be held annually

good, worth organizing again next year

poor, unless meeting is redesigned would not attend again

not worth the time and money

IV. Program Evaluation

A. Please indicate your interest in the topic and evaluation of the usefulness of the following program sessions:

| Session | Interest in Topic (check one) | | | Usefulness of Presentation (check one) | | |
|---|-------------------------------------|-------------------------------------|-------------------------------------|---|-------------------------------------|--------------------------|
| | Very Interesting | Somewhat Interesting | Not Interesting | Very Useful | Somewhat Useful | Not Useful |
| | Kinzer-Health Planning Myths | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Marylander-Graduate Medical Education | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Swanson-Graduate Medical Education | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Solivan-Housestaff Relations | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Kaufman-HMO's & G.W. | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Affeldt-JCAH | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Katz-JCAH | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Derzon-Looking Ahead | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Thursday-Business & Discussion Session | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |

V. Suggestions

A. Time for a Spring Meeting -- I suggest that future spring meetings be held in (check one):

March April May June no preference

B. Location for a Spring Meeting -- I suggest that future spring meetings be held in (check one):

major city resort hotel university conference center

C. In light of your objectives for this meeting and your evaluation of it, what suggestions would you make for future Spring Meetings?

REORGANIZE DISCUSSION SESSION
FEWER TOPICS - MORE TIME PER
TOPIC

1978 SPRING MEETING

Evaluation and Comments



COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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

I. COTH Attendees:

A. At my hospital, I am (check one):

the Chief Executive officer

other: please specify title DIRECTOR, MEDICAL EDUCATION

B. My hospital is owned by (check one):

a university

a municipal or county government (including a hospital district)

a church or church-related corporation

the Veteran's Administration

a non-profit corporation

II. My objectives in attending the 1978 COTH Spring Meeting were to (rank order from most important (#1) to least important):

2 learn from substantive speakers about contemporary issues

4 discuss institutional management with my professional colleagues

1 discuss COTH/AAMC positions on important issues

5 develop or renew acquaintances with COTH executives

3 other: please specify discuss implications of new essentials of GME

III. Overall Evaluation - I judge the meeting to have been (check one):

excellent, worth the time and money; should be held annually

good, worth organizing again next year

poor, unless meeting is redesigned would not attend again

not worth the time and money

- 2 - CONTINUED FROM PREVIOUS PAGE -- I'd suggest you are NOT really meeting their needs - i.e. low priority. This is quite imp. at a time when COTH dues are going to 2000\$/yr.

IV. Program Evaluation

A. Please indicate your interest in the topic and evaluation of the usefulness of the following program sessions:

| Session | Interest in Topic (check one) | | | Usefulness of Presentation (check one) | | |
|--|-------------------------------------|-------------------------------------|-------------------------------------|---|-------------------------------------|-------------------------------------|
| | Very Interesting | Somewhat Interesting | Not Interesting | Very Useful | Somewhat Useful | Not Useful |
| | Kinzer-Health Planning Myths | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Marylander-Graduate Medical Education | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Swanson-Graduate Medical Education | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Solivan-Housestaff Relations | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Kaufman-HMO's & G.W. | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Affeldt-JCAH | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Katz-JCAH | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Derzon-Looking Ahead | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Thursday-Business & Discussion Session | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

V. Suggestions

A. Time for a Spring Meeting -- I suggest that future spring meetings be held in (check one):

March April May June no preference

B. Location for a Spring Meeting -- I suggest that future spring meetings be held in (check one):

major city resort hotel university conference center

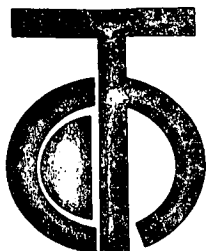
C. In light of your objectives for this meeting and your evaluation of it, what suggestions would you make for future Spring Meetings?

COTH might make an effort to recognize that "Teaching Hospital" is NOT synonymous to UNIV. owned or controlled only - i.e. DAVIS TALK - Teaching Hosp vs Community Hosp. Many of latter are teaching at USME, GME & CME levels by affiliation only. Mich. state, NE. Ohio, W. Dakota etc. I suggest simultaneous sessions for the different type of institutions, problems, relations etc. - see above -

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1978 SPRING MEETING

Evaluation and Comments



COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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

I. COTH Attendees:

A. At my hospital, I am (check one):

the Chief Executive officer

other: please specify title _____

B. My hospital is owned by (check one):

a university

a municipal or county government (including a hospital district)

a church or church-related corporation

the Veteran's Administration

a non-profit corporation

II. My objectives in attending the 1978 COTH Spring Meeting were to (rank order from most important (#1) to least important):

3 learn from substantive speakers about contemporary issues

5 discuss institutional management with my professional colleagues

1 discuss COTH/AAMC positions on important issues

4 develop or renew acquaintances with COTH executives

2 other: please specify Assess whether COTH can actually become what it has potential to be - a major political player on behalf of the tertiary care institutions in our industry

III. Overall Evaluation - I judge the meeting to have been (check one):

excellent, worth the time and money; should be held annually

good, worth organizing again next year

poor, unless meeting is redesigned would not attend again

not worth the time and money

I will probably attend next meeting or two to see if a attempt is made to address issues of non owned or controlled hospitals

the most speaker quality was excellent - was disappointed that there was no attempt to get at heterogeneity of membership interest - i.e. discussion groups

IV. Program Evaluation

A. Please indicate your interest in the topic and evaluation of the usefulness of the following program sessions:

| Session | Interest in Topic (check one) | | | Usefulness of Presentation (check one) | | |
|---|----------------------------------|---|--|---|--------------------|---------------|
| | Very Interesting | Somewhat Interesting | Not Interesting | Very Useful | Somewhat Useful | Not Useful |
| Kinzer-Health Planning Myths | _____ | <u>X</u> | _____ | _____ | <u>X</u> | _____ |
| Marylander-Graduate Medical Education | _____ | <u>X</u> | _____ | _____ | <u>X</u> | _____ |
| Swanson-Graduate Medical Education | _____ | <u>X</u> | _____ | _____ | <u>X</u> | _____ |
| Solivan-Housestaff Relations | <u>X</u> | <i>- An exceptionally well delivered paper No respect applicable to our situation, tho.</i> | | | <u>X</u> | _____ |
| Kaufman-HMO's & G.W. | _____ | <u>X</u> | _____ | _____ | <u>X</u> | _____ |
| Affeldt-JCAH | <u>X</u> | _____ | _____ | <u>X</u> | _____ | _____ |
| Katz-JCAH | <u>X</u> | <i>would like to see this paper published.</i> | | | <u>X</u> | _____ |
| Derzon-Looking Ahead | <u>X</u> | <i>- valuable perspective</i> | | | <u>X</u> | _____ |
| Thursday-Business & Discussion Session | _____ | <u>X</u> | <i>I find it hard to believe that #1 issue priority (as delivered in order of papers) could possibly be problems of funding of clinical fellows. Planning presentation could have been much more effective. This is where increasing action will be.</i> | | | |

V. Suggestions

A. Time for a Spring Meeting -- I suggest that future spring meetings be held in (check one):

_____ March X April X May _____ June _____ no preference
About same time as this one.

B. Location for a Spring Meeting -- I suggest that future spring meetings be held in (check one):

X major city _____ resort hotel _____ university conference center
for meeting of this length.

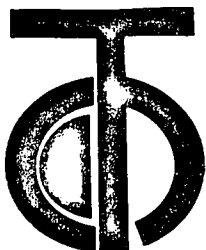
C. In light of your objectives for this meeting and your evaluation of it, what suggestions would you make for future Spring Meetings?

*CO²H must realize that ⁻¹²⁰⁻probably 100+ of their members are not
Univ owned or controlled but are major affiliates with such schools as
Mich State and similar programs. Our interests are not necessarily the
same but are legitimate concerns for teaching hospitals. There seems
to be a tendency for CO²H to be a Club of CEO's of the Univ
owned & controlled hospitals who may not be in touch with the real
world of delivery of patient services in communities. Perhaps
the "other 100+" could help provide the "bridge" for CO²H. With
the dues increase, some concentrated attention must be given
to the "other 100+." Some of us need to be in the "Inner Circle".*

*Perhaps a subdivision
of CO²H into 2-3
different parts might
be considered - at
least for discussion
group purposes*

1978 SPRING MEETING

Evaluation and Comments



COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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

I. COTH Attendees:

A. At my hospital, I am (check one):

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other: please specify title _____

B. My hospital is owned by (check one):

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a municipal or county government (including a hospital district)

a church or church-related corporation

the Veteran's Administration

a non-profit corporation

II. My objectives in attending the 1978 COTH Spring Meeting were to (rank order from most important (#1) to least important):

learn from substantive speakers about contemporary issues

discuss institutional management with my professional colleagues

discuss COTH/AAMC positions on important issues

develop or renew acquaintances with COTH executives

other: please specify state owned
Get ideas from meaningful
colleagial ~~with~~ interchange to help cope with complicated
problems facing the industry - especially teaching hospitals.

III. Overall Evaluation - I judge the meeting to have been (check one):

excellent, worth the time and money; should be held annually

good, worth organizing again next year

poor, unless meeting is redesigned would not attend again

not worth the time and money

IV. Program Evaluation

A. Please indicate your interest in the topic and evaluation of the usefulness of the following program sessions:

| Session | Interest in Topic (check one) | | | Usefulness of Presentation (check one) | | |
|---|----------------------------------|-------------------------------------|-------------------------------------|---|-------------------------------------|-------------------------------------|
| | Very Interesting | Somewhat Interesting | Not Interesting | Very Useful | Somewhat Useful | Not Useful |
| Kinzer-Health Planning Myths | _____ | <input checked="" type="checkbox"/> | _____ | _____ | _____ | <input checked="" type="checkbox"/> |
| Marylander-Graduate Medical Education | _____ | _____ | <input checked="" type="checkbox"/> | _____ | _____ | <input checked="" type="checkbox"/> |
| Swanson-Graduate Medical Education | _____ | _____ | <input checked="" type="checkbox"/> | _____ | _____ | <input checked="" type="checkbox"/> |
| Solivan-Housestaff Relations | _____ | <input checked="" type="checkbox"/> | _____ | _____ | <input checked="" type="checkbox"/> | _____ |
| Kaufman-HMO's & G.W. | _____ | _____ | <input checked="" type="checkbox"/> | _____ | _____ | <input checked="" type="checkbox"/> |
| Affeldt-JCAH | _____ | <input checked="" type="checkbox"/> | _____ | _____ | <input checked="" type="checkbox"/> | _____ |
| Katz-JCAH | _____ | <input checked="" type="checkbox"/> | _____ | _____ | _____ | <input checked="" type="checkbox"/> |
| Derzon-Looking Ahead | _____ | <input checked="" type="checkbox"/> | _____ | _____ | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| Thursday-Business & Discussion Session | _____ | <input checked="" type="checkbox"/> | _____ | _____ | <input checked="" type="checkbox"/> | _____ |

V. Suggestions

A. Time for a Spring Meeting -- I suggest that future spring meetings be held in (check one):

_____ March _____ April _____ May _____ June no preference

B. Location for a Spring Meeting -- I suggest that future spring meetings be held in (check one):

_____ major city resort hotel _____ university conference center

C. In light of your objectives for this meeting and your evaluation of it, what suggestions would you make for future Spring Meetings?

See Attached

COTH MEMBERSHIP COMMENTS ON 1978 SPRING MEETING

The following evaluative comments are organized on the basis of an individual's position and hospitals classified by ownership.

Chief Executive Officer - Nonprofit Corporation

- An environment and schedule which encourages more informal discussion.
- Assess whether COTH can actually become what it has potential to be -- a major political player on behalf of the tertiary care institutions in our industry. I will probably attend next meeting or two to see if an attempt is made to address issues of non-university owned or controlled hospitals. Though most speaker quality was excellent, I was disappointed that there was no attempt to get at heterogeneity of membership interest - i.e., discussion groups. (Kinzer-Health Planning Myths) - Nothing new for me. I'm on SHCC, HSA Board and Executive Committee. (Solivan-Housestaff Relations) - An exceptionally well-developed paper. Not especially applicable to our situation, though. (Katz-JCAH) - Would like to see this paper published. (Derzon-Looking Ahead) - Valuable perspective. (Thursday- Business Session) - I find it hard to believe that #1 issue priority (as delivered in order of papers) could possibly be problems of funding of clinical fellows. Planning presentation could have been much more effective. This is where increasing action will be. Perhaps a subdivision of COTH into 2-3 different parts might be considered - at least for discussion group purposes. (Future meetings) - About same time as this one. Major city for meeting of this length. COTH must realize that probably 100+ of their members are not university owned or controlled but are major affiliates with such schools as Michigan State and similar programs. Our interests are not necessarily the same but are legitimate concerns for teaching hospitals. There seems to be a tendency for COTH to be a Club of CEO's of the university owned and controlled hospitals who may not be in touch with the real world of delivery of patient services in communities. Perhaps the "other 100+" could help provide the "bridge" for COTH. With the dues increase, some concentrated attention must be given... (remainder unreadable)
- Start developing agenda in the fall.
- Follow same format. Be sure that hotel gears-up for breakfast crowd.
- O.K., needs much work. (Thursday afternoon) - poorly organized, too much material, not enough time. (Future) - more discussion time, better organization
- Reorganize discussion session; fewer topics; more time per topic.

Chief Executive Officer - Nonprofit Corporation (Cont.)

- I think it was well thought out. Staff does an amazing job at "jelling" the concerns of the field and spotting good people to discuss.
- Need for recognition of special role of teaching hospitals in reimbursement, can it happen? Town-gown, faculty-private practice controversies, solutions?
- (Thursday afternoon) - Tried to cover too much. (Future) - Continuing dialogue of the major issues facing academic medical centers and initiatives that can be taken individually as well as collectively to meet change.
- Good Program - truly up to the expectation of participants of the leading organizations of the "best" of the hospital industry. Interesting to note the number of smokers - almost all pipe smokers. Suggest a "smoker" and non smoker division of the room for next year.
- (Objective in attending) - Drink with Everhart. (Thursday after.) - Too many position papers during this session.
- Have governmental speakers who can speak to current issues and regulations. This was a worthwhile meeting and hope it will continue.
- We might consider a change in format with a break in the afternoon and an evening session.
- Organize at least one major program around a controversial topic presenting pro and con speakers with in-depth probing of issues. Session on Thursday afternoon had too many topics to learn anything new about any of them.
- (Location) - Variety. Post a strong national policy position for major debate and discussion - and if possible, agreement and resolution by the end of the conference.
- Pick-instruct speakers with aim of in-depth, provocative presentations. There wasn't much preparation evident. As a newcomer to teaching hospital scene, I was looking for more. Believe greatest usefulness was in out-of-session conversations. That's why I think resort hotel best - throws people together more. Pick as 1979 theme: The Hospital Organism - Obstacles and Opportunities - organization, politics, role of CEO, performance measures or How Long is Your Leash and What are you Gonna Do About It? Feature Peter Drucker for 2 days - have him perform the dissection. Invite Board Chairmen.
- Continue to have mix of presentations by executives of agencies and hospitals. Continue to urge (require) that speakers prepare written presentations. This is an excellent renewal of a Spring discussion for CEO's which Ray Brown created but no longer exists in the Duke Forum. Try having table mikes to facilitate questions and answer sessions and panel discussion. Thanks Irv, it was a great program.

Chief Executive Officer - Nonprofit Corporation (Cont.)

- Don't believe we should have commercials such as Cancelosi.
- Additional opportunities for dialogue between members on the key issues over which there is widely felt concern.
- JCAH presentation could have been organized as a panel with requests for specific answers to specific kinds of questions. Nobody seemed to know how to handle delineation of privileges in a specialty hospital so as not to increase liability rather than decrease it.
- Format is good. Business meeting is good, but too many topics. Communications via social events important. Consider reception each evening, banquet one evening.
- Improved format for the business meetings and issues discussion session.

Other - Nonprofit

- COTH might make an effort to recognize that "Teaching Hospital" is not synonymous with university owned or controlled only - i.e., Davis. Talk - teaching hospital as community hospital, many of latter are teaching at UGME, GME and CME levels by affiliation only, Michigan State, N.E. Ohio, North Dakota, etc. I suggest simultaneous sessions for the different types of institutions, problems, relations etc. I'd guess that about 100 of COTH hospitals are in this group and I'd suggest you are not really meeting their needs - i.e., low priority. This is quite important at time when COTH dues are going to \$2000 per year.
- Believe this session has been a good model - with targeted informants like Derzon.
- Even more focus with persons who can focus on key national issues. More careful selection of speakers who can bring relevant points to the attendees. Strongly urge continuing this type of meeting.
- Shorter sessions.
- Longer planning time - clearer consensus on major issues. Briefing on the issues which the AAMC intends to affect by lobbying and the anticipated posture of AAMC on these issues. Followed by floor reaction.
- Keep it up.
- More speakers on what government involvement means to us and what we can do about it.

Other - Nonprofit (Cont.)

- More encouragement of attendance by medical directors along with Executive Directors.
- Keep speakers of high quality as at this meeting. A topic suggestion would be - The Role of the Teaching Hospital and How to Determine its specific Objectives.
- Perhaps issues should be raised which are either a) more provocative or b) dealt with by more "spirited" individual speakers. A flavor of debate might be welcome.
- Much the same - current issues - suggested solutions - new directions.

Chief Executive Officer - University

- (Objectives) - Get ideas from meaningful collegial interchange to help cope with complicated problems facing the industry-especially teaching hospitals. (Future) - See attached (nothing was attached).
- Reconfigure the business sessions - suggest panel discussions (pro and cons).
- The "discussion sessions" Thursday afternoon could be strengthened. The Womer-Heysel papers were potentially the most controversial, but we didn't get to them. I look forward to an annual meeting of similar format.
- (Objectives) - Discuss specific, current problems with selected colleagues from similar settings.
- Sessions should be given adequate time for indepth presentations and discussions. Fewer topics with this format are more valuable than touching on many. Maintain CEO participation.
- More open discussion.
- Relate presentations more closely to the subjects suggested by the membership (who asked for a presentation about management contracts?)
- Start planning earlier - attempt to establish top-notch quality in all speakers. Place a few microphones around room for use by audience.
- Same as this year.
- Provide some more time for informal exchanges among the participants/registrants. The Thursday afternoon business session should be moved along quickly and not allowed to drag.
- Some small group time for one selected issue -- to attempt to define a position or recommend a solution or action, as appropriate.
- Hold meeting in April; continue polling membership for topics of current interest.

Other - University

- (Objectives) - To see first hand what and whom COTH was and to meet COTH staff and members.

Chief Executive Officer - V.A.

- More of the same.
- Continue the format - be as certain as possible that speakers are not only knowledgeable but dynamic in presentation.
- (Objective) - To keep an eye on Everhart. (Future) - Believe this was a resounding success. Should now move to make this an annual meeting, with a relatively fixed annual date (i.e., 1st, 2nd, 3rd, 4th week of selected month) so that CEO's could plan to set aside these dates well in advance.
- More emphasis on interaction between medical school and teaching hospital in the medical education program.
- I would suggest panels be set up for question and answer type discussion following presentation of position on critical issue affecting health care delivery.
- Business session Thursday, p.m., agenda too crowded.
- More timely advanced notification of places.
- If we get a speaker such as Bob Derzon, let's get him early in the day not last speaker - too many leave to catch planes, etc.
- Have some participation by representatives of the other AAMC Councils.
- None (suggestions) of significance! This was for me a re-introduction to AAMC affairs.

Other - V.A.

- Suggest more time be allowed for group discussions - afternoon was too planned.

Chief Executive Officer - Municipal

- Keep the attendance CEO and medical directors.
- Format is good - length of program and content excellent. May is a terrible month, schedule wise - would prefer later date.

Chief Executive Officer - Municipal (Cont.)

- The business meeting was good but could be better. I think a little more planning would be worth the time and effort. I was personally impressed with the great amount of questions related to medical school - teaching hospital relationships. I am fortunate that our Center and I personally have an excellent working relationship. I would like to see a working group of selected institutions' deans and CEO's meet to discuss and plan more effective discussions between the executives - deans on the task of delivering a quality program involving educating residents and patient care. One suggestion would be to combine those institutions who have a good relationship with those that may be struggling but willing to participate.



american society of internal medicine

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Johnson City, Tennessee

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MERVIN SHALOWITZ, MD
Skokie, Illinois

Executive Director
WILLIAM R. RAMSEY

Twenty-Third Annual Meeting
New Orleans, Louisiana
April 26-29, 1979

May 30, 1978

Ms. Kat Dolan
Association of American
Medical Colleges
Room 250
One DuPont Circle, N.W.
Washington, D.C. 20036

Dear Kat:

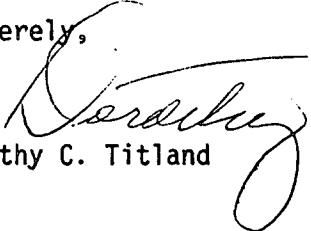
The following action was taken at our 1978 House of Delegates regarding four-year residency training programs in internal medicine:

RESOLVED, That the American Society of Internal Medicine endorse the concept of a four-year residency training program in internal medicine to include appropriate subjects within the purview of the broad-based internist.

RESOLVED, That the Board of Trustees implement this resolution by presenting it to appropriate agencies such as the Federated Council for Internal Medicine.

I am enclosing a copy of Board of Trustees J on Internal Medicine Manpower, which I hope is the one you had in mind. The House voted to file this report.

Sincerely,


Dorothy C. Titland

DCT/pw
Enclosure

May 1978

Board of Trustees Report J to the House of Delegates

Subject: Internal Medicine Manpower

Background

ASIM has a natural interest in Internal Medicine Manpower since it represents its present and future constituency. From the results of the Internal Medicine Manpower Study, sponsored in part by ASIM, one may conclude that a dramatic switch has been underway with remarkable growth in the numbers of subspecialists internists (SSI*) as compared to broad-based internists (BBI*). This development occurs against a background of an 8.3% annual growth in the numbers of medical students. From 1971 to 1976, this population per class increased from 8,974 to 13,561 with a projection to 16,500 by 1984.

At the same time, the number of medical students choosing internal medicine has remained constant at 35%, which also means an annual growth rate of over 8%. The popularity of internal medicine residency training programs has almost increased to the limit of current approved program slots. The figures project a doubling of the number of internal medicine trainees by 1990.

Furthermore, the number of internal medicine residents going into subspecialty fellowships has increased from 67% to 73%. Fellows are now predominantly clinical, providing subspecialty medical care and performing subspecialty procedures rather than laboratory work and research to prepare as future academicians. We must be mindful that 80% of medical resident stipends and 40% of fellowship stipends derive from governmental sources (federal, VA, state, and municipal). Importantly, 65% of all subspecialty fellows are in 20 training programs (some multi-institutional).

The sum and substance of the data being reported is that more and more internists are being produced but more and more are going into subspecialty medicine rather than basic broad-based internal medicine. In this age, when the perceived public and legislative needs are for more primary care physicians (e.g. BBI), our production line is churning out fewer than before, despite a larger total number of medical school graduates and a larger total number going into internal medicine training programs.

In these times of exploding medical knowledge and technology, the need for more comprehensive training in all the subspecialties of internal medicine increases, but the limitations of time and the subspecialty format in the training programs present difficulty in accomplishing the task of adequately covering the spectrum of internal medicine. Subspecialty care provides more technology, is probably more expensive, and may fragment medical services.

(See Page 7)

Board of Trustees Report J
May 1978

1 The Federated Council for Internal Medicine was formed to provide a forum
2 for discussion of mutual problems affecting internal medicine. It consists
3 of the Association of Professors of Medicine (APM), American Board of
4 Internal Medicine (ABIM), American Society of Internal Medicine (ASIM), and
5 American College of Physicians (ACP).
6

7 APM is composed of the 119 chairmen of departments of medicine in the United
8 States medical schools. It is concerned with the training of future
9 internists and subspecialists. The traditional model for medical students
10 in departments of internal medicine has been the subspecialist. This is where
11 prestige, promotion, research grants and prime time medical student exposure
12 occurs. The newly formed Association of Program Directors in Internal Medicine
13 (APDIM) gathers together the 419 approved internal medicine program directors.
14 This organization is, of course, conceptually and functionally part of the
15 same segment of internal medicine as APM. In many instances, the program
16 director is the APM member.
17

18 ABIM is a certifying body which measures the knowledge of residents and fellows
19 who complete approved internal medicine training programs. Requirements for
20 entry to examination in broad-based internal medicine and subspecialty internal
21 medicine are established by ABIM. ABIM has more recently been involved in re-
22 certifying examinations for the already certified internist.
23

24 ASIM represents the practice phase of internal medicine. Its arena encompasses
25 the science of health care delivery and the socio-economics of internal medicine.
26 Effectiveness, efficiency and clinical decision making are vital areas of ASIM
27 activities and are becoming increasingly important in relationship to cost
28 containment. The prerogatives of the internists are zealously guarded by ASIM
29 in relation to governmental and legislative regulatory bodies, health insurers,
30 and other segments of medical practice. Patient advocacy is another
31 prime objective of ASIM. As a grass roots state component organization
32 there is bi-directional flow of ideas, activities, education and organizational
33 policy.
34

35 ACP has traditionally focused on continuing education for the internist.
36 Through self-assessment programs and courses in broad-based internal medicine
37 and subspecialty areas, the College has provided a means for internists to
38 update their knowledge. The Medical Knowledge Self-Assessment Program (MKSAP)
39 is an important accomplishment in the field of continuing education.
40

41 What has ASIM done regarding internal medicine manpower?
42

- 43 1. ASIM has been actively interested in the manpower field for some time.
44 In 1975 representatives met with the Health Resources Administration
45 in Washington regarding its manpower program and regarding responses
46 to Senate and House Subcommittee recommendations on medical manpower.
47
- 48 2. ASIM has sponsored the concept of preceptorships in internal medicine
49 for residents and for medical students with practicing internists in
50 the office setting. This has been presented to FCIM previously.

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- 1 3. ASIM has promoted the use of allied health personnel to supplement
2 internal medicine manpower, to the extent permitted by local law and
3 regulations.
- 4
- 5 4. ASIM has addressed the problem of the duration of training programs
6 for the clinical practice of internal medicine. An extensive back-
7 ground has been developed on the identifiable reasons for and against
8 a change in the training time.
- 9
- 10 5. ASIM has developed a policy on new techniques in internal medicine as
11 it relates to manpower requirements which FCIM has adopted.
- 12
- 13 6. ASIM has an extensive policy on delineation of clinical privileges in
14 hospitals. This relates directly to the utilization of in-hospital
15 medical manpower.
- 16
- 17 7. ASIM has developed a policy statement on primary care which is identi-
18 fied as a more common function of broad-based internal medicine rather
19 than subspecialty internal medicine.
- 20
- 21 8. ASIM has joined with other representatives of FCIM in sponsoring the
22 NASIMM.
- 23
- 24 9. ASIM is developing a directional policy on internal medicine manpower
25 as data from NASIMM becomes available.

26
27 Evaluation

- 28
- 29 1. The number of physicians, number of internists and health care
30 professional for the population.

31
32 There are increases in the numbers of medical students, internists
33 and allied health personnel. There are forces which favor the continual
34 growth of the numbers of medical school graduates. The geographic
35 maldistribution of physicians, including internists, may be rectified
36 by social, educational and financial incentives from government and
37 non-governmental sources. Federal and state regulations are attempting
38 to provide a minimal guarantee of 10-20% of medical school graduates
39 to serve 2-4 years in physician deprived areas. More BBIs and/or FPs will
40 be needed for this obligation.

- 41
- 42 2. Subspecialty Medical Care Proliferation

43
44 The increases in subspecialty internal medicine as noted in preceding
45 paragraphs are proceeding with significant governmental financial support.
46 This may be changed by HSAs and the Bureau of Health Manpower if Internal
47 Medicine fails to act. Fewer patients are seen and less primary care is
48 provided by subspecialty internists when compared to broad-based internists.

1 Current internal medicine training programs are predominately sub-
2 specialty oriented rather than internal medicine oriented. The role
3 model for medical students is the subspecialist, and most department
4 of medicine programs are so structured. Many services and procedures
5 are provided by subspecialty fellows and are an important source of
6 income to many departments of medicine.
7

8 3. The Survival of Broad-Based Internal Medicine as a Specialty is
9 Endangered by the Inappropriate Production of Subspecialists.

10 Since the focus of training programs in internal medicine has been
11 on subspecialty training, the specialty is now threatened by federal
12 and some state legislation that preferentially supports FP programs
13 because Primary Care is the major area which will receive dollar support.
14 FP programs are lacking in the depth and breadth of training experience
15 found in internal medicine so essential to the delivery of high quality
16 primary care.
17

18 The power and strength of internal medicine in the AMA and the
19 American Board of Medical Specialties and relative to government
20 councils may be seriously diluted if the numbers of internists become
21 primarily subspecialty internists.
22

23 4. Cost-Effectiveness of Medical Care

24 Cost-effectiveness relates either directly or indirectly (third-
25 party insurance coverage) to the patient for the process of diagnosis
26 and therapy. Cost may then be measured by the outcome of patient
27 care. The training of the broad-based internist is designed to
28 accomplish the proper diagnosis and management in the most efficient
29 and effective manner as no other program is.
30

31 Strategies

32 The Board of Trustees has been considering this important subject for
33 some time and believes that implementation of some or all of the following
34 strategies may represent approaches that could modify the adverse trends
35 in internal medicine manpower training:
36

- 37 1. Develop objective methods to obtain data as guidance for future
38 national policy regarding any change in the total number of medical
39 school graduates as well as the number of trainees in BBI and SSI.
40
41 2. For specified diseases or diagnoses study relative cost-effectiveness
42 and outcome for BBI, SSI and other physicians.
43
44
45

*BBI - Broad-based internal medicine > (see page 7)
*SSI - Subspecialty internal medicine

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- 1 3. Decrease the numbers of subspecialty training slots.
2
3 a. Divert training funds to broad-based internal medicine
4 (BBI*) from subspecialty medicine (SSI*
5
6 b. Lengthen the programmatic time required to qualify for sub-
7 specialty certification. Mandate broad-based internal medicine
8 certification before entering subspecialty training.
9
10 c. Medical care services and procedures now provided by SSI
11 trainees would be provided by BBI trainees. There should be
12 mandatory rotation of trainees through most subspecialty
13 experiences.
14
15 d. Establish accreditation procedures for subspecialist fellowship
16 programs.
17
18 4. Lengthen BBI Training Programs to four years. This would enhance
19 opportunities to:
20
21 a. Expand experience in the various subspecialties of internal
22 medicine.
23
24 b. Permit the BBI to develop areas of special interest.
25
26 c. Develop cost-consciousness in the practice of medicine.
27
28 d. Emphasize the teaching of humanism in the practice of medicine.
29
30 e. Learn group dynamics for the team concept of medical care (the
31 internist as a manager).
32
33 f. Increase ambulatory care training programs through preceptorships
34 with practicing internists.
35
36 5. Change the Emphasis in Internal Medicine Training Programs.
37
38 a. Allow the primary role of the department of medicine to shift
39 to the production of more broad-based training in internal
40 medicine.
41
42 b. Restructure departments of medicine to enhance training in BBI.
43
44 6. Enhance the Role Model of the BBI in the Medical School through:
45
46 a. Recruiting
47
48 b. Promotions
49
50 c. Number of student contacts
51
52 7. Close substandard residency programs in internal medicine.

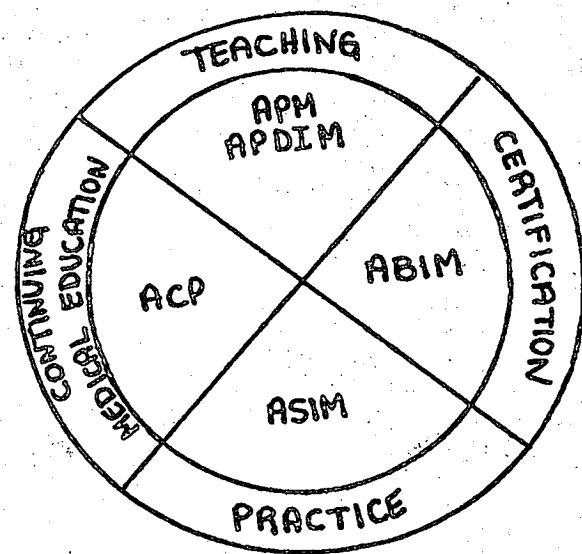
*BBI - Broad-based internal medicine
*SSI - Subspecialty internal medicine

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- 8. Promote further refinement of methods to delineate hospital privileges according to the training and demonstrated expertise of the individual physician.
- 9. Develop means to document clinical competence (DCC).
 - a. For all internists, certified and non-certified
 - b. For internists trained in internal medicine practicing internal medicine for more than 5 years.
 - c. ABIM certification and recertification would be identified as conferring DCC.
 - d. DCC should emphasize patient management. ASPERF, ABIM certification and recertification, or PIQuA, may prove to be acceptable methodologies.

This report is being presented to the House of Delegates for its information and consideration.



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- *BBI: A broad-based internist is skilled (peer-recognized) in diagnosis and in adult patient management. A BBI utilizes comprehensive training in the correlation of history, physical examination, laboratory data, and procedures. A BBI does not restrict his or her professional activities to a disease category or subspecialty of internal medicine. A BBI may, however, have an interest and special skills in one particular subspecialty or disease. A BBI is trained to serve as a consultant.
- *SSI: A subspecialty internist is one who intentionally restricts his or her professional activities to a disease category or subspecialty of internal medicine.

sd



**association of american
medical colleges**

May 18, 1978

Ms. Ronnie G. Tobin
Joint Commission on Accreditation of Hospitals
875 North Michigan Avenue
Chicago, Illinois 60611

Dear Ms. Tobin:

The Association of American Medical Colleges appreciates this opportunity to comment on the proposed revisions (draft A) for the Governing Body and Management sections of a revised Accreditation Manual for Hospitals. To prepare the attached comments, copies of the proposed sections were sent to the chief executive officers of thirteen hospitals belonging to the Association's Council of Teaching Hospitals. These hospitals were selected to represent differing types of teaching hospital ownership, affiliation, and specialty. Comments contained in this letter, therefore, are reasonably representative of the concerns of major teaching hospitals across our nation.

To facilitate the presentation and review of these comments, a standard format has been used. Following several general comments which apply to both draft sections, comments are separately organized for the Governing Body and Management drafts. In discussing each draft, general comments precede standard-specific concerns.

If you wish to discuss any of these comments, we would be happy to do so at your convenience. The AAMC has appreciated this opportunity to comment on the draft Governing Body and Management sections and would welcome the opportunity to review other sections, especially, medical staff, as they are revised.

Sincerely,

Richard M. Knapp, Ph.D.
Director
Department of Teaching Hospitals

RMK/tg
Enclosure

Comments on the
Governing Body and Management Section
of the JCAH
Accreditation Manual for Hospitals

At the outset, it should be noted that several of our responding hospital executives were pleased with the decision to develop separate manual sections for governing body and management standards. Clearly, most felt the separation offered the potential for a substantial improvement in the statement of those standards.

At the same time, the responding executives were deeply concerned that the tone and character of the proposed standards failed to attain the available potential for improvement. Repeatedly, the observation was made that these new standards attempt to provide an overly specific, cookbook approach to governance and management which is both unnecessary and usurping of hospital autonomy. Our member executives strongly took the position that standards and interpretations should provide policy level guidance rather than detailed specifications for the development of checklists. If operational flexibility is provided, hospitals can design their governance and management structures to meet the economic, social, political, and demographic constraints and opportunities they face.

COTH chief executives were also concerned about the JCAH's propensity to develop specific standards in response to federal regulations or proposed legislation. For example, the interpretive material of Standard VI for the governing body incorporates in JCAH materials Federal regulatory requirements for health planning. In a similar manner, the interpretation of Standard V under Management specifies the development and implementation of a hospital-wide cost containment program. Federal regulations and legislation are proposed to meet given needs. Because they are subject to revision and change, JCAH should only incorporate the specific details of regulations and legislation where the JCAH would independently arrive at the same standards. Otherwise, broadly stated policy standards, which are consistent with the objectives of Federal programs, would serve the JCAH purpose while allowing institutions to develop procedures which implement both JCAH and changing government requirements.

GOVERNING BODY

General Concerns

The proposed material on the governing body appears to assume that all hospitals are non-profit, community-based, free-standing corporations. No allowance or recognition is given to the unique governance arrangements of university-owned hospitals. Especially in light of the JCAH's "Guidelines for the Application of Hospital Accreditation Standards in University Hospitals", cognizance needs to be given to the unique and effective governance structures of the state and private university-owned teaching hospitals.

In a similar manner, recognition should be given to the changing pattern of governance in municipal and county hospitals. In some areas, appointed citizen boards and hospital district authorities are being replaced by either boards of elected officials or executive branch agencies. If the standards do not allow for these developments, public general hospitals will be placed in the untenable position of having legislated governance requirements which are contrary to JCAH standards.

Third, while the governance standards provide for a "designated person" as an alternative to a multi-person governing body, at no point in the standards or interpretations is there any attempt to conceptualize how such a person would function.

Standard I

The interpretation requires full disclosure of "owners" by publication of an annual report. Some public hospitals do not publish an independent annual report but are a part of a larger document for the whole political subdivision. In some areas, this may take the form of a "State of the County, City, etc." report by some responsible leader. Most governmental annual reports are statistical in nature and may not satisfy the requirement. It is suggested that consideration be given to adding, "or other official document which is available for public inspection" to the present standard.

COTH executives also questioned the recommendation that the governing body consider obtaining liability insurance for its acts of omission or commission. At a minimum, the interpretation should be expanded to recognize the protection provided by self-insurance programs. More reasonably, the governing body should be encouraged to provide for the uninterrupted operation of the hospital regardless of the peril or threat. Under such an interpretation, liability protection becomes one alternative in a more comprehensive set of considerations.

Standard II

It is suggested that this standard be restated as follows: "The governing body shall adopt by-laws in accordance with sound corporate management practices, legal and regulatory requirements, and its community responsibility." In addition, it is recommended that the interpretations for this standard clearly recognize that public general hospitals may use statutes, ordinances, and resolutions in lieu of by-laws and that university by-laws may be supplemented by appropriate corporate documents to accomplish similar purposes for university-owned hospitals.

In describing the minimum requisites of by-laws (or their equivalent), it would be beneficial if the governing body documents included the relationships of hospital management and hospital medical staff.

Standard III

The standard assumes a self-perpetuating governing board responsible for arranging for new members. This is often an unrealistic assumption, especially for public general hospitals. The standard should be modified, therefore, to recognize the legitimacy of circumstance in which the arrangement for, or selection of, governing body members is not the responsibility of the governing body itself.

The interpretations accompanying this standard are troublesome to university-owned and tertiary care hospitals. For these institutions, it is often difficult to select governing boards representative of "the community" because "the community" served may include an entire state, region or national population. In this circumstance, a representative board may be in conflict with the Joint Commission's emphasis on an active, responsible governing body.

The desirability of physicians on governing bodies remains open to debate among COTH members. Responding executives ranged from those opposed to physician members to those agreeable to them. Those opposing physician members were concerned that a conflict of interest would develop for these physicians and that other hospital personnel would seek a similar privilege. In addition, there was a concern that physicians attaining governing body membership as a consequence of a medical staff position may tend to represent that specific interest rather the broader institutional interest. Given this concern, one executive recommended that, if physicians are to be included, it is recommended that the interpretation for this standard provide that physicians are to be chosen in the same manner as other board members.

It is recommended that the conflict of interest and public disclosure interpretation presently included under Standard III (governing body selection) be relocated under Standard I (disclosure of ownership and control).

The interpretation specifying information to be provided to new governing body members is overly specific. The type and detail of the information needed by these members will depend upon the form and operation of the governing body itself. Moreover, having furnished a "laundry list" interpretation, it is reasonable to expect that some future inspectors will require a check list, demonstrating that these items have been furnished.

Standard IV

Two minor suggestions are offered. First, in listing usual governing body officers, the list should be expanded to state: "... and, where appropriate, a treasurer." Secondly, in the final interpretative statement, it would probably be preferable to identify the final meeting of a JCAH site visit as a "comment" or "report" session rather than a critique.

Standard I

With regard to the role of a medico-administrative liaison committee, it

is recommended that the suggested role be expanded, where appropriate, to include discussing matters relevant to physician recruitment and evaluation and medical staff governance. Given the importance of the matters under review by this committee, it is further recommended that the interpretation state that "This committee should meet as frequently as is necessary, but at least quarterly. Minutes should be recorded and sent to the Governing Body, Medical Staff, and to Administration."

In listing governing body functions in lines 13-16 on page 7, it is unclear whether the term education refers to trustee education, physician education, or allied health education. Because of the large volume of biomedical research conducted in some hospitals, it is recommended that the list of functions be expanded to include "and biomedical research, where appropriate."

Standard VI

For university-owned and governmental hospitals, the planning committee interpretation fails to recognize that hospital planning takes place within the context and organization of a larger administrative unit whose executive functions include the development of hospital plans. In addition, many of our large private hospitals now have full-time planning departments. Therefore, it is recommended that the governing body's role (in whole or committee), be changed from the development of to the review and approval of the hospital's planning documents.

Where a governing body does elect to develop a planning committee of the type presently described in the interpretations, the present wording of committee functions may conflict with the governing body's committee structure by detailing specific financial responsibilities for the committee with a planning function. While the planning and finance functions are obviously interdependent for some activities, it is strongly recommended that the governing body retain the discretion to determine the number and task responsibilities of its committees.

Finally, it is recommended that the final interpretive statement be restated. The position that the proposed program is "the most effective available method for defining and meeting the health needs of the community" is far too restrictive. Health planning continues to involve substantial amounts of informed judgment. A standard of "the most effective available method" is far too rigorous in this situation. It is suggested, therefore, that this interpretation be revised to state that the proposed program "is reasonable, from the viewpoint of regional planning, in terms of meeting the health needs of the community."

Standard VII

In defining the chief executive officer's responsibility and authority, COTH executives suggested that the interpretation explicitly state (1) that a designee representing the chief executive officer may attend appropriate meetings of governing body committees and (2) that the chief executive officer, or his designee, shall attend appropriate meetings of the medical staff.

COTH executives were supportive of the interpretation specifying an annual performance review of the chief executive officer; however, it is suggested

that the interpretation be reworded to state that "the governing board, or its designee, shall conduct" the review. In public general, university, and multi-institutional hospitals, where a CEO may report to another administrator or executive, the board should be free to delegate the performance review.

Standard VIII

While the interpretive standard on governing body-medical staff communication is highly desirable, the position suggesting presentations by representatives of the medical staff at all governing body meetings is too strongly worded. The agenda for any given governing body meetings should determine whether a medical staff presentation is appropriate or inappropriate.

The concern expressed under Standard III is reiterated; if physicians are to be included on the governing body, it is strongly recommended that they be chosen in the same manner and with the same criteria as other governing body members.

Standard IX

As planning agencies decrease the supply of hospital beds and services and increase occupancy, it is conceivable that a hospital may not be able to accommodate all of the needs of the medical staff. The numbers of patients may far outstrip the facilities of an individual hospital. Recognizing the legal and community problems this raises, it may be necessary that the governing body, because of facility capabilities, maintain their prerogative to limit on a basis of size (not competence) the number of appointments. This would be difficult, but nevertheless it is an issue the hospitals and the JCAH will have to face.

The interpretation that a physician or dentist sign a statement that he has read all of the hospital policies applying to him is most unreasonable. In large hospitals, such policies may constitute hundreds of pages. The imposition of this interpretation will not solve problems. As an alternative it is suggested that the physician acknowledge, by signature, reading medical staff by-laws and agreeing to be bound by hospital policies.

A physician or dentist in a medical administrative position has two kinds of responsibilities. If he is terminated for lack of performance for administrative functions, the termination procedure should follow regular administrative procedures or the procedures specified in the physician's contract with the hospital. There is no need for a long review and appeal procedure for administrative malfeasance as should be specified for clinical issues. On the other hand, if it is found that a physician in the medical administrative position has to be relieved because of bad clinical performance, there should be no great difficulty in terminating him from the administrative side according to normal hospital procedure or those specified in his contract. If the M.D. is given the right of appeal through governing body committees for poor administrative job performance, then all nonclinical personnel may demand the same consideration.

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Standard X

The interpretive statement addressing delegation of clinical practices is unclear because it fails to give any indication of the occupations of personnel receiving the tasks and because it does state that while tasks may be delegated to paraprofessionals, accountability cannot be delegated.

As a practical matter, the requirement relating to board ratification and medical staff approval of individual members' delegation of certain practices to specified professional personnel should be reconsidered. It is most difficult to comply with this in a teaching, tertiary hospital because of the very nature of the academic environment. It may be a highly desirable goal, but is very difficult to administer in a teaching hospital.

MANAGEMENT

General Comment

The repeated concern among COTH executives reviewing this proposed Manual section was its general "laundry list" character. Several questioned whether it was desirable to adopt an approach of listing specific chief executive officer/management tasks. Several were concerned that JCAH surveyors would begin arriving with check lists which replace any interest in the effectiveness of the hospital's administrative operation. They were also concerned that the level of detail specified might prove to restrict, rather than improve, hospital management. For example, one reviewer stated: "Being too specific can be restrictive and unimaginative. The challenge in all the standards is to develop them so they are effective, broadly stated, and will encourage bright, imaginative professionals to enter the health care field, and not those who are simply bureaucrats".

Standard I

Once again the interpretive statements assume that the hospital is a not-for-profit, free-standing corporation operating under the policy direction of its own governing body. In multi-hospital groups, university hospitals, and public general hospitals, the chief executive officer may be selected by and report to an administrative official of the corporation rather than a governing body. The interpretive statements should be modified to reflect this situation.

COTH executives were strongly opposed to the requirement that chief executive officers be graduates of accredited hospital administration programs and to the requirement for five years of experience. Recognizing that several alternative career paths can provide the appropriate education and experience for a chief executive officer, it is strongly recommended that the interpretation require the governing body, or its designee, to select capable administrators qualified by their education and work experiences.

There was almost complete opposition to the interpretive statement which provides for administrative departmental representatives on medical staff

committees "when requested by the medical staff." It was consistently suggested that the interpretation be restated to exclude this clause so that department representation would be provided where appropriate.

Standard II

No comment.

Standard III

The first interpretive statement is viewed as confusing rather than clarifying the issues surrounding organizational structure. It is suggested that it be restated as follows: "The organizational structure should establish clear lines of authority and accountability; delineate job roles and tasks and the limits and areas of appropriate independence of operation for each role; and assign record-keeping and record-maintenance responsibilities". Because of the growth of matrix organization, it is probably inappropriate to include in this interpretive statement the proposition that an individual is not responsible to more than one person.

The interpretive statement that the CEO should provide for a written plan for the care and/or referral of patients who are emotionally ill should, in the judgment of COTH executives, be relocated to the Manual section on Medical Staff.

Standard IV

The interpretive standards for this section do not recognize or provide an alternative for hospitals operating in a larger organizational context -- municipal or state government, university. In these settings, financial responsibilities may be provided by or shared with other units of the same entity.

The requirement for projecting a detailed three year budget for patient services and revenues is overly stringent. In an era of increasing regulatory activity, key variables underlying these projections are subject to rapid change, a change which depreciates the value of a detailed, projected budget. Therefore, a one-year budget projection would be more reasonable.

In stating the "chief executive officer should ascertain that the budget adequately presents the financial and professional objectives of the hospital," COTH executives were concerned that some parties would place the administration in the position of providing adequate resources for all possible professional objectives. If the phrase "approved professional objectives" were substituted in the interpretation, expectations and demands could be appropriately established.

Standard V

This standard could be used to develop or justify unreasonable financial

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requirements. The adequacy of the physical resources depends upon the availability of financial resources, the compatibility of professional objectives, and the requirements of governmental regulations.

The interpretive statement requiring a hospital-wide cost containment program is overly restrictive. A formal hospital-wide cost containment program may, in the long run, cost the hospital more than it is worth. The higher administrative cost of implementing such a program could easily outweigh the cost savings realized. One must always consider the additional manhours and paperwork generated by establishing cost containment procedures and committee meetings. The optimal "cost containment program" can be obtained without these additional procedural costs, by simply emphasizing a philosophy of effective and efficient day-to-day management. Also a cost containment program would, in many cases, only serve to duplicate already existing management practices. Perhaps the Joint Commission standard should only require that hospitals demonstrate that it is effectively monitoring the cost of its health care programs.

Standard VI

The interpretive statements for this standard are appropriate only if they are reformulated to clearly indicate that self-insurance and captive coverage is an acceptable alternative to commercial coverage.

Standard VII

In the first interpretive statement for this standard, reports are characterized as understandable, reliable, valid, and standardized. This last adjective, standardized, is most unclear as to its meaning. Are hospital reports to be format consistent, comparable to those prepared by other hospitals, or is another meaning intended for standardized?

A CONCLUDING COMMENT

Last November, the Health Care Financing Administration published draft specifications for hospitals participating in Medicare. While the AAMC and its members were concerned about some of the proposed specifications, a key characteristic of that draft was the following statements: "We have developed draft specifications... that retain the basic principles but allow hospitals greater flexibility in the use of resources, equipment, and facilities. We believe that this will permit better cost control without jeopardizing the health and safety of patients, staff, employees, or the general public." The draft Manual sections developed by the JCAH would benefit from the application of a similar logic. At present, the draft sections are overly specific and restrictive. They fail to allow the flexibility needed in alternative settings and for organizational and/or managerial innovation.