COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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

SELECTED ACTIVITIES
DEPARTMENT OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
NOVEMBER, 1977 - OCTOBER, 1978

THE COUNCIL OF TEACHING HOSPITALS

The Council of Teaching Hospitals of the Association of American Medical Colleges was formed in November, 1965. As one of the Association's three governing councils, the Council of Teaching Hospitals is organized to provide activities and programs relating to the special problems, concerns, and opportunities of medical school-affiliated and university-owned hospitals.

Membership

There are two categories of COTH membership: teaching hospital membership and corresponding membership. Both membership categories require the applicant institution to have a documented affiliation agreement with a medical school accredited by the Liaison Committee on Medical Education and a letter recommending membership from the dean of the affiliated medical school.

Teaching hospital membership is limited to not-for-profit -- IRS 501(C)(3) -- and publicly-owned hospitals which sponsor, or significantly participate in, at least four approved, active residency programs. At least two of the approved residency programs must be in the following specialty areas: internal medicine, surgery, obstetrics-gynecology, pediatrics, family practice, and psychiatry. In the case of specialty hospitals -- such as children's, rehabilitation, and psychiatric institutions -- the COTH Administrative Board is authorized to make exceptions to the requirement of four residency programs provided that the specialty hospital meets the membership criteria within the framework of the specialized objectives of the hospitals. Non-profit and governmental hospital and medical education organizations (e.g., consortia, foundations, federations) not eligible for teaching hospital membership are eligible for corresponding membership.

The present membership of the Council of Teaching Hospitals includes 400 teaching hospital members and eight corresponding members.

Governance

There are nine members on the COTH Administrative Board, each serving a three-year term. Three new members are elected annually. In addition, the Immediate Past Chairman, the Chairman, the Chairman-Elect, the Secretary and the COTH representatives on the AAMC Executive Council are members of the Administrative Board. COTH officers and Administrative Board members are listed in Appendix A to this report. The COTH Administrative Board meets four times a year and is authorized to conduct the business of the Council of Teaching Hospitals between the annual meetings of the membership.

The Council of Teaching Hospitals reports to the AAMC Executive Council and is represented on the Executive Council by four COTH Administrative Board members. Creation of standing committees and any major actions by the COTH Administrative Board are taken only after recommendation to and approval by the AAMC Executive Council. COTH officers, new Administrative Board members and new representatives to the AAMC Assembly -- the highest legislative body of the AAMC -- are elected annually by all COTH members during the AAMC Annual Meeting.

Staff

The Department of Teaching Hospitals is the staff component of the Association responsible for representing the interests of the teaching hospital community in AAMC activities and with other organizations and agencies. To ensure that COTH members have a comprehensive description of staff activities, this report presents a review of activities in-progress and completed since our last annual meeting. Individuals seeking more detailed and supplementary information on any of the activities described are encouraged to contact the Department of Teaching Hospitals.

MEDICARE REIMBURSEMENT PRACTICES

Payments to Physicians in Teaching Hospitals

The 1972 Social Security Amendments, P.L. 92-603, contained a provision, Section 227, establishing payment provisions for physicians' services provided to Medicare beneficiaries in teaching hospitals. As enacted, the law provides that physicians shall be paid for professional medical and surgical services on a reasonable cost basis, through the teaching hospital, ". . . unless (A) such an inpatient is a private patient (as defined in regulations), or (B) the hospital establishes that during the two-year period ending December 31, 1967, and each year thereafter all inpatients have been regularly billed by the hospital for services rendered by physicians and reasonable efforts have been made to collect in full from all patients and payment of reasonable charges (including applicable deductibles and coinsurance) has been regularly collected in full or in substantial part from at least 50 percent of all inpatients."

On July 19, 1973, the Department of Health, Education, and Welfare published proposed regulations for the implementation of Section 227. The proposed regulations were widely criticized by the medical education community as unworkable, inequitable, harmful to existing patterns of medical education, and punative to physicians practicing in teaching hospitals. Those proposed regulations were withdrawn before implementation and Congress chartered the

Institute of Medicine to conduct a study of the payment of physicians in teaching hospitals. While the IOM published its findings in March, 1976, new regulations were not available for the scheduled implementation on October 1, 1977. Therefore, Robert Derzon, Administrator of the Health Care Financing Administration, recommended -- to the respective Chairmen of the Senate Finance Committee and the House Ways and Means Committee -- a further deferral of Section 227 implementation until September 30, 1978. As discussed in the subsection on legislative activity, Senator Robert Dole (R-Kansas) sponsored legislation which accomplished the one year delay.

Draft Regulations

On December 8, 1977, Richard Knapp, Director of the AAMC's Department of Teaching Hospitals wrote the Administrator of the Health Care Financing Administration requesting a formal opportunity to provide consultation on and review of draft regulations for Section 227 prior to their publication in the Federal Register. On January 24, 1978, the request was repeated in a letter from AAMC President John A. D. Cooper. Shortly thereafter, the Administrator granted the AAMC request, and an AAMC Ad Hoc Committee on Medicare Section 227 was appointed -- with Charles B. Womer, President of the Hospitals of Cleveland as its Chairman -- to review draft regulations when they became available.

In late March, under a pledge of confidentiality, the Health Care Financing Administration furnished the AAMC with a copy of the March 22nd draft regulations for Section 227. The Ad Hoc Committee met with teaching hospital staff on April 5th to review the draft regulations and, at a separate session, to discuss major concerns with Medicare officials. In addition, teaching hospital staff prepared comprehensive written statements of the Ad Hoc Committee's concerns, interests, and questions. These statements were furnished to Medicare officials in early May.

Throughout the spring and early summer, Medicare officials indicated that revised draft regulations would be published in the Federal Register shortly; however, the regulations were delayed by their failure to comply with the requirements of Secretary Califano's "Operation Common Sense." Finally, on July 20th, the Deputy Administrator of the Health Care Financing Administration distributed copies of the revised draft of Section 227 regulations at an HEW Region Four meeting in Atlanta of medical center executives. Copies of this July 19th draft of the regulations were immediately distributed to all AAMC constituents, and the Ad Hoc Committee was reconvened to review the draft regulations.

The July, 1978 draft regulations included many provisions which the Ad Hoc Committee found objectionable to teaching hospitals, medical schools, and practicing and teaching physicians. Therefore, the Ad Hoc Committee prepared a report analyzing the draft regulations which included a set of implementing principles for Section 227, a series of recommendations for critical concerns raised by the draft regulations, and a section-by-section analysis of the draft regulations. Copies of the Ad Hoc Committee's report were distributed to all AAMC members as of August 22nd. In addition, an open meeting sponsored by the AAMC was held in Chicago to discuss the draft regulations and the Ad Hoc Committee's report. The 230 members attending the meeting were broadly representative of the Association's diverse constituents.

The report of the Ad Hoc Committee was considered at the September meetings of the Administrative Boards of the Council of Deans, Teaching Hospitals, and Academic Societies. The Councils recommended adding an implementing principle on the use of fraud and abuse legislation to correct inappropriate billings, dropping the recommendation on the table of allowances, and stating the issue of resident supervision in the context of educational instruction. Incorporating these changes, the AAMC Executive Council adopted the amended Committee report at its September 14th meeting.

As this report is written in early October, DHEW has still to announce formally proposed regulations for implementing Section 227. While proposed regulations could be published at any time, it does appear that the legislative activity discussed below will defer the implementation of Section 227 until October 1, 1979.

Legislative Activity

Following Robert Derzon's letter to Congress requesting a delay in the implementation of Section 227 until October 1, 1978, teaching hospital staff began working to obtain the legislation necessary to effect this change. On February 28, 1978, Senator Robert Dole (R-Kansas) introduced an amendment to the end-stage renal dialysis bill which would change the date of implementation. The amendment was approved, without objection, by the Senate Finance Committee. Subsequently, the amendment was approved by both the Senate and the House of Representatives. On June 13, 1978, President Carter signed the dialysis bill into law P.L. 95-292, and the delay in Section 227 was accomplished.

On August 17,1978, a meeting of the Council of Deans, Southern Region, was held under the leadership of Chairman D. Kay Clawson, M.D., Dean, University of Kentucky and Thomas A. Bruce, M.D., Dean, University of Arkansas. The purpose of the meeting was to discuss strategy with regard to the pending implementation of Section 227, and the dramatic implications this would have on some medical centers if the substance of those regulations was not altered Twenty-two medical centers were represented at the meeting, including several deans from outside the Southern Region who had learned of the meeting. After a thorough evaluation of the currently available draft regulations and various courses of action, those at the meeting unanimously agreed with the position advocated by Drs. Clawson, Bruce and Edward N. Brandt, Jr., of the University of Texas, that every effort should be made to repeal Section 227 and related supporting sections of the Medicare law. Prior to the August 17th meeting, several deans and hospital directors had discussed the seriousness of Section 227 with their Senators. In his discussions, Dr. Bruce had found that Senator Dale Bumpers (D-Arkansas) was interested in initiating a legislative solution to Section 227.

The following day, medical center officials at the deans' meeting met with staffs of their Senators to explain Section 227 and its impacts. Later, under the sponsorship of Senator Bumpers, officials from all schools present met with the Acting Director of the Medicare Bureau and supporting staff to discuss the draft regulations. The meeting revealed nothing that had not already been known. Senator Bumpers also hosted a meeting with Senate staff and medical center representatives to review Section 227. Senator Bumpers distributed a letter to his Senate colleagues soliciting their support for a repeal of Section 227. These developments were immediately communicated to all AAMC

members who were urged to contact their Senators to obtain co-sponsors for the Bumpers' amendment.

On September 12,1978, Senator Bumpers and twenty-three co-sponsors introduced the repeal as an amendment to H.R. 5285, a tariff bill that also includes Senator Talmadge's Medicare reform bill and Senator Nelson's proposed amendment for a hospital cost containment program. The Bumpers' amendment presently has twenty-five co-sponsors. In the House of Representatives, Congressman Tim Lee Carter (R-Kentucky) announced in the September 14th Congressional Record that he would introduce companion legislation to repeal Section 227. The Carter bill, H.R. 14167, was introduced with twenty-two co-sponsors on September 25th.

By early October, 1978, as the Congress worked toward a mid-October adjournment, the presence of substantial amounts of remaining legislation led Senator Bumpers to the conclusion that a repeal of Section 227, regardless of its merits, would not make it through the Congress this year. Therefore, Senator Bumpers and his staff are presently working with Senate Finance Committee members and staff, their House of Representatives counterparts, and HEW officials to obtain an agreement to defer Section 227 until October 1,1979, and to strongly encourage HEW and its Health Care Financing Administration to work with the medical education community to develop more acceptable regulations.

Medical School and Faculty Costs

When the Administrator of the Health Care Financing Administration requested a delay from 1977 to 1978 in the implementation of Section 227, he also notified the Congress of his concern for Medicare and Medicaid practices when reimbursing hospitals for services provided by medical schools. Intermediary letter #78-7 -- dated February, 1978 but effective with cost reporting periods ending on or after December 31, 1977 -- was promulgated to define "reasonable costs incurred by a teaching hospital for services renderd by faculty of a related medical school (or organization related thereto) and for medical school costs related to these services." Copies of the Intermediary letter were furnished to all AAMC members as soon as they became publicly available. Teaching hospital staff have discussed interpretive problems with affected members and have continued to monitor implementation problems.

Routine Service Payment Limitations

Federal regulations establishing per diem routine service cost limitations for hospital payments under the Medicare program became effective for accounting periods beginning after June 30, 1974. In May, 1975, the Association of American Medical Colleges filed suit in the U.S. District Court seeking relief from the regulations, arguing that the regulations were arbitrary, capricious, in excess of the HEW Secretary's authority, inconsistent with the 1972 Amendments to the Social Security Act, and would cause irreparable harm to teaching hospitals.

The initial court decision was in favor of the Department of Health, Education and Welfare. Therefore, the AAMC appealed the decision. While oral briefings on the appeal were presented on September 16, 1976, the U.S. Court of Appeals -- on April 1, 1977 -- requested a supplemental brief from the Association concerning the jurisdictional authority of the courts in this matter. On May 2, 1977, the AAMC filed the court-requested supplementary brief taking the position that,

while individual claimants seeking judicial review of specific benefit determinations must follow prescribed administrative procedures before turning to the courts, the court has direct and immediate jurisdiction to review agency regulations implementing legislation.

On December 1, 1977, the Court of Appeals for the District of Columbia, relying heavily upon two recent Supreme Court decisions addressing judicial review of Social Security Program actions (Califano vs. Sanders and Weinberger vs. Salfi), dismissed the Association's case for lack of jurisdiction. The court held, in effect, that the AAMC had failed to exhaust its administrative remedies because it, through its teaching hospitals, had not presented a claim to the Provider Reimbursement Review Board for what it believed to be the appropriate reimbursement for teaching hospitals. The Association had sought court review of the basic regulations themselves, rather than any particular dollar claim, because the Provider Reimbursement Review Board has no authority to invalidate Medicare regulations.

The opinion of the Court of Appeals does have some palliative effect in that it vacates the opinion of the District Court, which held that the regulations implementing Section 223 were valid. That opinion, therefore, now has no precedential value whatsoever. Nonetheless, the opinion of the Court of Appeals bodes ill for anyone wishing to mount a challenge to Medicare regulations in the future because it requires that the organization making the claim first make an application for higher benefits with the Provider Reimbursement Review Board. Such a claim could be a hollow, time consuming exercise because the Board is bound by law to follow the regulations.

Family Practice Grants

Existing Medicare regulations provide that "an appropriate part of the net cost of approved educational activities is an allowable cost" under the program where "the net cost means the cost of approved educational activities (including stipends of trainees, compensation of teachers, and other costs) less any reimbursement from grants, tuition, and specific donations." Under these regulations, the Medicare Bureau has taken the position that federal and state grants for medical education are restricted grants which must be deducted from the costs of the education program prior to determining allowable costs for services provided to Medicare beneficiaries. The result of this reimbursement policy is clear: the actual dollars received in federal grants are accompanied by a proportionate reduction in Medicare reimbursement. The consequences of this reimbursement reduction are similarly clear: (1) grant funds provide a lessor stimulus than that intended by the granting agencies; (2) state funds unintentionally support a federal social insurance program; and (3) provider incentives to respond to government programs are substantially reduced.

This reimbursement issue received increased visibility in 1977 because of developments and policy changes made by the Region IV (Atlanta) office of the Bureau of Health Insurance. In Intermediary Letter #3-75 of January 22, 1975, the Regional Medicare Bureau office specified that ". . . grants from HEW for the establishment of residency programs in family practice" are to be classified as "seed money" grants which are not offset against provider costs in determining Medicare reimbursement. On July 14, 1976, the Regional office issued Intermediary Letter #12-76 stating that its prior Intermediary Letter was in error. As a result of this change in policy, intermediaries attempted

to retroactively recover funds approved under the original Regional Intermediary Letter. In the case of at least one hospital, this retroactive recovery has the potential of amounting to over one million dollars.

Last year, teaching hospital staff worked with members in the Atlanta region office to clarify the reimbursement and public policy issues, prepared an AAMC letter to Secretary Califano strongly recommending revisions in Medicare regulations, and attended a DHEW conference on Medicare's treatment of graduate medical eduction grants. On February 14, 1978, in a letter to the AAMC, Califano stated that:

> We (HEW) have modified our position on family practice residency training grants in relation to Medicare reimbursement principles in order to support the Congressional and Administration priority of encouraging more primary care doctors. The recent health manpower legislation is clear in its intent to provide support for the training of primary care physicians, and the growth of the approved family practice residency training programs since 1972 attests to the interest and cooperation of our teaching hospitals in pursuing this objective.
>
> We believe that the intent of Congress in authorizing and appropriating funds for the support of primary care residency training mandates that the Department carry out a consistent position with regard to the use of other HEW funds for this activity. Thus, we intend to make the appropriate modifications in Medicare regulations in order that grants and donations to teaching hospitals for the specific support of primary care residency training activities will not need to be offset against allowable costs before Medicare reimbursement amounts are determined. We would apply this policy not only to PHS grants, but also to State and private grants made for educational support in the specialties of family practice, general medicine, general internal medicine, and general pediatrics.
>
> We must emphasize that this modification to existing Medicare procedures will not be used as a precedent for exempting other types of training grants from Medicare to offset requirements for reimbursement.

While Secretary Califano's letter indicated that the new policy would become effective for cost reporting periods beginning on or after January 1, 1978, implementing regulations, while developed, have not been published.

Allowable Interest Expense

In a 1977 advisory opinion from the Commissioner of the Social Security Administration, a private University was advised that the Medicare program would not recognize, as an allowable cost, interest expense on external borrowings when the University had unrestricted endowments which it is not applying to the costs of constructing a new University hospital.

During 1977, teaching hospital staff worked with the University's legal counsel to identify other university-owned hospitals that could be denied interest payments under the same arguments and to arrange a meeting of these university hospital officials with representatives of the involved University and its counsel. Staff also assisted the University's legal counsel in

identifying and preparing background materials for the University's formal request for a reversal of SSA's advisory opinion.

The original Social Security Administration advisory opinion was reversed by the Administrator of the Health Care Financing Administration in a December 12, 1977 letter to the University. The Administrator stated "we are persuaded, . . ., that the Medicare regulation at 42 CFR 405.419 does not preclude the allowability of interest costs solely because of the availability of capital derived from gifts and grants, whether restricted or unrestricted."

Uniform Hospital Reporting

Section 19 of the Medicare-Medicaid Anti-Fraud and Abuse Amendments, P.L. 95-143, provides the Secretary of HEW with authority to establish a uniform system for reporting, by hospital, on: "the aggregate cost of operation and the aggregate volume of services; the costs and volume of services for various functional accounts and subaccounts; rates, by category of patient and class of purchaser; capital assets, as defined by the Secretary, including (as appropriate) capital funds, debt service, lease agreements, used in lieu of capital funds, and the value of land, facilities, and equipment; and discharge and bill data." Section 19 also states: "In reporting under such a system, hospitals shall employ such chart of accounts, definitions, principles, and statistics as the Secretary may prescribe in order to reach a uniform reconciliation of financial and statistical data for specified uniform reports to be provided to the Secretary."

For several years, HEW has been developing a uniform hospital accounting and reporting manual. While present law emphasizes the authority to impose uniform reporting, HCFA continues to use the Section's language on a "chart of accounts, definitions, principles, and statistics" as authority to prepare a comprehensive system for hospital accounting. Teaching hospital staff have been included as observer members of the American Hospital Association's Advisory Panel to review HCFA's Proposed System of Uniform Hospital Reporting. This has permitted a close coordination of AHA and COTH comments.

HEALTH PLANNING

The National Health Planning and Resources Development Act of 1974 (P.L. 93-641) was due to expire on June 30, 1977, but received a one-year extension when President Carter signed into law in August the Health Services Extension Act of 1977 (P.L. 95-83). The extension was approved in order to provide the Administration and Congress an opportunity to review the planning law's implementation and other health related authorities. During the past year, Congress has given considerable attention to renewal legislation for the health planning act and HEW had proposed several regulations for implementation of the initial law.

Renewal Legislation

In an effort to expedite the identification of common positions for planning act renewal, majority and minority staffs from the Senate Human Resources Committee's Subcommittee on Health and Scientific Research established a joint effort to review the existing legislation and its implementation. In December,

teaching hospital staff met with these Senate staffs to discuss AAMC concerns and to comment on initial and tentative Subcommittee positions on planning act renewal.

With Congress preparing renewal legislation for the health planning act, the Association retained Eugene J. Rubel, former Acting Director of the Bureau of Health Planning and Resources Development, to study, via seven site visits, medical school and teaching hospital participation in the legislated planning process. Early in January, Rubel submitted the results of his study, including the following principal findings:

- There is very active involvement by medical schools and teaching hospitals in the planning process. This involvement is generally not for any altruistic reason; the new agencies are viewed as important and to be dealt with at the highest levels. At the start of the survey, the author would not have expected the level of involvement that exists.

- In those cases where a health science center exists the HSA looks to the vice-president for health affiars (or an equivalent position) as the point of contact and generally does not deal directly with the hospital or medical school components of the center.

- Those areas with more than one medical school generally exhibit more involvement in the planning activities than in single school areas. Competition between the schools and their associated teaching hospitals is apparent and raises concern about duplication of facilities and services.

- Representatives of medical centers are generally viewed by the HSA Board and staff as one additional provider group that is participating because it has a vested interest in the outcome. There was almost no indication that the university would provide either technical resources for addressing issues or serve as a resource for "solving" health service deficiencies identified by the HSA.

- All providers tend to be lumped together in the view of HSA staff with the medical centers perhaps having a somewhat higher "status".

- Major teaching hospitals are generally viewed by HSA board members as a community asset, providing much good patient care and having major political connections. They are valued far more for their service delivery capacity than for their teaching or research capacity.

- There will be greatly increasing strains in the future, to the extent that cost containment becomes a concern. To date, the planning process has had little direct impact on the medical schools and teaching hospitals. During the years ahead, decisions will be made which will most likely have significant impact.

These findings provided one basis for AAMC testimony on planning act renewal. Copies of the Rubel Report were distributed to all AAMC members.

Hearings on legislation to renew the health planning act were held by the House Subcommittee on Health and the Environment in late Januray, 1978. The AAMC testimony, in addition to favoring provisions of the bill which would extend certificate of need to non-institutional providers, increase Federal funding for health planning,permit planning agencies to carry-over funds from one year to the next, and permit individuals to serve on HSA's based on both their place of residence and place of employment, included several recommendations for strengthening and refining the present planning law. The AAMC's suggested planning amendments include recommendations:

- that institutional health service proposals be encouraged to address their impact on the clincial needs of medical education and biomedical research;
- that HSAs review and approval for Federal agency grants be eliminated for manpower and research grants without a significant service component;
- that HSAs be permitted to approve the limited introduction of new technologies prior to development of planning guidelines;
- that HSAs be prohibited from conditioning approval of one health service request on an agreement to develop another health service;
- that Congressional intent on health planning guidelines be clarified to indicate that guidelines are advisory, not mandatory; and
- that HSA and State Health Coordinating Council governing bodies be required to include a medical school dean, in areas with a medical school, and the chief executive officer of a tertiary care/referral hospital.

The testimony concluded with a recommendation that any renewal of the health planning act be accompanied by a Committee Report detailing criteria which will be used to evaluate the program for its continuation.

A written statement, with similar recommendations, was submitted to the Senate Subcommittee on Health and Scientific Research. Throughout the year, teaching hospital staff have worked with Senate and House staff repeatedly to promote HSA governing body positions for deans and hospital directors, less restrictive and clarifying language for HSA reviews of federal medical education and research funds, and certificate of need review for non-institutional settings.

Comments of Regulations

Health Planning Guidelines

In September, 1977, the Health Resources Administration of DHEW published proposed National Guidelines for Health Planning. The proposed guidelines, stated as standards, addressed general hospital beds, obstetrical inpatient services, pediatric inpatient services, neonatal intensive care units, open heart surgery units, cardiac catheterization units, radiation therapy, computed tomographic scanners, and end-stage renal disease.

On December 6th, the Association of American Medical Colleges (AAMC) submitted to HEW its comments and recommendations regarding the proposed National Guidelines for Health Planning. The Association's response placed particular emphasis on the failure of the guidelines to accommodate the unique role of the academic medical center/teaching hospital in the delivery of highly specialized and technologically advanced health services, in the education and training of our nation's health care professionals at all levels of the health sciences, and in biomedical research and development.

Other general concerns expressed by the AAMC regarding the proposed guidelines addressed the lack of adequate exception provisions; the rigid and arbitrary nature of the standards proposed and the need for flexibility; the questionable manner in which the numerical standards were promulgated and their inapplicability in certain settings; and, above all, the failure to clearly state that these guidelines are not federally mandated regulations but simply state general national objectives to be applied by health systems agencies (HSAs) on the basis of their determinations of the unique needs and conditions of their local health service areas.

The Association's response also contained detailed comments and suggestions for each of the proposed guidelines. Copies of the AAMC comments were distributed to all AAMC members.

In January, 1978, HEW Secretary Califano, in response to the more than 55,000 comments received regarding the originally proposed planning guidelines, announced revised National Guidelines for Health Planning. In announcing the revised set of proposed guidelines, the Secretary emphasized that "HEW's role is not to make decisions. It is to establish broad national standards to provide general guidance to the state and local agencies. Those agencies in turn must take HEW's standards and adapt them to special local needs and conditions." He also stated that, "These national standards are to be used by local and state agencies in preparing their plans. The plans, generally, should be made consistent with the guidelines within one year. But, they may be adjusted to meet special circumstances and requirements at the local or state levels. The guidelines have been revised to make it absolutely clear that such adjustments are in order."

On February 15th, the AAMC submitted comments on the revised guidelines. While the AAMC comments supported the increased flexibility of the proposed guidelines, they reiterated the previously submitted concern that the guidelines fail to adequately accommodate the special needs of medical education and research programs or the unique role of the academic medical center/teaching hospital in (1) the delivery of highly specialized health services, (2) the education of health care professionals at all levels of the health sciences, and (3) their research and development mission. Gestures had been made to recognize these special circumstances in the supplementary information section which preceded the actual guidelines, suggesting that such factors will <u>often</u> warrant specific analyses and consideration in relation to certain standards. However, the AAMC urged HEW to recognize that where medical education, biomedical research programs and teaching institutions exist, they should <u>always</u> be respected as potentially special local conditions which may justify adjustment of any of the proposed national standards.

It was stressed that access to health services is also important for medical education and research programs and that patient care, medical education, and biomedical research programs are mutually interdependent -- each requiring and serving the other two as a resource. Because of this interdependence, the AAMC noted the health services provided today also help develop health resources for tomorrow.

Final National Guidelines for Health Planning, to be used by local and state health planning bodies in the development and review of health plans, became effective with their publication in the March 28th Federal Register. The guidelines are essentially unchanged from the revised standards proposed for public comment on January 20th with the addition of some clarifying language but no alteration of the standards themselves.

Review of Federal Funds

In the May 9th Federal Register, the Public Health Service issued a notice of proposed rulemaking to govern the review and approval by Health Systems Agencies (HSAs) of certain proposed uses of federal health funds in the nation's 205 health service areas. The proposed regulations would implement the review requirement mandated under section 1513(e) of the planning act which gives a HSA authority to review and approve or disapprove the use within its health service area of federal funds appropriated under the Public Health Service Act, the Community Mental Health Centers Act, and the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act. In addition, HSA review authority has been expanded to include programs authorized under section 409 and 410 of the Drug Abuse Office and Treatment Act in accordance with 1976 amendments to that Act. In publishing the proposed regulations, publication of HSA review criteria for research and training fund applications was deferred.

The AAMC submitted written comments on the proposed regulations on June 14th. The Association expressed concern: that the proposed review procedure would not maintain the confidentiality of grant and contract proposals; that the regulations were unclear about review requirements when funds involved two health service areas; that HSA authority for periodic reporting requirements is excessively broad; that dollar threshholds were not included for determining review requirements; and that language providing special consideration to meet the needs of minorities, women, and the handicapped did not address the weight to be given these considerations.

Appropriateness Review

The National Health Planning and Resources Development Act of 1974, P.L. 93-641, requires health systems agencies (HSAs) and state health planning and development agencies (SHPDAs) to review the institutional health services within their areas and states at least every five years, to make recommendations, and to make public their findings regarding the appropriateness of the services reviewed. In the May 16 Federal Register, the Public Health Service issued proposed regulations governing how local and state health planning agencies are to review the appropriateness of existing and proposed new institutional health services. The proposed regulations establish the manner in which the

procedures and criteria for appropriateness review must be developed and published; identify the types of health services subject to review; and establish the requirements for review coordination between HSAs and SHPDAs.

The primary concern of the Association's was the feasibility of implementing the appropriateness review function, and the Association cited a DHEW-sponsored study, conducted by the Orkland Corporation, which concluded that HSAs were heavily burdened by other required activities and that it was questionable that they could effectively perform reviews for appropriateness. Therefore, the AAMC recommended that HSAs or state agencies not be permitted to undertake appropriateness review until other mandated planning functions are underway. Other AAMC comments concerned failure of the regulations: to recognize the special needs and circumstances of medical education; to provide notification to providers of the results of appropriateness reviews; to clearly identify appropriateness review as a planning, rather than regulatory, activity; and to adequately define essential terms such as "existing institutional services," "need," and "appropriateness" itself.

National Council on Health Planning

The National Council on Health Planning was created as a "focus for health policy discussions and a suitably representative body of knowledgeable people to help develop" a national health policy. Because of its significant role, teaching hospital staff have attended all public meetings of the Council.

This year, the only hospital "representative" on the National Council concluded the term of his original appointment. In June, when it became known that Secretary Califano was preparing to fill Council vacancies in a manner that excluded a representative of the hospital industry, the AAMC wrote the Secretary and urged him to reconsider his initial decision.

HOUSE STAFF UNIONIZATION

In March, 1976, when the National Labor Relations Board (NLRB) declared, in its Cedars-Sinai and similar decisions, that house staff are primarily students rather than employees for purposes of coverage under the National Labor Relations Act (NLRA), many anticipated a reduction in Association activities on this issue. Subsequent judicial and legislative actions, stimulated by house staff unions, have not supported the original expectation.

Judicial Activities

On Mary 3, 1977, the Physicians National Housestaff Association (PNHA) and four house staff associations brought suit against the National Labor Relations Board (NLRB) in the U.S. District Court for the District of Columbia. PNHA argued that the NLRB had exceeded its authority in its Cedars-Sinai decision, a decision which concluded that house staffs are primarily students rather than employees for purposes of coverage under the National Labor Relations Act.

Oral arguments on PNHA's suit were presented December 16, 1977. Because the National Labor Relations Act does not provide for Court review of representational decisions made by the NLRB and because the NLRB's Cedars-Sinai decision was in response to a house staff association's petition for recognition as an employee bargaining agent, District Court Judge Thomas A. Flannery

dismissed the PNHA suit for lack of jurisdiction on January 17, 1978. PNHA is appealing Judge Flannery's decision to the U.S. Court of Appeals for the District of Columbia.

Legislative Activity

In the House of Representatives, legislation to define house staff as employees for purposes of the National Labor Relations Act, H.R. 2222, advanced significantly early in the year. The bill, sponsored by Representative Frank Thompson of New Jersey, was adopted by the Subcommittee on Labor-Management Relations on February 21st and by the Committee on Education and Labor on March 1st. Following publication of a Committee Report containing majority and minority views on the legislation, the House Rules Committee granted H.R.2222 an "open rule" on April 25th. Under the terms of the open rule, H.R. 2222 could be brought to the House floor for one hour of debate, and it could be amended. The bill did not advance to the House floor for a vote, however, because the House leadership chose to avoid having the House consider the house staff unionization bill while the Senate was engaged in a major debate over labor reform. During periods of Subcommittee and Committee activity, teaching hospital staff worked with Congressmen and their staffs to fully explain the effect of H.R. 2222 and its implications for graduate medical education.

In the Senate, concern for and attention to the "national labor relations reform act" consumed available Subcommittee and Committee time for labor legislation and Senator Riegle's house staff bill, S. 1884, was not considered.

HOSPITAL COST CONTAINMENT

Voluntary Effort

The Association of American Medical Colleges (AAMC) has actively opposed the Carter Administration's hospital cost containment proposal. In place of the Administration's proposed revenue and capital expenditure limitations, the AAMC has advocated a six-point cost containment program based on: (1) the implementing uniform hospital cost reporting, (2) publishing hospital cost data, (3) ensuring health legislation is cost effective, (4) fully implementing PSRO and health planning programs, (5) enacting reimbursement limitations using comparisons of similar hospitals, and (6) permitting state rate or budget review programs under federal standards. This program was advocated to provide hospitals with the necessary flexibility and local initiative essential to meeting cost containment objectives within community service expectations.

Given the Association's position on hospital cost containment, the Administrative Boards and Executive Council of the AAMC considered the fifteen point program of the National Steering Committee for Voluntary Cost Containment at meetings held on January 18 and 19, 1978. The Executive Council of the Association adopted the following policy statement:

> the Association of American Medical Colleges supports the principle of voluntary cost containment and the overall objective of the program embodied in the December 20, 1977, statement of the National Steering

Committee on Voluntary Cost Containment. However, the AAMC has four concerns of significant importance which we request be addressed by the National Steering Committee and communicated to the state implementing committees.

As set forth in the above statement, the AAMC Executive Council adopted four related positions on specific cost containment concerns of tertiary care/ teaching hospitals.

The Association of American Medical Colleges strongly recommends that the National Steering Committee and state implementing committees -

- explicitly acknowledge and make appropriate allowances for changing hospital expenditures (revenues) which result from increasing the availability and number of ambulatory care services;

- adopt guidelines and procedures which do not discriminate economically against hospital-based physicians and capital expenditures;

- explicitly acknowledge and make appropriate allowance for changing hospital costs resulting from newly initiated, expanded, or reorganized manpower training programs which are accredited by an appropriate organization. Costs recognized should include faculty costs for educational instruction and supervision, costs for student stipends where provided, and costs for program support and institutional overhead; and

- explicitly acknowledge and make appropriate allowances for the impact of a hospital's approved scope of services and patient mix on its operating costs and capital expenditures.

In a letter written to John Alexander McMahon, President of the AHA, the AAMC requested that the Steering Committee be informed of the AAMC's support for its program and of the Association's specific concerns in the areas of ambulatory care, institutionally-based services, health manpower education, and tertiary care services.

While the AAMC is not a co-sonsor of the Voluntary Effort program, the inclusion of Richard Knapp, Director of the Department of Teaching Hospitals, in the AHA's Advisory Panel on Voluntary Cost Containment has assured teaching and tertiary hospital input into the development and implementation of the program.

Talmadge Bill

As originally proposed, Senator Talmadge's Medicare-Medicaid Administrative and Reimbursement Reform Act includes a provision that the classification system for determining hospital payment rates would include a category for the "primary affiliates of accredited medical schools" which was limited to one hospital per medical school. Given present variations in medical school organization and hospital affiliations, the AAMC has repeatedly objected to the limitation on one hospital per school. During the past year, teaching hospital staff were successful in obtaining a bill revision that removes the limitations of one hospital per school.

ADMINISTRATIVE BOARD PRESENTATIONS

As a part of its quarterly meetings, the COTH Administrative Board generally holds a brief seminar on a topic of current interest. At the January meeting, Stewart Shapiro, M.D., and David Winston, professional staff members from the Subcommittee on Health and Scientific Research of the Senate Human Resources Committee, met with the Board to consider upcoming proposals to review and extend the National Health Planning and Resource Development Act. Describing the collaborative process by which majority and minority staffs had met to formulate general positions for renewal legislation, Shapiro and Winston reported that committee members appeared to favor a three year extension of the bill which would build upon the present planning structure rather than totally revise it. Following the presentation, COTH Board members and selected representatives from other AAMC Councils discussed the Association's interest in, support for, and concerns about the present planning legislation.

At its March meeting, the Administrative Board met with Paul Rettig, professional staff member of the Subcommittee on Health of the House Committee on Ways and Means. Mr. Rettig, whose career includes several years with the Social Security Administration and its Bureau of Health Insurance, discussed the status and evolution of cost containment legislation in the House of Representatives. He described Representative Rostenkowski's interest in stimulating the voluntary cost containment effort and his interest in proposing "compromise" legislation which would require mandatory cost containment programs by the federal government if the voluntary cost containment program was unsuccessful. Lastly, Mr. Rettig reviewed the funding status of Social Security Administration programs and recent legislation which increased Social Security taxes.

Robert G. Petersdorf, M.D., present Chairman of the AAMC and Chairman of the Department of Medicine at the University of Washington in Seattle, met with the Administrative Board in June to discuss recent graduate medical education trends in internal medical programs. Reviewing published and previously unpublished findings from the National Study of Internal Medicine Manpower, Dr. Petersdorf drew the Board's attention to the rapid increase in the percentage of internal medicine residents who follow their initial residency training with a fellowship in a medical subspecialty. Dr. Petersdorf then led a discussion of the implications of this trend for the costs of graduate medical education, the availability of general internal medicine services, and the demand for subspecialty services.

AMERICAN INSTITUTE OF CPAs

On February 10, 1978, the Subcommittee on Health Care Matters of the American Institute of Certified Public Accountants (AICPA) proposed new hospital reporting practices for related organizations and for funds held in trust by others. Abandoning the existing principle that combined financial statements should be prepared for related organizations controlled by the hospital, the AICPA's proposal advocated combined financial statements for "resources handled by an organization separate from the hospital . . . if, in substance, (resource) use or eventual distribution is limited to the hospital by the organization's charter or by other means, or is limited to support activities managed by, or otherwise closely related to, the hospital."

On Wednesday, June 14, 1978, the AICPA Subcommittee held a formal hearing to obtain public comment on the proposed policy. In its testimony, the AAMC objected to the proposed reporting policy, strongly recommended retaining control as the primary determinant of reporting requirements, suggested eight criteria for developing reporting guidelines, and presented four suggested types of control relationships. The AAMC testimony concluded by discussing legal issues surrounding the proposed reporting policy. In addition to citing philanthropic foundation precedents, such as state university foundations, the testimony described, as a result of the Exposure Draft, the dilemma faced by an attorney whose client wants to make an undesignated gift to support the hospital without reducing future hospital reimbursements and without artificially inflating the hospital's apparent financial standing.

In addition to presenting the testimony before the Subcommittee on Health Care Matters, a copy of the statement was submitted to the Subcommittee on Non-Profit Organizations which was considering reporting practices for non-profit organizations not covered by audit guides.

JOINT COMMISSION ON THE ACCREDITATION OF HOSPITALS

The Joint Commission on the Accredition of Hospitals has decided, in revising its accreditation manual, to separate the governing body and management sections. When the initial drafts of the revised sections were developed, the AAMC was offered an opportunity to comment upon them. To prepare the Association's response, 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. The Association's comments, therefore, were reasonably representative of the concerns of major teaching hospitals across the nation.

Using the responses from the thirteen executives, teaching hospital staff developed a detailed, section-by-section commentary on the draft standards. In addition to the detailed comments, serious concerns were also expressed for the overly-specific, cookbook approach to the standards, to the tendency to incorporate present Federal regulations into JCAH standards, and to the failure to recognize the unique governance arrangements of university-owned and governmental hospitals. Subsequent revisions of the draft manual sections appear to have been responsive to many of the COTH concerns.

EXCESSIVE HEW REGULATIONS

On June 22, 1977, the Executive Committee of the AAMC, met with Secretary of HEW Joseph A. Califano to discuss areas of concern to both the DHEW and the constituency of the AAMC. At that meeting, the Secretary requested that the Association identify for him (1) those DHEW regulations which the AAMC constituency believe are too detailed, too onerous, or simply unnecessary, and (2) those DHEW paperwork requirements which the AAMC constituency believe to be excessive. The AAMC Executive Committee viewed this request as an unusual opportunity for the Association to make a significant contribution to more effective and efficient government programs, and toward that end convened a Task Force on Administrative Excesses in Federal Programs to seriously consider this issue and to formulate the Association's response. On January 9, 1978, the detailed final report of the Task Force was forwarded to Secretary Califano.

The Task Force Report is divided into three sections -- Education, Health-Related Research, and the Delivery of Health Services. Included in the report are extensive discussions of more than 20 programs and areas for which DHEW has issued regulations and/or administrative paperwork requirements. Interspersed throughout these discussions are 35 specific recommendations designed to improve the administration of the programs and reduce the burden which the excessive DHEW regulations and requirements place upon both program participants and the DHEW bureaucracy. Among the subject areas addressed in the report are: the protection of human subjects; the preparation of grants applications; Manpower Report (NIH 1749); health systems agencies; Medicare and Medicaid claims filing and final settlement; PSRO and State Medicaid Agency reviews; Social Security Act Section 223 regulations and exeeptions procedures; and the End Stage Renal Disease program.

Copies of the Task Force Report were sent to all AAMC members.

COTH SPRING MEETING

In May, 1978, the Council of Teaching Hospitals initiated a two-and-a-half day spring meeting to provide COTH representatives with an opportunity to personally interact and discuss problems faced by tertiary care/teaching hospitals. The two day meeting, held in St. Louis, opened with a dinner session addressed by David Kinzer, President of the Massachusetts Hospital Association. Kinzer, who spoke on "New Myths of Health Planning," took issue with several of the "conventional-wisdom" policy positions often advocated by health planners including: non-hospital modes of health care services will reduce health care expenditures; closing chronically understaffed beds will reduce health care expenditures; in the cause of cost containment, consumers will support cuts in health care services; and redistributing health institutions will redistribute health manpower.

The following day, the morning session featured a discussion of institutional responsibility for graduate medical education and presentations on hospital labor relations and HMO-teaching hospital relationships. In the debate, Stuart Marylander, Executive Vice-President of the Cedars-Sinai Medical Center in Los Angeles, reviewed the 12-year history of reports advocating institutional responsibility for graduate medical education and noted that the emphasis on the medical school as the responsible institution has now shifted to place teaching hospitals on an equal footing. Further, he advocated that teaching hospitals continue to support this changed emphasis by accepting a corporate responsibility for graduate medical education and by strengthening institutional affiliation agreements. In the responding presentation, August Swanson, M.D., Director of the AAMC's Department of Academic Affairs, reviewed the fragmented development of graduate medical education and its accreditation, described the unifying developments undertaken and the potential for further consolidation presented by the Liaison Committee on Graduate Medical Education (LCGME), and discussed the LCGME's draft revision of the "Essentials of Graduate Medical Education" -- a revision which advocates institutional responsibility for both medical schools and teaching hospitals.

Jess Solivan, Vice-President for Personnel of the NYU Medical Center, reviewed proposed legislation to amend the National Labor Relations Act to define house staff as employees, the Thompson Bill, and to facilitate unionization of employee groups, the Labor Law Reform Act of 1978. Solivan

then described the collegial house staff organization which developed and became institutionalized at NYU as an alternative to house staff unionization.

As Vice-President for Medical Affairs at George Washington University which has had two HMO relationships, Ron Kaufman, reviewed the Carter Administration's current emphasis on HMO's and discussed some of the GWU experiences with them. Recognizing that tertiary care/teaching hospitals are more costly to operate than non-teaching/community hospitals and that one of the HMO goals is to provide medical services at the lower costs than conventional settings, Kaufman suggested that the HMO-Teaching Hospital relationship will be stable and mutually beneficial if the relationship is based on a signed legal agreement which specifies the selection process for clinicians expected to have admitting privileges, clearly defined disciplinary procedures, and prospectively agreed upon bed access and staffing patterns.

Following the afternoon business meeting, attendees discussed four member-suggested issues: "Changing Funding Patterns for Clinical Fellowship Programs," led by James Moon, Administrator of the University of Alabama Hospital; "Management Contracts and the Teaching Hospital," led by Mike Cancelosi, Group Vice-President of Hospital Affiliates International; "Health Planning, Regionalization and the Teaching Hospital," led by Sam Davis, Director of the Mount Sinai Hospital in New York; and the "Voluntary (Cost Containment) Effort," led by Paul Earle, AHA Vice-President.

The final morning's session opened with a review of JCAH-Teaching Hospital relationships. John Affeldt, JCAH President, described new developments at the JCAH including special teaching hospital survey teams, special guidelines for hospital governance in University hospitals, and the development and promulgation of JCAH standards. In the accompanying presentation, Moe Katz, Deputy Director for Planning at Montefiore Hospital in New York, suggested that JCAH was misdirecting its activities by focusing on hospital operating procedures rather than the hospital's role in and contribution to the community. Affeldt responded by suggesting that other organizations, voluntary or governmental, were more appropriate for such a task.

The meeting concluded with an address by Robert Derzon, Administrator of the Health Care Financing Administration. He reviewed the legislative agenda that HCFA is involved in and summarized his first impressions and observations about Washington and the Federal government.

MULTIHOSPITAL SYSTEMS AND THE UNIVERSITY HOSPITAL

On August 21-22, 1978, individuals from medical schools and major teaching hospitals representing over 32 academic health centers met in Chicago at the Rush Presbyterian St. Luke's Medical Center to discuss the implications of multihospital systems for university teaching hospitals. The invitational meeting was sponsored by the Center for Multihospital Systems and Shared Services Organizations of the American Hospital Association, the Department of Teaching Hospitals of the Association of American Medical Colleges and the Rush Presbyterian St. Luke's Medical Center.

The objectives of the conference were:

- to inform academic health science centers and their teaching hospitals

of the changing configuration in the structure of the hospital industry;

- to evaluate the potential impact of this evolving configuration on the medical schools and their teaching hospitals; and

- to explore the dimensions of the interface, both in the public and private sectors, on the programs of the medical schools and their teaching hospitals in the areas of levels of care of patients and in the development of medical manpower.

The proceedings of the conference are being published and when available will be distributed to all members of the Council of Teaching Hospitals.

COTH REPORT

During the past year, ten issues of the expanded COTH Report have been published. In addition to reporting Washington developments and AAMC Activities of concern to COTH members, an expanded emphasis has been placed upon summarizing major government and private reports focusing on present health policy issues.

SURVEYS

The department has maintained its program of regular and special issue membership surveys.

Regular Surveys

The 1977 Executive Salary Survey, published in April of 1977, was compiled from the responses of 213 non-Federal COTH members. For chief executive officers, the survey described salaries, fringe benefits, and hospital compensation policies. For departmental executives, salary and fringe benefit data was published. Questionnaires for the 1978 survey were mailed to COTH members in August, and it is anticipated that findings from the survey will be published in February, 1979.

The seventh annual COTH Survey of University Owned Teaching Hospitals' Financial and General Operating Data, covering fiscal year 1976, was published in April, 1978. The report, based on responses from 61 hospitals, provides comparable and detailed hospital data on hospital income sources, expenses, utilization of services, and staffing. The next report, for fiscal years ending in 1977, will be published in January of next year.

The 1978 Survey of House Staff Policy and Related Information will be published in January, 1979. As in previous surveys, the 1978 edition will describe house staff stipend increases, fringe benefit programs, and recent trends in these areas. Information is published by geographic region, type of hospital control, bed size, and type of affiliation. This year's survey included new questions on the topics of cost awareness programs, shared schedule residencies, and the role of physician extenders.

In April of this year, COTH published its tenth annual Directory of Educational Programs and Services. The Directory provides a profile of each COTH member hospital, including selected operational and educational program statistics. Questionnaires for the 1979 Directory were mailed in August. In

response to member interest, a special effort is being made to gather information which will be used to prepare a descriptive report on formal medical staff leadership structures in teaching hospitals.

Special Surveys

Two special surveys of COTH membership were conducted during the past year. In late October of 1977, a questionnaire was mailed to members seeking information on the costs of JCAH-required capital expenditure projects. Results of the survey were presented in June, 1978, to the COTH Administrative Board which directed staff to redraft the findings under less restrictive assumptions and interpretations. As soon as the new data analysis and revised text is completed, copies will be provided to all COTH members. The other special survey was a review of present COTH members to assess their continuing eligibility for teaching hospital membership. When the AAMC Assembly added corresponding membership, it also directed that the membership characteristics of all COTH members be determined in 1977. Results of the membership survey were used by the COTH Administrative Board to prepare membership recommendations for action at the 1978 AAMC Assembly.

Appendix A

COUNCIL OF TEACHING HOSPITALS
OFFICERS AND ADMINISTRATIVE BOARD
1977-1978

Chairman
* David L. Everhart
President & Chief Executive Officer
Northwestern Memorial Hospital
Chicago, Illinois

Chairman-Elect
* Robert M. Heyssel, M.D.
Executive Vice-President & Director
The Johns Hopkins Hospital
Baltimore, Maryland

Immediate Past Chairman
* David D. Thompson, M.D.
Director
New York Hospital
New York, New York

Secretary
John Reinertsen
Executive Director
University of Utah Medical Center
Salt Lake City, Utah

Three-Year Term

Lawrence A. Hill
Executive Director
New England Medical Center
Boston, Massachusetts

Malcom Randall
Hospital Director
Veterans Administration Hospital
Gainesville, Florida

Elliott C. Roberts
Director
Charity Hospital of Louisiana
New Orleans, Louisiana

Two-Year Term

Jerome R. Dolezal
Hospital Director
Veterans Administration Hospital
Seattle, Washington

James B. Ensign
President
Creighton Omaha Regional Health Care Corporation
Omaha, Nebraska

Mitchell T. Rabkin, M.D.
General Director
Beth Israel Hospital
Boston, Massachusetts

One-Year Term

Stuart Maryland
Executive Vice-President
Cedars-Sinai Medical Center
Los Angeles, California

Stanley R. Nelson
Executive Vice-President
Henry Ford Hospital
Detroit, Michigan

Robert E. Toomey
General Director
Greenville Hospital System
Greenville, South Carolina

Ex Officio Member

* John W. Colloton
Director & Assistant Vice-President
for Health Affairs
University of Iowa Hospitals and Clinics
Iowa City, Iowa

AHA Representative

William T. Robinson
Senior Vice-President
American Hospital Association
Chicago, Illinois

* Representative to AAMC Executive Council

Appendix B

STAFF
DEPARTMENT OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Richard M. Knapp, Ph.D.
Director
202/466-5126

James D. Bentley, Ph.D.
Assistant Director
202/466-5122

Joseph C. Isaacs
Senior Staff Associate
202/466-5128

Gail Gross
Administrative Secretary
202/466-5136

Tobi B. Goldfus
Secretary
202/466-5103

Judy Thomas
Secretary
202/466-5054