DOCUMENT RESUME

ED 080 058 HE 004 402

TITLE	Senior Medical Consultants Project: A Continuing Medical Education Program Utilizing Recently or Near-Retired Medical School Faculty Members. Final Report, August 1, 1971 - January 31, 1973.
INSTITUTION	National Institutes of Health (DHEW), Bethesda, Md. Div. of Physician Manpower.
PUB DATE	Jan 73
NOTE	45p.
EDRS PRICE	MF-$0.65 HC-$3.29
DESCRIPTORS	*Consultation Programs; Faculty; *Higher Education; Inservice Education; *Medical Consultants; *Medical Education; *Physicians; Program Descriptions

ABSTRACT

This document reviews the Senior Medical Consultant Program; a program designed to utilize recently or near-retired medical school faculty members in a continuing medical education program. Evaluation of the program by physician teachers, physicians attending the sessions, both attending staff and house staff, and by physicians scheduling the teaching session was based on written reports, interviews, and observations of teaching sessions. Results indicated the success of the program, which received enthusiatic response from all medical groups contacted. (MJM)

FINAL REPORT

August 1, 1971 - January 31, 1973

SENIOR MEDICAL CONSULTANTS PROJECT:

A Continuing Medical Education Program Utilizing Recently Or Near-Retired Medical School Faculty Members

Sponsored by

National Institutes of Health, Division of Physician Manpower, Bureau of Health Professions, Education and Manpower Training. N. I. H. United Stated Public Health Service, Department of Health, Education and Welfare.

Contract No. N.I.H. 72-4002

PROGRAM ORIGIN

There is a large reservoir of unused knowledge, experience and talent among the numerous medical professors recently retired from teaching positions. There is also a tremendous need in many hospitals for the help and expertise of this group of outstanding specialists. In many medical schools the mandatory retirement of the active staff is set at 65 years (sometimes at a younger age), but in about 15% of the hospitals the age is between 68 and 70 years. These specialists, while fully active on their hospital staffs, seldom have the time to be of assistance to local hospitals in isolated areas or even in the cities. Some hospitals, although affiliated with medical schools, find that their relationship is only a token one and provides minimal teaching services. Busy physicians cannot keep abreast with all the recent advances in medicine. With the present rate of medical progress, their training becomes outdated rapidly. To provide these physicians with an opportunity to remain abreast of current medical information and to allow the retired faculty members to exercise their skills, the Senior Medical Consultants Program was conceived to bring the two groups of physicians together in the clinical setting.

When the program was first conceived, it was presented to hospital medical educators and administrators. Their reactions indicated that the hospitals in the New York City area vary a great deal with regard to their training needs, and that the consultant-teaching program should be as flexible as possible in order to be responsive. Some hospitals, for example, have only foreign medical graduates on their staffs; these

graduates may require specific teaching skills from the consultants. Others have a more heterogenous house staff. Some hospitals, located in ghetto communities, face particular problems in connection with ghetto medicine, drug abuse, and community relations. These hospitals would require consultants with different interests than those who might be teaching in a suburban hospital. In general, respondents were very enthusiastic about the possibilities of the project described, and all said that they would welcome this innovation in their teaching programs.

In some hospital settings, very little formal training is offered. Other hospitals do have an extensive teaching program. Rounds are conducted daily by Chief Residents, twice or three times weekly by appointed attendings, and once or twice a month grand rounds are presented by Chiefs of Service or visiting staff. Usually these physicians are obtained on an "informal referral" basis. The Senior Medical Consultants Program would be of help to these hospitals, because the project would routinize and make formal this practice. It appears that some non-affiliated hospitals are more reluctant to ask for help from outside teachers and that they have more difficulty obtaining it when they do ask. This project, then, would institute a formal system of referral, eliminate in large part a reluctance to use outside men, and enable hospitals to obtain help when needed, more efficiently than they can at the present time.

OBJECTIVES

Interviews conducted with medical education personnel in hospitals

focused on several broad topics: the most prevalent teaching and service problems in the hospital; the present teaching situation; personnel (both teaching personnel and the types of interns and residents on the staff); the patient population; and initial reactions and questions about the Senior Medical Consultants project.

In response to this discussion and the above purposes of the Senior Medical Consultants Program, the following primary and secondary objectives were specified:

Primary

1. To demonstrate that sufficient numbers of community hospitals, with little or no medical school affiliation, have the critical need for much improved Continuing Medical Education Programs.
2. To demonstrate that they would be responsive to the possibility of utilizing retired Physician-Teachers to bolster and catalyze development of their Continuing Medical Education Programs.
3. To show that Continuing Medical Education-Physician manpower resources exist, highly qualified retired and near-retired Physician-Teachers who are most willing participate in Continuing Medical Education Programs.
4. To show the effectiveness of utilizing a previously untapped medical manpower resource to overcome the maldistribution of Physician-Teachers.

Secondary

5. To explore the policies in Continuing Medical Education, as found

in the policy framework of these community hospitals.

6. To encourage participating hospitals to think in terms of the clinical teaching modality. Directors of Medical Education usually perceive the didactic type of consultation as more expedient to fit into their existent Continuing Medical Education Programs.

HOSPITALS

Hospitals who expressed initial interest were sent a series of questions asking for additional factual information, and for a description of the specific educational needs at the hospitals. The questions referred to the following areas:

I. Hospital Description

Size

Average length of in-patient care per patient

Average waiting time for admission

Necropsy rate

Size of out-patient department

II. Personnel

Number of American-trained and foreign-trained interns and residents

Number of positions unfilled this academic year

Proportion of residents who completed internship at the same hospital

Number of attending physicians associated with the hospital

III. Educational Programs

Number of approved internship and residency programs

Anticipated changes and improvements in the teaching program

Description of present training programs on each service

Frequency of visits by outside consultants

Predominant needs in the educational programs

IV. Senior Medical Consultants Program

Interest in participating in the program

Description of possible advantages and disadvantages for the hospital

Comments and suggestions

The typical participating hospitals are: medium sized, non-affiliated, mainly staffed by foreign medical graduates; located within one hour of New York City in the three sta' · selected for this pilot project (New York, New Jersey and Connecticut); located in sururban, urban and ghetto areas; serving high, low and mixed income populations.

PHYSICIAN-TEACHERS

Names of senior Physician-Teachers were solicited from the Deans of medical schools in the metropolitan area. The physicians named were sent letters describing the program and including the following questions:

a. Interest in participating in the Senior Medical Consultants Program

b. Present professional activities (consultative, teaching positions, committee memberships)

c. Educational background (medical school, internship and residency training hospitals, specialty boards)

d. Academic activities (last teaching position held and period of

time, recent courses taught, research and teaching interests, hospital teaching positions held)

e. Restrictions and limitations (previous time commitments, travel and distance restrictions, types of hospitals preferred or teaching activity).

It was further felt that it would be useful to offer the program to faculty members who were not yet near retirement age. This would increase participation in the program and lessen the tendency for faculty members to define their professional life as over when they retire. Younger Physician-Teachers in their fifties, still very active in their medical schools, well motivated and looking at this project as a civic service, also joined as participating Physician-Teachers. (By definition, a Senior Consultant is not necessarily a retiree).

CONTINUING MEDICAL EDUCATION

The Directors of Medical Education repeatedly spoke of the need for continuing education in their hospitals and felt that the Senior Medical Consultants Program would enhance the continuity of their teaching. They felt that their present staff would benefit a great deal from repeated contacts with the Senior Medical Consultants. Many of the hospitals in New York City are also trying to include the local physician (i.e., those who are practicing in nearby areas, but not affiliated with any hospital) in their training programs and conferences.

Directors of Medical Education in these hospitals hope that the presence of new consultants might increase interest on the part of the local

doctors. They see the problem of Continuing Medical Education in relation to their own staff members and, in addition, in connection with the quality of medical care being given outside the hospital setting.

In most hospitals there is a continual problem of motivating the attending staff to participate in presentations and discussions. In these settings, the Directors of Education stressed that the Teacher-Consultant would have to be extremely well qualified and respected in his field, in order to overcome the generally low level of interest in presentations by outside men.

In summary, the responses from the hospitals were enthusiastic. Directors see this program as becoming either a major part of their teaching sequence or augmenting one already in existence. They feel that the introduction of Senior Medical Consultants, especially in the more disadvantaged smaller hospitals, will help to attract both American medical school graduates and additional attendings, thus helping to improve patient care.

ADMINISTRATION

After reviewing the Senior Medical Consultants roster, each hospital indicated interest by selecting the individual Physician-Teacher for specific dates and times. These were communicated by phone from the Director of Medical Education to the Senior Medical Consultants staff.

Although the physician in charge of medical education serves as coordinator for the hospital, each Chief of Service was actively involved in the timing sessions, the selection of the Physician-Teacher, subject

matter and teaching methods to be employed.

Hospital requests for specific consultants must be converted into confirmed arrangements. Telephone contact with all parties to the arrangement is essential. Most physicians in the New York Metropolitan Area have elaborate schedules. Very early in their relationship with the Senior Medical Consultants staff these schedules were noted to permit rapid contact when determining availability for teaching. Most retired faculty members have remained professionally active, which means that careful clearing of each date was essential.

In community hospitals it is not always possible to arrange to have patients with specific diseases available on the dates scheduled for Senior Medical Consultants Physician-Teacher visits. The hospital was expected to provide case presentations as a back-up for bedside rounds. Because of the broad experience as a clinical professor, each Senior Medical Consultants participant was prepared to branch out from his basic assignment to provide an appropriate program of medical education in his specialty.

RESPONSE OF MEDICAL STAFFS

Many questions had to be resolved in the minds of the attending staff in order to gain acceptance of the Senior Medical Consultants concept. It is not intended that the Physician-Teacher supplant the traditional role of the attendings on the medical staff or serve as their critic. Once it was clear that Senior Medical Consultants Physician-Teachers would not be conducting peer review or managing patient care while

conducting case conferences, the way was opened for trial programs.

A few of the directors felt that the perennial lack of "motivation" among staff members would, in all likelihood, continue to be a problem. That is, in some settings the house staff members are reluctant to attend conferences and specialty rounds presided over by in-house staff. Even outside consultants may fail to draw a substantial proportion of the staff. These directors felt that the consultants who might be involved with the program would have to be expert in their fields, be able to communicate well and effectively with staff members at all levels of training, and have personality characteristics which would allow them to "fit in" with the present hospital personnel hierarchy. Directors of Medical Education mentioned the possible problems that faculty members might face as they teach foreign medical school graduates. Obviously, this would depend on the teaching abilities of the consultant and the language abilities and learning attitudes of the foreign staff. In addition, foreign medical graduates vary a great deal in their educational backgrounds and medical abilities.

Another problem that we were repeatedly faced with is the disillusionment of the foreign medical graduates who staff many of our hospitals. Some of these interns and residents, to whom we extend our teaching services, came to the United States expecting to receive the best Continuing Medical Education in the world. They have been sorely disappointed in many of our non-affiliated hospitals. The Directors of Medical Education, as well as our Physician-Teachers have been finding that the apathy of many of these foreign medical graduates quickly turns into enthusiasm

when well motivated.

Some Directors of Medical Education felt that the Senior Medical Consultants teaching programs should not be instituted until well into the first training year, in order that the foreign graduates have some period of time to become adjusted to the hospital and educational environments. Also, because foreign graduates may not have the medical background common among American graduates, the hospitals may request that Physician-Teachers orient their presentations around a basic science course, rather than stressing the more esoteric knowledge.

EVALUATION

Flexibility in program goals was necessary, because of the variability found in teaching programs. In some hospitals, very little formal training is offered, whereas others do have an extensive teaching program in operation. Consequently, the needs of the hospitals vary widely, and it is imperative that the Physician-Teachers be prepared for these kinds of variations in expectations and practices.

Our approach to evaluation is to observe the subjective impact of a situation and attempt to generate a meaningful range of opinions and reactions. We feel that from all these sources, we can obtain a picture of the following:

1. how our teaching fits into established medical education programs;
2. how our teaching approach stimulates increased attendance, reaches greater number of physicians and generates a demand for updated medical knowledge delivered in their own community hospital;

3. whether the physicians attending the sessions feel they have acquired new knowledge and techniques they could utilize in the future; and
4. how Directors of Medical Education felt that our services updated, expanded and improved their hospitals' medical education programs.

We found that obtaining all of the above reactio[illegible]cessary because sometimes Directors of Medical Education are unconsciously protective of their own programs and may not be able to provide an accurate assessment; sometimes the physicians are too busy to give true reactions to a series of teaching sessions; sometimes they are expressing an overall frustration with being overworked rather than giving their specific reactions to our teaching services. The picture is too complex to understand through one measure. Therefore, we are trying to juxtapose these several assessments as a way of understanding the hospitals' needs; how our teaching resources are being utilized; how our services might be used better in a given hospital and what impact the services are having on these non-affiliated hospitals' medical education program.

The following are the measurement and evaluation techniques employed:

1. Patterned evaluations on each teaching session done both by the Physician-Teacher and the Director of Medical Education. Included in these evaluations are, for example, the following variables: description of presentation, content, type of cases selected, attendance level, (expected and actual) audience reaction and involvement, indication of further interest generated on the part

of hospital staff and the Physician-Teacher, shortcomings of the presentation, etc.

2. The evaluations of the impact of these teaching sessions done by house staff and attendings after a series of teaching sessions. These evaluations include such variables as: their perception of the quality and needs of their own Continuing Medical Education Program, how Senior Medical Consultants services fulfilled their needs; what requests for future consultations would be made by house staff and attendings; how relevant to current cases of house staff and attendings was the consultation program? Comparisons are then made of the house staff's and attending's evaluations as compared with the Directors' of Medical Education overall perspective and the Physician-Teachers' evaluation from his vantage point.
3. Another variable assessed is the changes in attendance levels at teaching sessions over a period of time.
4. Another assessment is whether participating hospitals establish with the Physician-Teachers a schedule, which would indicate if this kind of consultation program had been incorporated into the hospitals' Continuing Medical Education Programs.
5. Also recorded are requests from house staff and attendings to continue participation in the program.
6. Finally, qualitative assessment of a representative sampling of teaching sessions made through direct observations by the Senior Medical Consultants staff.

1. Teaching Activities

The number of participating hospitals obviously had to be limited in

our pilot project to 35. Our roster of Physician-Teachers, which is steadily increasing, is now 70. Table #1 shows the rate of expansion of teaching sessions provided by the Senior Medical Consultants. Totals for each quarter are shown as well as cumulative totals.

Limitations of funding has prevented our program from reaching its potential. The demand for services was greater than we could provide as seen by comparing the number of sessions "requested to date" in Table #2 with numbers actually scheduled and held. It should be noted that we are continuing to receive requests from new hospitals to which we cannot at present make any commitments since all resources under the current contract have been committed. Among these hospitals are the following:

New York State

New York State Rehabilitation Hospital (West Haverstraw, N.Y.)
Smithtown General Hospital (Smithtown, L.I., N.Y.)
Williamsburg General Hospital (Brooklyn, N.Y.)
St. John's Hospital (Smithtown, L.I., N.Y.)
Auburn Memorial Hospital - Oswego Medical Society (Auburn, N.Y.)
Community-General Hospital of Greater Syracuse (Syracuse, N.Y.)
Cuba Memorial Hospital (Cuba, N.Y.)
Glens Falls Hospital (Glens Falls, N.Y.)
Coney Island Hospital (Brooklyn, N.Y.)
The Gelder Medical Group (Sidney, N.Y.)
Hempstead General Hospital (Hempstead, N.Y.)

Interboro General Hospital (Brooklyn, N.Y.)

South Beach Psychiatric Center of Brooklyn (Brooklyn, N.Y.)

Lenox Hill Hospital (N.Y.C.)

Nursing Sisters of the Sick Poor (Brooklyn, N.Y.)

New Jersey

Perth Amboy General Hospital (Perth Amboy, N.J.)

Central General Hospital (Plainview, N.J.)

Overlook Hospital (Summit, N.J.)

Children's Specialized Hospital (Westfield-Mountainside, N.J.)

Other Areas

Green Cross General Hospital (Cuyahoga Falls, Ohio)

Leigh Memorial Hospital (Norfolk, Virginia)

The Silver Hill Foundation (New Canaan, Connecticut)

TABLE #1

TEACHING SESSIONS HELD TO DATE WITH

QUARTERLY AND CUMULATIVE TOTALS

YEAR	MONTH	TEACHING SESSIONS	TOTALS	CUMULATIVE TOTALS
1971	Aug.	14		
	Sept.	2		
	Oct.	11	27	27
	Nov.	17		
	Dec.	10		
1972	Jan.	19	46	73
	Feb.	17		
	Mar.	21		
	April	34	72	145
	May	23		
	June	27		
	July	13	73	218
	Aug.	14		
	Sept.	32		
	Oct.	38	84	302
	Nov.	32		
	Dec.	28		
1973	Jan.	32	92	396

TABLE #2

SUMMARY OF ACTIVITY BY HOSPITAL

FOR PERIOD AUG. '71 - JAN. '73

AS OF 1/31/73

HOSPITAL	Sessions Scheduled and Confirmed	Number of Months Scheduled	Sessions Completed	Requested to Date
Alexian Brothers Hospital	1	1	1	1
Beekman Downtown Hospital	6	5	6	7
Bergen Pines County Hospital	4	2	4	4
Bridgeport Hospital	6	2	6	6
Dover General Hospital	1	1	1	1
East Orange General Hospital	11	10	10	13
Elizabeth General Hospital	36	8	30	32
Englewood Hospital Assoc.	92	15	99	91
Flushing Medical Center	30	15	29	42
Community Hospital at Glen Cove	1	1	1	1
Grasslands Hospital	1	1	1	1
Greenwich Hospital	2	2	2	2
Hackensack Hospital	9	5	9	14
Helene Fuld Hospital	2	2	2	2
Interboro General Hospital	2	2	2	2
Jewish Memorial Hospital	9	7	9	13
Knickerbocker Hospital	34	16	32	34
Manhattan-Dunlap Psychiatric	1	1	1	1
Methodist Hospital of Brooklyn	3	2	3	2
Mountainside Hospital	1	1	1	1
New York Infirmary	9	9	8	9
New York Polyclinic	11	5	10	11
Orange Memorial Hospital	5	5	4	5
Rockland Children's Hospital	39	10	30	33
St. Clare's Hospital	17	14	14	17
St. Mary's Hospital	31	11	27	29
St. Michael's Hospital	6	3	6	8
St. Vincent's - Staten Island	5	4	3	5
Sydenham Hospital	38	16	38	7
Vassar Brothers	5	5	5	5
White Plains Hospital	1	1	1	1
TOTAL:	419	182	395	470

2. Evaluation and Achievement

The program has been evaluated independently by the Physician-Teachers; by physicians attending the sessions, both attending staff and house staff; and by physicians scheduling the teaching session (usually department chairmen or directors of medical education). Evaluation methods have included written reports, interviews and observation of teaching sessions. From the outset of our project, each session has been independently evaluated. Information obtained regularly and rapidly has enabled us to provide prompt guidance to all participating hospitals, as well as physicians, thereby enabling us to increase the effectiveness of the program.

1. Of the total sessions held to date, 70.5% were evaluated. There was an increase in the number of sessions that were primarily clinical to 84%. This progress has been the result of our emphasis upon clinical teaching and case presentations as the most effective modality for Continuing Medical Education. Also, the preference expressed in the evaluation forms by both the Physician-Teachers and all participants, has been for clinical conferences.

2. 95% of the participating hospitals expressed great satisfaction with the interest generated among their physicians attending the sessions.

3. The average attendance was increased to 22 per session. The attendance range was 7 to 75. Variables influencing the attendance are the type of teaching programs, numbers of approved residencies and sophistication of the clinical conference.

4. Satisfaction, which is expressed by the number of hospitals

which continue to participate in the program and their request for particular Physician-Teachers to return, has been very high (95%).

5. Rather than house staff officers alone being responsible for preparation of cases to be presented at clinical conferences, many attending physicians are becoming involved currently in approximately 20% of the cases. This is possibly due to increasing interest among attendings in Continuing Medical Education.

6. During clinical sessions two or three cases are routinely presented. The average length of time for the previous 168 sessions reported was close to two hours. While this average time is unchanged, it is interesting to note that nearly all of the 22 of 84 sessions held this quarter, which were longer than two hours, were clinical sessions.

7. We have requested more complete briefings for the Physician-Teachers from the participating physician preparing the session to increase benefits to all participants. It increased satisfaction to the Physician-Teacher who could contribute more and generate greater interest among the attending and house staff. Physician-Teachers who felt the briefing was exceptional increased from 17% previously to 23% in the current quarter. Those whose briefing was adequate increased from 75% to 76%.

8. 18 of 22 participating hospitals re-engaged the same Physician-Teacher. This finding appears to indicate that lasting Physician-Teacher hospital relationships are being developed through goals initially stipulated for the program.

9. In 167 evaluated teaching sessions, 17% had no case presentation, while 83% utilized clinical cases. In 62% of these, only house

staff were responsible for the cases presented, however, 21% of the time the attending physicians were responsible for case demonstration, either alone or in collaboration with the house staff. Although no conclusions are warranted from this finding, it does seem to indicate increased involvement of attending physicians in the Continuing Medical Education programs where Senior Medical Consultants have been introduced. Many Directors of Medical Education previously reported little involvement of their attending physicians. This phenomenon warrants further observation in the future.

10. In those teaching sessions involving clinical presentations, the average number of cases was 2.4.

11. Of sessions evaluated to date, the average length of the sessions was 1.8 hours.

12. Of the sessions evaluated by the Physician-Teachers, they felt that their medical briefings prior to each session were: Inadequate - 8%, Adequate - 75%, Exceptional - 17%.

13. The average age of the participating Physician-Teachers is 67, with a range from 50 to 80 years.

14. The average percentage of time our consultants spent teaching in medical schools prior to their retirement from medical schools was 5% to 60%, with an average of 23.4%. Therefore, we are utilizing the services of men and women who are partially retired and consequently still active in practice and research. These physicians are still involved in an active professional life.

3. Reactions of Medical Groups

The program received enthusiastic responses from all groups that were contacted, including the New York Academy of Medicine, the American

Academy of Family Physicians, the Metropolitan and New Jersey Regional Medical Groups, the Medical Society of the County of New York, and others. Further letters have been received from other areas asking for information about the project (e.g., Kansas City, Chicago, Las Vegas, North Carolina, Halifax, Nova Scotia, France and Belgium).

In the early part of January, 1972, ten hospitals in several cities of Arizona and numerous medical groups and Directors of Continuing Medical Education were visited. A group of 110 physicians in Sun City were addressed, among them were recently retired medical teachers from major medical schools of different parts of the country, including the Mayo Clinic. Many of them expressed the desire to become participants as soon as a program could be established in their state. Dr. James L. Grobe, President of the Arizona State Medical Society and Past President of the American Academy of Family Physicians, expressed strong hope that such a program could be initiated in his state.

Early patterns in hospital demands for our services indicate the following causes for our success: word-of-mouth endorsements made by one hospital to another; the hospitals growing confidence in our teaching services as they witness the enthusiasm generated among their house staff and attending physicians; several journal articles and laudatory newspaper articles; many public endorsements by Medical Societies, the American Hospital Association, eminent, nationally known medical educators, the former president of the American Medical Association, and by health advocates in the United States Congress. A period followed of rapid expansion and dramatic results in many hospitals which reported the positive impact of Senior Medical Consultants services on their

medical education programs. Some of these hospitals have been so enthusiastic about the long-range potential of this project that they have taken it upon themselves to seek out local newspaper publicity. Excitement generated in some of these hospitals has led to the occurrence of hospitals encouraging nearby hospitals to also seek out Senior Medical Consultants services.

Interest in the concept of enhancing Continuing Medical Education in non-affiliated hospitals was recently expressed by the Medical Society of the State of New Jersey in the form of an endorsement of our program.

Articles describing the Senior Medical Consultants Program have appeared in the following publications:

American Medical News, Wesley W. Hall, AMA, 2/14/72

Continuing Medical Education Newsletter, "New Role for Retired Faculty Members", J.M., 11/70

The Evening Times, Dr. John P. West, Helene Fuld Hospital, 9/20/72 Trenton, N.J.

Hospital Medical Staff, "Innovation in Inhouse Education", 5/72

The Journal of the Medical Society of New Jersey, "An Innovation in Continuing Medical Education" , 4/72, Vol. 69, Pg. 345-348

Medical Society of County of Queens, 7/71

Medical Tribune, 12/20/72

Medical World News, "Consultants (Emeritus) Reach Out", 1/7/72, pg. 29

National Institutes of Health Record, 6/7/72, Vol. XXIV, No. 12

New York Medicine, "The Senior Medical Consultants Program", 9/71, Vol. XXVII, No. 9

The New York Times, "Doctors Briefed by Ex-Professors", Nancy Hicks, 4/23/72

Stethoscope, "A Means of Utilizing Retired Talent: Dr. Moldaver's Senior Medical Consultants", 2/72, Vol. XXVII, No. 2

4. Incorporation of Senior Medical Consultants as a Non-Profit Organization

An attempt to make the organization financially sound was the securing of certification under Section 501(c) (3) of the Internal Revenue Code as a non-profit organization, effective September 29, 1972. This could enable us to solicit donations from private donors. It will also help us to work toward membership in the National Health Council and the many benefits of cooperative relationships with other health agencies. We realize that being incorporated and not having a long range support from some National agencies, our program could collapse despite its recognized high value.

SUMMARY

The above findings indicate that Senior Medical Consultants has been and will continue to be a dramatic success story. An unmet need has been found; and an untapped resource is being utilized to partially fulfill that need. Although it cannot yet be conclusively stated that Senior Medical Consultants directly results in improved health care delivery, it does appear to be a reasonable assumption.

Continued research and support in this area is planned. However, expanded funding of Senior Medical Consultants by government, private foundations and participating hospitals will be necessary.

Experiences of the past year dictate that plans should be developed

to become a national organization with regional and/or state chapters. Furthermore, Senior Medical Consultants must find the necessary resources to service many more hospitals within the tri-state area, as well as extending more teaching sessions to presently participating hospitals.

Furthermore, the impact of Senior Medical Consultants on a regional basis will be felt in response to the need for well qualified Physician-Teachers as Continuing Medical Education can be very effective in community hospitals. Regional development and coordination by Senior Medical Consultants will enable all non-affiliated community hospitals in a region to have access on a demand basis to a roster of excellent teachers, who are available for a small honorarium to complement their Continuing Medical Education Programs.

In addition to these long-range goals, plans are being discussed with several hospitals for the use of our Physician-Teacher services in their out-patient programs. Many participating community hospitals concur with the belief that out-patient clinics in community hospitals are health care delivery sub-systems in need of clinical teaching programs. Out-patient clinics deliver health care to the majority of residents by a hospital's physicians who would perhaps benefit from Continuing Medical Education most effectively in this setting.

Senior Medical Consultants as supportive to comprehensive clinics should enable them to function as coordinated units, eventually avoiding hospitalization, capable of diagnosing and treating the whole patient in a manner at least equal to the care extended to hospitalized patients.

The comprehensive clinic program is also an extension of our efforts in Continuing Medical Education and to have teaching done where it is most effective, in the clinical setting, and this should apply to the too often neglected out-patient departments in the great majority of hospitals affiliated or not.

A selection of a limited number of out-patient departments is contemplated as a pilot study for comprehensive medical care. This could be proven to be successful in some of the hospitals which have already shown great interest in our current program.

The Only Independent Medical Newspaper in the U.S.

Medical Tribune

CURRENT OPINION

Senior Medical Consultants

Why Waste Valuable Clinical Experience?

By JOSEPH MOLDAVER, M.D.
New York

WE ARE FACING A DILEMMA today which is really a paradox. We in the medical profession fight to provide additional healthy years for each person, but when that individual attains the age of 65, the second part of the paradox occurs: we retire people and cast them aside.

In these times, when the way we deliver health care services is being severely questioned, and when continuing education of physicians tends to become mandatory, we must ask ourselves: How can we utilize the talents of dedicated physicians who have held responsible teaching positions until they were 65 years old? We say there is an answer.

How would you like to have a clinical professor of medicine or surgery or a professor of pathology as a teacher in your continuing medical education program, and for consultation on clinical rounds, and to lend his varied expertise to your residents and house staff? Highly motivated physicians who were formerly respected teachers in the different fields of medicine have formed a group known as Senior Medical Consultants (SMC). These SMCs are recently retired faculty members whose skills, competence, experience, and wisdom are an untapped source of wealth for hospitals and clinics that are not affiliated with medical schools. Here are distinguished physicians, available on a regular basis for clinical conferences or rounds. Our objectives for the group are:

1. To provide clinical consultants or physician-teachers to hospitals not affiliated with medical schools—in any department.

2. To provide outpatient departments and clinics with the same type of expertise.

3. To assist hospitals and clinics to become small teaching centers.

4. To provide an opportunity to bring SMCs to the patient's bedside, and to present at clinical conferences the hospitalized patient, as well as some cases selected from outpatient departments.

SMC is currently funded by NIH as a pilot project. It is functioning in 32 hospitals in the New York–New Jersey–Connecticut area. There are 68 clinical consultants involved, and the response by participating hospitals has been one of steady demand.

The SMCs themselves have an advisory council of younger, yet-to-be-retired people from all lines of the health care spectrum, from the clinical professor of medicine to an executive hospital director to a president of a medical society.

The SMC physician is not chosen by a hospital to conduct peer review, be a critic, or manage patient care while conducting case conferences. The hospital selects the individual physician-teacher whom it feels will be of most benefit. Briefings prior to engagement are held, so that the best possible preparation can be undertaken by the physician-teacher. After each period of attendance there is an evaluation by both the physician-teacher and the hospital. This is accomplished by means of a questionnaire and an interview. There is a token honorarium for the clinical session (two to three hours) paid for under the group's NIH contract.

We believe that over-all evaluation of the project will show the following:

1. The period of some hospitalizations could eventually be shortened.

2. The number of tests per patient could be reduced.

3. Fewer visits to outpatient departments could be expected.

We also feel that in many instances a complete diagnostic work-up could be achieved and that therapeutic advice given in the outpatient departments could avoid some hospitalizations.

One could also expect that, by using the expertise of the SMC, the strength of an outpatient department, or even a hospital department, could be enhanced significantly. This would finally result in better care in the community hospital, especially in ghetto-area hospitals, where chronic shortages of staff and unbearable burdens on clinics and outpatient departments are endemic.

SINCE THERE IS SUCH a tremendous need in hospitals throughout the country for the services of outstanding, knowledgeable physicians, the SMC program could provide men who are authorities in their fields. The hospital taking part in the program can achieve a university-quality educational level without its staff having to travel to a medical center. The program is also beneficial to the foreign physicians who make up a large part of our house staff.

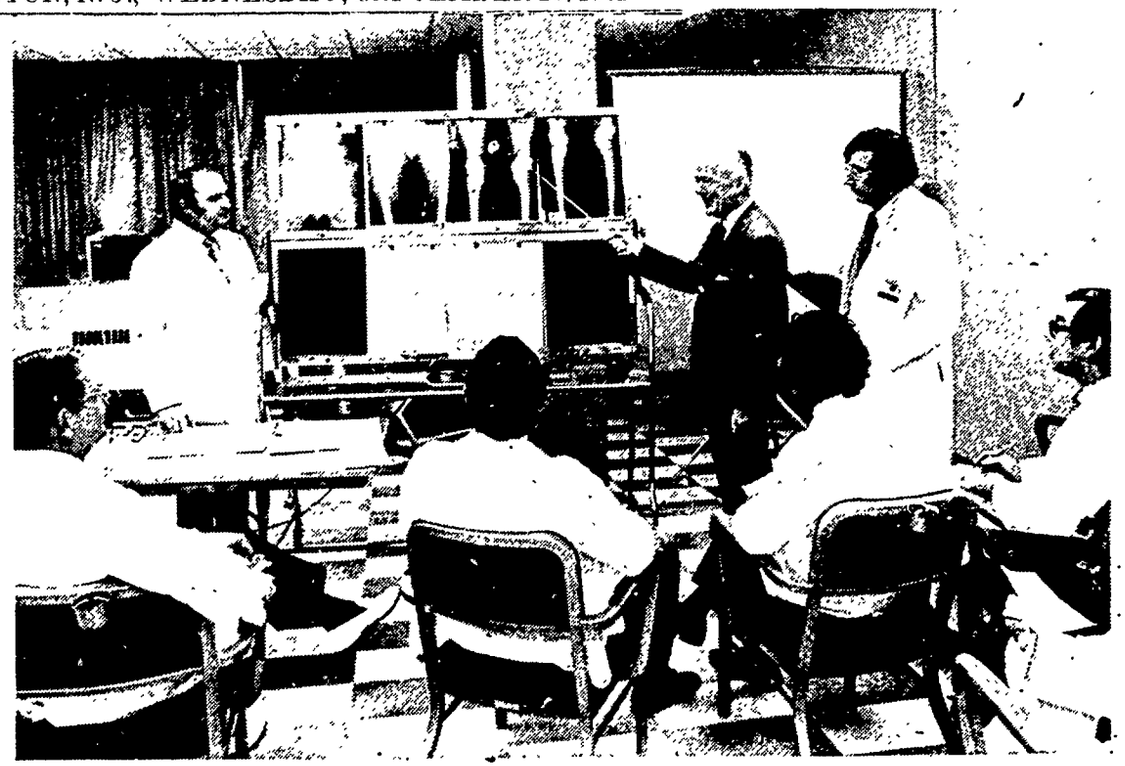
The SMC program is flexible, to conform to the needs of the utilizing hospital. Its members are available for diagnostic or management duties, for help in the introduction of new approaches and methods; as aides in creating small teaching centers, to participate in clinical conferences, to make ward rounds, attend outpatient clinics, and to bring teaching-center expertise to outlying institutions.

With the willingness of the SMCs to "fill gaps," to complement existing programs, and to expand services, the wasteful policy of retirement at 65 will be reversed, and we will be able to return healthy, energetic, motivated, and knowledgeable physicians, clinicians, and teachers to the service of the health care field. In a time of dire need for health skills, this program provides one way out of the current paradox.

Inquiries from directors of medical education, hospital administrators and interested faculty members are welcome, and should be addressed to Joseph Moldaver, M.D., Director, Senior Medical Consultants Program, 140 East 54th Street, New York, N.Y., 10022, or to the Administrative Office of Senior Medical Consultants Program, St. Barnabas Hospital, Third Avenue and 183rd Street, Bronx, N.Y., 10457.

65 And Out? Not For MDs

Group of N.Y. Professors Still Serve Medicine And Suburban Hospitals



Dr. John P. West, a retired physician from New York, makes a point on an x-ray to younger doctors at Helene Fuld Hospital. Flanking him are Dr. Lester Robbins (left) and Dr. Stanley Gould.

By GLEDHILL CAMERON
Staff Writer

THERE WERE FOUR large x-rays on the light screen at the front of the room. A member of the medical staff of Helene Fuld Hospital glanced at papers in front of him and detailed a case history. Another staff member gave a technical description of the x-rays.

The room full of interns (white coats, white pants), externs (white coats, suit pants) and other hospital staff members leaned forward to hear the next speaker. Dr. John West, surgeon of New York, is a slight man with grey hair whose soft voice and slight southern accent failed to fully account for the keen attention

For the young doctors in his audience this was a special opportunity, made possible by a year-old program.

DR. WEST CAME to the Trenton hospital as one of some 50 physicians in New York participating in an innovative program called Senior Medical Consultants

It is the brain-child of Dr. Joseph Moldaver, clinical professor of neurology at Columbia Presbyterian Hospital.

At most medical schools, no matter how eminent or successful a teacher, doctors are required to give up their teaching roles when they reach 65. They may continue as special lecturers, in addition, of course, to maintaining active private practices.

BUT DR. MOLDAVER thought that this great reservoir of over-65 medical expertise could be tapped to much better effect if such men could provide badly needed top-notch teaching for hospitals outside the city, but within a reasonable area particularly at the non-university affiliated community hospitals.

Dr Moldaver interested a number of colleagues, such as Dr West, in his idea The program began last September with a grant of $150,000 from the National Institute of Health.

The "retired" medical professors travel to three states, New York, Connecticut and New Jersey. Dr. West, who visited a hospital in Patterson four times last year, and is scheduled for five seminars there this year, says hospitals an hour to an hour-and-a-half traveling time away is the maximum range.

"CONTINUING EDUCATION" is the name of this medical game, and the Senior Medical Consultant program is a way to take it into suburban hospitals, close to the homes of the doctors.

Faculty status, reputation as a doctor and teacher and the desire to continue teaching were the criteria used in inviting physicians to participate in the project.

Using the clinical conference as the teaching method, members of the Senior Medical Consultants are expected to supplement the regular teaching program of a hospital staff. It is carefully pointed out, however, that the SMC is not intended to supplant the traditional role of the resident staff or to serve as its critic, since the physician-teacher does not conduct peer review or manage patient care while conducting case conferences.

The Evening Times

Wednesday 47
September 20, 1972
90th YEAR — No. 243

The NIH

U S DEPARTMENT OF
HEALTH, EDUCATION AND WELFARE

Record

June 7, 1972
Vol. XXIV, No. 12

NATIONAL INSTITUTES OF HEALTH

Retired Med. Professors Hold Clinical Seminars In Unaffiliated Hospitals

A cadre of retired medical professors is helping to offset the shortage of medical instructors in isloated hospitals that are not affiliated with universities.

The group, called Senior Medical Consultants, was formed by Dr. Joseph Moldaver, a neurologist and a former professor at the Columbia University College of Physicians and Surgeons. Dr. Moldaver is now director of Neuropsychiatry at Saint Barnabas Hospital, N.Y.C.

50 Doctors Are Involved

The innovative project, sponsored by the Division of Physician and Health Professions Education, BHME, consists of 50 doctors who have given seminars in 20 hospitals throughout New York, New Jersey, and Connecticut.

In describing the program which is now in its second year, Dr. Kenneth M. Endicott, BHME Director, said, "It not only provides a relatively inexpensive way to teach house staff but is also an excellent vehicle for getting continuing education into suburban hospitals near the homes of many physicians."

senior medical consultant: innovation in inhouse education

by Marvin M. Wedeen

The unaffiliated teaching hospital is an integral part of our medical education system. It is charged not only with training interns and residents but also is expected to provide continuing education for attending staff. A volunteer teaching staff provides the foundation for this training. Because of the varying degrees of knowledge, activity, and teaching experience of local hospital staffs, differences in educational effectiveness exist, as evidenced by recent surveys of house staffs.*

Birth of SMC

Addressing himself to the challenge of improving medical training for house staff in unaffiliated hospitals, Joseph Moldaver, M.D., clinical professor of neurology at Columbia University, New York City, sought to place a unique reservoir of professional talent at the disposal of these hospitals. As Dr. Moldaver approached retirement age, his desire to continue teaching, coupled with a belief in the use of bedside rounds and clinical conferences as effective teaching methods, prompted him to establish the Senior Medical Consultants (SMC) program; the purpose of the program is to supplement the medical education of the house and attending staffs in community hospitals.

An advisory council composed of prominent hospital administrators, nationally known physicians, and medical school faculty members representing many disciplines, guided

*Goldberg, J. L. Training that disenchants house officers. *Hosp. Physician* 7:60 May 1971.

Marvin M. Wedeen is assistant administrator of Sewickley (Pa.) Valley Hospital.

Reprinted from THE HOSPITAL MEDICAL STAFF
Volume 1
May 1972
Printed in U.S.A.

the development of a philosophy and formulation of a blueprint for utilizing retired and near-retired teachers.

Feasibility study

For 11 months, under contract with the National Institutes of Health, the consultants studied the feasibility of engaging medical school faculty members from the Greater New York Metropolitan Area who, as they approached retirement, had time available for outside activities; 50 physicians at the clinical professor level agreed to conduct at least one teaching session monthly.

Equipped with a list of nationally recognized teachers proficient in major areas of medical education, members of the SMC staff attempted to determine the degree of interest in the program evinced by directors of medical education in unaffiliated hospitals. The services of these physician-teachers were offered to hospitals with the understanding that a token honorarium of $100 would be paid to the consultant through NIH funding for a one-year implementation and evaluation program. This funding was necessary because many hospitals operated under fiscal constraints, and economic considerations might have prevented a fair test of hospital interest.

Positive responses from 9 of 16 hospitals queried initially indicated that their needs varied from an occasional guest lecturer to an urgent need for six hours a week of bedside teaching.

The Senior Medical Consultants program has contracted for 75 per cent of its 200 funded teaching sessions. During the first 30 days of operation, 13 sessions were held at 6 hospitals in Connecticut, New Jersey, and New York; 19 hospitals are actively developing schedules to utilize SMC physician-teachers during the remainder of the year.

Program implementation

Experience to date indicates that a number of key factors must be considered before a hospital will accept the concept of SMC.

Recognition and credibility. Through the establishment of a knowledgeable advisory council, coupled with distribution of news releases and personal interviews with hospital administrators and directors of medical education, it is possible to have the SMC program placed on the agenda of medical education committees of community hospitals. This recognition is imperative for the success of the program.

Acceptance. Each hospital must make its own decision regarding its needs for supplementing present teacher staffing and its willingness to utilize SMC participants. There are many questions that must be resolved by the attending staff in order to accept the SMC concept. The physician-teacher is not intended to supplant the traditional role of the attending staff or to serve as its critic. Once it is clear that SMC physician-teachers do not conduct peer review or manage patient care while conducting case conferences, the way is opened for trial programs.

After reviewing the SMC roster, each hospital indicates its interest by selecting individual physician-teachers for specific dates and times. This information often is confirmed by phone with the hospital's director of medical education after orientation and phone interviews by the SMC staff.

Although the physician in charge of medical education serves as coordinator for the hospital, each chief of service is actively involved in the timing of sessions and in the selection of the physician-teacher, the subject matter, and the teaching methods to be employed.

Processing requests. Hospital requests must be converted into confirmed arrangements; telephone contact with all parties to the arrangement is essential. Most retired faculty members remain professionally active and follow elaborate schedules, making careful confirmation of each date essential.

All booked teaching sessions are confirmed verbally and by a "letter of understanding" sent to the hospital and the physician-teacher. It is expected that, as host, the hospital will contact the teacher to confirm the subject of the conference for placement on the hospital calendar. Each teacher is briefed by phone on the hospital and its teaching programs to familiarize him with the environment he will enter. Because most hospitals are insured for malpractice under a blanket policy, the physician-teacher's visit would be covered in the sa
other guest lecture

In community
always possible to
specific diseases
dates scheduled f
teacher visits. Th
pected to provide
as a back-up for
Because of his bro
clinical professor,
pant is prepared t
his basic assignm
comprehensive pr
education in his sp

Evaluation and f
hospital and the
are asked to comp
tionnaire recordin
and initial reaction
the evaluation,
honorarium is issu
which in turn pa
teacher.

Evaluati

Techniques for
gram impact now
it is anticipated t
and interviews wi
termine the progr
teacher, student,
cian, and hospital

Initial comment
fessors suggest tha
may prove to be
house staff enthus
of the teaching b
teacher comment
dance was most s
group evinced an
ceeded my most

programs.
ing the SMC roster,
ndicates its interest by
idual physician-teach-
dates and times. This
ten is confirmed by
hospital's director of
tion after orientation
terviews by the SMC

e physician in charge
ucation serves as co-
he hospital, each chief
tively involved in the
sions and in the se-
physician-teacher, the
r, and the teaching
employed.
requests. Hospital re-
e converted into con-
ments; telephone con-
parties to the arrange-
al. Most retired faculty
ain professionally ac-
w elaborate schedules,
l confirmation of each

teaching sessions are
bally and by a "letter
ing" sent to the hospi-
physician-teacher. It is
, as host, the hospital
he teacher to confirm
of the conference for
the hospital calendar.
is briefed by phone on
and its teaching pro-
liarize him with the en-
e will enter. Because
s are insured for mal-
r a blanket policy, the
che would be

covered in the same manner as any other guest lecturer.

In community hospitals it is not always possible to have patients with specific diseases available on the dates scheduled for SMC physician-teacher visits. The hospital is expected to provide case presentations as a back-up for bedside rounds. Because of his broad experience as a clinical professor, the SMC participant is prepared to branch out from his basic assignment to provide a comprehensive program of medical education in his specialty.

Evaluation and follow-up. Both the hospital and the physician-teacher are asked to complete a short questionnaire recording pertinent details and initial reactions. Upon receipt of the evaluation, a check for the honorarium is issued to the hospital, which in turn pays the physician-teacher.

Evaluating program impact

Techniques for evaluating program impact now are being tested; it is anticipated that questionnaires and interviews will be used to determine the program's reception by teacher, student, community physician, and hospital administrator.

Initial comments from some professors suggest that their satisfaction may prove to be a barometer of house staff enthusiasm for the skill of the teaching being offered. One teacher commented: "The attendance was most satisfactory and the group evinced an interest which exceeded my most sanguine expectations. Following the formal talk, I invited an open discussion and question period. This also exceeded my expectations, particularly since most of it emanated from the resident staff."

The SMC staff was curious to learn of the hospital's reaction to this same teaching session. It came a few days later in the form of an invitation to the teacher to conduct eight additional teaching sessions in his field, along with an invitation for eight teaching sessions to be conducted by professors from other specialty fields.

Planning for the future

There now is a need to determine how to continue the program. The immediate goal of SMC is to prove that there are educators available to meet the teaching needs of hospitals' inpatient and ambulatory care programs. Once these needs are met, SMC plans to determine the elements and format necessary to expand its present program and initiate similar programs throughout the country. Although continuing medical education traditionally has emphasized the study of inpatients, SMC hopes to provide an opportunity for physicians to improve ambulatory patient care. With the growing consciousness of the need for out-of-hospital patient care, instruction cannot be complete if case studies are limited to the period of patient confinement in the hospital.

The opportunity to provide unaffiliated or loosely affiliated hospitals with the talents of men normally clustered around academic medical centers presents a new concept in expanding the quality of medical education. By exporting university teaching practices to the suburban, rural, and poor urban unaffiliated teaching hospitals, a new ingredient can be added to these teaching programs that should make recruitment of house staff easier and serve to improve the quality of patient care in these hospitals. Another objective is to effect more uniform distribution of U.S. medical school graduates who at present are clustered in the affiliated hospitals.

An equally important aim of the SMC program is the revitalization of continuing medical education in hospitals that have been unsuccessful in stimulating interest on the part of the attending staff. Exposure to master teachers through case conferences and bedside rounds should provide an attraction worthy of the physician's time.

Motivation

The senior physician-teacher is motivated by his desire to help his fellow physicians extend their knowledge through continuing education. The case conference that may develop into a one-hour or two-hour discussion is an exciting experience in learning stimulated by the interaction of facts and minds. Both teachers and physicians agree that didactic classroom-style lectures no longer are effective, making it necessary for the senior physician-teachers to ap-

ply modern teaching methods, augmented by their experience and wisdom.

Further information about this program may be obtained from Joseph K Moldaver, M.D., director, Senior Medical Consultants, St. Barnabas Hospital for Chronic Diseases, 183rd St. and Third Ave., Bronx, N.Y. (212) CY 5-2000, ext. 215. □

THE NEW YORK TIMES, SUNDAY, APRIL 23, 1972

20 L

DOCTORS BRIEFED BY EX-PROFESSORS

Retired Group Works Among Hospital Practitioners

By NANCY HICKS

A cadre of retired medical professors is going into hospitals in New York, New Jersey and Connecticut to help doctors keep abreast of developments in their fields in a hospital setting.

The group, called Senior Medical Consultants, was formed by Dr Joseph Moldaver, a neurologist who taught for years at the Columbia University College of Physicians and Surgeons, and who is director of neuro-muscular service at the Hospital for Special Surgery.

The group consists of 50 doctors who, since September, have given seminars in 20 hospitals in the three states. It is financed by a $150,000 grant from the National Institutes of Health.

The idea for the program came from Dr. Moldaver, who saw it as a relatively inexpensive way to use medical experience in teaching younger doctors. It was also seen as a way to get continuing education into suburban hospitals, near the homes of many physicians.

They 'Don't Stop Thinking'

"So many medical schools have compulsory retirement ages for their professors," said Dr. Moldaver, who is "more than 70," "but people don't stop thinking because they are retired."

Most of the senior medical consultants are still very active themselves. Like Dr. Moldaver, they still continue their private practice and lecturing at their universities.

The program is being praised in medical-education circles as the subject of continuing education for doctors receives more attention.

The New Mexico state legislature passed a law requiring doctors to receive 120 hours of such continuing education over a three-year period in order to retain their licenses.

Medical societies in four other states require 150 hours of continuing education over a three-year period—about one hour a week.

Hospitals interested in the program may write to the Manhattan office, 140 East 54th Street, for a list of specialists. The hospital makes arrangements with the individual consultant, who tailors a seminar to the needs of the hospital staff, and both parties then

Reprinted from THE JOURNAL of
The Medical Society of New Jersey
April, 1972, Vol. 69, No. 4, Pp. 345-348

Here is an innovative approach that could make a community hospital a real teaching agency.

An Innovation in Continuing Medical Education

The Senior Medical Consultants Program
Grant Loavenbruck, M.S.W., Research Director
Joseph Moldaver, M.D., Director, New York

Continuing medical education, the springboard for quality medical care today, is sorely in need of innovative change. Traditionally the medical schools have been the foci for the intern's, resident's, and attending physician's continuing medical education. The health care structure has become so complex (and the other demands made upon the medical schools have become so burdensome), however, that an increasingly larger role in continuing medical education must befall the community hospital. Is your community hospital equipped to meet this challenge?

The Senior Medical Consultants Program, sponsored by National Institutes of Health (NIH), Bureau of Health Manpower Education, is attempting to disseminate teaching expertise from university medical centers to non-affiliated community hospitals, add a previously underutilized medical manpower resource to the medical education milieu, and generate noteworthy, relevant continuing medical education when and where the practicing physician will use it. Compulsorily retired and near-retired faculty members from medical schools in New York, New Jersey, and Connecticut were selected according to rigorous criteria as the underutilized manpower resource for this pilot project. Their faculty status, eminent reputations, and desire to continue teaching, especially where most needed, were the characteristics which made them the most logical manpower choice for this program. These physician-teachers are acting as consultants to selected community hospitals, engaging in patient presentations and informal discussions with house staff members and attendings several times over the course of an academic year. They are serving as educational adjuncts to existing continuing medical education programs.

Need for Change

In the area of continuing medical education a marked shortage and maldistribution of quality physician-teachers already exists. This shortage and maldistribution will worsen as responsibility for offering CME courses continues its present trend of shifting from the medical schools to non-affiliated hospitals. In 1962-1963, medical schools offered 55 per cent and hospitals offered 9 per cent of the CME courses; in 1971-1972 medical schools offered 38 per cent of the CME courses and hospitals offered 26 per cent.[1] We see, therefore, that the creation of physician-teacher manpower resources to staff these non-affiliated hospital CME programs satisfies a growing critical need. Many of these non-affiliated hospital CME programs currently count on the teaching services of their own attending staff. Senior Medical Consultants Program is designed to supplement these existing medical education programs.

The American Association of Medical Colleges Committee on the Expansion of Medical Education called for "diminished dependence upon the importation of foreign trained M.D.'s[2]." Until then, however, our non-affiliated hospitals have the yet unattained goal of better education of these foreign physicians, both for the good of the many patients they serve here and for the health of the doctors' own countrymen. Exceptional, high quality physician-teachers are necessary for this difficult task—men who can both impart complex medical knowledge and move beyond cultural barriers. Many of the Senior Medical Consultants have extensive teaching

[1] "Medical Education in the U.S.—1970-71" in JAMA, Nov. 23, 1971, Vol. 218, No.8
[2] AAMC Committee Report, *Journal of Medical Education*, 46:105-116, 1971

experience with foreign medical graduates. One particularly encouraging sign that the CME programs of these non-affiliated hospitals will be upgraded in the near future is the increase in the proportion of hospital directors of medical education (DME) who are full-time personnel. Sixty-four per cent of all DME's are now full-time.[3] It is with these physicians that the SMC staff and the consultants themselves most often communicate and coordinate their teaching activities.[4]

Today we need to extend medical education into ghettos, rural areas, and suburbs, which do not have medical school professors readily at their disposal, but do have to deliver health care. With the galloping complexity of medical-technologic advances, the question remains, however, how do we entice these practicing physicians to continue their medical education? There are little or no legal or professional requirements for them to meet, once they have passed their state boards.[5] Numerous methods for the non-affiliated hospital are available in this respect, but the method with the most lasting impact would seem to be "the recruitment of qualified physician-teachers."

Innovative programs such as Senior Medical Consultants might be a step in the right direction toward negating the need for such a coercive tactic as compulsory education for attending physicians.

Participating Hospitals

This program, which started only four months ago, has been functioning in nineteen hospitals; hospitals in which teaching sessions have already been requested and scheduled and/or held, thus far. There is excellent potential for scheduling sessions in more hospitals at the present time. Some preliminary review of the data on these 19 hospitals indicates the following:

1. They are all medium-sized hospitals (the mean size is 347 beds).

2. They have minimal or no affiliation with a medical school.

3. All but one have at least 80 per cent of their house staff who are foreign medical graduates.

4. Of the nineteen hospitals, eight are in New Jersey, nine are in New York State, and two in Connecticut —located in suburban areas, urban areas, and ghettos.

5. Of the nineteen hospitals, three serve a primarily high income population, three a primarily low income population and thirteen a "mixed" income population.

6. All of the participating hospitals state a need to improve their medical education programs in a wide range of specialties; mostly in internal medicine, rheumatology, pediatrics, surgery, obstetrics, gynecology, pathology, psychiatry, neurology, and radiology.

7. All of these hospitals have directors of medical education, twelve of whom are part-time and seven of whom are full-time.

8. Some of the participating hospitals already have well developed continuing medical education programs with medical school professors consulting, but these hospitals were so impressed with the high quality of the Senior Medical Consultants that they requested inclusion of a particular specialty or sub-specialty in their own programs.

The Physician Teachers

Faculty members are from medical schools in New York, New Jersey, and Connecticut who are approaching or who have reached a predetermined retirement age. Many of these faculty members wish to continue teaching and being near retirement have increasing time and interest to devote to hospital education programs. Their status as faculty members ensures that their teaching and communicating skills have been highly developed.

The project's list of participating physician-teachers is still expanding due to a continuous recruitment program, the basis of which has generally been the attractiveness of the concept itself. The number of physician-teachers so far stands at 44. Multiple specialties are represented in an outstanding list of talent including internal medicine, obstetrics, gynecology, ophthalmology, pathology, pediatrics, psychiatry, radiology, rehabilitation

[3] Medical Education in the U.S., 1970-71, *op, cit.*
[4] See Vaun, W. and Leonard, J., article—"The Director of Medical Education" in *The Medical Staff in the General Hospital,* McGraw-Hill, New York, 1967, and Letourneau. Charles, *The Hospital Medical Staff,* Starling Publ., Chicago, 1964, for detailed descriptions of the roles of DME's.
[5] In recent years, however, a few states have legislated such requirements. Perhaps this represents the foundation of a future national trend.

medicine, surgery, and genetics. The majority of these physician-teachers are committing themselves to between two and four sessions per month. This pool of medical educators is confined to those who have the title of professor, associate, or assistant professor, and who have had extensive experience in teaching, diagnostic work, and research. These physician-teachers, in keeping with the medical tradition, believe in the use of clinical conferences with case presentations as the most direct and effective way of enhancing continuing medical education. These physician-teachers are continuously engaged in the process of up-dating their own and their students' medical knowledge, thus making them doctors of the future not of the past.

Evaluation and Follow-up

Both the hospital and the physician-teacher are asked to complete a short evaluation to record salient facts and reactions to each teaching session. Upon receipt of the evaluation, a check for the honorarium is issued to the physician-teacher.

Description of Consultation Services

Physician-teachers are contributing to the programs by being available for meetings several times a month, rather than by presenting only a single lecture at a hospital. In this way, working relationships are developing between them and the hospital staff members. There is more potential, consequently, of involving those attendings and local physicians who do not usually participate in continuing education programs. Some physician-teachers are able to participate in clinical conferences only a few times a year; more commonly the pattern is for them to offer their services much more often, perhaps up to two or three times a week. Those with sufficient time are rotating among several hospitals, visiting each one weekly. The program is flexible to accommodate the needs of both hospital programs and physician-teacher's schedules. The program provides a token honorarium for each session (about two to three hours). The teaching activity is considered by the physician-teachers as a civic service. These teachers are not to supplant private consultants. They are not involved in any peer function. The program is flexible enough to conform to the needs and desires of the utilizing hospital and these men could participate as desired or requested in the diagnosis or management of complex cases, in the introduction of new approaches and methods, and aid in the creation of small "teaching centers." They participate in clinical conferences and ward rounds and, in general, bring teaching center expertise to outlying institutions. The outstanding feature of this innovative teaching program is that it delivers the expertise of medical schools directly to the practicing physician in relation to the patients who are most relevant to him—his own.

Evaluation

The evaluation of this program will fall into one of the following categories: (1) *hospitals'* CME needs, (2) *physician-teacher manpower* resources for meeting these needs, (3) *utilization,* and (4) *impact* of program. Data relevant to the program will be acquired from the reactions of directors of medical education, chiefs of services, hospital residents, interns, and attendings to those hospitals, and from the physician-teachers. The staff of senior medical consultants is beginning to gather pertinent data through a variety of evaluation mechanisms, data of both quantitative and qualitative natures.

Conclusion

While university hospital and medical school complexes are the main teaching centers, the activities of physician-teachers in this program will contribute to the development of small teaching centers in community hospitals which do not have this type of activity. The dissemination of teaching resources may, in time, help hospitals to attract house staff members with a wider variety of backgrounds than is now the case. In sum, a continued healthy competition between non-affiliated hospitals and those affiliated with medical schools may very well enhance the educational and health service systems.

Perhaps the real contributions of such an innovation as Senior Medical Consultants can be summarized best in some of the words of participating hospitals and physicians.

One teacher commented: "The attendance was a most satisfactory one, and I enjoyed being with the group very much, because they evinced an interest which exceeded my most sanguine expectations. Following the formal talk, I invited an open discussion and question period. This also exceeded my expectations, particularly since most of it emanated from the resident staff." The Senior Medical Consultants' staff was curious to learn of the hospital's evaluation of the same teaching session. It came a few days later in the form of an invitation to the same teacher to conduct eight additional teaching sessions in his field, plus a separate invitation for eight teaching sessions to be conducted by teachers from another specialty field. Another hospital evaluating the same physician-teacher wrote: "Your adjectives should have included 'excellent'. Dr. . . . captivated everyone. Age has done nothing to his volume of knowledge or familiarity with modern medicine. He was just a joy."

An Advisory Council for the Senior Medical Consultants Program has been formed, consisting of leading clinicians, educators, administrators and leaders in the health fields (their names are listed below*). Council members have been meeting regularly over the past ten months to formulate program policies.[6]

*Advisory Council, Senior Medical Consultants (S.M.C).

Dana W. Atchley, M.D.
Jeremiah A. Barondess, M.D.
David P. Barr, M.D.
Addison Bennett
Detlev W. Bronk, Ph.D.
Andre Cournand, M.D.
A. Wilbur Duryee, M.D.
Richard H. Freyberg, M.D.
Frank Glenn, M.D.
George H. Humphreys II, M.D.
W. Graham Knox, M.D.
John T. Kolody
Joseph Moldaver, M.D.
Robert L. Patterson, M.D.
Howard A. Rusk, M.D.
Frank E. Stinchfield, M.D.
L. Ramsay Straub, M.D.
Peter B. Terenzio
Irvin G. Wilmot
Irving S. Wright, M.D.
Harry M. Zimmerman, M.D.

[6]Inquiries from directors of medical education, hospital administrators and interested faculty members are welcome, and should be addressed to Joseph Moldaver, M.D., Director, Senior Medical Consultants Program, 140 East 54th Street, New York, 10022 (phone: 212-838-6047); or the Administrative Office of Senior Medical Consultants Program, St. Barnabas Hospital, Third Avenue and 183rd Street, Bronx, New York 10457 (phone: 212-295-2000).

AMERICAN MEDICAL news

FEBRUARY 14, 1972

Wesley W. Hall, MD

"Surely there are enough tasks in our society to utilize older people while not denying job opportunities to the young."

Key role urged for elderly MD

Consigning people to a park bench just because they've turned 65 is an arbitrary notion that needs to be reshaped, said Wesley W. Hall, MD, president of the American Medical Association, who gave the annual Walter L. Bierring lecture at the meeting of the Federation of State Medical Boards.

Dr. Hall noted that Dr. Bierring, AMA president in 1934-35, was active in medicine until his death at 92.

"If such men as Walter Bierring did nothing more than share their experiences with youth," Dr. Hall emphasized, "it would be significant."

Dr. Hall said, "Surely there are enough tasks in our society to utilize older people while not denying job opportunities to the young."

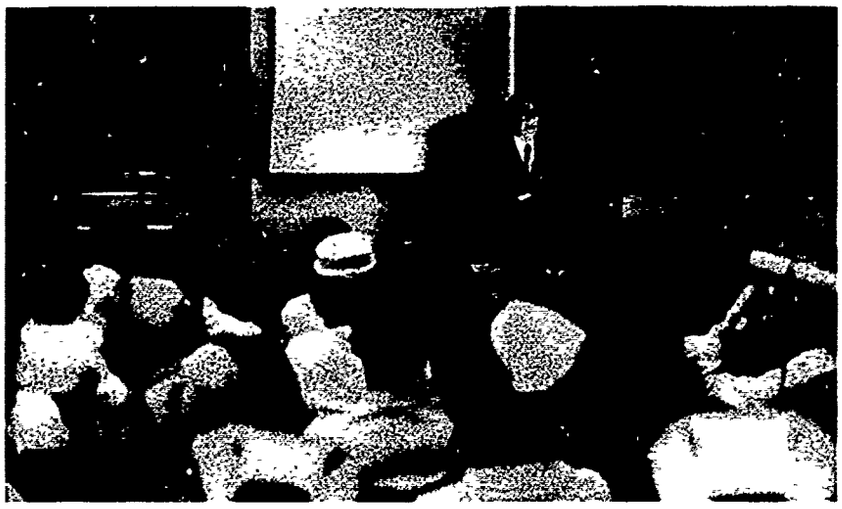
He continued, "A new project in the medical profession admirably demonstrates what can be done. It is called Senior Medical Consultants, and it was developed by Dr. Joseph Moldaver (of New York) . . . Looking around, he discovered that community hospitals without university affiliation had trouble attracting outstanding men to their continuing education programs. Dr. Moldaver sought out his fellow retirees—and now 35 of them visit 14 hospitals in the greater New York area to share their experience and expertise."

Earlier, Dr. Hall declared his pride in the achievements of the AMA and the federation, although, he said, "we still have much to do." He cited such activities as the Federation Licensing Examination (FLEX), the high quality of health care, and the emphasis on continuing medical education and peer review.

Further, Dr. Hall continued, "The AMA has led efforts to get more federal support for our medical schools. Efforts culminating in the new Health Manpower Act which greatly expands such aid and is geared to turning out more physicians at a faster pace must be cited.

"On our own, through the AMA-Education and Research Foundation, we have guaranteed more than $50 million in loans to medical students, interns, and residents—and recently we started a special interest-free loan project for especially needy students.

"We have advocated, and seen, increases in the number of woman medical students and those from minority groups."



Tapping the teaching talents of Cornell's Dr. Nathanson, Flushing Hospital typifies new community hospital program.

Consultants (emeritus) reach out

Retired medical professors bring top education to the hustings

The conference room at Flushing (N.Y.) Hospital and Medical Center was jammed to standing-room-only capacity for a recent lecture on OB-Gyn aspects of venereal disease. There were two unusual things about the meeting: the identity of the speaker and his auspices.

He was Dr. Joseph N. Nathanson, clinical professor emeritus of OB-Gyn at Cornell University Medical College. And he had been brought to a community hospital situated at the outer reaches of the city—well beyond the end of the subway line—through a new program called Senior Medical Consultants.

The program is the brainchild of Dr. Joseph Moldaver, a lively septuagenarian who had to step down as associate clinical professor of neurology at Columbia when he reached mandatory retirement age, and who is by no means ready for the boneyard yet. Whatever the merits of medical school mandatory retirement rules may be, Dr. Moldaver believes that they leave a great deal of first-class teaching talent lying around loose. At the same time, community hospitals that don't have university affiliations find it difficult to attract outstanding men to their continuing education programs. Why not bring the two together?

So almost single-handedly he started the Senior Medical Consultants Program, assembled an advisory board of distinguished names, got a grant from the National Institutes of Health, and began rolling this fall. Now members of a panel of about 35 consultant-teachers are visiting 14 hospitals in the New York area, including suburban Connecticut and New Jersey.

The fact that Dr. Nathanson lectured is unusual; most of the presentations are of clinical material and discussion of cases, Dr. Moldaver says. Doctors in the audience frequently describe patients of their own, of course, and the visiting teacher is available for consultation, if asked. "But we're not involved in peer review," Dr. Moldaver cautions. "We're not there to criticize the attending doctor or to manage his patient."

The program has great advantages for both sides, he believes. It offers the retiring teacher a way of changing his career smoothly; because of the plan's flexibility, he can devote to it as much or as little time as he chooses. (Not all of the consultants are changing careers yet, a few active teachers well below retirement age are enthusiastic enough about the program to give some time to it.)

The hospital gets men who are not only outstanding authorities in their fields, but who have also demonstrated teaching ability. Its staff gets university-quality education without having to travel to a medical center, a feature that should increase attendance. Dr. Moldaver believes the program to be especially beneficial to foreign medical graduates, who comprise probably the majority of house staff in the New York area's community hospitals.

Dr. Louis J. Delli-Pizzi, thoracic and cardiac surgeon who is Flushing's director of medical education, agrees. (Most of his 15 interns and 29 residents are FMGs.) He finds the Senior Consultants a rich augmentation to his extensive education program. "You can't teach if you don't practice," he says. "That's why these fellows are so great; they have a wealth of clinical experience."

Dr. Delli-Pizzi has been using the principle of the program right along; several of his own "regulars" are retired. But he is so enthusiastic about Senior Consultants that he sold two other hospitals on the program.

The consultants receive an honorarium of $100 per hospital visit, which is paid from the NIH grant. Dr. Moldaver has received inquiries about the program from all over the country, and even from abroad. After any "bugs" have been worked out locally, he hopes to see programs established nationwide. He believes their worth will be so demonstrable that financing will not be a serious problem.

He has already learned one curious thing: to avoid the word "professor." "For some strange psychological reason, some people resent it," he says. "Perhaps they felt oppressed by the faculty when they were back in medical school. In any case, when we come in, we're not professors. We're consultants." ■

AMERICAN MEDICAL ASSOCIATION
Continuing Medical Education Newsletter, November, 1970

SENIOR MEDICAL CONSULTANT: NEW ROLE FOR RETIRED FACULTY MEMBERS

Joseph Moldaver, M.D., of the Columbia University College of Physicians and Surgeons, and the Hospital for Special Surgery which is affiliated with the New York Hospital-Cornell University Medical College, has developed a project which would utilize the skills, competence, and experience of recently retired faculty members of medical schools. Such retired faculty members would be appointed as Senior Medical Consultants for Continuing Education in hospitals and clinics which are non-affiliated with medical schools. Depending on the needs of the hospital they served, they would be available on a regular basis for consultations and clinical conferences or rounds.

Among the purposes of the project are to:

1. Provide clinical consultants or physician-teachers to hospitals non-affiliated with medical schools, in any department where needed.
2. Provide out-patient departments and clinics with the same type of expertise.
3. Assist hospitals and clinics to become small teaching centers.
4. "Provide an opportunity to bring /Senior Medical Consultants/ to the patient's bedside, and to present at clinical conferences the hospitalized patient, as well as some cases selected from out patient departments."

Provision would be made that such Senior Medical Consultants would be appointed on a courtesy basis, with his role being specifically that of a Consultant for the hospital only.

The S.M.C. project is sponsored by the National Institutes of Health and is being conducted in two phases. The first, which is in progress, is for a period of eight months, ending February, 1971. Data is being compiled on hospitals in critical need and on physician-teachers recently retired from academic duties. The second phase will be the actual implementation of the program. It is believed that evaluation of this project would show that:

1. The period of some hospitalizations could eventually be shortened.
2. The number of tests per patient could be reduced.
3. Fewer patient's trips to out-patient departments could be expected.

"It is furthermore strongly felt that in many instances, a complete diagnostic work-up could be achieved, and the proper therapeutic advice given in the out-patient departments, avoiding on occasions unnecessary hospitalizations. One could also expect that by using the expertise of the /Senior Medical Consultant/, the strength of an out-patient department, or even a hospital department, could be enhanced and eventually be placed on a par with University-affiliated hospitals. This would finally also result in better care of the sick." A great deal of interest and enthusiasm has already been shown for this project, and the chances of it becoming a nationwide program are very great.

St. Barnabas Hospital for Chronic Diseases in New York is administering this program with Joseph Moldaver, M.D., as Project Director. For further information, write to:

The Stethoscope

News of the COLUMBIA-PRESBYTERIAN MEDICAL CENTER

VOLUME XXVII, NUMBER 2 FEBRUARY, 1972

A Means of Utilizing Retired Talent:

Dr. Moldaver's Senior Medical Consultants

A neurologist's brain wave six years ago is now giving new impetus to many retired teachers of medical schools and is shortening the hospitalization of many patients.

The neurologist, Dr. Joseph Moldaver, had been aware for some time of the "great waste of talent" caused by the mandatory retirement of professors by medical schools. Dr. Moldaver himself is retired from teaching at the College of Physicians and Surgeons. He maintains a private practice of neurology, although he is listed as "inactive" among the Associate Attending Neurologists at Presbyterian Hospital. He was formerly Associate Clinical Professor of Neurology, P&S.

In 1965, Dr. Moldaver conceived of a program that would use the skills and the experience of recently retired faculty members of medical schools. These talented persons could become Senior Medical Consultants for Continuing Education at hospitals and clinics that do not benefit from affiliations with medical schools.

The Senior Medical Consultants, or SMC's, would serve as clinical consultants or physician-teachers in any department where needed, including out-patient departments and clinics. They could also assist hospitals and clinics to become small teaching centers.

Through their presence as consultants at the patient's bedside and through their contributions to clinical conferences involving both the hospitalized patient and the outpatient, the SMC's would be instrumental in shortening the period of some hospitalizations, in reducing the number of tests per patient, and in obviating some out-patient visits.

Further contemplating the potential contribution of SMC's, Dr. Moldaver felt that in many instances, a complete diagnostic work-up could be achieved, and the proper therapeutic advice given in the outpatient departments, avoiding on occasions unnecessary hospitalizations.

Convinced of the viability of his idea, Dr. Moldaver began to recrui leading medical educators as members of an advisory board. Today there are 24 doctors and hospital administrators on the board, including Dr. Detlev Bronk, Honorary President of Rockefeller University.

Dr. Frank Stinchfield, Director of Orthopedic Service, PH, and Chairman of the Department of Orthopedic Surgery, P&S, who is another member of the board, has predicted that the SMC program may become "one of the most important contributions to medicine that has been made in years."

In July 1970, Dr. Moldaver's project began to receive operating funds from the National Institutes of Health. The first phase of the federally financed program consisted of compiling information on hospitals in crucial need of consultants and of drawing up a list of consultant teachers.

Dr. Moldaver reports that the second, or assignment, phase is now in progress — and that SMC's are already helping nineteen community hospitals in the tri-state area, including Englewood and Hackensack, New Jersey.

Cautioning that the program is still being considered a "pilot project" on a local scale, Dr. Moldaver nevertheless emphasizes that it has generated much enthusiasm and that it has a good chance of assuming national proportions.

As director of the project, Dr. Moldaver invites interested physicians to telephone him or to write to him for additional information. His telephone number is 838-6047 and his address is 140 East 54th Street, New York, New York 10022.

The Senior Medical

Consultants Program

An Innovation in Continuing Medical Education

A new program in Continuing Medical Education has been initiated and is being sponsored by the National Institutes of Health. It offers several innovative features and promises to become one avenue toward some future changes in the health care structure. Entitled *Senior Medical Consultants,* the program's goals are to disseminate teaching expertise from university medical centers to community hospitals, add a previously underutilized source of manpower to the medical education field, and improve the educational resources and opportunities available to practising physicians in local areas.

Faculty members from medical schools in New York, New Jersey and Connecticut who are approaching or who have reached retirement age are the participants. Many of these faculty members wish to continue teaching and, being near retirement, have an increasing amount of time and interest to devote to hospital education programs. Their status as faculty members ensures that their teaching and communicating skills have been highly developed. They will act as Consultants to selected community hospitals, engaging in patient presentations and informal discussions with house staff members and attendings, several times over the course of an academic year. They will therefore serve as educational adjuncts to existing programs, supplementing teaching expertise in hospitals and locales where they are needed.

It is planned that Consultants will contribute to educational programs by being available for meetings several times a month, rather than presenting only a single lecture at a hospital. In this way, working relationships can develop between the Consultants and the hospital staff members. There is more potential, consequently, of involving attendings and local physicians who do not usually participate in Continuing Education Programs. Some Consultants will be able to participate in clinical conferences only a few times a year; more commonly the pattern will be for Consultants to offer their services much more often, i.e., up to two or three times a week. Those with sufficient time could eventually rotate among several hospitals, visiting each one weekly. The program is designed to be as flexible as possible in this regard, in order to accommodate the needs of both hospital programs and Consultants' schedules. The participants will be paid an honorarium for each session (about two–three hours).

It should be emphasized that the faculty members will act as educational consultants to the hospitals at the request of the directors of medical education in accord with their department heads. The Consultants, in choosing to participate, are all considering their roles in terms of civic service rather than as a means of furthering income. Since participants will be selected on the basis of their medical expertise, teaching ability and motivation, acceptance into the program will signify both a recognition of past achievements and a promise of future ones.

The ultimate goal of any change in medical education is to improve patient care. Consultants in this program will be requested, if possible, to participate in out-patient departments as well. We hope that the addition of various kinds of specialists in educational roles may reduce hospitalization costs and further the quality of patient care in these departments.

While university hospital and medical school complexes are the main teaching centers, the activities of Consultants in this program will contribute to the development of small teaching centers in community hospitals which do not have this type of activity. The dissemination of teaching resources may, in time, help hospitals to attract house staff

Reprinted from N.Y. Medicine
Vol. XXVII. No. 9. September 1971
The official publication of
The MEDICAL SOCIETY of the COUNTY of NEW YORK

members with a wider variety of backgrounds than is now the case. In sum, a continued healthy competition between non-affiliated hospitals and those affiliated with medical schools may very well enhance the educational and health service systems.

Many Continuing Education Programs are centered in the affiliated hospitals, requiring that interested participants travel from their areas to these other centers. Unfortunately, evaluations of many programs show that those physicians least in need of Continuing Education are most apt to participate partly due to the programs' locations. The present plan is innovative in that it provides a sustained interaction with educators "on the spot"——that is, in the physician's own hospital, with patient presentations and discussions geared to his individual needs. This strong local orientation should increase attendance and commitment among the hospital staff. It will be possible to develop working relationships not only with the staff members but also with the attendings and local physicians who do not usually participate in educational programs.

This will introduce a new source of needed health manpower. At a time of urgent need in medical education and health care delivery, the waste of talent should not go unheeded. The faculty members can still offer many years of useful service to this civic enterprise, and the Senior Medical Consultants Program aims to reduce some of this present waste of knowledge and talent.

The program has been funded to date by the Bureau of Health Manpower Education of the National Institutes of Health. Data on community hospitals in the three states have been gathered, including information on present training programs, staff sizes, and other factual material. Interviewing has begun in approximately twenty-five of these hospitals, which were chosen on the basis of location, size and patient population. The names of prospective Consultants have been obtained from the relevant medical schools. At this point, interviews are continuing, and medical directors and administrators are being asked to specify their educational and training needs. The faculty members are also requested to list their areas of academic interest for the program.

The implementation of the program, namely the second phase, will commence in August, 1971, in hospitals in the three states of New York, New Jersey and Connecticut. Medical directors and Consultants are now discussing the most feasible schedules in each hospital, along with specifications of the training areas most in need of supplementary teaching and case presentations.

The program has already generated a great deal of interest from educators in other states, as well as abroad. Understandably, medical students, interns and residents are also interested in the success of this approach, since they see most directly the discrepancy in teaching quality between affiliated and non-affiliated hospitals.

The increasing emphasis on inter-organizational cooperation in health care delivery and the dispersion of health facilities to various community locales will bring about some of the needed changes in the medical profession and the availability of care to all groups in the population, particularly the underprivileged. It is our aim to facilitate these changes through innovations in Continuing Education.

An Advisory Council for the Senior Medical Consultants Program has been formed, consisting of leading clinicians, educators, administrators and leaders in the health fields (their names are listed below*). Council members have been meeting regularly over the past ten months to formulate program policies. Inquiries from directors of medical education, hospital administrators and interested faculty members are welcome, and should be addressed to Joseph Moldaver, M.D., Director, Senior Medical Consultants Program, 140 East 54th Street, New York, N.Y. 10022 (phone: 212 838-6047).

* Advisory Council, SENIOR MEDICAL CONSULTANTS (S.M.C.):
Dana W. Atchley, M.D.
Jeremiah A. Barondess, M.D.
David P. Barr, M.D.
Mr. Addison Bennett
Andre Cournand, M.D.
Joseph Delaney, M.D.
A. Wilbur Duryee, M.D.
Richard H. Freyberg, M.D.
Frank Glenn, M.D.
George H. Humphreys II, M.D.
W. Graham Knox, M.D.
Mr. John T. Kolody
Samuel Z. Levine, M.D.
Robert L. Patterson, M.D.
Howard A. Rusk, M.D.
Frank E. Stinchfield, M.D.
L. Ramsay Straub, M.D.
Mr. Peter B. Terenzio
Mr. Irvin G. Wilmot
Irving S. Wright, M.D.
Harry M. Zimmerman, M.D.

BULLETIN

Medical Society of the County of Queens, Inc.

for the month of
July, 1971

SENIOR MEDICAL CONSULTANTS

There is a program in Continuing Medical Education — called — **Senior Medical Consultants**, funded by NIH, Bureau of Health Manpower Education, aimed at the utilization of selected and recently retired faculty members of Medical Schools as Senior Medical Consultants in non-affiliated hospitals.

These men are not to supplant private consultants; there will be no compulsory mechanism for the use of the group and they will not be involved in any peer review function. The program is flexible, to conform to the needs and desires of the utilizing hospital and these men could participate as desired or requested in the diagnosis or management of difficult cases; in the introduction of new approaches and methods; aid in creating small "teaching centers"; they could participate in clinical conferences, ward rounds and consultations and, in general, bring teaching center expertise to outlying institutions.

For further information; contact: Joseph Moldaver, M.D., Director
Senior Medical Consultants Program
140 East 54th Street, New York 10022