

SEPT 14 1967
COTH EXECUTIVE
COMMITTEE MEETING

COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
1346 Connecticut Avenue, N.W.
Washington, D.C. 20036
202/223-5364

Meeting of the Executive Committee (No. 67-3)
Thursday, May 11 and Friday, May 12, 1967
at the Hotel Dupont Plaza
1500 New Hampshire Avenue, N.W. (Dupont Circle)
Washington, D.C. 20036

Present:

Stanley A. Ferguson, Chairman
Lad F. Grapski, Chairman-Elect
Russell A. Nelson, M.D., Immediate Past Chairman and COTH
Representative to the AAMC Executive Council
Matthew F. McNulty, Jr., Secretary, Director, COTH and
Associate Director, AAMC
LeRoy E. Bates, M.D., Member
Ernest N. Boettcher, M.D., Member
Charles H. Frenzel, Member
Charles R. Goulet, Member
T. Stewart Hamilton, M.D., Member
Dan J. Macer, Member
LeRoy S. Rambeck, Member
Lester E. Richwagen, Member
Richard D. Wittrup, Member
Robert C. Berson, M.D., Executive Director, AAMC (Friday,
May 12, 1967 only)
Cheves McC. Smythe, M.D., Associate Director, AAMC (Thursday
evening, May 11, 1967 only)
Joseph M. Merrill, M.D., Chief, GCRC Branch, NIH (Thursday
evening, May 11, 1967 only)
Frederick N. Elliott, M.D., Director, Bureau of Professional
Services, AHA (an invited participant)
Augustus J. Carroll, Assistant Director, AAMC Division of
Operational Studies (Friday, May 12, 1967 only)
Miss Grace W. Beirne, Staff Assistant
Mrs. Jean A. Rozett, Staff Assistant
Mrs. Henrietta Jones, Executive Secretary

Group of Teaching Hospital Administrators -- (Friday morning, May 12, 1967
only)

Leonard W. Cronkhite, Jr., M.D., Children's Memorial Medical Center,
Boston, Mass.
Nelson F. Evans, University Hospital, Boston, Mass.

F. Lloyd Mussells, M.D., Peter Bent Brigham Hospital, Boston, Mass.
Mitchell T. Rabkin, M.D., Beth Israel Hospital, Boston, Mass.
Lewis H. Rohrbaugh, Ph.D., Boston University Medical Center
Richard T. Viguers, New England Medical Center Hospital, Boston, Mass.

Absent: None

II. Call to Order

The evening meeting was called to order at 8:15 p.m. by Stanley A. Ferguson, Chairman. A reception and dinner starting promptly at 6:00 p.m. preceded.

III. Introduction of New Staff Members

Miss Grace W. Beirne, Staff Assistant (Effective April 1, 1967)

Mrs. Henrietta Jones, Executive Secretary (Effective February 1, 1967)

Mrs. Jean A. Rozett, Staff Assistant (Effective February 1, 1967, to return to Boston as of July 31, 1967)

IV. Presentation: Activities of GCRC, Joseph M. Merrill, M.D., Chief of the GCRC Branch, Division of Research Facilities and Resources, NIH

Doctor Merrill presented a description of the activities of the General Clinical Research Center Branch (A copy of the presentation is attached as Addendum #1 and made part of the permanent file of these minutes.) Two items of particular interest were discussed with no definitive action concerning the first at this time. First, the "recapture" possibilities with relation to the original (1960-1964) 85=15 reimbursement formula. Secondly, the FY 1968 total CRC operating appropriation need was estimated

by NIH at approximately \$40,000,000 as compared with the Administration-budgeted figure of approximately \$30,000,000.

ACTION #1: AGREEMENT THAT THE DIRECTOR AND STAFF SHOULD DEVELOP AN EDUCATIONAL APPROACH TO CONGRESS AS TO CONTRIBUTION OF GCRC PROGRAM AND THE NEED FOR ADEQUATE SUPPORT WITHOUT PENALTY FOR BOTH THE VOLUNTARY CONTRIBUTION OF SPACES AND RESOURCES TO INITIATE THE PROGRAMS AND THE "START-UP" COSTS THEREIN INVOLVED.

V. Presentation: Activities of AAMC-Evanston Office, Cheves McC. Smythe, M.D., Associate Director, AAMC

Dr. Smythe gave a summary of the basic programs of the AAMC which are operational at the Evanston office, including: the accreditation of medical schools, publication of the Journal of Medical Education; other publications; National Intern Matching Program; other programs and, of particular interest to COTH, the combined Evanston-Washington program for development of computer capability.

VI. Recess

Following the presentation of the two program activities and the ensuing discussion, Chairman Ferguson recessed the meeting at 10:00 p.m. until 8:30 a.m., Friday, May 12.

VII. Reconvene

Chairman Ferguson reconvened the meeting of the Executive Committee at 8:30 a.m. in the Gallery Room of the Hotel Dupont Plaza. Roll

call of the previous evening and the morning session indicated attendance at both sessions as noted previously in these minutes.

VIII. Approval of Minutes of Executive Committee Meeting No. 67-2, Thursday, January 11 and Friday, January 12, 1967

The minutes of the meeting of January 11, 1967, the second meeting of the Executive Committee for the administrative year 1966-1967, held at the Dupont Plaza Hotel, Washington, D.C., January 11 and January 12, were approved as presented.

ACTION #2: VOTED APPROVAL OF MINUTES OF JANUARY 11-12, 1967, MEETING OF EXECUTIVE COMMITTEE.

IX. Informal Report of Income and Expense

Mr. McNulty reported that COTH was solvent. The operation for the 1966-1967 fiscal year (July 1, 1966 through June 30, 1967) would be completed "in the black." He indicated that the annual financial statements for the AAMC, including COTH would be completed in time for the October 27 COTH Executive Committee meetings. He indicated that the availability of the financial statement was related to the speed with which the national accounting firm employed by the AAMC would accomplish the annual audit for the fiscal year ending June 30.

X. Dues Payment Inquiry by Several Hospitals

Mr. McNulty reported that several hospitals, including two in the Boston area, had protested mildly as to payment of dues, indicating

disappointment at the corresponding inability to cast a vote for policy decisions executed and funded from dues payment revenue. He indicated that undoubtedly several of these institutions would increase the intensity of the protest. There was general discussion relating to the history of the present voting mechanism whereby voting on all matters except election of officers is restricted to the chief executive officer of one institution as he is designated by each dean of an AAMC institutional member medical school. The historical development concerning COTH voting privileges was reviewed briefly for it was well understood. Though no action was proposed at this time, several members of the Committee expressed the belief that there is now a clear understanding of the partnership objectives of the Council and the AAMC which should make it possible to initiate a one-vote-for-one-hospital policy.

XI. Need to Review Rules and Regulations for Reasons Other Than Dues Payment and Voting

From the foregoing discussion there arose an informal review and discussion of the present rules and regulations for eligibility for nomination as a member of COTH. There was a general agreement that the present rules and regulations probably defined the total membership at the level at which it now exists -- namely, in the neighborhood of 300 to 350 teaching hospitals. There was also general agreement that these rules and regulations should be reviewed, though the opinion was expressed by several committee members to which there was general agreement, that the matter not

be pursued at this time. Rather, it was believed that the matters of representation to the Executive Council and hospital member voting privileges be explored first and settled before discussing any change in the admission criteria.

XII. Report on Results of Executive Committee Mail Ballot of March 6, 1967

A mail ballot which had been circulated on March 6, 1967, bringing to the attention of the Executive Committee, for decision, the applications for membership from six hospitals were discussed. Mr. McNulty reported the results of the mail ballot had been unanimous for approval of the four hospitals listed hereafter. The Chairman suggested that the matter now be reviewed again by the Executive Committee. If there was continued concurrence then the minutes of this meeting should then record approval of the mail ballot as well as confirmation of membership of the four institutions. It was further agreed that if approved for membership, these four hospitals would be billed at one-half annual dues as their membership commenced in the latter half of the fiscal year.

ACTION #3: VOTED THAT THE FOUR HOSPITALS BE CONFIRMED UNANIMOUSLY AS ORIGINALLY APPROVED ON THE MAIL BALLOT.

1. The Brookdale Hospital Center -- Brooklyn, New York (institution application, affiliated with Columbia University)
2. Veterans Administration Center -- Dayton, Ohio (nominated by Richard L. Meiling, M.D., Dean, Ohio State University School of Medicine)

3. Veterans' Administration Hospital -- Boston, Massachusetts
(nominated by Franklin G. Ebaugh, Jr., M.D., Dean, Boston University School of Medicine)
4. U.S. Public Health Service Hospital -- Seattle, Washington
(nominated by John R. Hogness, M.D., Dean, University of Washington School of Medicine)

XIII. New Applications for Membership (to be billed for fiscal year 1967-1968 and not for 1966-1967)

Two institutions (A.4 and B.5 hereafter) were also on the mail ballot of March 6, 1967, but for each institution some question was expressed on the return ballot so no action as to membership was taken. Subsequently, applications were received from seven other institutions, as noted below. Three of the hospitals more recently applying were nominated by a dean and four applied under the criteria of meeting the internship and residency requirements.

- A. Nominated by a Dean (4)
 1. Veterans' Administration Hospital, Louisville, Kentucky
 2. Madison General Hospital, Madison, Wisconsin
 3. Lafayette Charity Hospital, Lafayette, Louisiana
 4. Conemaugh Valley Memorial Hospital, Johnstown, Pennsylvania (originally on mail ballot of March 6, 1967)
- B. Applying as Having Met Internship and Residency Criteria (5)
 1. San Joaquin General Hospital, Stockton, California
 2. Hermann Hospital, Houston, Texas
 3. Mount Sinai Hospital, Milwaukee, Wisconsin
 4. Saint Joseph's Hospital, Baltimore, Maryland
 5. Children's Hospital and Adult Medical Center, San Francisco, California (originally on mail ballot on March 6, 1967)

ACTION #4: VOTED APPROVAL FOR MEMBERSHIP OF HOSPITALS LISTED IN A.1. THROUGH A.4. AND B.1 THROUGH B.4.

ACTION #5: VOTED TO DEFER ACTION ON CHILDREN'S HOSPITAL AND ADULT MEDICAL CENTER UNTIL SUCH TIME AS THE INSTITUTION WAS EITHER NOMINATED BY A DEAN OR COULD IN SOME OTHER WAY MEET THE MEMBERSHIP CRITERIA.

XIV. Review of Hospitals Favorably Considered by Which Have Not Paid Dues

Mr. McNulty requested recommendations from the Executive Committee as to the procedure to be followed for hospitals which had been favorably considered for membership in the initial announcement stage of the spring or summer of 1966, but which hospitals subsequently had not paid dues for the fiscal year 1966-1967.

ACTION #6: IT WAS VOTED THAT THESE HOSPITALS BE CONTACTED INFORMALLY ONCE AGAIN. IF THEY DID NOT EVIDENCE A SPECIFIC INTENT TO REMIT MEMBERSHIP DUES AT AN EARLY DATE, THE INSTITUTIONS SHOULD BE DROPPED FROM THE MEMBERSHIP LIST.

XV. The Modernization of Teaching Hospital Facilities; Group of Teaching Hospital Administrators from Boston, Massachusetts

The preliminary results of a study accomplished by the Group (COTH general informational memoranda 67-7 and 67-8) entitled Urgent Need of Hospitals (Especially Teaching Hospitals) for Construction Funds representing Teaching Hospitals of Boston, Massachusetts (updated to July 20, 1967) -- (Copy of statement presented at this meeting by several of the "Boston Group" and made part of the permanent file of these Minutes) -- were discussed.

ACTION #7: IT WAS VOTED THAT COTH ESTABLISH A SUB-COMMITTEE OF THE COTH GOVERNMENT RELATIONS COMMITTEE, FOR THE PURPOSES OF EXAMINING, EVALUATING AND RECOMMENDING ACTION ON THE FINANCING FOR THE MODERNIZATION NEEDS OF TEACHING HOSPITALS AND FURTHER THAT SEVERAL OF THE "BOSTON GROUP" SERVE AS A NUCLEUS OF THE SUB-COMMITTEE.

XVI. Pilot Study of Educational Costs in Teaching Hospitals (Yale-New Haven Hospital Study) A. J. "Gus" Carroll, Assistant Director, Division of Operational Studies, AAMC

The Chairman called upon Mr. Carroll to bring the Executive Committee up to date on his pilot study of educational costs in teaching hospitals. Mr. McNulty mentioned, by way of introduction, that this item had been on the agenda for the COTH Executive Committee Meeting in January, 1967. He also indicated that replies had been received from several of the COTH Executive Committee members concerning the three chapters of the study thus far written and distributed. Some of the members then presented their observations concerning the report. Mr. McNulty suggested that the best way of getting at the subject matter would be for Mr. Carroll to meet with the Executive Committee (thus, this is an agenda item) and present a progress report, completion timetable objective, and to elaborate on any detail of particular interest to the members of the Committee.

Mr. Carroll thanked the members who had responded to the circularization to the Executive Committee of the material. He said he

found the observations helpful as he did not believe he was always able to gain the broadest perspective in working at one hospital -- Yale-New Haven. He noted that the final document would be the result of the total involvement of the Steering Committee (AAMC-AHA-AMA representatives). Mr. Carroll further indicated that Albert W. Snoke, M.D., Executive Director, Yale-New Haven Hospital and Edwin L. Crosby, M.D., Director of AHA, have had hospital administrative people and other staff members, review the material and that it was also being reviewed by the nine members of the Steering Committee (AAMC-AHA-AMA Steering Committee).

Mr. Carroll emphasized that the purpose of his study is not to produce a formula of cost-sharing between hospitals and medical schools. Rather, he believed that the information produced could be helpful in establishing these agreements. He also indicated that all the data had been collected and that the report was in the interpretive stage. He noted that because this was the first study of this nature, it would take longer than studies of an ongoing basis. He further stated that the preparatory work was completed and he believed he could work rather quietly from this point on.

ACTION #8: VOTED THAT A COMMITTEE ON FINANCIAL MANAGEMENT AND COST ALLOCATION FOR TEACHING HOSPITALS BE FORMED TO INCLUDE MR. MCNULTY, MR. CARROLL, AND OTHER SELECTED ADMINISTRATORS.

XVII. Luncheon - 12:30 p.m., Dupont Room

XVIII. Reconvene - 1:30 p.m., Dupont Room

XIX. Starting Date for Internship Programs - Early Starting Dates
Causing Problems at Some Schools

There was general discussion of the inconvenience to interns, such as a conflict with state medical board examinations, caused by internship starting too early. It was reported that in some instances the intern nominee had not been advised of early reporting dates.

ACTION #9: VOTED THAT INSTITUTIONS PRESENTLY INVOLVED BE CONTACTED AND ADVISED DIPLOMATICALLY OF THE PROBLEMS BEING CREATED. FURTHER, BEFORE THE START OF THE NEXT INTERN SELECTION PERIOD, COTH ISSUE A MEMORANDUM TO MEMBER HOSPITAL ADMINISTRATORS WITH COPIES TO DEANS ON THE PROBLEM OF EARLY INTERNSHIP STARTING DATES, WITH A RECOMMENDATION THAT INTERNSHIPS BEGIN NOT EARLIER THAN FOUR (4) DAYS BEFORE THE TRADITIONAL JULY 1 STARTING DATE. FURTHER, THAT ADMINISTRATORS BE INFORMED OF THE DESIRABILITY DURING THE INTERNSHIP INTERVIEW PERIOD OF ADVISING PROSPECTIVE INTERNS OF ALL PARTICULARS, INCLUDING STARTING DATE, STIPEND PAYMENT AND PAYMENT PERIOD, ETC.

XX. Number of Representatives from COTH Elected to Executive Council,

AAMC

In light of a possible expansion of the Executive Council, AAMC,

there was general discussion of increasing COTH representation on the AAMC Executive Council from one member to two or three in order to provide an additional input of ideas from COTH to the Executive Council.

ACTION #10: VOTED THAT RECOMMENDATION BE MADE TO THE AAMC EXECUTIVE COUNCIL FOR THREE (3) COTH REPRESENTATIVES TO THAT COUNCIL AT SUCH TIME AS THE COUNCIL IS ENLARGED.

XXI. Program for 1967 Annual Meeting

Mr. McNulty outlined the COTH Program for the Friday, October 27 - Monday, October 30 Annual Meeting as it had evolved from suggestions of the January COTH Executive Committee meeting. He asked for any further comments. He indicated that this was the second meeting of "integrated" program with the AAMC. Prior to 1965-1966, the COTH program had been held separately for two days. The integrated program resulted in a loss of half day in COTH Program, but resulted in a total COTH-AAMC combined program. Mr. McNulty reported that all five speakers had been scheduled. Mr. Rambeck suggested that if possible to "fit him in" - Mr. Thomas M. Tierney, Director, Bureau of Health Insurance, Social Security Administration be considered as a speaker because of his extensive experience in the area of finance in the health-care field, because of his background in Blue Cross and because of his present position in the Social Security Administration.

Mr. Wittrup suggested that the title of Mr. McNerney's talk be

changed from the "Impact of Prepayment on Medical Education and Teaching Hospitals" to the "Impact of Medical Education on Prepayment."

With reference to the afternoon discussion groups, it was suggested that groups 1 and 3 be combined. It was the general recommendation that only four (4) discussion groups be scheduled. It was further suggested that an additional subject for a group be added - "The Changing Role of the House Officer and the Impact on the Teaching Hospitals."

(Copy of Initial Preliminary Program for the Annual Meeting is attached hereto and made part of the permanent file of these Minutes.)

XXII. Information-gathering Unit: Request of HEW

The request from the Department of HEW for the circulation by COTH of a questionnaire was discussed. Mr. McNulty reported that Francis Land, M.D. (a member of the Council on Medical Education of the AMA and a member of the Willard Committee) had joined the present Welfare Administration of the Department of HEW. Dr. Land had expressed interest in obtaining factual information regarding the impact, if only, of Title 19 on teaching programs and teaching opportunities as they exist in teaching hospitals. His interest arose in part from inquiries received by the Welfare Department from such areas as California and Oklahoma, where teaching hospitals utilized extensively by medical schools for teaching of medical students, had reportedly undergone a significant change in patient population. The inquiries to the Welfare Department were requests for information as to what, if anything, was occurring nationally as to patient population of teaching hospitals in relation to any baseline period for comparison if some changes had occurred or were occurring, where, when how and why? Finally, in light of determined changes, was any constructive action worthy of consideration? The office of Dr. Land had proposed a questionnaire to be sent by COTH as a method of trying to determine some of the answers to the questions posed.

The matter of the questionnaire proposed by the Welfare Department was first discussed at the meeting of the COTH Government Relations Committee (April 10, 1967) and later (April 11, 1967)

at the joint meeting of the COTH Government Relations Committee and the AAMC Committee on Federal Health Programs. It was then agreed that the questionnaire (prepared by the Department of Welfare) would need considerable revision. It was then noted that the reason for COTH to undertake the circulation of the questionnaire was due to the length of time it would take for a Federal Agency to initiate such a request through the Bureau of the Budget, a period usually taking nine to twelve months.

There was a discussion concerning the type of questionnaire that would provide the best in-depth information for COTH and for federal agencies. It was also mentioned by several that it might be well for COTH to plan to develop and circulate an annual questionnaire. Financial support could be sought for such a program as it apparently would meet a need that is not now and apparently will not be accomplished otherwise.

ACTION #11:

VOTED THAT THE DIRECTOR IS AUTHORIZED WITHIN PRESENT RESOURCES, OR TO SEEK ADDITIONAL RESOURCES, FOR THE PURPOSE OF INITIATING WHAT MIGHT BE TERMED A "DATA BANK" OF PERTINENT INFORMATION CONCERNING THE ACTIVITY OF MEMBER HOSPITALS OF COTH FOR USEFULNESS TO THE MEMBERS, FEDERAL AND VOLUNTARY AGENCIES, AND OTHERS.

XIII. Review of Coggeshall Report

Dr. Nelson, in his capacity as representative from COTH to the Executive Council of the AAMC, reported to the Committee on the review of the Coggeshall report (prepared by Robert C. Berson, M.D.) and the accomplishments to date by the AAMC for implementation

of recommendations therein. (Copy of the Robert C. Berson, M.D. report is attached and made a part of the permanent file of these minutes.) Dr. Nelson complimented the record of accomplishment.

XXIV. Minutes, COTH-AHA Liason Committee

ACTION #12.

VOTED THAT THE MINUTES OF COTH-AHA LIASON COMMITTEE MEETING OF FEBRUARY 24, 1967, BE APPROVED.

XXV. AAMC Committee on Ways and Means

Dr. Nelson remarked that a visit to the Evanston office offers offers clear evidence of one significant problem for the AAMC, which is the heavy concentration of staff in inadequate space. He commented on the work of an AAMC Ad Hoc Ways and Means Committee to consider improvement of the financial base for the AAMC. For that Committee, and at their request, Dr. Berson identified the core programs of all AAMC divisions, excluding peripheral programs financed from term, or soft money support. The findings of the Ad Hoc Committee was that the basic programs were appropriate, minimal and soundly managed and that if the basic programs were to be supported by dues of institutional members, then the dues structure will have to be more than doubled. Present dues are \$1,500, for each U.S. medical school, regardless of size. The Ad Hoc Ways and Means Committee is recommending to the medical school institutional membership that dues payments be keyed to annual medical school institutional expenditures. Dues could then be as high as \$6,000 \$7,000 per year, which is a four-fold increase from the present dues structure. It was reported that the Ad Hoc Committee was concerned

with all phases of their suggestion, including the fact that a dues assessment of \$6,000 per year is more than the dues other university groups pay to their associations.

XXVI. COTH Government Relations Committee

Charles H. Frenzel, Chairman of the COTH Government Relations Committee, discussed further the matter of the survey requested by the Welfare Department. He indicated that this study should be broader and should be a continuing program. He expressed support of the action by the Executive Committee authorizing the COTH Staff to search for resources, and, if found, to then proceed. Mr. Frenzel indicated that the matter of the Comprehensive Health Planning Act had been discussed sufficiently. He believed that COTH should continue the position that it does support those parts of the legislation aimed at strengthening State Departments of Public Health, but urges that the education, employment, and methods of practice of non "Public Health" health professionals be specifically exempted from the areas falling within the purview of state planning agencies.

He further indicated that COTH can support the first part of this proposal and then, agreeing that planning for the training, employment, and utilization of physicians and paramedical personnel is desirable, can ask that such planning functions be emphasized separately in this item of legislation, or otherwise be assigned as a responsibility of the regional medical program bodies created under the Heart, Disease, Cancer, Stroke Act. This recommendation

was in accordance with the results of discussion and action of the joint COTH Government Relations Committee and AAMC Committee on Federal Health Programs.

Mr. Frenzel reported on the visit of April 11, 1967, by the members of his Committee and the AAMC Committee on Federal Relations, with U.S. Representative Daniel J. Flood, Chairman of the House Sub-Committee on Appropriations for the Departments of Labor and HEW. From that visit, it was determined that Congress was in a mood to cut appropriations. Congressman Flood had reported that there was little chance of an increase in appropriations (at least in the House) and that Congressman Flood could not be certain of the action his Committee would take in determining the amount of the appropriations for the Department of HEW. This possibility places heavy responsibility on the COTH staff to accomplish effective education concerning the needs and benefits involved.

Earlier in the meeting, Stanley A. Ferguson, Chairman of COTH, had introduced the subject of the testimony on Comprehensive Health Planning Act Amendments which had been presented by Thomas B. Turner, M.D., (Dean of the School of Medicine, the Johns Hopkins University, and Past President of the AAMC) before the House of Representatives Committee on Interstate and Foreign Commerce on May 4, 1967. It was considered that this testimony should be circulated by the Deans, in whole or in part, to the chairmen of their clinical departments. Dr. Derson indicated that the policy aspects of this testimony have been discussed by the

members of the Executive Council, the AAMC Committee on Federal Health Programs, and the COIH Committee on Government Relations, and that this item will be on the agenda when the Institutional Members (Medical Schools), meet the week of May 15, 1967.

There was more general discussion concerning the provisions of the Regional Medical Program legislation as well as the Comprehensive Health Planning Program. Included in the discussion was the matter of depreciation funds and how these funds should be handled. It was agreed that each hospital should have the opportunity for self-determination with regard to these funds. However, the members recognized the import of the "Anderson Bill."

At this stage of the meeting, there was further discussion concerning the "Modernization" need of teaching hospitals and the visit to the Executive Committee (earlier in the day) by the "Boston Group." There was general agreement, with which Mr. Frenzel concurred, that at the appropriate point in time a subcommittee be appointed with representation from the "Boston Group" but also to have other geographic, institutional-type and financial-interest-type representation. It was suggested that another emphasis on a goal of 85% return on the questionnaire be first pursued.

ACTION #13:

VOTED:

- a. THAT THE MINUTES OF THE COIH GOVERNMENT RELATIONS COMMITTEE AND COMBINED GOVERNMENT RELATIONS COMMITTEE AND AAMC COMMITTEE ON FEDERAL HEALTH PROGRAMS BE

APPROVED; AND

- b. THAT THE COTR DIRECTOR AND THE CHAIRMAN OF THE COTR COMMITTEE ON GOVERNMENT RELATIONS WORK TOGETHER, AND WITH THE AAMC STAFF AND OFFICERS AND COMMITTEE OFFICIALS, EVOLVE THE MOST EFFECTIVE TOTAL POSITION WITH RELATION TO THE PROVISIONS OF THE COMPREHENSIVE HEALTH PLANNING ACT; AND
- c. THAT CONSISTENT WITH THE COMPLETION OF THE QUESTIONNAIRE SURVEY AND THE POSSIBILITY OF PROGRESS ON "MODERNIZATION" AS A LEGISLATIVE MATTER, THE DIRECTOR IS AUTHORIZED TO APPOINT A SUB-COMMITTEE OF THE COMMITTEE ON GOVERNMENT RELATIONS. THE SUB-COMMITTEE SHOULD BE REPRESENTATIVE OF THE "BOSTON GROUP" AND REPRESENTATIVE ALSO OF GEOGRAPHIC DISTRIBUTION, TYPES OF INSTITUTIONS AND CAPITAL FUND INTEREST.

XXVII. National Conference on Medical Care Costs - Tuesday and Wednesday, June 27-28, 1967. Washington Hilton Hotel (Lawrence N. Klainer, M.D., HEW South Building, Washington, D. C.)

The National Conference on Medical Care Costs to be held in Washington on June 27-28, 1967 was discussed. Dr. Berson indicated that he and Mr. McNulty had met with staff planning the conference. Upon request of that staff, Dr. Berson had written a letter to John J. Corson, Ph.D., suggesting possible candidates to be considered for presentation of papers.

Mr. McNulty reported the emphasis on the part of the planning committee to make the conference small in the number of people invited to participate. He mentioned that Lawrence M. Klainer, M.D.,

one of the committee staff, working with the AAMC, had been associated with the MGM-Harvard complex. It was also indicated that Norman Topping, M.D., President of the University of Southern California, would be General Chairman of the Conference.

XXVIII. Association of Canadian Teaching Hospitals - Information
Reference: Association Membership in COTH. Arnold L. Swanson,
M.D., Executive Director, Victoria Hospital, London, Ontario
Hospit 1, Montreal, Quebec

Mr. McNulty reported continuing discussion with the Canadian teaching hospitals and their recently (1966) organized Association of Canadian Teaching Hospitals. Several of the teaching hospitals in Canada have reported to COTH difficulty in payment of dues to COTH because of Provincial government budgeting controls and the position that dues payment to one teaching hospital association (Canadian) is sufficient.

As discussed at an earlier COTH Executive Committee meeting, Arnold L. Swanson, M.D., then President of the CTHA, had inquired (knowledge of which inquiry he had transmitted to his successor in office as CTHA President - J. Gilbert Turner, M.D.) as to the Canadian Teaching Hospital Association becoming a member-at-large in COTH. The COTH Executive Committee members agreed that at this point in the history of COTH, no action should be taken with regard to membership to alter the present membership program restricted to teaching hospital institutions.

XXIX. Other Old Business

None

XXXI. New Business

None

XXXII. Next Meeting of Executive Committee - Suggested Date, Thursday and Friday, September 24-25 in Washington, D. C.

XXXIII. Informational Items (Attached)

There was general discussion without action concerning the

Informational Items listed as follows:

- a. Information regarding legislation, First Session, 90th Congress.
- b. Preliminary Schedule of Regional Meetings Tab a
- c. Testimony concerning P.L. 89-749, H.R. 6413 and S. 1131 Tab b
- d. Membership Certificate Tab c
- e. Billing for 1967-68
- f. "White Paper" Tab d
- g. Meeting of the American Medical Colleges Institutional Membership, May 17, 1967
- h. Appreciation to and response from George N. Aagaard, M.D. and C. Arden Miller, M.D. Tab e
- i. Robert H. Ebert, M.D., Steering Committee for 1968 Institute
- j. Graduate Education of the Physician - Committee (Edmund D. Pellegrino, M.D., Chairman, and Stanley A. Ferguson, Member) Tab f
- k. National Advisory Commission on Health Manpower - Peter S. Bing, M.D., Executive Director, Executive Office of the President, Washington, D. C. 20050
- l. National Advisory Commission on Health Facilities
- m. New Roster of Teaching Hospitals Tab g

- n. Last 1966-1967 Executive Committee Meeting, at Annual Meeting - Friday, October 27, 1967, New York Hilton Hotel, 10:00 a.m.
- o. First 1967-68 Executive Committee Meeting (Organizational) - Luncheon Meeting, Monday, October 30, 1967, New York Hilton Hotel
- p. List of approved and operational RMP grants Tab 1
- q. List of Jurisdictions with Approved Comprehensive Planning Agencies Tab 2
- r. NIH Questionnaire to Hospitals Tab 3
- s. Council of Academic Societies

XXXXIII. Each member was furnished copies of bills of immediate interest to COH Membership introduced to date in the U.S. Congress, as follows:

- A. Health and Education Message from The President of the United States.
- B. Public Law 89-749 - Comprehensive Health Planning and Public Health Services Amendments of 1966.
- C. Public Law 89-751 - Allied Health Professions Personnel Training Act of 1966.
- D. Public Law 89-705 - Veterans Hospitalization and Medical Services Modernization Amendments of 1966.
- E. S-233 - Senator Anderson - Amend Social Security Act - Depreciation.
- F. S-679 - Senator Gorton - Federal assistance to hospitals in meeting costs of paying nursing personnel.
- G. S-720 - Senator Nelson - Drug Cost Control.
- H. S-859 - Senator Magnuson - Emergency Federal Assistance to hospitals. Similar legislation HR-4773 introduced by U.S. Representative Ottlinger.

- I. S-1131 - Senator Hill - Comprehensive Health Planning Act amendments. Similar legislation HR-6418 introduced by U.S. Representative Staggers.
- J. S-1303 - Senator Long - Quality and Cost Control Standards for Drugs Act.
- K. S-1459 - Senators Javits and Kennedy - For relief of certain non-profit medical research institutions similar legislation HR-511 introduced by U.S. Representative Dulski.

XCV. Adjournment

There being no further business Chairman-Elect Lad F. Grapski (Chairman, Stanley A. Ferguson having had to depart at 3:30 p.m.) adjourned the meeting at 3:50 p.m.

Joseph M. Merrill, M. D., Chief of the
GCRC Branch, Division of Research Facilities and Resources, NIH

I. Definition of Problem:

Largely by empirical observations, physicians and surgeons working in hospitals during the 19th century advanced medical science as far as they could. This era was followed during the first half of the 20th century by a striking increase in the scientific base of medicine. This growth of knowledge accompanied by impressive and varied developments in technology and the requirement to minimize variables in the study of human disease led to the realization that something new and different was required if clinical science was going to keep pace with the rapid changes occurring in the biological sciences.

In 1959, the United States Senate in response to this emerging requirement recommended that centralized facilities be created in universities to provide highly integrated research opportunities and services to large numbers of investigators and research groups. The National Advisory Health Council interpreted this directive to mean creation of Clinical Research Centers to support research of the highest quality, centered around patients and backed by laboratories and other ancillary facilities.

The data in Table I show how the country responded to this expressed need. Development of these 91 centers with 1129 beds has improved the efficiency and productivity of clinical science. However, 24 established or new medical schools have not yet developed such a resource. Because it is useful in attracting a superior clinical faculty, a general clinical research center is of high priority to these new schools.

TABLE I

<u>Fiscal Year</u>	<u>Activated</u>		<u>Appropriations</u>
	<u>Centers</u>	<u>Beds</u>	
1960	2	33	\$ 3,000,000
1961	13	169	8,000,000
1962	32	398	27,500,000
1963	54	624	33,500,000
1964	64	749	27,900,000
1965	75	891	27,684,000
1966	82	911	28,500,000
1967	91	1,129	28,463,000
1968	96	1,161	30,400,000*

* President's budget

Executive Committee, COTH
Meeting of May 11-12, 1967
Addendum No. 1 (12 pages)

Attempts to project the country's future needs of this type of resource are tied quite naturally to a number of variables which include: our growing population with its physician needs, the ability of the economy to support medical research, the continued aspirations of society for provision of superior health care to all our citizens, and lastly, the type of physician that we desire for America's future.

At the present time a view is abroad in the country that support of medical research is adequate and that we should now turn our national emphasis to medicine's social aspects. The staff of this program rejects this point of view or such a proposed change in emphasis and reassignment of priorities. It is our contention that our improved life expectancy is a direct result of basic and applied science. We further contend that as a profession we were humanitarians before we became scientists and that our use of scientific methods in pursuit of precise knowledge to help our patients has in no way deterred us from our raison d'etre, which is healing the sick. Furthermore, we intend to use our energies to see that in the future education of physicians the scientific method is maintained as the core of the curriculum. Stated another way, we believe that there are few, if any, short cuts to becoming acquainted with scientific methods or, in essence, becoming a "good doctor." These and other well-defined problems with which this program is concerned will be discussed subsequently in the Projected Development Section of this report.

II. Program Goals

A. Research

The goal of the General Clinical Research Centers program is to provide centers where physicians and scientists can define and attempt to conquer the great unsolved problems of human disease. As technological and conceptual advances emerge from research in the basic sciences, medical scientists working in these centers take these advances, translate them into tools suitable for clinical investigation, and apply them to human problems. This type of approach has shortened the lag time between discovery and application and has helped to provide a more precise description and a better understanding of disease. Development of these centers has meant that new diagnostic procedures, therapeutic techniques, and drugs could be tested in a proper scientific environment and their effectiveness in human disease proved before being turned over to the practicing physician.

Each center provides a highly coordinated environment that allows the controlled conditions necessary for precise clinical investigation. The peculiar problems associated with research in human disease are recognized and every effort is made to provide the resources necessary to minimize the difficulties inherent to clinical investigation.

III. Scope

A. Research Program

As reflected in Table I, this program is in a period of significant growth. During fiscal year 1965, \$23.6 million was provided for 15,474 patients who spent a total of 210,713 days (577.3 patient years) in hospitals. During 1965, 273 preclinical and 2,007 clinical scientists conducted research in these centers. More than 2,000 active research projects were used as experimental designs to attack the disease areas enumerated in Table II.

TABLE II

<u>Disease Area</u>	<u>Total no. of Patients (% distributed)</u>	<u>Total no. of Dollars (% distributed)</u>
1. Aging (diabetes mellitus, arthritis, etc.)	18.9	21.0
2. Blindness	1.6	.9
3. Cancer	8.3	9.5
4. Heart Disease	13.6	12.3
5. Diseases contributing to high infant mortality rates	9.3	8.6
6. Pharmacology and Toxicology	17.4	24.5
7. Stroke and neuropsychiatric disorders	9.0	7.2
8. Organ Transplantation	11.2	7.0
9. Other	10.8	8.9

During FY 1966, \$29.3 million was provided for 18,298 research patients who spent a total of 231,504 days (634.3 patient years) in hospitals. A total of 2,599 research projects were actively being pursued by 2,490 scientists.

B. Training

For the clinical scientist to retain his mettle, he requires a steady stream of bright young students to challenge him. An important goal of this program, inseparable from research itself, is to train physicians in the techniques and discipline of clinical investigation. This means that the facilities and resources provided for clinical investigation must be adequate not only for senior investigators but must also include a quarter where the young investigator may cut his teeth. The training responsibilities of this program do not end with production of physician-scientists alone. All types of hospital personnel are trained in research techniques which will enable them to assume their role in clinical investigation in the years ahead. It is only by providing such a wide training program that an adequate "pool" will be available from which the faculties and support personnel of the new medical schools can be drawn.

C. Interdisciplinary cooperation

It is a rare investigator who can appreciate the data and generalizations of a scientist far removed from his own area of research. However, one of the difficulties which medical research faces is that solutions to major disease problems will require skills and utilization of knowledge from several disciplines, some of which are far removed from medicine. The General Clinical Research Center program attempts to minimize these scientific subcultures by providing a relatively neutral ground where representatives from the various disciplines of clinical, biological and physical sciences may address themselves to a problem presented by a single sick patient. By stimulating this form of interaction, future health scientists hopefully will be fluent in the languages and philosophies of physics, chemistry, mathematics and biology.

D. Integration

Many citizens of this country representing diverse segments of our society are troubled by the failure of the practicing physician to be able to keep abreast of new methods of diagnosis and treatment. A specific goal of this program is to encourage an interchange between research activities of the Center and the local organizations in the community primarily concerned with the practice of medicine. The General Clinical Research Center program has approached this problem by means of ward rounds, research seminars, demonstrations, and conferences in the medical community. Any future national program of continuing medical education will depend heavily upon these centers not only as a source of new knowledge but for demonstration purposes as well.

B. Physical Facilities

Since the inauguration of this program, 13.6 million dollars have been spent to renovate existing hospital facilities to provide a place where medical research may be done under carefully controlled conditions. At present 879 adult beds and 176 pediatric beds are supported. In profile, an "average" center consists of 12 research beds, approximately 7,000 square feet of floor space, a director's laboratory, 1.6 core laboratories, a kitchen, a procedure room, and a treatment room. To keep pace with the needs of additional investigators, expanded research capabilities, and the "information explosion," many of these ongoing centers will require additional beds in the future.

Several centers are designed to handle particular disease constellations; maternal and child health, premature, and acute care centers are examples.

C. Research Productivity

During FY 1965, 976 papers and 446 abstracts were published as a result of work emanating from clinical research centers; during 1966, 1,200 papers and 560 abstracts were published. The 48 journals most frequently used as a publishing medium by General Clinical Research Centers are listed in Table III.

TABLE III

Journals Most Frequently Used as a Publishing Medium
by GCRC Scientists

Journal of Pediatrics	53
J. Clinical Endocrinology and Metabolism	51
New England Journal of Medicine	49
Circulation	46
Annals of Internal Medicine	38
Journal of the American Medical Assn.	33
Journal of Clinical Investigation	33
J. of Laboratory and Clinical Medicine	29
American Journal of Medicine	24
Pediatrics	23
Arthritis and Rheumatism	22
Diabetes	22
Gastroenterology	22
Metabolism	21
Annals of New York Academy of Science	20
American J. of Diseases of Childhood	20

The Lancet	18
Archives of Internal Medicine	16
American Surgery	15
American Journal of Surgery	14
Neurology	14
Proc. Society Exp. Biological Medicine	13
American Journal of Clinical Nutrition	13
American Heart Journal	12
Surgical Forum	12
Southern Medical Journal	11
American Journal of Cardiology	11
Transactions Assoc. American Physicians	10
American J. Obstetrics & Gynecology	10
Amer. J. of Digestive Diseases	9
Amer. J. of Ophthalmology	9
Amer. J. of Medical Sciences	9
Archives of Neurology	9
Analytical Biochemistry	8
Archives of Surgery	8
Science	8
Archives of Ophthalmology	7
Biochemistry	7
Bulletin of Johns Hopkins Hospital	7
California Medicine	7
Endocrinology	7
Amer. J. Roent. Rad. Thera. & Nuc. Med	6
Archives of Dermatology	6
British Journal of Hematology	6
Medical Clinics of North America	6
Pediatric Clinics of North America	6
Surgery	6
Trans. Amer. Clin. & Climat. Assoc.	6

D. Research Support Personnel

Seven years have lapsed since inauguration of this program and this period of time has been utilized to develop a large number of hospital personnel who are now well-trained in their tasks and are familiar with the objectives of clinical investigation. The most recent tabulation of paramedical employees in the total program is given in Table IV.

TABLE IV

<u>Category</u>	<u>Number</u>
Registered Nurses	613
Practical Nurses	158
Nurses' Aides	227
Ward Clerks	62
Dietitians	99
Dietetic Aides	182
Laboratory Technicians	200
Social Workers	10
Secretaries	129
Other	104

E. Training

The corps of people in Table IV working together with the clinical and basic scientists in these centers constitute one of the country's major resources for training future clinical investigators. This opportunity for training is being utilized and is summarized in Table V. It is gratifying to note that in several categories there has been a 100 percent increase in trainees over the past three years.

TABLE V

	<u>1964</u>		<u>1965</u>		<u>1966</u>	
	<u>Total</u>	<u>Average*</u>	<u>Total</u>	<u>Average</u>	<u>Total</u>	<u>Average</u>
Medical Students	684	(10.9)	1,169	(15.5)	1,682	(21.2)
Interns	308	(4.9)	362	(4.8)	585	(7.5)
Residents	596	(9.5)	937	(12.5)	1,272	(16.3)
Fellows	578	(9.2)	816	(10.9)	1,171	(15.0)
Dietetic Interns	234	(3.7)	278	(3.7)	376	(4.8)
Student Nurses	382	(6.1)	562	(7.5)	1,337	(17.1)
Total	2,782	(43.2)	4,115	(54.9)	6,423	(82.3)

* per Center

IV. Projected Development

A. New Centers

Meritorious applications for traditional clinical research centers from new medical schools and established institutions are being received and processed and will be funded as congressional appropriations become available. The center is important to established medical schools since it provides a unique facility where support for bedside research can be obtained and represents a valuable innovation to the traditional academic activities of schools. This very quality makes the center important to newly-established medical schools and to those schools that are making serious efforts to upgrade their quality. The opportunities for research that the center provides are important factors in attracting a new school's faculty.

B. Outpatient Clinical Research Centers

Disease in active people, gainfully employed, is one of the more difficult areas of clinical investigation and one that has been relatively neglected. When a new form of treatment is discovered, it is very difficult to assess its effect on the disease under study because almost invariably enough is not known about the natural course of the disease. The controversies in management of common disorders such as atherosclerosis and diet, the usefulness of drugs in hypertension, the "anticoagulant dilemma," fibrinolytic therapy, dietary treatment of duodenal ulcer, and sixteen other major topics have recently been discussed in a book entitled, Controversy in Internal Medicine, edited by Ingelfinger, Relman, and Finland. Further knowledge of transfer RNA, or another facet of the Krebs cycle, or another enzymatic defect in some obscure disease is not going to answer these questions. Accurate quantitative observations collected in an unbiased manner on well-defined populations is the manner in which these controversies should be studied. This need for opportunities to study disease in ambulatory patients led the Senate Appropriations Committee in 1966 to direct this Branch "to establish, on an experimental basis, a limited number of outpatient clinical research centers in connection with well-established outpatient clinics serving an adequate number of patients with chronic diseases to warrant an investment in the necessary research facilities and research staff." This major new development will mean a rapid expansion of this program over the next few years.

C. Utilization of the Special Program Areas

Many clinical investigators and academic administrators have requested a conceptual extension of the center program for the study of certain patients who because of the nature of their illness must be housed in special areas of the hospital. Each of these units has

personnel highly trained in the special care required by patients in these areas. Meritorious requests have been submitted for opportunities to investigate maternal-child and neonatal problems that were not funded by other agencies because of the noncategorical nature of the work proposed. The country's high infant mortality rate expresses effectively the need for more effort in this area. Authorization is being sought to create subunits of the clinical research center to study diseases in the premature nursery, in the recovery room, in the maternity wing, in locked wards, and in the emergency room. The clinical investigator whose research interests relate to these problems needs access to these existing special units.

D. Postgraduate Training in General Clinical Research Centers.

During FY 1966, 3,028 interns, residents or postdoctoral fellows spent some time in training on General Clinical Research Centers. Although this figure represents a 100 percent increase over the past three years, the shortage of well-trained clinical investigators and the growing gap between basic research and clinical investigation remain persistent problems and unless effective steps are taken shortly the problem will get worse. A statement by Rogers in a recent issue of Clinical Research emphasizes that "the extraordinary strides which have taken place in biology over the last 20 years have created new horizons" for the physician interested in research. The article highlights the need to develop more individuals who are qualified to study disease with this new and growing scientific base of knowledge.

A clinical investigator must be a skilled clinician and, either by previous, concurrent or post-residency training, a skilled scientist. The General Clinical Research Center provides examples of the best in patient care and, because of the Center's facilities, also provides excellent opportunities for intensive study of patients. Knight, in the same issue of Clinical Research, urges use of these Centers to increase the number of physicians skilled in clinical investigation. To increase the number of clinical investigators in the country, the General Clinical Research Center award should make available opportunities for research training at three different levels of professional competence, as follows:

- (1) To provide salary stipends for senior residents assigned exclusively to the GCRC for 6 to 12 month periods. This type of support will offer the Center and its patients continuity of professional staffing. Also, much more in the way of opportunities will be available to stimulate residents into pursuing either a future career in investigation or studying in depth a clinical problem over a period of time.

- (2) To offer 12 month stipends for clinical associates who would function as fellows and junior assistants to the Program Director.
- (3) To encourage clinical work and training on the Center interspersed with course work and periods of assignment to basic science departments. This program, initiated after the internship, would train physicians in basic science who could apply their newly acquired skills to their area of clinical interest. Support for this program would be limited to clinical research centers with strong laboratory backing and with a strong University tie. If the trainee so desired, an opportunity would exist for him to obtain a Ph.D. degree at the end of this training period. These physicians could rapidly reacquaint themselves with information and concepts that have developed in the biological sciences since their undergraduate years. They would develop rapidly in their scientific capability and apply at the bedside in a short period of time new technological skills for the study of disease.

E. Increased Support of Basic Science in Clinical Research Centers.

Laplace, the French astronomer and mathematician, advocated admission of physicians to the Academy of Sciences. When questioned about this move he replied: "This is why: to get them among men of science." Flexner, in his 1909 assessment of the state of medical education in the United States and Canada, concluded that effective prosecution of research was an integral and necessary part of medicine. During the past few years with increased support of the life sciences, biology and medicine have moved apart. Henry Miller, in his paper entitled, "Fifty Years after Flexner," (Lancet, September 24, 1966), reminds us that physiology and anatomy are secondary derivatives of clinical medicine and not the reverse. Continuing in this vein he warns us that the enthusiasm fired in many young recruits to medicine by clinical problems may be easily extinguished by forced feeding with anatomist's anatomy and physiologist's physiology. Jacobson, in the April 1967 issue of Clinical Research, applies this point of view to the graduate student, "nowhere in the graduate student's curriculum is the spark introduced that would interest the graduate student in the disease problem that begs for investigation on a basic level. Instead, the graduate student imbibes an attitude that disease is a poor source of stimulation for research, one that can only sully the purity of a basic science approach." These viewpoints spanning 160 years of western thought are expressed again to emphasize the continuing need

to bring the biological sciences and clinical investigation closer together and to reiterate that a General Clinical Research Center is a place where the two groups may collaborate to the advantage of both.

If doubts remain that clinical medicine is a potent stimulus to rapid development of science, one only has to review the increased number of immunologists in this country once the technical ease of organ transplantation was demonstrated. This rapid growth in scientific capability and knowledge, though generated by a common interest, has not been optimally applied. Take a disease entity such as the end-stages of kidney disease. For effective treatment the patient's kidneys must be replaced. This mode of therapy offers limitless opportunities to study tissue antigens, to develop improved methods of renal dialysis, to improve dietary methods for management of the uremic syndrome, and to measure sequentially discrete renal function in a transplanted organ. Many other equally exciting opportunities to make giant strides forward on highly relevant health problems of today could be cited. Clinical Research Centers are available for such opportunities and the NIH staff encourages and will support such multidisciplinary activities.

The best available academic talent in clinical medicine is working on research problems in Clinical Research Centers. These centers have their administrative organization within the University structure; hence, all the inherent difficulties associated with recruitment of basic scientists to clinical research are minimized in this program. To infuse more scientific competence into clinical investigation, it is proposed that General Clinical Research Centers be authorized to recruit basic scientists from either the physical or life sciences depending upon the interests and needs of the clinical research center. These scientists would preferably be young, with an interest in application of their knowledge to human problems. In order to maintain their own identity, they will be encouraged to have their faculty appointment in their own University department and have available 50 percent of their time to pursue research problems that may not relate directly to current Center research. It is recognized that it is difficult to attract from his own environment bright young scientists who would contribute most. Consequently, a fairly rapid turnover of these scientists would be expected which would be an acceptable feature of this program. Such support of clinical investigation would mean that the skills of the basic scientist would be utilized toward solving problems under active investigation in sick people.

Summary

The General Clinical Research Center program has made a beginning toward meeting a national need of providing the environment necessary

for the scientific study of disease. In effect, a new dimension in clinical investigation has been created that supports more than 2,000 scientists who use these centers. The program has emphasized the importance of an interdisciplinary approach to medical research. Important diagnostic and therapeutic discoveries have been made in these centers. By their common efforts, universities, clinical investigators, hospitals, and the Federal Government can take pride in having established a national program that provides the support required for clinical investigation. It is our firm intention to see that this program grows and flourishes in the future so that clinical investigation will continue to be the pace-setter in medical research.

STATEMENT OF
URGENT NEED OF HOSPITALS
(Especially Teaching Hospitals)
for
CONSTRUCTION FUNDS

Committee of Teaching
Hospital Administrators

20 July 1967

(Draft for review by Committee)

Please mark up and return
one copy to R.T. Viguers.
The other copy is for your
file.

R.T.V.

Executive Committee, COTH
Meeting of May 11-12, 1967
Addendum No. 2 (26 pages)

V. Committee on Ways and Means

The report of the Ad Hoc Committee on Ways and Means was furnished to the Council (see copy attached to file copy of these minutes.) Dr. Anlyan supplemented the report with a formula for increasing support of the Association's core activities. The Council recommended a formula of 1/10 of 1% of total expenditures of each Institutional Member, with a ceiling.

Action: On motion, seconded and carried, the Executive Council accepted in principle the Committee's proposal that the membership support its core activities through a fee structure which would provide about \$750,000 annually to support the Association's core program.

The Council asked Dr. Anlyan to report to the Institutional Members at their next meeting.

CONTENTS

Page

- I. SUMMARY STATEMENT
- II. HOSPITAL CAPITAL NEEDS
- III. CRUCIAL POSITION OF THE TEACHING HOSPITALS
- IV. FINANCING HOSPITAL CONSTRUCTION
- V. MAJOR FEDERAL AID PROGRAMS FOR HOSPITAL CONSTRUCTION
- VI. POSSIBLE SOLUTIONS
- VII. *Recommended Solution*

Committee of Teaching Hospital Administrators

- Leonard W. Cronkhite, Jr., M.D. - General Director
Children's Hospital Medical Center
- Nelson F. Evans - Administrator, University Hospital, Boston University Medical Center
- John H. Knowles, M.D. - General Director
Massachusetts General Hospital,
- F. Lloyd Mussells, M.D. - Director, Peter Bent Brigham Hospital
- Mitchell T. Rabkin, M.D. - Director, Beth Israel Hospital
- Lewis M. Rohrbaugh, Ph.D. - Director, Boston University Medical Center
- Richard T. Viguers - Administrator, New England Medical Center Hospitals

I. SUMMARY STATEMENT

The people of the United States acting through their elected representatives in the Federal and State legislatures have made it abundantly clear that they want adequate health care freely available. Great strides have been made in removing economic, geographical and social barriers to the availability of health care. In addition, our growing and aging population is placing increased demands on our health resources.

It is also abundantly clear and well documented that we lack the health services manpower, and facilities to deliver the health care which is being demanded and promised.

The strategic organization in this dilemma is the teaching hospital. It is basically the teaching hospital which must educate and train our health services manpower. It is the teaching hospital which provides the facilities for care of a large proportion of our population. It is in the teaching hospital that much of the research is done to advance medical knowledge. It is in the teaching hospital that new and more efficient systems of rendering health care are being developed and studied.

Because of the shortage of capital funds hospital facilities are largely obsolete and inadequate even for present needs. To meet the future health care needs a great expansion of the teaching hospitals is necessary.

Under present legislation necessary capital funds for hospital construction are not available. The numerous bills introduced in the present session of Congress indicate the wide concern of the legislators and the public they represent.

There is an urgent need to provide capital funds to finance construction of expansion and modernization of the hospitals of our country. Many teaching hospitals which occupy a crucial position in meeting the present and future health care needs of the country face disaster unless legislation is passed which will provide capital financing on a feasible basis.

A combined grant-loan program is recommended which is realistic and feasible and would meet the current critical need of hospitals for facilities to care for patients, to train needed health manpower and to continue research.

II. HOSPITAL CAPITAL NEEDS

The plight of many of our hospitals - particularly those in urban areas - is no secret.

President Johnson, on signing Hill-Harris amendments of 1964 (P.L. 88-443), stated

"The hospitals which serve more than two-thirds of our population in nearly 200 metropolitan areas are obsolete, are out of date, are desperately in need of modernization."

Hospital Review and Planning Council of Southern New York, Inc., 28th Annual Report, 1965-66, pp. 22-23, as a result of 18 months study of modernization needs of New York City's hospitals, stated,

"Forty-seven of New York City's 130 general hospitals should be replaced and virtually all the remaining 83 facilities require costly modernization. The task of making these hospitals adequate for their current tasks, without adding more beds or new programs, would require an expenditure of \$705 million."

On April 11, 1967, the New York Times reported:

"Manhattan's leading private nonprofit hospitals, including major medical centers, were reported April 10 to have widespread repair and safety problems just as the 21 municipal hospitals do.

"Charles G. Moerdler, New York City Buildings Commissioner, reported that the first comprehensive inspection of the borough's 52 hospitals revealed 994 violations - 462 in voluntary institutions, 506 in the eight municipal hospitals and 26 in proprietaries. The report revealed also that prestige institutions had widespread peeling paint and plaster, piles of debris, leaky ceilings, defective fire escapes and locked exits, among other hazards.

"Grant Adams, executive director of the United Hospitals Fund, an organization of voluntary hospitals, asked to comment, said: 'We've known for some time that New York City's voluntary hospitals are fast approaching a crisis, and that one of the major causes of this crisis is the serious under-financing of hospitals. This has forced hospitals to delay improvements in plant, equipment, and necessary repairs.'.....

"Mr. Moerdler said that 'all of these hospitals have suffered years of neglect and abuse, which has taken a terrible toll.'".....

The American Hospital Association, testifying on Bill S3009, the "Hospital and Medical Facilities Modernization Amendments of 1966" before the Subcommittee on Health of the Committee on Labor and Public Welfare, U.S. Senate, stated:

"The legislation (for hospital modernization) suggests a program involving approximately 10 billion dollars over a ten year period. We believe this figure can be well supported in terms of immediate pressing needs together with projections of obsolescence over the coming years.

"The Congress recognized the problems of older hospitals when it passed the Hill-Harris amendment to the Hill-Burton program in 1964. Though the program initiated by these amendments provides a small start, it is largely ineffectual in relationship to the size of the problem."

Dr. Philip R. Lee, Assistant Secretary for Health and Scientific Affairs, Health, Education and Welfare, stated:

"In 1966 we find ourselves with a fine system of hospital facilities in rural, small-town and suburban areas, while in our great urban centers -- where more than one-half of our population lives -- we find dilapidated, decaying, obsolete facilities, that are inefficient, uneconomical, unattractive, and unable to provide high quality medical care around the clock.

"We find ourselves with 273,000 hospital beds - almost 35 percent of all general hospital beds now in use -- in facilities which are obsolete in one degree or another, and require modernization, renovation or complete replacement. Beyond this, more than 20,000 additional general hospital beds become obsolete each year.

"The present grant program for modernization will affect only about 16,800 beds in general hospitals in the next three years, far short of the total need and actually less than one-third of the number required to replace even the 60,000 beds that will become obsolete during the period."

While the major need for hospital modernization and expansion is in the urban areas, some hospitals in suburban and rural areas face critical needs. Senator Magnuson has recognized this in his proposed "Hospital Emergency Assistance Act of 1967" (S.859) as has Representative Ottinger (H.R.4773). It is reported that according to a U.S. Public Health Survey in 1966 at least 143 hospitals located in 29 states would meet the very strict criteria of "critical condition" and probably another 1300 hospitals might fall into this category. The total appropriation under this legislation is only \$58 million dollars - about $\frac{1}{2}$ of 1% of what is needed by the hospitals of the nation.

III. CRUCIAL POSITION OF THE TEACHING HOSPITAL

By a teaching hospital we mean those hospitals which have a primary responsibility in the education and training of physicians, specifically hospitals which meet the definition of the Association of American Medical Colleges:

1. Hospitals involved in the education of medical students and so designated by the Dean of a medical school or
2. Hospitals having internship programs and approved residencies in four of the five specialties: medicine, surgery, pediatrics, obstetrics and gynecology, and psychiatry.

Of the 7,000 hospitals in the country only about 400 meet this definition and would qualify as teaching hospitals.

The primary function of the hospital, regardless of the adjective used to designate its character, is the care of the sick and injured of the community. An additional responsibility of the teaching hospital is the conservation and expansion of knowledge through educational endeavor and scientific research. The teaching of medical students; the graduate training of interns and residents; the support of schools for nurses, dietitians, medical record librarians physiotherapists, x-ray and laboratory technicians and other

allied health personnel; the conduct of postgraduate refresher courses for practicing physicians and teaching conferences open to all physicians on a regular basis; the publication of clinical experience and research findings and the further sharing of knowledge through visiting lecturers, all round out the activities of the teaching hospital and its staff. In such an environment of constant inquiry, high intellectual activity, repeated questioning of the conventional wisdom, constant scrutiny of established procedure, and the rigorous application of the scientific method, the quality of patient care is likely to be optimal.

Our country depends on such teaching hospitals for the setting of standards in the best care of the sick and for the provision of the all-too-scarce supply of well-trained doctors, nurses, dietitians, technicians and others. The urban, university-affiliated, teaching hospitals set standards of excellence in medicine. They must be understood, supported, and protected by the community as well as by the profession so that the long-range interests of the community in matters of health and disease will be served in optimal fashion.

As Dr. Philip R. Lee, Assistant Secretary for Health and Scientific Affairs, Health, Education and Welfare, has

said, "We cannot separate these problems of the inadequate health services for the poor, our obsolete hospital facilities and our unmet manpower needs from our system of delivering total health care. This, in turn, cannot be separated from medical education and research."

TEACHING HOSPITAL SURVEY

Ninety-six per cent of the teaching hospitals replying to a questionnaire reported that a major remodeling and/or expansion program was needed by their institution and planned sometime during the next 10 years. The questionnaire was sent to 239 members of the Teaching Hospital Council of the Association of American Medical Colleges (Federal and Canadian hospitals were not included). Replies were received from 164 teaching hospitals, giving a 69% return.

It is significant that the construction programs planned an equal number of replacement beds and additional beds. Much consideration has been given to replacement of obsolete facilities but the need for additional beds has not been sufficiently emphasized.

Why are more hospital beds needed?

1. Great emphasis has been placed on the critical need for increased health manpower. To achieve this new

medical schools are being built, existing medical schools are expanding their classes, strenuous efforts are being made to interest more girls in nursing careers, programs for training members of the Allied Health Professions are being encouraged and supported by government funds. All of these training and educational programs require clinical facilities and we must increase our beds and out-patient facilities to provide the clinical basis for training increased health manpower.

2. Many hospitals are planning to build much needed extended care facilities either by new construction of such facilities or by new construction of general hospital beds and conversion of existing structures to extended care facilities.

3. Many hospitals cannot meet the demands placed upon them. A typical example of what is going on all over the country is reported in the New York Times, April 9, 1967

"The victim of a minor stroke was placed on a three-week waiting list for admission to a prestige hospital in the Bronx. A Manhattan physician reports that acute coronary cases face a delay of 6 to 12 hours for admission to a prestige Manhattan hospital. The administrator of a prestige Brooklyn hospital reports a one-to-two-week admission delay for patients requiring breast surgery, for diabetics out of control, and for victims of slight congestive heart failures...."

"The shortage of hospital beds is caused by the high occupancy rate of the better hospitals. University medical centers and the better voluntary hospitals report occupancy rates of more than 90 percent. The occupancy rates of all hospitals have increased by about 3 percent in the last year, with the highest increases reported by the better hospitals."

(Note to Lou Rohrbaugh:

You or one of your associates might write a summary of the Survey.

Should a copy of the survey be attached to this statement?)

REGIONAL PLANNING

The public is rightly concerned that the remodeling and/or expansion of hospitals be on an orderly planned basis to meet the health needs of the country and to prevent unnecessary duplication of facilities or the perpetuation of unneeded health facilities. The Comprehensive Health Planning Act (P.L. 89-749) and proposed amendments and the numerous regional and local planning agencies springing up all over the country are making health planning by representative citizen groups a reality. Planning will improve the health care system of our country.

However, health planning is not a panacea. It will not solve all our problems or even substantially reduce our

health care costs. Health planning is not an exact science - in fact our knowledge is extremely limited, based on judgment and experience. Experts frequently disagree. In a time of revolutionary change in the science of medicine and in the patterns of delivery of health care, future predictions upon which planning is based must be educated guesses, at best.

There can never be absolute control under a health plan and a voluntary hospital system at the same time. We can and must develop a partnership between government and voluntary hospitals but each must recognize the special responsibilities and contributions of the other.

In any planning program teaching hospitals and especially those owned or affiliated with medical schools where medical students are taught, must be regarded in a special category. These teaching hospitals are not only local agencies, they are national resources. As Dr. Thomas B. Turner, Dean of the School of Medicine, The Johns Hopkins University, said in his statement for the Association of American Medical Colleges regarding the "Partnership for Health Amendments of 1967 (May 4, 1967)

"Most importantly, each medical school and major teaching hospital, whether state supported or not, exists, at least in part, to serve our entire nation. Each is

"located within a state but no one exists to serve only the needs of that state. Medical schools accept students and teaching hospitals accept interns, residents and patient from throughout the nation. After completing their training, young physicians serve in the Armed Forces, the Public Health Service and settle in various parts of the nation to serve the civilian population. And many members of the allied health professions are similarly mobile.

"The idea that such institutions should be completely subject to control by a planning agency in the state in which they happen to be located simply would not work -- that is, save to the great detriment of the United States.

"Ohio, for instance, is the home of some three medical schools with another being developed. Their graduates serve in countless states. Surely it is not the intent of Congress to make it possible for a state planning agency to say that if perhaps two of those institutions would turn out enough physicians for Ohio, no federal funds would go to expand the others until all of California's needs for venereal disease clinics, drug addiction centers, sewage plants, and other public health facilities of high priority for that one state had been met."

IV. FINANCING HOSPITAL CONSTRUCTION

The dilemma facing hospitals in financing construction is basically due to the fact that they are non-profit institutions, being reimbursed on a cost basis and unable to accumulate any surplus to be used for development of new plant facilities. The depreciation received, even when funded, must be used for replacements or maintenance of existing plant and equipment. The situation is just the opposite in industry, where profits are permitted and a significant proportion of them are plowed back into capital development programs.

Before 1929 hospital construction was largely financed by contributions from philanthropically minded individuals. This gave us the basis for our present system of voluntary hospitals but proved to be totally inadequate to meet increasing demands for health care and scientific advances in medicine.

In 1946 the Hill-Burton Act was passed providing for from 33 1/3% to 66 2/3% of hospital construction costs from the Federal government and the balance from charitable contributions. This epic-making federal legislation which provided assistance for over 8,000 projects enabled the country

to overcome a shortage of hospital beds, particularly in our small towns and rural areas.

In the 1960's the so-called, one-third, one-third, one-third formula began to emerge. This formula called for one-third of the hospital construction costs to come from Hill-Burton funds, one-third from charitable contributions and one-third from borrowing.

But Federal, State and charitable contributions were not sufficient to meet the needs for hospital construction and the present trend is increasingly toward borrowing more and more of the funds needed for construction. This borrowing is from endowment funds when they are available, from banks or insurance companies and in a few cases from tax-exempt bonds.

Borrowing for capital funds seems attractive but it adds significantly to the cost of hospital operation and is not a socially wise or desirable method of financing hospital construction. It places an added cost on the sick and those who are least able to pay for it. We need a system which will spread the cost of hospital construction more equitably over the total population.

The cost of borrowing is high. If we assume a cost of \$33,000 per hospital bed, a 75% occupancy and 6% interest,

then if there is a 20 year life of the building it will add approximately \$10.50 to the operating cost for each and every patient day.

The difficulty in hospital financing has forced hospitals to use added personnel to get the job done in obsolete and inefficient facilities. This has tended to increase hospital operating costs and has caused the inefficient use of medical and other health personnel.

V. MAJOR FEDERAL AID PROGRAMS FOR
HOSPITAL CONSTRUCTION

A review of the Federal Aid Program for Hospital Construction shows that there are no programs now available which can make any significant contribution to the current great needs of hospitals for construction funds.

The Hospital and Medical Facilities Act (Hill-Burton) is primarily designed to meet the needs of rural, small town and suburban communities. Its assistance to teaching hospitals is insignificant. For example, in Massachusetts the maximum aid through the Hill-Burton funds is limited to \$450,000 and the teaching hospital construction project cost may well run \$30,000,000 to \$40,000,000.

The Health Professions Educational Assistance Act of 1963 has as its primary purpose the increasing of medical students. In effect, assistance is available only to those hospitals associated with medical schools which increase the enrolment of medical students by 20%. In many situations this is neither possible nor desirable. Funds are available under this act only to support "educational space" in teaching hospitals. For those teaching hospitals where there are no medical students there is no assistance.

The Community Mental Health Centers Act of 1963 and the Mental Retardation Facilities Act of 1964, and the related Mental Retardation Acts are important but lend assistance only in a limited area of total health care facilities.

Under the Health Research Facilities Act matching funds are available but this is only for research facilities and this does not meet the general needs of the teaching hospitals.

Under the Hospital and Medical Facilities Research Program the maximum available to hospitals for construction has been about \$500,000.

All of these programs are important and make significant contributions to the health care needs of our country but there is a great lack since none of them provide significant construction funds for general needs.

PENDING RELEVANT LEGISLATION

H.R. 9179 - "Mortgage Insurance for Needed Non-Profit Hospital Facilities"- Representative Gerald Ford and others.

A plan which requires total repayment of principal plus interest and premiums which could be as high as 7%, is not feasible. It could increase costs by more than \$10 a day

and load this all on the sick patient rather than spreading some of the cost over the general public.

H.R. 4473 - Representative Ottinger and S-859, Senator Magnuson, "Hospital Emergency Assistance Act of 1967". The proposed appropriation of \$58 million would permit assistance to a few small hospitals, but would have no effect on the needs of the hospital system of the country.

"Hospital Modernization & Improvement Act of 1967" introduced by Senator Javits (R) N.Y., and Representative Celler (D) N.Y. on July 10, 1967 has not been reviewed. It has useful features but since it appears that the total principal plus 2% interest must be repaid by the hospital it loaded a considerable increased patient day cost on the patient rather than spreading this cost over more of the entire community as would be done if grants for part of the principle were included.

VI. POSSIBLE SOLUTIONS

There appear to be three types of possible solutions which are discussed below.

Plan A - Major Construction Grants to Teaching Hospitals

COMMENT:

Because of the size of the construction money needed and the deep involvement of the federal government at this time in other programs, major construction grants appear to be a most unlikely solution and are not further discussed.

Plan B - Matching Grants for Construction Similar to Hill-Burton

COMMENT:

Even if the matching is on a 50/50 basis, the amount required from federal funds is far in excess of that available. Additionally, it is clear that the teaching hospitals will be unable to raise their 50% from private philanthropy. These hospitals are already aware that

that the traditional sources of money are not any longer available in the same quantity as before. This is particularly true for programs whose primary purpose is to replace obsolete bed facilities or to add new beds to existing facilities.

PLAN C - Combination Grant-Loan Programs

10% - Applicant must assure federal authorities that he has in hand from private sources 10% of proposed construction monies.

20% - Federal government grants applicant 20% of total at the time construction begins.

35% - Government assures applicant of 25% of construction monies from government borrowing. Principal and interest are paid by government over a period not to exceed 10 years.

35% - Government authorizes applicant to borrow 35% on a straight loan or bond issue basis. The government insures both interest and principal for the period not to exceed 25 years.

Plan C - Combination Grant-Loan Programs (continued)

The above formula provides a viable mechanism for large-scale construction over a period of 10 years. The federal government share amounts to 55% of the total of which 20% is paid at once and 35% represents deferred payment for a period of 10 years. The applicant share represents 45% of which 10% is raised from the applicant's own sources and 35% on a straight loan or bond issue basis. Interest and principal on the latter are paid from the applicant's operating revenues for a period not in excess of 25 years.

VII. RECOMMENDED SOLUTION

1. Interim Solution

Plan C appears to offer the most hope for the nation to mount a massive hospital bed construction program. This one-time combination of grant and loan program minimizes the immediate impact on federal spending. The net effect of this program makes available large sums of money in the immediate future.

2. Funding Depreciation

No program involving outright grants or grants plus loans provides an acceptable long-range solution to the problem of teaching hospital construction needs. The long-term solution is a requirement by the government that reimbursement formulae used in the determination of patient cost include depreciation of the present plant at cost of doing business. All hospitals accepting payment under such formulae must be required to fund these monies for ultimate replacement of bed care and clinical facilities.

3. What can Hospitals Expect from Private Philanthropy and Foundations?

It is abundantly clear from the annual reports of the major foundations in the country which relate to health

services that their primary interest lies in new, innovative, experimental programs in the delivery of health care. They have a low level of interest in providing funds for the replacement of obsolete facilities or for the expansion of existing facilities which they believe to be a public responsibility.

RTV:ea
7/24/67

DEVELOPMENT OF THE AAMC
SINCE JANUARY 1965

Introduction

At its meeting on March 15, the Executive Council adopted a resolution which reads:

"The Executive Council reaffirmed its support of the Coggeshall Report (through page 48) and requested its staff to prepare a memorandum on the portions of that report which have been implemented, and intends to utilize the report as the outline for its systematic review of the structure and functions of the AAMC."

January - April 1965

From the time the new Executive Director reported for duty, January 1st, until the report of the Coggeshall Committee, "Planning for Medical Progress Through Education" was received, the main preoccupations were the continuity of previously established programs and the opening of a Washington office for the AAMC.

The stability and loyalty to the Association of key members of the staff and inherent soundness of the established programs made it possible for all of them to continue in a sound manner through that period of transition.

After the national elections in the fall of 1964, the Executive Council was convinced that the 89th Congress was so certain to adopt legislation of major importance to medical schools that it approved the recommendation of the Executive Director-Designate that steps be taken immediately to open an office in Washington, however small. Accordingly, a small amount of space was rented from the American Council on Education and occupied early in the calendar year. So little time was available (and so little financial support for the purpose) that the decision was made that it was not practical to add someone to the staff with sufficient knowledge of the needs and attitudes of the medical schools, the past activities and policies of the AAMC, and the background of legislative proposals and considerations to be the key person in the Washington office. It was therefore decided that the Washington office should be the direct responsibility of the Executive Director, that Dr. William Maloney, Associate Executive Director, should be given increased responsibility for the Evanston office, and that the Director of each Division should be expected to carry on his program within established policies with the Executive Director commuting frequently between the two offices.

April - November 1965

On April 19, 1965, Dr. Coggeshall presented his principal recommendations to the Executive Council in person, and delivered the written report of his committee. Thereafter, the Executive Council decided to hold numerous extra meetings of its own for thorough discussion of the report and its recommendation. Quite early in those discussions the Executive Council accepted the report in principle in the spirit that action along those general lines was necessary. It also decided that although a number of the recommendations could, under the Bylaws, be implemented simply by action of the Council, the collective wisdom of the membership was necessary. The Council decided that the function of

recommending objectives and philosophy and reviewing programs and plans of the Association, which Dr. Coggeshall had recommended be carried out by a "blue ribbon committee", should not at that time be delegated to such a committee, but should be carried out by the Council itself.

During the summer of 1965, regional meetings were held in five different cities for discussion of the Coggeshall Report with the representatives of institutions encouraged to attend that meeting most convenient for them. The Council or its representatives also discussed parts of the recommendations with the presidents of universities holding membership in the AAU, officials of several organizations in higher education, foundations and federal agencies. These discussions led the Council to decide not to accept, or propose to the Institutional Members, the recommendation that the university - rather than the medical school - become the institutional member of the Association.

At the annual meeting in 1965, the Institutional Members thoroughly discussed, modified and adopted a statement of objectives for the Association, which reads:

"The purpose of the Association is the advancement of medical education. In pursuing this purpose, it shall strengthen, expand, and cooperate with all educational programs that are important to the nation's health, with particular concern for the entire span of education and training for the medical profession and health sciences. The Association will foster studies in research, provide means of communication and forums, and perform services necessary to program and policy decisions that the above broad objectives require."

The Institutional Members approved converting the "Teaching Hospital Section" into a "Council of Teaching Hospitals" and authorized it to designate a person to be elected as a voting member of the Executive Council and changed the Bylaws to accomplish this objective.

July 19th and 20th, 1966

At a special meeting on July 19th and 20th, the Institutional Members took action to establish a formal regional organization of Institutional Members whose major function should be to identify, define, and discuss issues relating to medical education, and to make recommendations for further discussion of such issues at the national level. They approved the principle that the Executive Council should be reconstituted so as to be representative of the regions.

The Institutional Members approved the formation of the Council of Academic Societies and authorized a task force to work out the details and bring back specific recommendations at the annual business meeting.

At that meeting, the Institutional Members approved in principle a resolution urging the coordination and simplification of regulations and procedures of federal agencies and authorizing the President to transmit a strong, appropriately worded resolution to the President and the Secretary of HEW, as well as other officials. And the Institutional Members adopted a proposal that there

be more frequent meetings of the Institutional Members for thorough discussion leading to the determination of AAMC policy on topics of national concern to medical education.

Annual Business Meeting, October 23, 1966

At the annual business meeting on October 23, 1966, the Institutional Members approved revision of the constitution and bylaws which had been prepared by a special committee, and which provided explicitly for a formal regional organization of the Association, the Executive Council's being constituted so as to be representative of those regions, and a specific mechanism for the establishment of "councils" of the Association.

The Institutional Members also adopted a specific description and pattern for the regional organization of the Association, and guidelines for the development of the Council of Academic Societies with procedures for its further development and representation on the Council of the Association.

REVIEW OF RECOMMENDATIONS
AND ACTIONS ON THEM

Dr. Coggeshall's recommendations are summarized on pages 100-104, of "Planning for Progress Through Medical Education", under eight separate headings.

Philosophy and Objectives

The first two recommendations have been accepted by the Institutional Members.

1. The philosophy of the Association should be enlarged to permit the Association to assume and exercise a greater leadership role.
2. The philosophy and objectives of the Association should not be restricted to emphasis on the medical school but should be more broadly conceived in terms of service to the nation and community as well as to members.

The third recommendation has not been explicitly accepted or rejected.

3. A broader and more precise philosophy should be adopted with respect to bonds between the Association and the universities.

It can be said that the fourth and fifth objectives have been accepted implicitly and passively but not effectively carried out.

4. The Association should undertake to be a more effective spokesman, and its philosophy and objectives should be spread across the land.
5. The broader philosophy should be the basis for realistic and concrete objectives that can be guides to action directed toward agreed ends.

The Executive Council has decided not to implement the sixth recommendation but to fill the role described for the blue ribbon committee itself.

6. An ad hoc "blue ribbon" committee should be established by Executive Council to work with the Executive Director to formulate statements of philosophy and objectives for the Association.

The Executive Council has embarked upon efforts related to the seventh, eighth and ninth recommendations, but a good bit remains to be done before it can be said that they have been fully implemented.

7. The Executive Council should adopt official statements of the Association's philosophy and objectives.
8. The statements of objectives should be used as continuing guides for planning and evaluating the Association's programs and actions and for interpretation of the Association's work.
9. Particular effort should be made to inform members of the Association's philosophy and objectives, once they have been established.

Programs

The first three recommendations have been carried out in large part.

1. The accreditation program should be continued and strengthened. Enlarged panels of visitors should be provided to afford greater flexibility, coverage, and timeliness in the accreditation process.
2. The Association should continue to make special one-time studies and, occasionally, recurring studies concerned with the general operation of medical schools.
3. International medical education activities should be continued.

The enlarged panels have not been fully implemented. Fairly good progress is being made toward achieving greater flexibility, coverage and timeliness in the visitation of medical schools, but more needs to be done. During this transitional year for the Division of International Medical Education, the Association faces difficult decisions as to the future direction of that program.

The fourth recommendation has not been carried out.

4. "Core" research projects should be given more concentrated attention and resources and be expedited.

Each of the major elements of the "core" research program has been developed logically to an appropriate terminal point, but increased resources have not been available in such a way as to fit precisely with the "core" program.

The fifth recommendation has not been carried out.

5. The "blue ribbon" committee should make a systematic examination of all present programs and needs for new programs.

The Executive Council is heavily engaged in playing this role itself.

It can be said that the sixth recommendation has been accepted, although this is a never ending process.

6. Important new program fields should receive attention as possible parts of a new program structure.

Discussions indicate that the Executive Council is favorably disposed toward the seventh recommendation, but no specific means of carrying it out have yet come into focus.

7. Particular attention should be given to developing improvements in the team approach in both hospital care and medical practice.

Much the same thing can be said about the eighth and ninth recommendations.

8. Attention should be devoted to the development of basic educational programs leading to an earlier differentiation in specialties.
9. Particular effort should be made to provide leadership and aid in the development of improved approaches to family practice.

There has been little discussion of the tenth recommendation.

10. Serious consideration should be given to developing a program to study and exchange information concerning computer applications.

No practical way for the Association itself to mount a clearly visible and effective program in regard to this has been seriously proposed.

Some of the programs and activities of the Association, particularly its Division of Education, can be said to be relevant to the eleventh recommendation.

11. More intensified work leading to curriculum improvement should be considered.

But it would be difficult to be certain whether the words "more intensified" would accurately describe what has happened.

The Executive Council, and to some extent, the Institutional Members, are now engaged in discussions and considerations that are highly relevant to recommendations 12 and 13.

12. Some programs should be reviewed with particular attention to their importance and priority for the future.
13. The Association should provide for the elected leadership and senior staff members to evaluate programs continually, using established objectives as the standard of evaluation.

It is probable that Dr. Coggeshall had in mind a more highly organized and systematic approach to program evaluation than has been carried out to date or than could readily be done without assigning appropriate members of the staff to program evaluation on a nearly full time basis.

Services

The first recommendation has not been carried out.

1. Services provided to members and others should be reexamined by the "blue ribbon" committee established to review programs.

The second recommendation has been carried out.

2. Basic data and general information services should be continued and improved.

The recent grant from the Markle Foundation will make it possible to move more rapidly and effectively toward improvement in this area.

The third recommendation has not been carried out.

3. Editing and production of all publications should be brought under one individual.

Dr. Cooper serves very effectively as editor of the Journal on a part time basis, he would not want or accept the responsibility of supervising all of the publications, nor would it be appropriate at this stage to assign a member of the staff to detailed supervision of the activities of the Journal. The other publications of the Association should be brought more effectively under the supervision of one individual.

The fourth recommendation is being carried out.

4. Publications should be self-sustaining.

If a rational portion of dues from individual or Institutional Members were allocated to the cost of the Journal, all of the publications efforts of the Association would be seen to be self-sustaining.

The fifth recommendation is being carried out.

5. The Association of American Medical Colleges Directory and Medical School Admissions Requirements should be continued as basic publications, on a self-sustaining basis.

The sixth recommendation is being carried out.

6. Efforts to improve The Journal of Medical Education and increase its circulation should continue.

These efforts should be markedly increased. Serious consideration should be given to distributing the Journal to a much longer list of full time members of the faculties (perhaps all) and to upgrading the appearance and type face of the Journal itself.

The seventh recommendation is being carried out.

7. Continued effort should be made to improve the content and organization of annual meetings.

The eighth recommendation has not been fully or effectively carried out.

8. Meetings should be arranged and conducted on a self-sustaining basis.

The registration fee which has been charged in each of the last two annual meetings has partially offset the expense, but it is far from popular. Since the attendance at the annual meeting is larger and now includes the administrators of a considerable number of the most important hospitals in the country,

paid exhibits should probably be encouraged and actively promoted.

The ninth recommendation is being carried out.

9. Regional meetings should be provided for.

The tenth recommendation is being carried out.

10. The Medical College Admission Test and National Intern Matching Program should be continued.

It can be said that the eleventh recommendation is largely being followed.

11. Printing services should be provided only where essential and where needed services cannot be obtained elsewhere at equivalent cost.

The staff has reviewed the printing activities with care and concern. It seems clear that having all of the printing done on a contract basis would add modestly to the cost. A much more important consideration is the impossibility of getting outside contractors to accept such irregular schedules and very short lead times as many of the publications of the Association involve.

The twelfth recommendation has not been fully accepted or implemented.

12. Arrangements should be made to assure that costs of consultations and seminars are met by the institutions benefitted.

The 13th and 14th recommendations are rather general. It can be said that they have been accepted and carried out in part but that this is a continuing process.

13. New services should be considered that will be in keeping with the enlarged leadership role of the Association.

14. The Association should maintain positive working and informational contacts with all organizations concerned with education for health and medical sciences.

The 15th recommendation has been and is being carried out.

15. The Association should publish a bulletin providing current information about federal government programs of vital concern to medical education.

The 16th recommendation has not yet been carried out.

16. The Association should plan and conduct periodic training institutes for new administrators.

The staff is actively working on a proposal for serious study of the problems of administrators of medical schools that will involve more than, but will probably include, seminars or orientation sessions for new administrators.

Development and Review of
Programs and Services

It is probable that Dr. Coggeshall had in mind a much more systematic and orderly approach to program planning than has yet been practical.

A sound approach to planning should be developed, adopted, and followed so that programs and services can be consciously and systematically planned in relation to agreed objectives and on the basis of careful analysis of need.

Organization

The first recommendation was given consideration, particularly by the Committee on Constitution and Bylaws, although the revisions they recommended and which were adopted represent slight changes in the plan of organization of the Association.

1. The plan of organization of the Association should be revised to reflect clearly the new philosophy and enlarged leadership role that has been proposed.

The second recommendation has been considered and not accepted.

2. A new name such as "American Council on Medical Education" or "Association for the Advancement of Medical Education" should be adopted.

The third, fourth and fifth recommendations have been accepted.

3. The Association should continue primarily as a membership organization of educational institutions.

4. The basic class of membership should be "institutional membership." In addition to primary institutional members there should be "graduate institutional members," "associate institutional members," and "provisional institutional members."

5. A second class of Association membership should be "individual members." The three categories of individual membership should be "emeritus members," "participating members," and "sustaining and contributing members."

It is not entirely accurate to describe the sustaining and contributing members as individual members. Nor is it entirely clear what Dr. Coggeshall had in mind concerning "participating members".

Efforts to carry out the sixth recommendation in slightly modified form are under way.

6. Provision should be made for suitable participation by other organizations. "Affiliate members" should be provided for as a third class of membership.

The Council of Academic Societies represents a serious effort to obtain the very active participation of certain other organizations and through them, of key members of medical faculties.

The seventh recommendation has not been carried out.

7. The Association should recognize as "related organizations" other organizations primarily concerned with education or practice in health and medical sciences.

Relations and liaison with such organizations continue to be cordial and pretty good, and it is not entirely clear what would be accomplished by formally establishing and attempting to recognize "related organizations."

The eighth and ninth recommendations have not been carried out as explicitly as recommended.

8. A "general assembly" should be established as the constitutional governing body of the Association and to represent all members.
9. The general assembly membership should comprise (1) institutional representatives, (2) affiliate representatives, and (3) related organization representatives.

The constitutional governing body continues to be the representatives of medical schools who are Institutional Members, but the meetings of the Institutional Members are developing into serious discussions of policies and national problems.

The tenth, eleventh, and twelfth recommendations have neither been accepted nor rejected.

10. The senior officer of the Association elected annually should be designated the "chairman."
11. The full-time chief executive officer of the Association should be given the title of "president."
12. The Executive Council should serve as "board of directors" of the Association.

The Executive Council should probably give serious consideration to these three recommendations at an early date.

A substantial modification of the 13th recommendation has been adopted.

13. Three councils should be established: (1) council of deans, (2) council of administrators, and (3) council of faculty.

The Council of Teaching Hospitals has been fully activated and the Council of Academic Societies has been fully approved and is being developed. It would be logical to follow this line of reasoning and convert the Group on Student Affairs into a council on student affairs. In a reconsidered terminology for use in the organization of the Association, a "council" might be used for clearly defined portions of the Association which are composed of representatives of many institutions or of many societies.

The 14th recommendation has been made inappropriate by action taken to establish the Council of Teaching Hospitals and the Council of Academic Societies.

14. Three commissions should be established: (1) commission of related health organizations, (2) commission of teaching hospitals, and (3) commission of teaching organizations.

If the term commission is to be used in the reconsidered terminology for the Association, it probably should be applied to standing committees.

Recommendation 15 has not been adopted.

15. Standing committees should include the (1) program committee, (2) finance committee, (3) accreditation committee, (4) public interpretation committee, (5) government relations committee, and (6) research committee.

The committee structure of the Association has been modified but little.

Recommendations 16, 17 and 18 have been adopted.

16. Provision should be made in the revised plan of organization to extend and encourage participation and communication within regions.
17. "Regional assemblies" should be established by member institutions. "Regional councils" should be developed.

The regional meetings have not been developed to this full extent and it is not yet certain how far they should go toward more formal organization.

18. There should be five regions: (1) east, (2) southeast, (3) north central, (4) central and southwest, and (5) west.

The five regions adopted by the Institutional Members vary slightly from this description and follow the pattern of the Group on Student Affairs.

Specific consideration has not yet been given to the 19th recommendation.

19. Study should be given to the desirability of encouraging formation of local or institutional chapters of the Association.

The Committee on Constitution and Bylaws did give some consideration to the 20th recommendation.

20. A definite plan of organization covering the governance, legislative functions, advisory duties, and staff functions should be adopted.

The Executive Council should consider a comprehensive plan of organization and functions.

Relationships

Efforts were made to carry out the first recommendation, but they were not very successful.

1. To strengthen relationships with universities, strong effort should be made to involve university presidents and vice presidents responsible for health programs in Association affairs.

Though the chance of involving university presidents actively seems remote, intensive efforts to develop a productive role for vice presidents might be productive.

In a sense, the second recommendation has been adopted.

2. The Association should seek positive and active relationships with key organizations interested in all aspects of education for health and medical sciences.

It cannot be said that the third recommendation has been fully accepted or could be fully implemented.

3. The Association should serve as spokesman for organizations concerned with education for health and medical sciences.

The Association is making some progress toward being a more effective spokesman for itself and for the medical schools and on a broader basis than the educational program leading to the M.D. degree, but much more progress in this direction is highly desirable.

It cannot be said that the fourth recommendation has been fully implemented.

4. The Association should take the initiative in developing the United States Government's interest in support for education, for health and medical sciences.

The Government's interest is so keen and its support is growing and changing so rapidly that they need little development. It remains highly desirable that the Association anticipates the future to such an extent that it can provide more initiative and guidance.

The fifth recommendation has been carried out.

5. The Association should establish regular representation in Washington to fulfill its leadership role and assure effective continuing contacts with the United States Government and other organizations primarily concerned with higher education.

This assignment is so large that it fully justifies far more time and effort than are currently available.

Little progress has been made toward implementing the sixth and seventh recommendations.

6. The Association should expand its efforts to interpret to the American public the objectives, programs, and needs of education for health and medical sciences.
7. Serious consideration should be given to the development of public interpretation services.

A very great deal could be done in this direction if resources could be made available for the purpose.

Facilities

None of the three recommendations as stated have been taken. The development of the Washington office was literally necessary to provide regular representation in Washington, to establish liaison with other organizations in higher education, officers responsible for administering established federal programs, and keeping up with legislative developments, as well as providing necessary additional space.

Studies of the future requirements for facilities in Evanston and in Washington have been made, but their usefulness is sharply limited by the lack of certainty about programs and services to be provided in the future. It is clear that the possibility for expanding the building in Evanston is limited to about 5,000 additional square feet at a cost of something like \$100,000. It is also clear that the Washington office will have to be relocated promptly and that the activities of that office which can now be predicted with some confidence will require between three and four thousand square feet of space.

Improvements in the utilization of present space in Evanston have been studied with some care and some modest improvements are clearly practical.

1. Initial steps should be taken leading to eventual relocation of Association headquarters in Washington, D.C.
2. Thorough study should be made of future facilities requirements with the intent of relocating headquarters in Washington.
3. Interim improvements should be made in the headquarters and other space in Evanston.

The decision has been made to retain and improve these facilities at least for a number of years.

Financing

The first two recommendations have been tacitly agreed upon by the Executive Council, although the accomplishments to date have not been very impressive.

1. The Association should make efforts to develop general financial support and support for major programs.

The recently appointed ad hoc committee on ways and means represents a more intensive effort in this direction.

2. Government support should be more actively sought for the Association's programs.

Federal support has been obtained for the Library Study, the faculty roster, and the AID project, and federal support for other projects is under active consideration.

The third and fourth recommendations have not been explicitly considered by the Executive Council, but they have been partially explored by the staff.

3. The Association should adopt a program approach to budgeting.
4. Actual or possible subsidy situations should be examined.

PRELIMINARY
PROGRAM FOR ANNUAL MEETING

Tenth Annual Meeting
Council of Teaching Hospitals

Seventy-Eighth Annual Meeting
Association of American Medical Colleges

Friday, October 27 through Monday, October 30

New York Hilton Hotel
New York City

Saturday Afternoon, October 28, 1967

12:30 P.M. - 1:30 P.M. - Annual Council of Teaching Hospitals Luncheon

1:30 P.M. - Comprehensive Planning and the Role of the University
and the Teaching Hospital.

William H. Stewart, M.D.
Leo J. Gehrig, M.D.
Albert W. Snoke, M.D.
Robert C. Wood, Undersecretary,
Department of Housing & Urban Development

2:45 P.M. - The Role of the Teaching Hospital in Comprehensive,
Community Planning.

Anne R. Somers

3:30 P.M. - The Impact of Prepayment on Medical Education and
Teaching Hospitals.

Walter J. McNerney

4:15 P.M. - Manpower and the Teaching Hospital.

Leonard D. Fenninger, M.D.

Tentative AAMC Theme

The Education of the Physician -- A Holistic Approach

Executive Committee, COTH
Meeting of May 11-12, 1967
Addendum No. 4 (2 pages)

Sunday Afternoon, October 29, 1967

2:00 P.M. - 4:00 P.M. - Simultaneous Discussion Groups.

Group 1 - Comprehensive Planning for the
National Scene.

Moderator
Public Health Service
Others

Group 2 - The Teaching Hospital Director and
His Community Leadership Responsibility.

Moderator
Anne R. Somers
Others

Group 3 - Regional Medical Programs and
Comprehensive Planning Act 89-749
- What are the Differences.

Moderator
Public Health Service
Others

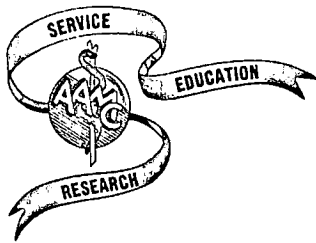
Group 4 - Financing the Teaching Hospitals.

Moderator
Ray E. Brown
George Bugbee
William Gorham
Others

Group 5 - How Do ^{to} We Increase the Health Man-
power Supply?

Moderator
Leonard D. Fenninger
Others

H. A. L. Hunt



ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF TEACHING HOSPITALS
1346 CONNECTICUT AVENUE, N.W.
WASHINGTON, D. C. 20036
202/223-5364

MATTHEW F. McNULTY, JR.
DIRECTOR

STATUS OF COTH MEMBERSHIP
Fiscal Year 1968-69
As of September 6, 1967

Total Membership 1966-67	323
Paid Membership to Date for Fiscal Year 1967-68	264
Unpaid to Date	74

PLEASE READ INSTRUCTIONS ON REVERSE SIDE

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership
in the
Council of Teaching Hospitals

(Please type)

VETERANS ADMINISTRATION HOSPITAL

Hospital:

10701 East Boulevard

Name

Cleveland

Street
Ohio

44106

City

State

Zip Code

Principal Administrative Officer:

SAMUEL L. ASPIS, M.D.

Hospital Director

Name

Title

Hospital Statistics:

Date Hospital was Established: **May 7, 1964**

Average Daily Census: **731**

Annual Outpatient Clinical Visits: **108,039**

* **As of Fiscal Year ending 6/30/67**

Approved Internships:

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

Approved Residencies:

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total Residencies Filled
Medicine	1947	42	29
Surgery	1947	*	
OB-Gyn	0		
Pediatrics	0		
Psychiatry	1947	*	

* **These are integrated Residency Programs with University Hospital of Cleveland. Therefore, no Residency positions are offered separately by this hospital.**

Information submitted by:

SAMUEL L. ASPIS, M.D.

Name

August 10, 1967

Date

Samuel L. Aspis

Title

Signature

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

PLEASE READ INSTRUCTIONS ON REVERSE SIDE

Instructions:

Please complete all copies and return three copies to the Council of Teaching Hospitals, Association of American Medical Colleges, ~~2530 Ridge Avenue, Evanston, Illinois 60201~~, retaining the blue copy for your file.

MATHEW J. ROBBINS, JR.
President
Council of Teaching Hospitals
Assoc. of American Medical Colleges
1501 New Hampshire Ave., N.W.
WASHINGTON, D. C. 20036

Membership in the Council:

Hospitals as institutions will be members of the Council and each institution will be represented by a designated person, designated by the hospital, for the purpose of conducting the business of the Council.

Membership in the Council will be annually determined and consist of:

- a. Those hospitals nominated by a medical school member of the AAMC from among the major teaching hospitals affiliated with the school,

and

- b. Teaching hospitals which are either nominated by a medical school member of the AAMC on the basis of important affiliations for the purposes of medical education or which have approved internship programs and full residencies in three of the following five departments: Medicine, Surgery, OB-Gyn, Pediatrics, Psychiatry, and are elected to membership by the members of the Council of Teaching Hospitals.

All members will vote at the annual meeting for officers and members of the Executive Committee. Voting on all other matters will be limited to one representative member for each medical school, who, in order to give broad representation, shall consult with the other teaching hospital members in his geographic region before votes are taken.

If nominated by School of Medicine, complete the following:

Name of School of Medicine SCHOOL OF MEDICINE,
CASE WESTERN RESERVE UNIVERSITY

Name of Parent University _____

Name of Dean of School of Medicine FREDERICK C. ROBBINS, M.D.

Complete address of School of Medicine Case Western Reserve University
School of Medicine
2065 Adelbert Road
Cleveland, Ohio 44106

FOR AAMC OFFICE USE ONLY:

Date _____ Approved _____ Disapproved _____ Pending _____

Remarks: _____

Invoiced _____ Remittance Received _____

PLEASE READ INSTRUCTIONS ON REVERSE SIDE

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership
in the
Council of Teaching Hospitals

(Please type)

Hospital: SACRAMENTO COUNTY HOSPITAL
 Name
2315 Stockton Boulevard
 Street
Sacramento California 95814
 City State Zip Code
 Principal Administrative Officer: Gordon R. Cumming
 Name
Administrator
 Title

Hospital Statistics: Date Hospital was Established: 1,849
 Average Daily Census: 524
 Annual Outpatient Clinical Visits: 120,000

Approved Internships:

Type	Date Of Initial Approval by CME of AMA*	Total Internships Offered	Total Internships Filled
Rotating	<u>prior to 1938</u>	<u>32</u>	<u>32</u>
Mixed	<u>0</u>	<u>0</u>	<u>0</u>
Straight	<u>0</u>	<u>0</u>	<u>0</u>

Approved Residencies:

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total Residencies Filled
Medicine	<u>0</u>	<u>0</u>	<u>0</u>
Surgery	<u>July 1, 1967</u>	<u>6</u>	<u>6</u>
OB-Gyn	<u>0</u>	<u>0</u>	<u>0</u>
Pediatrics	<u>0</u>	<u>0</u>	<u>0</u>
Psychiatry	<u>0</u>	<u>0</u>	<u>0</u>

Information submitted by:

Gordon R. Cumming Hospital Administrator
 Name Title
7/23/67 Gordon R. Cumming
 Date Signature

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

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and

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If nominated by School of Medicine, complete the following:

Name of School of Medicine _____

Name of Parent University University of California

Name of Dean of School of Medicine C. J. Tupper, M. D.

Complete address of School of Medicine School of Medicine

University of California - Davis

Davis, California; 95616

FOR AAMC OFFICE USE ONLY:

Date _____ Approved _____ Disapproved _____ Pending _____

Remarks: _____

Invoiced _____ Remittance Received _____

PLEASE READ INSTRUCTIONS ON REVERSE SIDE

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership
in the
Council of Teaching Hospitals

(Please type)

Hospital: VETERANS ADMINISTRATION HOSPITAL
Name

CLARKSBURG, WEST VIRGINIA 26301
Street City State Zip Code

Principal Administrative Officer: PAUL O. BATTISTI
Name
HOSPITAL DIRECTOR
Title

Hospital Statistics:
Date Hospital was Established: MARCH 12, 1951
Average Daily Census: 183
Annual Outpatient Clinical Visits: 10,500

Approved Internships:

Type	Date Of Initial Approval by CME of AMA*	Total Internships Offered	Total Internships Filled
Rotating	<u>INTEGRATED WITH WEST VIRGINIA UNIVERSITY SCHOOL OF MEDICINE.</u>		
Mixed	<u>INTERNS, IF ASSIGNED HERE, WOULD BE ON THE BASIS OF THIS</u>		
Straight	<u>INTEGRATED PROGRAM.</u>		

Approved Residencies:

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total Residencies Filled
Medicine	<u>RESIDENCIES INTEGRATED WITH WEST VIRGINIA UNIVERSITY SCHOOL OF</u>		
Surgery	<u>MEDICINE. NORMALLY, WE ARE ASSIGNED TWO RESIDENTS IN MEDICINE</u>		
OB-Gyn	<u>AND TWO IN SURGERY ON A CONTINUING BASIS. FUTURE PLANS INCLUDE</u>		
Pediatrics	<u>AFFILIATION WITH THE MEDICAL SCHOOL FOR RADIOLOGY, PATHOLOGY, AND</u>		
Psychiatry	<u>PSYCHIATRIC RESIDENTS.</u>		

Information submitted by:

PAUL O. BATTISTI
Name
SEPTEMBER 1, 1967
Date

HOSPITAL DIRECTOR
Title

Signature

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

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and

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All members will vote at the annual meeting for officers and members of the Executive Committee. Voting on all other matters will be limited to one representative member for each medical school, who, in order to give broad representation, shall consult with the other teaching hospital members in his geographic region before votes are taken.

If nominated by School of Medicine, complete the following:

Name of School of Medicine WEST VIRGINIA UNIVERSITY SCHOOL OF MEDICINE

Name of Parent University WEST VIRGINIA UNIVERSITY

Name of Dean of School of Medicine CLARK K. BLEETH, M. D.

Complete address of School of Medicine WEST VIRGINIA UNIVERSITY MEDICAL CENTER
SCHOOL OF MEDICINE
MORGANTOWN, WEST VIRGINIA 26506

MATTHEW F. MCNULTY, JR.
 DIRECTOR
 Council of Teaching Hospitals
 Association of American Medical Colleges
 1346 Connecticut Avenue, N.W.
 Washington, D.C. 20036
 Phone: 202/223-5364

FOR AAMC OFFICE USE ONLY:

Date _____ Approved _____ Disapproved _____ Pending _____

Remarks: _____

Invoiced _____ Remittance Received _____

PLEASE READ INSTRUCTIONS ON REVERSE SIDE

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Application for Membership
in the
Council of Teaching Hospitals

(Please type)

Hospital: St. Joseph Hospital
Name
2900 North Lake Shore Drive
Street
Chicago, Illinois 60657
City State Zip Code
Principal Administrative Officer: Sister Vincent, D.C.
Name
Administrator
Title

Hospital Statistics:
Date Hospital was Established: 1868
Average Daily Census: 480
Annual Outpatient Clinical Visits: 25,077

Approved Internships:

Table with 4 columns: Type, Date Of Initial Approval by CME of AMA*, Total Internships Offered, Total Internships Filled. Rows include Rotating (16 offered, 14 filled), Mixed, and Straight.

Approved Residencies:

Table with 4 columns: Specialties, Date Of Initial Approval by CME of AMA*, Total Residencies Offered, Total Residencies Filled. Rows include Medicine (12 offered, 12 filled), Surgery (6 offered, 6 filled), OB-Gyn (6 offered, 6 filled), Pediatrics, and Psychiatry.

Information submitted by:

Richard W. Zalar, M.D. Director of Medical Education
Name Title
August 23, 1967 Date Signature

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

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RECEIVED

JUN 16 '66

Beth Israel Hospital

330 BROOKLINE AVENUE • BOSTON, MASSACHUSETTS 02215

AAMC

SIDNEY S. LEE, M.D., Dr. P.H.

General Director

10 June 1966

Dr. Robert C. Berson
Executive Director
Association of American
Medical Colleges
2530 Ridge Avenue
Evanston, Illinois 60201

Dear Dr. Berson:

I am writing in my shortly to be assumed role as Associate Dean of Harvard Medical School for Hospital Programs, in reply to your letter of April 8th asking Dr. Ebert to nominate hospitals for membership in the new Counsel of Teaching Hospitals.

First, as to Harvard's 'primary' representative, we have agreed that this should be a rotating assignment. For an initial period of two years, the Massachusetts General Hospital, Dr. John Knowles, General Director has been selected.

✓ Voting group

In addition, the following list is designated for membership because of the importance of our affiliation:

✓ Beth Israel Hospital - Dr. Mitchell T. Rabkin - *does not, invoice*
General Director (from July 1st)

— Boston City Hospital - Mr. Donald DeHard (acting) - *does not, invoice*

✓ Boston Hospital for Women - Dr. John G. Freymann *about*
General Director (a recent merger of the former Boston Lying-In Hospital and the Free Hospital for Women)

— Children's Hospital Medical Center - Dr. Leonard W. Cronkhite, Jr.
General Director

XS - Dr. Berson 6-20

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*make
circle*

Massachusetts Eye & Ear Infirmary - Mr. Charles T. Wood
Director

Massachusetts Mental Health Center - Dr. Jack R. Ewalt
Superintendent

Peter Bent Brigham Hospital - Dr. F. Lloyd Mussells
Director

inquiry log

Robert Breck Brigham Hospital - Mr. Horace Altman
Director

Veterans Administration Hospital,
West Roxbury, Mass. - Dr. Richard P. Stetson
Chief of Staff

There is some question about the intent of the AAMC with regard to dues. This becomes especially pertinent for the Harvard Group where there are such a large number of hospitals. Is it the intent that only the "primary" representative pay dues at the rate of \$500. per year or is this amount to be assessed against each hospital which elects to join after having been nominated? If the latter is true, is the dues structure appropriate for schools with large numbers of affiliated hospitals?

I shall be at present address until June 30th and thereafter at the School, and would appreciate clarification of this matter.

Sincerely,

Sidney S. Lee
Sidney S. Lee, M.D.
General Director

s
p
b

~~SAR~~

BOSTON
HOSPITAL FOR
WOMEN

20 July 1967

Mr. Matthew F. McNulty, Jr.
Director
Council of Teaching Hospitals
Association of American Medical Colleges
1501 New Hampshire Avenue, N.W.
Washington, D.C. 20036

Dear Matt:

I am returning with regret the bill recently received for membership dues on the Council of Teaching Hospitals for the year beginning July 1, 1967. I do this as a matter of principle. In its first year of operation I believe that the information bulletins, publications, etc. have been worth our membership fee. However, I cannot accept the principle of paying full membership dues but sharing only one vote with all the other Harvard-affiliated hospitals. If I understand the regulations correctly, we would have a vote if we were not affiliated with Harvard. If this is to be truly a Council of Teaching Hospitals, why do we not vote by hospital rather than by university? The mixture between a single university vote and a number of non-affiliated institutions voting as hospitals seems to me inconsistent and clumsy.

I do not write to close the subject of payment of dues by this hospital. Rather I hope to open the question by this action. I will await your answer with interest.

Very sincerely,


John G. Freymann, M.D.
General Director

JGF/11

cc: Dr. Sidney Lee

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ROBERT B. BRIGHAM HOSPITAL

For Arthritis and Rheumatic Diseases

PARKER HILL AVENUE

BOSTON, MASSACHUSETTS 02120

August 9, 1967

Mr. Matthew F. McNulty, Jr.
Director, Council of Teaching Hospitals
Association of American Medical Colleges
Washington, D. C. 20036

Dear Mr. McNulty:

You have received letters from Dr. Sidney S. Lee, Associate Dean of Harvard Medical School, and Dr. John G. Freymann, General Director of the Boston Hospital for Women, on the subject of individual payment of dues by each hospital which is affiliated with Harvard.

Their letters were dated March 24 and July 20 respectively, and I am writing to re-affirm and re-emphasize the thoughts expressed in them, with the hope that a fair and equitable solution can be worked out.

Sincerely yours,



Horace F. Altman
Administrator

HFA:cw

FINAL PROGRAM -- ANNUAL MEETING

October 27, 1967 -- October 30, 1967

Annual Meeting Program:

Friday, October 27, 1967

6:00 p.m. - 7:30 p.m. Council of Teaching Hospitals Reception, all participants invited
Dress: Informal Business
Sutton Ballroom, North (2nd Floor)
(Pay Bar)

Saturday, October 28, 1967

9:00 a.m. - 12:00 noon General Sessions

12:00 p.m. - 1:00 p.m. COTH Annual Luncheon
Murray Hill Suite (2nd Floor)

1:00 p.m. - 2:15 p.m. Local, Regional, and National Comprehensive Health Planning - The Role of the Teaching Hospital

Leo J. Gehrig, M.D.
Deputy Surgeon General
Public Health Service
Department of Health, Education and Welfare

Albert W. Snoke, M.D.
Executive Director
Yale-New Haven Hospital

2:15 p.m. - 3:00 p.m. Community Expectations from Comprehensive Health Care Planning

Anne R. Somers, Research Associate
Industrial Relations Section, Princeton University

- 3:15 p.m. - 4:00 p.m. Key Developments in Medical Economics-
Their Relevance to Medical Education
- Walter J. McNerney
President
Blue Cross Association
- 4:00 p.m. - 5:00 p.m. Health Care Manpower and the Teaching
Hospital
- Leonard D. Fenninger, M.D.
Director
Bureau of Health Manpower
Public Health Service
Department of Health, Education and Welfare
- 5:00 p.m. - 6:00 p.m. COTH Nominating Committee - Open Session
(see program in New York for room designation)
- 6:00 p.m. - 7:30 p.m. President, AAMC Reception, all participants
invited (Pay Bar)
- 7:30 p.m. AAMC Annual Banquet
Presentation of the Borden Award in the
Medical Sciences Presentation of the Abraham
Flexner Award for Outstanding Service to
Medical Education
- Sunday, October 29, 1967
- 9:00 a.m. - 12:00 noon General Sessions
- 12:30 p.m. - 1:30 p.m. COTH Nominating Committee (see program in New
York for room designation)
- 2:00 p.m. - 4:00 p.m. Simultaneous Discussion Groups (please see
program in New York for room designation)
- Group 1 - Comprehensive Planning and the
Teaching Hospital
- Group 2 - Developments in Medical Economics
and the Teaching Hospital
- Group 3 - Educator and Consumer - The Teach-
ing Hospital and Health Care Man-
power
- Group 4 - The Changing Role of the House
Officer in the Teaching Hospital

Monday, October 30, 1967

9:00 a.m. - 11:30 a.m.

COTH Plenary Business Session
Sutton Ball Room, North

12:30 p.m. - 2:30 p.m.

Luncheon Meeting, First 1967 - 68 COTH
Executive Committee Meeting

range of disciplines and interests, and the lack of any primary interest or expertise in university work. It seems desirable that the professional organizations (such as the Association of American Medical Colleges and the American Medical Association) and the service organizations (such as the American Hospital Association) join together in a cooperative program for the accreditation of training programs for health service personnel, much as they have joined together in an accreditation commission for services in the health field through the Joint Commission on Accreditation of Hospitals. Such a cooperative program could redefine the training, as contrasted with educational, needs of health workers, an essential determination precedent to attempts to structure programs and determine institutional responsibilities. The public is unlikely to accept a distinct separation between the organizations that educate the health professional and the organization, usually the hospital, to which the public looks for the delivery of high quality health service. The hospital is a training institution and also an essential supportive institution to the university programs producing educated, professional personnel for the health field.

The committee recommends that the Association explore with other organizations in the field of health education and health services the creation of a joint commission on education and training for health services in order to establish patterns and standards for the education and training of health services personnel.

In pursuing its interests in education and training, the Association should continue to study its program of instructional institutes with the goal of assisting allied hospital associations to establish such programs on state and regional levels. As has been stated in other studies, especially the *Study to Delineate Proper Relationships Between the American Hospital Association and Allied Hospital Associations*, such an arrangement would permit the AHA to experiment with new forms of programs after established and well-formulated institutes have been absorbed and conducted by allied groups.

The Association should continually evaluate the AHA institute program with the aim of assisting allied hospital associations to establish similar programs at the state and regional levels in order to provide eventual transition, where practical and appropriate, of such programs to the state and local levels; the Association should continue experimentation with new training forms.

The Teaching Hospital

The primary function of the hospital, regardless of the adjective used to designate its character, is the care of the sick and injured of the community. An additional responsibility of the *teaching* hospital is the conservation and expansion of knowledge through educational endeavor and scientific research. The teaching of medical students, the postgraduate training of interns and residents, the support of schools for nurses, dietitians, medical record librarians, physiotherapists, x-ray and laboratory technicians; the conduct of postgraduate refresher courses for practicing physicians and teaching conferences open to all physicians on a regular basis; the publication of clinical experience and research findings and the further sharing of knowledge through visiting lectures, all round out the activities of the teaching hospital and its staff. In such an environment of constant inquiry, high intellectual activity, repeated questioning of the conventional wisdom, constant scrutiny of established procedure, and the rigorous application of the scientific method, the quality of patient care is likely to be optimal.

Our country depends on such teaching hospitals for the setting of standards in the best care of the sick and for the provision of the all-too-scarce supply of well-trained doctors, nurses, dietitians, technicians, and others. The urban, university-affiliated, teaching hospitals are our islands of excellence in medicine. They must be understood, supported, and protected by the community as well as by the profession so that the long-range interests of the community in matters of health and disease will be served in optimal fashion.

The lot of the teaching hospital is not an easy one. There are only some 1000 approved as such among the 7000 hospitals in this country. Generally they are the same ones that carry the greatest burden of caring for the indigent sick and, therefore, face the constant crisis of financial disaster. The town-gown battle rages on, and the teaching hospital and its staff bear the brunt of the town's attack. The costs and charges of the teaching hospital are the highest of all hospitals and the explanation, though constantly sought, is still only poorly understood. The teaching hospital is attracting more and more the complicated and severely ill patient or the patient who requires the care of a specialist, special procedures, and the massive and expensive technical facilities of the large urban hospital. The load it shoulders for the community and its smaller, nonteaching hospitals is becoming increasingly heavy. Moreover, many teaching hos-

pitals are centrally responsible for the delicate and increasingly vital relationships of the hospital field with medical schools and universities. Those teaching hospitals without university or medical school affiliations are virtually without organizational spokesmen in their special role, and those having affiliations are scarcely in a better position at the present time.

The special problems of teaching hospitals merit immediate attention by the American Hospital Association. The AHA has no provision within its present structure for consideration of the special problems of teaching hospitals, which, however, support a large proportion of Association activities through dues. These institutions as a group have had no distinct voice within AHA, although they have contributed heavily to its financing. The Association, through its council structure, therefore, should now provide them with a working forum for the discussion of such issues and accord them recognition for the greater leadership role they will inevitably have in the future. To further enhance this role, the AHA should establish formal liaison with the Council on Teaching Hospitals of the Association of American Medical Colleges.

The Association should establish within its structure a council on teaching hospitals to further their unique interests and establish formal liaison with the Council on Teaching Hospitals of the Association of American Medical Colleges.

Research in Education

The Association should, at its earliest opportunity, stimulate colleges and universities to con-

sider the development of major programs in education and training of leaders in medical administration for the hospital field of tomorrow.

These individuals would become the hospital directors of the future, possessing knowledge of the hospital and the university, of the learning process, of professional and paraprofessional roles, of needs and requirements, and of the functions of the hospital as a social and public health instrument. The program would be very much involved in redefinitions of hospital service in keeping with social, scientific, and technological changes; it would define the educational and training needs of various hospital personnel, channelling such definitions to universities and colleges that, in turn, would be responsible for pre-service education. It would provide for medical care research interests. In short, the education and training of hospital and medical care administrators is in desperate need of review. Leaders in medical and hospital administration are in severe short supply at a time when their skills are desperately needed. The AHA should through its Hospital Research and Educational Trust stimulate a review and reformulation of the educational requirements for medical administrative leaders in the operation and direction of hospitals. Such a proposal should be discussed with the appropriate educational and training institutions, including such groups as colleges and universities and schools of public health, as well as with such bodies as the American Public Health Association, the American College of Hospital Administrators, and the Association of University Programs in Hospital Administration.

INDIVIDUALS TO RECEIVE TRIBUTE
at
ANNUAL MEETING

Chairmen, MS-TH Section

Term

- | | |
|----------------------------|------------------------------|
| 1) Gerhard Hartman, Ph.D. | October 1958 -- October 1959 |
| 2) Donald J. Caseley, M.D. | October 1959 -- October 1960 |
| 3) Albert W. Snoke, M.D. | October 1960 -- October 1961 |
| 4) Richard O. Cannon, M.D. | October 1961 -- October 1962 |
| 5) Phillip D. Bonnet, M.D. | October 1962 -- October 1963 |
| 6) Harold H. Hixson | October 1963 -- October 1964 |
| 7) Matthew F. McNulty, Jr. | October 1964 -- October 1965 |
| 8) Russell A. Nelson, M.D. | October 1965 -- October 1966 |
| 9) Stanley A. Ferguson | October 1966 -- October 1967 |

AAMC Presidents

- | | |
|------------------------------|--------------|
| 1) Robert C. Berson, M.D. | 1963 -- 1964 |
| 2) George A. Wolf, Jr., M.D. | 1964 -- 1965 |
| 3) Thomas B. Turner, M.D. | 1965 -- 1966 |
| 4) Donald G. Anderson, M.D. | 1961 -- 1962 |

MS-TH Section Secretaries

- 1) Duane E. Johnson
- 2) John Danielson
- 3) Lad F. Grapski

Committee on MS-AHR

- 1) George N. Aagaard, M.D.
- 2) C. Arden Miller, M.D.

Miscellaneous

- 1) Lowell T. Coggeshall, M.D.
- * [REDACTED]
- 3) William N. Hubbard, Jr., M.D.
- 4) John Parks, M.D.
- 5) Ward Darley, M.D.

for Planning for Medical Progress
Through Education

President & Chairman, Executive Council,
AAMC
President-Elect, AAMC
for his tenure as Executive Director, AAMC

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COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF HOSPITAL DIRECTORS OF MEDICAL EDUCATION
MINUTES OF MEETING OF AD HOC COMMITTEE
Tuesday, August 1, 1967 at 9:45 a.m.
Gallery Room, Dupont Plaza Hotel, Washington, D.C.

Present:

Angelo P. Angelides, M.D.

Co-ordinator; Division of Professional Activities and Director of Medical Education,
Lankenau Hospital, Philadelphia, Pennsylvania

Keith D. Blayney, Ph.D.

Assistant Professor, School of Health Service Administration, University of Alabama,
Birmingham, Alabama

Robert L. Evans, M.D.

Director of Professional Services and Medical Education, York Hospital, York, Penn-
sylvania; President, Association of Hospital Directors of Medical Education

Jack H. Hall, M.D.

Director of Medical Education, Methodist Hospital, Indianapolis, Indiana (currently
on leave of absence to NIH, Division of Regional Medical Programs)

James O. Hepner, Ph.D.

Director, Graduate Program in Hospital Administration, Washington University, School
of Medicine, St. Louis, Missouri

Matthew F. McNulty, Jr.

Director, Council of Teaching Hospitals and Associate Director, Association of Amer-
ican Medical Colleges

Fletcher H. Bingham, Ph.D.

Assistant Director, Council of Teaching Hospitals and Acting Recorder

Mr. McNulty indicated that the purpose in calling the ad hoc session was to explore certain areas of common, mutual interest between AHDME and COTH on an informal basis. He further expressed the belief that the meeting should attempt to approach the following questions: 1) Is there a role that COTH can play with regard to the Directors of Medical Education? 2) If so, what is that role? and 3) Upon role identification, what are the priority items for implementation?

Doctors Blayney and Hepner reviewed their individual dissertation efforts concerning Directors of Medical Education and other substantive elements of graduate and continuing medical education.

Doctors Evans, Angelides and Hall reviewed the historical evolution of the DME and indicated the current role which AHDME is playing regarding representation of some 200-225 active and 300 associate members. It was noted the criteria for membership in AHDME were twofold; 1) that the individual be salaried, and 2) that he spend fifty percent of his time in medical education activities.

The ensuing discussion, prompted by Dr. Hall's comments concerning the relationships of graduate and post-graduate education with the process of delivery of health care services, resulted in an expressed concurrence that further dialogue was needed as the teaching

hospital represented the point of common linkage between medical practice and education, and it was agreed that the COTH membership could provide substantial leadership in coupling the medical schools, the university hospitals, and the community non-affiliated hospitals. It was further indicated that discussion might be most profitable if it revolved especially about various experimental models of the interface between this triad.

With the development of Regional Medical Programs, medical education and clinical practitioners would have to work in close harmony and the necessary relationships for joint educational efforts between these two would have to be devised. In this regard, it was agreed that two urgent areas for empirical study emerged:

- 1) Because medical education is a process designed basically to meet the needs of the consumers, some investigation is appropriate to measure the needs and to explore various medical care delivery systems.
- 2) There is a need for the development and implementation of criteria of measurement whereby the effectiveness of continuation medical education could be ascertained. These criteria should be developed with regard to both the substantive content being taught in these programs and the methodological approach that is being utilized for the transmission of this content.

There was general agreement that there was also a need to upgrade the standards of post-graduate medical education, and that one method of approach to this problem could be the establishment of a formal COTH-AHDME Liason Committee, taking into consideration the role which COTH could play with regard to the educational activities provided in non-affiliated community teaching hospitals. It was noted that the many forces that currently prevail may introduce something of an operational stumbling block, but that there is a definite need for positive, constructive action. Two of the forces are: 1) the town-gown syndrome, and 2) the involvement of governmental programs, (89-239, Regional Medical Programs; and 89-749, Comprehensive Health Planning) and their joint effects on the contemporary pattern of delivery of health care services. With these forces recognized, it was nevertheless agreed that COTH and AHDME could jointly take a leadership role in this effort.

The Ad Hoc Committee also briefly directed its attention to the feasibility and practicability of establishing a broadly-based commission, consisting of representation by the AMA, AAMC, AHDME, and COTH, which would have as its prime objective the development of standards for programs in continuation medical education. Also noted was the observation that the university medical schools, for the most part, have not considered graduate, post-graduate, and continuing medical education as within the dimensions of their main mission and that therefore, a joint effort of this nature might prove most beneficial.

Discussion then ensued on the role which teaching hospitals can play with regard to research in the delivery of health care services, specifically with regard to the graduate and continuing education of the physician. There was a consensus that this had been an area largely neglected by investigators and that there was a critical need for empirical research and subsequent demonstrations based on the results of such investigations. It was agreed that perhaps the most appropriate method of study would be of the experimental models of the interface between teaching hospitals and medical schools. The adoption of a broad program of investigation would include: alternate methods of financing graduate medical education, the existing roles and relationships between medical schools and teaching hospitals, and so

forth. Both organizations, because of the shortage of available manpower resources, concurred that such studies might best be implemented by an organization such as the Medical Care Research Center at Washington University in St. Louis or some other appropriate university-based research faculty.

Prior to adjournment there was general accord that the meeting had been both beneficial and productive. Additionally, it was noted that there were a number of problem areas of common, mutual interests to both COTH and AHDME, and that there was a need for future meetings of this nature to define, in a more systematic and discrete fashion, these problem areas. Additionally, it was anticipated that the encouragement of empirical research studies by this group could develop positive demonstration projects in the medical education process at both the graduate and post-graduate levels.

The meeting adjourned at 2:45 p.m.

Respectfully submitted by

Fletcher H. Bingham, Ph.D.
Acting Secretary

Research and Educational Hospitals

Administration

UNIVERSITY OF ILLINOIS AT THE MEDICAL CENTER, CHICAGO

840 South Wood Street · Chicago, Illinois · Area Code 312, Telephone 663-6801 and 6803

Mailing Address: P.O. Box 6998 · Chicago, Illinois 60680

June 6, 1967

Mr. Matthew F. McNulty, Jr., Director
Council of Teaching Hospitals, AAMC
1501 New Hampshire Avenue, N. W.
Washington, D. C. 20036

Dear Matt:

Sorry that I missed the meeting at Vanderbilt which, I understand, you attended as a guest. I learned from Harry Higgins that your contributions were significant. As he probably explained, I had to be at a conference at Lake Tahoe, and it is one of the outgrowths of that meeting about which I am writing you. I was reminded, as a matter of fact, that I had fully intended to get a letter off to you by your memorandum of May 29 on the National Conference on Medical Costs.

The Lake Tahoe conference was called by the Chancellor's Office of the Davis Campus, University of California, which, as you know, is developing a new medical school. They had a number of people from over the country to help them discuss and think through the many ramifications of their project, particularly as it affects an already strong and operating school of veterinary medicine. The panel on which I served involved discussions of the clinical setting for medical learning, and was chaired by George Wolf.

As we spent time before our panel, we lapsed into a discussion of the two Teaching Institutes that he and I had been closely related to--the one on Medical Education in Practice, 1962; and the Second Administrative Institute, Medical School-Teaching Hospital Relations. As we reviewed the material in those, particularly the latter one, it occurred to us that just in these past three years changes in the setting, the ground rules, socio-economic factors, relationships, etc., have run along at such a breakneck pace that much of the material is already outdated. In an almost facetious manner one of us said, "This Institute should probably be redone and rather quickly."

I know that the AAMC has, at least for the moment, set aside the Teaching Institute process as a part of its ongoing program, but the validity of the concept seemed strengthened as we reviewed these conclusions of the 1964 Institute and tried to bring them into the context of 1967 and project into 1970-75. I received a note from

Mr. Matthew F. McNulty, Jr. - 2
June 6, 1967

George Wolf last week in which he suggested, at least as far as your office is concerned, that I go ahead and pursue such a possibility and, possibly, plant a seed that could germinate.

I think we will all be interested in the outcome of the National Conference on Medical Costs but, since the strength and value of such conferences in the past have been almost directly proportional to the length and depth of the planning, I am wondering if this is not a kind of a "fast whistle."

If you think there is any merit in the proposal that George Wolf and I hatched, we would be glad to pursue it further.

Kindest personal regards,



Donald J. Caseley, M.D.
Medical Director

DJC:ldm

cc: Dr. George Wolf

Donald J. Caseley, M. D.

June 1967

17 1st St

...member, it is an activity for which representation by the Council
in planning activities was of importance for identification and contribution.
The name was contributed and the 17 June 1967 responsibility of Health, Edu-
cation and Welfare.

I appreciate your generous cooperation by contributions to Vanderbilt. I have
not discussed part of these university hospital groups. I have learned from
...conditions.

Donald J. Caseley, M. D.

Medical Director ... I am anxious to get you, Gerry Hartman, and
University of Illinois at the Medical Center to review the early
P. O. Box 6998 ... Hospital Section (perhaps by each of you regarding
Chicago, Illinois 60680 ... preparatory to having a historical consultant
... on October 28, 29 and 30. You

Dear Don: ...

Your letter of June 6th, reporting the discussion between you and George Wolf as
to the possibility of the Council of Teaching Hospitals sponsoring a "Teaching
Institute" was welcome indeed. My enthusiasm is related to the fact that two
weeks ago I had discussed this possibility with Bob (Robert C. Berson, M. D.,
Executive Director, AAMC) as one of the long-range objectives that I could see
as a desirable educational undertaking by COTH. Our joint reaction following
discussion was that of cautious endorsement. The aspect of cautiousness was re-
lated to the six-day schedule we have been maintaining in getting organized, ac-
complishing both internal (AAMC) and external (Congressional Committees, agencies,
volunteers, organizations, etc.) developing and undertaking other activities to
rapidly create a voice and representation for teaching hospitals but still with
only one professional staff member.

I had in mind an institute that would have its existence at the earliest some-
time in the fall of 1968 -- if we could meet that schedule. I have discussed
this matter very casually with Lee Powers, M. D., Director, Division of Oper-
ational Studies. As you know from your intimate contact in developing previous
institutions, Lee was responsible for much of the excellent work attendant to the
other institutes. My perspective after discussion with Lee is that the spring of
1969 might be a more appropriate timetable.

In any event you can see why my enthusiastic response to your letter of June 6th.
It is not too early to begin thinking of the project. As soon as I can recruit
the type of individual I am insisting upon as a prototype for staffing this of-
fice, it would be appropriate to meet with you, George, Bob, Lee and others, so
as to start the planning process. I shall also take this subject to the Executive
Committee meeting (early September) to be certain that the interest of the staff,
reinforced by the interest of you and George, has the policy concurrence of the
Executive Committee. I anticipate no difficulty.

Your observation concerning the National Conference of Medical Costs is undoubtedly
correct. It may develop as an exercise in form rather than as a production of

Donald J. Caseley, M. D.

Page Two

17 June 1967

Research and Educational History

MEDICAL EDUCATION

substance. However, it is an activity for which representation by the Council in planning activities was of importance for identification and contribution. We have now contributed and the balance is the responsibility of Health, Education and Welfare.

I appreciated your comments concerning my contributions to Vanderbilt. I have now attended four of these university hospital groups. I have learned from and enjoyed the opportunities.

One other unrelated subject. I am anxious to get you, Garry Hartman, and Duane Johnson together for half a day sometime this summer to review the early history of the Teaching Hospital Section (perhaps by each of you recording your memory to a dictating machine) preparatory to having a historical pamphlet prepared for our annual meeting in New York on October 28, 29 and 30. You either have received or will be receiving a separate letter on this subject.

contributions were significant. I had probably explained, I had to be at a conference at Luke T... is one of the outgrowths of last meeting about which I am writing you. I was reminded, as a matter of fact, that I had fully intended to get a letter off to you by your memorandum of May... Conference on Medical Costs.

Cordially,

MATTHEW F. McNULTY, JR.

Director, COTH

Associate Director, AAMC

The Luke... conference was... Office of the David... University of California, which, as you know, is... medical... they had a number of people from

MF:vw

cc: George A. Wolf, Jr., M. D.

Dean & Provost

The University of Kansas Medical School

Rainbow Boulevard at 39th Street

Kansas City, Kansas 66103

As we spent time before our panel, we lapsed into a discussion of the two Teaching Institutes that he and I had been closely related to. The one on Medical Education in Practice, 1962; and the Second... School-Teacher Hospital Relations. We reviewed the material in... particularly the latter one, it occurred to us that just in these past three years changes in the... the ground rules, socio-economic factors, relationships, etc., have run along at such a breakneck pace that much of the material is already outdated. In an almost facetious manner one of us said, "This Institute should probably be redone and rather quickly."

BCC:

JJB, CWT, FHB, McN (History File)

I hope that the AAMC has, at least for the moment, set aside the Teaching Institute process as a part of its ongoing program, but the validity of the concept seemed strengthened as we reviewed these... 1964 Institute and tried to bring them into the context of 1967 and project into 1970-75. I received a note from

UNIVERSITY OF ILLINOIS

Handwritten signature or initials

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UNIVERSITY OF KANSAS MEDICAL CENTER

RAINBOW BOULEVARD AT 39TH STREET
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OFFICE OF THE PROVOST

June 27, 1967

Mr. Matthew F. McNulty, Jr.
Association of American Medical Colleges
1501 New Hampshire Ave., N.W.
Washington, D.C. 20036

Dear Matt:

Thank you for sending me a copy of your response to Don Caseley. The reason I supported Don's suggestion is that I believe with the establishment of the Council on Teaching Hospitals that we might be able to develop a very good institute on teaching hospital relationships or some comparable topic.

I certainly agree that Lee Powers that the lead time required is considerable but I don't think this is too bad because the experience with Medicare and Medicaid might be more meaningful after a little longer period of time. At any rate, I think this possible activity may be a very useful step in defining for the Deans over the next couple of years the activities which the Council on Teaching Hospitals are involved in.

Have a good summer. Hope to see you soon.

Sincerely yours,

GEORGE A. WOLF, JR., M.D.
Dean and Provost

GAW:MW

cc: Donald J. Caseley, M.D.

Research and Educational Hospitals
Administration

UNIVERSITY OF ILLINOIS AT THE MEDICAL CENTER, CHICAGO

840 South Wood Street · Chicago, Illinois · Area Code 312, Telephone 663-6801 and 6803
Mailing Address: P. O. Box 6998 · Chicago, Illinois 60680

June 30, 1967

Dr. Matthew H. McNulty, Director
Council of Teaching Hospitals, AAMC
1501 New Hampshire Avenue, N W
Washington, D. C. 20036

Dear Matt:

Thanks very much for your letter, it was most encouraging. George and I will continue to give thought to the form and substance for such an institute so that if, as and when we (you, Bob, Lee, George and I) have a chance to get together, we will have something reasonably productive to contribute.

The more I reflect on the possibility of such an institute, the more excited I get, because of the rapidity with which change is altering the role of the teaching hospital and the total medical community. It appears to be moving so fast that I am not sure we are all completely aware of "who's on first." I am sure that you can count on George Wolf and me for any help that we are able to give.

Cordially,



Donald J. Caseley, M.D.
Medical Director

DJC:ldm

cc: George A. Wolf, Jr., M.D.

COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
1346 Connecticut Avenue, N.W.
Washington, D.C. 20036
202/223-5364

COTH
General Membership Memorandum
No. 67-27G
July 20, 1967

Subject: Fifteenth International
Hospital Congress.

1. Fifteenth International Hospital Congress:

The Fifteenth International Hospital Congress, organized by the International Hospital Federation, will take place in Chicago, Illinois, from August 24 to August 29, 1967, following immediately after the American Hospital Association's Annual Meeting of August 21-24. As you are aware, Edwin L. Crosby, M.D., Executive Vice-President and Director of the American Hospital Association, is currently President of the I.H.F. and will serve as Chairman of the Congress.

2. Elements of Particular Interest to Administrators of Teaching Hospitals:

The entire program of the Congress has been excellently conceived and developed under the chairmanship of Dr. Crosby. Specifically, however, there is one segment of the program that will be of special interest to those involved in the administration of teaching hospitals. One major section of the program deals specifically with the broad economic and social issues that are attendant to the international community of teaching hospitals. This section of the program has been ably developed by its chairman, L.F. Detwiller, Consultant Administrator, University of British Columbia, Canada. Among the topics on which papers and discussions in this section will focus are:

"Relationship of the Health Teaching Complex to the Total Health Community"
Speaker: Dr. J.F. McCreary, Canada
Chairman: Mr. Matthew F. McNulty, Jr., U.S.A.

"Teaching and Research Requirements in a Health Teaching Complex"
Speaker: Dr. J. Blanpain, Belgium
Chairman: Mr. P.H. Constable, Great Britain

"Analysis of the Space Requirements of Health Teaching Centers"
Speaker: Dr. R. J. Sahl, Germany
Chairman: Dr. A. L. Bravo, South America

It is anticipated that each of these subject areas will be examined carefully with close attention given to the various facets of each issue. Each subject is scheduled for approximately three hours, including the major presentation by the speaker and the subsequent discussions.

General Membership Memorandum

No. 67-27G

Page 2

3. Further Information and Registration Forms:

If any chief administrative officers of member hospitals are interested in attending, or having an associate attend, further information regarding the Congress, as well as the necessary registration forms, can be obtained by writing the Secretariat of the International Hospital Federation in London. The address is:

International Hospital Federation
The Hospital Centre
24 Nutford Place
London W. 1, England

MATTHEW F. McNULTY, JR.
Director, COTH
Associate Director, AAMC

September 9, 1966

Mr. Nathaniel H. Karol, Director
Division of Grant Administration Policy
Office of Comptroller
Department of Health, Education and Welfare
330 Independence Avenue, S.W.
Washington, D.C.

Dear Mr. Karol

Upon receipt from you of the proposed Principles for Determining Costs Applicable to Research and Development under Grants and Contracts with Hospitals, I appointed a group of hospital representatives to review it. This group met on September 7, 1966 and has recommended changes which are summarized in the attached document entitled American Hospital Association Comments on Proposed Principles for Determining Cost Applicable to Research and Development under Grants and Contracts with Hospitals. These proposed changes are recommended to you by the Association.

I understand that the principles will become a circular of the Bureau of the Budget on overhead rate determination applicable to all federal grants and contracts with hospitals for research and development. The Association requests the opportunity to review the document for final comment before its issuance as a Bureau of the Budget circular.

Also, I would like to recommend the presentation of a workshop or series of workshops under the auspices of the American Hospital Association for hospitals to review the circular when it is issued. In this way, the broadest possible coverage of the administrative regulations could be achieved and a broad range of hospitals could be apprised of the potentialities for research and development under expanding federal programs.

The Association appreciates the opportunity to review the principles for grants and contracts. We are available for any further assistance you may require.

Sincerely

Edwin L. Crosby, M.D.
Director

lg
enclosures

REL/9/9/66

American Hospital Association

Comments on Proposed Principles for
Determining Cost Applicable to Research
and Development under Grants and Contracts
with Hospitals

In response to a request to comment on proposed Principles for Determining Cost Applicable to Research and Development under Grants and Contracts with Hospitals, the American Hospital Association invited the following people to review the document.

Mr. Ronald Bruni, University of Wisconsin Hospitals
Mr. John Glavas, Passavant Hospital, Chicago
Mr. William McGuire, University of Wisconsin Hospitals
Mr. Lawrence Martin, Massachusetts General Hospital, Boston
Mr. Donald Oder, Presbyterian St. Luke's Hospital, Chicago
Mr. John Stagl, Passavant Hospital, Chicago
Mr. Allan Winick, Arthur Andersen and Company, Chicago

Mr. Robert Linde, American Hospital Association, Chicago
Mr. John Nelson, American Hospital Association, Chicago

After reviewing the history of the need for principles for cost determination the group made recommendations for changes. The group believed that a set of principles such as proposed for hospitals would be more pertinent for hospital grants and contract negotiation and cost determination than the guidelines used in the past. They also believed that such principles should be consistent with principles established by other Federal programs of reimbursement to hospitals in order to achieve equity.

The suggested changes and reasons will follow by reference to page and section numbers of the document submitted to the Association.

Page 2 B.1.

We suggest the substitution of "other" for "non-federal" in the third line to be more descriptive of broad sources.

B.4.

We recommend the elimination of examples of other hospital activities because the practices of direct charging and allocation will vary from hospital to hospital. For instance, central supply items may be charged directly in one hospital and be assigned in an allocation procedure in another hospital.

B.6.

We suggest elimination of this definition and its use throughout the rest of the document. See next comment for reasons.

B.7.

We suggest this section read: "Allocation means the process by which the indirect costs are assigned as between (a) sponsored research, (b) patient care, including self-sponsored research, and (c) other hospital activities." This suffices for B.6 and B.7 and we recommend this because the hospital field has had a well defined cost allocation procedure (see attached manual Cost Finding for Hospitals) which has had increased acceptance and is used as a basis for federal reimbursement programs and local reimbursement. This procedure is capable of directly determining the overhead allocations to

the areas you have defined without intermediate apportionment.

Page 4 C.4.

We suggest the substitution of "allowable" for "allocable" in order to avoid confusion with the "allocation" process. Your use of the term "allocable" is often used for direct charges as well as allocated costs.

Page 5 C.5.b.

We suggest the first sentence refer to "finance current hospital activities...." More importantly we object to netting of the cost of facilities financed in part or wholly by federal funds when these facilities are jointly used in routine patient care, have been used in routine patient care, or will be used in routine patient care. The hospital must maintain and preserve the capital employed in production of services. Depreciation on such facilities has been recognized by third party reimbursers for patient care including the federal government. Hospitals cannot maintain productive capacity for the future if a partial user of the facilities does not contribute his share nor can this cost fairly be shifted to other users. Each user of the facility must bear his share of these costs. The cost of facilities is a far different matter than payment for current resources which are expended immediately.

Page 6 line 4

We suggest making extraordinary utility consumption an "example" rather than "including."

E.1.

We suggest the following substitution in the sentence: "In hospitals such costs normally are classified but not necessarily restricted to the following functional categories..." because practices of direct charging to research may vary between hospitals. The previously cited central supply situation is an example.

Page 9 E.2.d.(7)

We object to this treatment because of percentage limitations on some grants (e.g. training grants) will work inequities in the allocation under research and development grants and contracts. (See comments on page 10 for further comments.)

Page 10 E.3.

We object to any limitation to the per cent of direct costs allowed. This whole section should be eliminated. The hospital in order to be a viable organization must recover all costs equitably from all users. Subject to our comments, this suggested circular provides a mechanism for so doing and this section is inconsistent. We particularly object to the use of administrative regulations being used to return less than cost to hospitals. We would vigorously oppose legislation that would do such.

- Page 12 F.3.a. The sentence starting "Added to these direct costs in the Operation of Plant...." should be eliminated in its entirety because it is inconsistent with the other sections of this group.
- Page 14 F.6.b. The Association recommends the primary allocation be on hours of service as defined in the manual Cost Finding for Hospitals. The other bases could be used when this is impractical to gather.
- Page 15 F.7.b. We suggest the use of numbers of employees or meals where practicable, same reference source.
- Page 16 F.10. We recommend deletion of this whole section inasmuch as it is already sufficiently covered under C.5 on page 5.
- Page 18 G.3. We recommend this change in the sentence "Such amount negotiated in lieu of indirect costs...offset to appropriate indirect expenses before allocation to patient care..."
- Page 22 J.4. We recommend "The costs of equipment buildingsll., should be capitalized except as provided..." because this reflects more proper accounting practices.
- Page 25 J.9. The Association is on record as endorsing current replacement cost depreciation in order to maintain productive ability of the hospital. (Page 15 Chart of Accounts for Hospitals). We feel strongly that

this should be the basis for cost determination. A copy of the Chart of Accounts and our Statement on Reimbursement is enclosed for your analysis. These principles should include depreciation on a replacement cost basis.

Page 28 J.15.a.

We object to the exclusion from research costs of interest on borrowed capital or temporary use of endowment funds. Again, costs should be shared by all users of hospital facilities and services, your disallowance would cause an undue burden of cost to fall on the patients. As an element of full cost interest is recognized by reimbursers for patient care, all other users must bear their portion of full costs.

Page 34 J.33.d.

We believe that refunding or credit for relocation costs to government would be unfair when the person is hired in good faith, indeed such costs may not exceed those of a consultant in travel. Some recognition and credit for good faith on the part of the employer should be given.

Page 35 J.38.

The title and references should be Sponsored Research from Hospital Funds because the definition of self sponsored research at B.2. would make this provision inoperative.

Page 37 J,41.

We object to the exclusion of specified special services, the costs of separating details may be increased costs for other users. Specifically, general public relations may be used for necessary applications in grants and contracts as catalogs may be done. A clause should imply demonstrable absence of any relationship to grants and contracts.

Page 41 J.47

Use allowances should be specifically defined in this document.

We object to the percentages allowed and recommend that 2 per cent for buildings and 10 per cent for usable equipment be the ratios applied. Recent life tables included in chapter 7 of Chart of Accounts for Hospitals show shorter lives and heavier obsolescence in the hospital field than that your rates imply. Our principles on current replacement costs should also apply here.

Appendix

Page 1 A.I.

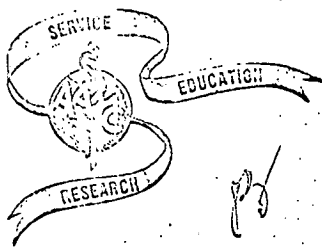
On line 4 we recommend this addition: "For purposes of this document, a minimum requirement would be a step down cost analysis..." Other federal programs allow several alternative and more sophisticated methods. The hospital should be allowed the same system which they are using in other programs in order to avoid excess work.

Page 43 A.II.b.

We recommend the hospital have an option between using the gross method or departmental method. The third line should have inserted as follows: "be used. Either of two methods may be used as explained. (1) Gross Method - After arriving at the total cost..." We then would add this section "(2) Departmental Method - after arriving at the total cost for each of the ancillary or special services as outlined in A-I above, each of these total costs should be compared to the total gross charges of each of the ancillary or special services. Each of the percentages arrived at by dividing the costs by gross charges would then be applied to the charges made in the applicable ancillary or special services for inpatients supported by sponsored research."

The attached material contains American Hospital Association references referred to in our comments. They are: (1) American Hospital Association Statement on Reimbursement, (2) Chart of Accounts for Hospitals, and (3) Cost Finding for Hospitals.

REL/9/9/66



ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF TEACHING HOSPITALS
1346 CONNECTICUT AVENUE, N.W.
WASHINGTON, D. C. 20036
202/223-5364

MATTHEW F. McNULTY, JR.
DIRECTOR

July 28, 1967

File

Mr. James F. Kelly
Assistant Secretary
Department of Health, Education, and Welfare
330 Independence Avenue
Washington, D.C. 20201

Dear Mr. Kelly:

From informal information it is my understanding that there has been issued by the Department of Health, Education, and Welfare a publication titled as follows:

"A Guide for Hospitals--Establishing Indirect Cost Rates for Research Grants and Contracts with HEW"

The Council of Teaching Hospitals (COTH), representing the major teaching hospitals of this country, was not aware of any initial discussion, subsequent preparation, and then publication of the aforementioned Guide. As a newly organized activity of the Association of American Medical Colleges, it could well have been that our existence was not known when the Guide was under preparation. This is understandable, though I trust that through the opportunity of this letter our desire and ability to be of assistance in the future is now established. The material suggested by the above title is of direct interest to the major teaching hospitals of this country as represented by this Council.

Any information you can furnish concerning the contemplated dissemination of "A Guide for Hospitals" would be appreciated so that we may be informed as to possible inquiries from teaching hospital member institutions. Also, a copy of the Guide would be appreciated so that we may become knowledgeable as to its content.

Thank you for your assistance in this matter.

Cordially yours,

Enclosed is one copy of the brochure you requested. For additional copies please contact your Operating Agency.
August 3, 1967

Matthew F. McNulty, Jr.
MATTHEW F. McNULTY, JR.
Director, COTH
Associate Director, AAMC

MM:eab

August 31, 1967

Mr. James F. Kelly
Assistant Secretary
Comptroller
Department of Health, Education, and Welfare
330 Independence Avenue
Washington, D.C. 20201

Dear Mr. Kelly:

In response to my letter of July 28th, your office forwarded to me one copy of A Guide For Hospitals: Establishing Indirect Cost Rates for Research Grants and Contracts with the Department of Health, Education, and Welfare. This assistance is appreciated.

As I expressed to you in my letter of July 28th, this recently organized Council of Teaching Hospitals (COH) is interested and intends to work closely and cooperatively with all Federal agencies and offices, and particularly with those agencies whose activities, in some measure, affect either the medical education process as it is accomplished in the teaching hospital, or the administrative and fiscal framework which supports such educational efforts. With regard to this latter item, a very cursory review of the Guide For Hospitals indicates that the Guide could have an influence on the financial system of teaching hospitals, as well as upon carefully developed and presently prevailing methods of cost allocation and determination.

In the letter of transmittal, which accompanied our copy of the publication, you indicated that you would welcome comments on the substantive content included in the document. On behalf of the officers and Executive Committee of COH, a committee of senior hospital executives and fiscal management experts is being appointed for certain responsibilities of review and analysis in the area of teaching hospital management with specific observation concerning the Guide. We would, therefore, appreciate the opportunity for careful review, observation, and recommendation, if any, with your office concerning this document, A Guide For Hospitals before it is disseminated to hospitals.

Mr. James F. Kelly

-2-

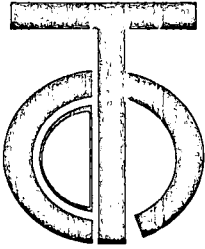
Aug. 31, 1967

In order that the attention of the COFH Committee mentioned previously may be directed to an early consideration of the Guide, we would appreciate someone in your office, at their convenience, arranging to have fifteen copies of the document sent to this office. If there is any charge for this assistance, we shall arrange for prompt remittance upon advice.

We shall be in contact with your office as soon as it is possible to accomplish review of the Guide. Thank you for your consideration of this matter.

Cordially,

MATTHEW F. McNULTY, JR.
Director, COFH
Associate Director, AAMC



COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

1346 CONNECTICUT AVENUE, N. W. • WASHINGTON, D. C. 20036 • (202) 223-5364

General Membership Memorandum No.67- 32G
28 July 1967

Subject: Expiring Federal Legislation
of Interest to COTH Member-
ship.

1. Expiring Federal Legislation:

When the AAMC Committee on Federal Health Programs met in Washington, D.C. on 5 July 1967, one of the items in the agenda for consideration and of particular interest to COTH and the AAMC was the matter of Federal legislation which will be expiring either on 20 June 1968 or 30 June 1969.

2. List of Legislation Considered:

- | | | | |
|----|---------------------|--|--------------|
| a) | P.L. 88-443 | Hospital and Medical Facilities Amendments of 1964 (Hill-Burton) | Expires 1969 |
| b) | P.L. 88-497 | Graduate Public Health Training Amendments of 1964 | Expires 1968 |
| c) | P.L. 88-581 | Nurse Training Act of 1964 | Expires 1969 |
| d) | P.L. 89-109 | Community Health Services Extension Amendments of 1965 | Expires 1968 |
| e) | P.L. 89-115 | Health Research Facilities Amendments of 1965 | Expires 1968 |
| f) | P.L. 89-239 | Heart Disease, Cancer and Stroke Amendments of 1965 | Expires 1968 |
| g) | P.L. 89-290 | Health Professions Educational Assistance Amendments of 1965 | Expires 1969 |
| h) | P.L. 89-751 | Allied Health Professions Personnel Training Act Amendments of 1966 | Expires 1969 |
| i) | Section 301 PHS Act | Research Contract Authority Provision for extension is made in "Partnership for Health Amendments of 1967" -- HR 6418, 3/1/67 under RESEARCH CONTRACT AUTHORITY, Section 9, Paragraph (h) of section 301 of the Public Health Service Act (42 U.S.C. 241 is amended by striking out "during the fiscal year ending 30 June 1966 and each of the two succeeding fiscal years"). | Expires 1968 |

3. Recommendations Made by AAMC Committee:

At this point in time and particularly in light of a prospective 1967 Federal budget deficit of some \$20 billion, as well as impending FY 1968 increases due to the Federal-State financing of Medicaid of approximately \$4 billion, it is anticipated that there will be serious consideration and evaluation made of these nine programs.

28 July 1967

Page Two

The proportions involved can be given perspective by a preliminary evaluation which indicates that if the Congress were to extend for one year, without any increase, the Hill-Burton Act, the Health Professions Act, the Health Research Facilities Act, the Nurse Training Act, the Regional Medical Programs Act, and the Medical Library Assistance Act, the total appropriations involved would be one billion, three hundred million dollars!

4. Recommendations of COTH Membership Solicited:

After you have had an opportunity to review the attached list, your headquarters would be interested in receiving any recommendations or suggestions to assist in our evaluation of this impending legislation which to this office seems of the greatest immediate importance to COTH membership. Copies of the Public Laws listed may be obtained from your U.S. Representatives or Senators.

5. Discussion with Congressional Leaders:

The most significant contribution on behalf of any Congressional action is the "back home" influence. Teaching hospitals are among the most significant elements of any local and state "grassroots." The opinion of your teaching hospital expressed to your U.S. Representatives and Senators between now and the opening of the 2nd Session 90th Congress, in January, 1968, would do much to create a greater understanding of the benefits accruing to society from these nine items of legislation.

MATTHEW F. McNULTY, JR.
Director, COTH
Associate Director, AAMC

EXISTING HEALTH LEGISLATION FOR REVIEW - SECOND SESSION, 90TH CONGRESS

- | | | | |
|----|---------------------|--|--------------|
| a) | P.L. 88-443 | Hospital and Medical Facilities Amendments of 1964 (Hill-Burton) | Expires 1969 |
| b) | P.L. 88-497 | Graduate Public Health Training Amendments of 1964 | Expires 1968 |
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HOSPITAL AND MEDICAL FACILITIES CONSTRUCTION

Purpose

During the depression years and for the duration of World War II, few hospitals were constructed in the United States. For this reason, many hospitals became obsolete and there were manifest shortages in the number of hospital beds and other related health facilities and services. To identify and meet these needs, Congress enacted into law on August 13, 1946, the Hospital Survey and Construction (Hill-Burton) Act (P.L. 725, 79th Congress). The purpose of the Act was to survey needs and to assist the local sponsors in the several States in the construction of public and other non-profit hospitals. As a result, the United States undertook, for the first time, an orderly appraisal of its existing hospital and public health center resources and developed comprehensive State plans for furnishing "adequate hospital, clinic, and similar services to all their people." Annual revisions of these plans by each State became mandatory by regulation.

Since the original Hill-Burton legislation was passed several major amendments have been enacted. In 1954, the Act was amended to assist the several States in the construction of diagnostic or treatment centers, hospitals for the chronically ill, rehabilitation facilities, and nursing homes. In 1958, Congress gave an eligible sponsor the option to take a loan in lieu of a grant. The Community Health Services and Facilities Act of 1961 increased the annual appropriation authorization for nursing homes from \$10 million to \$20 million and liberalized the definition of rehabilitation facilities.

On August 18, 1964, the President signed into law the Hospital and Medical Facilities Amendments of 1964 (P.L. 88-443), extending and revising the Hill-Burton program to keep pace with changing concepts of health facility construction and operation.

The most far-reaching change in the program was the establishment of a new grant program, beginning with fiscal year 1966, for modernization or replacement of public and non-profit hospital and other health facilities.

In addition to the modernization program, the Hill-Harris amendments also provided:

- (1) A single category of long-term care facilities, which combined the previously separate grant programs for chronic disease hospitals and nursing homes, and lifted the annual ceiling from \$40 million to \$70 million.
- (2) The use by the States of 2 percent of their allotments (up to \$50,000 a year) to assist in the efficient and proper administration of the State plan.

Financing

The following table shows Hill-Burton authorizations, appropriations, and obligations for selected years.. Funds unobligated in the fiscal year for which appropriated remain available for the next fiscal year.

<u>Fiscal Year</u>	<u>Authorization</u>	<u>Appropriation</u>	<u>Federal Expenditures</u> ^{1/}
1948	\$ 75,000,000	\$ 75,000,000	\$ 4,009,380
1950	150,000,000	150,000,000	117,869,156
1962	220,000,000	209,728,000	187,271,800
1963	220,000,000	220,000,000	211,862,406
1964	220,000,000	220,000,000	213,351,249
1965	250,000,000	220,000,000	204,098,509
1966	260,000,000	258,500,000	NA

1/ Obligations.

Since 1956 funds have been appropriated for the various categorical grants as follows:

	<u>Authorization</u> 1966	<u>Appropriation</u>					
		<u>1957</u>	<u>1958</u>	<u>1959- 1961</u>	<u>1962</u>	<u>1963- 1965</u>	<u>1966</u>
(In millions)							
Hospitals and public health centers	\$140.0	\$102.8	\$99.0	\$150.0	\$150.0	\$150.0	\$140.0
Modernization	20.0	-	-	-	-	-	20.0
Diagnostic or treatment centers	20.0	6.5	6.5	7.5	14.2	20.0	18.5
Long-term care facilities	70.0	10.5	10.5	17.5	38.5	40.0	70.0
Rehabilitation facilities	10.0	4.0	4.0	10.0	7.0	10.0	10.0
Total	\$260.0	\$123.8	\$120.0	\$185.0	\$209.7	\$220.0	\$258.5

Method of Distribution

Annual appropriations for hospital and medical facilities construction are allotted to the States in the ratio which the population of each State,

weighted by the square of its allotment percentage (as defined hereafter), bears to the sum of the corresponding products of weighted populations for all of the States.

The "allotment percentage" of a State is defined as: 100 percent minus 50 percent multiplied by the ratio of the per capita income of that State to the United States per capita income. Upper and lower limits are fixed for the allotment percentage, at 75 percent and 33-1/3 percent. Arbitrary allotment percentages are defined for Puerto Rico, Guam, American Samoa, and the Virgin Islands (75 percent).

In this formula for allotting appropriations, the allotment percentage is applied twice (or squared) as a weighting factor for population. Its first use is as a measure of State financial ability. Its second use is as an indirect measure of relative need among the States.

Appropriations for modernization of health facilities will be allotted to States according to a formula based on population, the extent of the need for modernization, and the financial need of the respective States.

The Act provides for minimum allotments to any State as follows:

For hospitals and public health centers	\$200,000
For modernization	200,000
For diagnostic or treatment centers	100,000
For long-term care facilities	200,000
For rehabilitation facilities	50,000

American Samoa, Guam, and the Virgin Islands are eligible for minimum allotments of one-half of the above State minimums if the Surgeon General is satisfied as to their need for the increased allotment.

Matching Requirements

The rate of Federal participation is established by the State administering agency each fiscal year and applies to all projects approved during such fiscal year. In adopting the rate of Federal participation the following alternatives are available to the State agency:

- (a) A uniform rate for all projects which may be an amount not less than 33-1/3 percent nor more than either 66-2/3 percent or the State's allotment percentage whichever is the lower; except that in case of long-term care, diagnostic or treatment, or rehabilitation projects the State agency may establish a rate of 50 percent regardless of the allotment percentage.

- (b) A variable rate between areas of the State within the range of 33-1/3 percent and 66-2/3 percent based upon economic status of areas, and other appropriate factors permitted by regulations, in the approved State plan.

Who May Receive Federal Aid

Private non-profit organizations, States and other public agencies are eligible to receive a Federal grant or loan for the construction or modernization of hospitals and other related health facilities providing that the proposed project meets a community need as determined by the Hill-Burton State agency and is included in the State plan. Projects may consist of the construction of completely new facilities of the replacement, remodeling, or expansion of existing facilities.

Application Procedure

The sponsor (or owner) at the local level should consult with the State agency responsible for administering the Hill-Burton program within his State.

The State agency will advise the applicant of the eligibility of the proposed project and the possibility of receiving Hill-Burton assistance. If the project is of sufficiently high priority and in line for consideration, the State agency will make available the application forms that must be filed and other material pertinent to the proposed project. All application documents including plans and specifications must be reviewed and approved by the State agency. The agency in turn, transmits the documents, along with approval and recommendations, to the regional office of the Public Health Service for final approval.

Developments During the Past Year

New procedures for determining hospital bed capacity and modernization needs were initiated in 1965 in the preparation of fiscal year 1966 State plans. The need for modernization will be based on the number of non-conforming beds according to a plant evaluation using uniform minimum standards. Existing beds will be counted on the basis of minimum square footage requirements. State agencies will now use three basic factors in calculating total hospital bed needs -- population projected five years, utilization data, and a desirable occupancy rate.

Legal Basis

Authority for hospital and medical facilities construction and modernization grants is included in Title VI of the Public Health Service Act, as amended (42 USC 291-291(o)).

Additional information may be obtained from the Chief, Division of Hospital and Medical Facilities, Public Health Service, Department of Health, Education, and Welfare, 7915 Eastern Avenue, Silver Spring, Maryland 20910.

PUBLIC HEALTH--GRADUATE TRAINING

Purpose

The Surgeon General is authorized to make project grants to any public or private nonprofit institution which provides graduate or specialized training in public health for the purpose of strengthening or expanding graduate public health training. An administrative decision has been made to limit the award of grants in fiscal year 1966 to the following institutions in the United States or its territories:

- (1) Schools of public health accredited for the degree of M.P.H. by the American Public Health Association;
- (2) Schools of nursing accredited by the National League for Nursing and which provide graduate or specialized preparation in public health;
- (3) Schools of engineering accredited by the Engineers Council for Professional Development and which provide graduate or specialized training in public health;
- (4) Departments of preventive medicine in schools of medicine accredited by the Liaison Committee on Medical Education and in schools of osteopathy accredited by the American Osteopathic Association; and
- (5) Departments of preventive or community dentistry in schools of dentistry accredited by the Council on Dental Education of the American Dental Association.

These grants are made to assist these schools in improving and enriching their curriculums to meet the needs of changing and emerging public health programs; in strengthening programs of basic training in public health administration; in developing and demonstrating improved public health training methods and procedures; and in enlarging faculties and supporting staff to provide for increased enrollments.

Projects which would strengthen or expand graduate public health training in such schools are eligible for grant support. For purposes of this program, graduate public health training means that specialized academic training in public health offered at the post-baccalaureate or post-professional registration level.

Financing

Appropriations are authorized and ceilings established for each fiscal year through June 30, 1969.

<u>Fiscal Year</u>	<u>Authorizations</u>	<u>Appropriations</u>	<u>Federal Expenditures</u> ^{1/}
1961	\$ 2,000,000	\$ 1,430,000	\$ 1,429,335
1962	2,000,000	2,000,000	1,999,939
1963	2,000,000	2,000,000	1,987,881
1964	2,000,000	2,000,000	1,993,620
1965	2,500,000	2,500,000	2,498,130
1966	4,000,000	4,000,000	NA

1/ Obligations.

Method of Distribution

These grants may be made by the Public Health Service only for those projects which are recommended by the National Advisory Committee on Public Health Training, which also advises the Service concerning the Public Health Traineeship Program as required by Section 306 of the Public Health Service Act.

Matching Requirements

None.

Who May Receive Federal Aid

See the first paragraph under Purpose.

Application Procedure

Applications for these grants are made on PHS Form 4744-1.

Developments During the Past Year

Support was continued for teaching programs under 91 projects to strengthen and expand public health training in schools of public health, engineering, nursing, medicine and dentistry. This was the first year that grants were awarded to the two latter types of schools.

Legal Basis

Section 309 of the Public Health Service Act as amended (42 USC 242g).

Additional information may be obtained from the Chief, Division of Community Health Services, Public Health Service, Department of Health, Education, and Welfare, Washington, D. C. 20201.

NURSE TRAINING--PROJECTS FOR IMPROVEMENT

Purpose

The Nurse Training Act of 1964 authorizes a program of project grants to enable public and non-profit private diploma, collegiate, and associate degree schools of nursing which are accredited or have reasonable assurance of accreditation to strengthen, improve, and expand programs to teach and train nurses. These grants are expected to improve the quality of instruction and to assist some of the 441 nonaccredited nursing schools to meet accreditation standards.

Financing

<u>Fiscal Year</u>	<u>Authorization</u>	<u>Appropriation</u>	<u>Federal Expenditures</u> ^{1/}
1965	\$ 2,000,000	\$ 2,000,000	\$ 1,989,564
1966	3,000,000	3,000,000	NA

1/ Obligations.

Method of Distribution

The National Advisory Council on Nurse Training will consider applications and make recommendations to the Surgeon General who will award grants on the basis of:

- (1) The relative extent to which the project will contribute to improvement in the teaching and training of nurses in the school involved.
- (2) The relative extent to which the project explores and develops new and improved teaching methods which can be adapted for use by other schools.
- (3) The relative extent to which the project will aid in attaining the wider geographical distribution of high quality schools of the type involved.
- (4) The relative need in the area in which the school is situated for nurses of the type trained in such a school.
- (5) Extent to which the project will increase the enrollment in the school.
- (6) Extent to which the project will help the school achieve accreditation.

Matching Requirements

None.

Who May Receive Federal Aid

Project grant funds are available to public and non-profit private diploma, collegiate, and associate degree schools offering programs which are accredited or which have been given reasonable assurance of being accredited at the time the project is terminated.

Application Procedure

Application forms may be obtained from the Division of Nursing, Public Health Service, Department of Health, Education, and Welfare, Washington, D. C. 20201.

Developments During the Past Year

Policies and procedures applicable to this program have been developed and the program put into operation.

Legal Basis

Grants for projects to improve nurse training programs are authorized under Section 805 of the Nurse Training Act of 1964, P.L. 88-581. (Title VIII, Public Health Service Act, as amended, 42 USC 296-298.)

Additional information may be obtained from the Chief, Division of Nursing, Public Health Service, Department of Health, Education, and Welfare, 7915 Eastern Avenue, Silver Spring, Maryland 20910.

COMMUNITY HEALTH SERVICES, PARTICULARLY FOR
THE CHRONICALLY ILL AND AGED

Purpose

Project grants for studies, experiments, and demonstrations looking toward the development of new or improved methods of providing health services outside the hospital, with particular emphasis on the needs of chronically ill or aged persons, were authorized by the Community Health Services and Facilities Act of 1961 and extended by the Community Health Services Extension Amendments of 1965, P.L. 89-109.

Financing

The following table shows appropriated funds and awards since the start of the program:

<u>Fiscal</u> <u>Year</u>	<u>Authorization</u>		<u>Appropriation</u>	<u>Federal</u> <u>Expenditures</u> ^{1/}
1962	\$ 10,000,000	^{2/}	\$ 2,319,000	\$ 2,294,128
1963	10,000,000		6,000,000	5,628,046
1964	10,000,000		7,000,000	6,956,625
1965	10,000,000		7,000,000	6,984,873
1966	10,000,000		10,000,000	NA

^{1/} Obligations.

^{2/} Amount available.

Method of Distribution

Grant requests may be submitted by any State or local public agency or any non-profit private agency, institution, or organization. Projects will be approved by the Surgeon General or his designee after considering the recommendations of an expert review committee.

Matching Requirements

None.

Who May Receive Federal Aid

Project grants are available to any State or local public agency, or any non-profit private agency, institution, or organization.

Application Procedure

Applications for project grants should be submitted to the Office of Grants Management on form PHS-4744-1 in accordance with applicable instructions and regulations.

Developments During the Past Year

During the past year, the number of approved and funded projects has increased from 106 to 230. Authorization for the program was also extended for one year by the "Community Health Services Extension Amendments of 1965." Funds were made available to support renal insufficiency projects and for special planning projects in the areas of heart, cancer, and stroke.

Legal Basis

Section 316 of the Public Health Service Act, as amended (42 USC 247a), and P.L. 89-109.

Additional information may be obtained from the Chief, Office of Grants Management, Bureau of State Services (CH), Public Health Service, Department of Health, Education, and Welfare, Washington, D. C. 20201.

HEALTH RESEARCH FACILITIES CONSTRUCTION

Purpose

Grants for large-scale construction of health research facilities were not made prior to 1948. In that year, Congress appropriated \$2,303,000 for grants for construction of research facilities to be made through the National Cancer Institute. Additional grants for such construction were made by the National Cancer Institute and National Heart Institute in fiscal years 1950 through 1952 under general authority conferred in 1950 by Section 433 of the PHS Act, as amended. The total from the National Cancer Institute thus amounted to \$16,303,000 and from the National Heart Institute \$6,059,000 for the years 1950-52. Support of this program was not continued by Congress during the years of the Korean War.

In 1956, in the Health Research Facilities Act (Public Law 835), the 84th Congress authorized establishment of the National Advisory Council on Health Research Facilities and the appropriation of \$30,000,000 for each of three years, for grants on a matching basis, to assist in the construction of facilities for research in the sciences related to health, including the fundamental sciences. In 1958 the program was extended for an additional three-year period. In 1961 the program was extended for an additional one-year period with an increase in the authorization to \$50,000,000; the law was also amended to provide that facilities for which grants may be made may include those for research training and for other purposes related to research. Public Law 87-838, approved October 17, 1962, again extended this program for another three years, at the \$50,000,000 authorization. Public Law 88-129 (approved September 24, 1963) amended the Health Research Facilities Act by designating it as Part A of Title VII and by adding a new section to provide for technical assistance to applicants. This Law further provided that grants awarded under this Part now are subject to the provisions of the Davis-Bacon (prevailing wage) Act and the Contract Work Hours Standards Act. Public Law 89-115 (approved August 9, 1965) extended the program through fiscal year 1969 and increased the authorization to \$280,000,000 over the three-year period.

The regulations recommended by the National Advisory Council on Health Research Facilities and approved by the Surgeon General and the Secretary (42 CFR, Part 57, Subpart A) require particular consideration be given in the use of available funds to (1) research facilities contributing to research in disciplines or diseases which have the most urgent need, (2) institutions or localities with broad research programs and potentials, and (3) various geographical areas of the Nation having at present relatively few such research facilities.

Financing

The fiscal data on grants for construction of health research facilities under the 1956 Act are as follows:

Fiscal Year	Authorization	Appropriation	Expenditures	
			Federal 1/	Matching
1957	\$ 30,000,000	\$ 30,000,000	\$28,062,026	\$39,720,475
1958	30,000,000	30,000,000	29,125,575	48,054,216
1962	30,000,000	30,000,000	30,732,149	49,358,947
1963	50,000,000	50,000,000	47,221,576	67,717,745
1964	50,000,000	50,000,000	53,243,401	73,927,827
1965	50,000,000	50,000,000	50,553,804	64,673,664
1966	50,000,000	50,000,000	NA	NA

1/ Obligations.

Method of Distribution

Funds for construction of health research facilities are distributed in response to grant applications from eligible applicants which are recommended for approval by the National Advisory Council on Health Research Facilities and approved by the Surgeon General. Evidence that the purposes and intent of the Health Research Facilities Act will be served is provided in each case.

Matching Requirements

The Surgeon General, at his discretion, awards support to an applicant institution in the amount recommended by the Council, or in a lesser amount. In no case is the amount to exceed 50 per cent of the total necessary construction costs of the research portion of the facility; the remaining sum is provided by the institution through funds available to it and from non-Federal sources.

The sum awarded to the grantee institution is paid in installments consistent with construction progress.

The Law (Section 709) provides that the Surgeon General, after consultation with the Council and with the approval of the Secretary, shall prescribe general regulations covering the eligibility of institutions and the terms and conditions for approving applications. Regulations, published in the Federal Register (21 Fed. Reg. 9867, December 12, 1956, 27 Fed. Reg. 6328, July 4, 1962, 29 Fed. Reg. 12649, September 5, 1964), cover the period of authorization of funds for this program, fiscal year 1957 through fiscal year 1969.

Who May Receive Federal Aid

Universities and other private non-profit and non-Federal public institutions authorized and competent to engage in the type of research for which the facility is to be constructed may apply for funds under this program.

Application Procedure

The application must be executed by an official or officials legally authorized by the applying agencies, corporations, or associations to make on their behalf such application and to provide the required assurances outlined in the program Rules and Regulations.

The application includes detailed information on the administration, research program and construction plans for the facility. The administration information includes details on plans for budgeting, staffing and managing the facility. The information on the research program includes a description of the need for the research, the nature of the planned research and the capability of the scientific staff. The information for construction plans includes a Program of Requirements for the facility, schematic drawings, outline specifications and a cost estimate.

Applications are evaluated by the National Advisory Council on Health Research Facilities with respect to their potential value in expanding health research in the Nation and recommendations are made to the Surgeon General.

Developments During the Past Year

The Law was extended through fiscal year 1969.

Legal Basis

Part A of Title VII of the Public Health Service Act (42 USC 292-292(i)), as amended by the Health Research Facilities Amendments of 1965, P.L. 89-115.

Additional information may be obtained from the Chief, Division of Research Facilities and Resources, National Institutes of Health, Public Health Service, Department of Health, Education, and Welfare, Bethesda, Maryland 20014.

REGIONAL MEDICAL PROGRAMS

Purpose

To encourage and assist in the establishment of regional cooperative arrangements among medical schools, research institutions, and hospitals for research and training and for demonstrations of patient care in the fields of heart disease, cancer, stroke, and related diseases; and through such cooperative arrangements to afford to the medical profession and medical institutions of the Nation the opportunity of making available to their patients the latest advances in the diagnosis and treatment of these diseases.

Financing

For fiscal year 1966, \$90,000,000 was authorized and \$25,000,000 was appropriated (\$24,000,000 grants, \$1,000,000 administration and technical assistance), to remain available until December 31, 1966.

Method of Distribution

Grants for planning or for establishment and operation of regional medical programs are made to eligible applicants upon approval of a grant application by the Surgeon General, upon the recommendation of the National Advisory Council on Regional Medical Programs.

Matching Requirements

A grant can be for all or part of the cost of the planning or other activities with respect to which the application is made, except it may not exceed 90% of the cost of any construction of, or built-in equipment for, any facility, or of the cost of alteration and renovation of facilities and of initial equipment and replacement of obsolete built-in equipment.

Who May Receive Federal Aid

Public or nonprofit private universities, medical schools, research institutions, and other public or nonprofit private institutions and agencies.

Application Procedure

Apply directly to the National Institutes of Health, Bethesda, Maryland.

Developments During the Past Year

The legislation was enacted.

Legal Basis

The Heart Disease, Cancer, and Stroke Amendments of 1965: P.L. 89-239.

Additional information may be obtained from the Associate Director for Regional Medical Programs, National Institutes of Health, Public Health Service, Department of Health, Education, and Welfare, Bethesda, Maryland 20014.

EDUCATIONAL IMPROVEMENT GRANTS TO SCHOOLS OF
MEDICINE, DENTISTRY, OSTEOPATHY, OPTOMETRY,
AND PODIATRY

Purpose

To assist schools of medicine, dentistry, osteopathy, optometry, and podiatry to improve the quality of their educational program.

Financing

<u>Fiscal Year</u>	<u>Authorization</u>	<u>Appropriation</u>	<u>Federal Expenditures</u>
1966	\$20,000,000	\$10,482,000	NA
1967	40,000,000		
1968	60,000,000		
1969	80,000,000		

Method of Distribution

Basic Improvement Grants: To eligible applicants on approval of the grant application by the Surgeon General after consultation with the National Advisory Council on Medical, Dental, Optometric and Podiatric Education.

For fiscal year 1966, a school whose application has been approved shall be paid \$12,500 plus an amount equal to \$250 multiplied by the number of full-time students in the school.

In each of the three succeeding fiscal years, a school whose application has been approved for that year shall be paid \$25,000 plus an amount equal to \$500 multiplied by the number of full-time students in the school.

Special Improvement Grants: To eligible applicants which have an approved application for basic improvement grants, upon approval of the Surgeon General upon the recommendation of the National Advisory Council on Medical, Dental, Optometric and Podiatric Education. No special improvement grant to any school may exceed \$100,000 for fiscal year 1966; \$200,000 for FY 1967; \$300,000 for FY 1968; or \$400,000 for FY 1969. These grants will be funded from remaining sums not used under basic improvement grants.

Matching Requirements

None.

Who May Receive Federal Aid

Public or non-profit schools of medicine, dentistry, osteopathy, optometry, or podiatry accredited by a recognized body or bodies approved for such purpose by the Commissioner of Education (except that the accreditation requirement shall be deemed to be satisfied if (1) in the case of a

new school, there is reasonable assurance that the school will meet accreditation standards prior to the beginning of the academic year following the normal graduation date of students who are in the first year of school during the FY in which the Surgeon General makes a final determination as to the approval of the application, or (2) in the case of any other school, there is reasonable ground to expect that with the aid of the improvement grant or grants, under this law, the school will meet such accreditation standards within a reasonable time).

Application Procedure

Schools which wish to apply for a basic improvement grant must submit an "Application for a Health Professions Educational Improvement Grant" (PHS-T343-1). Detailed instructions are provided with the application.

Developments During the Past Year

New program.

Legal Basis

Health Professions Educational Assistance Amendments of 1965, Public Law 89-290, approved October 22, 1965 (79 Stat. 1052).

Additional information may be obtained from the Division of Community Health Services, Public Health Service, Department of Health, Education, and Welfare, Washington, D. C. 20201.

HEALTH PROFESSIONS PERSONNEL

DEPARTMENTAL REPORTS

EXECUTIVE OFFICE OF THE PRESIDENT,
BUREAU OF THE BUDGET,
Washington, D. C., September 14, 1966.

HON. LISTER HILL,
Chairman, Labor and Public Welfare Committee, U. S. Senate, 4230 New
Senate Office Building, Washington, D. C.

DEAR MR. CHAIRMAN: This is in response to your request for the views of the Bureau of the Budget on S. 3102 and the House passed version of H.R. 13196, bills "To amend the Public Health Service Act to increase the opportunities for training of medical technologists and personnel in other allied health professions, to improve the educational quality of the schools training such allied health professions personnel, and to strengthen and improve the existing student loan programs for medical, osteopathic, dental, podiatry, pharmacy, optometric, and nursing students, and for other purposes."

Both of these bills embody Administration proposals to carry out the intent of the President as expressed in his Health Message to the Congress, to encourage training of additional personnel in certain critical health specialties which are dangerously undermanned. Measures already enacted by the Congress in the last few years have authorized programs which will, in the future, help alleviate the short supply of personnel in the health field. The Health Professions Educational Assistance Act provides support for schools and for students of medicine, dentistry, and other health professions. The Nurse Training Act of 1964 provides Federal aid to increase the supply of professional nurses. The Vocational Education Act provides for the training of practical nurses and other health workers. The basic purpose of H.R. 13196 is to furnish a basis for training needed personnel in the so-called allied health professions, some of whom may, in turn, help to train more health workers, supervise them in their work, and provide professionally trained health workers for highly skilled technical services.

The House passed version proposes a program of guaranteed student loans in addition to the direct Federal loans presently available to students in medicine, dentistry, nursing, and other health professions. The Secretary of Health, Education, and Welfare, in his report to you on this bill, proposes to substitute a simpler student loan program for the guaranteed loan version in the House-passed bill. The Bureau of the Budget agrees with the views expressed in that report.

The House-passed version of H.R. 13196, if amended as suggested in the report of the Secretary of Health, Education, and Welfare, would carry out the President's recommendations. Its enactment, if amended, would be in accord with the program of the President.

Sincerely yours,

WILFRED H. ROMMEL,
Assistant Director for Legislature Reference.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
September 15, 1966.

HON. LISTER HILL,
Chairman, Committee on Labor and Public Welfare,
U. S. Senate,
Washington, D. C.

DEAR MR. CHAIRMAN: This is in response to your request of June 27, 1966, for a report on H.R. 13196, the Allied Health Professions Person-

5137

nel Training Act of 1966, as passed by the House of Representatives on June 23, 1966.

H.R. 13196, as introduced in the House, and S. 3102, now pending action in the Senate, are identical bills designed to carry out President Johnson's recommendations for expanding and improving the training of highly qualified people in the allied health professions and for encouraging greater use of private capital in financing student loan programs for training physicians, dentists, optometrists, podiatrists, pharmacists, and nurses.

As passed by the House of Representatives, H.R. 13196 retains the essential features of the President's recommendations. Amendments adopted by the House are directed primarily at broadening the scope of the proposed programs and increasing the amount of authorized financial assistance. The principal amendments made by the House are as follows:

1. Whereas H.R. 13196 and S. 3102, as introduced, limited eligibility for allied health professions training grants to programs for the training of personnel requiring baccalaureate or higher degrees and to colleges and universities providing such training, the House-passed bill extends eligibility for these training grants also to junior colleges and to junior college programs for the training of health technicians requiring less than baccalaureate level education.

2. The House-passed bill contains annual appropriation authorizations for each of the allied health professions training grant programs which, because of the inclusion of junior college eligibility, are somewhat higher than the forecast of appropriation requirements submitted by the Department.

3. The provision in H.R. 13196, as introduced, which would authorize forgiveness of up to 100 percent of student loans to physicians at the rate of 15 percent per year of practice in poor rural areas was amended by the House to provide the same forgiveness benefits also to dentists and optometrists.

4. The student loan conversion provisions in H.R. 13196 were amended to delete any changes in financing or operation of the current student loan programs for physicians, dentists, optometrists, pharmacists, podiatrists, and nurses and to provide that the proposed new authorizations for encouraging utilization of private capital in financing student loans for such health professionals would be in addition to and financed separately from the currently authorized programs.

We believe that the provisions of H.R. 13196 and S. 3102, as introduced, would provide the basis for meeting the highest priority needs in the training of allied health professionals and in financing student loans for training physicians, dentists, nurses, and other health professionals. Inasmuch as the House-passed bill retains virtually all of these provisions and includes some improvements, we urge that your Committee act favorably on the bill as passed by the House, with only two modifications of substance. One of these relates to the provisions described in item 4, above. The student loan provisions contained in the Administration's proposal were always intended to be (as they were) patterned after the student loan provisions in the Administration's 1966 legislative proposal on higher education. Since we have requested modification of those provisions in the higher education proposal, the student loan provisions in the proposal here under consideration should be similarly modified. For the convenience of the Committee we have enclosed amendments to the House-passed bill, H.R. 13196, to accomplish this modification.

The second of the modifications relates to the eligibility of hospitals affiliated with educational institutions for grants under the bill. It has been brought to our attention that only hospitals which are part of a college, university, or junior college, or which are affiliated with a school of medicine or osteopathy would be eligible for grants under the bill. We feel this may prove unduly restrictive in excluding hospitals used by other colleges, universities, or junior colleges for provision of part of the train-

ing in the allied health professions. To avoid this exclusion, we recommend addition of the following definition of "affiliated hospital" on page 19, between lines 7 and 8, of the House-passed bill:

(5) The term "affiliated hospital" means a hospital, as defined in section 625, which is not owned by, but is affiliated (to the extent and in the manner determined in accordance with regulations) with, one or more training centers for allied health professions.

The Bureau of the Budget advises that there is no objection from the standpoint of the administration's program to the submission of this report.

WILBUR J. COHEN,
Under Secretary.

AUTHORIZATION FOR ADDITIONAL APPROPRIATIONS

H.R. 13196, as passed by the House of Representatives, authorized a total of \$155 million in appropriations for the 3 fiscal years 1967, 1968, and 1969. As a result of the adoption of the revised amendments pertaining to student loans under the Health Professions Educational Assistance Act and the Nurse Training Act and the amendments authorizing scholarships for nursing students and recruitment contracts, the total additional authorization for appropriations is reduced by \$49.7 million to a net total of \$105.3 million for the 3 years:

Item	Fiscal years		
	1967	1968	1969
1. Allied health professions	\$14,250,000	\$26,750,000	\$37,000,000
(a) Construction grants	3,000,000	9,000,000	13,500,000
(b) Improvement grants	9,000,000	15,000,000	17,000,000
(c) Fellowship grants	1,500,000	2,250,000	3,500,000
(d) Developmental grants	750,000	2,250,000	3,000,000
2. Student loans	12,000,000		
(a) Health professions	10,000,000		
(b) Nursing	2,000,000		
3. Nursing	3,100,000	5,100,000	7,100,000
(a) Opportunity grants	3,000,000	5,000,000	7,000,000
(b) Recruitment	100,000	100,000	100,000
Grand total	29,350,000	31,850,000	44,100,000

SECTION-BY-SECTION ANALYSIS

SECTION 1

This section provides that the act may be cited as the "Allied Health Professions Personnel Training Act of 1966."

SECTION 2

This section amends title VII of the Public Health Service Act (42 U.S.C. ch. 6A) by adding at the end thereof a new part G ("Training in the Allied Health Professions"), consisting of sections 791 through 795, as follows:

Section 791. Grants for Construction of Teaching Facilities for Allied Health Professions Personnel

Subsection (a). Authorization of Appropriations

This subsection authorizes to be appropriated \$3 million for fiscal year 1967, \$9 million for fiscal year 1968, and \$13.5 million for fiscal year 1969, for grants to assist in the construction of new facilities, or the replacement of existing facilities, for "training centers for allied health professions", as defined in section 795(1). Sums so appropriated for a fiscal year shall remain available until the close of the next fiscal year.

Subsection (b). Approval of Applications for Construction Grants

This subsection sets forth the prerequisites for approval by the Surgeon General of applications for grants under section 791.

Paragraph (1) of this subsection provides that no application may be approved unless submitted to the Surgeon General before July 1, 1968 (or by such earlier date as may be set by the Surgeon General for any fiscal year, but not earlier than the fiscal year preceding the year for which the grant is sought).

Paragraph (2) of this subsection provides that the grant may be made only if the Surgeon General approves the application therefor, upon his determination that the applicant is a public or nonprofit private training center; that there are reasonable assurances that the facility will be used for training for allied health professions for at least 10 years and will not be used for sectarian instruction or for worship; and that there will be sufficient funds for the non-Federal share of construction costs and, after completion of construction, for the contemplated use of the facility. Where the grant sought is for construction to expand an existing training center, there must also be assurances that the enrollment of full-time students for the 10 school years immediately following completion of the construction will exceed by at least 5 percent the enrollment of full-time students for any of the 5 school years preceding the year in which the application is made. (This requirement of enrollment increase is in addition to the one required under sec. 742(b)(2).) A grant for construction of a new facility must be for construction of a new, or expansion of the capacity of an existing, center; and, where a grant is for replacement or rehabilitation of existing facilities, such facilities must now be obsolete. To approve an application, the Surgeon General must also determine that the plans and specifications are in accordance with regulations and that there are adequate assurances with respect to labor standards and prevailing wage scales.

Paragraph (3) of this subsection provides that, in the case of an affiliated hospital an application which is approved by the training center with which the hospital is affiliated may be filed by any public or other nonprofit private agency qualified to file an application under section 605.

Paragraph (4) provides that, in the case of any application, whether filed by a training center or, in the case of an affiliated hospital, by any public or other nonprofit agency, for a grant under this section to assist in the construction of a facility which is a hospital or part of a hospital, as defined in section 625, only that portion of the project which the Surgeon General determines is reasonably attributable to the need of the training center for the project for teaching purposes or in order to expand its training capacity or in order to prevent curtailment of enrollment or quality

of training, as the case may be, shall be regarded as the project with respect to which payments may be made under section 791.

Paragraph (5) provides that, in considering applications for grants, the Surgeon General shall take into account the extent to which the grant would increase the number of training centers furnishing training in three or more related allied health professions curriculums. (See sec. 795(1).) In the case of a project for a new training center or for expansion of an existing center, he shall take into account also the relative effectiveness of the proposed facilities for expansion of capacities for training in the allied health professions and for promotion of equitable geographic distribution of opportunities for such training; the relative unavailability of personnel of the kinds to be trained by the center; and the available resources for training such personnel in various areas of the country. In the case of a project for replacement or rehabilitation of existing facilities of a training center, he shall also take into account the extent to which, without the grant, there might be curtailment of enrollment or deterioration of the quality of training. Where the applicant is located in an area for which a State, local, regional, or interstate agency for planning of facilities for allied health professions personnel exists, the Surgeon General shall give consideration to the relationship of the application to the program being developed by such agency and, if it has reviewed the application, to the agency's comments.

Subsection (c). Amount of Construction Grant; Payments

Paragraph (1) of this subsection states that the amount of any grant under section 791 for a construction project shall be the amount which the Surgeon General determines to be appropriate, but it may not exceed 66 $\frac{2}{3}$ percent of the necessary cost of construction in the case of a grant for a project for a training center, or for new facilities for a training center, or for new facilities for an existing center where such facilities are of particular importance in providing a major expansion of the training capacity of the center; nor may it exceed 50 percent of the necessary cost of construction of the project in the case of any other grant.

Paragraph (2) of this subsection states that, upon approval of an application for a grant under section 791, the Surgeon General shall reserve from any available appropriation the amount of the grant and may pay it in advance, or by way of reimbursement, and in installments consistent with construction programs.

Paragraph (3) of this subsection provides that, in the determination of the amount of a grant under section 791, there shall be excluded from the cost of construction an amount equal to the sum of any other Federal grant to the applicant with respect to the same construction plus the amount of any non-Federal funds required to be expended as a condition to such other Federal grant.

Subsection (d). Recapture of Payments

This subsection provides that if, within 10 years of the completion of any construction for which funds have been paid under section 791, the applicant or other owner of the facility ceases to be a public or nonprofit private training center for allied health professions, or the facility ceases to be used for the training purposes for which it was constructed (unless the Surgeon General finds good cause to grant a release from the obliga-

tion to use it for such purposes), or the facility is used for sectarian instruction or as a place of worship, then the United States shall be entitled to recover an amount bearing the same ratio to the then value of the facility as the amount of the Federal participation bore to the cost of construction of such facility.

Section 792. Grants To Improve the Quality of Training Centers for Allied Health Professions

Subsection (a). Authorization of Appropriations

This subsection authorizes to be appropriated \$9 million for fiscal year 1967, \$13 million for fiscal year 1968, and \$17 million for fiscal year 1969 to assist training centers for allied health professions to develop new or improved curriculums for training allied health professions personnel and otherwise to improve the quality of their educational programs.

Subsection (b). Basic Improvement Grants

Paragraph (1) of this subsection provides that, subject to the provisions of paragraph (2), the Surgeon General may, for fiscal years 1967, 1968, and 1969, make a grant, to each training center whose application for a basic improvement grant has been approved by him, equal to the product obtained by multiplying \$5,000 by the number of allied health professions curriculums (see section 795(1)) offered by the center during such year, plus the product obtained by multiplying \$500 by the number of full-time students in such center receiving training in such curriculums.

Paragraph (2) of this subsection provides that the Surgeon General shall not make a grant under this subsection to any center unless he receives assurances that, for the first school year beginning after the fiscal year for which such grant is made and each school year thereafter during which such grant is made, the enrollment of full-time students at such center will exceed the highest enrollment of such students in such center for any of the 5 school years between July 1, 1961, and July 1, 1966, by at least the greater of 2½ percent of such highest enrollment or three students. This is in addition to the requirement pertaining to increase of enrollment set forth in section 791(b) (2). The Surgeon General is, however, permitted to waive the provisions of paragraph (2) where he determines that their application would lower the quality of training in the center, due to limitations of physical facilities.

Subsection (c). Special Improvement Grants

Paragraph (1) of this subsection provides that the Surgeon General may make an additional grant ("special improvement grant") from the sums appropriated under subsection (a) for a fiscal year and not required for making grants under subsection (b), to any training center which had an application approved under subsection (b) and for which an application is also approved under subsection (c), if he determines that the requirements of paragraph (2) are satisfied.

Paragraph (2) says that no such special improvement grant may be made unless the Surgeon General determines that it will be utilized for specialized functions which the recipient center serves, and unless the recipient center will not provide training in not less than three of the allied health professions curriculums (see section 791(1)) and such curriculums are related to each other to the extent prescribed by regulations.

Paragraph (3) of this subsection provides that no grant to any center under this subsection may exceed \$100,000 for any fiscal year.

Subsection (d). Application for Grants

Paragraph (1) of this subsection provides that the Surgeon General may set dates (not earlier than in the fiscal year preceding the year for which a grant is sought) by which applications for basic and special improvement grants under section 792 must be filed for any fiscal year.

Paragraph (2) of this subsection sets forth the prerequisites for approval by the Surgeon General of applications for grants under section 792. In order to approve such an application, he must determine that the applicant is a public or nonprofit private training center for allied health professions; that it will spend, during the fiscal year for which it seeks a grant, an amount (other than for construction) from non-Federal sources at least as great as the average which it spent for such purposes in the 3 fiscal years immediately preceding the fiscal year for which the grant is sought; and that the application contains such additional assurances and information, and provides for such fiscal control and access to records, as he may require.

Paragraph (3) of this subsection provides that, in considering applications for grants under subsection (c) ("special improvement grants"), the Surgeon General shall consider the relative financial need of the applicant and the relative effectiveness of its plan.

Section 793. Traineeships for Advanced Training of Allied Health Professions Personnel

Subsection (a) of this section authorizes to be appropriated \$1.5 million for fiscal year 1967, \$2.5 million for fiscal year 1968, and \$3.5 million for fiscal year 1969, to cover the cost of traineeships for the training of allied health professions personnel. Such training is to enable them to teach health services to technicians or in any of the allied health professions, to serve in administrative or supervisory capacities in such professions, or to serve in specialties which are determined to require advanced training.

Subsection (b) of this section states that such traineeships shall be awarded by the Surgeon General through grants to public or nonprofit private training centers.

Subsection (c) of this section provides that payments may be in advance, or by way of reimbursement, and at intervals and on conditions determined by the Surgeon General; may be used only for traineeships; and shall be limited to the amounts the Surgeon General finds necessary to cover the costs of tuition and fees, and a stipend and allowances (including travel expenses) for the trainees.

Section 794. Development of New Methods

This section authorizes to be appropriated \$0.75 million for fiscal year 1967, \$2.25 million for fiscal year 1968, and \$3 million for fiscal year 1969, for grants to public or nonprofit private training centers, for projects to develop, demonstrate, or evaluate curriculums for the training of new types of health technologists.

Section 795. Definitions

This section sets forth the definitions applicable throughout part G. Paragraph (1) of this subsection defines "training center for allied health professions" as a junior college, college, or university which provides, or

can provide programs leading to a baccalaureate or associate degree or to the equivalent of either, or to a higher degree in medical technology, optometric technology, dental hygiene, or any other allied health professions curriculums specified by regulations, or which, if in a junior college, provides a program (1) leading to an associate or an equivalent degree; (2) of education in medical technology, optometric technology, dental hygiene, or any of such other of the allied health technical or professional curriculums as are specified by regulation; and (3) acceptable for full credit toward a baccalaureate or equivalent degree in the allied health professions or designed to prepare the student to work as a technician in a health occupation specified by regulations of the Surgeon General. In addition, such department, division, or other administrative unit would have to be one which provides training for not less than 20 persons in such curriculums (except where the application is for a construction grant under section 791 and there is reasonable assurance that the applicant will train at least 20 persons by the academic year following graduation of the first entering class in the unit or, if later, upon completion of the project); which, if the junior college, college, or university does not include a teaching hospital, is affiliated with one; and which is accredited (or is in an accredited college or university) or which is in a junior college which is accredited by the regional accrediting agency for the region in which it is located or with respect to which there is satisfactory assurance afforded by such accrediting agency to the Surgeon General that reasonable progress is being made toward accreditation by such junior college. In the case of an applicant for a grant under section 793 (traineeship for advanced training), the center must be part of a college or university which includes a school of medicine or dentistry or is affiliated with such a school.

Paragraph (2) of this subsection defines "full-time student" as a student pursuing a full-time course of study in one of the allied health professions curriculums (see sec. 795(1)) leading to a baccalaureate or equivalent or higher degree in a training center for allied health professions. The Surgeon General shall include in regulations provisions relating to the number of students enrolled at a training center, for purposes of this paragraph.

Paragraph (3) of this subsection defines "nonprofit", as applied to a training center, as being a center of which no part of the net earnings may inure to the benefit of any private shareholder or individual.

Paragraph (4) states that the terms "construction" and "cost of construction" include the construction of new buildings, and the alteration of existing buildings, including architects' fees, but not the cost of acquisition of land. These terms also are defined to include equipping of new buildings and existing buildings, whether or not expanded, remodeled, or altered.

Paragraph (5) defines the term "affiliated hospital" as a hospital, as defined in section 625, which is not owned by, but is affiliated (to the extent and in the manner determined in accordance with regulations) with, one or more training centers for allied health professions.

SECTION 3

This section amends section 725(d) of the Public Health Service Act by changing the maximum compensation for members of the National Advisory Council on Education for Health Professions from \$50 per diem

to \$100 per diem, and amends section 841(c) of the act by changing the maximum compensation for members of the National Advisory Council on Nurse Training from \$75 per diem to \$100 per diem.

SECTION 4

Subsection (a) amends section 741(f) of the Public Health Service Act which now provides for the forgiveness of up to 50 percent of the amount of any loan made under part C of title VII of that act to physicians, dentists, or optometrists who practice in an area having a shortage of and a need for members of their profession. The amendment made by this subsection would provide that, in the case of a physician, dentist, or optometrist, the rate shall be 15 percent (rather than 10 percent) for each year of such practice in an area in a State which has been determined by the Secretary, pursuant to regulations and after consultation with the appropriate State health authority, to be a rural area characterized by low family income. For this purpose, an amount equal to an additional 50 percent of the total amount of such loans plus interest could be forgiven.

Subsection (b) of section 4 would add to section 741 of the Public Health Service Act a new subsection (j). This proposed subsection (j) provides that, in order to encourage students who have obtained a loan under this part to refinance such loan through the student loan program carried out under part B of title IV of the Higher Education Act of 1965, and likewise to encourage students to obtain new loans under such part B program in lieu of obtaining such loans under this part, a student who does so with the approval of the educational institution involved shall, with respect to so much of the loan under such part B as (1) is a refinancing of a student loan made by the institution under this part, or (2) in the case of a loan under such part B obtained in lieu of a loan from the institution, does not exceed the amount which he was eligible to borrow from the institution, be entitled, in accordance with regulations of the Secretary, to have the following loan reimbursement payments paid to him by the Secretary: where such person (1) engages in the practice of medicine, dentistry, optometry, or osteopathy in an area in a State determined by the appropriate State health authority, in accordance with regulations prescribed by the Secretary, to have a shortage of and need for physicians, optometrists, or dentists; and (2) the appropriate State health authority certifies to the Secretary, in accordance with regulations prescribed by the Secretary, that such practice helps to meet the shortage of and need for physicians, optometrists, or dentists in the area where the practice occurs, than an amount equal to 10 percent of the total amount of each such loan shall be paid for each year of such practice, up to a total of an amount equal to 50 percent of such loan. In the case of a physician, dentist, or optometrist the annual amount shall be 15 percent (rather than 10 percent) for each year of such practice in an area in a State which has been determined by the Secretary, pursuant to regulations and after consultation with the appropriate State health authority, to be a rural area characterized by low family income. For this purpose, an amount equal to an additional 50 percent of any such loan may be paid. However, no payment shall be made under this subsection for service performed more than 15 years from the execution of the note or written agreement evidencing it.

Subsection (c) amends section 823 of the Public Health Service Act by adding at the end thereof a new subsection (f). This proposed subsection (f) provides that, in order to encourage students of nursing who have obtained a loan under part B of title VIII of the Public Health Service Act to refinance such loan through the student loan program carried out under part B of title IV of the Higher Education Act of 1965, and likewise to encourage students to obtain new loans under such part B program in lieu of obtaining such loans under this part, a student who does so with the approval of the educational institution involved shall, with respect to so much of the loan under such part B as (1) is a refinancing of a student loan made by the institution under this part, or (2) in the case of a loan under such part B obtained in lieu of a loan from the institution, does not exceed the amount which he was eligible to borrow from the institution, be entitled, in accordance with regulations of the Secretary, to have paid to such student by the Secretary, as loan reimbursements, an amount equal to 10 percent of the total principal amount of any such loan for each complete year of service as a full-time professional nurse (including teaching in any of the fields of nurse training and service as an administrator, supervisor, or consultant in any of the fields of nursing) in any public or nonprofit private institution or agency, up to a total of an amount equal to 50 percent of such loan. However, no payment shall be made under this subsection for service performed more than 15 years from the execution of the note or written agreement evidencing it.

Subsection (d) amends section 435 of the Higher Education Act of 1965, so as to amend certain definitions used in part B of title IV of that act. These amendments are made in order to conform with amendments to Public Health Service Act (which are covered in the description of subsections (a), (b), and (c) above).

Among other things, subsection (d) would add a definition of "school of health" to such section 435. As defined, it would mean a school which is accredited as provided in section 721(b) (1) (B) of the Public Health Service Act and which provides training leading to a degree of doctor of medicine, doctor of dentistry, or an equivalent degree, doctor of osteopathy, bachelor of science in pharmacy, or doctor of pharmacy, doctor of podiatry, or doctor of surgical chiropody, or doctor of optometry, or an equivalent degree.

In addition, subsection (d) would add a definition of the term "diploma school of nursing". This would be defined to mean a school affiliated with a hospital or university, or an independent school, which provides primarily or exclusively an accredited program of education in professional nursing and allied subjects leading to a diploma or to equivalent indicia that such program has been satisfactorily completed.

Further, it would amend the definition of the term "accredited" (which applies to programs of nurse education) so as to provide that where a program of nurse education is not eligible for accreditation by a recognized body or bodies it would, nevertheless, be deemed accredited for purposes of part B of title IV of the Higher Education Act of 1965 if the Commissioner of Education finds, after consultation with the appropriate accreditation body or bodies, that there is reasonable assurance that the program will meet the accreditation standards of such body or bodies prior to the beginning of the academic year following the normal graduation

date of students who are in their first year of instruction at such school during the fiscal year in which such findings by the Commissioner were made.

SECTION 5

Subsection (a) of this section of the bill would insert in title VII of the Public Health Service Act a new section 744 which supersedes the present section 744 of the Public Health Service Act.¹ The new section 744 would authorize the Secretary of Health, Education, and Welfare, during the fiscal years ending in 1967 and 1968, to make loans, from the revolving fund established by subsection (d) of this section, to schools of medicine, osteopathy, dentistry, pharmacy, podiatry, and optometry to provide all or part of the capital needed for their student loan funds. To the extent that student loan fund capital is obtained from the Secretary in the form of loans from the revolving fund, the institution would not be required to make the institutional contribution required under section 740(b) (2) (B) of \$1 for every \$9 in Federal capital contributions, i. e., an institution's student loan fund could, under the bill, be financed 100 percent by loans from the Secretary under this section. Such loans may be upon such terms and conditions as the Secretary deems appropriate, bearing interest at a rate based on the going Federal rate on comparable U.S. obligations plus probable losses. (But see analysis of subsection (b) as to Secretary's reimbursement obligation to institution.) If the Secretary finds it necessary, he may agree to provisions making the institution's obligation to the Secretary on such a loan payable solely from particular revenues or other assets or security such as collections on loans to students.

Subsection (b) of the new section 744 would provide that if an institution borrows funds from the revolving fund, the Secretary shall agree to reimburse the institution for (1) 90 percent of the loss to the institution from defaults on student loans; (2) the excess of the interest which the institution must pay on loans borrowed from the revolving fund over the interest received by the institution's student loan fund from student borrowers to whom loans were made from proceeds of the Federal loan made to the institution; (3) administrative expenses as authorized in the existing section 740(b) (3); and (4) the amount of principal canceled under the forgiveness provisions (sec. 741(d) and (f)).

Subsection (c) of the new section 744 would limit the total of the loans which could be made from the revolving fund in any fiscal year to an amount equal to the lesser of the following: (1) Any specific limitations contained in appropriation acts. (2) The excess of \$35 million and the amount of Federal capital contributions paid into institutional student loan funds for that year.

Subsection (d) of the proposed new section 744 would establish on the books of the Treasury a revolving fund designated as the health profession education fund, to be available to the Secretary without fiscal year limitation as a revolving fund for the purposes of the new section 744. This

¹The superseded sec. 744 authorized appropriations aggregating \$1¼ million for loans by the Secretary to the schools of medicine, etc., to help finance an institution's capital contributions (usually one-ninth of the Federal capital contributions) to a student loan fund of the institution established pursuant to an agreement under sec. 740 of title VII. Since the new program of loans to institutions would be more advantageous to institutions and would be available to finance institutional student loans funds entirely, as explained below, loans for the purposes specified in the superseded section would no longer be available.

revolving fund would consist of appropriations paid into the fund under section 742 (under an amendment to that section explained below) as well as the additional appropriation of \$10 million (see below) authorized to be appropriated under this new subsection in fiscal year 1967; and the revolving fund would also receive any interest payments and principal repayments received by the Secretary on loans made to institutions, and any other property or assets received in connection with the Secretary's operations under this section, including receipts from the sale of participations in institutional loan notes held in the fund (see below). The total amount of appropriations deposited in the revolving fund which have been paid out as loans to institutions for their student loan funds would bear interest at the going Federal rate, payable into the Treasury annually. In addition to the appropriations authorized by section 742 of the act, the bill would authorize the appropriation of \$10 million to the revolving fund in fiscal year 1967.

Subsection (b) of the proposed new section 5 of the bill would amend section 742 of the Public Health Service Act to provide that sums appropriated pursuant to this section shall be available to the Secretary, not only for Federal capital contributions in accordance with agreements between the Secretary and institutions (as in the present law), but also for payments into the revolving loan fund. Subsection (c) makes conforming amendments to sections 740 and 742 of the Public Health Service Act.

Subsection (d) of this section of the bill makes the amendments effected by this section applicable in the case of payments to student loan funds made after the enactment of the bill, except as to payments honoring loan commitments made prior to enactment of the bill under the superseded section 744 of the Public Health Service Act.

This subsection also authorizes the Secretary, if so requested by a participating institution, to convert a Federal capital contribution, made to an institution's student loan fund from funds appropriated under title VII, part C, of the Public Health Service Act for the fiscal year 1967, to a loan under the new section 744 of the Public Health Service Act enacted by the bill.

SECTION 6

Subsection (a) of this section of the bill would insert in title VIII of the Public Health Service Act a new section 827 which supersedes the present section 827 of the Public Health Service Act.¹ The new section 827 would authorize the Secretary of Health, Education, and Welfare, during the fiscal years ending in 1967 and 1968, to make loans, from the revolving fund established by subsection (d) of this section, to schools of nursing to provide all or part of the capital needed for their student loan funds. To the extent that student loan fund capital is obtained from the Secretary in the form of loans from the revolving fund, the institution would not be required to make the institutional contribution required under section 822(b) (2) (B) of \$1 for every \$9 in Federal capital contributions, i. e., an institution's student loan fund could, under the bill, be financed 100

¹ The superseded sec. 827 authorized appropriations for loans by the Secretary to schools of nursing to help finance an institution's capital contributions (usually one-ninth of the Federal capital contributions) to a student loan fund of the institutions established pursuant to an agreement under sec. 822. Since the new program of loans to institutions would be advantageous to institutions and would be available to finance institutional student loans funds entirely, as explained below, loans for the purposes specified in the superseded section would no longer be available.

percent by loans from the Secretary under this section. Such loans may be upon such terms and conditions as the Secretary deems appropriate, bearing interest at a rate based on the going Federal rate on comparable U.S. obligations plus probable losses. (But see analysis of subsection (b) as to Secretary's reimbursement obligation to institution.) If the Secretary finds it necessary, he may agree to provisions making the institution's obligation to the Secretary on such a loan payable solely from particular revenues or other assets or security such as collections on loans to students.

Subsection (b) of the new section 827 would provide that if an institution borrows funds from the revolving fund, the Secretary shall agree to reimburse the institution for (1) 90 percent of the loss to the institution from defaults on student loans; (2) the excess of the interest which the institution must pay on loans borrowed from the revolving fund over the interest received by the institution's student loan fund from student borrowers to whom loans were made from proceeds of the Federal loan made to the institution; (3) administrative expenses as authorized in the existing section 822(b) (3); and (4) the amount of principal canceled under the forgiveness provisions (sec. 823(b) (3)).

Subsection (c) of the new section 827 would limit the total of the loans which could be made from the revolving fund in any fiscal year to an amount equal to the lesser of the following: (1) Any specific limitations contained in appropriation acts. (2) The excess of \$35 million and the amount of Federal capital contributions paid into institutional student loan funds for that year.

Subsection (d) of the proposed new section 827 would establish on the books of the Treasury a revolving fund designated as the nurse training fund, to be available to the Secretary without fiscal year limitation as a revolving fund for the purposes of the new section 827. This revolving fund would consist of appropriations paid into the fund under section 824 (under an amendment to that section explained below) as well as the additional appropriation of \$2 million (see below) authorized to be appropriated under this new subsection in fiscal year 1967; and the revolving fund would also receive any interest payments and principal repayments received by the Secretary on loans made to institutions, and any other property or assets received in connection with the Secretary's operations under this section, including receipts from the sale of participations in institutional loan notes held in the fund (see below). The total amount of appropriations deposited in the revolving fund which have been paid out as loans to institutions for their student loan funds would bear interest at the going Federal rate, payable into the Treasury annually. In addition to the appropriations authorized by section 824 of the act, the bill would authorize the appropriation of \$2 million to the revolving fund in fiscal year 1967.

Subsection (b) of the proposed new section 6 of the bill would amend section 824 of the Public Health Service Act to provide that sums appropriated pursuant to this section shall be available to the Secretary, not only for Federal capital contributions in accordance with agreements between the Secretary and institutions of higher education (as in the present law), but also for payments into the revolving loan fund.

Subsection (c) of the proposed new section 6 of the bill amends section 202 (allotments among States and suballotments to institutions within

LEGISLATIVE HISTORY

States) so that, as a first step, an amount equal to the amount appropriated under section 824 of the Public Health Service Act will be allocated according to the existing distribution formulas specified in section 825, assuring each participating institution of a minimum amount of Federal assistance for its student loan fund (either in the form of Federal loans, if it desires, Federal capital contributions) equal to the amount of Federal assistance available under the present distribution formulas specified in these sections. To the extent that an excess over the amount appropriated under section 824 is available for assistance under the program, e. g., as a result of appropriations directly to the revolving fund, an amount equal to that excess is to be allocated by the Secretary among States and institutions within States in such manner as will best carry out the purposes of the program. In no event, of course, could the aggregate of loans to institutions for any fiscal year exceed the applicable ceilings for loans from the revolving fund.

Subsection (d) of section 6 of the bill would make conforming amendments to section 826 of the Public Health Service Act (relating to capital distributions from student loan funds to which the Secretary has made Federal capital distribution).

Subsection (e) of this section of the bill makes the amendments effected by this section applicable in the case of payments to student loan funds made after the enactment of the bill, except as to payments honoring commitments made prior to enactment of the bill under the superseded section 827 of the Public Health Service Act.

This subsection also authorizes the Secretary, if so requested by a participating institution, to convert a Federal capital contribution, made to an institution's student loan fund from funds appropriated under the existing provisions of law for the fiscal year 1967, to a loan under the new section 827 enacted by the bill.

SECTION 7

This section of the bill would amend the provision in section 302(c) of the Federal National Mortgage Association Charter Act (added by the Participation Sales Act of 1966 (Public Law 89-429)) which authorizes FNMA to establish trusts for, among other agencies, the Office of Education "but only with respect to loans for construction of academic facilities." As amended, this provision would also authorize such trusts for "loans to help finance student loan programs" under programs of the Department of Health, Education, and Welfare.

SECTION 8

This section would amend the Nurse Training Act to authorize the transfer of construction funds between the category for baccalaureate degree schools (sec. 801(a) (1)) and the category for associate degree or diploma schools (sec. 801(a) (2)), in the event the Surgeon General determines that appropriated funds will not be utilized in a category, but can be used in the other category.

The section also authorizes a total of \$15 million over the 3 fiscal years 1967-69 for scholarships for nursing students and a total of \$10,000,000 over the 3 fiscal years 1967-69 to encourage young people to enter the nursing profession.

GENERAL RESEARCH SUPPORT--NIH

Purpose

General Research Support grants provide for research and research training activities which are complementary to specific research projects and traditional research training programs. The grants are designed to provide institutions an increased measure of control over the quality, content, emphasis and direction of their own research and training programs. The General Research Support grants permit institutions unprecedented flexibility in allocation of part of the total Federal research funds locally expended. They allow increased institutional initiative in developing the institution's best research and research training capabilities, for consolidating scattered elements of research support, and for bettering the general research environment. The program is thus complementary to other forms of Public Health Service grants-in-aid.

The General Research Support program permits institutions to meet emerging opportunities in research, explore new and unorthodox ideas, recognize and support creative talent earlier, and in general, utilize funds flexibly and in ways that will be catalytic for fostering improved research performance and for attracting additional means for research and training support. The grants may be used to provide stable salary support for key research personnel, flexible and discriminating support for emerging scientific talent, ideas and techniques, improvement of central research resources which serve the needs of multiple research projects and programs, and for both general and specialized training programs. It is expected that the GRS grant will be used in different ways in succeeding years to encourage the most effective and rapid evolution of the institution's research excellence.

Financing

Funds available for the GRS program from NIH appropriations since the inception of the program are:

F.Y. 1962	\$20,000,000
F.Y. 1963	30,000,000
F.Y. 1964	35,000,000 ^{1/}
F.Y. 1965	45,000,000 ^{1/}
F.Y. 1966	45,200,000 ^{1/}

^{1/} Of the amounts shown for F.Y. 1965 and 1966, \$39M and \$39.2M were for the programs described herein, the remaining funds for development of additional programs under this authority. (See Developments During the Past Year, page 365).

Method of Distribution

The program is designed to provide general research support for all institutions heavily engaged in health related research. The General Research Support Grant may be used for any direct cost of research and research training activities as defined in the GRS Policy and Information Statement and in the relevant sections of the "Guide for Operating Procedures" for Training Projects and for Research Projects effective July 1, 1965. The General Research Support Grant may not be used for indirect costs or for costs of new construction, alteration or renovation.

The four health professional schools, medicine, dentistry, osteopathy, and public health are considered automatically eligible for GRS grants. Other types of institutions must have been awarded during the past fiscal year a minimum of \$100,000 in appropriate NIH research grants. In addition, the National Advisory Health Council, in its review of applications, takes into consideration criteria of a judgmental nature relating to the degree of diversity, complexity and breadth of research activity supported by the applicable NIH grants, and the related integrational problems this may impose on the institution. In addition the NAHC may wish to consider an institution's total research activity, including activities supported from sources other than the NIH.

Determination of Amount of General Research Support Awards

The amount of an individual award is based on a formula which is computed according to the health related research expenditures of the institution. Salient features of the formula are:

1. A base grant of \$25,000 is provided each eligible health professional school. All other eligible institutions, such as research institutions, laboratories, hospitals, excepting the health professional schools, do not receive this base grant.
2. A Federal expenditures factor is based on the total health related research expenditures of the grantee institution, during its latest complete fiscal year, sponsored by Federal research grants and contracts restricted for research, to a maximum of \$2 million. GRS entitlement according to this Federal factor is 5 percent for the first \$1 million of such expenditures and 3 percent of the amount between \$1 million and \$2 million.
3. A non-Federal expenditures factor is based on the total health related research expenditures of the grantee institution, during its latest complete fiscal year, sponsored by non-Federal gifts, grants, and contracts restricted for research, to a maximum of \$2 million. GRS entitlement according to this non-Federal factor is 10 percent for the first \$1 million of such expenditures and 6 percent of the amount between \$1 million and \$2 million.
4. The amount computed by formula is increased or decreased by whatever uniform proration factor is required to adjust the total amount of all awards to the total funds available in the GRS budget.

Matching Requirements

None.

Who May Receive Federal Aid

Schools of medicine, dentistry, osteopathy, public health, veterinary medicine, pharmacy and nursing, hospitals, separate research institutes, laboratories, centers, and other nonprofit research organizations heavily engaged in health related research may receive General Research Support awards.

Each year all institutions other than schools of medicine, dentistry, osteopathy and public health need to establish eligibility for General Research Support.

Application Procedure

Application for General Research Support Grants must be made on forms prescribed by Division of Research Facilities and Resources, National Institutes of Health, and must be executed by an official authorized to sign for the applicant institution. In addition, institutions which must establish eligibility for GRS are required to furnish (1) a listing of appropriate NIH research project grants awarded to that institution during the previous fiscal year, (2) a current Internal Revenue Service tax exemption letter to certify institutional "not-for-profit" status and (3) a description of organizational arrangements.

Developments During the Past Year

Proposed for 1966 are programs extending general research support to academic institutions other than health professional schools which are heavily engaged in health research and research training, and a program of advancement awards in the health sciences. These two programs are called the Health Sciences Advancement Award Program and the Biomedical Sciences Support Grant Program. Future public announcements will be made about the details of these programs.

Legal Basis

Section 301(d) of the PHS Act as amended by Public Law 86-798, approved September 15, 1960, and later amended by Public Law 87-838, October 17, 1962, (42 USC 241(d)).

Additional information may be obtained from Chief, General Research Support Branch, Division of Research Facilities and Resources, National Institutes of Health, Public Health Service, Department of Health, Education, and Welfare, Bethesda, Maryland 20014.

SUGGESTED MEETING DATES FOR COTH EXECUTIVE COMMITTEE

1968:

- 1st meeting: Monday, October 30, 1967.
Luncheon get-together at N.Y. Hilton Hotel
Adjourn 2:00 p.m.
- 2nd meeting: Thursday and Friday, January 11-12, 1968.
Washington, D.C.
- 3rd meeting: Thursday and Friday, May 9-10, 1968.
Washington, D.C.
- 4th meeting: Thursday and Friday, September 5-6, 1968.
Washington, D.C.
- 5th meeting: Friday, November 1, 1968.
Shamrock Hilton Hotel
Houston, Texas

1969:

- 1st meeting: Monday, November 4, 1968.
Luncheon get-together at Shamrock Hilton Hotel
Adjourn 2:00 p.m.
- 2nd meeting: Thursday and Friday, January 9-10, 1969.
Washington, D.C.
- 3rd meeting: Thursday and Friday, May 8-9, 1969.
Washington, D.C.
- 4th meeting: Thursday and Friday, September 11-12, 1969.
Washington, D.C.
- 5th meeting: Friday, October 31, 1969
(Netherland Hilton Hotel) (Terrance Hilton Hotel)
Cincinnati, Ohio
Adjourn 2:00 p.m.

COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
1346 Connecticut Avenue, N.W.
Washington, D.C. 20036
202 223-5364

COTH Special Membership Memorandum No. 67- 29G
25 July 1967

Subject: General Clinical Research Centers,
Fiscal Year 1968 Appropriations
(Supplement to COTH Special Member-
ship Memorandum No. 67-5S dated
June 27, 1967).

1. Testimony of Robert C. Berson, M. D., Executive Director of the AAMC Before the Subcommittee on Labor-HEW of the Committee on Appropriations, United States Senate on June 26, 1967:

In follow-up to Special Membership Memorandum No. 67-5S, relative to amount of funds budgeted and appropriations voted in the House of Representatives to provide funds for the operation of General Clinical Research Centers, I thought you would be interested in an excerpt of Dr. Berson's (Robert C. Berson, M. D., Executive Director of the AAMC) testimony in connection with the funds for general clinical research centers. Dr. Berson prefaced these remarks with the observation that if the amount of the appropriation voted by the House of Representatives were not increased it would result in serious damage to existing capabilities.

"Clinical research centers, gentlemen, are the places where the results of the millions spent for research are translated into new and decidedly improved methods of patient care. It is in these units -- a very small number of hospital beds in each instance -- that the fruits of the laboratory are applied to carefully selected patients in such ways that shortly doctors throughout the country have new methods of saving life and repairing the ravages of disease.

These are crucial instrumentalities of medical education; not just for the student or the faculty but for all doctors everywhere. If they function properly the millions of dollars invested in research are translated into billions of dollars of savings in health care. To cut back on the funds needed to keep these centers going is in effect to waste rather than to save Federal funds.

Yet, that is what the budget and the House appropriations would do. The bill before us calls for \$30,443,000 for clinical research centers and that, we are told, represents an increase of 7% over last year's appropriation. But, gentlemen, these are hospital beds we are talking of and you and I both know what has happened to hospital costs over the last year. They have increased from 20 to 30 percent. And they will increase next year.

Mr. Chairman, I have for submission later, carefully reasoned conservatively figured, thoroughly documented letters from our schools showing the impact of the proposed budget on their operations. I shall not read them but let me give you a few samples relative to the proposed funding of clinical research centers.

The University of Virginia Medical School says that loss of its anticipated support could result in the non-operation of its center. The University of

25 July 1967

Page Two

Cincinnati must have a yearly increase of at least 15 percent for its operation. Georgetown's increased costs necessitate a 25 percent increase. Tulane reports that its program will be in jeopardy. The University of Washington will have to cut back drastically. The University of Missouri reports that reduction or loss of Federal funding will close its unit.

Gentlemen, instead of the \$33,443,000 in this bill, we must have at least \$40.5 million. Applications already received from 60 of the 90 clinical research centers show this to be a conservative figure. If the House figure stands it will represent a cut of 25% below what is needed and that, Mr. Chairman, could have crippling effects."

2. Senate Hearings on Labor-HEW Appropriations Bill Completed:

Senator Lister Hill (D) of Alabama, the Chairman of the Senate Subcommittee on Appropriations for the Departments of Labor and HEW has now completed his hearings on the Appropriations bill and we are hopeful that he and the members of his Committee may see their way clear to recommend the increased amount. If the increased amount over that voted in the House of Representatives is approved in the Senate the difference will have to be resolved by the House of Representatives and Senate Conferees at a later date.

This is a Special Memorandum on this subject since there are only 91 centers involved but in keeping with COTH policy, an informational copy is being sent to every member hospital.

MATTHEW F. McNULTY, JR.
Director, COTH
Associate Director, AAMC

90TH CONGRESS
1ST SESSION

H. R. 12571

IN THE HOUSE OF REPRESENTATIVES

AUGUST 23, 1967

Mr. ROONEY of Pennsylvania introduced the following bill; which was referred to the Committee on Interstate and Foreign Commerce

A BILL

To amend the Nurse Training Act of 1964 to provide for increased assistance to hospital diploma schools of nursing.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*
3 That section 806 of the Public Health Service Act is amended
4 to read as follows:

5 "SEC. 806. (a) In order to prevent further attrition and
6 promote the development of public and nonprofit private
7 diploma schools of nursing, there are hereby authorized to
8 be appropriated such sums as may be necessary for the fiscal
9 year ending June 30, 1968, and for the four succeeding years
10 to defray a portion of the cost of training students of nursing.

11 "(b) From the amounts appropriated pursuant to sub-

90TH CONGRESS
1ST SESSION

H. R. 12571

A BILL

To amend the Nurse Training Act of 1964 to provide for increased assistance to hospital diploma schools of nursing.

By Mr. ROONEY of Pennsylvania

AUGUST 23, 1967

Referred to the Committee on Interstate and Foreign Commerce

1 section (a), the Surgeon General shall pay to each public or
 2 nonprofit diploma school of nursing for each fiscal year in
 3 the five-year period beginning July 1, 1967, an annual grant
 4 of \$24,000, an annual library resources grant of \$6,000,
 5 and an annual grant of \$400 per full-time student. The Sur-
 6 geon General shall make such amounts available to those
 7 diploma schools of nursing as approved by the appropriate
 8 State agency.

9 “(c) That an annual grant of such sums as may be nec-
 10 essary on a 75 per centum-25 per centum Federal-State
 11 matching basis be made toward the establishment and opera-
 12 tion of a State comprehensive planning committee for nurs-
 13 ing education. Such committee shall be appointed by each
 14 State’s coordinating board of higher education. Such com-
 15 mittee should:

16 “1. avoid costly duplication of programs;

17 “2. insure strategic location of new, expanding
 18 programs;

19 “3. create and maintain balance among various
 20 kinds of educational programs;

21 “4. provide a balanced supply of all kinds of nurses
 22 needed;

23 “5. determine statewide needs for nursing personnel
 24 of all kinds on a succession of target dates;

25 “6. plan an educational system which will provide

1 the needed personnel, with specific recommendations
 2 about individual institutions and their capacities;

3 “7. recommend the means of attracting students and
 4 sources of financial support for capital and operating ex-
 5 penses of programs;

6 “8. maintain continued planning and evaluation of
 7 progress.

8 “(d) For the purpose of this section, the full-time enroll-
 9 ment in any school shall be determined as of February 15
 10 of each fiscal year.”

STATEMENT ON BEHALF OF BARNES HOSPITAL
IN OPPOSITION TO USE OF EXAMPLE IN
PROPOSED REGULATION SECTION 1.513-1(b)
RELATING TO SALES BY HOSPITALS

Mr. Chairman:

My name is John L. Davidson, Jr. I am with the law firm of Lewis, Rice, Tucker, Allen and Chubb, located at 1555 Railway Exchange Building, 611 Olive Street, St. Louis, Missouri, 63101. I am admitted to the practice of law in the states of Missouri and Illinois and in the District of Columbia.

I appear here today as counsel for the Trustees of Barnes Hospital, which trust was created under the will of Robert A. Barnes, deceased, and which trust has been held by the Supreme Court of Missouri to be a public charity in the case of Buchanan vs. Kennard, 234 Mo. 117, 136 S.W. 415.

The Trustees of Barnes Hospital feel that the choice of the example of a hospital pharmacy in the language of the proposed regulation Sec. 1.513-1(b) is most unfortunate. I am here specifically to object to the following language:

"Thus, for example, the regular sale of pharmaceutical supplies to the general public by a hospital pharmacy does not lose identity as trade or business merely because the pharmacy also furnishes supplies to the hospital in accordance with its exempt purposes."

To make clear the basis from which we object, I must presume upon the time of this group to outline the workings of Barnes Hospital.

I have been counsel for this hospital since 1961. During that time, in connection with divers matters I have become thoroughly acquainted with its operation, including the over-all operation of its pharmacy.

Barnes Hospital is a university affiliated hospital. Under agreement between The Washington University in St. Louis and the Trustees of Barnes, all of the physicians on the faculty of the University's Medical School are available to staff the hospital. The hospital, in turn, will not appoint any physician to its staff except from that faculty. All of the patients within the hospital are available for teaching purposes.

Barnes Hospital, within the complex, provides patient care facilities in excess of 1000 acute care beds. They also operate 120 rooms for ambulatory patients and 20 rooms for self-care patients. Within the complex it conducts teaching programs for the Medical School, the Washington University program of hospitalization administration, a Baccalaureate Nurse program for Washington University, a nurses training course for the Junior College District of St. Louis and St. Louis County, St. Louis Board of Education program to license practical nursing, Barnes Hospital Dietary internship, Barnes Hospital School of Nursing and Anesthesia, Barnes Hospital Pharmacy internship, Mallinckrodt Institute of Radiology Technician program and the educational program for high school students.

Barnes Hospital rendered charitable work for the years 1961 to 1966 inclusive, in the total amount of \$7,155,000.00, and during the same years sustained operating deficits in the amounts of \$2,383,000.00. During the year 1966 Barnes trained 282 residents and interns and 70 to 80 fellows, at a cost in excess of \$1,300,000.00 to the hospital and University in stipends. In addition to the work done by the paid staff within the hospital, volunteers rendered 52,000 hours, which, at a current hospital rate, were of the value of \$103,000 in service to patients and their families within the hospital.

As a result of a program of teaching, research and patient care, Barnes draws patients from all over the midwest, many of whom are treated as out-patients. In addition, it operates different clinics on a 5-1/2 day a week basis, where its staff sees 500 persons per day.

There is an emergency room. There is also space where faculty members may see and do see private patients.

We protest the selection of a hospital pharmacy as an example: first, because under no circumstances can a university affiliated hospital pharmacy be considered a trade or business within any sort of accepted definition of that term; it is a service to the faculty of the medical school and to the patients; it is open 24 hours a day. Few community pharmacies so operate. It carries substantially greater stocks, both in variety and quantities than are carried in a

commercial pharmacy. It must have pharmacists readily available to advise nurses and physicians about the nature of a particular medication. It must answer questions that cannot be answered from readily available publications. These pharmacies as part of their service carry the experimental drugs that can only be used on hospital patients. The hospital pharmacy has facilities for making up medications to be given intravenously. In no sense should it be called a trade or business.

Secondly: there is an implication that the conduct of a pharmacy is unrelated to hospital business. The function of a university hospital is tripartite, - research, teaching, patient care. Like St. Patrick's shamrock, this tripartite function is derived from a single unit, the hospital. It is inconceivable that a hospital could run without a pharmacy. It could not be accredited by any reputable accrediting agency. The Federal Government, in its Hill-Burton Regulations, prescribes that there should be a pharmacy. The implication that a pharmacy is unrelated to hospital purposes is not only totally unwarranted, but contrary to accepted medical practice.

The phrase "to the general public" is so vague as to be without meaning. A hospital exists to serve the general public. Does it mean only bed patients? Does it mean bed and clinic patients? Does it mean patients coming there to consult as a private patient a member of its faculty? Does it mean some one unable to find a drug in a commercial pharmacy?

Obviously, a modern hospital, and indeed the Federal Government so urges, exists as a community health center.

I have in my hands two Federal publications. I would like to read from them.

The first of these is "Elements of Progressive Patient Care" put out by the Public Health Service. From page 1:

"Progressive patient care not only has important implications for individual hospitals, but, in its broadest sense, encourages the development of a coordinated pattern of services and facilities on a communitywide basis. The concept has special application to what has evolved as one of the ultimate goals of areawide health facility planning - the establishment on a common site of a regional medical center which would offer a wide spectrum of services and facilities for both the inpatient as well as outpatient. As shown in figure 1, this medical center would include a hospital offering varying levels of care, a nursing home, housing for the aged, a health service center containing offices for both official and voluntary health agencies, a building for physician's offices, and a motel for ambulatory patients as well as visitors of inpatients. It should also be feasible to have a shopping center nearby.

The development of such centers would result in better utilization of scarce professional and technical personnel, and would permit a more flexible use of facilities as medical advances result in changes in the character of the institutionalized population. This center would serve as the focal point for community health services."

Another publication, "Medical Education Facilities" of Public Health Service says:

"The hospital pharmacy should be convenient for outpatients. If this cannot be done, provision of a separate dispensing pharmacy in the outpatient department may be required convenient to the outpatient reception area. An adjacent waiting space

should be provided for patients waiting to have prescriptions filled."

Thus, it can be seen that the health needs of the community must be served, not simply in terms of caring for the bed patient, but caring for others who do not need the nursing care but need other hospital facilities.

The shortage of physicians in terms of total population makes it desirable, from every point of view, that more doctors become geographically full time at a hospital. This is particularly so where the physician must carry on the duties of education and research in a teaching hospital. The physician in his office and his patient seeing him in that office need the services of the pharmacy just as much as do that physician in his role of attending man within the nursing divisions of the hospital and his bedfast patient.

I recognize that this is not the first time when policies of the Internal Revenue Service have run contra to those of another branch of the Federal Government. I submit that the invitation in the Internal Revenue Service proposed language that hospitals treat only the bedfast patient is contrary to the published policies of the Public Health Service.

By objecting to the language used in the example of the proposed rule, we do not suggest for one minute that the hospital pharmacy is an unrelated business or that it is offering its service "to the public" in the sense that it

vies with the community drug store for that store's customers. On the contrary, our pharmacy does not deliver; it does not have charge accounts; it does not have a special telephone listing.

In short, our pharmacy is a professional service to our physicians in their role as healers, as teachers and researchers and to those who must be in the complex.

Last year, in the first six months, our pharmacy filled 230,000 prescriptions, 85% of them went to bed patients; of the balance, except for 30 prescriptions, the rest were filled for employees, students within the complex and patients of the staff, either in the clinics or private patients. Of the 30 prescriptions not in those categories - .015 of 1% - each was filled for a person whose needs could not be met elsewhere. In most instances the patient had been sent by a commercial pharmacy.

The legislative history of the section upon which this proposed regulation is based indicates that the type of operation which I have described to you is not that which Congress intended to tax. This is not an organization using its tax exemption to buy an ordinary business. This is not using "profits" to expand operations.

I am quite confident that the type of operation which we have would be held not taxable by any court. The problem which the regulation poses is that it compels the field agent

to assess a deficiency against a hospital for its out-patient drug sales. This puts the hospital on the extensive and time-consuming road to relief from an erroneous assessment.

The hospitals today are overworked; they are having a difficult enough time to make their books balance. Don't put this additional burden on their backs.

July 20, 1967

Leonard D. Fenninger, M.D.
Director, Bureau of Health Manpower
United States Public Health Service
Tower Building
800 North Quincy Street
Arlington, Virginia 22203

Dear Len:

I enjoyed our brief telephone ~~chat~~ of a week ago Friday and the indication that you would write to your New Zealand friend suggesting, for himself and other colleagues, that he contact this office for opportunities of information and experience concerning teaching hospitals in the United States.

Although the Council of Teaching Hospitals is a relatively young organization, and I am of even more recent vintage as its Director, there is one element of this position that has caused me both disappointment and concern. I refer specifically to the number of times that COTH has been asked, formally or informally, by its members to provide names of individuals who would be effective in administering the activities and operation of a teaching hospital or the activities of an assistant dean for administration. Quite frankly, I have been able to provide the names of only a few individuals, who have displayed either the ability or potential to perform effectively in the unique environment which the teaching hospitals and the medical schools provide. The demand for such talent far exceeds the known supply.

The many graduate programs in hospital administration have thus far done an excellent job in training hospital administrators. To date there are some 7,000 individuals who are graduates of these programs. Yet, with the exception of one of the more recently developed programs which allows a concentration of study in "Medical Center Administration," none of these programs have fully evaluated or attempted a course specifically designed at the administration of the teaching hospital. Hence, the major intent of this letter--to propose the offering of a structured avenue of entrance for those individuals who wish to involve themselves in the administration of the modern teaching hospital.

Essentially, what I am suggesting is the development through COTH of an "Administrative Fellowship Program" which would allow those persons interested in teaching hospital administration to realize their aspirations by some other

July 20, 1967

Leonard D. Benninger, M.D. page 2

mechanism than chance. There is an analogue to the program being outlined here; specifically, an activity conducted by the American Council on Education. They have termed their activity the "Administrative Intern Program." Generally, the apparatus for accomplishment is essentially the same as that which I am proposing. In this regard, I envision a method of "matching" interested individuals to interested organizations following a period of orientation and "training."

For a carefully screened and selected group of individuals chosen for competency and motivation for entering, there would be an initial orientation period followed by assignment for preceptor training to a pre-selected group of institutions, the administrators of which have displayed interest in the same educational and training goals. I would envision further that the minimum personal requirements for participation in this program would be either a Master's Degree from one of the program members of the Association of University Programs in Hospital Administration or a certain, specified period of time as administrator of a non-teaching institution or other adequate preparation, experience, or motivation. I mention the latter for I believe an affirmative attempt should be made to attract more physicians specifically and generally terminal degree individuals in related disciplines, to the discipline of hospital and health-care administration.

Additionally, I would think that our program should be international in design and provide the necessary focal point for the type of inquiry which you mentioned in our recent telephone conversation. In this regard, I think it necessary that COTH take an imaginative approach to the development of such a program, yet one which is feasible and capable of being operationalized.

In order to support a program of this nature, I estimate that it would be necessary to add to the COTH staff one relatively senior professional individual, one junior professional individual, and one secretarial individual. This staff would be responsible for organizing the program screening, and identifying the talent, conducting the orientation program, as well as implementing and assuring that its ongoing activity meets with success and that a placement program affords a range of opportunity. Of course, the usual other needs of space, equipment, supplies, travel, consultant and advisory committee expenses would be involved, also. The resources need for such an activity are beyond the capability of COTH. Hence, this informal approach to determine the interest of the Bureau of Health Manpower in providing support for such a development.

There is no question in my mind that the "pay off" of such a program will far exceed attendant cost. The social investment in teaching hospitals becomes greater each year with no abatement in the foreseeable future. It is said that the modern university, in order to cope with the environment of the late 20th century, must become a "university without walls." The same analogy can be maintained for the modern teaching hospital. There is an urgent need for it to participate more actively in the community of which it is a part. The major commitment that the teaching hospital has toward the multiple goals of education,

July 20, 1967

Leonard D. Fenáinger, M.D. page 3

research, and community service, in addition to exemplary patient care, demands that the individual entrusted with the social accountability of such an enterprise have a true understanding of the intricate relationships, both internal and external, to the organization. The development of these types of individuals, through a program of the nature proposed, is the "pay off" referred to above.

Needless to say, these are only initial thoughts. However, this subject has been in mind the last several months. The more I informally explored the idea, the more convinced I have become of the need and, given the resources, the ability of the COTH and the AAMC to meet that need.. I do not want to be too assertive or eager, but if these ideas have any merit I certainly would like to initiate such a program on occasion of the approaching academic year. At your convenience, I would be pleased to explore the possibilities of the foregoing with you.

Warmest regards.

Cordially yours,

MATTHEW F. McNULTY, JR.
Director, COTH
Associate Director, AAMC

FHB!eab



BUREAU OF HEALTH MANPOWER

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
800 NORTH QUINCY STREET
ARLINGTON, VIRGINIA 22203

REFER TO:

August 18, 1967

Dr. Robert Berson
Executive Director
Association of American Medical Colleges
1346 Connecticut Avenue, N.W.
Dupont Circle
Washington, D. C. 20036

Dear Dr. Berson:

I thought it would be well just to recapitulate the conversation that I had with you and Mr. McNulty on August 17. There can be little question of the importance of the study to determine effects of federal service programs on medical education, particularly Title XVIII and Title XIX. I know you have received the material which was submitted to Dr. Rosinski by various federal agencies that have programs which impinge on medical schools and their hospitals. I know also that you, Mr. McNulty and the staff of the AAMC have a number of thoughts about developing a suitable instrument and making this information available on an on-going basis.

It would be most helpful to us if you or Mr. McNulty would write a brief letter to either Dr. Joseph Gallagher or to me proposing that the AAMC undertake such a study. In this letter if you would include the aim and scope of the study and give some indication of what you estimate of its cost and the time required for it might be, it would be helpful to us as the basis for further discussion.

I enjoyed very much having the chance to talk with you yesterday and look forward to seeing you when I return from my vacation.

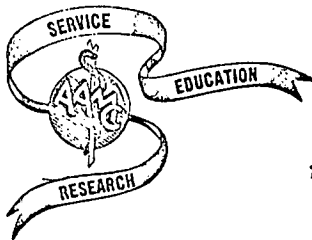
Sincerely yours,

Leonard D. Fenninger, M.D.
Director
Bureau of Health Manpower

RECEIVED

ANG 22 1967

AAMC-WASH. D. C.



ASSOCIATION OF AMERICAN MEDICAL COLLEGES
2530 RIDGE AVENUE EVANSTON, ILLINOIS 60201
1346 CONNECTICUT AVENUE, N.W. WASHINGTON, D. C. 20036

FHB

August 21, 1967

ROBERT C. BERSON, M.D.
EXECUTIVE DIRECTOR
WASHINGTON, D. C.

EVANSTON: 312: 328-9505
WASHINGTON: 202: 223-5364

Leonard D. Fenninger, M.D.
Bureau of Health Maintenance
Public Health Service
National Institutes of Health
Tower Building
Arlington, Virginia

Attention: Dr. Charles H. Boettner

Dear Len:

As a sequel to our discussion on Thursday, August 17th, I want to take this means of requesting that the Bureau of Health Manpower provide the financial resources that will make it possible for the Council of Teaching Hospitals of the Association of American Medical Colleges to collect a broad spectrum of facts and carefully considered opinions that are relevant to the impact of Federal Programs on Teaching Hospitals. It is quite obvious that the implementation of Title XVIII and XIX of the Social Security Amendments and the evolution of other programs augment and change somewhat the demands on all hospitals. In large and complex hospitals in which internships and residencies are important features (Teaching Hospitals) these changes are of particular importance to the future supply of trained health manpower. But it is not obvious just what changes are occurring or whether they bode well or ill for the future of the educational or patient care programs because there is no current program for collecting appropriate data and considered opinions that are relevant.

For many years the Association of American Medical Colleges, in partnership with the American Medical Association, has been collecting a wide variety of factual information about medical schools which is extraordinarily useful for analyzing trends and providing a factual basis for decisions. Somewhat more than a year ago the AAMC organized a Council of Teaching Hospitals which now consists of more than 300 of the most highly developed and productive hospitals in the country, and which has a competent nuclear staff. We are convinced that it is feasible to design an instrument for collecting the factual information that will delineate the "mix" of patients and their problems, as well as the sources of funds for their care, the integration of the care of the patients with programs of education and training and the effect of new or expanded sources of financial support on the economics of education and training. We are also convinced the COTH can readily organize advisory groups to advise the staff concerning the collection and interpretation of facts and opinions and that the institutions will cooperate eagerly with such an effort by the COTH.

(2)

Leonard D. Fenninger, M.D.

August 21, 1967

Since no proper base line of the sort of information needed now exists, we consider it urgent to get this study underway, establish such a base line as quickly as possible, then collect appropriate information for succeeding periods of time so trends can be accurately described. It is already late, but it may still be possible to collect such base line information for a period before Title XVIII was implemented.

While the present staff of the COTH can plan for and give leadership to this study, we will need additional staff to implement it, travel for staff and advisors will be necessary, as well as sophisticated analysis of a large volume of data. The experience of the AAMC in analyzing slightly comparable data from medical schools will be of great assistance. It is our considered opinion, however, that about \$100,000 a year, in addition to the resources the AAMC and the COTH now have, will be needed for a period of 18-24 months. We are convinced that repeated collection of some of the data at appropriate intervals should be continued indefinitely, but cannot now predict how expensive that process will be.

It is our opinion that future decisions concerning national and institutional policy will require the careful analysis of the facts and opinions we propose to collect; that the missions of both the Bureau of Health Manpower and the Council of Teaching Hospitals of the Association of American Medical Colleges make it entirely logical for the Bureau to provide the financial support and for the COTH to conduct the study. We are prepared to begin at once to negotiate a contract to that end.

Sincerely yours,

Robert C. Barson, M.D.
Executive Director

RCB/nc

cc; Matthew F. McNulty, Jr.

Memorandum

TO : Dr. Edwin Rosinski
Consultant for Health Manpower, OS

DATE: August 1, 1967

FROM : Director, NIH

SUBJECT: Effects of Titles XVIII and XIX of the Social Security Amendments of 1965 on Teaching Hospitals

We are pleased to know of your prospective study, in collaboration with the Association of American Medical Colleges, of the effects of Titles XVIII and XIX on teaching hospitals. The National Institutes of Health is seriously interested in the possible effects of this important legislation on its ongoing programs at teaching hospitals. While the legislation is new and the body of experience in working with it is limited, certain issues and questions have already arisen, and we welcome the opportunity to have them included in the proposed study.

1. Impact on NIH Training Programs

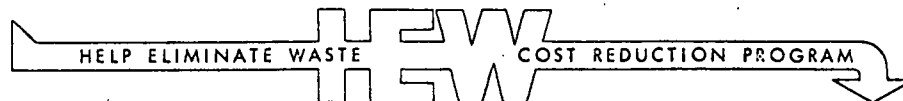
The reimbursement of residency salaries under training programs approved by the AMA Council on Medical Education is authorized as a "reasonable cost" of providing "inpatient hospital services" for the purposes of Titles XVIII and XIX (Sec. 1861(b), P.L. 89-97).

Questions:

- (a) Will such reimbursement reduce the necessity for the National Institutes of Health to subsidize clinical training?
- (b) Will this alternate mechanism for paying residency salaries change or obviate the need for supporting such costs under NIH training programs?
- (c) Will the ability to attribute to Medicare and Medicaid the costs of such approved training programs (including the salaries of instructors, equipment, supplies, etc.) markedly diminish the need for the NIH to pay such costs as part of clinical training programs?

2. Impact on the Availability of Patients in Teaching Hospitals

A second matter of concern to the NIH (and particularly to the National Cancer Institute) will be the effect of Medicare and Medicaid on the character and volume of patients being admitted to teaching hospitals.



Questions:

- (a) Has the change in the rate of hospital admissions affected the number of teaching and research patients available in teaching hospitals throughout the Nation?
- (b) What will be the impact of changes in demand for services on the quality of patient care in teaching hospitals?
- (c) What is or will be the effect of new rates of patient admission together with the patients' altered "ability to pay" on research facilities, personnel, and programs?
- (d) What will be the impact of Medicare and Medicaid on admissions to specialized hospitals and clinics?

3. Impact on the Payment of Hospitalization Costs

This new source of support for basic hospitalization costs raises questions concerning the future scope and role of other sources of support.

Questions:

- (a) Will this alternative source of support eliminate the need for the reimbursement of bed costs under NIH research projects?
- (b) Are there adequate devices available to distinguish between those costs appropriately attributable to definitive treatment and those appropriately attributable to research (i.e., still to be supportable under research grants, clinical research centers, etc.)?
- (c) Will research grants have to provide a greater or lesser amount of support for research-related patient costs?
- (d) Other related questions:
 - (1) Will or should formulae be established for the allocation of costs among the Government agencies involved, the insurance company, and the patient?
 - (2) Will special laboratory tests and procedures be more or less readily available?
 - (3) Will total patient care costs rise because of the change in the supply and demand balance?

4. Impact on the General Support of Research

The 1965 amendments to Titles XVIII and XIX of the Social Security Act are going to have a profound impact on the financial base and operating practices of teaching hospitals and all other institutions participating in these programs.

Questions:

- (a) How much money will now be available for payment of other costs of the teaching hospital which formerly had to be spent for basic hospitalization costs?
- (b) What will be the impact of these newly available funds on the need for Federal research support?
- (c) Has any consideration been given to possible double payments which could result from reimbursement (under Titles XVIII and XIX) of the salaries of individual physicians who are providing services to persons eligible for Medicare and Medicaid benefits, when such salaries may also be reimbursed through other Federal programs such as NIH's General Research Support Program, research project grants, training grants, etc?

5. Impact on Research Grant Costs

What will be the effects on the institutions' accounting and other business management procedures? For example, if more complex and sophisticated cost accounting systems will be required, will the result be increases in the direct and indirect costs for ongoing research grants?

We appreciate very much the opportunity to present these problems of concern to the National Institutes of Health, and we would like to be kept informed of the progress of this study.



James A. Shannon, M.D.

Memorandum

TO : Edwin F. Rosinski, Ed.D. :
Consultant for Health Manpower
Office of the Secretary

DATE: JUN 23 1967

FROM : Acting Director, Bureau of Health Manpower

SUBJECT: Effects of Titles XVIII and XIX of the Social Security Amendments of 1965 on Teaching Hospitals

Thank you for the opportunity of providing questions that might be answered in a possible study of the effects of Titles XVIII and XIX of the Social Security Amendments of 1965 on teaching hospitals. As you are aware, this is a highly complex and intricate subject.

Medicare and Medicaid are among the significant factors which have increased the demands for trained health personnel. As opportunities are provided for additional numbers of physicians, nurses, therapists, etc., to receive the clinical portion of their training, the well being of the patient must be a primary concern. One of the major tasks must be to achieve a meaningful balance between optimum patient care and appropriate clinical learning experiences. This may mean increasing the number of hospitals affiliated with teaching institutions. It is generally agreed that better patient care is provided in hospitals affiliated with educational programs.

In planning for the development and support of educational programs for the training of additional numbers of health professionals, it is important to know the numbers and types of patients and the settings available for the clinical practicum. More specifically we need to know:

1. Patients who participate in existing educational programs.
 - (a) Kinds of patients by age group - acute, chronic, other.
 - (b) Where seen - home care, clinic, emergency department, in-patient.
 - (c) Percentage of patients participating in educational programs who are covered by private insurance plans.
 - (d) Percentage of patients in educational programs paid for by public insurance plans, Titles XVIII and XIX.
 - (e) Percentage of patients in educational programs who pay for their own care.

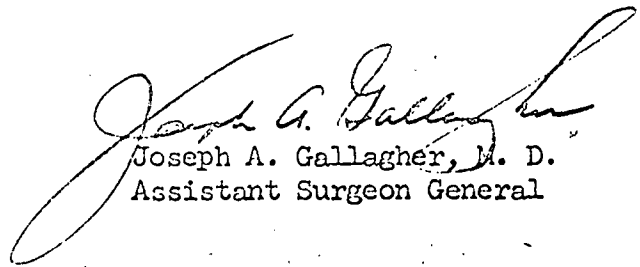
2. Relationship of medical students and residents to attending physician in the care of patients.
 - (a) Differences between largely non-procedural clinical disciplines (medicine, pediatrics, etc.), and more procedural disciplines (surgery and its specialties, obstetrics and gynecology).



JUN 26 1967

GPO : 1966 O-797-642

- (b) Responsibilities given to residents in the various specialties.
- 3. Length of patient stay and turnover by age group and clinical service.
- 4. Organization of hospital with respect to kinds and levels of care.



Joseph A. Gallagher, M. D.
Assistant Surgeon General

UNITED STATES GOVERNMENT

Memorandum

TO : Edwin F. Rosinski, Ed.D.
Consultant for Health Manpower

DATE: July 18, 1967

FROM : Paul Q. Peterson, M.D.
Deputy Director, Bureau of Health Services

SUBJECT: Effect of Titles 18 and 19 on Teaching Hospitals

On June 16, 1967, a memorandum was forwarded to you from Dr. John Cashman, Director of the Division of Medical Care Administration, which transmitted the agenda of a meeting dealing with this problem. On June 29, 1967, a report of the meeting was forwarded to you by the Deputy Surgeon General. I suggest that you might find the answers to your query in your memorandum of July 13, 1967, contained in those documents.



5010-108

Buy U.S. Savings Bonds Regularly on the Payroll Savings Plan

Memorandum

Edwin F. Rosinski, Ed.D.
Consultant for Health Manpower
TO : Office of the Assistant Secretary for
Health and Scientific Affairs

DATE: JUL 12 1967

FROM : Mary E. Switzer
Commissioner

SUBJECT: The Effects of Titles XVIII and XIX of the Social Security
Amendments of 1965 on Teaching Hospitals - your memorandum
of June 8, 1967

The following questions relate to the interests of the Vocational
Rehabilitation Administration in the effects of Titles XVIII and
XIX on teaching hospitals.

- I. How has the increased demand for services affected the quality
and comprehensiveness of services provided by teaching hospitals
to disabled persons?
 1. Have departments of physical medicine and rehabilitation,
speech and hearing, psychiatry, and social service been
able to recruit the numbers of qualified persons necessary
to serve greater numbers of people with a high quality of
care?
 2. Have services for the mentally ill, the mentally retarded,
paraplegics, quadriplegics, persons disabled by stroke,
arthritis, etc. become more comprehensive or have the demands
for care and shortages of staff led to episodic care or
fragmented services?
 3. Have teaching hospitals assumed greater responsibility for
the quality of care at extended care facilities, including
rehabilitation facilities?
- II. When beneficiaries of Title XIX are admitted to teaching hospitals
how are appropriate candidates now identified and referred to State
vocational rehabilitation agencies?
- III. Are beneficiaries of Titles XVIII and XIX given the personalized
attention and respect by the staff of teaching hospitals that
this staff gives to patients who are paying directly or through
other insurance carriers for the care they receive?



JUL 12 1967

- IV. How do residents and interns in rehabilitation medicine develop responsibility for patient management without experience in "wards"?
- V. How adequate are cost accounting systems at teaching hospitals to identify and account for impact costs arising as a direct result of the introduction of Titles XVIII and XIX into the teaching hospital? Are incremental costs attributed to these programs which may otherwise tend to inflate the overall per diem rate and thus have an adverse effect on State vocational rehabilitation agency costs for client care in teaching hospitals?
- VI. Will it be possible for State vocational rehabilitation agencies to refer clients for one type of service, e.g., OT or PT, and be billed for that one service?
- VII. Will teaching hospitals have sufficient clinical patient load variation to provide training in the type of care and procedures required by vocational rehabilitation clients?
- VIII. Does the medical school's curriculum content provide an introduction to students on the comprehensive nature of vocational rehabilitation services and the importance of a fully coordinated rehabilitation plan?

Memorandum

Children's Bureau

TO: Dr. Edwin F. Rosinski
Consultant for Health Manpower - OS

DATE: June 15, 1967

FROM: Arthur J. Lesser, M.D. *AJL*
Deputy Chief, Children's BureauSUBJECT: Your memo of June 8 on the Effects of Titles XVIII and XIX
of the Social Security Amendments of 1965 on Teaching Hospitals

I have the following questions:

Has the common pattern of selective admissions (by interesting diagnosis) been altered?

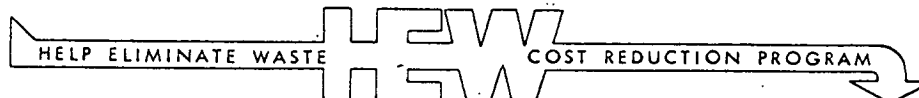
What effect have Title XVIII, XIX had on the salaried physicians system? Has the size of the hospital staff been affected?

What has been the effect on the availability of patients for teaching? Are all patients considered to be private patients? If not, are private patients used for teaching?

Is there a decrease in obstetric beds that can be related to Medicare and Medicaid?

Have admission procedures with respect to financial eligibility been changed by Title XIX? More detailed and restrictive? Less so?

JUN 19 1967



Memorandum

PUBLIC HEALTH SERVICE
Arlington, Virginia 22203TO : Consultant for Health Manpower, OS
Through: Deputy Director, Bureau of Health Services

DATE: JUN 16 1967

FROM : Director, Division of Medical Care Administration

SUBJECT: Memorandum of June 8, 1967, concerning the proposed study between the Welfare Administration and the Association of American Medical Colleges.

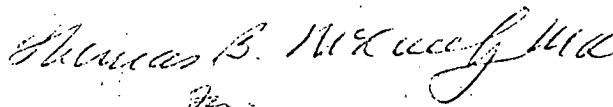
This is in response to your memorandum of June 8, 1967, concerning the proposed study of the effects of Titles XVIII and XIX of the Social Security Amendments of 1965 on teaching hospitals, which is proposed as a joint effort of the Welfare Administration and the Association of American Medical Colleges.

On June 19-20, 1967, the Division of Medical Care Administration, in cooperation with the Bureau of Health Manpower, will conduct a conference on the influence of new and expanded Federal and State health care legislation on public (tax-supported) hospitals. Dr. Mark Novitch of the Office of the Secretary and Mr. Matthew McNulty of the Association of American Medical Colleges will serve as conferees, and other participants are listed on the attached sheet.

The enclosed list of suggested topics, which was developed for guiding discussion, illustrates the type of subject material that will be covered. It is expected that additional issues and questions will be generated during the course of the conference. The second day of the conference is to be directed at developing concrete recommendations as to the roles and responsibilities of the several public and private agencies in studying the problems further and effecting solutions.

As you can see, this Division and others in the Public Health Service are already actively involved in the areas proposed as a Welfare Administration project. We believe that the Public Health Service must continue to have a principal role in the area of effects of Titles XVIII and XIX in hospitals. We would be pleased to cooperate with the Welfare Administration in developing relationships with the AAMC in exploring areas for study. Our conference next week should provide the framework for doing this.

We will keep you informed on the results of the conference.



John W. Cashman, M.D.

Enclosure



JUN 21 1967

Memorandum

TO : Edwin F. Rosinski, Ed.D.
Consultant for Health Manpower, OS

DATE: JUL 1 6 1967

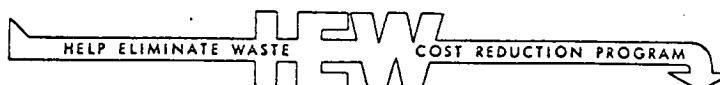
FROM : Thomas M. Tierney, Director
Bureau of Health Insurance, SSA

REFER TO: HI:PS:RSP

SUBJECT: Effects of Titles XVIII and XIX of the Social Security Amendments of 1965 on teaching hospitals--your memorandum of June 8, 1967

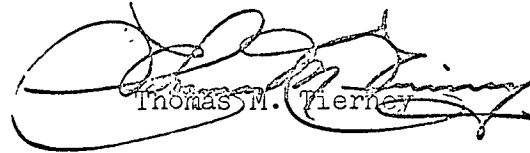
You requested that we submit to you a list of questions which we would like to have answered if a study is undertaken by the Association of American Medical Colleges on the effects on teaching hospitals of Titles XVIII and XIX of the Social Security Act. Following is a list of questions which are of interest to the Bureau of Health Insurance:

1. To what extent has the occupancy rate in teaching hospitals been affected by the free choice of institution available to beneficiaries of title XVIII?
2. To what extent, if any, has the level of compensation of interns and residents been influenced by the reimbursement to the hospitals of the costs of providing interns' and residents' services to title XVIII beneficiaries?
3. To what extent, if any, has the character of the teaching programs changed, by type of patient accommodation, as a result of the medicare cost reimbursement principles? Specifically, to what degree have the teaching programs shifted from the ward setting to the semi-private and private settings?
4. To what extent, if any, have the medicare program's principles of reimbursement for hospital costs encouraged hospitals to retain full-time or part-time directors of medical education or chiefs of services, or to assume intern and resident costs previously borne by affiliated medical schools?
5. To what extent, if any, has the ratio of approved internship and residency positions to hospital beds been affected by guaranteed cost reimbursement under titles XVIII and XIX?
6. To what extent, if any, have teaching hospitals changed the nature of their programs involving undergraduate medical education since the enactment of titles XVIII and XIX and what are the cost consequences of these changes?



7. To what extent, if any, do teaching hospitals arrange to make available the services of their interns and residents to extended care facilities and home health agencies that participate in the medicare program? What changes in these relationships are attributable to the implementation of titles XVIII and XIX?

8. To what extent have the title XVIII regulations concerning reimbursement for services of supervising physicians in the teaching setting affected teaching programs? Has the definition of "attending" physician contained in these regulations had any effect on the organization of teaching programs for interns and residents, any effect on the nature of the supervision given interns and residents, or any effect on the relationship between supervising physician and patient? Is there any indication that medicare's provision for reimbursement of professional fees for the services attending physicians render in the teaching setting has encouraged physicians to involve their private patients in the teaching process?



Thomas M. Tierney

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF TEACHING HOSPITALS
MINUTES

Southern Regional Meeting
Wednesday, July 26, 1967
Air Host Inn
Atlanta, Georgia

10:00 A.M.

I. Attendance

The attached Roster to these Minutes indicates the persons and institutions represented at this meeting.

II. Call To Order

Mr. Charles H. Frenzel, Superintendent, Duke University Medical Center, called the meeting to order promptly at 10:00 A.M. and extended greetings to those present.

III. Statement Of Purpose: Introduction And Historical Summary:

Mr. Matthew F. McNulty, Jr., Director, COTH, and Associate Director, AAMC stated that the purposes of the regional meetings were to exchange ideas and discuss common problems on a regional basis and noted that COTH was continuing to place emphasis on medical education.

He further indicated that a number of additional Council activities are being considered. Mr. McNulty emphasized that this is not to change the individual interest - and certainly not to create any conflicts or dispersion within AHA. The point is to establish a forum from which the various educational endeavors common to teaching hospitals can be discussed.

He noted further that preliminary indications are favorable that AHA would create a Council of Teaching Hospitals within that organization as recommended in the American Hospital Association's Report on Committee on Programs. Mr. Frenzel then acknowledged the work of Mr. McNulty in the development of the Council and re-emphasized the importance of these regional meetings.

IV. Summary Of Discussion By Participants

A. Rising costs of medical care in relation to Teaching Hospital Operations:
Education as a cost of medical care

At Mr. Frenzel's suggestion, Mr. McNulty commented on the rising costs of teaching hospitals and ways of financing these costs. Mr. McNulty discussed the relatively high costs of teaching hospitals and the occasional difficulty in explaining them to the general public. He also stressed that economists are concerned about the amount of the Gross National Product going for health care. The economists would like to see some sort of agreement to insure that this expense would not exceed a specified percentage of the GNP. One of the impacts of the rising costs of medical care is the difficulty it introduces for any group (labor, etc.) to make any long range plans in this

area.

Several participants suggested that any increase in house staff salaries should hinge on whether this activity is a service or falls in the category of education. A factor discussed at some length is the tax exempt status of monies paid to the house staff. Several cases are awaiting decision by the area offices of the Internal Revenue Service.

It was noted that some hospitals are asking patients to sign a consent form agreeing to be a teaching case. The effect of Medicare on the patient load was generally discussed. Many former clinic patients are now Medicare patients and are continuing to use the same facilities, but it is felt by some that this will gradually decrease and that these patients will want to know more about their treatment and perhaps demand a particular physician. It was especially noted that there is a decrease in those persons seeking surgical services. A group practice of faculty physicians operating within the clinics is one suggestion to this future problem. An increasing number of states are becoming involved in Medicaid and the same sort of problems are anticipated in regard to this for teaching hospitals.

B. The Role of Teaching Hospitals in Planning for Health Care Service:

During the afternoon session, Mr. McNulty stated that there had been very initial involvement by teaching hospitals in the Regional Medical Programs. These programs are considered a major method of delivery of medical services. He pointed out that it has been estimated that \$10 billion is needed to modernize hospitals in this country, and that financing is desperately needed to do this. This fact makes it important for each hospital to know precisely how they are classified and exactly what funds are available to them under the Hill-Burton Act.

The meeting was adjourned by Mr. Frenzel at 4:07 P.M.

H. William Anderson
Grady Memorial Hospital
Acting Recorder

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF TEACHING HOSPITALS
MINUTES

Meeting of the Midwest & Great Plains Regions
Thursday, July 27, 1967
Flying Carpet Motor Inn
Chicago, Illinois

10:00 A.M.

I. Attendance

The attached Roster to these Minutes indicates the persons and institutions represented at this meeting.

II. Call To Order

Mr. Lad F. Grapski called the meeting to order promptly at 10:00 A.M. He welcomed the group on behalf of the Officers and members of the Executive Committee of the Council of Teaching Hospitals. He further noted that the agenda was prepared on the advice of the membership and suggested that the discussions be frank and informal. Recognition to the Committee on Arrangements, namely, Messrs. Goulet, Boettcher, and Grapski, as well as the Staff of COTH was acknowledged. Three former Chairmen of this section, namely, Dr. Caseley, Dr. Hartman and Mr. McNulty were recognized for their contributions to the development of the organization.

III. Statement Of Purpose; Introduction And Historical Summary

Mr. Matthew McNulty, Director of COTH, gave a brief history of the development of the organization and the establishment of Regional groups and meetings and expressed satisfaction at the number of institutions active in the Council. Out of a possible universe of some 350 hospitals, which meet established criteria for membership, the Council membership now numbers 324 institutions.

IV. Summary Of Discussion By Participants

The Chairman suggested that the discussion follow the same order as printed in the agenda.

A. The Medical School, its Teaching Hospital and their Responsibilities to the Community

1. Discussion concerning the university-based medical center contribution to the educational programs in non-university affiliated, community hospitals and the advantage of affiliation between the university teaching hospital and the community teaching hospital.

The University of Minneapolis reported that monthly meetings were being held in that city to discuss common problems between the teaching hospital and community hospitals.

Jack Hall reported in detail on recent Indiana legislation which is designed to initiate and augment programs to keep physicians in Indiana.

Gerhard Hartman, Ph.D., asked that Indiana circulate the plan to the COTH membership. Elton Ridley and Jack Hall will see that COTH receives adequate copies to do so.

Mr. McNulty observed that Louisiana has passed legislation assisting L.S.U., Tulane, and five charity hospitals in Louisiana with programs designed to better relate the teaching hospital to community non-affiliated hospitals.

B. The Design And Methods By Which University Hospitals Have Developed Program Cooperation With Affiliated Teaching Hospitals

Mr. Lad Grapski suggested the members refer to the study by Dr. Cecil Sheps, et al., published by AAMC.

C. Definition Of The Existing Or Anticipated Role Of Teaching Hospitals And Medical Education In The Current Programs Of Extended Care

Minnesota reported a \$200,000 grant for study of diseases with no known cure.

Indiana and Minnesota reported having interns and residents in extended care facilities.

Dr. Schlessinger of the Hines, V.A., stated that by the end of 1967, the V.A. will have 4000 extended care beds that will provide a good education resource.

D. Discussion Of How Medical Schools And Teaching Hospitals Have Or Can React To The Need For OEO Neighborhood Health Centers

Dr. James Campbell of Presbyterian-St. Luke's Hospital, Chicago, reported in detail on their O.E.O. program. He stated that the program does not use house staff or students; it is not an educational program, but rather a service program. He further observed that this work of the O.E.O. is a preliminary step to actualize Title 19 and other programs before 1975.

E. Need For Local Educational Programs To Explain Teaching Hospitals' Costs.

Mr. McNulty reported that the results of the Yale-New Haven cost study should be available in 1968. The steering committee for this work is comprised of membership from the A.H.A., A.A.M.C. and the A.M.A. Mr. McNulty also observed that one of the results of the recent Presidential Conference on Health Care was the establishment of the Advisory Committee on Hospital effectiveness chaired by John A. Barr, Dean of the Business School of Northwestern University.

F. Discussion Relating To Nursing Education With Particular References To The Strengthening Of Diploma Programs While Working Toward The Development Of More Associate Degree And More Baccalaureate Degree Programs

No discussion.

..... Break for lunch.....

Mr. Goulet resumed as Chairman.

V. Intern And Resident Education In The Teaching Hospital: A Discussion Of Common Problems (Topics Suggested by Members).

A. Existing Plans And Anticipated Effects Of Higher Stipend Scales For Residents

The observation was made that if the Residency is an educational experience, the term "Stipend" is appropriate. If service is the goal of the Residency, that the term "Salary" is realistic.

Dr. Campbell stated that COTH should have excellent educational standards to pursue, and that perhaps it should consider accrediting hospitals which carry on graduate education. Donald Caseley, M.D., observed that perhaps COTH has the opportunity to pull post-graduate medical education into the spectrum of excellence as it exists in the university setting. Dr. Campbell then stated that teaching hospitals must accept the corporate responsibility for post-graduate medical education and that perhaps COTH is the proper body to implement the Millis Report. He quoted from a part of the Millis Report, and stated emphatically that COTH should have representation on the "Super Board" mentioned in this report.

Fred Elliot, M.D., representing AHA, observed that if hospitals share in the accreditation process, they have a trusteeship to the patient and the community. Further, policies must be developed within the constraints of financial resources. Dr. Elliot also noted that the AHA is increasing its concern about representing teaching hospitals. The Chairman asked for a voice vote on whether or not there should be a uniform stipend for all hospitals. There was a strong "No" to this vote.

Mr. Goulet reported that there is serious discussion within AAMC regarding foreign interns, i.e., the possibility of allowing them to intern only at University Hospitals.

B. The Feasibility Of Establishing A Matching Program For Residents And Its Potential Impact On Non-Affiliated Hospitals.

Mr. McNulty observed that the matching program will continue to be expanded to include more residency programs. In fact, the Intern matching program has officially changed its name to the Intern/Resident Matching Program. Services will be available from those who wish to use it as a trial for residents as of July 1, 1968, in the specialities of Psychiatry and Orthopedics.

C. The Establishment Of A Uniform Starting Date For Residents - Two Week Variance About July 1.

It was pointed out that a uniform date could lead to possible conflict with the National Boards.

It was recommended that the date be the Monday preceding July 1. Mr. Goulet reported that the Deans of several Medical Schools have advised interns not to accept contracts if the resident is asked to begin his assignment before the agreed upon date.

D. The Need For A "Clearing House" For Qualified Physicians Interested In Positions As Full-Time Chiefs Of Service.

Mr. McNulty reported that COTH has very informally been performing this role.

E. Possibility Of An Organized Education Program For Interns In Order That They Might Be Able To Take Histories And Make Physical Examinations Of Patients.

There was active discussion regarding the differences between a "clerkship" and an "externship".

Dr. Campbell observed that an approved externship is as educationally worthwhile as other disciplines' practice of research fellowships, and that we should have externships as an elective. This elective would afford the student opportunity to observe other than the rare and the exotic in medical treatment.

The COTH Director will circulate copies of the Approved Extern Program at the University of Michigan.

VI. The Role Of The Teaching Hospital In Planning For The Delivery Of Health Care Services

A. Participants' Activities With Regard To P.L. 89-239, "Regional Medical Programs" - Progress, Nature And Effect On The Teaching Hospital.

Mr. McNulty reported that 80 of the 323 member hospitals in the COTH are involved, to some extent, in Regional Medical Programs. He urged the membership to learn of the projects and to become involved. Mr. Goulet polled those present and determined that only Missouri and Kansas have operational grants in the Midwest. All other states have planning grants.

B. Anticipated Involvement Of Teaching Hospitals Under Provisions Of P.L. 89-749, "Comprehensive Health Planning Act".

Mr. McNulty reported that COTH membership needs to be involved if only for their own self-protection. He further noted that the AAMC legislative Committee on Federal Relations, in Congressional testimony, had suggested that the provisions of this Act be directed at the environment aspects of health care, not the delivery of health care.

VII. General Clinical Research Centers

A. Experience To Date Relating To The Development Of Centers And Discussions Of Problems Inherent In The Program.

No discussion.

B. HEW "Cost Recapturing Program".

Mr. McNulty noted that the old "85-15" formula is being reviewed by HEW, and he further noted that hasty settlement of costs with the Government Accounting Office is not recommended. Further information should be forthcoming on this matter.

VIII. Other Subject Matters Of Interest To The Participants

A question from the floor asked how the membership could learn more about electronic data processing and how one could learn to use it as a management tool.

Mr. Grapski thanked the participants for their excellent contributions to the program and then informally polled the membership and determined that March, 1968, in Chicago, 10:00 A.M. to 4:00 P.M. was an acceptable meeting time.

The meeting was adjourned at 4:00 P.M.

H.J. Curl,
Assistant Administrator
Loyola University Hospital
Recorder

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF TEACHING HOSPITALS
MINUTES
OF
Northeastern Regional Meeting
New York University Medical Center
New York, New York
Thursday, August 3, 1967

10:00 A.M.

I. Attendance

The attached Roster to these minutes indicates the persons, and institutions represented at this meeting.

II. Call To Order

The Northeast Regional Meeting of the Council of Teaching Hospitals was held at New York Medical Center on August 3, 1967 at 10:00 A.M. The meeting was chaired by Dr. Stewart Hamilton, member of the Council of Teaching Hospitals Executive Committee. Mr. Matthew McNulty, Jr., Director of the Council of Teaching Hospitals, and Mr. Irvin G. Wilmot, host for the meeting, shared the head table with Dr. Hamilton.

III. Greetings And Purposes Of Establishing Regional Meetings

Dr. Hamilton offered a brief welcome to the members, presented the format and discussed the day's proposed agenda. Mr. McNulty followed with a brief history of the Association of American Medical Colleges, the Council of Teaching Hospital's evolution from AAMC, and the growth and development of AAMC as an "umbrella organization for education in the health sciences" as defined in the Coggeshell Report. Mr. McNulty envisioned further expansion of AAMC into the field of para-medical education.

Mr. McNulty related that this was the third regional conference to be held, with council members discussing pertinent regional problems as determined by a member poll. These conferences have displayed in part, the potential of both COTH and AAMC in the "health services" field.

IV. Summary Of Discussion By Participants

A. The Rising Costs of Medical Care in relation to Teaching Hospital Operations:
Education as a cost of medical care.

Interest centered on the relation of rising medical care costs to the operation of the teaching hospital. Discussion revolved around the allocation of house staff costs to the hospital or medical school. Dr. Albert Snoke (Yale-New Haven Hospital) presented findings of a study which attempted to define the time the house staff spent in the various activities of research, education and patient care. The preliminary evidence seemed to indicate the house staff spend a disproportionately large amount of time in patient care relative to research and education. The possibility of basing the house staff cost as a professional component of patient services was suggested. The expressed belief of the participants was that it would be difficult to adequately separate and

define the areas of research, education and patient care to an extent that would allow medical schools, teaching hospitals or third party interests to formulate reimbursement plans based on house staff activity. The cost of house staff services and the assignment of cost responsibility generated a topic of considerable interest among the attending members.

B. Loss of Clinical Material Due to P.L. 89-97

Concern here was the potential loss of clinical material from teaching hospitals due to the enactment of Public Law 89-97, Titles XVIII and XIX. The problems of providing clinical material for surgical resident and obstetrical-gynecology resident teaching was viewed as a potential danger to the medical education of those residents. Several approaches to this problem, such as the "team" approach, were presented as possible solutions for the use of private patients as clinical material for house staff teaching.

C. The Teaching Hospital and Its Responsibilities for Non-Medical Education

Public Law 89-751, "Allied Health Professional Act," was the basis for discussion as to whether the teaching hospital or the University should function as the responsible agency for the implementation of programs to provide para-medical education. Some opinion was expressed that the University had abdicated its role in the training of sub-baccalaureate, para-medical personnel and that the teaching hospital should be the logical location for funding and implementing such programs.

D. The Role of Teaching Hospitals in Planning for the Delivery of Health Care Services

The afternoon session was primarily centered around two pieces of national health legislation: Public Law 89-239, "Regional Medical Programs," and Public Law 89-749, "Comprehensive Health Planning Act." Of major concern was the responsibility of the teaching hospital in the regional planning scheme. The teaching hospital's role as the focal point in the health care system was emphasized by the attending members. The possible implications of Public Law 89-749 were held to be much greater than previously realized and the need for active participation in implementation of both Public Laws by administrators of teaching hospitals was re-emphasized. Another problem area opened for discussion was the pressing need for modernization funds. The passage of appropriate legislation at the present seems highly unlikely due to government foreign involvement. However, legislation for modernization cannot be underestimated in the future provision of medical care within many urban settings. The role of the teaching hospital with respect to the community hospital was an examined topic. The apparent trend of American medical students towards internships in affiliated hospitals and the trend towards employment of foreign trained physicians as house staff, places a staffing burden on the community general hospital. The problems of how to make community hospitals attractive residencies; the need for further education of foreign medical students; the resident matching program's implications for the community hospital; and, the responsibilities of the teaching hospital to the practitioners and interns in the community hospital were examined in breadth and depth.

Additionally, the character and responsibility of the accreditation agency for teaching hospitals was examined. There exists a need for an agency that represents those institutions responsible for the clinical education of the medical student. The consensus was that the agency now performing this function fails to represent the purveyors of the finished product. An organization, such as the Council of Teaching Hospitals, would be better qualified to carry out this accrediting function.

Mr. John Scott
Mr. Edward Stein
New York University Medical Center
Acting Recorders

July 3, 1967

TO: Members, Executive Council
FROM: Robert C. Berson, M.D., Executive Director
SUBJECT: Proposed Merger of Great Plains and Midwest Regional
Groups

Four letters concerning a proposed merger of the Great Plains and
Midwest Regional Groups follow.

Recommendation: It is recommended that the Executive Council
support the merger of the Great Plains and Midwest Regional Groups
proposed in these letters.

6226-21/ct

NORTHWESTERN UNIVERSITY
Medical School
Chicago, Illinois 60611

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Y

Richard H. Young, M.D.
Dean

May 25, 1967

Dr. Robert B. Howard
Dean, The University of
Minnesota Medical School
Minneapolis, Minnesota 55414

Dear Bob:

As you know, the Midwest Region knowing of the interest in a joint meeting with the Great Plains group had taken action on April 21 to invite them to join us at our next scheduled meeting on October 20 from 10 to 5:00 in the VIP room of the Seven Continents Restaurant at O'Hare airport, Chicago.

It is my understanding that the Great Plains Regional group has scheduled its next meeting in July. I do not think the Midwest Region is ready to try to meet a July dateline but hope that you can meet with us on October 20.

Sincerely yours,

/s/

Richard H. Young, M.D.
Dean

RHY:vh

UNIVERSITY OF MISSOURI
Columbia
65202

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School of Medicine
Office of the Dean

228 Medical Science Building
Area 314 GI 2-5111 Ext. 611

May 29, 1967

Robert B. Howard, M.D., Dean
University of Minnesota
School of Medicine
Minneapolis, Minnesota 55414

Dear Bob:

I have had no further information about our inter-regional meeting with the mid-west group. It would seem to me we should be getting these plans specific and underway and I would appreciate knowing where we stand, so that plans can be made accordingly.

I know that this comes at an inopportune time from your point of view, but am so concerned that we continue the momentum which was evident in Omaha, that I'm willing to volunteer to be of some help if you think this would be necessary.

Best personal regards,

/s/

Vernon E. Wilson, M.D.
Dean and Director

VEW:ems

UNIVERSITY OF MINNESOTA

College of Medical Sciences - Minneapolis, Minnesota 55455

C
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Y

Office of the Dean.

June 21, 1967

Dr. Richard H. Young, Dean
Northwestern University Medical School
Chicago, Illinois 60611

Dear Dick:

Enclosed is a copy of a letter I have just written to Vern Wilson which is, in part, responsive to your note of May 25, 1967, concerning the merger of the Great Plains and the Midwest regional groups. As you can see, we are planning a meeting on July 6, and at that time we will make further plans to join the Midwest group at its October meeting.

The Great Plains group has moved in the direction of faculty participation in these regional meetings. Specifically, two faculty representatives from each institution have been elected or selected as representatives of their respective faculties. Many of these individuals were present at the April meeting in Omaha, and I am sure that many of them will similarly be present at the July meeting in Kansas City. Does this fact pose any particular problems with respect to the proposed merger? In other words, has the Midwest group given any consideration to a somewhat similar faculty participation? I would be happy to have your reaction on this score.

Again, with many thanks and best wishes, I am

Sincerely yours,

/s/

Robert B. Howard, M.D.
Dean

RBH?rk

cc: Dr. Vernon Wilson
Dr. William Hubbard
Dr. Cheves Smythe

UNIVERSITY OF MINNESOTA

College of Medical Sciences - Minneapolis, Minnesota 55455

C
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Y

Office of the Dean

June 21, 1967

Dr. Vernon E. Wilson
Dean and Director
University of Missouri
School of Medicine
Columbia, Missouri 65202

Dear Vern:

I am late in responding to your note of May 29, 1967, concerning the Regional Meeting of the AAMC because recent weeks have been dominated by the annual frenzy known as preparation of the budget.

In any event, however, we have made arrangements for a meeting in Kansas City on July 6. George Wolf has been good enough to take the lead in making the arrangements, and notification has gone out to all of the deans, as well as to the faculty members who attended the Omaha meeting. Like you, I am eager to pursue the gains made at that meeting. During the next week, I shall get out some materials to all those who are on the list for prospective attendance.

It does seem that our merger with the Midwest Region cannot be consummated until the fall. I am enclosing a copy of Dick Young's letter relative to this matter. At the Kansas City meeting we can discuss participation in the October meeting scheduled for Chicago. I am taking the liberty of sharing a copy of this letter with Dick in order that he will be informed about this. Copies will also go to Bill Hubbard and to Cheves Smythe.

Again, with many thanks for your help and with best wishes, I am

Sincerely yours,

/s/

Robert B. Howard, M.D.
Dean

RBH/rk

cc: Dr. Richard Young
Dr. William Hubbard
Dr. Cheves Smythe

COUNCIL OF TEACHING HOSPITALS
MEMBERSHIP ROSTER
AUGUST, 1967

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