

COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
1501 New Hampshire Avenue, N.W.
Washington, D. C. 20036
Area Code 202 232-5870

AGENDA

EXECUTIVE COMMITTEE 66-2

Wednesday and Thursday, January 11 & 12, 1967
Dupont Plaza Hotel
1500 New Hampshire Avenue, N. W.
Washington, D. C. 20036

Wednesday - 6:30 P.M., Dupont Room
Lower Level

Thursday - 8:30 A.M., Gallery Room
Lower Level

Hotel Telephone No. - HU 3-6000

- I. Call To Order: Roll Call - Welcome to new members (Tab 1 - list of officers and Executive Committee members and committees of COTH).
- II. Approval of Minutes
 - A. Minutes of the Executive Committee Meeting (66-6) of Friday, October 21, 1966 (Tab 2)
 - B. Minutes of Executive Committee Meeting (67-1) of Monday, October 24, 1966 (Tab 3)
- III. New Applications For Membership: (Rules & Regulations for membership under Tab 4)
 - A. Nominated by a Dean of a Medical School (1)
 1. VA Center, Jackson, Mississippi
(John A. Gronville, M.D., Acting Dean)
 - B. Applying as Having Met Criteria (b) of Internship Program and Full Residencies in Three of Five Disciplines.

MATTHEW F. McNULTY, JR.
DIRECTOR

-1- Council of Teaching Hospitals
Ass'n. of American Medical Colleges
1501 New Hampshire Ave., N.W.
WASHINGTON, D. C. 20036
Phone: 202 - 232-5870

1. Akron City Hospital, Akron, Ohio
Internship; Medicine; Surgery; OB-Gyn.
2. Carney Hospital, Boston, Mass.
Internship; Medicine; Surgery; OB-Gyn.; Pathology.
3. Emanuel Hospital, Portland, Oregon
Internship; Medicine; Surgery; OB-Gyn.
4. Miami Valley Hospital, Dayton, Ohio
Internship; Medicine; Surgery; OB-Gyn.
5. Misericordia - Fordham Hospitals, Bronx, New York
Internship; Medicine; Surgery; OB-Gyn; Pediatrics.
6. Rhode Island General, Providence, R. I.
Internship; Medicine; Surgery; OB-Gyn; Pediatrics
7. St. Vincent Hospital, Worcester, Mass.
Internship; Medicine; Surgery; Pediatrics.

IV. Total Membership Assuming Approval of the Foregoing Institutions:
(Tab 5 for December 15, 1966 Roster of Member - Paid and not paid -
Hospitals numbering 328)

- A. Nominated by a Dean - 232
 1. Voting members - 81
 2. Other members - 151
- B. Applying under Criteria for Internship and Residency Programs - 100
- C. Canadian Hospitals - 12
 1. Paid - 6
 2. Not Paid - 6
- D. Canal Zone - 1
- E. Puerto Rico - 2
- F. VA Hospitals - 44
- G. U.S. PHS Hospitals - 4
- H. Total Members - 332
 1. Paid - 286
 2. Not Paid - 46 (7 today & 39 at Tab 6)

- V. Report of Joint Survey (COTH and DIME of AAMC): Foreign Medical Graduates (FMG) for Presidential Commission on Manpower - Harold Margulies, M.D., Division of International Medical Education (DIME), Washington, D. C.
- VI. Report from Editor, Bulletin of the Association of American Medical Colleges: William G. Reidy, Editor (Tab 7 for Vol. 1, No. 8 and Vol. 2 No. 1)
- VII. Report from Director on other AAMC Media Used: (Tab 8 for Editorial, The Journal of Medical Education, Vol. 41, No. 11)
- A. Journal of Medical Education
 - B. Datagram AAMC
 - C. Bulletin of the AAMC
 - D. Directory of the AAMC
 - E. First Institute on Medical School Administration: October 5-8, 1963, Atlanta, Georgia (Report).
 - F. Second Institute on Administration: Medical School - Teaching Hospital Relations, December 6-9, 1964, Miami Beach, Florida (Report).
 - G. Third Institute on Administration: The Medical Center and the University, December 12 - 15, 1965, Miami Beach, Florida (Report of the Institute not yet published).
 - H. Cecil G. Sheps, M.D., et al, Medical Schools and Hospitals; Interdependence for Education and Service.
 - I. Employment Service Review: Bureau of Employment Security, U. S. Employment Service, Department of Labor, November 1966 - Health Manpower.
 - J. Training Health Service Workers: The Critical Challenge: Proceedings of the Department of Labor - Department of HEW, Joint Conference on Job Development and Training for Workers in Health Services, February 14-17, 1966.
 - K. Health Services Research I
 - L. Health Services Research II
- The Millbank Fund Quarterly.

- VIII. The Report of a Pilot Study of Hospital Program Costs and Manual of Instructions for Program Cost Finding in Hospitals: The A. J. "Gus" Carroll Study.
- IX. General Clinical Research Center Full Reimbursement: Rapidly Escalating Hospital Costs - Director
- X. AAMC Committee to Study Training for Family Practice and Graduate Education of Physicians - Chairman of Council.
- XI. Fair Labor Standards Act: Amendments of 1966 (P.L. 89-601) - Status of Interns and Residents.
- XII. Report of COTH Procedure on Washington Executive Agencies and Legislative Matters: Director and Kenneth Williamson, Associate Director, AHA and Director Washington Service Bureau. (Mr. Williamson has agreed to join us at 10:00 A.M. Thursday morning).
- XIII. AAMC - Council of Academic Societies - Report by Director.
- XIV. COTH - AAMC 1967 Annual Meeting: Report of Change of Place and Dates - New York Hilton Hotel, Friday, October 27 - Monday, October 30 - (Executive Council Meeting, Tuesday, October 31).
- XV. Program For Annual Meeting of COTH: Discussion For Opinions and Ideas.
- XVI. Meetings: AAMC Administrative Committee (the officers); Executive Council (Tab 9) and Regional Meetings - Report.
- XVII. Possible Subsequent Meetings for Executive Committee COTH Friday: Saturday, April 7 and 8, and/or Friday, May 12. (Least objectionable time?)
- XVIII. Financial Report: Income of Council, July 1, 1966 (start of fiscal year) to date - \$139,749.96. Expenditures through November 30, 1966, \$25,730.43.
- XIX. AAMC Relations with Allied Health Professions - Report.
- XX. Regions of AAMC and Application to COTH: (Tab 10)
- XXI. National Conference on Regional Medical Programs: January 15-17, 1967, Washington Hilton Hotel - Information.
- XXII. Activity of COTH Headquarters: October through December - Report. Conference on International Medical Education at New Delhi.
- XXIII. 63rd Annual Congress on Medical Education - Information (Tab 11)

*How Perant
Organization
intend
to use.*

*① List Basic
Principles
on
Apparitionment*

*② Add Home
Committee*

- XIV. AAMC Proposals for the Support of Medical Education by the Federal Government. (Tab 12). Discussion.
- XV. Projection of Medical Students Faculty & Graduates to 1985: Information, unpublished Report. (Tab 13)
- XVI. Address by Surgeon General USPHS: Information (Tab 14)
- XVII. Appointment of Nominating Committee: For Nomination of 1967-68
Officers and Executive Committee.
- XVIII. Other Business
- XIX. Date and Time of Next Meeting.

→ Attendees for WEdnesday January 11, 1967, 6:30 p.m. Social and
Second Meeting of Executive Committee, Council of Teaching Hospitals.

COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
1501 New Hampshire Avenue, N. W.
Washington, D. C. 20036
Area Code (202) 232-5870

EXECUTIVE COMMITTEE 1966-67

Chairman	Stanley A. Ferguson, Director University Hospitals of Cleveland 2065 Adelbert Road Cleveland, Ohio 44106
Chairman Elect	Lad F. Grapski, Administrator Loyola University Hospital 706 S. Wolcott Avenue Chicago, Illinois 60612
Immediate Past Chairman	Russell A. Nelson, M.D., President Johns Hopkins Hospital 601 Broadway Baltimore, Maryland 21205
Secretary	Matthew F. McNulty, Jr., Director Council of Teaching Hospitals 1501 New Hampshire Avenue, N. W. Washington, D. C. 20036
COTH voting representative to the AAMC Executive Council	Russell A. Nelson, M.D., President Johns Hopkins Hospital 601 Broadway Baltimore, Maryland 21205
Three year terms	LeRoy E. Bates, M.D., Director Palo Alto-Stanford Hospital Center 300 Pasteur Drive Palo Alto, California 94304
	Charles H. Frenzel, Administrative Director Duke University Medical Center Durham, North Carolina
	T. Stewart Hamilton, M.D. Executive Director Hartford Hospital Hartford, Connecticut
Two year terms	Dan J. Macer, Director Veterans Administration Hospital University Drive Pittsburgh, Pennsylvania 15240
	Lester E. Richwagen, Executive Vice President and Administrator Mary Fletcher Hospital Burlington, Vermont

Two year terms
cont'd:

Richard D. Witttrup, Administrator
University of Kentucky Hospital
800 Rose Street
Lexington, Kentucky 40506

One Year Term

Charles R. Goulet, Supt.
University of Chicago Hospital and Clinics
950 East 59th Street
Chicago, Illinois 60637

Ernest N. Boettcher, M. D., Director
St. Louis University Hospitals
1325 South Grand Boulevard
St. Louis, Missouri 63104

LeRoy S. Rambeck, Director
University of Washington Hospital
Seattle, Washington 98105

Harold Margulies, M.D.
Division of International Medical Education
Association of American Medical Colleges
1501 New Hampshire Avenue, N.W.
Washington, D.C.

William G. Reidy, Editor
Bulletin of the Association of
American Medical Colleges
1785 Mass. Avenue, N.W.
Washington, D.C.

COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
1501 New Hampshire Avenue, N. W.
Washington, D. C. 20036
Area Code (202) 232-5870

COTH-AHA Liaison Committee 1966-67

Chairman
(COTH Section)

* Lad F. Grapski, Administrator
Loyola University Hospital
706 S. Wolcott Avenue
Chicago, Illinois 60612

COTH Member

Russell H. Miller
Associate Director and Administrator
University of Kansas Medical Center
Rainbow Boulevard at 39th Street
Kansas City, Kansas 66103

COTH MEMBER

Ernest C. Shortliffe, M.D.
Executive Director
Wilmington Medical Center
Chestnut at Broom Street
Wilmington, Delaware 19899

Chairman
(AHA Section)

* Mark Berke, Director
Mt. Zion Hospital and Medical Center
1600 Divisadero Street
San Francisco, California 94115

AHA Member

David B. Wilson, M.D.
Director
University of Mississippi Hospital
2500 North State Street
Jackson, Mississippi 39206

AHA Member

Howard R. Taylor, Director
Aultman Hospital
625 Clarendon Avenue, S. W.
Canton, Ohio

Chicago
W

Meet
(a) Liaison
(b) Legislative

Set Fred
Send Bill

Residency

COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
1501 New Hampshire Avenue, N. W.
Washington, D. C. 20036
Area Code (202) 232-5870

COTH Committee on Government Relations 1966-67

- Chairman Charles H. Frenzel
Administrative Director
Duke University Medical Center
Durham, North Carolina
- Member J. Theodore Howell, M.D.
Director
Henry Ford Hospital
2799 West Grand Boulevard
Detroit, Michigan 48202
- Member Harold H. Hixson, Administrator
University of California Hospitals
San Francisco Medical Center
San Francisco, California 94122

Modification of
medicare
outpt. services,
specialty services.

~~Withdraw to
maximum extent~~

C. GARDNER child
1st Feb.

Ernest
Ken Coispeal
C. Gardner child
Bob Williams
Ernest

Dick without
for RAMBECK
Lad Gardner

Keep an
eye on T.H.E
19
Report

COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
Meeting of Executive Committee (No. 66-6)
Friday, October 21, 1966

at
The San Francisco Hilton Hotel
Mason and O'Farrell Streets
San Francisco, California

3:00 PM -- 6:00 PM

Present:

Russell A. Nelson, M.D., Chairman
Stanley A. Ferguson, Chairman-Elect
Matthew F. McNulty, Jr., Immediate Past Chairman, and Director of
the Council of Teaching Hospitals
Lad F. Grapski, Secretary
Lester E. Richwagen, Member
Richard T. Viguers, Member
Robert C. Berson, M.D., Executive Director, AAMC
Joseph H. McNinch, M.D., Director, Southeastern Office, AHA (Representing
Edwin L. Crosby, M.D., Executive Vice President & Director, AHA,
an Invited Participant)
Mary L. Doty, Secretary

Absent:

LeRoy S. Rambeck, Member

I. CALL TO ORDER

The meeting was called to order promptly at 3:00 P.M. by
Russell A. Nelson, Chairman, COTH.

II. MINUTES

The minutes of the Executive Committee meeting of Friday, September 9,
1966, were approved as presented.

III. ANNUAL MEETING SCHEDULE

Dr. Nelson reviewed the annual meeting activities. Attendance of COTH
members particularly was encouraged for the reception Friday evening
in Teakwood Room at 6:00 PM. It was also suggested that the luncheon
on Saturday be promoted. Dr. Nelson to make an announcement at the
General Session Saturday morning to this effect.

There was discussion and agreement concerning the agenda for the
COTH Business Meeting of Monday morning, October 24, 1966. It was
agreed that a summary should be presented of the actions for 1965-66
taken by Executive Committee before approval of those actions by
the Council was asked.

IV. NEW APPLICATIONS FOR MEMBERSHIP - TOTAL 11

A. Nominated for consideration by Dean of a Medical School (6).

1. Fitzgerald Mercy Hospital, Darby, Pennsylvania
(William F. Kellow, M.D., Hahnemann Medical College & Hospital
of Philadelphia)
 - a. Approved
2. VA Hospital, Augusta, Georgia
(Walter G. Rice, M.D., Medical College of Georgia)
 - a. Approved
3. VA Hospital, West Haven, Connecticut
(Vernon W. Lippard, M.D., Dean, Yale University)
 - a. Approved
4. VA Hospital, Durham, North Carolina
(William G. Anlyan, M.D., Dean, Duke University)
 - a. Approved
5. USPHS Hospital, Carville, Louisiana
(John C. Finerty, Ph. D., Dean, Louisiana State University)
 - a. Approved
6. Milwaukee Psychiatric Hospital, Wauwatosa, Wisconsin
(Gerald A. Kerrigan, M.D., Dean, Marquette University)
 - a. Approved

B. Qualifying as Having met Criteria b of the Rules & Regulations
of December 12, 1965 (All were approved)

1. Mobile General Hospital, Mobile, Alabama
(Internship; Medicine, Surgery, OB-Gyn, Pediatrics)
2. St. Joseph Mercy Hospital, Pontiac, Michigan
(Internship; Medicine, Surgery, OB-Gyn, Pediatrics)
3. St. Mary's Hospital of the Sisters of Charity, Rochester, New York
(Internship; Medicine, Surgery, OB-Gyn)
4. Allegheny General Hospital, Pittsburgh, Pennsylvania
(Internship; Medicine, Surgery, OB-Gyn, Pediatrics)
5. Columbia Hospital, Columbia, South Carolina
(Internship; Surgery, OB-Gyn, Pediatrics)

- C. Mr. Grapski made a comment as to procedure. He recommended for the future that all applications be processed by the Washington office of COTH under the direction of the Director of the Council of Teaching Hospitals. There was unanimous agreement.

V. TOTAL MEMBERSHIP (331)

- A. Nominated by Dean - 236
1. Voting Members - (81)
 2. Other Members - (155)
- B. Qualifying by Criteria (b)
(Internship & Residency Programs) - 95
- C. Canadian Hospitals - 12
- D. Canal Zone Hospital - 1
- E. Puerto Rico Hospitals - 2
- F. VA Hospitals - 44
- G. USPHS Hospitals - 4
- H. Membership Dues (331) (Including 11 Hospitals in A & B of Section IV heretofore but not including the Clinical Center).
1. Paid - Approximately 250
 2. Unpaid - Approximately 81
 3. Approved today - 11
 4. Not approved or not applied (As best as can now be determined 100 hospitals have not been approved or did not respond to the circularization of last spring. Some of the records concerning these hospitals are still in transit between Evanston, Illinois and Washington, D. C., having apparently been "trapped" by the Chicago Post Office difficulty).

VI. FINANCIAL REPORT

As of September 30th reported paid dues were - \$114,000. Audited report of June 30, 1966, \$20,000 dues paid. Expenses charged to the Council to date (July - September 30th) totalled \$5,200.

VII. ASSOCIATION OF CANADIAN TEACHING HOSPITALS AND PROVINCIAL
LIMITATION ON EXPENSE OF MEMBERSHIP DUES

A. Mr. McNulty presented a report concerning Canadian Hospitals.

1. Six (6) of twelve (12) hospitals circularized last spring have paid their dues.

A list of the paid and not-paid Canadian Hospitals is attached.

2. The Canadian Teaching Hospitals have formed an independent (not affiliated with Canadian Medical Schools) association titled The Association of Canadian Teaching Hospitals.
3. In general these Canadian Teaching Hospitals have expressed an opinion through Arnold L. Swanson, M.D., Chairman, Association of Canadian Teaching Hospitals and Executive Director, Victoria Hospital, London, Canada, that they would be unable to belong to both groups (i.e., COTH and the Association of Canadian Teaching Hospitals) because of limitation of funds and a restrictive interpretation by the Provincial Governments on multiple membership fees. However, Dr. Swanson suggested that the ACTH take out a membership in COTH and that ACTH membership continue to benefit from material, programs and other activities of COTH.
4. The reaction and expressed decision of the Executive Committee after thorough discussion was that if the Canadian Hospitals are forming an association of their own that is probably good and perhaps helpful to them but there is no provision at this time for group membership in COTH. It was suggested and agreed that the Canadian Hospital group be invited annually to send a representative to the Annual Meeting.

Because six (6) Canadian Hospitals have already paid their dues it was decided not to solicit further Canadian Hospitals but to encourage continued membership of these present members.

5. Mr. McNulty indicated that J. Gilbert Turner, M.D., Executive Director, Royal Victoria Hospital, has succeeded Dr. Swanson as Chairman of the Association of Canadian Teaching Hospitals.
6. The final decision concerning this matter was that after a period of encouragement Canadian Hospitals (U.S. Hospitals, also) that did not pay their dues should be dropped from the membership roster.

VIII. Membership Size

Dr. Nelson reported on a survey conducted for him by his office which indicated that of the total hospitals listed in the 1966 Guide Issue, JAHA, the membership of COTH (not including hospitals admitted today) represented:

- A. 4.7% of the hospitals listed by AHA.
- B. 37% of the beds listed by AHA.

IX. ANNUAL REPORTS

A. It was agreed that the Council of Teaching Hospitals should make an annual report. The report as contained in the 1966 Annual Reports of the AAMC and distributed at this 77th Annual Meeting of the AAMC was indicated as the type desired.

1. Mr. Grapski noted that we should indicate special recognition to George N. Aagaard, M.D. and C. Alden Miller, M.D. Both of these gentlemen are former chairmen of the former Medical School Teaching Hospital Relations Committee. It was agreed that the records of that Committee should be sent to the Washington office. (Medical School Affiliated Hospitals Committee)

B. Dr. Berson discussed with the members of the Executive Committee the changes that were being considered in the by-laws of the AAMC.

1. Dr. Nelson suggested that the Executive Committee of the COTH should discuss the Millis Report as well as the AAMC. Regional meeting would help in raising questions on the Millis Report.

2. Dr. Berson discussed the possibility of a standard form for students entering Medical School.

X. Dues Payment Budget Limitation

A. Several of the PHS and other government type (state)(county) hospitals are having budget problems and have asked for a deferment of dues payment to January of 1967.

1. It was approved that such hospitals could pay later (within a reasonable period to be determined by the Director) but that membership should not start until dues were paid.

XI. The NIH Clinical Center - Membership

A. Dr. Nelson posed the question whether the Clinical Center, Bethesda, Maryland should be given a membership on the usual criteria.

- B. There was unanimous agreement that the Clinical Center should be offered membership in the Council, even though the type of educational commitment of this national clinical center did not conform directly with the membership criteria as outlined in the Rules and Regulations. It was moved, seconded and passed unanimously that the Rules and Regulations be amended to provide membership eligibility for the NIH Clinical Center. It was noted that the Clinical Center would probably apply for membership effective July 1, 1967, the start of the next federal fiscal year.
- C. Dr. Berson suggested that maybe there should be another category of membership. There was a question as to whether this would set a precedent. There does not seem to be another situation like the Clinical Center. If special category is set up, the rules should be set to avoid loopholes.
- D. It was decided that there should be a category for specially invited members. The Council can invite hospitals that are not eligible under present regulations but play an important role in Medical education. It was agreed also that at this time the Rules and Regulations should not be changed but that the route of exception be retained and more experience be observed.

XII. CERTIFICATE OF MEMBERSHIP

- A. The possibility of Certificates of Membership had been discussed at the September meeting but a final decision had not been reached. At that time a preliminary draft had been submitted through the effective effort of Mr. Grapski. That draft was being held until after the annual AAMC Meeting (Printing in Evanston for annual meeting was taking first priority). The format presented in September was agreed upon with a target date of early 1967 for printing and distribution. A delayed time was suggested so that all applications would have been received and some "slow pay" hospitals would have ample time for payment.

XIII. DISCUSSION OF VARIATIONS IN QUALIFYING CRITERIA

- A. Internships: The subject of an "approved" internship program was discussed. One hospital that did not have any interns in their program had been disapproved. The hospital responded by indicating that they did have interns in their program. They were Canadian school graduates. This did not appear in the AMA material.
 - 1. It was agreed that every U. S. and Canadian hospital filed with the AMA as to Internships. It should not matter whether the Intern was from the U. S. or Canada. The problem in this case was that correct information was not given to begin with. If the hospital has been listed with an approved internship and there was an intern on duty, then it could be recommended for membership -- if that was the only limitation.

B. Full Residencies:

1. Some hospitals feel that they have a stronger program by being affiliated for "Residency" programs than if they were operating "free standing" Residency Programs.
 - a. It was agreed that if the hospital could submit significant information to the Council that an active, fully approved, well-staffed, affiliated residency had been evolved and working and that the institution that with which it was affiliated was fully approved, that affiliate could be considered for membership.
 - b. Whenever there is doubt concerning an application, then the Council will have to probe and use individual judgment for that hospital.

C. NIMP - Uniform Application for Internships

1. It was agreed that this subject which was mentioned also in the meeting of September be tabled until more specific request be indicated by NIMP.

XIV. REGIONAL ORGANIZATION OF AAMC

- A. Discussion of Regional Organization proposal for AAMC and Relation to COTH.

1. General discussion for members information but no action.

XV. POSSIBLE MEETING DATES FOR EXECUTIVE COMMITTEE

- A. Decided not to have a meeting in December. A meeting was held December, 1965, but it was more in connection with the 1965 Institute in Miami than a separate meeting.
- B. It was agreed that the first year of a formally organized Council would have more organizational emphasis than program activity. Therefore, scheduled meetings would not be essential. Meetings should be called by the Chairman and Director. Any meetings that are called can be cancelled if there does not seem to be any pertinent business to discuss.

XVI. "RECOVERY" PROCEDURE - PARTICULARLY RE: GCRC

- A. The events and circumstances concerning a proposed U. S. Senate amendment to the F/Y 1967 Appropriation Act for HEW (among other departments), which amendment among other benefits would have eliminated the threat of recovery of 85-15 funds for the early years of GCRC, was discussed. For several reasons which were explained the amendment had been withdrawn. The subject of "Recovery" still remains indefinite.

XVI. POSSIBLE PROGRAM ACTIVITY

- A. Millis Commission should be discussed.
- B. Role of Hospital and Medical School.
 - 1. Future of the Internship in hospitals.
 - 2. Comprehensive medical care.
- C. Regional Medical Programs. (Mr. McNulty mentioned with "reasonable certainty" his opinion that a national meeting would be called for 1967.)
- D. Cost, Income and Expense for Professional Services in Teaching Institutions.
- E. Capital financing of Teaching Hospitals plant (modernization, capital funds, grants, etc.)
- F. Role of Medical School and Teaching Hospitals together.
 - 1. Education and training of nurses.
 - 2. Education and training for other health care disciplines.
- G. Rising costs in medical care, in relation to hospital operation.
 - 1. Education as a cost to medical service.
- H. Maintenance of a residency program with the change in availability of "teaching patients".

XVII. ADJOURNMENT

There being no further business, the Monday, October 24th, organizational meeting of the new 1966-67 Executive Committee for 12:30 p.m. luncheon was announced and this last meeting of the 1965-66 Executive Committee was adjourned at 6:00 p.m.

COUNCIL OF TEACHING HOSPITALS
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
1501 New Hampshire Avenue, N. W.
Washington, D.C. 20036

HOSPITALS OUTSIDE THE CONTINENTAL UNITED STATES
As of Friday, Oct. 21, 1966

CANADA (12) (6 have paid)

1. Hotel Dieu De Montreal
Dr. Pierre Nadeau
3840 St. Urbain Street
Montreal, Quebec, Canada
2. Kingston General Hospital
Mr. Donald M. Mac Intyre
Stuart Street
Kingston, Ontario, Canada
3. *Ottawa Civic Hospital
Dr. Dougals R. Peart
Carling Avenue
Ottawa 3, Ontario, Canada
4. *Saint Josephs Hospital
Sister Mary Elizabeth
Grosvenor Street, N.
London, Ontario, Canada
5. Saint Lukes Hospital
Dr. Jacques Bernier
1058 St. Denis Street
Montreal, Quebec, Canada
6. Toronto Western Hospital
Dr. R. J. Nodwell
399 Bathurst Street
Toronto 2, Ontario, Canada
7. *Victoria General Hospital
Dr. C. M. Bethune
330 Tower Road
Halifax, N.S., Canada
8. Victoria Hospital
Dr. A. Swanson
375 South Street
London, Ontario, Canada
9. *University Hospital
Mr. Earl Dick
Saskatoon, Saskatchewan, Canada
10. *University of Alberta Hospital
Dr. Bernard Snell,
112th Street & 84th Avenue, Edmonton, Alberta, Canada

11. *Vancouver General Hospital
F. W. G. Ruddick
12th & Heather Street
Vancouver 9, B. C.; Canada
12. Winnipeg General Hospital
Dr. L. O. Bradley
700 William Avenue
Winnipeg 3, Manitoba, Canada

CANAL ZONE (not paid)

1. Gorgas Hospital
Harry D. Offutt, Jr. Col., M.C.
P. O. Box 0 Balboa Heights, M.D.
Ancon, Canal Zone

HAWAII (not paid)

1. *The Queens Hospital
Mr. Will J. Henderson
1301 Punchbowl
Honolulu, Hawaii

PUERTO RICO (not paid)

1. San Juan City Hospital
Dr. Fernando A. Batlle
Puerto Rico Medical Center
Rio Piedras, Puerto Rico
2. University District Hospital
Dr. Jose Nine Curt
Caparra Heights Station
Rio Piedras, Puerto Rico 00935

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF TEACHING HOSPITALS
MINUTES

Meeting of Executive Committee (No. 67-1)
Monday, October 24, 1966
The San Francisco Hilton Hotel
Mason and O'Farrell Streets
San Francisco, California 94102

Luncheon - 12:30 P.M. - 2:30 P.M.

Present

Stanley A. Ferguson, Chairman
Lad F. Grapski, Chairman Elect
Charles H. Frenzel, Member
Dan J. Macer, Member
LeRoy S. Rambeck, Member
Lester E. Richwagen, Member
Richard D. Wittrup, Member
Matthew F. McNulty, Jr., Secretary and Director, COTH
Joseph H. McNinch, M.D., Director, Southeastern Office, AHA,
an Invited Representative from AHA
Mary E. Doty, Secretary

Absent

Russell A. Nelson, M.D., Immediate Past Chairman
LeRoy E. Bates, M.D., Member
Ernest N. Boettcher, M.D., Member
Charles R. Goulet, Member
T. Stewart Hamilton, M.D., Member

I. Call to Order

The meeting was called to order promptly at 12:30 P.M. by Stanley A. Ferguson, Chairman, COTH.

II. Discussion of Future Executive Committee Meetings

- A. It was suggested that there be two to three meetings during the 1966-67 year with the first meeting in January or February, 1967.
- B. The Chairman outlined to the new members of the Executive Committee, the general format of meetings and the number of meetings that had been held during 1965-66.
- C. The Chairman and others emphasized that COTH and the Executive Committee continue to operate with an awareness of their role as a federated activity of the total AAMC.

III. Appointment of Initial COTH Committees

- A. The Chairman appointed representatives from COTH for an AHA-COTH Liaison Committee. Those members are as follows:

Lad F. Grapski, Chairman
Russell H. Miller, Member
Ernest C. Shortliffe, M.D., Member

- B. The Chairman appointed a Government Relations Committee with members as follows:

Charles H. Frenzel, Chairman
J. Ted Howell, M.D., Member
Harold H. Hixson, Member

- C. These appointments meet with the concurrence of all Executive Committee Members.
- D. It was recommended by two of the members with general agreement of the Committee that the Council initiate as an early priority the establishing of rapport with Washington governmental and voluntary organizations.
- E. The Chairman suggested that at the first meeting of the Executive Committee - which would be called by the Chairman and the Director - there be explored the extent of likely Executive Committee business for 1966-67 and at that time any tentative schedule of 1967 meetings.

IV. PROGRAMS

- A. One member suggested that the Council get out a News Letter or a Memorandum on a quarterly basis.
- B. It was agreed that the Director should utilize existing media to inform the general membership as to what happened at the meetings held in San Francisco.
1. Mr. Ferguson proposed that Mr. McNulty present at the next meeting a program of activities and objectives.
- C. It was proposed that the Council consider regional meetings to get the membership together locally - these meetings to be separate from the AAMC. It was agreed that this matter be considered and discussed at the next meeting of the Executive Committee.
- D. It was reaffirmed that when determined by the COTH headquarters office, membership applications from hospitals could be passed by telephone vote concurrence.

V. Study by A. J. "Gus" Carroll on Cost of Medical Schools and Hospitals

- A. Mr. Carroll reported on study at the Yale-New Haven Hospital. The Director of COTH outlined the desirability for an early reporting. A date of spring 1967 was mentioned. The Director suggested that a chapter by chapter distribution in draft could start at an earlier date. An AHA-AMA-AAMC Steering Committee is involved also. There was agreement that the project be moved as quickly as possible.

VI. PROPOSALS

- A. One member suggested that at the next meeting we discuss problem of house staff. Have a subcommittee to do research on this subject. Be sure the report is meaningful.
- B. It was suggested that the Executive Committee authorize the Director to decide what should be the priority projects and how we should be staffed to take care of the various projects. This was seconded and agreed unanimously.

VII. MILITARY SERVICE HOSPITALS

- A. None have joined as yet.
1. They seem to be cleared to join but many of them have budget problems the same as the Public Health Services.
- B. There may be other such groups that have not applied. As of now no further applications are pending.
- C. Membership will be 332 as soon as the formality of AAMC Executive Council concurrence on the hospitals approved by the members of the Executive Committee on Friday, October 21, 1966 is accomplished.
1. The Executive Committee is the official committee for approval of all applications. As a member of the total AAMC, applications are referred to the AAMC Executive Council for information and concurrence. (Explanation by Mr. Ferguson).
- D. It was noted by several members that undoubtedly a percentage of the hospitals so far not paying their dues would eventually be dropped. As of this time a membership of approximately 300 might be considered. There was general agreement that between 275 and 310 hospitals would be the first year dues paying members.

VIII. APPRECIATION TO GUS CARROLL FOR JOINING US AND DISCUSSING HIS PROJECT WITH US.

- A. It was suggested that this study be a topic at one of the annual meetings.

IX. CERTIFICATE

- A. A certificate of membership has been approved.
- B. It will be distributed in early 1967.

X. REGISTRATION FEES

- A. The Hospital Chief Administrative Officer did not have to pay a registration fee for this meeting. If any of them did pay and has not yet received a refund, they should write to John L. Craner in the Evanston Office of the AAMC for prompt refund.

XI. ADJOURNMENT

- A. Meeting was adjourned at 2:30 P.M.

**ASSOCIATION OF
AMERICAN
MEDICAL
COLLEGES**

**Council of Teaching Hospitals
Rules and Regulations**

AS APPROVED
DECEMBER 12, 1965

**2530 Ridge Avenue
Evanston, Illinois - 60201**

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Council of Teaching Hospitals Rules and Regulations

At the meeting of the institutional members of the Association of American Medical Colleges held Tuesday, November 2, 1965, in Philadelphia, the Association acted to convert the Teaching Hospital Section into a "Council of Teaching Hospitals," with its voting membership to be determined in the same way as membership in the Teaching Hospital Section has been and to provide that the Council nominate a person to be elected by the Institutional Membership as a voting member of the Executive Council. The discussion which preceded formal action included the desire for the Teaching Hospital Section to develop and propose appropriate ways to bring into its activities, on the basis of affiliation, other major teaching hospitals.

Purpose and Function. The Council is organized to provide as part of the program of the AAMC special activity relating to teaching hospitals. For this purpose, a teaching hospital is defined as an institution with a major commitment in undergraduate, post-doctoral, or post-graduate education of physicians. In keeping with the action of the AAMC, each medical school will designate a primary teaching hospital and other eligible institutions may be designated by schools or become members by virtue of meeting specific requirements in teaching programs as may be set up by the Council from time to time. It is expected that the Council will hold educational meetings, conduct and publish studies and take group action on various subjects concerning the teaching hospital. The Council's program will be subject to the approval of the AAMC.

Nature of the Program of the Council. As a part of the AAMC, the Council of Teaching Hospitals would develop, through the appointment of specific study groups, information concerning specific items or problems relating to hospital operation as it relates to the furtherance of education in medicine. The Council would conduct meetings for the presentation of papers and studies relating to education in hospitals and would stimulate, in addition to annual meetings, regional and local meetings of the educational type as seems indicated. The Council could also from time to time recommend group action on items considered of importance for the furtherance of medical teaching in hospitals and upon approval of appropriate bodies take action as indicated to further this objective.

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.

Officers and Executive Committee. Officers and appropriate members of the Executive Committee shall be elected annually by all members, at which time the Chairman, Chairman-Elect, Secretary, and indicated members of the Executive Committee will be chosen. From time to time a member representative shall be nominated for membership on the Executive Council of the AAMC by vote of the single medical school representative members.

There shall be nine (9) members of the Executive Committee, serving for three-year terms. Each year three (3) members shall be elected. In addition, the immediate Past Chairman, the Chairman, the Chairman Elect, and the Council of Teaching Hospitals' representative on the Executive Council of the AAMC shall be ex-officio members of the Executive Committee. The Executive Committee shall meet as frequently as necessary under the chairmanship of the Chairman of the Council. It shall carry the authority of the members between meetings and all actions shall be considered for ratification at the next meeting of the members.

Operation and Relationships. The Council shall report to the Executive Council of the AAMC, and shall be represented on the Council of the AAMC by a member nominated for a three-year term by the teaching hospital members. Creation of standing committees and any major actions shall be taken only after recommendation to and approval from the Executive Council of the AAMC.

Staff, Expenses for Attendance at Meetings, and Dues. It is intended that the Council of Teaching Hospitals will be provided adequate staff for the conduct of its work. It is also intended that the Executive Committee of the Council shall have standing and ad hoc committees of its members, which shall meet from time to time, with expenses of these meetings paid for by the Association. In all this, it is understood that the staff and the basic conduct of the program are subject to the approval of the officers and Executive Council of the AAMC.

It is intended that the activities of the Council of Teaching Hospitals shall be financed by its members through appropriate dues established at the outset at \$500.00 per year.

Russell A. Nelson, M.D.
Chairman
Executive Committee
Council of Teaching Hospitals

Approved by the Executive Committee of the Council of Teaching Hospitals
and the Executive Council of the AAMC December 12, 1965.

COUNCIL OF TEACHING HOSPITALS

December 15, 1966

TAB 5

JOSEPH S. LICHTY, M.D.
EXECUTIVE DIRECTOR
AKRON GENERAL HOSPITAL
400 WABASH AVENUE
AKRON, OHIO 44307

MR. WILLIAM B. FORSTER
ADMINISTRATOR
BEXAR COUNTY HOSP. DISTRICT FACHA
P. O. BOX 7190
SAN ANTONIO, TEXAS 78207

DR. THOMAS HALE, JR.
ADMIN. VICE PRES. AND DIR.
ALBANY MEDICAL CENTER HOSPITAL
NEW SCOTLAND AVENUE
ALBANY, NEW YORK 12208

RONALD YAW
DIRECTOR
BLODGETT MEMORIAL HOSPITAL
1840 WEALTHY STREET, S.E.
GRAND RAPIDS, MICHIGAN 49506

DR. P. F. LUCCHESI
MEDICAL DIRECTOR
ALBERT EINSTEIN MEDICAL CENTER
YORK & TABOR ROADS
PHILADELPHIA, PENNSYLVANIA 19141

DR. JOHN G. FREYMANN
DIRECTOR
BOSTON HOSPITAL FOR WOMEN
221 LONGWOOD AVENUE
BOSTON, MASSACHUSETTS 02115

MR. WALTER E. LANDGRAF
SUPERINTENDENT
ALLEGHENY GENERAL HOSPITAL
320 EAST NORTH AVENUE
PITTSBURGH, PENNSYLVANIA

MR. CLARENCE W. BUSHNELL
ADMINISTRATOR
BRIDGEPORT HOSPITAL
267 GRANT STREET
BRIDGEPORT, CONNECTICUT 06602

MR. FREDERIC HUBBARD
DIRECTOR
BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE
BALTIMORE, MARYLAND 21224

DR. EDWARD KIRSCH
EX. DIRECTOR
BRONX-LEBANON HOSPITAL CENTER
1276 FULTON AVENUE
NEW YORK, NEW YORK 10456

MR. GENE KIDD
ADMINISTRATION
BAPTIST HOSPITAL
2000 CHURCH STREET
NASHVILLE, TENNESSEE 37203

DR. EVA VANDOW
EXECUTIVE HOSPITAL ADMINISTRATOR
BRONX MUNICIPAL HOSPITAL CENTER
EASTCHESTER RD. & PELHAM PARKWAY
BRONX, NEW YORK 10461

DR. FRANK S. GRONER
ADMINISTRATOR
BAPTIST MEMORIAL HOSPITAL
829 MADISON AVENUE
MEMPHIS, TENNESSEE 38103

MR. JOSEPH V. TERENCE
EX. DIRECTOR
BROOKLYN-CUMBERLAND MEDICAL CENTER
121 DE KALB AVENUE
BROOKLYN, NEW YORK 11201

ROBERT E. FRANK
ACTING DIRECTOR
BARNES HOSPITAL
600 BARNES HOSPITAL PLAZA
ST. LOUIS, MISSOURI 63110

MR. RUDOLF G. HILS
ADMINISTRATOR
THE BUFFALO GENERAL HOSPITAL
100 HIGH STREET
BUFFALO, NEW YORK 14203

MR. BOONE POWELL
ADMINISTRATOR
BAYLOR UNIVERSITY MEDICAL CENTER
3500 GASTON AVENUE
DALLAS, TEXAS 75246

DR. DAVID LITTAUER
EXECUTIVE DIRECTOR
CEDARS-SINAI MEDICAL CENTER
4833 FOUNTAIN AVENUE
LOS ANGELES, CALIFORNIA 90029

DR. MITCHELL T. RABKIN
GENERAL DIRECTOR
BETH ISRAEL HOSPITAL
330 BROOKLINE AVENUE
BOSTON, MASS. 02115

DR. LOUIS BURROUGHS
ACTING DIRECTOR
CHARITY HOSPITAL
1532 TULANE AVENUE
NEW ORLEANS, LOUISIANA 70114

MR. WILLIAM N. WALLACE
ADMINISTRATOR
THE CHARLES T. MILLER HOSP., INC.
125 WEST COLLEGE AVENUE
ST. PAUL, MINNESOTA 55102

MR. FREDERICK R. VEEDER
ADMINISTRATOR
CHILDRENS HOSPITAL
226 EAST CHESTNUT ST.
LOUISVILLE, KENTUCKY 40202

MR. JOHN W. RANKIN
DIRECTOR
CHARLOTTE MEMORIAL HOSPITAL
1000 BLYTHE BOULEVARD
CHARLOTTE, NO. CAROLINA 28203

MR. CARL R. BAUM
DIRECTOR
CHILDRENS HOSPITAL OF PHILADELPHIA
1740 BAINBRIDGE STREET
PHILADELPHIA, PA. 19146

RICHARD H. YOUNG M. D.
DIRECTOR
CHICAGO MATERNITY CENTER
1336 S. NEWBERY
CHICAGO, ILLINOIS

MR. GEORGE H. STONE
ADMINISTRATOR
CHILDRENS ORTHO. HOSP. & MED. CNTR.
4800 SAND POINT WAY, N.E.
SEATTLE, WASHINGTON 98105

MR. KENATH HARTMAN
SUPERINTENDENT
CHICAGO WESLEY MEMORIAL HOSPITAL
250 E. SUPERIOR ST.
CHICAGO, ILLINOIS 60611

DR. ROBERT H. PARROTT
DIRECTOR
CHILDRENS HOSPITAL OF D. C.
2125 13TH STREET, N.W.
WASHINGTON, D.C. 20009

DR. HARRY SHIRKEY
DIRECTOR
CHILDRENS HOSPITAL OF BIRMINGHAM
1601 6TH AVENUE
BIRMINGHAM, ALABAMA 35233

MR. T. G. WHEDBEE, JR.
DIRECTOR
CHURCH HOME & HOSP. CITY OF BALTI.
100 NORTH BROADWAY
BALTIMORE, MARYLAND 21231

DR. LEONARD W. CRONKHITE, JR.
GENERAL DIRECTOR
CHILDRENS HOSPITAL MEDICAL CENTER
300 LONGWOOD AVENUE
BOSTON, MASSACHUSETTS 02115

MR. DAVID A. REED
ADMINISTRATOR
CINCINNATI GENERAL HOSPITAL
3231 BURNET AVENUE
CINCINNATI, OHIO 45229

MR. JOSEPH R. GREER
ADMINISTRATOR
CHILDRENS MEMORIAL HOSPITAL
707 FULLERTON AVENUE
CHICAGO, ILLINOIS 60614.

MR. JAMES G. HARDING
ADMINISTRATOR
CLEVELAND CLINIC HOSPITAL
2020 EAST 93RD STREET
CLEVELAND, OHIO 44106

MR. MOIRE TANNER
DIRECTOR
CHILDRENS HOSPITAL OF BUFFALO
219 BRYANT STREET
BUFFALO, NEW YORK 14222

MR. DAVID A. MILLER
DIRECTOR
CLEVELAND METROPOLITAN GENL HOSP.
3395 SCRANTON ROAD
CLEVELAND, OHIO 44109

DR. HUGO V. HULLERMAN
EXECUTIVE VICE-PRESIDENT
CHILDRENS HOSPITAL OF MICHIGAN
5224 ST. ANTOINE
DETROIT, MICHIGAN 48202

MR. JAMES M. DANIEL
SUPERINTENDENT
COLUMBIA HOSPITAL, RICHLAND COUNTY
2020 HAMPTON STREET
COLUMBIA, SOUTH CAROLINA 29204

MR. HENRY DUNLAP
ADMINISTRATOR
CHILDRENS HOSP. OF LOS ANGELES
4614 SUNSET BOULEVARD
LOS ANGELES, CALIFORNIA 90027

MR. WILLIAM M. MC COY
ADMINISTRATOR
COOK COUNTY HOSPITAL
1825 W HARRISON
CHICAGO, ILLINOIS 60612

ROBERT Y. GARRETT, JR.
VICE-PRESIDENT & ADMINISTRATOR
THE COOPER HOSPITAL
SIXTH AND STEVENS STREETS
CAMDEN, NEW JERSEY 08103

MR. F. K. NEUMANN
DIRECTOR
EDWARD W. SPARROW HOSPITAL
1215 E. MICHIGAN AVENUE
LANSING, MICHIGAN 48912

SISTER M. ANTONETTE, O.S.F.
ADMINISTRATOR
CREIGHTON MEMORIAL ST. JOSEPH HOSP.
2305 S. 10TH STREET
OMAHA, NEBRASKA 68108

MR. BURWELL HUMPHREY
ADMINISTRATOR
EMORY UNIVERSITY HOSPITAL
1364 CLIFTON ROAD, N.E.
ATLANTA, GEORGIA 30322

MISS DOROTHY PELLENZ
ADMINISTRATOR
CROUSE-IRVING HOSPITAL
850 S. CROUSE AVENUE
SYRACUSE, NEW YORK 13210

J. MILO ANDERSON
EXECUTIVE DIRECTOR
EPISCOPAL HOSPITAL
FRONT ST. & LEHIGH AVENUE
PHILADELPHIA, PENNSYLVANIA 19125

HENRY E. MANNING
ADMINISTRATOR
CUMBERLAND HOSPITAL
39 AUBURN PLACE
BROOKLYN, N.Y. 11205

DR. RUFUS PAYNE
SUPERINTENDENT
EUGENE TALMADGE MEMORIAL HOSPITAL
1120 15TH ST.
AUGUSTA, GEORGIA 30902

MR. JOHN F. BERRY
ADMINISTRATOR
DE GOESBRIAND MEMORIAL HOSPITAL
PEARL AND PROSPECT STS.
BURLINGTON, VERMONT

MR. JOHN M. DANIELSON
VICE-PRESIDENT
EVANSTON HOSPITAL
2650 RIDGE AVENUE
EVANSTON, ILLINOIS 60201

MR. FRANKLIN D. CARR
ADMINISTRATOR
DETROIT MEMORIAL HOSPITAL
690 MULLETT ST.
DETROIT, MICHIGAN 48226

MR. LYLE W. BYERS
EXECUTIVE DIRECTOR
EYE AND EAR HOSP. OF PITTSBURGH
230 LATHROP STREET
PITTSBURGH, PENNSYLVANIA 15213

DR. MEYER BEBER
DIRECTOR
DOUGLAS COUNTY HOSPITAL
4201 WOOLWORTH AVENUE
OMAHA, NEBRASKA 68105

MR. FRANKLIN P. IAMS
ADMINISTRATOR
FAIRFAX HOSPITAL
3300 GALLOWS ROAD
FALLS CHURCH, VIRGINIA 22046

MR. CHARLES H. FRENZEL
ADMINISTRATIVE DIRECTOR
DUKE UNIVERSITY MEDICAL CENTER
DURHAM, NORTH CAROLINA 27706

MR. DAVID V. CARTER
ADMINISTRATOR
FITKIN MEMORIAL HOSPITAL
CORLIES AVENUE
NEPTUNE, NEW JERSEY 07753

MR. MICHAEL J. WOOD
EXECUTIVE DIRECTOR
DUVAL MEDICAL CENTER
2000 JEFFERSON STREET
JACKSONVILLE, FLORIDA 32206

SISTER MARIE, R.S.M.
ADMINISTRATOR
FITZGERALD MERCY HOSPITAL
LANSLOWNE AVE. & BAILY RD.
DARBY, PENNSYLVANIA 19023

DR. L. EDGAR HUMMEL
ADMINISTRATOR
EDWARD J. MEYER MEMORIAL HOSPITAL
462 GRIDER STREET
BUFFALO, NEW YORK 14215

MR. LAWRENCE L. SMITH
HOSPITAL ADMINISTRATOR
FLOWER & FIFTH AVENUE HOSPITALS
FIFTH AVE. AT 106TH ST.
NEW YORK, NEW YORK 10029

DR. CHARLES E. BURBRIDGE, PH.D.
SUPERINTENDENT
FREEDMENS HOSPITAL
6TH AND BRYANT STS. N.W.
WASHINGTON, D.C. 20001

MR. EDWIN L. TAYLOR
DIRECTOR
GRAD. HOSP. OF UNIV. OF PENNA.
19TH AND LOMBARD STREETS
PHILADELPHIA, PA. 19146

DR. ELLSWORTH R. BROWELLER
ADMINISTRATIVE DIRECTOR
GEISINGER MEDICAL CENTER
DANVILLE, PENNSYLVANIA 17821

MR. J. WILLIAM PINKSTON, JR.
SUPERINTENDENT
GRADY MEMORIAL HOSPITAL
80 BUTLER STREET, S.E.
ATLANTA, GEORGIA 30303

MR. LAWRENCE J. BRADLEY
DIRECTOR
GENESEE HOSPITAL
224 ALEXANDER ST.
ROCHESTER, NEW YORK 14607

MR. CHARLES S. PAXSON, JR.
ADMINISTRATOR
HAHNEMANN HOSPITAL
230 N BROAD STREET
PHILADELPHIA, PENNSYLVANIA 19102

MR. WILLIAM H. VANSTONE
ADMINISTRATOR
GEORGE W. HUBBARD HOSPITAL
1005 18TH AVENUE, NORTH
NASHVILLE, TENNESSEE 37208

VERNON SPENCER
ADMINISTRATOR
HARLEM HOSPITAL CENTER
532 LENOX AVENUE
NEW YORK, NEW YORK 10037

MR. VICTOR F. LUDEWIG
ADMINISTRATOR
GEO. WASHINGTON UNIV. HOSPITAL
901 23RD STREET, N.W.
WASHINGTON, D.C. 20037

MR. GEORGE CARTMILL
DIRECTOR
HARPER HOSPITAL
3825 BRUSH STREET
DETROIT, MICHIGAN 48201

MR. JOHN IMIRIE
ADMINISTRATOR
GEORGETOWN UNIVERSITY HOSPITAL
3800 RESERVOIR ROAD, N.W.
WASHINGTON, D.C. 20007

MR. JAMES E. PEARS
ADMINISTRATOR
HARRIS COUNTY HOSPITAL DISTRICT
1502 TAUB LOOP
HOUSTON, TEXAS 77025

MR. STEPHEN M. MORRIS
PRESIDENT & ADMINISTRATOR
GOOD SAMARITAN HOSPITAL
1033 EAST MC DOWELL ROAD
PHOENIX, ARIZONA 85006

MR. WALTER S. SHAKESPEARE
ADMINISTRATOR
HARRISBURG HOSPITAL
SOUTH FRONT STREET
HARRISBURG, PA.

SISTER GRACE MARIE, S.C.
ADMINISTRATOR
GOOD SAMARITAN HOSPITAL
3217 CLIFTON AVENUE
CINCINNATI, OHIO 45220

DR. T. STEWART HAMILTON
EXECUTIVE DIRECTOR
HARTFORD HOSPITAL
80 SEYMOUR STREET
HARTFORD, CONN. 06115

HARRY D. OFFUTT, JR. COL., M.D.
DIRECTOR
GORGAS HOSPITAL
P.O. BOX 0 BALBOA HEIGHTS
ANCON, CANAL ZONE

MR. PAUL VOGT
ADMINISTRATOR
HENNEPIN COUNTY GENERAL HOSPITAL
619 S. FIFTH ST.
MINNEAPOLIS, MINNESOTA 55415

DR. ROGER W. DE BUSK
DIRECTOR
GRACE HOSPITAL
4160 JOHN R STREET
DETROIT, MICHIGAN 48201

DR. JAMES T. HOWELL
EXECUTIVE DIRECTOR
HENRY FORD HOSPITAL
2799 W. GRAND BLVD.
DETROIT, MICHIGAN 48202

DR. KENNETH R. NELSON
DIRECTOR OF MEDICAL INSTITUTIONS
HIGHLAND GENERAL HOSPITAL
2701 14TH AVENUE
OAKLAND, CALIFORNIA 94606

ALLEN M. HICKS
ADMINISTRATOR
ILLINOIS MASONIC HOSPITAL ASSN.
836 W. WELLINGTON AVENUE
CHICAGO, ILLINOIS 60657

MR. ALLAN C. ANDERSON
ADMINISTRATOR
HIGHLAND HOSPITAL OF ROCHESTER
SOUTH AVE. AND BELLEVUE DRIVE
ROCHESTER, NEW YORK 14620

MR. ELTON T. RIDLEY
DIRECTOR
INDIANA UNIVERSITY MEDICAL CENTER
1100 W. MICHIGAN STREET
INDIANAPOLIS, INDIANA 46207

MISS MARGARET J. WHERRY
ADMINISTRATOR
HOSPITAL OF THE GOOD SAMARITAN
1212 SHATTO STREET
LOS ANGELES, CALIF. 90017

MR. CHARLES W. NORDWALL
EXECUTIVE DIRECTOR
JAMES M. JACKSON MEMORIAL HOSPITAL
1700 N.W. TENTH AVENUE
MIAMI, FLORIDA 33136

SISTER LOUISE ANTHONY
ADMINISTRATOR
HOSPITAL OF ST. RAPHAEL
1450 CHAPEL STREET
NEW HAVEN, CONNECTICUT 06511

MR. MAURICE P. COFFEE, JR.
DIRECTOR
JEFFERSON MEDICAL COLLEGE HOSPITAL
11TH AND WALNUT STREETS
PHILADELPHIA, PENNSYLVANIA 19107

MR. T. GORDON YOUNG
DIRECTOR
HOSPITAL FOR SPECIAL SURGERY
535 EAST 70TH STREET
NEW YORK, N.Y. 10021

MR. OTIS M. WHEELER
DIRECTOR
JEWISH HOSPITAL
217 EAST CHESTNUT STREET
LOUISVILLE, KENTUCKY 40202

MR. RALPH L. PERKINS
DIRECTOR
HOSP. OF THE UNIV. OF PENNA.
3400 SPRUCE STREET
PHILADELPHIA, PA. 19104

DR. SAMUEL GELMAN
EXECUTIVE DIRECTOR
JEWISH HOSPITAL OF BROOKLYN
555 PROSPECT PLACE
BROOKLYN, NEW YORK 11238

MR. GEORGE A. HAY
ADMINISTRATIVE VICE PRESIDENT
HOSP. OF THE WOMANS MED. COLL. PA.
3300 HENRY AVENUE
PHILADELPHIA, PENNSYLVANIA 19129

MR. DAVID A. GEE
EXECUTIVE DIRECTOR
JEWISH HOSPITAL OF ST. LOUIS
216 S. KINGSHIGHWAY BLVD.
ST. LOUIS, MISSOURI 63110

DR. PIERRE NADEAU
HOTEL DIEU DE MONTREAL
3840 ST. URBAIN STREET
MONTREAL, QUEBEC, CANADA

CHARLES GELLMAN
EXECUTIVE DIRECTOR
JEWISH MEMORIAL HOSPITAL
BROADWAY & 196TH ST.
NEW YORK, NEW YORK 10040

MR. E. W. MILLER
EXECUTIVE DIRECTOR
HURON ROAD HOSPITAL
13951 TERRACE ROAD
CLEVELAND, OHIO 44112

MR. OSCAR MARVIN
ADMINISTRATOR
JOHN GASTON HOSPITAL
860 MADISON AVENUE
MEMPHIS, TENNESSEE 38103

ROBERT E. MACK, M.D.
MEDICAL DIRECTOR
HUTZEL HOSPITAL
432 EAST HANCOCK
DETROIT, MICHIGAN 48201

DR. RUSSELL A. NELSON
PRESIDENT
JOHNS HOPKINS HOSPITAL
601 N. BROADWAY
BALTIMORE, MARYLAND 21205

DR. RICHARDSON K. NOBACK
DIRECTOR
KANSAS CITY GENL. HOSP. & MFD. CTR.
24TH AND CHERRY STS.
KANSAS CITY, MISSOURI 64108

LESLIE R. SMITH
HOSPITAL ADMINISTRATOR
L.A. COUNTY HARBOR GENERAL HOSPITAL
1000 WEST CARSON
TORRANCE, CALIFORNIA 90509

DR. SANDER SMITH
HOSPITAL ADMINISTRATOR
KINGS COUNTY HOSPITAL CENTER
451 CLARKSON AVENUE
BROOKLYN, NEW YORK 11203

MR. JOHN B. BUSCHEMEYER
DIRECTOR
LOUISVILLE GENERAL HOSPITAL
232 EAST CHESTNUT ST.
LOUISVILLE, KENTUCKY 40202

MR. DONALD M. MAC INTYRE
SUPERINTENDENT
KINGSTON GENERAL HOSPITAL
STUART STREET
KINGSTON, ONTARIO, CANADA

MR. LAD F. GRAPSKI
DIRECTOR - ASSOC. DEAN HOSP. ADMIN.
LOYOLA UNIVERSITY HOSPITAL
706 S. WOLCOTT AVENUE
CHICAGO, ILLINOIS 60612

MR. LOUIS SCHENKWEILER
VICE-PRESIDENT & ADMINISTRATOR
LENOX HILL HOSPITAL
100 EAST 77TH STREET
NEW YORK, NEW YORK 10021

MR. GEORGE ADAMS
EXECUTIVE DIRECTOR
LUTHERAN MEDICAL CENTER
4520 FOURTH AVENUE
BROOKLYN, NEW YORK 11220

DR. NASRY MICHELEN
HOSPITAL ADMINISTRATOR
LINCOLN HOSPITAL
320 CONCORD AVENUE
NEW YORK CITY, NEW YORK 10454

C. R. YOUNGQUIST
EXECUTIVE DIRECTOR
MAGEE-WOMENS HOSPITAL
FORBES AVENUE AND HALKET STREET
PITTSBURGH, PENNSYLVANIA 15213

SISTER MARY CHRISTOPHER, M.H.A.
ADMINISTRATOR
LITTLE COMPANY OF MARY HOSP., INC.
2800 W. 95TH ST.
EVERGREEN PARK, ILLINOIS 60642

DR. IRVIN J. COHEN
DIRECTOR
MAIMONIDES HOSPITAL OF BROOKLYN
4802 10TH AVENUE
BROOKLYN, NEW YORK 11219

MR. CLARENCE A. MILLER
ADMINISTRATOR
LOMA LINDA UNIVERSITY HOSPITAL
11055 ANDERSON STREET
LOMA LINDA, CALIFORNIA 92354

MR. PHILIP K. REIMAN
DIRECTOR
MAINE MEDICAL CENTER
22 BRAMHALL STREET
PORTLAND, MAINE 04104

MR. WILLIAM K. KLEIN
DIRECTOR
LONG ISLAND COLLEGE HOSPITAL
340 HENRY STREET
BROOKLYN, NEW YORK 11201

DR. ARVINE G. POPPLEWELL
DIRECTOR OF HOSPITALS
MARION COUNTY GENERAL HOSPITAL
960 LOCKE STREET
INDIANAPOLIS, INDIANA 46207

DR. PETER ROGATZ
EXECUTIVE DIRECTOR
LONG ISLAND JEWISH HOSPITAL
270-05 76TH AVENUE
NEW HYDE PARK, NEW YORK 11043

MR. LESTER RICHWAGEN
EXEC. VICE-PRES. & ADMINISTRATOR
MARY FLETCHER HOSPITAL
COLCHESTER AVENUE
BURLINGTON, VERMONT 05401

MR. DAVID ODELL
DIRECTOR
LOS ANGELES COUNTY GENERAL HOSPITAL
1200 NORTH STATE STREET
LOS ANGELES, CALIF. 90033

MR. WILLIAM L. WILSON
ADMINISTRATOR
MARY HITCHCOCK MEMORIAL HOSPITAL
2 MAYNARD STREET
HANOVER, NEW HAMPSHIRE 03755

DR. JAMES BORDLEY III, M.D.
DIRECTOR
MARY IMOGENE BASSETT HOSPITAL
ATWELL ROAD
COOPERSTOWN, NEW YORK 13326

MR. RICHARD D. VANDERWARKER
EXECUTIVE VICE PRESIDENT
MEM. HOSP. FOR CANCER & ALLIED DIS.
444 EAST 68TH STREET
NEW YORK, NEW YORK 10021

MR. STEWART B. CRAWFORD
SUPERINTENDENT
MARYLAND GENERAL HOSPITAL
827 LINDEN AVENUE
BALTIMORE, MARYLAND 21201

MR. DONALD C. CARNER
EXECUTIVE VICE-PRESIDENT
MEMORIAL HOSPITAL OF LONG BEACH
2801 ATLANTIC AVENUE
LONG BEACH, CALIFORNIA 90801

MR. CHARLES T. WOOD
DIRECTOR
MASSACHUSETTS EYE & EAR INFIRMARY
243 CHARLES STREET
BOSTON, MASSACHUSETTS 02114

MR. ELLIOTT C. ROBERTS
EXECUTIVE DIRECTOR
MERCY-DOUGLAS HOSPITAL
5000 WOODLAND AVENUE
PHILADELPHIA, PENNSYLVANIA 19143

DR. JOHN KNOWLES
GENERAL DIRECTOR
MASSACHUSETTS GENERAL HOSPITAL
FRUIT STREET
BOSTON, MASSACHUSETTS 02114

SISTER M. FERDINAND
ADMINISTRATOR
MERCY HOSPITAL OF PITTSBURGH
1400-30 LOCUST STREET
PITTSBURGH, PENNSYLVANIA 15219

DR. JACK R. EWALT
SUPERINTENDENT
MASSACHUSETTS MENTAL HEALTH CENTER
74 FENWOOD DRIVE
BOSTON, MASSACHUSETTS 02115

SISTER MARY GWENDOLINE R.S.M.
ADMINISTRATOR
MERCY MEDICAL CENTER
2537 SOUTH PRAIRIE AVENUE
CHICAGO, ILLINOIS 60616

MR. WARREN RAYMAN
ADMINISTRATOR
MAUMEE VALLEY HOSPITAL
2025 ARLINGTON AVENUE
TOLEDO, OHIO 43609

MR. TED BOWEN
ADMINISTRATOR
THE METHODIST HOSPITAL
6516 BERTNER AVENUE
HOUSTON, TEXAS 77025

DR. JAMES F. COLLINS
SUPERINTENDENT
MEADOWBROCK HOSPITAL
CARMEN AVE. & BETHPAGE TURNPIKE
EAST MEADOW, LI., NEW YORK 11554

MR. J. M. CREWS
ADMINISTRATOR
METHODIST HOSPITAL
1265 UNION AVENUE
MEMPHIS, TENNESSEE 38104

MR. GLEN D. SEARCY
SUPERINTENDENT
MEDICAL COLLEGE HOSPITAL
55 DOUGHTY STREET
CHARLESTON, SOUTH CAROLINA 29401

MR. VERNON STUTZMAN
DIRECTOR
METHODIST HOSPITAL OF BROOKLYN
506 6TH STREET
BROOKLYN, NEW YORK 11215

MR. CHARLES P. CARDWELL
DIRECTOR
MED. COLL. OF VIRGINIA HOSP. DIV.
1200 EAST BROAD STREET
RICHMOND, VIRGINIA 23219

DR. JACK A. L. HAHN
EXECUTIVE DIRECTOR
METHODIST HOSPITAL OF INDIANA, INC.
16TH AND NORTH CAPITOL AVENUE
INDIANAPOLIS, INDIANA 46207

MR. CHARLES SHOWALTER
ADMINISTRATOR
MEMORIAL HOSPITAL
3200 NOYES AVENUE, S.E.
CHARLESTON, WEST VIRGINIA 25304

MR. WILLIAM J. SILVERMAN
DIRECTOR
MICHAEL REESE HOSPITAL
2900 S. ELLIS AVENUE
CHICAGO, ILLINOIS 60616

MR. LEON CARSON
ADMINISTRATOR
MILLARD FILLMORE HOSPITAL
3 GATES CIRCLE
BUFFALO, NEW YORK 14209

MR. NATHAN HELMAN
EXECUTIVE VICE-PRESIDENT
MOUNT SINAI HOSPITAL
2755 WEST 15TH PLACE
CHICAGO, ILLINOIS 60608

MR. EDWARD J. LOGAN
ADMINISTRATOR
MILWAUKEE CHILDRENS HOSPITAL
1700 W. WISCONSIN AVENUE
MILWAUKEE, WISCONSIN 53233

MR. SIDNEY LEWINE
DIRECTOR
MOUNT SINAI HOSPITAL OF CLEVELAND
UNIVERSITY CIRCLE
CLEVELAND, OHIO 44106

MR. DEAN ROE
ADMINISTRATOR
MILWAUKEE PSYCHIATRIC HOSPITAL
1220 DEWEY AVENUE
MILWAUKEE, WISCONSIN 53213

DR. HERBERT FREILICH
ADMINISTRATOR
MOUNT SINAI CITY HOSPITAL CENTER
79-01 BROADWAY
ELMHURST, NEW YORK 11373

SISTER PETER MARY, R.S.M.
ADMINISTRATOR
MISERICORDIA HOSPITAL
54TH AND CEDAR AVENUE
PHILADELPHIA, PENNSYLVANIA 19143

MR. SAMUEL GERTNER
EXECUTIVE VICE-PRESIDENT
MOUNT SINAI HOSP. OF GREATER MIAMI
4300 ALTON ROAD
MIAMI BEACH, FLORIDA 33140

MR. WINSTON C. WHITFIELD
ADMINISTRATOR
MOBILE GENERAL HOSPITAL
2451 FILLINGIM STREET
MOBILE, ALABAMA 34417

DR. MARTIN R. STEINBERG
DIRECTOR
MOUNT SINAI HOSPITAL
11 EAST 100TH ST.
NEW YORK, NEW YORK 10029

DR. MARTIN CHERKASKY
DIRECTOR
MONTEFIORE HOSP. & MEDICAL CENTER
111 EAST 210TH ST.
BRONX, NEW YORK 10467

MR. MARK BERKE
DIRECTOR
MOUNT ZION HOSP. & MEDICAL CENTER
2600 DIVISADERO ST.
SAN FRANCISCO, CALIFORNIA 94115

IRWIN GOLDBERG
EXECUTIVE DIRECTOR
MONTEFIORE HOSPITAL
3459 5TH AVENUE
PITTSBURGH, PENNSYLVANIA 15213

MR. CHARLES D. TREXLER
ADMINISTRATOR
NATIONAL CHILDRENS CARDIAC HOSPITAL
1475 N.W. 12TH AVENUE
MIAMI, FLORIDA 33136

MR. MARTIN KAPLAN
EXECUTIVE DIRECTOR
MOSS REHABILITATION HOSPITAL
12TH ST. & TABOR ROAD
PHILADELPHIA, PENNSYLVANIA 19141

BLISS B. CLARK, M.D.
EXECUTIVE DIRECTOR
THE NEW BRITAIN GENERAL HOSPITAL
100 GRAND STREET
NEW BRITAIN, CONNECTICUT 06050

SISTER M. LOLITA, C.S.C.
ADMINISTRATOR
MOUNT CARMEL HOSPITAL
793 WEST STATE STREET
COLUMBUS, OHIO 43222

MR. RICHARD VIGUERS
ADMINISTRATOR
NEW ENGLAND MEDICAL CENTER HOSPITAL
171 HARRISON AVE. AND BENNET
BOSTON, MASSACHUSETTS 02111

SISTER MARY DOLORA, R.S.M.
HOSPITAL ADMINISTRATOR
MOUNT CARMEL MERCY HOSPITAL
6071 WEST OUTER DRIVE
DETROIT, MICHIGAN 48235

DR. HENRY N. PRATT
DIRECTOR
NEW YORK HOSPITAL
525 EAST 68TH STREET
NEW YORK, NEW YORK 10021

MISS ANNA SAUNDERS
ADMINISTRATOR
NEW YORK INFIRMARY
STUYVESANT SQUARE EAST & 15TH ST.
NEW YORK, N.Y. 10003

MR. JACK PRICE
ADMINISTRATOR
PARKLAND MEMORIAL HOSPITAL
5201 HARRY HINES BLVD.
DALLAS, TEXAS 75235

DR. J. A. ROSENKRANTZ
EXECUTIVE DIRECTOR
NEWARK BETH ISRAEL HOSPITAL
201 LYONS AVENUE
NEWARK, NEW JERSEY 07112

MR. H. ROBERT CATHCART
DIRECTOR
PENNSYLVANIA HOSPITAL
8TH AND SPRUCE STREET
PHILADELPHIA, PA. 19107

MR. REID T. HOLMES
ADMINISTRATOR
NORTH CAROLINA BAPTIST HOSPITAL
300 S. HAWTHORNE ROAD
WINSTON-SALEM, N. C. 27103

DR. F. LLOYD MUSSELLS
DIRECTOR
PETER BENT BRIGHAM HOSPITAL
721 HUNTINGTON AVENUE
BOSTON, MASSACHUSETTS 02115

MR. EUGENE B. CRAWFORD, JR.
DIRECTOR
NORTH CAROLINA MEMORIAL HOSPITAL
PITTSBURO ROAD
CHAPEL HILL, NORTH CAROLINA 27514

DR. HENRY W. KOLBE
EXECUTIVE DIRECTOR
PHILADELPHIA GENERAL HOSPITAL
34TH STREET AND CURIE AVENUE
PHILADELPHIA, PENNSYLVANIA 19104

MR. H. E. HAMILTON
DIRECTOR
OCHSNER FOUNDATION HOSPITAL
1516 JEFFERSON HIGHWAY
NEW ORLEANS, LOUISIANA 70121

DR. GERALD L. HAIDAK
DIRECTOR, MEDICAL EDUCATION
PITTSFIELD AFFILIATED HOSPITALS
379 EAST STREET
PITTSFIELD, MASSACHUSETTS 01201

MR. BERNARD J. LACHNER
ADMINISTRATOR
OHIO STATE UNIVERSITY HOSPITAL
410 WEST 10TH AVENUE
COLUMBUS, OHIO 43210

ROY R. ANDERSON
EXECUTIVE DIRECTOR
PRESBYTERIAN HOSPITAL
EAST 19TH AVENUE AND GILPIN
DENVER, COLORADO 80218

LEE S. SANDERS
EXECUTIVE VICE-PRESIDENT
ORTHOPEAEDIC HOSPITAL OF LOS ANGELES
2400 SOUTH FLOWER STREET
LOS ANGELES, CALIF. 90007

MR. A. J. BINKERT
EXECUTIVE VICE PRESIDENT
PRESBYTERIAN HOSPITAL CITY OF N.Y.
622 WEST 168TH STREET
NEW YORK, NEW YORK 10032

DR. DOUGLAS R. PEART
EXECUTIVE DIRECTOR
OTTAWA CIVIC HOSPITAL
CARLING AVENUE
OTTAWA 3, ONTARIO, CANADA

DR. JAMES A. CAMPBELL
PRESIDENT
PRESBYTERIAN-ST. LUKES HOSPITAL
1753 W. CONGRESS STREET
CHICAGO, ILLINOIS 60612

DR. LE ROY BATES
EXECUTIVE VICE-PRESIDENT & DIRECTOR
PALO ALTO-STANFORD HOSPITAL CENTER
300 PASTEUR DRIVE
PALO ALTO, CALIFORNIA 94304

MR. JACK W. SHRODE
ADMINISTRATOR
OKLAHOMA PRESBYTERIAN HOSPITAL
300 NW 12TH STREET
OKLAHOMA CITY, OKLAHOMA 73103

MR. JOHN STAGL
DIRECTOR
PASSAVANT HOSPITAL
303 EAST SUPERIOR STREET
CHICAGO, ILLINOIS 60611

MR. EDWARD H. NOROIAN
EXECUTIVE DIRECTOR
PRESBYTERIAN-UNIVERSITY HOSPITAL
230 LATHROP STREET
PITTSBURGH, PENNSYLVANIA 15213

MR. CARL MOSHER
DIRECTOR
PRESBYTERIAN-UNIV. PENN. MED. CNTR.
51 NORTH 39TH STREET
PHILADELPHIA, PENNSYLVANIA 19104

DR. CHRISTOPHER PARNALL, ADMIN.
ROCHESTER GENERAL HOSPITAL
NORTHSIDE DIVISION
1425 PORTLAND AVENUE
ROCHESTER, NEW YORK 14621

MR. C. EDWARD DEAN III
ADMINISTRATOR
PRESBYTERIAN MEDICAL CENTER
CLAY & WEBSTER STREETS
SAN FRANCISCO, CALIFORNIA 94115

MR. PETER B. TERENCE
EXECUTIVE VICE PRESIDENT
ROOSEVELT HOSPITAL
428 WEST 59TH STREET
NEW YORK, N.Y. 10019

MR. HARRY W. PENN, JR.
ADMINISTRATOR
PRINCE GEORGES GENERAL HOSPITAL
CHEVERLY, MARYLAND 20783

SISTER ALBERTA
ADMINISTRATOR
SAINT AGNES HOSPITAL
CATON & WILKENS AVENUES
BALTIMORE, MARYLAND 21229

SISTER IRENE
ADMINISTRATOR
PROVIDENCE HOSPITAL
16001 NINE MILE ROAD
SOUTHFIELD, MICHIGAN 48076

MR. WILLIAM R. HOWES
ADMINISTRATOR
ST. CHRISTOPHERS HOSP. FOR CHILDREN
2600 N. LAWRENCE ST.
PHILADELPHIA, PENNSYLVANIA 19133

SISTER MARGARET EILEEN
ADMINISTRATOR
PROVIDENCE HOSPITAL
1150 VARNUM STREET, N.E.
WASHINGTON, D.C. 20017

SISTER M. JOHN KEVIN, O.S.F.
ADMINISTRATOR
SAINT CLARES HOSPITAL
415 WEST 51ST STREET
NEW YORK, NEW YORK 10019

MR. WILL J. HENDERSON
ADMINISTRATOR
THE QUEENS HOSPITAL
1301 PUNCHBOWL
HONOLULU, HAWAII 96813

SISTER M. CONSOLATA
ADMINISTRATOR
SAINT ELIZABETH HOSPITAL
1044 BELMONT AVENUE
YOUNGSTOWN, OHIO 44505

DR. PHILIP J. KAHAN
HOSPITAL ADMINISTRATOR - MEDICAL
QUEENS HOSP. CNTR.-LONG ISL. JEWISH
82-68 164TH STREET
JAMAICA, NEW YORK 11432

DR. JOHN T. RATTIGAN
GENERAL DIRECTOR
SAINT ELIZABETHS HOSPITAL OF BOSTON
736 CAMBRIDGE STREET
BRIGHTON, MASSACHUSETTS 02135

MR. E. ATWOOD JACOBS
ADMINISTRATOR
READING HOSPITAL
6TH AVE. AND SPRUCE STREET
READING PENNSYLVANIA 19602

SISTER M. GERTRUDIS, O.S.F.
ADMINISTRATOR
ST. FRANCIS HOSPITAL
355 RIDGE AVENUE
EVANSTON, ILLINOIS 60202

MR. ALAN H. TOPPEL
ADMINISTRATOR
REHABILITATION INSTITUTE OF CHICAGO
401 E. OHIO ST.
CHICAGO, ILLINOIS 60611

SISTER MARY MADELEINE
ADMINISTRATOR
ST. FRANCIS HOSPITAL
114 WOODLAND STREET
HARTFORD, CONNECTICUT 06105

HORACE F. ALTMAN
ADMINISTRATOR
ROBERT BRECK BRIGHAM HOSPITAL
125 PARKER HILL AVENUE
BOSTON, MASSACHUSETTS

SISTER M. ADELE, O.S.F.
ADMINISTRATOR
SAINT FRANCIS GENERAL HOSPITAL
45TH STREET OFF PENN AVENUE
PITTSBURGH, PENNSYLVANIA 15201

SISTER MARY OSWALDINA
ADMINISTRATOR
SAINT FRANCIS HOSPITAL
929 NO. ST. FRANCIS AVENUE
WICHITA, KANSAS 67214

MR. KENNETH J. SHOOS
SUPERINTENDENT
ST. LUKES HOSP. OF THE METH. CHURCH
11311 SHAKER BOULEVARD
CLEVELAND, OHIO 44104

MR. PAUL J. CONNOR, JR.
DIRECTOR
ST. JOHNS EPISCOPAL HOSPITAL
480 HERKIMER STREET
BROOKLYN, NEW YORK 11213

DR. JACQUES BERNIER
SAINT LUKES HOSPITAL
1058 ST. DENIS STREET
MONTREAL, QUEBEC, CANADA

SISTER MARY ISIDORE LENNON, R.S.M.
ADMINISTRATOR
SAINT JOHNS MERCY HOSPITAL
615 SOUTH NEW BALLAS ROAD
ST. LOUIS, MISSOURI 63141

MR. CHARLES W. DAVIDSON
EXECUTIVE DIRECTOR
SAINT LUKES HOSPITAL CENTER
AMSTERDAM AVENUE AT 114TH STREET
NEW YORK, N.Y. 10025

SISTER MARY ELIZABETH
ADMINISTRATOR
SAINT JOSEPHS HOSPITAL
GROSVENOR STREET, N.
LONDON, ONTARIO, CANADA

SISTER MARGARET
ADMINISTRATOR
ST. MARYS HOSPITAL
89 GENESEE STREET
ROCHESTER, NEW YORK 14511

SISTER M. MONICA
ADMINISTRATOR
SAINT JOSEPHS HOSPITAL
350 W. THOMAS ROAD
PHOENIX, ARIZONA 85013

SISTER M. ROSARIA, S.F.P.
ADMINISTRATOR
SAINT MICHAEL HOSPITAL
306 HIGH STREET
NEWARK, NEW JERSEY 07102

SISTER MARY LEONETTE R.N.
ADMINISTRATOR
SAINT JOSEPH MERCY HOSPITAL
326 N. INGALLS STREET
ANN ARBOR, MICHIGAN 48104

SISTER ELIZABETH, FACHA
ADMINISTRATOR
ST. PAUL HOSPITAL
5909 HARRY HINES BOULEVARD
DALLAS, TEXAS 75235

SISTER M. XAVIER RSM
ADMINISTRATOR
ST. JOSEPHS MERCY HOSPITAL
900 WOODWARD AVENUE
PONTIAC, MICHIGAN 48053

THOMAS E. BROADIE M. D.
SUPERINTENDENT
SAINT PAUL RAMSEY HOSPITAL
1640 JACKSON STREET
ST. PAUL, MINNESOTA

MISS LILLY HOEKSTRA
ADMINISTRATOR
SAINT LOUIS CHILDRENS HOSPITAL
500 S. KINGSHIGHWAY BLVD.
ST. LOUIS, MISSOURI 63110

SISTER JOHN GABRIEL
ADMINISTRATOR
ST. THOMAS HOSPITAL
2000 HAYES STREET
NASHVILLE, TENNESSEE 37203

DR. ERNEST N. BOETTCHER
DIRECTOR
SAINT LOUIS UNIVERSITY HOSPITALS
1325 SOUTH GRAND AVENUE
ST. LOUIS, MISSOURI 63104

SISTER CLAIR
ADMINISTRATOR
SAINT VINCENTS HOSPITAL
2820 MAIN STREET
BRIDGEPORT, CONNECTICUT 06606

MR. RICHARD L. SUCK
ADMINISTRATOR
SAINT LUKES HOSPITAL
801 OSTRUM STREET
BETHLEHEM, PENNSYLVANIA 18015

SISTER VIRGINA
ADMINISTRATOR
ST. VINCENTS HOSPITAL
BARRS AND ST. JOHNS AVENUE
JACKSONVILLE, FLORIDA 32203

SISTER ANTHONY MARIE
ADMINISTRATOR
ST. VINCENTS HOSP. & MED. CNTR. NY.
153 WEST 11TH STREET
NEW YORK, NEW YORK 10011

DR. ARTHUR D. NELSON
DIRECTOR
TEMPLE UNIVERSITY HOSPITAL
3401 N. BROAD ST.
PHILADELPHIA, PENN. 19140

HAROLD G. BARRY, LT. COLONEL
ADMINISTRATOR
SALVATION ARMY BOOTH MEMORIAL HOSP.
MAIN ST. AT BOOTH MEMORIAL AVE.
FLUSHING, NEW YORK 11355

MR. NEWELL FRANCE
ADMINISTRATOR
TEXAS CHILDRENS HOSPITAL
6621 FANNIN STREET
HOUSTON, TEXAS 77025

A. F. CRUMLEY, M.D.
ADMINISTRATOR
SAN DIEGO COUNTY-UNIV. HOSPITAL
225 WEST DICKINSON STREET
SAN DIEGO, CALIFORNIA 92103

DR. R. J. NODWELL
MEDICAL SUPERINTENDENT
TORONTO WESTERN HOSPITAL
399 BATHURST STREET
TORONTO 2, ONTARIO, CANADA

DR. FERNANDO A. BATLLE
MEDICAL DIRECTOR
SAN JUAN CITY HOSPITAL
PUERTO RICO MEDICAL CENTER
RIO PIEDRAS, PUERTO RICO

DR. H. S. MAYERSON
ACTING EXECUTIVE DIRECTOR
TOURO INFIRMARY
1400 FOUCHER ST.
NEW ORLEANS, LOUISIANA 70115

MR. HERLUF V. OLSON, JR.
DIRECTOR
SHANDS TEACHING HOSP. & CLINICS
UNIVERSITY OF FLORIDA
GAINESVILLE, FLORIDA 32601

MR. B. LEE MOOTZ
DIRECTOR
UNION MEMORIAL HOSPITAL
33RD AND CALVERT STREETS
BALTIMORE, MARYLAND 21218

DR. ARNOLD B. KURLANDER
EXECUTIVE DIRECTOR
SINAI HOSPITAL OF BALTIMORE
BELVEDERE AVE. AND GREENSPRING
BALTIMORE, MARYLAND 21215

DR. MERLIN L. BRUBAKER
MEDICAL OFFICER IN CHARGE
U. S. PUBLIC HEALTH SERVICE HOSP
CARVILLE, LOUISIANA

DR. JULIAN PRIVER
EXECUTIVE VICE-PRESIDENT
SINAI HOSPITAL OF DETROIT
6767 W. OUTER DRIVE
DETROIT, MICH. 48235

ROBERT W. RASOR, M.D.
EXEC. DIRECTOR/MED. OFCR. IN CHARGE
U.S. PUBLIC HEALTH SERVICE HOSPITAL
BOX 2000
LEXINGTON, KENTUCKY 40501

MR. HARRY C. F. GIFFORD
EXECUTIVE DIRECTOR
SPRINGFIELD HOSPITAL
759 CHESTNUT STREET
SPRINGFIELD, MASSACHUSETTS 01107

DR. JOHN J. WALSH
MEDICAL DIRECTOR-MED. OFCR. IN CHG.
U. S. PUBLIC HEALTH SERVICE HOSP.
210 STATE STREET
NEW ORLEANS, LOUISIANA 70118

MR. JAMES H. ABBOTT
ADMINISTRATOR
STATE UNIV. HOSP. UPSTATE MED. CTR.
750 E. ADAMS STREET
SYRACUSE, NEW YORK 13210

DR. J. FRED OESTERLE
MEDICAL DIRECTOR IN CHARGE
U.S. PUBLIC HEALTH SERVICE HOSP.
P. O. BOX 3145
SEATTLE, WASHINGTON 98144

DR. LEONARD FENNINGER
MEDICAL DIRECTOR
STRONG MEMORIAL HOSPITAL
260 CRITTENDEN BLVD.
ROCHESTER, NEW YORK 14620

MR. GEORGE A. MILLER
ADMINISTRATOR
UNITY HOSPITAL
1545 ST. JOHNS PLACE
BROOKLYN, NEW YORK 11213

DR. JOSE NINE CURT
MEDICAL DIRECTOR
UNIVERSITY DISTRICT HOSPITAL
CAPARRA HEIGHTS STATION
RIO PIEDRAS, PUERTO RICO 00935

MR. RUSSELL H. MILLER
ASSOCIATE DIRECTOR
UNIVERSITY OF KANSAS MEDICAL CENTER
RAINBOW BLVD. & 39TH STREET
KANSAS CITY 12, KANSAS 66103

MR. JOHN F. HARLAN
DIRECTOR
UNIVERSITY OF VIRGINIA HOSPITAL
JEFFERSON PARK AVENUE
CHARLOTTESVILLE, VIRGINIA 22903

DONALD J. CASELEY, M.D.
MEDICAL DIRECTOR
U. OF ILL. RESEARCH & EDUC. HOSPS.
840 SOUTH WOOD STREET
CHICAGO, ILLINOIS 60612

MR. VERNON L. HARRIS
ADMINISTRATOR
UNIVERSITY OF UTAH HOSPITAL
50 N. MEDICAL DRIVE
SALT LAKE CITY, UTAH 84112

MR. STANLEY A. FERGUSON
DIRECTOR
UNIVERSITY HOSPITALS OF CLEVELAND
2065 ADELBERT ROAD
CLEVELAND, OHIO 44106

MR. DANIEL BOBBITT
GENL. ADMINISTRATOR OF UNIV. HOSPS.
UNIV. OF TEX. MEDICAL BRANCH HOSPS.
8TH AND MECHANIC STREETS
GALVESTON, TEXAS 77550

MR. ROBERT C. TERRILL
ADMINISTRATOR
UNIVERSITY HOSPITALS
800 N.E. 13TH STREET
OKLAHOMA CITY, OKLAHOMA 73104

MR. JAMES E. FERGUSON
ADMINISTRATOR
U. TENN. MEM. RESEARCH CN. & HOSP.
1924 ALCOA HIGHWAY
KNOXVILLE, TENNESSEE 37920

MR. EDWARD CONNORS
SUPERINTENDENT
UNIVERSITY HOSPITALS
1300 UNIVERSITY AVENUE
MADISON, WISCONSIN 57706

DR. CHARLES N. HOLMAN
DIRECTOR
U. OF OREGON MED. SCH. HOSP. & CL.
3181 S.W. SAM JACKSON PARK ROAD
PORTLAND, OREGON 97201

DR. GERHARD HARTMAN, PH.D.
SUPERINTENDENT
UNIVERSITY HOSPITALS
NEWTON ROAD
IOWA CITY, IOWA 52240

MR. RICHARD C. SCHRIPEMA
MHA HOSPITAL DIRECTOR
UNIV. OF NEBRASKA HOSPITAL
42ND AND DEWEY AVENUE
OMAHA, NEBRASKA 68105

MR. LEROY RAMBECK
ADMINISTRATOR
UNIVERSITY HOSPITAL
1959 N.E. PACIFIC STREET
SEATTLE, WASHINGTON 98105

VERNON E. WILSON, M.D.
DIRECTOR
UNIV. OF MISSOURI MEDICAL CENTER
807 STADIUM ROAD
COLUMBIA, MISSOURI 65201

MR. EARL DICK
EXECUTIVE DIRECTOR
UNIVERSITY HOSPITAL
SASKATOON, SASKATCHEWAN, CANADA

MR. JOHN WESTERMAN
UNIV. OF MINNESOTA HOSPITALS
412 UNION STREET, S.E.
MINNEAPOLIS, MINNESOTA 55455

MR. IRVIN G. WILMOT
ADMINISTRATOR
UNIV. HOSP. OF N.Y. MED. CTR.
560 FIRST AVENUE
NEW YORK, NEW YORK 10016

MR. RICHARD WITTRUP
ADMINISTRATOR
UNIVERSITY OF KENTUCKY HOSPITAL
800 ROSE STREET
LEXINGTON, KENTUCKY 40506

MR. ROBERT C. HARDY
ADMINISTRATOR
UNIVERSITY HOSPITAL
4301 WEST MARKHAM STREET
LITTLE ROCK, ARKANSAS 72205

DR. DAVID B. WILSON
DIRECTOR
UNIVERSITY HOSPITAL
2500 N. STATE ST.
JACKSON, MISSISSIPPI 39216

F. W. G. RUDDICK
EXECUTIVE DIRECTOR
VANCOUVER GENERAL HOSPITAL
12TH & HEATHER STREET
VANCOUVER 9, B.C., CANADA

MR. NELSON EVANS
ADMINISTRATOR
UNIVERSITY HOSPITAL, INC.
750 HARRISON AVENUE
BOSTON, MASSACHUSETTS 02118

DR. RICHARD O. CANNON
DIRECTOR
VANDERBILT UNIVERSITY HOSPITAL
1161 21ST AVENUE, S.
NASHVILLE, TENNESSEE 37203

DR. GEORGE H. YEAGER
DIRECTOR
UNIVERSITY HOSPITAL
REDWOOD AND GREENE STREETS
BALTIMORE, MARYLAND 21201

DR. RICHARD BEAN
MANAGER
VETERANS ADMINISTRATION HOSPITAL
113 HOLLAND AVENUE
ALBANY, NEW YORK 12208

DR. A. C. KERLIKOWSKE
DIRECTOR
UNIVERSITY HOSPITAL
1405 EAST ANN STREET
ANN ARBOR, MICHIGAN 48104

DR. A. J. KLIPPEN
DIRECTOR
VETERANS ADMIN. HOSPITAL
2215 FULLER ROAD
ANN ARBOR, MICHIGAN 48105

DR. GEORGE TYNER
ASSOC. DEAN & ASST V.P. MED. AFFAIR
UNIV. OF COLORADO MEDICAL CENTER
4200 EAST 9TH AVENUE
DENVER, COLORADO 80220

JOHN G. HOOD, M.D.
DIRECTOR
VETERANS ADMINISTRATION HOSPITAL
5189 PEACHTREE ROAD, N.E.
ATLANTA, GEORGIA 30319

MR. CHARLES GOULET
SUPERINTENDENT
UNIV. OF CHICAGO HOSPITALS & CLINIC
950 EAST 59TH STREET
CHICAGO, ILLINOIS 60637

DR. E. P. BRANNON
DIRECTOR
VETERANS ADMINISTRATION HOSPITAL
WRIGHTSBORO ROAD
AUGUSTA, GEORGIA 30904

MR. HAROLD H. HIXSON
ADMINISTRATOR
U. OF CALIF. HOSPS. - S.F. MED. CN.
PARNASSUS AND THIRD AVENUES
SAN FRANCISCO, CALIF. 94122

MR. CLYDE G. COX
DIRECTOR
VETERANS ADMINISTRATION HOSPITAL
700 S. 19TH STREET
BIRMINGHAM, ALABAMA 35233

DR. BALDWIN G. LAMSON
DIRECTOR
UNIVERSITY OF CALIFORNIA HOSPITAL
10833 LE CONTE AVENUE
LOS ANGELES, CALIFORNIA 90024

DR. P. R. CASESA
DIRECTOR
VETERANS ADMINISTRATION HOSPITAL
800 POLY PLACE
BROOKLYN, NEW YORK 11209

DR. BERNARD SNELL
EXECUTIVE DIRECTOR
UNIVERSITY OF ALBERTA HOSPITAL
112TH STREET & 84TH AVENUE
EDMONTON, ALBERTA, CANADA

DR. HERBERT FINEBERG
DIRECTOR
VETERANS ADMINISTRATION HOSPITAL
3495 BAILEY AVENUE
BUFFALO, NEW YORK 14215

MR. MATTHEW F. MC NULTY, JR.
GENERAL DIRECTOR
UNIV. OF ALABAMA HOSPITALS & CLINIC
619 SOUTH 19TH STREET
BIRMINGHAM, ALABAMA 35233

MR. ROBERT L. RUSSELL
DIRECTOR
VETERANS ADMINISTRATION HOSPITAL
109 BEE ST.
CHARLESTON, SO. CAROLINA 29403

RUSSELL L. NORDSTROM
DIRECTOR
VETERANS ADMIN. RESEARCH HOSPITAL
333 E. HURON STREET
CHICAGO, ILLINOIS 60611

DR. JOHN FOLEY DEE
DIRECTOR
VETERANS ADMIN. WEST SIDE HOSPITAL
820 S. DAMEN AVENUE
CHICAGO, ILLINOIS 60612

MR. L. H. GUNTER
DIRECTOR
VETERANS ADMINISTRATION HOSPITAL
3200 VINE STREET
CINCINNATI, OHIO 45220

ALBERT TOMASULO, M.D.
DIRECTOR
VETERANS ADMIN. HOSPITAL
1200 ANASTASIA AVENUE
CORAL GABLES, FLORIDA 33134

DR. J. B. CHANDLER
DIRECTOR
VETERANS ADMINISTRATION HOSPITAL
4500 S. LANCASTER ROAD
DALLAS, TEXAS 75216

ALAN W. CHADWICK
DIRECTOR
VETERANS ADMIN. HOSPITAL
SOUTHFIELD & OUTER DRIVE
DEARBORN, MICHIGAN 48121

MR. NELSON A. JACKSON
HOSPITAL DIRECTOR
VETERANS ADMINISTRATION HOSP
FULTON STREET AND FRWIN ROAD
DURHAM, NORTH CAROLINA 27705

MR. REUBEN COHEN
ADMINISTRATOR
VETERANS ADMINISTRATION HOSPITAL
TREMONT AVENUE & S. CENTRE ST.
EAST ORANGE, NEW JERSEY 07019

MR. MALCOM RANDALL
DIRECTOR
VETERANS ADMINISTRATION HOSPITAL
GAINESVILLE, FLORIDA 32601

DR. LEE H. SCHLESINGER
DIRECTOR
VETERANS ADMIN. HOSPITAL
5TH AVENUE AND ROOSEVELT ROAD
HINES, ILLINOIS 60141

DR. JOHN W. CLAIBORNE, JR.
HOSPITAL DIRECTOR
VETERANS ADMINISTRATION HOSPITAL
2002 HOLCOMBE BLVD.
HOUSTON, TEXAS 77031

DR. JOSEPH J. FRANKEL
HOSPITAL DIRECTOR
VETERANS ADMINISTRATION HOSPITAL
1481 WEST 10TH STREET
INDIANAPOLIS, INDIANA 46207

DR. SAMUEL L. ASPIS
HOSPITAL DIRECTOR
VETERANS ADMINISTRATION HOSPITAL
4801 LINWOOD BOULEVARD
KANSAS CITY, MISSOURI 64128

DR. AARON S. MASON
DIRECTOR
VETERANS ADMINISTRATION HOSPITAL
LEESTOWN PIKE
LEXINGTON, KENTUCKY 40507

CHARLES S. MODICA, M.D.
DIRECTOR
WADSWORTH HOSPITAL - V.A. CENTER
WILSHIRE AND SAWTELLE BLVDS.
LOS ANGELES, CALIFORNIA 90073

M. GOTTLIEB, M.D.
DIRECTOR
VETERANS ADMINISTRATION HOSPITAL
2500 OVERLOOK TERRACE
MADISON, WISCONSIN 53705

DR. CLIFFORD C. WOODS
DIRECTOR
VETERANS ADMIN. HOSPITAL
PARK AVENUE AT GETWELL
MEMPHIS, TENNESSEE 38115

DR. EDWARD MANDELL
DIRECTOR
VETERANS ADMINISTRATION HOSPITAL
48TH AVENUE & 54TH STREET, SOUTH
MINNEAPOLIS, MINNESOTA 55417

DR. W. C. WILLIAMS
HOSPITAL DIRECTOR
VETERANS ADMINISTRATION HOSPITAL
1310 24TH AVENUE, S.
NASHVILLE, TENNESSEE 37203

DR. GEORGE W. HOBSON
HOSPITAL DIRECTOR
VETERANS ADMINISTRATION HOSPITAL
1601 PERDIDO STREET
NEW ORLEANS, LOUISIANA 70140

S. SELESNICK, M.D.
HOSPITAL DIRECTOR
VETERANS ADMINISTRATION HOSPITAL
FIRST AVE. & 24TH STREET
NEW YORK, NEW YORK 10010

DR. DONALD NOLAN
DIRECTOR
VETERANS ADMINISTRATION HOSPITAL
4435 BEACON AVENUE
SEATTLE, WASHINGTON 98108

DR. JOHN D. CHASE
DIRECTOR
VETERANS ADMINISTRATION HOSPITAL
921 N.E. 13TH STREET
OKLAHOMA CITY, OKLAHOMA 73104

DR. T. J. READY
DIRECTOR
VETERANS ADMIN. HOSPITAL
50 IRVING STREET, N.W.
WASHINGTON, D.C. 20422

DR. KENNETH BROWN
HOSPITAL DIRECTOR
VETERANS ADMINISTRATION HOSPITAL
4101 WOOLWORTH AVENUE
OMAHA, NEBRASKA 68105

MR. DAVID ANTON
HOSPITAL DIRECTOR
VETERANS ADMINISTRATION HOSPITAL
WEST SPRING STREET
WEST HAVEN, CONNECTICUT 06516

MR. LOWELL C. LIKE
DIRECTOR
VETERANS ADMINISTRATION HOSPITAL
3801 JUNIPERO SERRA BLVD.
PALO ALTO, CALIFORNIA 94304

JOHN V. SHEEHAN
DIRECTOR
VETERANS ADMINISTRATION HOSPITAL
1400 VETERANS OF FOREIGN WARS PKWY.
WEST ROXBURY, MASSACHUSETTS 02132

MR. WILLIAM J. DANN
DIRECTOR
VETERANS ADMINISTRATION HOSPITAL
UNIVERSITY AND WOODLAND AVES.
PHILADELPHIA, PENN. 19104

MR. WILLIAM B. SHEPPARD
CENTER DIRECTOR
VETERANS ADMIN. CENTER HOSPITAL
WHITE RIVER JUNCTION, VERMONT 05001

DAN J. MACER
DIRECTOR
VETERANS ADMINISTRATION HOSPITAL
UNIVERSITY DRIVE
PITTSBURGH, PENNSYLVANIA 15240

MR. D. C. FIRMIN
CENTER DIRECTOR
VETERANS ADMINISTRATION HOSPITAL
5000 W. NATIONAL AVENUE
WOOD, WISCONSIN 53193

DR. GEORGE R. CLAMMER
HOSPITAL DIRECTOR
VETERANS ADMINISTRATION HOSPITAL
SAM JACKSON PARK
PORTLAND, OREGON 97207

DR. C. M. BETHUNE
ADMINISTRATOR
VICTORIA GENERAL HOSPITAL
330 TOWER ROAD
HALIFAX, N.S., CANADA

DR. ROBERT J. SCOTT
DIRECTOR
VETERANS ADMINISTRATION HOSPITAL
1201 BROAD ROCK ROAD
RICHMOND, VIRGINIA 23225

DR. A. SWANSON
EXECUTIVE DIRECTOR
VICTORIA HOSPITAL
375 SOUTH STREET
LONDON, ONTARIO, CANADA

MR. S. H. FRANKS
ADMINISTRATOR
VETERANS ADMINISTRATION HOSPITAL
500 FOOTHILL DRIVE
SALT LAKE CITY, UTAH 84114

MR. RICHARD M. LOUGHERY
ADMINISTRATOR
WASHINGTON HOSPITAL CENTER
110 IRVING STREET, N.W.
WASHINGTON, D.C. 20010

DR. RALPH METHENY
HOSPITAL DIRECTOR
VETERANS ADMINISTRATION
42ND AND CLEMENT STREET
SAN FRANCISCO, CALIFORNIA 94121

H. J. WELLS, M.D.
GENERAL SUPERINTENDENT
WAYNE COUNTY GEN. HOSP. & INFIRMARY
ELOISE, MICHIGAN 48132

JAMES I. MC GUIRE
EXECUTIVE DIRECTOR
THE WESTERN PENNSYLVANIA HOSPITAL
4800 FRIENDSHIP AVENUE
PITTSBURGH, PENNSYLVANIA 15224

HARRY M. DORSEY
EXECUTIVE DIRECTOR
WESTERN PSYCHIATRIC INST. & CLINIC
3811 OHARA STREET
PITTSBURGH, PENNSYLVANIA 15213

MR. ERWIN J. REMBOLDT
ADMINISTRATOR
WHITE MEMORIAL MEDICAL CENTER
1720 BROOKLYN AVENUE
LOS ANGELES, CALIFORNIA 90033

DR. ERNEST C. SHORTLIFFE
EXECUTIVE DIRECTOR
WILMINGTON MEDICAL CENTER
P. O. BOX 1668
WILMINGTON, DELAWARE 19899

DR. L. O. BRADLEY
EXECUTIVE DIRECTOR
WINNIPEG GENERAL HOSPITAL
700 WILLIAM AVENUE
WINNIPEG 3, MANITOBA, CANADA

JOHN B. HUGHES
SUPERINTENDENT
WORCESTER CITY HOSPITAL
26 QUEEN STREET
WORCESTER, MASSACHUSETTS 01610

DR. ALBERT W. SNOKE
EXECUTIVE DIRECTOR
YALE-NEW HAVEN HOSPITAL
789 HOWARD AVENUE
NEW HAVEN, CONNECTICUT 06504

MR. GARRETT P. SNYDER
ADMINISTRATOR
YORK HOSPITAL
1001 S. GEORGE ST.
YORK, PENNSYLVANIA 17403

UN PAID - 12/30/66

TAB
6

* X B R M
L M O 100

ALLEGHENY GENERAL HOSP	PITTSBURGH PA	22828	500.00
CHILDREN HOSPITAL	LOUISVILLE KY	20962	500.00
CHILDRENS HOSP MED CTR	BOSTON MASS	20857	500.00
COLUMBIA HOSPITAL	COLUMBIA S C	22829	500.00
CUMBERLAND HOSP	BROOKLYN N Y	20995	500.00
DETROIT MEMORIAL HOSP	DETROIT MICH	20996	500.00
DEGOESBRIAND MEMORIAL HOSP	BURLINGTON VT	20952	500.00
DOUGLAS COUNTY HOSPITAL	OMAHA NEBR	20948	500.00
HARLEM HOSP CENTER	NEW YORK N Y	22031	500.00
HURON ROAD HOSPITAL	CLEVELAND OHIO	22005	500.00
HOTEL DIEU DE MONTREAL	MONTREAL QUE CAN	20971	166.66
JEWISH MEMORIAL HOSP	NEW YORK N Y	22007	500.00
KINGS COUNTY HOSPITAL CENTER	BROOKLYN N Y	20956	500.00
KINGSTON GENERAL HOSP	KINGSTON ONT CAN	20969	166.66
LOUISVILLE GENERAL HOSP	LOUISVILLE KY	20963	500.00
V A HOSPITAL	DURHAM N C	22043	500.00
MASS MENTAL HEALTH CTR	BOSTON MASS 02115	20859	500.00
MERCY-DOUGLASS HOSPITAL	PHILADELPHIA PA 19143	20895	500.00
MOSS REHABILITATION HOSPITAL	PHILADELPHIA PA	20950	500.00
NAT'L CHILDREN CARDIAC HOSP	MIAMI FLA	20960	500.00
NEW YORK INFIRMARY	NEW YORK N Y	22017	500.00
OKLAHOMA PRESBYTERIAN HOSP	OKLAHOMA CITY OKLA 73103	20853	500.00
PARKLAND MEMORIAL HOSPITAL	DALLAS TEXAS	20837	250.00
PETER BENT BRIGHAM HOSPITAL	BOSTON MASS 02115	20860	500.00
PHILADELPHIA GENERAL HOSP	PHILADELPHIA PA	20957	500.00
REHABILITATION INST OF CHGO	CHICAGO ILL 60611	20875	500.00
SAN DIEGO COUNTY UNIV HOSP	SAN DIEGO CALIF 92103	20848	250.00
SAN JUAN CITY HOSP	RIO PIEDRAS P A	22026	500.00
ST JOSEPH MERCY HOSPITAL	ANN ARBOR MICH	20959	500.00
ST JOSEPH MERCY HOSP	PONTIAC MICH	22827	500.00
ST LUKE HOSP	MONTREAL QUE CAN	20970	166.66

Document from the collections of the AAMC Not to be reproduced without permission

TEXAS CHILDRENS HOSP	HOUSTON TEXAS 77025	20705	500.00
<i>Eff 1-1-67 this is NIMH Bureau</i> U S PUBLIC HEALTH SERV HOSP	LEXINGTON KY	20976	500.00
<i>d.k.</i> U S PUBLIC HEALTH SER HOSP	NEW ORLEANS L A	22036	500.00
UNIV DISTRICT HOSP	RIO PIEDRAS P R	22037	500.00
UNIV OF TENN MEM RESEARCH CTR	KNOXVILLE TENN 37920	20920	500.00
UNITY HOSPITAL	BROOKLYN N Y 11213	20919	500.00
<i>d.k.</i> U S PUBLIC HEALTH SERVICE HOSP	CARVILLE LA	22824	500.00
* VICTORIA HOSPITAL	LONDON ONT CAN	20972	166.66
* WINNIPEG GENERAL HOSPITAL	WINNIPEG MANTIOBA CAN	20934	166.66
			17833.30
<i>Fairland Mem. - both lists</i>			$\frac{40}{39}$

* Canadian - 5
 USPH S-BHS - 3
 USPH S-NIMH - 1
 * CUMBERLAND* - 1
~~WICKERMAN~~
 ** Kings County - 1
 *** Louisville Gen - 1
 Un Known - 27
39

* Duplicate - same as BKYN - Cumberland.
 ** Indicated could not pay until 7-1-66.
 *** IN PROCESS OF PAYING.



Bulletin of the TAB
7A

Association of American Medical Colleges

Volume I, Number 8

November 14, 1966

In This Issue

AAMC at San Francisco	P. 1	Public Law 89-709	Veterinary Medical Schools	P. 8
Public Law 89-751	Allied Health Professions Act	P. 4	Public Law 86-601	Minimum Wages P. 8
Public Law 89-749	Comprehensive Health Planning Act	P. 5	Public Health Reorganization	P. 8
Public Law 89-785	VA Education, Modernization, and Training	P. 6		

AAMC IN SAN FRANCISCO

The 77th annual meeting of the Association was very well attended, its sessions lively and productive, its conclusion regretted. San Francisco was at its best and so, apparently, were those in attendance: particularly, the wives.

The papers presented and the consequent discussions will be reported in due course in the Journal. The most important actions taken at the institutional membership meeting are recounted below.

With respect to regional meetings, it was agreed that initially the country would be divided into five regions; that there will be two stated meetings held in each region each year; that meetings would be held in an attempt to identify, define, and discuss issues relating to medical education and to make recommendations concerning such issues for consideration at the national level; that faculty and medical center administrators will be encouraged to participate actively in the meetings; that institutions may choose the regions with which they would like to identify.

The constitution and by-laws of the Association were amended to reconstitute the Executive Council so as to assure representation on it from each region; to set forth explicitly the fact that Institutional Members will establish policy; to vest in the Executive Council and the officers of the Association the responsibility for carrying out that policy and the authority for taking interim action and managing the affairs of the Association.

In a major, new but long considered departure, the Association voted overwhelmingly to create a mechanism for faculty participation in its affairs by approving the formation of an AAMC Council of Academic Societies. An Academic Society was defined as a society "which has as a prerequisite for membership appointment at a medical school faculty or a society which, in the opinion of the Executive Council, has as one of its major functions, a commitment to the problems of medical education." It was further agreed that the new council will be represented on the Executive Council of the AAMC and that those teaching disciplines not currently represented by official societies will be encouraged to form such organizations so as to make it possible for the AAMC to invite each such discipline to nominate two members to the Council.

The membership voted unanimously to endorse the position of the Executive Council as regards medical schools and selective service. That position was so well stated that your editor is unwilling to attempt to summarize it. Therefore, for the benefit of those members who were unable to be present and who cannot yet have copies of the proceedings, we are reproducing it as set forth in San Francisco:

The Executive Council of the Association of American Medical Colleges has given serious consideration to the problems medical schools and teaching hospitals are facing due to the need for a larger number of draftees and young physicians to go on active military duty and the way in which individuals are selected for such active duty.

The Council is confident that it speaks for all medical schools and teaching hospitals when it avows a continued desire to see to it that the needs of our armed forces for medical manpower are given first priority over all considerations. The Council and the Association also adhere to the belief that all students of medicine should continue to understand that they are obligated to serve their country upon completion of their training, and that such deferments as are granted them in their capacities as students or physicians in training must continue to be regarded as "deferments" and not as "exemptions" from the draft. The Council would emphasize, however, that the long-range needs of our armed forces, as well as the total health needs of our nation, require that the selection of young physicians for active duty at the present stage of military commitment be carried out in a way that will disrupt as little as possible the education of medical students and young physicians and the efforts of medical schools and teaching hospitals to expand enrollments to more fully meet the future needs for health manpower.

Within this frame of reference the Council would point out that there is a continuing need to recruit and provide uninterrupted training for an optimum number of medical students. It has long been the policy of Selective Service to defer medical students and interns. The recent necessity to reactivate the college qualifications test and to draft some college and graduate students has created uncertainty in the minds of the present generation of intending and actual medical students as to whether this policy will be continued.

During the last academic year (1965-66) some teaching services were seriously disrupted by having a very large percent of their residents called to active duty, and many teaching services now face such uncertainty as to how many residents will be able to complete their programs, that planning new and badly needed programs to increase the number and quality of medical manpower is made much more difficult.

We believe the problems which have arisen can be solved. We believe these problems stem from the fact that individuals continue to be registered with Selective Service boards in the communities in which they were resident at age 18 during the whole period of their registration, despite the fact that during the years in which they are progressively medical students, interns, residents, and young members of the faculty they migrate to other communities and progress through different roles in the medical school and teaching hospital. The Council believes that medical students, interns, residents, and young members of the faculty should be considered as a national pool of scarce and essential manpower from which selections should be made on the basis of national needs; but the fact is that selection is often based on the various situations confronting local boards which have but little knowledge of the effect of their decisions on the institution in which the young physician is serving or on the national picture.

The Council believes that two things are needed: 1) a reaffirmation of the policy that no student who has been formally accepted for, or is enrolled in, an accredited school of medicine and doing work acceptable to that institution will be called up prior to the completion of the four years of medical school and one year of internship, and 2) the development of procedures that will give due consideration to the need of the medical schools and teaching hospitals to insure the continuity of educational programs by the retention of a reasonable number of residents and junior members of the faculty until suitable replacements become available.

The Borden Award, given for outstanding research in medicine conducted by a member of the faculty of an affiliated college was bestowed, jointly, on Dr. Janet V. Passonneau, Ph. D. and Dr. Oliver H. Lowry, M. D., Ph. D. Dr. Passonneau is assistant professor of pharmacology and Dr. Lowry is professor and chairman of the Department of Pharmacology at Washington University School of Medicine.

Dr. James A. Shannon, Director of the National Institutes of Health, was the recipient of the Abraham Flexner Award for Distinguished Service to Education. Dr. Shannon also honored the Association by delivering the annual Alan Gregg Lecture.

Dr. Thomas B. Turner, immediate past-president, received a standing ovation and a paean of acclamation for the great service he has rendered the Association as he turned over the gavel to Dr. William N. Hubbard, Jr., incoming president of the AAMC. New officers are Doctors John Parks, President-elect and Robert B. Howard, Secretary-Treasurer. Other members of the Executive Council include Doctors Richard H. Young; Russell A. Nelson; John R. Hogness; Robert M. Bucher; and Franklin G. Ebaugh.

Council of Teaching Hospitals

The Council of Teaching Hospitals recognized birthday number one in San Francisco. The occasion was the first Annual Meeting of the Council as a formal organizational element of the AAMC.

Now numbering 332 major teaching hospitals of the United States, Canada and Puerto Rico, the concept of the Council has taken form rapidly over the past year. Two hundred and thirty-six (236) hospitals have been nominated by deans of medical schools as representing hospitals affiliated with those schools in medical education endeavor of some type. Ninety-six (96) hospitals qualified as having both a fully approved, active independent internship program and three fully approved, active independent residency programs from the disciplines of Medicine, Surgery, OB-Gyn, Pediatrics and Psychiatry.

The Chairman of the Council for 1966-67 is Stanley A. Ferguson, Director, University Hospitals of Cleveland. The Chairman-elect is Lad F. Grapski, Director, Loyola University Hospital, Chicago, Illinois. Matthew F. McNulty, Jr. is the new Director of the Council and an Associate Director of the AAMC.

1966 LEGISLATIVE WRAP-UP

The 89th Congress—"the education Congress"—adjourned while the AAMC was holding its 77th annual meeting in San Francisco. Measures dealing with international health and with hospital modernization were not enacted. Presumably similar bills will be introduced in the 90th Congress which convenes next January 10. They must then start over at the beginning of the legislative process. However, to the spate of legislation it had enacted in 1965 and to the animal care bill passed earlier this year, the Congress, in a flurry of pre-adjournment activity, added five measures of distinct interest to us. It passed and the President has signed into law, the Allied Health Professions Act; the Comprehensive Health Planning Act; a measure greatly adding to the educational and service potential of VA's Department of Medicine and Surgery; an act bringing schools of veterinary medicine under the umbrella of the Health Professions Educational Assistance Act; and, amendments to the Fair Labor Standards Act which, by sharply increasing minimum wages for certain classes of employees, will have serious impact on our schools and, particularly, on our teaching hospitals. Each of these measures is discussed below.

Allied Health Professions Act
Public Law 89-751

Signed by the President on November 3, extends to the education and training of the entire range of paramedical personnel much the same types of Federal aid as exist under the Health Professions Educational Assistance Act. The legislation as originally introduced would have been limited to programs requiring baccalaureate degrees and the definition of training centers eligible for grants was so restrictive that even schools of medicine would have been ineligible. However, as enacted, the bill covers even such training courses as may be properly conducted at the junior college level and the Senate wrote into the law not only specific provision for participation by schools of medicine and dentistry but also several other technical amendments suggested by AAMC.

The major purpose of the Act is to extend to the allied health professions financial assistance for the construction of teaching facilities, educational improvement grants, development grants, and traineeships for advanced training. Provision is also made for student loan funds. This measure should not only result in a decided increase in the numbers of allied health personnel and in the number of institutions engaged in training such personnel but it also promises, through its traineeship and other provisions, to make it financially possible to promise recruits that in entering the health professions at any level they will find themselves faced with a series of open-ended opportunities to repeatedly progress both professionally and financially.

Although the bill had not yet been signed into law by the President, the Congress, in an unusual move, did provide some funds for its immediate implementation. No money for construction but \$2.8 million for grants to help develop new or improved curriculums or otherwise improve quality of existing programs (authorized are grants of \$5,000 per curriculum and \$500 per student contingent on an increase of 2-1/2% or three students per curriculum); \$750,000 for traineeships which can be used for the training of teachers, administrators, or specialists and applied to "tuition, fees, stipends, and allowances"; \$200,000 in grant money for the development of new methods.

These are but fractions of the amounts authorized and it is assumed that the Administration will request and the Congress will appropriate additional funds for fiscal 1967 early in 1967. The Act, itself, authorizes:

	<u>Fiscal 1967</u>	<u>Fiscal 1968</u>	<u>Fiscal 1969</u>
<u>For Construction</u>	\$3,000,000	\$ 9,000,000	\$13,500,000
<u>Basic and Improvement Grants</u>	9,000,000	13,000,000	17,000,000
<u>Traineeships</u>	1,500,000	2,500,000	3,500,000
<u>New Methods</u>	750,000	2,250,000	3,000,000

Under the Act, a training center eligible for grants is defined as "a junior college, college, or university, which provides or can provide" appropriate programs training not less than 20 persons.

Currently, this program is being administered in Dr. William H. Cope's Training Resources Branch, Division of Community Health Services, U. S. P. H. S., 800 N. Quincy Street, Arlington, Virginia 22203. After PHS reorganization takes place on January 1,

it will be administered in the Division of Allied Health Manpower, Bureau of Health Manpower, United States Public Health Service.

For complete details and detailed explanation ask your Senator or Representative for copies of Public Law 89-751 and Senate Report 1722.

Comprehensive Health Planning Act
Public Law 89-749

This Act results from legislative action on S. 3008 and H. R. 18231. It is a most complex and, to your editor at least, confusing piece of legislation. Depending on

how its various provisions are interpreted or administered, its operation can have a profound effect on all facets of the health profession of this country. The national and State plans it would bring into being could have tremendous impact on the administration of pre-existing statutes of great interest to us and, indeed, on the shape of medical education itself in future years.

With much of the Act there will be little quarrel. Its provisions for strengthening State departments of public health are long overdue. Its novel provision for exchanges of personnel between the Federal public health service and that of states and local communities seems most promising. One of its major objectives, that of doing away with the some 16 categories under which Federal funds are allocated to states for specific public health purposes and substituting a bloc grant to be used by each State in accordance with its own scale of priorities in public health needs has long been sought by outstanding authorities in the field although some in Washington wonder whether the Congress will be as apt to vote funds for health as it has been wont to vote funds against specific diseases. Its continuation of grants to schools of public health and other such provisions are, of course, welcome.

Had such provisions been separated out from the planning functions written into the Act and handled in separate legislation, our task of evaluation would be much easier. It is the comprehensive health planning provisions of the bill that give rise to concern. In each State there is to be an agency for planning and a resulting "comprehensive State health plan." The Senate Committee report on the bill refers repeatedly to planning for "public health" activities. It says the "planning of the State health planning agency would complement and build on such specialized planning as that of the regional medical program and the Hill-Burton program but would not supplant them." It specifically lists some thirteen areas for which comprehensive and coordinated planning are needed and all but two of these fall in the area of conventional, old-line, public health services.

Nonetheless, the Senate report says that this is not an all-inclusive list and the bill, itself, speaks of " . . . comprehensive State planning for health services (both public and private), including the facilities and persons required for the provision of such services . . ."

It is obvious that if such all-inclusive plans are to be made; if they are to influence State legislatures and Federal policy-makers and granting agencies; if they are to effect coordination at the State and local level of all Federal health programs; if they are to be attuned to or in conflict with regional medical program planning; if they are to decide what numbers and what types of health personnel are to be trained and at what institutions, in what localities, and with what facilities, our schools of medicine will be profoundly affected by the results.

Fortunately we may have a few months in which to further analyze the implications of the legislation, to consider our relationship to it both as separate institutions at the State level and as a national association, and, perhaps, an opportunity to affect changes in the Act before it becomes fully operational should changes prove desirable.

The Administration bill called for a six year program. The Senate cut it to four. The House version (which was enacted into law) cut it down to two years. The Congress has not appropriated any funds for the program and cannot be expected to do so before February at the earliest. Moreover, Chairman Staggers of the House Committee expressed himself as deeply distressed at having to act on so complex a measure so precipitously and promised to have extended hearings and to go into the implications of the Act "thoroughly" shortly after the new Congress convenes.

Nonetheless, the law is now on the statute books and State governments, anticipating Congressional appropriations and grants, may well be deciding in the immediate future how the planning will be done and by whom. Under the terms of the Act, a "State must designate or provide for the establishment of a single State agency, which may be an interdepartmental agency" to undertake the planning function. The addition of the underlined words represents a partial acceptance of the position taken by AAMC. The original bill would have insisted on the designation of an existing agency. AAMC believes that if the planning contemplated is to be so all-inclusive as to encompass every aspect of health in a State, including provisions for the education and training of health personnel, there are, with very, very few exceptions, no existing State agencies with background, experience, knowledge, or expertise sufficient for such a grave responsibility. Your Governor would undoubtedly value your opinion on this. AAMC feels very strongly that such planning (not for "public health" as we have known it, but for "health services, both public and private") logically requires the creation of a new State Health Planning Agency upon which will be represented those State agencies having operational responsibilities in this area (e. g. State mental health, public health, Hill-Burton, welfare, sanitation, public works, etc. authorities) and those institutions and organizations which represent both the actual purveyors and recipients of health services and those charged with the responsibility of educating the health personnel essential to the entire program. Such an agency should be charged with planning alone and should not have operational responsibilities in one segment of the health field. This belief, to which AAMC testified, has been made even more urgent by a provision written into the legislation by the House which stipulates that a majority of members of the State Planning Council (advisory to the agency designated or created) "shall consist of representatives of consumers of health services."

For the Act and explanations thereof, ask your Senator or Representative for copies of Public Law 89-749, Senate Report 1665, and House Report 2271.

Veterans Administration
Amendments
Public Law 89-785

H. R. 11631 started life as a relatively simple measure designed to give the VA statutory authority to include "education" along with research and the care and treatment of patients as among its major functions. In approving the House-passed bill to that effect, the Senate Committee said, "The medical schools have unanimously requested that this situation be remedied . . ." The Committee then proceeded to add a host of technical amendments to the bill most of which seem apt to be of interest to and welcomed by all concerned with

relationships between the VA, schools of medicine, and teaching hospitals. While such people will want to read the Act for those details, we would highlight three of its aspects.

By giving the VA statutory responsibility to carry on an educational function, the Act authorizes the VA to specifically request the appropriation of funds needed to discharge this responsibility. Heretofore VA's educational activities could be justified only as and to the extent that they might be necessarily incident to the primary task of caring for veterans. Its new authority should enable the VA to do an even better job in terms of the mutual relationships between itself and our schools of medicine. It also promises to enable the VA, which has greater hospital bed capacity than any other single administrative entity in the western world, in cooperation with colleges and universities, to undertake on a grand scale the training of all grades of paramedical personnel. Should this possibility be realized—and the President's Commission on Health Manpower is interested in it—the VA could make a tremendous contribution to the solution of manpower shortages in hospitals and clinics throughout the country.

The Act also authorizes the Administrator of the VA to enter into agreements "providing for the exchange of use (or under certain conditions the mutual use) of specialized medical facilities between Veterans Administration hospitals and other public or private hospitals or medical schools in a medical community." As the Senate report states, "Possession of the newer complex medical diagnostic or treatment modalities in the Veterans Administration, and others by affiliated or local hospitals, with shared use of each by both groups, would make for more efficient use of such diagnostic or treatment modalities at lower unit costs for all. For example, very special facilities, staff, and equipment are necessary for hemodialysis. Sharing some of the costs for such services could have the effect of increasing the Nation's limited supply of scientists and equipment in this field." In short, a VA hospital, its equipment, and staff should now be considered as a functioning part of the community's total medical care resources rather than as a walled-off, limited purpose entity.

Sections 5054 and 5055 of the Act are particularly interesting inasmuch as they authorize the Administrator to enter into agreements with medical schools for the exchange of medical information; to utilize electronic equipment to provide a close educational, scientific, and professional link between Veterans Administration hospitals and major medical centers; to make grants to medical schools to assist them to carry out cooperative agreements with VA with respect to the first two undertakings.

Whereas no added funds are immediately available for these purposes, the Act does authorize appropriations of \$3 million for fiscal 1968 and each of the four succeeding fiscal years for the proposed "medical information programs."

For this Act and explanatory materials thereon ask your Senator or Representative for copies of Public Law 89-785 and of Senate Report 1727.

Veterinary Medical Education Act
Public Law 89-709

As originally introduced this legislation would have granted schools of veterinary medicine much the same benefits as those proffered certain other schools under the Health Professions Educational Assistance Act but under a separate statute. Many were concerned when the House, seeking the same objective, sought to do it simply by adding the words "veterinarians" after "podiatrists" in the basic Act. The result would have been to throw schools of veterinary medicine into competition with those previously covered for the already too-limited funds authorized by and appropriated under the basic Act. However, the Senate, while agreeing to write veterinarians into the Act, insisted upon adding a separate and additional authorization of \$17 million per year for this specific purpose. No funds were actually appropriated for this purpose and Senators Hill, Yarborough and Morse joined on the Senate floor in instructing Secretary Gardner that "not one dime" of the current appropriation was to be used for this purpose. They did make it obvious that they would strongly support the special appropriation next year.

The Act increases the membership of the National Advisory Council on Education for the Health Professions from 16 to 17 and contemplates the naming of a representative of the schools of veterinary medicine to the new post.

Fair Labor Standards
Public Law 86-601

The Congress adopted an extremely complex series of amendments to the Fair Labor Standards Act which, by raising minimum wages for selected categories of workers and making them applicable to educational institutions, may have to have serious impact on medical schools and teaching hospitals. The American Council on Education is analyzing its effects on institutions of higher education and the American Hospital Association, we are advised, is doing the same as regards hospitals.

Public Health Reorganization

HEW Secretary Gardner has approved the detailed reorganization plan for the United States Public Health Service proposed by Surgeon General Stewart. While the proposal is quite definite regarding the numbers and names of divisions to be assigned each of the five bureaus in the Service, final decisions have not yet been made as to who will head what divisions nor even as to where will be vested initial responsibility for administering the statutes with which we are concerned. When these decisions are made the Bulletin will advise you in detail. The change-overs are to be effective January 1, 1967.

BULLETIN OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Edited by William G. Reidy

Published approximately 16 issues per year by the Association of American Medical Colleges as a service to members, with the cooperation of the American Council on Education. Editorial office: American Council on Education, 1785 Massachusetts Avenue, N.W., Washington, D. C. 20036 (Telephone: Area Code 202, 483-6620). Distribution: Free in fixed quantities to designated members of the Association of American Medical Colleges. Subscription price: \$20 per year. Order from: Publications Division, American Council on Education, 1785 Massachusetts Avenue, N.W., Washington, D. C. 20036.



Bulletin of the

TAB
7B

Association of American Medical Colleges

Volume II, Number 1

January 5, 1967

THE REORGANIZED UNITED STATES PUBLIC HEALTH SERVICE

This issue will be devoted in its entirety to the long-heralded reorganization of the United States Public Health Service which became effective January 1, 1967 and which presages the development of new and even more effective relationships between schools of medicine, their affiliated teaching hospitals and the Service. As a most fitting introduction to the subject we are pleased to reproduce here a letter just sent us all by the Surgeon General.



THE SURGEON GENERAL OF THE PUBLIC HEALTH SERVICE
BETHESDA, MARYLAND

JAN 4 1967

To: Members of the Association of American Medical Colleges

We, in the Public Health Service, are entering a new year with a new organizational structure which will, I believe, help us to fulfill our rapidly changing responsibilities as the principal Federal health agency. The new organization should be especially helpful in strengthening our partnerships with our allies outside the Federal establishment. Of these, none is more promising or more critically important than our relationships with the Nation's medical schools and their teaching hospitals.

We shall continue, essentially unchanged, our highly productive associations in the conduct and support of research and in the continued advance of the national biomedical research capability. We shall be better organized and equipped to work with you in strengthening the national health manpower resource. Through such new approaches as regional medical programs and comprehensive health planning, we shall improve the accessibility and raise the quality of health services available to the American people.

These objectives and commitments we in the Public Health Service share with you in the AAMC. They cannot be wholly achieved by either of us alone, nor even by a bilateral partnership between us; they require nothing less than the total involvement of all our health resources. But we share a special responsibility for leadership in attaining these goals.

I look forward with confidence to continuing and expanding relationships between the Nation's medical schools and the reshaped and rededicated Federal health effort.

Sincerely yours,

William H. Stewart

Surgeon General

The new organizational structure, referred to by Surgeon General Stewart, is depicted in Chart I on pages six and seven. It outlines both the greatly strengthened Office of the Surgeon General and its administrative relationships to the five co-equal bureaus into which the Service has been organized. A second chart will outline relationships and functions of the units which will make up the new Bureau of Health Manpower, an entity which will prove of great importance to our readers. Finally we will provide an up-to-date list of the names, addresses, and phone numbers of key members of the Service who have recently moved or received new assignments. We hope it proves helpful and we shall try to up-date them as changes occur in the future.

Overview Under the new arrangement, five co-equal Bureaus will report directly to the Office of the Surgeon General. So too will the National Library of Medicine, the National Center for Health Statistics, and the Regional Health Directors assigned one to each of HEW's nine regional offices. The roles, functions, and responsibilities of the National Center and of the National Library of Medicine remain unchanged. The five Bureaus, each of which is discussed below, are (1) Bureau of Health Services, (2) Bureau of Health Manpower, (3) Bureau of Disease Prevention and Environmental Control, (4) National Institutes of Health, (5) National Institute of Mental Health.

OFFICE OF THE SURGEON GENERAL

The Surgeon General and key personnel assigned to his office have moved to Building 31 on the Bethesda, Maryland campus of the National Institutes of Health. Superficially this move has at least two implications which may be of significant interest to us. The move itself presages a greater interest in and more direct and continuing oversight of NIH programs and policies on the part of the Surgeon General. It also underscores the latter's removal from the immediate environs of the Secretary of HEW and the increased role of the Department's Assistant Secretary for Health, Dr. Philip P. Lee and his staff as intermediary between the Service and the Secretary—a role created by a little noted legislative rider on the Health Research Facilities Amendments of 1965 Act, P. L. 89-115.

Top three in the Service are Drs. William H. Stewart, Surgeon General; Leo J. Gehrig, Deputy Surgeon General; and Eugene H. Guthrie, Associate Surgeon General. Of the nine "offices" within the Office of the Surgeon General, the following three will have particular interest for AAMC.

Office of Extramural Programs Under the direction of Dr. Ernest M. Allen, will have responsibility for coordinating and formulating policy for all of the Service's extra-mural programs. While this office will not develop substantive programs, it will oversee and make policy in such areas as construction standards and grants policies and procedures. It will have responsibility for harmonizing such separately arrived at standards emanating from different branches of the Service as have on occasion created difficulties for institutions seeking to cooperate with the Service.

Office of Comprehensive Health Planning and Development This office is intended to serve as the overall directing and policy-setting unit for the comprehensive health planning called for by the recently enacted P. L. 89-749. It will have an "in-house" advisory committee representing each of the Bureaus. It is intended that it shall function through PHS regional office personnel whose regional health directors

are expected to be granted an unusual degree of autonomy with the power to adjust and shape the program to fit local regional needs. The Office will be directed by Dr. James H. Cavanaugh.

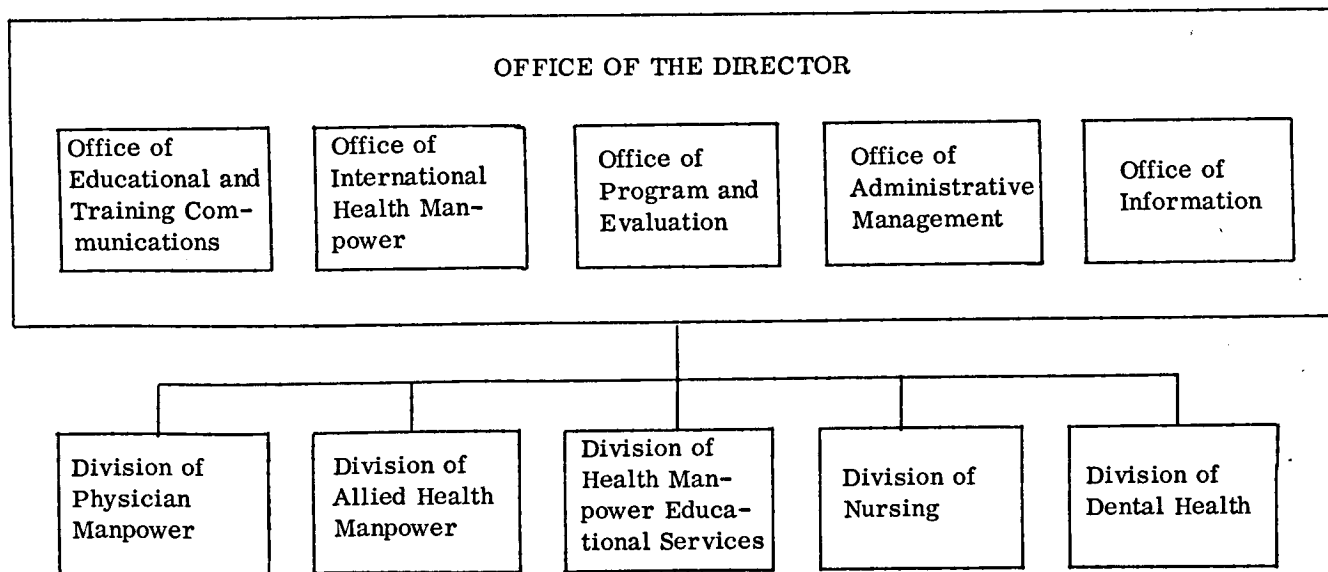
Office of Legislation Will centralize and coordinate in-house legislative activities of the Service. It will provide liaison with legislative committees, scrutinize and evaluate legislative proposals affecting Service activities which may be proposed by outside groups, and will serve as the focal point of legislative policy-making within the Service, subject, of course, to Departmental review. No director has yet been named for this body.

BUREAU OF HEALTH MANPOWER

This Bureau, particularly through its Division of Physician Manpower, will be of particular importance to AAMC. Dr. Leonard D. Fenninger has been named its director. Until his arrival in early February, Dr. Joseph A. Gallagher, who will be Deputy Director, is acting as chief. It will be located in Arlington, Virginia some twenty minutes from downtown Washington.

Readers of the Bulletin will find an interest in each of the five PHS Bureaus. Most certainly they will maintain their interest in and cooperation with NIH and its now co-equal offspring, the National Institute of Mental Health, each of which now ranks as a Bureau. They will maintain their interest, too, in the Division of Hospital and Medical Facilities and the Division of Community Health Services both of which are now identified with the Bureau of Health Services. We will describe all three briefly later on. But because the Bureau of Health Manpower is a really new entity and because it will have primary responsibility for administration of the Health Professions Training Act, the Nurse Training Act, the Allied Health Professions Act, and PHS legislation involving international health manpower on the American scene, we shall outline the organization and functioning of this one Bureau in detail. The quoted summaries of the responsibilities of the Bureau's components which follow the chart have been provided by the Bureau.

BUREAU OF HEALTH MANPOWER



Document from the collections of the AAMC. Not to be reproduced without permission.

The Bureau itself will provide a consolidation of Public Health Service programs supporting education and training of urgently needed health professionals, paramedical and allied services personnel. The five staff offices in the office of the Director will not have programmatic responsibilities and our institutions should not expect to have more than occasional direct contact with them. Their analysis, evaluations, deliberations and recommendations, however, may be expected to have decisive effect on the form which programs and legislation in the area of health manpower take in the future. As yet directors have not been named for the officers of Educational and Training Communication or International Health Manpower. The Office of Program Planning and Evaluation will be directed by Mrs. Margaret West, long recognized in Washington as a real pro in the health manpower field. The Office of Administrative Management will not directly affect our institutions and the Office of Information is expected to channel most of its efforts through the Bureau's operative divisions.

Readers who have looked carefully at the charts may be somewhat confused at the appearance of an "Office of International Health" in the Surgeon General's immediate office and of an "Office of International Health Manpower" in this Bureau of Health Manpower. At the risk of further compounding the confusion, we will anticipate our discussion of the Division of Health Manpower Education Services and point out that it contains a "Foreign Students Educational Branch."

Current understanding of the distinctions among the three are as follows. (1) The Office of International Health in the Surgeon General's Office will be concerned with our official national health area relationships with representatives of other governments (as in WHO or PAHO) and with the Department of State. (2) The "Foreign Students Education Branch" in this Bureau's Division of Health Manpower Educational Services is the same in personnel and function as what used to be called "The International Education and Exchange Division" of the Office of International Health. Still directed by Dr. Howard M. Kline, it will continue to receive and program students for AID. (3) "The Office of International Health Manpower" in the Bureau of Health Manpower is as yet unstaffed, unbudgeted, and unfinanced. On paper it "provides a Public Health Service focus for international health manpower activities involving the United States. Assesses the need for and promotes the development and implementation of manpower programs in this area. Coordinates and evaluates these programs. Provides a source for information on the availability, content, and quality of international educational and training programs for persons in the health occupations (foreign nationals in the United States and United States citizens abroad)."

Division of Physician Manpower

"Conducts and supports grant and operational programs to increase the supply and improve the education, utilization and effectiveness of physicians. Projects national needs and analyzes trends, assessing impact of technological, medical research and practice and other factors. Assesses need for, availability and quality of medical education programs, facilities and teaching personnel. Studies costs, financing and means of improving the quality of the medical education process. Provides consultation and assistance on curriculum development, teaching methods and other elements of medical education programs. Administers educational facilities construction grant programs. Promotes research and demonstrations in planning and constructing these facilities. Develops, demonstrates and implements concepts and programs to improve physician utilization. Stimulates interest in physician careers. Develops, conducts and supports training and continuing education programs."

This, of course, will be the most important Division in the Bureau as far as medical schools are concerned. It will handle applications for medical (and osteopathic) school construction, basic and special improvement grants, traineeships, student loans and scholarships and hospital construction under the Health Professions Educational Assistance Act. (Construction of research facilities, libraries, and Hill-Burton financed hospitals will continue to be handled as in the past elsewhere in PHS. It will still be possible to group multi-grant construction requests in one application which will be sent NIH's Division of Research Grants for parceling out to the operative administrative entities involved.) Aside from programmatic phases, this Division will administer all the Bureau's responsibilities for construction save in the fields of nursing and dentistry.

Pending the naming of a director of the Division, Dr. Joseph A. Gallagher, deputy director of the Bureau, is holding the reins.

Division of Allied Health Manpower

Primary responsibility for administering the new Public Law 89-751 (Allied Health Professions Act) will rest with this PHS entity. Here again no director has as yet been named. The acting chief, who will be Deputy Director of the Division, is Mr. Fred Erickson.

"The Division conducts and supports grant and operational programs to increase the supply and improve the education, utilization and effectiveness of manpower in allied community, clinical, research and environmental health occupations. Projects national needs and analyzes trends, assessing impact of technological, environmental, health program and other factors. Assesses need for, availability and quality of educational programs, training centers and other facilities and teaching personnel. Studies costs, financing and means of improving the quality of these programs and develops concepts and implementation programs. Provides consultation and assistance on curriculum development, teaching methods and other elements of educational programs. Develops concepts and programs to improve the utilization and effectiveness of allied health occupations personnel. Stimulates interest in health careers. Develops and supports appropriate programs of continuing education."

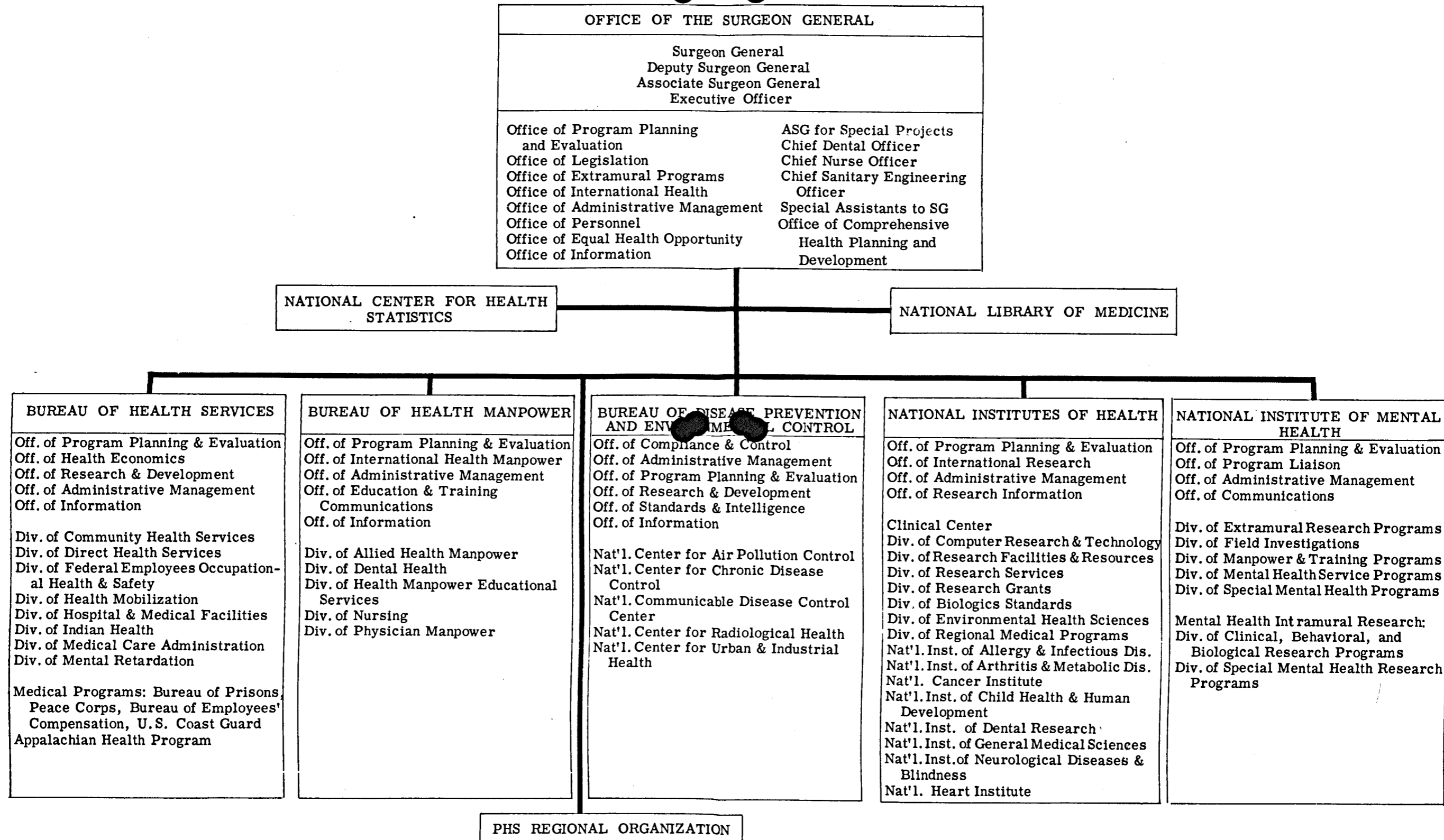
Division of Health Manpower Educational Services

Under the direction of Mr. Ray Dixon and in addition to the functions listed below, this Division will serve, in effect, as a service area for the other programmatic divisions in the Bureau.

It will, for instance, receive and initially process all grant applications received by the Bureau. The applications will then be passed on to other appropriate divisions for review, site visits and program approvals. Applications are then to be returned to this division for final approval and funding. (When priorities on funding must be established it will be done by a Council at the Bureau level.)

As set forth by the Bureau, this Division "serves as a national clearinghouse for information on the availability and content of educational and training programs for the health occupations (secondary, collegiate, graduate, continuing and specialty) and the availability of financial assistance for students in such programs. Administers and evaluates the PHS aspects of programs for the education and training of personnel from other countries in the health occupations. Provides consultation and assistance on the design, operation, and evaluation of Bureau and PHS training grant programs. Develops and administers the procedural, fiscal and management aspects of Bureau grant and loan programs designed to increase the supply and improve the quality of education for the health occupations. Evaluates grant and loan use, impact and need and the long-range program and policy significance of

Public Health Service



Document from the collections of the AAMC. Not to be reproduced without permission.

grant-aided operations. Provides staff services to Bureau councils and committees concerned with multi-divisional manpower programs."

It is in this Bureau that Dr. Kline's "Foreign Students Educational Branch" will be located administratively (it is still physically at its old location).

Division of Nursing Will be directed by Miss Jessie M. Scott, R. N. It "provides a Federal focus for nursing nation-wide. Conducts and supports research, grant, and operational programs to: Increase supply and improve education, utilization and effectiveness of nursing manpower; improve nursing practice and the organization and delivery of nursing services in and out of hospitals, including areas of special practice; and to provide a national center for information and assistance in these areas. Projects national needs; analyzes supply and requirement trends assessing impact of technological, research, nursing practice and other factors. Assesses requirements for, availability and quality of programs, facilities and teaching personnel for nursing education; studies costs, financing and means of improving quality of education; and develops and conducts implementation programs. Provides consultation and assistance on curriculum development and methodology. Develops and conducts programs to improve utilization and effectiveness of nursing manpower and services. Stimulates interest in nursing careers. Promotes research and the application of research findings. Coordinates nursing services activities with related programs throughout the Service."

Division of Dental Health Dr. Viron L. Diefenback serves as director. The Division "conducts and supports research, grant and operational programs to increase the supply and improve the education, utilization, and effectiveness of dental manpower; to prevent and control dental diseases and disorders; and to promote and extend provision of dental services. Projects national needs and analyzes trends. Assesses requirements for, availability and quality of educational programs, facilities and teaching personnel; studies costs, financing and means of improving the quality of education. Provides consultation and assistance on curriculum development, teaching methods and other elements of dental education programs. Develops concepts and programs to improve utilization of dental manpower. Conducts and supports training and continuing education programs. Stimulates interest in dental careers. Conducts and supports studies and programs on the characteristics of oral diseases and the factors associated with their occurrence and correction. Conducts programs of applied research to link research findings with clinical and public health practice. Evaluates and extends the organization, delivery and financing of dental services and the utilization of dental facilities. Coordinates dental services activities with related programs throughout the Service."

NATIONAL INSTITUTES OF HEALTH

Under the reorganization and except for two changes, NIH remains as we have known it in recent years, under the direction of Dr. James A. Shannon and his capable associates and with the same responsibilities as in the past.

The first of the two changes is the addition of a new Division of Environmental Health Sciences. The second is the separation of the National Institute of Mental Health from the other institutes and from Dr. Shannon's jurisdiction and its elevation to co-equal Bureau status. The result, which will no doubt cause a certain amount of confusion outside the PHS,

is that one of its five Bureaus will be called "The National Institutes of Health" and another "The National Institute of Mental Health."

The new Division of Environmental Health Sciences will be headed by Dr. Paul Kotin. Pursuing and encouraging research on the effects of hazards present or introduced into man's environment, the Division will "conduct research, make grants for research and research training to scientists in the nation's colleges and universities" and will also enter into contracts "with universities, research institutes, national laboratories and private industry to provide services needed to expedite work in the laboratories." (Note: Development of Control programs in environmental health will be the responsibility, not of NIH, but of the Bureau of Disease Prevention and Environmental Control.)

The Division will be located at the proposed Environmental Health Science Center in The Research Triangle of North Carolina.

NATIONAL INSTITUTE OF MENTAL HEALTH

This Institute, with Dr. Stanley F. Yolles as Director and Dr. Bertram S. Brown as Deputy Director, will have its offices in the Barlow Building, at 5454 Wisconsin Avenue, Chevy Chase, Maryland. Intramural research now carried on in the Clinical Center and elsewhere will continue in those locations. In addition to its previous responsibilities, NIMH has had transferred to it from the Service's Bureau of Medical Services the Lexington, Kentucky and Fort Worth, Texas addiction hospitals of the PHS. They will become clinical research centers.

In addition to offices and divisions serving the Director or for intramural work, the Institute will have the following five Divisions and Directors thereof: Division of Extramural Research Programs, Dr. D. Oken (acting); Division of Field Investigations, Dr. S. M. Keeffer (acting); Division of Manpower and Training Programs, Dr. R. J. Balester; Division of Mental Health Service Programs, Dr. A. I. Levenson; Division of Special Mental Health Programs, Dr. Morton Miller.

BUREAU OF HEALTH SERVICES

This Bureau will be located in Silver Spring, Maryland and has as Director Dr. Carruth J. Wagner, with Dr. Paul Q. Peterson serving as Deputy Director. Its Division of Community Health Services, under Dr. James D. Wharton, will still administer research grants in the field of health services but jurisdiction over student loans and grants has been transferred to the Bureau of Health Manpower. The Bureau's Division of Hospital and Medical Facilities, under Dr. Harold M. Granning, continues to administer basic Hill-Burton hospital construction grants and will continue to play a role in the academic picture in terms of architectural design and review but has transferred to the Bureau of Health Manpower those functions of P. L. 89-129 it has administered heretofore.

The Division of Medical Care Administration, under Dr. John W. Cashman, will represent PHS interest in HEW's administration of both Title XVIII and Title XIX (Medicare and Medicaid) of the Social Security Act.

The Appalachian Health Program also will be operated out of this Bureau under the direction of Dr. Charles Boettner.

BUREAU OF DISEASE PREVENTION
AND ENVIRONMENTAL CONTROL

This Bureau has Dr. Richard A. Prindle as its Director and Mr. Vernon G. MacKenzie as Deputy Director. Along with the National Center for Air Pollution Control and the National Center for Chronic Disease Control, it will administer the National Communicable Disease Control Center at Atlanta, Georgia, the National Center for Radiological Health at Rockville, Maryland and the National Center for Urban and Industrial Health at Cincinnati, Ohio.

NATIONAL LIBRARY OF MEDICINE

Its status and functions unchanged, the Library retains Dr. Martin M. Cummings as its Director.

NATIONAL CENTER FOR HEALTH STATISTICS

Dr. Forrest E. Linder continues as Director and the Center's role remains the same.

WHO'S WHAT AND WHERE IN PHS

The following is an up-to-date directory of those Public Health Service officers with whom readers of the Bulletin seem most apt to communicate and whose positions or locations have been changed recently.

Office of the Surgeon General

U. S. P. H. S., Dept. of H. E. W.
Building 31, NIH
9000 Rockville Pike
Bethesda, Maryland 20014

Dr. William H. Stewart
Surgeon General
Area Code 301, 496-1025

Dr. Leo J. Gehrig, Deputy Surgeon General
Room 3A49
Area Code 301, 496-2358

Dr. Eugene H. Guthrie
Associate Surgeon General
Room 3A03B
Area Code 301, 496-4301

Dr. Ernest M. Allen, Director
Office of Extramural Programs
Room 3A10
Area Code 301, 496-1006

Bureau of Health Manpower

U. S. P. H. S., Dept. of H. E. W.
The Tower Building
800 N. Quincy Street
Arlington, Virginia 22203

Dr. Leonard D. Fenninger, Director
Room 1105
Area Code 703, 521-5600, ext. 6614

Dr. Joseph A. Gallagher, Deputy Director
Room 1105
Area Code 703, 521-5600, ext. 6611

(Not yet named)
 Director
 Division of Physician Manpower
 (Dr. Gallagher is acting chief)

Dr. Howard M. Kline, Director
 Foreign Students Educational Branch
 U. S. P. H. S. Bureau of Health Manpower
 Room 5111, HEW Building South
 330 C Street, S. W.
 Washington, D. C. 20202
 Area Code 202, 963-5381

Dr. Viron L. Diefenbach, Director
 Division of Dental Health
 Room 601, 8120 Woodmont Avenue
Bethesda, Maryland 20014
 Area Code 301, 495-6301

Mr. Fred Erickson, Acting Chief
 Division of Allied Health Manpower
 Room 808
 Area Code 703, 521-5600, ext. 6655

Mrs. Margaret West, Director
 Office of Program Planning and Evaluation
 Room 419

Bureau of Health Services

U. S. P. H. S. , Dept. of H. E. W.
 The Willste Building
 7915 Eastern Avenue
 Silver Spring, Maryland 29010

Dr. Carruth J. Wagner, Director
 Area Code 301, 495-5201

Dr. Herald M. Graning, Chief
 Division of Hospital and
 Medical Facilities
 Area Code 301, 495-5331

Dr. John W. Cashman, Director
 Division of Medical Care Admin.
Room 712, The Tower Building
800 N. Quincy Street
Arlington, Virginia 22203
 Area Code 703, 521-5600, ext. 6324

Dr. Paul Q. Peterson, Deputy Director
 Area Code 301, 495-5203

Dr. James D. Wharton, Chief
 Division of Community Health Services
800 N. Quincy Street
Arlington, Virginia 22203
 Area Code 703, 521-5600, ext. 6253

Dr. Charles H. Boettner, Executive Director
 Health Advisory Committee
Appalachian Regional Commission
1666 Connecticut Avenue, N. W.
Washington, D. C. 20235
 Area Code 202, 967-5085

Bureau of Disease Prevention and Environmental Control

U. S. P. H. S. , Dept. of H. E. W.
 330 C Street, S. W.
 Washington, D. C. 20201

Dr. Richard A. Prindle, Director
 Room 2006
 Area Code 202, 962-3191

Mr. Vernon G. McKenzie, Deputy Director
 Room 2006
 Area Code 202, 963-6902

Dr. John T. Middleton, Director
National Center for Air Pollution Control
Room 2058
Area Code 202, 963-3428

Dr. David J. Sencer, Director
Communicable Disease Control Center
1600 Clifton Road, N. E.
Atlanta, Georgia 30333
Area Code 404, 633-3311, ext. 3291

Mr. James G. Terrill, Jr., Director
National Center for Radiological Health
1901 Chapman Avenue
Rockville, Maryland
Area Code 301, 496-8053

Dr. Donald R. Chadwick, Director
National Center for Chronic Disease Control
The Webb Building
4040 North Fairfax Drive
Arlington, Virginia 22202
Area Code 703, 521-5600, ext. 7401

Dr. Jerome H. Svore, Director
National Center for Urban and Industrial Health
6935 Wisconsin Avenue
Bethesda, Maryland

National Institute of Mental Health

U. S. P. H. S. , Dept. of H. E. W.
Barlow Building
5454 Wisconsin Avenue
West Chevy Chase, Maryland 20015

Dr. Stanley F. Yolles, Director
Area Code 301, 496-1393, ext. 275

Dr. Bertram Brown, Deputy Director
Area Code 301, 493-1393, ext. 351

National Institutes of Health, National Library of Medicine, National Center for Health Statistics unchanged.

BULLETIN OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Edited by William G. Reidy

Published approximately 16 issues per year by the Association of American Medical Colleges as a service to members, with the cooperation of the American Council on Education. Editorial office: American Council on Education, 1785 Massachusetts Avenue, N.W., Washington, D. C. 20036 (Telephone: Area Code 202, 483-6620). Distribution: Free in fixed quantities to designated members of the Association of American Medical Colleges. Subscription price: \$20 per year. Order from: Publications Division, American Council on Education, 1785 Massachusetts Avenue, N.W., Washington, D. C. 20036.

Editorial

THE TIME IS NOW

The creation of a Council of Teaching Hospitals within the AAMC adds a significant new dimension to the role of the Association in the improvement of health in all of its aspects. The teaching hospitals are assuming an increasingly important place in education and research in the medical sciences. If the medical schools and the hospitals are to meet their current responsibilities and the challenges of the future in the most effective and efficient way, there must be close cooperation and interaction between these 2 institutions. Such interaction is built into the organizational relationships of university-owned hospitals and medical schools. However, in many places where affiliated teaching hospitals are important components of a medical center complex, the growing demands of educational and research programs and patient care are creating increasing tension between these hospitals and the medical schools. In a number of instances the strain has almost broken relationships that have been harmonious over the years.

Hopefully, the Council will function as a forum for the exchange of views and will facilitate the forging of effective working relationships. However, the teaching hospitals represent only one of a large number of groups involved in education and practice in the health sciences with which Lowell Coggeshall urged the AAMC to establish formal and continuing relations.¹

Some of these groups are subsets of the faculties in the medical schools; some are from other health professions. Many are represented by strong organizations. And all are finding it of growing importance to speak out on public policy. As government participation in health affairs increases, these groups can be expected to be even more intent on making their voices heard.

At present there is no effective mechanism for the exchange of ideas and the coordination of activities of the many groups and organizations in the health professions. Their influence is often cancelled out just as one wave of light cancels another with which it is out of phase. The need for better interaction is urgent. Some organizations are pessimistic about the ability of the AAMC to provide the structures for this interaction. They are already proposing that a coordinating organization be formed to perform functions that should be assumed by the AAMC.

Time is running out for the AAMC to implement the recommendations of the Coggeshall Report.¹ The Council of Teaching Hospitals is a substantial first step; but now we must run, not walk, if we are to play the role that the times demand.

JOHN A. D. COOPER

1. COGGESHALL, L. T. *Planning for Medical Progress through Education*. Evanston, Illinois: Association of American Medical Colleges, April, 1965.

TAB # 9
Robert B. Howard

OFFICERS OF THE ASSOCIATION
AND
MEMBERS OF THE EXECUTIVE COUNCIL
1966-1967

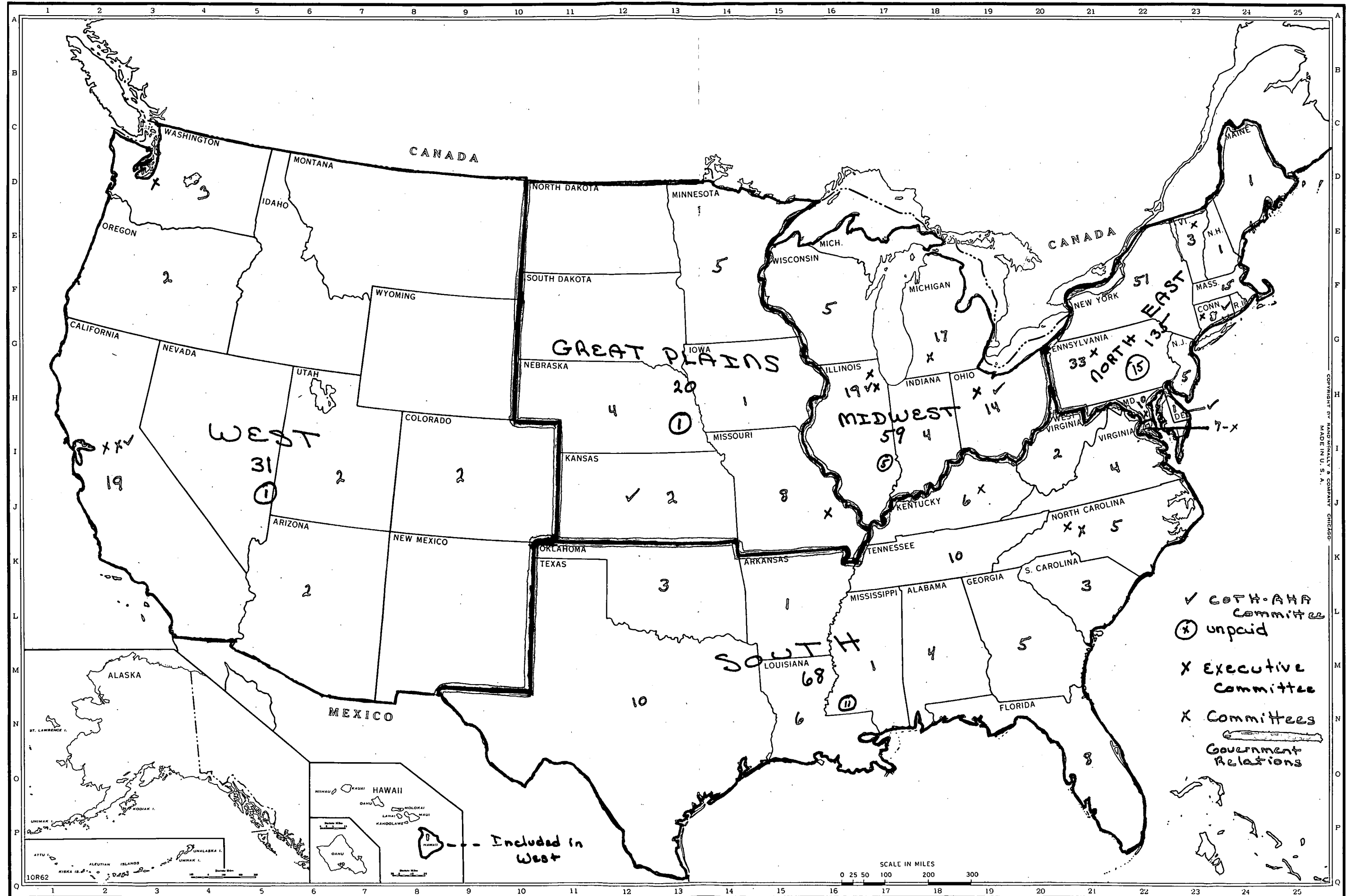
- | | | | |
|---|------------------------------|--------|---|
| 1 | President & Council Chairman | | William N. Hubbard, Jr., M.D.
Dean
The University of Michigan
Medical School
Ann Arbor, Michigan 48104 |
| 2 | President-Elect | | John Parks, M.D.
Dean
George Washington University
School of Medicine
1339 H Street, N.W.
Washington, D. C. 20005 |
| 3 | Immediate Past President | | Thomas B. Turner, M.D.
Dean
The Johns Hopkins University
School of Medicine
725 North Wolfe Street
Baltimore, Maryland 21205 |
| 4 | Secretary & Treasurer | | Robert B. Howard, M.D.
Dean
University of Minnesota
Medical School
Minneapolis, Minnesota 55414 |
| 5 | Executive Council Member | (1968) | Richard H. Young, M.D.
Dean
Northwestern University
Medical School
303 East Chicago Avenue
Chicago, Illinois 60611 |
| 6 | Executive Council Member | (1969) | Robert M. Bucher, M.D.
Dean
Temple University
School of Medicine
Broad & Ontario Streets
Philadelphia, Pennsylvania 19140 |
| 7 | Executive Council Member | (1969) | John R. Hogness, M.D.
Dean
The University of Washington
School of Medicine
Seattle, Washington 98105 |
| 8 | Executive Council Member | (1969) | Frank G. Ebaugh, Jr., M.D.
Dean
Boston University
School of Medicine
80 E. Concord Street
Boston, Massachusetts 02118 |

Officers of the Association and Members of the Executive Council (cont.)

- 9 Executive Council Member (1968) William G. Anlyan, M.D.
Dean
Duke University
School of Medicine
Durham, North Carolina 27706
- 10 Executive Council Member (1968) Kenneth R. Crispell, M.D.
Dean
The University of Virginia
Medical School
Charlottesville, Virginia 22903
- 11 Executive Council Member (1967) Robert Q. Marston, M.D.
Associate Director for Regional
Medical Programs
National Institutes of Health
Bethesda, Maryland 20014
- 12 Executive Council Member (1967) Vernon E. Wilson, M.D.
Dean
University of Missouri
School of Medicine
Columbia, Missouri 65201
- 13 Executive Council Member (1967) Russell A. Nelson, M.D.
Director
Johns Hopkins Hospital
601 N. Broadway
Baltimore, Maryland 21205

EXECUTIVE DIRECTOR:

Robert C. Berson, M.D.
Executive Director
Association of American Med. Colleges
1501 New Hampshire Avenue N.W.
Washington, D. C. 20036



Document from the collections of the AAMC. Not to be reproduced without permission.

COPYRIGHT BY RAND McNALLY & COMPANY CHICAGO MADE IN U.S.A.

TAB 11

The AMA News - JAN 2, 1967

63rd ANNUAL CONGRESS ON MEDICAL EDUCATION

PALMER HOUSE • CHICAGO • FEBRUARY 9-15, 1967

Association of Hospital Directors of Medical Education

Friday, February 10

Greetings

Robert L. Evans, M.D.
President, AHDME

New Rotating Internship Program

John C. Nunemaker, M.D.
Associate Secretary
Council on Medical Education
American Medical Association

Report of Internship Evaluation Project

Erwin O. Hirsch, M.D.
Director of Medical Education
Princeton Hospital, Princeton, New Jersey

Implication of the Citizens Commission on Graduate Medical Education Report to the Teaching Community Hospital

John S. Millis, Ph.D., President
Western Reserve University

Correlation of Interns Obtained Through National Intern Matching Program with Presence of a Director of Medical Education

Ward Darley, M.D., Executive Secretary
National Intern Matching Program

A Study of the Effect of Medicare and Title XIX Legislation on House Staff Programs in California

Woodbury Perkins, M.D.
Director of Medical Education
Mercy Hospital, San Diego, California

Research in Community Hospitals

Jack H. Hall, M.D.
Director of Medical Education
Methodist Hospital, Indianapolis, Indiana

Saturday, February 11

PANEL ON MEDICAL CARE AND HEALTH SERVICES SYSTEMS

Present and Future Medical Care and Health Needs

Richard M. Magraw, M.D.
Professor of the Departments of Internal
Medicine and Psychiatry
University of Minnesota

Research in Medical Care and Health Services Systems

Kerr L. White, M.D.
Professor of Medical Care and Hospitals
Johns Hopkins School of Medicine

Applicability of the Systems Analysis Approach to Planning and Programming Medical Care and Health Services

Arthur S. Stankovich, Manager
Operations Research Studies
General Electric Company
Valley Forge, Pennsylvania

ANNUAL BUSINESS MEETING OF AHDME

Each presentation will be followed by a question and answer period.

MORE

- 2 -

Document from the collections of the AAMC. Not to be reproduced without permission.

**The Federation of State
Medical Boards of
the United States**

Friday, February 10

LEGAL COUNSELORS OF STATE MEDICAL BOARDS

Saturday, February 11

ANNUAL EXAMINATION INSTITUTE

Leo T. Heywood, M.D., Chairman
Omaha, Nebraska

**ARE THERE STATE LICENSURE BARRIERS TO
INNOVATIONS IN MEDICAL EDUCATION?**

Joint Sponsorship:
Federation of State Medical Boards of the U.S.
Council on Medical Education of the American
Medical Association
Association of American Medical Colleges

Summary of Medical Practice Acts

C. H. William Ruhe, M.D.
Council on Medical Education of
American Medical Association

Innovations in Medical Education

Existing Schools

William A. Sodeman, M.D., Dean
Jefferson Medical College
Philadelphia, Pennsylvania

Developing Schools

Joseph Stokes, III, M.D.
University of California, San Diego
School of Medicine

Individualization of Learning

Paul J. Sanazaro, M.D.
Division of Education
Association of American Medical Colleges

**Problems & Challenges from the
Federation's Standpoint**

Leo T. Heywood, M.D., Vice President
Chairman of Examination Institutes Committee
Federation of State Medical Boards of the U.S.

General Discussion

Examination Institute Development Plan

Leo T. Heywood, M.D., Chairman

**Annual Conference of Secretaries and
Executive Officers—State Medical Boards**

M. H. Crabb, M.D., Secretary, Presiding
Fort Worth, Texas

Annual Federation Dinner

Twelfth Annual Walter L. Bierring Lecture
Charles L. Hudson, M.D., President
American Medical Association
Cleveland, Ohio

Sunday, February 12

ANNUAL MEETING

George H. Lage, M.D., President, Presiding
Portland, Oregon

Reports of Officers & Committees

**CONTINUING EDUCATION AND
REVALUATION OF THE PHYSICIAN**

Responsibility of the Medical Schools
William Neill Hubbard, Jr., M.D.
Ann Arbor, Michigan

Responsibility of Organized Medicine

Albert Eugene Ritt, M.D.
St. Paul, Minnesota

Responsibility of the Individual

Melvin W. Breese, M.D.
Portland, Oregon

Responsibility of the State Medical Boards

Justin J. Stein, M.D.
Los Angeles, California

GENERAL SESSION

Rhett McMahon, M.D., President-elect, Presiding
Baton Rouge, Louisiana

Presidential Address

George H. Lage, M.D., President

Public Responsibility of the Press

John Troan, Associate Editor
The Pittsburgh Press

**Separation of Licensing and
Disciplinary Board Functions**

Against:

Thomas Lyle Carr, M.D.
Albuquerque, New Mexico

For:

Donald C. Walker, M.D.
Albany, New York

Uniform Applications for Licensure

Bernard A. O'Hara, M.D.
Midland, Michigan

Monday, February 13

**HERBERT M. PLATTER LUNCHEON
ANNUAL BUSINESS MEETING**

MORE

Council on Medical Education of the AMA

Sunday, February 12

SURGICAL TEACHING FOR MEDICAL STUDENTS

CO-SPONSORED BY THE SOCIETY OF
SURGICAL CHAIRMEN

Presiding

W. Clarke Wescoe, M.D.
Chancellor, University of Kansas
Chairman, Council on Medical Education
and

-6- |

Jonathan E. Rhoads, M.D.
Chairman, Department of Surgery
University of Pennsylvania School of Medicine
President, Society of Surgical Chairmen

Surgical Teaching in the Development of Clinical Competence

Francis D. Moore, M.D.
Professor of Surgery
Harvard Medical School

Surgical Clerkship—Milestone or Millstone

C. Gardner Child, M.D.
Chairman, Department of Surgery
University of Michigan Medical School

Surgical Specialties in the Medical Curriculum— Their Pertinent and Impertinent Purposes

C. Rollins Hanlon, M.D.
Chairman, Department of Surgery
Saint Louis University School of Medicine

Surgery's Relevance to an Understanding of Basic Biology

Tissue Repair and Cellular Regeneration
J. Englebert Dunphy, M.D.
Chairman, Department of Surgery
University of California School of Medicine,
San Francisco

The Immune Process

David M. Hume, M.D.
Chairman, Department of Surgery
Medical College of Virginia

Bodily Responses to Infectious Agents

William A. Altemeier, M.D.
Chairman, Department of Surgery
University of Cincinnati College of Medicine

Alterations in Pulmonary Functions

William K. Hamilton, M.D.
Chairman, Department of Anesthesiology
University of Iowa College of Medicine

Biochemical Response to Tissue Injury

Henry T. Randall, M.D.
Attending Surgeon and
Director of Surgical Research
Memorial Hospital for Cancer and Allied Diseases,
New York, New York

The Surgical Service—A Unique Resource for the Behavioral Sciences

Carlyle F. Jacobsen, Ph. D.
President, Upstate Medical Center
State University of New York
Syracuse, New York

-7-

Page-3-

Sunday, February 12

PLENARY SESSION

Kenneth C. Sawyer, M.D.
Vice Chairman, Council on Medical Education
Presiding

Public Expectations and the Responsiveness of Medical Education Chairman's Valedictory Address

W. Clarke Wescoe, M.D.
Chancellor, University of Kansas
Chairman, Council on Medical Education

Rational Responses to "Meeting the Challenge of Family Practice"

William R. Willard, M.D.
Vice President, University of
Kentucky Medical Center
Member, Council on Medical Education
Former Chairman, Ad Hoc Committee on
Education for Family Practice

Rational Responses to "The Graduate Education of Physicians" (Exclusive of Chapter 5 on comprehensive medicine and the primary physician).

Leland S. McKittrick, M.D.
Clinical Professor of Surgery Emeritus
Harvard Medical School

PANEL DISCUSSIONS

Panel A

"Meeting the Challenge of Family Practice"
William R. Willard, M.D.
Moderator

Panelists

George Burket, Jr., M.D.
Kingman, Kansas

W. Philip Corr, Sr., M.D.
Riverside, California

L. William Earley, M.D.
Pittsburgh, Pennsylvania

Robert J. Haggerty, M.D.
Rochester, New York

William C. Keettel, Jr., M.D.
Iowa City, Iowa

Merle M. Musselman, M.D.
Omaha, Nebraska

-8-

Panel 5

"The Graduate Education of Physicians"
(Exclusive of Chapter 5)
John S. Millis, Ph. D.

President, Western Reserve University
Former Chairman, Citizens Commission on
Graduate Medical Education
Moderator

Panelists

Douglas D. Bond, M.D.
Cleveland, Ohio

Thomas Brem, M.D.
Los Angeles, California

Robert L. Evans, M.D.
York, Pennsylvania

Leland S. McKittrick, M.D.
Boston, Massachusetts

John Parks, M.D.
Washington, D. C.

Robert J. Slater, M.D.
New York, New York

Monday, February 13

MEDICAL MANPOWER—A CONTINUING CRISIS

W. Clarke Wescoe, M.D., *Presiding*

The Profession's View

Dwight L. Wilbur, M.D.
San Francisco, California
Member, AMA Board of Trustees
Member, AMA Committee on Health Manpower
Member, National Advisory Commission on
Health Manpower

An Economist's View

Rashi Fein, Ph.D.
Senior Economist
Brookings Institution

Pertinent But Neglected Considerations

Carl E. Taylor, M.D., D.P.H.
Professor and Director, Division of
International Health Studies
Johns Hopkins University School of Hygiene
and Public Health

Systems Analysis and the Conservation of
Professional Talent

Mark S. Blumberg, M.D.
Assistant to Vice President for Administration
University of California
Berkeley, California

Adapting Medical Education to Meet Increasing
Manpower Requirements

Robert B. Howard, M.D., Ph.D., Dean
University of Minnesota Medical School

Monday, February 13

MEDICAL SCHOOL AND COMMUNITY
INTER-RELATIONSHIPS

The Relation of a Medical School to its
Surrounding Community

William H. Stewart, M.D.
Surgeon-General, USPHS

Case Studies

The Medical School of a Land-Grant University
and its Relation to the Health Care of the State
Vernon E. Wilson, M.D.
Dean, University of Missouri School of Medicine

The Role of the Medical School in Health Care
in Oklahoma
James L. Dennis, M.D., Dean
University of Oklahoma School of Medicine

The Tufts Comprehensive Community
Health Action Program
William F. Maloney, M.D., Dean
Tufts University School of Medicine

The Medical School of the Future
and its Role in the Community
George James, M.D.
Vice-President, Mt. Sinai Medical Center
Dean, Mt. Sinai School of Medicine

- 1 Report of the Ad Hoc Committee on Education for Family
Practice
 - 2 Report of the Citizens Commission on Graduate Medical
Education
- Copies available, upon request, from the American Medical
Association.

10

TAB 12

FOR DISCUSSION ONLY
BY THE INSTITUTIONAL MEMBERSHIP

THIRD DRAFT
October 23, 1966

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
PROPOSALS FOR THE SUPPORT OF MEDICAL EDUCATION
BY THE FEDERAL GOVERNMENT

1966

PREAMBLE

The medical schools of the United States, constituting the Institutional Membership of the Association of American Medical Colleges, recognize and accept the responsibility they have to serve the health needs of the people by increasing the supply of physicians and other health related personnel, and that the fulfillment of this responsibility will be through a partnership of effort with the Federal Government.

In 1961, the medical schools through their Association proposed new programs of support of medical education by the Federal Government to supplement the construction of health care (Hill-Burton) and health research facilities and the support of medical research then in effect. Then, as now, the concern of the medical schools is for both the availability and quality of health services to all of the people.

In the intervening five years, laws have been established providing matching funds for the construction of educational and library facilities; loans and scholarships have been provided for medical and other health professional students; educational improvement grants and general research support grants have been instituted; the full costs of research have been more nearly paid, based upon a formula allowing for

variations in cost from institution to institution; and the growing responsibility of medical centers to provide leadership in coordinating medical services and providing postgraduate education for practicing physicians within their regions has been recognized through new regional cooperation programs.

All this has been accomplished while continuing to support the vital growth of the basic research and research training programs of the National Institutes of Health. These new programs of support correspond closely to the specific proposals made in 1961 by the Association of American Medical Colleges and through their fulfillment the medical schools of the United States are more nearly able to meet the needs of the people.

In the five years since 1961, there has been an unprecedented increase in the demands upon the total system of efforts required to deliver health services. The increasing size of our population with its growing preponderance of the younger and the older segments, the demand that new knowledge and skill be made generally available without delay; the growing governmental support of payment for health services; and the expectations of an increasingly urbanized and prosperous society that medical services should be readily available to all who can benefit from them are factors which together place the utmost stress on the capacities of our system of medical research, medical education and medical care.

In order that medical education in the United States can meet these new challenges without sacrificing the quality of its efforts, these proposals for support by the Federal Government are made.

I. Support of the integrity of the medical center and its inseparable functions of research, education and patient service

A. The Need

The unique responsibility of medical education is for the curriculum leading to the M.D. degree; being not only unique but essential to the health of the people. The environment necessary for the education of the physician includes scholarly research in the sciences relevant to health, as well as patient care services that are as nearly comprehensive and of ideal quality as can be achieved.

Once established, this medical center environment provides a suitable educational setting for many health related students other than medical students. Its research programs produce knowledge for the benefit of all mankind and properly serve this creative role as well as the needs of education. Its patterns of patient care constitute a major regional resource and have served historically as models for community hospitals.

As Federal programs of support have evolved one at a time over the past twenty years, they have dealt separately with education, research and medical care. There is now a need for a review of these several programs in order that the institutional entity of the medical center be better recognized and strengthened as the principal resource for meeting the national need for new knowledge and new manpower essential to the national health.

B. Policy

The memorandum of September 13, 1965, from the President to the Heads of Department and Agencies states the fundamental policy

we respectfully endorse. One element of this statement illustrates this policy:

... "at the apex of this educational pyramid, resting on the essential foundation provided for the lower levels, is the vital top segment where education and research become inseparable."

C. Proposals

The Surgeon General of the United States Public Health Service has recognized the need for better coordinating and unifying the administration of extramural programs by establishing a senior post in his office to serve this function.

1. It is proposed that where changes in regulations and in legislation are required to achieve uniform administrative practices, that such changes be sought from the appropriate branch of the Federal Government.
2. It is proposed that in recognition of the inseparability of medical education and medical research within the medical center, legislative authority be requested for the allocation of a maximum of 15 percent of an award in each of these two categories for expenditure in the other, at the discretion of the grantee institution.
3. It is proposed that in a medical center, construction grants need not be restricted exclusively to either education or research; but that as much as one-third of a new building may be used interchangeably for either medical education or medical research at the discretion of the grantee institution.

In making this proposal it is recognized that existing legislation and regulations reflect the historic intent of the Congress and that such a proposal implies the need for new legislation.

4. It is proposed that basic educational improvement grants be increased and include postgraduate education of practicing physicians and other health related practitioners.
5. It is proposed that in accounting for the distribution of effort of clinicians, teachers and researchers whose full time is devoted to the programs of the medical center, it be recognized that their effort does not deal separately and in isolation with education, research and clinical service. Indeed, such efforts are most fruitful in a medical center only when a maximum coincidence of education, research and clinical care is achieved. An accounting system which requires complete separation of these functions is not in the best national interest nor does it recognize the reality that in the medical center, education and research as they coincide are inseparable. The total health related research effort of the institution should be the basis of accountability rather than requiring a separate accounting of the research effort of each individual period.

II. Basic research and research training support as the foundation of medical education and effective health services

A. The Need

The prevention, early detection, and curative treatment of the commonest forms of neoplastic, cardiovascular, neurologic and

psychiatric diseases that afflict the people of the United States cannot be effectively achieved within our present knowledge. Furthermore, the expanded number of teachers necessary to the education of physicians and other health related practitioners at all levels must be developed in an environment of scholarly inquiry if the quality of medical education is not to be sacrificed.

The support of individual scientists' research projects within the mission of the National Institutes of Health after a review of merit by scientific peers is our basic national resource in the production of new knowledge essential to improved health service. It is this same research setting which is optimal for the training of scientists who will be teachers and investigators as well as practitioners. The support of project research and research training in the established patterns of the National Institutes of Health must be maintained and expanded in order to provide new knowledge and new health related scientists.

B. Policy

The remarks of the Secretary of the Department of Health, Education, and Welfare on August 23, 1966, to a meeting of consultants to the National Institutes of Health states the question and the response we would support.

"First, has there been a major change in the basis and nature of the Federal relationship to fundamental research, graduate training and the expansion of the academic and scientific resources of this country? Has there been a major policy decision to shift resources from the support of the individual scientist

on a long-term basis to directed short-term research programs aimed at specific targets and to application?

"I can dispose of these questions directly. There has been no change in the conviction of this Department concerning the essential role of fundamental science in the pursuit of its program goals and none is contemplated. Nor has there been any policy decision to diminish the national investment in the fundamental sciences relevant to health and medicine. The development and maintenance of a stable framework for the support and continued advancement of the national scientific effort in these areas is and will be a major objective of this Department.

"Indeed, it is my own belief that in our practical-minded society, committed as we are to the large-scale, organized pursuit of our shared purposes, the individual efforts of the basic researcher will always be in danger of neglect, always in need of special encouragement. It would be incredibly shortsighted if at this time of swiftly expanding horizons in the biological sciences we were to conclude that basic research should be de-emphasized."

This policy has been emphasized by the report of the United States Senate Committee on Appropriations in September of 1966:

"It was clear to the Committee, as a consequence of the extensive testimony of both public and private witnesses, that both the current state of medical knowledge and the changing nature of medical and health

problems require substantial, sustained and unrestricted commitment to the free ranging individual research efforts selected for support through a process of reaching a consensus of the scientific community on the excellence, significance and relevance of the intended work. A major portion of the increased appropriation recommended by this Committee over the years has been in support of this commitment. The Committee continues to be convinced that progress in medical knowledge is basically dependent upon full support of undirected basic and applied research efforts of scientists working independently or in groups on the ideas, problems and purposes of their selection and judged by their scientific peers to be scientifically meaningful, excellent and relevant to extending knowledge of human health and disease."

C. Proposals

1. It is proposed that directed research should be supported only when it supplements the level of support required for undirected research and research training programs.

The capacity of unrestricted research to provide new scientific knowledge of importance to health should be fully utilized and its collateral capacity to provide an optimum setting for training of future teachers, investigators and practitioners should be fully realized as well.

2. It is proposed that general research support grants be increased to the maximum authorized level of enabling legislation.

This could be accomplished by separate funding which would have the advantage of avoiding competition for funds within each institute. Alternatively, this could be accomplished within the five-year plans of the several categorical institutes themselves. In either case, this would avoid a sudden drain on funds for project research and research training.

3. It is proposed that there be an over-all review of administrative policies and regulations governing grants for research and research training to ensure their contribution to the strengthening of the medical centers and their parent universities, to the end that these institutions can even better serve the future needs of the nation.

III. Support of the enlarging responsibilities of medical centers supplementary to their continuing commitment to physician education and undirected research

A. The Need

The fundamental purpose of medical education and medical research is to improve the health of the people and so contribute to their general welfare. Thus is established the basis of the effective partnership of medical centers with the public and private sectors upon which they depend for support.

Medical schools and their related medical centers look forward to responding to opportunities for expanded contributions to the

nation's health, recognizing that this depends upon having available the increased manpower, facilities and clinical resources that are needed beyond the requirements of traditional commitments.

The Community Mental Health Act; Part B and Title XIX of "Medicare"; the Regional Medical Programs for Heart Disease, Cancer, Stroke and Related Diseases; the Partnership for Progress in Health (S. 3008) are examples of legislation intended to enhance the delivery of health services. Each of these and other similar programs is dependent upon an increased supply of physicians, health related professionals, paramedical and technical workers. Each depends upon the development of new knowledge and new patterns of organizing delivery of health services. The expanded educational and research programs necessary to meet these demands will depend heavily and probably primarily upon the medical centers of the United States and their associated universities for leadership and the development of operating models. The full effort will involve the entire system of higher education, including the teaching hospitals not a part of medical center complex.

The total costs of these health service programs is so large that competition for available funds will be inevitable. Regardless of the distribution of funding among these programs, the demands upon the medical centers will be more closely related to the total magnitude than the size of a given program. Because of these considerations, each program depends on the basic institutional strength of the medical centers.

B. Policy

The strength of the many Federal programs for improving delivery of health services to the nation depends heavily upon the institutional

strength of the medical centers and their parent universities. These varied programs should be administered not only with a view to producing increased delivery of health services but also with a view to increasing the institutional strength of existing medical centers and increasing the number of medical centers capable of education, research and health services of high quality.

C. Proposals

1. It is proposed that research programs leading to the improvement of the delivery of personal health services be intensified. The resources necessary for such experimental efforts would include an ambulatory clinical base with supporting hospital facilities designed for this type of research. A representative cross section of the community population should be provided health services in these research facilities. The professional research staff should receive long-term stable support of their efforts.

Such a program is analogous in principle to the general clinical research centers. The goal of this research would be to develop models of more efficient and effective personal health care which would be suitable for general community use. In addition, it would provide a clinical base for the education of physicians and other health workers in this pattern of patient care.

The need for such research is urgent if we are to meet the demands for increasing amounts of health service

without sacrificing scientific quality and the essential personal relationship of the patient to his physician.

2. It is proposed that the Basic Educational Improvement Grants be expanded to include the total span of the formal and post-graduate phases of the education of the physician.

The medical center concerns itself with the entire span of the education of the physician. Although it has unique responsibility for the four-year medical school curriculum, it also extends into the collegiate and postdoctoral phases of the physician's education. If this entire span is to be improved in quality and hopefully shortened in time, then the resources for educational improvements must be applicable to that entire span.

3. It is proposed that the Special Educational Improvement Grants be made adequate to provide major, stable increases in the institutional strength of medical centers that are now underdeveloped and so unable to fulfill their role as a national resource.

In making this proposal, the Association of American Medical Colleges commends the announcement by the Secretary of Health, Education, and Welfare that a full and frank dialogue begin between the universities and the Department of Health, Education, and Welfare. In the appointment of a Special Advisory Committee on University Relations, we respectfully suggest that consideration be given to the special responsibilities

carried by the university medical schools and medical centers in partnership with the health related programs of the Federal Government.

4. It is proposed that where the national interest would be served the Surgeon General of the United States Public Health Service be authorized to grant awards with matching formulas adjusted to the resources of the institution responsible for essential health related programs of education and research.

The matching formulas of grants are in principle essential to the maintenance of multiple sources of support. Overriding, however, is the principle that the health needs of the nation should be met. The merits of matching formulas should not be translated into administrative rigidity that thwarts the development of essential health related education and research.

5. It is proposed that the V. A. Hospitals and the U. S. Public Health Service Hospitals be an integral part of community oriented regional health programs and that authorizations be extended to allow them to contribute to and draw from the resources of the community and region. Wherever feasible, this should be achieved within the medical center complex.

IV. The administration of the partnership of the medical centers and the Federal Government

A. The Need

The conditions of the interdependence of such different institutions as the Federal Government and the medical centers that are a part of the university tradition have been administered for almost thirty years, and particularly within the programs of the National

Institutes of Health, with remarkable wisdom and enormous benefit to the well being of mankind.

The Federal Government has shown deep understanding and respect for the independence and the special obligations of the academic community -- its individuals as well as its institutions. Once more to quote the Secretary of Health, Education, and Welfare:

"The problem is to fashion the terms of the relationship in a manner that acknowledges the mutual dependence among the three parties and at the same time respects the integrity of their respective responsibilities -- without distortion, without subordination of one to the other, and without interference in the performance of these primary roles.

"It isn't an entirely easy assignment."

B. Policy

Programs of Federal Agencies conducted in cooperation with medical centers should be administered not only to produce specific results but also with a view to increasing the strength of the institution.

C. Proposals

1. It is proposed that salary scales for top scientists and administrators in the federal agencies concerned with health be placed at the level of comparable positions of leadership and responsibility in the university and their related medical centers.

The very high quality of the men who have led the U. S. Public Health Service from its inception must be maintained in the

future. The present salary levels are a serious impediment to meeting this qualitative staffing requirement.

2. It is proposed that the methods used to provide accountability by scientists for expenditure of funds from the Federal Government be reviewed. The present consumption of the time and thought of scientists by this phase of grants management is wasteful and demoralizing.

Present expenditures of this most precious human resource in effort reports, progress reports, grant renewals, human use review, separate site visit representation for multiple agencies interested in a single program, purchase justifications and cost-sharing analyses are examples of administrative practices that are individually readily justified but in their total effect probably detract from the scientist's direct contribution to education and research.

3. It is proposed that a formal liaison be established through the Association of American Medical Colleges between the medical centers of the United States and the Congressional and Executive Branches of the Federal Government; to the end that a continuing exchange of viewpoints may take place on both established and developing policies affecting the partnership of the medical centers and the Federal Government.

13A

PROJECTION OF MEDICAL STUDENTS, FACULTY, AND GRADUATES TO 1985

	1945-46	1950	1955	1960	1965	1970**	1975**	1980**	1985**
Population U.S. in 000's	139,928	151,683	165,069	179,992	194,572	206,110#	220,133#	233,140##	247,953##
Total Medical Students	23,216	26,186	28,639	30,288	32,835	37,370	41,070	45,000	50,000
1st Year Medical Students	6,060	7,177	7,686	8,298	8,757	10,400	11,300	12,300	13,750
M.D. Degrees Awarded Annually*	5,826	6,135	6,845	6,994	7,574	8,800	9,450	10,150	11,200
Medical Grads./100,000 Pop.	4.16	4.04	4.15	3.89	3.89	4.27	4.29	4.33	4.52
Full-time Faculty	NR	3,933	6,719**	11,111	17,149	24,000	28,000	37,000	46,000
Full-time Faculty/Medical Student Ratio		6.65	4.26	2.73	1.91	1.56	1.47	1.22	1.09
Graduate Students (Candidates for M.S. and/or Ph.D.)	NR	4,281	2,411	3,304	7,076	8,500	12,500	18,000	25,000
Full-time Postdoctorate Students and/or Fellows	NR	1,238	1,000**	4,317	5,014	8,500	12,500	18,000	25,000
Ph.D. Degrees Awarded Annually	NR	225**	282	339	606	900	1,200	1,700	2,400

NOTE: Projections based on past 20-year experience and presently known factors which may alter the earlier trends.
Estimate 110 4-year and 3 2-year medical schools in 1985.

* Based on 1st year enrollments 4 years earlier

** Estimated

Series C Projection of Population

Series D Projection of Population

TABLE I

1313

RANGES, MEDIANS, AND MEANS OF
STUDENTS, FACULTY, AND GRADUATES FOR
84 FULLY DEVELOPED FOUR-YEAR MEDICAL SCHOOLS
IN 1965

ESTIMATED RANGES, MEDIANS, AND MEANS OF
STUDENTS, FACULTY, AND GRADUATES FOR
110 FOUR-YEAR MEDICAL SCHOOLS
IN 1985

	Total	Range	Median	Mean	Total	Range	Median	Mean
Medical Students	32,521	190 - 791	353	387	49,500	250 - 950	425	450
First Year Medical Students	8,592	50 - 215	95	102	13,750	75 - 250	120	125
M.D. Graduates	7,574	44 - 191	83	90	12,650##	70 - 225	110	115##
Graduate Students (M.S. and/or Ph.D.)*	6,964	0 - 464*	64	83	24,750	50 - 600	200	225
Full-time Fellows and/or Postdoctorates**	4,991	0 - 531**	40	59	24,750	50 - 600	200	225
Full-time Student Equivalents	75,478	285 - 1,974	847	899	154,000	500 - 3,000	1,300	1,400
Full-time Faculty	16,666	51 - 436	191	198	46,200	150 - 900	400	420
Ph.D. Degrees Awarded#	606	0 - 41#	6	7	2,420	5 - 60	21	22
Full-time Faculty/Medical Student Ratio	1.95	3.73 - 1.81	1.85	1.96	1.08	1.67 - 1.06	1.06	1.07

- * Three schools had no graduate students in 1965
- ** Ten schools had no Full-time Fellows and/or Postdoctorates in 1965
- # Eight schools awarded no Ph.D. degrees in 1965
- ## If computed on basis of entering class four years earlier, total M.D. graduates would be approximately 11,200 and the average would be 102.

TABLE II

TAB -14

ADDRESS*

by

William H. Stewart, M. D.
Surgeon General, Public Health Service
U. S. Department of Health, Education, and Welfare

Since I first met with you a year ago, two powerful currents have converged upon the nation's health resources, both public and private, at every level. Each has received clear and forceful expression, and the most effective way I can find to stress these two points is to set two quotations back to back.

The first is from President Johnson's Special Message to the Congress on Education and Health. The President stated as a national goal: "Good health for every citizen to the limits of our country's capacity to provide it."

The second is from Secretary Gardner's testimony before the Senate Subcommittee on Intergovernmental Relations three weeks ago:

"The old system of governmental arrangements--unmanageable city government, inadequate state government, disjointed relations between federal, state and local levels, and uncoordinated federal programs-- is dying."

The import of these two statements is clear. The people shall be served. And new social instruments, institutions and patterns of operation shall be developed to serve them.

*Presented at the Surgeon General's Joint Conference with State and Territorial Health Authorities, Mental Health Authorities, Hospital and Medical Facilities Construction Authorities, and Mental Retardation Construction Authorities, Washington, D. C., December 6, 1966.

These are our marching orders--yours as well as mine--delivered not just by the nation's leaders but by its people. I look upon this challenge as an invitation, and I am confident that you do also.

Underlying this challenge is an assumption--one that has been almost universally accepted in the United States in very recent times--that health is a human right. Once this proposition is accepted, at least two corollaries become self-evident:

--that every person should have ready access to high quality personal health services;

--that every person should live in an environment which is safe from preventable hazard and conducive to healthful and productive living.

All of us know that these two sets of conditions do not exist today for many millions of our people.

Many obstacles stand between the individual and the care he needs--obstacles of shortages in manpower and facilities, of unequal distribution of resources, of economics, of inadequacies in the quality of service, and many more.

Similarly there are many gaps and failings in our health protection systems: diseases which could be eradicated are still taking their yearly toll; pollutants that could be removed are still doing injury; and so on.

Responsibility for the various functions required to remedy these shortcomings is widely dispersed. But recent trends have dictated a clear mandate that all government--city, state, and national--has a fundamental responsibility for assuring that the people's right to health is fulfilled to the greatest possible extent.

This does not mean that governmental agencies will do all things for all people. Nor does it imply that government must be the directive force in all health enterprises. Quite the contrary. The pluralistic base of our American health endeavor brings many benefits. Many parts of the nation's total health mission can best be initiated, performed or directed by non-governmental institutions and systems. But in health as in many other spheres of activity, government--which is ultimately accountable and responsive to the public--has an obligation to assure that the public's needs are met.

This assurance can be achieved only through full and productive partnership, not only between the Federal government and its state and local counterparts but among all health resources, public and private, individual and institutional. In this partnership each element would direct its efforts toward a common goal, rather than toward a separate objective, separately established. This concept is my interpretation of "creative federalism" as applied to health.

This is also what Secretary Gardner is talking about in his testimony before the Senate Subcommittee. Following the sentence I have already quoted comes the following passage:

"Meanwhile one can see at all levels the groping attempts to create a new system--a system that will be less wasteful of resources, that will profit by the advantages of large-scale organization, and will give a wider range of Americans easy access to the benefits of our society. The new system has not yet taken shape, and that fact is of critical importance for our future. It means that we still have major choices."

All of us are in the throes of a harsh transition. The old order is giving place to a new one. The shape of the new order is not yet altogether clear. We are, to use the Secretary's word, "groping"--and groping is an uncomfortable act. But in the painful passage from discontent with things-as-they-were to discomfort with things-in-transition, there is great hope for the future.

Moving from the abstract one step into the specific, it seems to me that there are two great action thrusts ahead for the entire health partnership. I have already mentioned them as corollaries to the acceptance of health as a human right.

The first is to remove the inequities and inadequacies in access to and quality of personal health care.

The second is to assure maximum protection against preventable diseases and hazards in the environment.

In support of these action thrusts, there are three major areas of resource development.

The first is knowledge, derived through research--not in the biomedical sciences alone but in all fields related to the delivery of health care and the development of a healthful environment.

The second is manpower--recruited and trained to high levels of competence for the performance of all the tasks related to our total health mission.

The third field of resource development has to do with patterns of organization, the creation of systems which assure that our other resources are efficiently used in achieving our goals. It includes the development of needed facilities, institutions and arrangements for making full and effective

use of knowledge and manpower, the shaping of ways of doing things that pay off in better health care and health protection.

We in the Public Health Service have redesigned our own structure so as to provide effective leadership and support in these areas of action thrust and resource development. Two of our new Bureaus--Health Services, and Disease Prevention and Environmental Control--are directed toward achievement of the national goals of access to care and health protection. The new Manpower Bureau and the NIH are concerned with the fundamental resources of personnel and knowledge. The fifth Bureau, the National Institute of Mental Health, is a new organizational form which combines all these component areas in a unified attack on a single field of health concern.

I know that most of you are already familiar with the broad outlines of the Public Health Service reorganization, and I do not intend to discuss it in detail. The central points I would like to make on the reorganization are these:

First, that it was long overdue and urgently needed;

Second, that its endorsement, in principle by the President and the Congress and in detail by the Secretary, represents a strong vote of confidence;

Third, that we believe our new structure will enable us to function more effectively in discharging our responsibilities;

And fourth, that this reorganization will in turn be changed as responsibilities and priorities change, since we now have the authority to be responsive and flexible.

As all of you are keenly aware, the structure and functioning of the Public Health Service and its changing relationships with other health agencies and institutions make up only a part of the Federal commitment

to health. In fact, in recent years there has been a rapid and tangled growth of governmental programs at all levels, directly or indirectly involved in health.

Here in Washington, we need to look no farther than our own Department--every one of the major agencies of HEW has a substantial health commitment. Then there are the programs of OEO, Appalachia, the new Departments of Transportation and Housing and Urban Development, the old Departments of Agriculture and Interior--all involved to a greater or lesser extent in work related to our own. This same fragmented pattern carries over to the states, the cities and the rural areas. It is extraordinarily difficult--as you well know--to find out who is in charge of what, spending which dollar for what purpose.

It is easy to deplore this jungle. It is much more difficult to do anything about it. This is the heart of the challenge to which Mr. Gardner was addressing his remarks--extended not only through the health field but throughout the associations among governmental and private entities. We need to preserve our pluralistic base of initiative--because we need all the ideas and all the energy we can muster. Concentration of all the power, all the decision-making, in one place would be stifling. At the same time we need to develop combinations that will enable us to take full advantage of all these separate initiatives and forces.

Insofar as it is possible to generalize at all about the Federal programs that have developed, it can be said that Public Health Service programs up to the present time have been principally directed toward resource development. Ours has been the unquestioned primary responsibility in the generation of new health knowledge and the strengthening of the research enterprise. Ours has been the predominant thrust in the development

of facilities for health care. Since 1963, the succession of legislative actions in the manpower field have given to the Service the largest--though not the only--share of responsibility for health manpower development.

By contrast, mechanisms for financing care for certain population groups--including Titles 18 and 19 and others--are administered in the Social Security Administration, the Welfare Administration, and elsewhere. If these programs are to fulfill their purposes with maximum benefit, it is essential that professional and technical competence in health be linked effectively with competence in economics and social insurance. Only thus can resources be developed to meet the demand. Only thus can standards of service be established and raised above the level of the lowest common denominator. The bridges between these programs, moreover, must be designed to encourage a two-way flow of mutual assistance.

Thus we arrive at a critical moment of truth. We have a rising tide of public insistence upon better health care and better health protection. We have verbal expressions of this insistence from the nation's highest executive leadership, and concrete legislative expressions of this insistence from the nation's lawmakers. These expressions have given us a powerful over-all mandate, and provided us with a growing wealth of scattered and uncoordinated resources.

Our mandate implies broad national goals--universal access to high quality care and creation of an environment that promotes healthful and productive living. Beyond that point, however, we have no unified, coherent national health policy which relates resources and priorities to these goals. Moreover, having no way of framing mutually agreed-upon priorities we have no effective way of measuring results against input.

You recognized the importance of these deficiencies in last year's Conference, with this statement: "The State and Territorial Health Officers feel there is an urgent need, and it is timely, to establish a coherent set of long-range goals and objectives, as aims for a national policy to maintain and improve the health of every person in the community in which he lives." One of your formal recommendations urged that the Surgeon General take the initiative in shaping such a policy with the Administration and the Congress, and you further recommended that each State and Territorial Health Officer assume such leadership within his jurisdiction.

The need for such a policy becomes clearer every year. We are faced with the problem of translating a genuine revolution in public expectation into a genuine advance in the public's health. No challenge could better fit Dr. Mustard's definition of a public health problem, written in 1938:

"A health problem becomes a public health one when, because of its nature or extent, it may be solved only by systematized social action."

What experience do we have that can be used as a launching-pad for the kind of social action now required of us? Let me call your attention to three innovative experiments leading in the direction toward which we must move.

The first is the hospital planning enterprise. The concept of planning across logical, functioning geographic areas for the development of health facilities has been tested and proved sound within its prescribed limits of resource development. This was a major breakthrough, and all of you who have contributed to it can place yourselves among the ranks of the innovators.

The second is the community mental health effort. Beyond question this is one of the most exciting and promising developments in health in our time. It will continue to bear abundant fruit for many years to come within its very broad but still limited sphere of activity.

The third is the regional medical programs concept now getting off to an excellent start. This program envisions a powerful new kind of partnership among public and private health resources, based on functional regions, with enormous built-in flexibility for adapting to local needs and resources. All across the country these new partnerships are being forged.

Each of these three programs, in a sense, creates a new kind of social institution to perform a specific task not being adequately performed before. Each exemplifies genuine cooperation among a wide range of agencies. Significantly, each requires participation not only by health professionals but by the consuming public. Each is an example of the merging of what we used to call the "public and private sectors" in the public interest, for a common purpose.

But each operates independently. Nothing exists which relates these three to each other, and to other efforts, in the achievement of a total health objective.

With this as a stage setting, let me now proceed to the principal item I wish to discuss with you today--Public Law 89-749, the Comprehensive Health Planning and Public Health Services Amendments of 1966. As you know, this legislation was passed during the final week's sessions of the 89th Congress and signed by the President early last month.

In introducing the subject I should like to quote liberally from the Act's Declaration of Purpose, which states the case concisely and serves, in a way, as a summary of what I have said thus far:

"The Congress declares that fulfillment of our national purpose depends on promoting and assuring the highest level of health attainable for every person, in an environment which contributes positively to healthful individual and family living; that attainment of this goal depends on an effective partnership, involving close intergovernmental collaboration, official and voluntary efforts, and participation of individuals and organizations...."

The Congress then declares that Federal financial assistance must be directed to the marshalling of all health resources and "finds that comprehensive planning for health services, health manpower and health facilities is essential at every level of government...." It calls for strengthening of State health agencies and for broadening and increasing the flexibility of support for health services in the community.

This is the stated purpose. Unstated but implicit is the attempt to break down unnecessary restrictive barriers among categories; to provide for priority determination and decision at a level closer to the needs of the people; and thus to use this instrument as a means for reorienting federal-state relations--and by extension, all relationships--within the health field.

Before we look in detail at the legislative instrument provided for the attainment of these purposes, let me sketch for you briefly a breakdown of the kinds of federal funds now flowing into any given state. Depending on how you count them, there are from 40 to 100 different programs involved

in this flow, stemming from many federal agencies. Despite their diversity, I think they can be generally categorized in three types.

First there are the funds that create resources. This includes the money that helps to build medical schools, nursing schools, hospitals, and other facilities; the research grants and other funds intended to create new knowledge; the training programs aimed at manpower development. These funds have many sources--PHS, VRA, Children's Bureau, etc. In the given State, the money is received and used by a variety of agencies. Some are governmental, some are private.

The second category includes those programs which provide services. For the most part these are vendor payment programs on behalf of the individual who purchases services from various sources. Here again there are numerous sources--Title 19, the OEO Programs, VRA, and so forth--and there are numerous separate channels of flow at the state level.

The third category is made up of programs aimed at specific targets, designed to encourage innovation, to demonstrate new methods, to find and apply better ways of doing things. These consist for the most part of what we have called "categorical" programs.

Obviously all of these types of funds and the programs they support are interrelated in fact. They are also interwoven at the point of delivery with state and local funds and--largest of all--with private dollars.

The importance of these interrelationships is obvious. Resource development cannot be logically separated from the resource consumption that takes place in the providing of services. Setting of standards of service cannot logically be divorced from innovative programs designed to upgrade standards, to do things better.

Meanwhile we have a great deal of planning going on in connection with each of these programs, considered separately. Some of the planning is statewide. Some of it is based on a locality or a metropolitan area. This multiplicity of planning efforts at the state level operates under the same multiplicity of agencies and authorities--some governmental, some non-governmental, some a mixture of both.

But nowhere is there an entity that relates these plans to each other and decides on relative priorities. There are no data on which to base decisions between alternatives. No one is equipped to say, for example, that unless money is poured into five new nursing schools in our state next year we cannot extend the benefits of Title 19 to more people. No one has either the knowledge or the authority to decide to give top priority to building nursing homes in a particular area of the state instead of spending those dollars for something else.

The first part of the Comprehensive Health Planning and Health Services Act is an attempt to provide a focus for this kind of decision. To qualify for this planning aid, the Governor must designate or create a single state agency with the responsibility for administering or supervising the State's health planning functions in the development of a comprehensive plan. This can be a new agency, an existing agency, or an interdepartmental entity. Its basic job is to examine the needs of the state and recommended priorities for meeting those needs with the resources available.

This state health planning agency will have to possess a base in official governmental authority which permits it to obtain plans and data from all agencies charged with health responsibilities and relate these into a total health planning effort. It will need authority to receive and

spend funds, to employ a full-time executive and qualified planning staff. It will require the competency to provide staff support for comprehensive health planning, as a basis for decision-making by the Governor and legislature and by the many other official and non-official participants in the planning process.

The Act does not endow this agency with direct authority. But if it does its job well, it will certainly be influential in the fundamental decision on where the state health dollar should go, and on where a great many federal dollars would go as well.

P.L. 89-749 requires that this designated state agency be advised by a state health planning council, representing state and local agencies and groups concerned with health but with a majority of its members representing consumers of health services. This state health planning council, if it is wisely selected and utilized, can be an important new social instrument for relating health planning to the needs felt by the public we seek to serve.

Thus P.L. 89-749 supports the creation of a state health planning agency. It also has other provisions supportive of health planning. One of these is a project grant program for areawide health planning similar to the existing program except that the new law requires a relationship between these project grants, made on a regional or local basis, and the comprehensive planning program I have just outlined. This relationship is of vital importance. It links statewide planning with the plans and actions undertaken in the metropolitan areas where so many of our people, and our problems, are concentrated. A third aspect of support for planning is provided through funds for training people in planning skills--a field of critical manpower shortage.

The second major aspect of P.L. 89-749 deals with service-providing functions--the Public Health Service-State Health Department programs for health services. As you know, these have been compartmentalized stringently in the past into 8 or 9 categories. For example, before P.L. 89-749, if a state health department should decide in a given year that it was more important to concentrate on a specific health need which it believes to be important and soluble, rather than on a nationally-determined disease control priority, it has had no flexibility to fit these funds into the state's priorities.

It is self-evident that needs vary from one part of the country to another, from one state to another, and within a single state. Variations are especially dramatic in urban settings. Therefore the second principal thrust of the new law is to provide flexibility in the use of these formula grant funds. Now, the state will be able to plan its use of health services money--to strike hard at the eradication of syphilis, for instance, because it appears that this is an area in which important success can be attained. Obviously the granting of these funds will be dependent upon a state plan which shows what the state intends to do. This plan, in turn, must be related to the comprehensive plan. The important thing is that there is now a range of choice within the structure of formula grants for health services.

The third important aspect of P.L. 89-749 relates to the series of project grant authorities which have proliferated over a period of years. These were grants from the Public Health Service to public or non-profit private organizations in the cities and counties. Most of them were for specific disease control purposes or for developing new ways of delivering a variety of services. These were the targeted, innovative grants I discussed awhile ago. Each of these authorities was quite strictly limited--

even the community health services and facilities project grants, for example, were limited to out-of-hospital services and weighted toward the chronically ill and aged.

What has been done in this instance is to pool these project grant funds, and to broaden the possibilities of using these grants for innovation, demonstration, or a specific target. One such target might be tuberculosis. Another might be narcotics addiction. A third might be putting services into a local area with a critical shortage of health manpower. None of these three examples represents a uniformly distributed national need, but each is of critical importance in certain places.

This is the Act we have constructed. Its intent is clear--to give to the states, cities and counties more initiative, more flexibility and--just as important--the attendant responsibility. It is designed to permit federal funds to meet the special requirements of different areas.

In looking at this revolutionary new approach to the federal-state relationship, many people have been skeptical. They have pointed out that states will vary widely in their initial capability to handle this big new delegation of responsibility. They have predicted dire conflict and skirmishing among vested interests at the state level. Some have also cocked a quizzical eyebrow at us--we are calling for the creation of a genuine policy-creating and priority-setting mechanism at the state level while no such animal yet exists in the federal government. As I have already pointed out, we feel this lack of coherent policy direction and are taking beginning steps to remedy it.

No one claims the total job will be easy. But the job is ours to do, and I hope you share with me the conviction that it is worth the doing.

Our own planning for the administration of this Act, within the Public Health Service, has been a strenuous and sometimes painful process. Essentially, we have decided to change our way of doing business, in a rather radical way.

In the past, as you know, the bureaus, divisions and programs of the Service have carried full operating responsibility. This responsibility has prevailed not only in Washington but through our nine regional offices to the actual level where the program is being carried out. The Office of the Surgeon General has primarily performed a coordinative and policy-setting function, and the nine regional offices have served principally as "hotels" for the program operators whose first line of responsibility traces back to the Bureau and Division Chief in Washington. This structure was a reflection of the extreme fragmentation of programs.

But this new program simply would not fit this mold. Every Bureau is deeply involved: the Bureaus of Health Services and Manpower almost by definition, the Bureau of Disease Prevention and Environmental Control through its targeted programs, the NIH through the regional medical programs, the NIMH through its deep roots in state and community planning and activity.

Thus we have reached the decision to put the budget for this program in an organizational entity responsible directly to the Surgeon General, and related closely to all the Bureaus. It will be administered as a Public Health Service enterprise. And its operations will stem from the regional offices.

Stating it a little differently, the development of policy and tools for implementation will be the responsibility of my immediate office, with strong and continuing input from all five bureaus. A special responsibility for assisting the Regional Health Directors in the operating phase of the

program is assigned to the Bureau of Health Services. The Regional Offices will be where the action is.

Specifically, the management of the new grants programs will be located there. They will receive applications, arrange for and supervise their review both technically and in terms of conformance with comprehensive plans, award the grants and carry out necessary follow-up procedures. One obvious advantage appears immediately--instead of some 15 places to which applications were directed for these grant programs, there will now be a central focus and a single point of application.

Obviously it will not be possible to have all the necessary technical skills in every regional office. Our intention is that the regional health director will be able to get his technical advice from a wide variety of sources--a university, a local health department, a program in the Public Health Service, etc.--wherever the competence exists to meet his need.

In this connection too, we hope to create in each region an outside advisory council which would be a strong source of guidance to the regional health director in managing this program. These councils would include competencies from industry and the universities, from medical practitioners, from experts in public affairs, and the like. This council system, in addition to serving a vital purpose in support of the regional health director, would have further advantage of bringing additional talented and competent people into the review of federal-state-local programs.

As I have indicated, this involves almost a 180-degree turn in the operation of our regional offices. Heretofore each has had a very small "house" staff plus a large number of program representatives from the various Bureaus, all owing their basic allegiance to their home program and frequently engaged in a kind of competitive scramble for grants business.

This was a perfectly natural outgrowth of a system which measured accomplishment in terms of "sales".

We anticipate that the changed procedure will bring about a changed climate in this regard. The programs will now be charged with defining objectives, assisting States in setting goals, measuring program effectiveness, and similar activity.

Above and beyond these practical benefits, we believe that there will be an intangible but important strengthening of the Federal-state partnership through the geographic decentralization of substantial authority. We are truly joining together--not in a contest over rights and powers but in a common cause. We are striving to meet needs as they exist, where they exist.

We have a great deal to do together. Our ultimate goal has been set for us by society--the best level of health for all our people up to the limits of our national potential. Toward this end we need to achieve access to high quality health care for all and create an environment that fosters rather than impedes human fulfillment.

It is manifest that the Federal government cannot do this job alone, that it cannot do the job in sole partnership with State government, nor in dual partnership with state and local government. Total health achievement requires total commitment of health resources. More than that, it requires their deployment in organizational patterns that cause the whole to be greater than the sum of the parts.

I am not talking about a monolithic system at the federal, the state, or any level. Rather I am talking about a fusion of public and private endeavor for the ultimate good of the people we serve. If we create the right kind of partnership, every partner will be strengthened in his capability to do his job supremely well.

I am convinced that this year we are taking an important step toward solving a number of the problems with which all of us are deeply concerned. I believe that, by entering freely and fully into partnership, we can eliminate many of the difficulties that have resulted from fragmentation of effort, here in Washington and across the nation. More importantly, by so doing, I believe we can generate the social action necessary to deliver the nation's full potential for advancing the health of the American people.

#####