

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

AGENDA

COTH COMMITTEE ON CONSTRUCTION AND
MODERNIZATION FUNDS FOR TEACHING HOSPITALS

Monday, February 19, 1968

The Potomac Room

The Mayflower Hotel

1127 Connecticut Avenue, N.W.

Washington, D. C.

10:00 a.m. - 4:00 p.m.

- I. Call to Order and Call of Roll: 10:00 a.m.
- II. Welcome to John W. Kauffman, Chairman, AHA Council on Government Relations
- III. Welcome to Thomas J. Campbell, Assistant Director, AAMC Division of Operational Studies
- IV. Approval of Minutes - Meeting of December 12, 1967 - TAB 1
- V. Report on Action Items From Last Committee Meeting and Other Outstanding Action Items From Previous Meetings - TAB 2
- VI. Recent Statement of Definitions By American Hospital Association - TAB 3
- VII. Report: Meeting of Society of University Health Administrators (January 20-22, 1968) - Lewis H. Rohrbaugh, Ph.D. - TAB 4
- VIII. Report by Committee Members and Discussion - Individual contact with members of the President's Advisory Commission on Health Facilities - TAB 5
- IX. Discussion of Proposed "White Paper" on Need for Modernization and Construction Funds for Teaching Hospitals
- X. Review: Proposed Study of Need of Funds for Expansion of Teaching Hospitals
- XI. Other Business
- XII. Date of Next Meeting
- XIII. Adjournment: 4:00 p.m.

At 12:30, the Committee will be joined for lunch by William L. Kissick, M.D., Executive Director, President's Advisory Commission on Health Facilities in the Concord Room.

MEMBERSHIP OF COMMITTEES

Committee on Modernization
and Constructions Funds
for Teaching Hospitals

Richard T. Viguers, Chairman
Lewis H. Rohrbaugh, Ph.D., Vice Chairman
Robert C. Hardy
John H. Knowles, M.D.
David Littauer, M.D.
John H. Westerman
Richard D. Vanderwarker

COTH Representatives
on AAMC Committee on
Federal Health Programs

Charles H. Frenzel
Harold H. Hixson
J. Theodore Howell, M.D.

AHA Representatives

John W. Kauffman

Staff

Matthew F. McNulty, Jr.
Fletcher H. Bingham, Ph.D.
Grace W. Beirne
William G. Reidy
Thomas J. Campbell

MINUTES
COUNCIL OF TEACHING HOSPITALS
COMMITTEE ON CONSTRUCTION AND MODERNIZATION
FUNDS FOR TEACHING HOSPITALS
December 12, 1967
Washington Hilton Hotel
10:00 a.m. to 4:00 p.m.

Present:

Richard T. Viguers, Chairman
Lewis H. Rohrbaugh, Ph.D., Vice-Chairman
Charles H. Frenzel, COTH Member on AAMC Committee on Federal Health Programs
Harold H. Hixson, COTH Member on AAMC Committee on Federal Health Programs
Robert C. Hardy
David Littauer, M.D.
John H. Westerman

Staff:

Matthew F. McNulty, Jr., Director, COTH
Fletcher H. Bingham, Ph.D., Assistant Director, COTH
Grace W. Beirne, Staff Assistant, COTH
Elizabeth A. Burgoyne, Secretary to the Director, COTH

Committee was joined at 12:30 p.m. for lunch by:

James H. Cavanaugh, Ph.D., Director of Comprehensive Planning, HEW and
Thomas G. Moore, Jr., Director, Office of Legislation USPHS

Absent:

J. Theodore Howell, M.D., COTH Member on AAMC Committee on Federal Health Programs
John H. Knowles, M.D.
Richard D. Vanderwarker

I. Call to Order:

The meeting was called to order at 10:00 a.m. by Chairman Viguers

II. Approval of Minutes--Meeting of October 10, 1967:

ACTION #1 DR. ROHRBAUGH MOVED THAT THE MINUTES OF THE OCTOBER 10 MEETING BE APPROVED AS PRESENTED. THE MOTION WAS SECONDED BY MR. HIXSON AND PASSED UNANIMOUSLY.

At Mr. Viguers' suggestion, Mr. McNulty used the minutes as a base for review of events relative to the subject of modernization and construction funds subsequent to the October 10 meeting. He noted the committee had endorsed Hill-Burton Amendment Legislation but that no hearings had been scheduled as yet.

Mr. McNulty also indicated a definite governmental trend toward economy. He reported that: 1) At the request of Secretary Gardner a National Conference on the Cost of Health Care Facilities was held which seemed to present nothing innovative beyond the concept that limiting the number of hospitals would curtail the cost for modernization and construction, 2) The National Advisory Commission on Health Facilities, chaired by Boisfeuillet Jones, met for the first time on December 11, with the emphasis on organization rather than productivity. He said the chief emphasis by COTH, in early stages of the National Advisory Commission on Health Facilities, should be on the priorities of pursuit of modernization funds. He further reported that there is great disagreement within the Department of HEW on what will happen to Hill-Burton in fall of 1968. He said that it is highly likely that action on Hill-Burton might be dependent on the report of the Commission's recommendations, which is slated for completion by next October.

With these developments in mind, Mr. McNulty summarized the actions of the COTH staff in implementing the actions enacted at the October 10 committee meeting, as follows:

Action 1 -- A follow-up on the modernization questionnaire is in the design stage and will be completed.

Action 2 -- The results of the original survey have been distributed and many comments have been received expressing appreciation.

Action 3 -- On the advice of Boisfeuillet Jones to Mr. McNulty, a statement of recommendation to the National Advisory Commission on Health Facilities has not been prepared. Mr. Jones cautioned COTH not to state any position until it was known where the Commission would direct its energies -- and then to tailor any COTH recommendation to what the Commission decides to do.

Action 4 -- COTH has voiced its support of S. 2251 and it will extend to the second session of the current congress.

Action 5 -- In relation to the package "Health Manpower Legislation", Mr. McNulty directed the Committee's attention to the report of the National Advisory Commission on Health Manpower, which covers more than just manpower, including support for facility modernization. Specifically, it was noted that the Report recommended: (1) Federal assistance in the form of grants or loans (or loan guarantees) be provided to obsolete hospitals in those areas where modernization needs are so extensive that nongovernment sources of capital funds will be closely insufficient.

(2) Before any decision is made to finance modernization, on a large scale, state and Federal Governments should carry out a careful study to determine criteria for deciding between modernization and replacement.

III. Executive Committee Action of Monday, October 30, 1967, that the Subcommittee be made a Full Committee:

Dr. Bingham reported that at the October 30 meeting of the COTH Executive Committee, subsequent to the combination of the COTH Government Relations Committee and the AAMC Committee on Federal Health Programs, the Subcommittee on Construction and Modernization Funds for Teaching Hospitals was made into a full committee of COTH. In relation to this, Mr. Frenzel outlined some of the events at the November 21 meeting of the AAMC Committee on Federal Health Programs, of which he is one of the COTH representatives. Mr. Frenzel indicated that they met with Ralph K. Huitt, (Assistant Secretary, Legislation) and Philip R. Lee, (Assistant Secretary, Health and Scientific Affairs). The

meeting presented no specific action, being primarily organizational. Mr. Frenzel indicated that the Committee had expressed the belief that if there were forced cuts in funding, they should come out of research activities and not education. He said that the Committee also discussed any reaction that the AAMC should make officially to the "Fountain Report" and decided to let the matter rest as saying anything could bring another barrage of criticism from the representative.

Mr. Frenzel then said that one crucial area for COTH to consider was the working relationship between committees, and the AAMC Committee on Federal Health Program's request that the COTH Committee report directly to them. Mr. Frenzel and others felt that the prime responsibility of the Committee was to report to the COTH Executive Committee and then let any report to the AAMC Committee originate from COTH as a whole.

ACTION #2 IT WAS AGREED THAT THE COTH COMMITTEE ON MODERNIZATION AND CONSTRUCTION FUNDS REPORT FIRST TO THE COTH EXECUTIVE COMMITTEE WHICH COULD THEN USE ITS OWN DISCRETION IN REPORTING FOR COTH TO THE AAMC COMMITTEE ON FEDERAL HEALTH PROGRAMS, WITH EACH COTH MEMBER ON THE AAMC COMMITTEE PARTICIPATING FULLY WITH THE AAMC FOR THE TOTAL BENEFIT.

IV. Problem of Inadequate Overhead on Direct Research Grants and Training Grants:

Mr. Viguers, who had requested this item on the agenda, recognized that although a very important topic, it could be more properly handled by the COTH Committee on Financial Principles for Teaching Hospitals. He said that he had established contact with the Bureau of the Budget on this subject, as had Lawrence E. Martin of Massachusetts General Hospital who is a member of the Financial Principles Committee. The Committee members all recognized that this problem was becoming increasingly difficult to resolve and if there was any information they could

supply to the Committee on Financial Principles, they would be glad to do so.

ACTION #3 IT WAS AGREED TO REFER THE AGENDA ITEM CONCERNING THE PROBLEM OF INADEQUATE OVERHEAD ON DIRECT RESEARCH GRANTS AND TRAINING GRANTS TO THE COTH COMMITTEE ON FINANCIAL PRINCIPLES FOR TEACHING HOSPITALS, WITH THE COMMITTEE ON MODERNIZATION REMAINING AVAILABLE TO BE OF HELP.

V. Report on HEW Conference on Cost of Health Care Facilities:

This item had been covered earlier by Mr. McNulty. Many Committee members voiced the opinion that there were countless commissions, conferences, and committees studying current problems in the field of health care and the delivery of health services, so many in fact that they were hard to delineate and to perceive any kind of tangible results. Mr. McNulty echoed their sentiments, stressing the need for each hospital to involve someone on the staff of the local and state levels as this is the level at which the results of such conferences and commissions will most likely be implemented.

VI. National Advisory Commission on Health Care Facilities:

This item was discussed under Item II, but the Committee took the opportunity to review the composition of the Commission. Mr. McNulty reported that Dr. William L. Kissick, of the Public Health Service would serve as Executive Director of the Commission. Mr. Hardy said that he understood from Dr. Dennis, one of the members of the Commission, that they were extremely eager to be exposed to as many points of view as possible in order that their study could be more comprehensive.

ACTION #4 IT WAS AGREED THAT MEMBERS OF THE COMMITTEE ON MODERNIZATION AND CONSTRUCTION FUNDS FOR TEACHING HOSPITALS ESTABLISH INFORMAL, INDIVIDUAL LIAISON WITH COMMISSION MEMBERS TO SOUND THEM OUT AND APPRISE THEM OF THE COTH POINT OF

VIEW PRIOR TO ISSUING A FORMAL POSITION STATEMENT TO THE COMMISSION.

VII. Consideration of AHA Position on Proposed Hill-Burton Amendments:

This item was mainly informational since Mr. Kenneth Williamson had read the position at the October 10 meeting. The only question was the meaning of "Hospital Educational Facilities" under Item 6 of the AHA position. Mr. McNulty suggested that the phrase was in reference to diploma schools of nursing as well as the paramedical educational function.

VIII. Discussion Regarding Selected Provisions of Social Security Amendments of 1967 (H.R. 12080):

Mr. Viguers said that this item was more of historic interest since it had been defeated, however, he considered that the issue was not totally dead since there was still the matter of handling depreciation funding. Mr. McNulty added that he thought state and territorial health officials would favor Hill-Burton as it is.

IX. "Fund Freeze" for HEW:

Mr. Viguers confirmed that this was the present situation, with Mr. McNulty mentioning that it has now been suggested that an amount over the 2.7 billion dollars previously mentioned be withheld from this point forward. Mr. Viguers said that while the impact has not yet reached some medical schools and hospitals, in all likelihood, it will be very soon.

In response to Dr. Rohrbaugh's question as to whether approved grants would be withheld, Mr. McNulty said that the policy was not that definitive, but that such a possibility existed. Mr. Westerman referred to the testimony of Dr. Frank McKee, (Director, Division of Physician Manpower) in which he stated that programs for the development of new medical schools would run into great difficulty and that the Health Education Assistance Acts projects of the Bureau of Health Manpower are doing worse. He interpreted Dr. McKee's

statements as meaning that a priority schedule would have to be established in which new schools, even though approved for grants, would have a low priority. Mr. McNulty confirmed this comment by stating that George T. Harrell, M.D., at the Pennsylvania State University (Hershey Campus), had experienced a hold-up of funds. Miss Beirne advised that although appropriations had been made there would probably be a 10 percent cut in the amount released because of congressional action, although each department could use its discretion in administering the cuts.

In relation to this topic, Mr. Hixson raised the possibility of having the Committee on Financial Principles look at the "fund freeze" problem of holding up funds that have already been promised as many places expect the hospital to absorb the cost. He also said investigation by that Committee could check into GCRC appropriations. Mr. McNulty said that Miss Beirne and Dr. Bingham had established contact with the Acting Director of the GCRC Branch, Dr. DeCesare. Miss Beirne said that at a meeting with him he said that it appeared there would be no problem this year on funding and seemed quite optimistic. When Mr. Hixson stated that he had a letter from the Chief Investigator to him saying that the government said to remove funding for his Pediatric GCRC, Mr. McNulty asked Mr. Hixson to forward to him a copy of that letter if possible since it was almost the reverse of what Dr. DeCesare had indicated.

ACTION #5 IT WAS AGREED TO REFER THIS ISSUE TO THE COTH COMMITTEE ON FINANCIAL PRINCIPLES.

X. AHA Proposed Definition of Teaching Hospital:

Mr. Viguers noted that there should probably be some coordination for a definition between COTH and the AHA because there can be difficulty when you have two organizations defining the same thing. Mr. Littauer commented that

the proposed definition was two steps away from final approval within the AHA. Mr. McNulty noted that the AHA definition will be discussed by the Executive Committee at its next meeting.

ACTION #6

IT WAS AGREED THAT THE QUESTION OF THE PROPOSED AHA DEFINITION OF THE TERM "TEACHING HOSPITAL" BE PRESENTED TO THE COTH EXECUTIVE COMMITTEE FOR DISCUSSION AND REFERRAL AS THEY SAY FIT AND THAT ALL COTH COMMITTEES WATCH FOR ANY POSSIBLY CONFLICT BETWEEN THE AHA AND THE AAMC.

XI. Discussion and Committee Proposals for Future Activities:

Mr. Viguers said that under this item it was necessary to consider and establish priorities for future action. He said that the assignment regarding maintaining a contact with the Boisfeuillet Jones Commission was the first priority. Mr. McNulty -- as well as other members -- agreed, saying that although definitive action may not be possible immediately it is crucial that a liaison be maintained. Dr. Littauer then raised the question of whether or not COTH has elaborated the term, "teaching hospital" in terms of construction and operating costs. While none has yet been written, it was agreed that a documented definition is necessary, perhaps getting the information from the follow-up to the COTH questionnaire. Mr. Frenzel reiterated that there is a need to show what beds are needed, why they are needed, when they are needed because the government seems to think that the growing number of outpatient centers diminishes the need for inpatient centers. The group also stressed the necessity of knowing the reason for the number of beds. Mr. McNulty said that this information would be incorporated in the COTH follow-up questionnaire. In line with the foregoing discussion, Mr. Frenzel suggested the need for a position paper defining what we want and why we want it, and Dr. Rohrbaugh suggested that the Committee draw up several pieces of proposed legislation designed to cover hospital needs. After discussion of the possibilities in

these suggestions, Mr. McNulty agreed to the need for a definitive position paper with an addition of three or four legislative possibilities since it would serve to crystalize ir for the Committee.

ACTION #7 THE COMMITTEE AGREED THAT THE COTH STAFF PREPARE A POSITION PAPER DEFINING THE TERM TEACHING HOSPITAL AND BACKING UP A DEFINITION WITH A PRESENTATION OF THE TEACHING HOSPITAL IN TERMS OF CONSTRUCTION AND OPERATING COSTS, WITH A CERTAIN AMOUNT OF DOCUMENTATION OF THE NEED, THE CAUSE FOR THE NEED, ETC., AND WITH AN ADDITION OF SEVERAL LEGISLATIVE POSSIBILITIES TO RESOLVE THE NEED.

XII. Other Old Business:

There was no other old business.

XIII. New Business:

The date of the next meeting was set for February 19, 1967.

XIV. Adjournment:

The meeting was adjourned by Chairman Viguers at 4:00 p.m.

SUMMARY OF ACTIONS OF DECEMBER 10 MEETING OF COMMITTEE
ON MODERNIZATION AND CONSTRUCTION FUNDS
FOR TEACHING HOSPITALS

ACTION #2 - It was agreed that the COTH Committee on Modernization and Construction Funds report first to the COTH Executive Committee which could then use its own discretion in reporting for COTH to the AAMC Committee on Federal Health Programs, with each COTH member on the AAMC Committee participating fully with the AAMC for the total benefit.

ACTION #3 - It was agreed to refer the agenda item concerning the problem of inadequate overhead on direct research grants and training grants to the COTH Committee on Financial Principles for Teaching Hospitals, with the Committee on Modernization remaining available to be of help.

ACTION #4 - It was agreed that members of the Committee on Modernization and Construction Funds for Teaching Hospitals establish informal, individual liaison with commission members to sound them out and apprise them of the COTH point of view prior to issuing a formal position statement to the commission. (National Advisory Commission on Health Facilities)

ACTION #5 - It was agreed to refer the HEW "Fund Freeze" issue to the COTH Committee on Financial Principles.

ACTION #6 - It was agreed that the question of the proposed AHA definition of the term "teaching hospital" be presented to the COTH Executive Committee for discussion and referral as they saw fit and that all COTH Committees watch for any possible conflict between the AGA and the AAMC.

ACTION #7 - The Committee agreed that the COTH staff prepare a position paper defining the term teaching hospital and backing up a definition with a presentation of the teaching hospital in terms of construction and operating costs, with a certain amount of documentation of the need, the cause for the need, etc., and with an addition of several legislative possibilities to resolve the need.

American Hospital Association

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DEFINITION OF A TEACHING HOSPITAL

Approved by American Hospital Association

November 15-17, 1967

Definition

A hospital that allocates a substantial part of its resources to conduct, in its own name or in formal association with a college or university, formal educational program(s) or course(s) of instruction in the health disciplines that lead to the granting of recognized certificates, diplomas, or degrees, or that are required for professional certification or licensure, is a teaching hospital.

Interpretation

1. The allocation of resources in facilities, personnel, and funds must be adequate to demonstrate the discharge of corporate responsibility for the support and high quality of teaching programs.
2. Educational programs or courses of instruction are "formal" when based upon published or recorded curricula covering specified periods of study and have faculty qualification and student admission requirements established or agreed to by the hospital. They are not work-and-learn or on-the-job training arrangements that primarily augment the hospital's capability to provide services. Further, the hospital controls, or agrees to, the appointment of faculty and selection of students except during the term of agreements that give a college or medical school exclusive authority therefor.
3. Certificates, degrees, or diplomas must be recognized and accepted by national educational agencies, professional qualifying bodies, or state approving authorities. This implies that the course(s) or educational program(s) meets standards generally recognized in the health field.

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REVISED STATEMENT ON HILL-BURTON AMENDMENTS (S.2251)

Approved by American Hospital Association

November 15-17, 1967

1. Modernization

Modernization and replacement are the first great needs in terms of health facility programming for the future. Modernization and replacement of facilities should be related to community needs determined by good planning. Where planning also indicates the need for additional beds, these beds should be considered as a part of the modernization project, but should be funded from new construction money.

2. Rehabilitation Facilities

The language of the Hill-Burton legislation should continue to provide participation of other than completely comprehensive rehabilitation centers, and should be amended so as to provide that only those rehabilitation facilities that are health related should be included in the program.

3. Diagnostic and Treatment Facilities

The language of the Hill-Burton legislation should be amended so that the concept of the law is broadened. The definition of facilities should be changed to "ambulatory care facilities," so that other methods and facilities for the care of ambulatory patients by members of the medical staff in carrying out the program of the hospital, including such systems as group practice, may be included. The use of the facilities should be specifically permitted to inpatients as well as outpatients.

4. General Hospitals

The definition of "general hospitals" should be amended so as to include the following:

- A. Acute psychiatric inpatient facilities in general hospitals;
- B. Regional hospital service centers incorporating services that might otherwise be provided by hospitals; and
- C. Hospital-based home care facilities.

5. Long-Term Care Facilities

The language of the Hill-Burton legislation should be amended so as to specifically include extended care facilities developed as a part of general hospitals.

6. Hospital Educational Facilities

It is recommended that the Hill-Burton legislation be amended so as to establish a special category for educational facilities developed in, or in connection with, general hospitals. The sum of 20 million dollars would be suggested as an appropriate amount in this category.

7. State Allotments

- A. It is recommended that the Hill-Burton legislation provide for allocation of funds for new construction on the basis of per capita income and need.
- B. It is recommended that the squaring factor in the present formula be eliminated.
- C. It is recommended that funds be allotted for modernization on the basis of per capita income and population.

8. Priorities

- A. It is recommended that the Hill-Burton legislation be amended to remove the required first priority for rural areas. The need for facilities should be determined by the states.
- B. In order to assist both new construction and modernization in an orderly manner, two separate priority systems are required.

9. Coordination with Regional Planning

It is recommended, in accordance with long-standing Association policy, that the federal government require that the development of health care program under the Office of Economic Opportunity, the Department of Housing and Urban Development, and any other agencies, be coordinated with regional planning activities.

10. Loans

It is recommended that the present 25-year loan provision for modernization be lengthened to 40 years.

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AMERICAN HOSPITAL ASSOCIATION PROGRAM IN COMPREHENSIVE HEALTH PLANNING

Approved by American Hospital Association
November 15-17, 1967

Until recently, the primary emphasis in the nation's attempt to provide adequate health care for all the people has been upon specific programs intended to meet specific needs (e.g., Medicare, Title 19, community mental health centers, categorical disease programs, mental retardation centers, etc.). In an effort to meet urgent needs as rapidly as possible, many of these programs have developed relatively independently of one another.

Now, however, there is a growing social awareness of the need for comprehensive health planning and for coordination of the aims and efforts of individual programs, if the most imaginative and effective use is to be made of scarce facilities, manpower, and funds. This awareness is reflected in current federal legislation dealing with comprehensive health planning, the regional medical programs, state mental health and mental retardation plans, etc. The accelerated timetable for implementation of these planning efforts and the clamor for early results calls attention both to the urgency of this problem and to the need for the American Hospital Association to provide broad leadership for planning as rapidly as possible at national, regional, state, and local levels.

Particularly, the Association should be able to take the initiative in the development of planning and planning concepts for health rather than acting only in response to the proposals made by other agencies and groups. The implications of this level of involvement in planning are not entirely clear; certainly the commitment will have to be at a much higher level than at present.

The American Hospital Association expresses its intention to exercise its leadership efforts in the following directions:

1. To serve as a national focal point in relating to the several federal agencies involved in health planning and also to other national organizations so involved, including the American Medical Association, American Public Health Association, United Community Funds and Councils of America, National Health Council, etc. The Association's staff would serve as a point of contact for federal agencies and private health planning organizations, would represent Association views and concerns to these other agencies, and would participate in defining national program goals, through initiation of and participation in national meetings and conferences that include governmental agencies and other national organizations.

2. To provide the membership of the Association and its allied associations with basic information and leadership toward enthusiastic support of and active participation in the process of planning for health at all levels.

Mechanisms for carrying out the vigorous program in promoting understanding of and involvement in planning at many levels should have the following objectives, subject to the availability of staff and funds:

1. To develop an active task force to complete early in 1968 the work of bringing together national interests in planning, both governmental and nongovernmental;
2. To stimulate and take part actively in formation of the National Resource Facility outlined in the report of the Community Action Studies Project of the National Commission on Community Health Services on "Action-Planning for Community Health Services;"
3. To distribute to the field regular bulletins similar to the Medicare bulletins on implementation of Public Law 89-749 and other health planning programs;
4. To expand and promote a vigorous counseling service for planning for communities, hospital associations, and health planning agencies;
5. To greatly increase the activity of the Association in Washington related to comprehensive health planning and its implementation, as well as to other health planning sponsored by any governmental agency, to include both initiation of and response to legislative proposals regarding planning by technical planning personnel possibly located in the Washington office;
6. To encourage development of educational programs for planning personnel by appropriate institutions;
7. To develop, as soon as possible, manuals on comprehensive planning, covering both personal health services and environmental health services;
8. To conduct regional meetings to inform voluntary state health leadership groups regarding specific implementation of comprehensive planning and to train them in appropriate techniques;
9. To assist statewide health organizations in training leaders and implementing meetings within the individual states for health institutions and health associations, including particularly the county medical societies;

10. To appoint advisory panels to existing AHA committees that would involve full-time planners in health care institutions and planners who are on staffs of state and metropolitan hospital associations; and
11. To contact state hospital associations to suggest revision of annual meeting programs to include strong and urgent emphasis on comprehensive health planning.

The American Hospital Association and its allied and member associations must play an active and vital role in future planning efforts at all levels - national, regional, and local - if the voluntary role of hospitals as community health centers is to be maintained and if future planning is to provide for the most effective use of health services, manpower, and facilities in broad community health efforts. The program outlined above is a response to the extreme urgency of the hour.

American Hospital Association

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STATEMENT ON MANDATORY PLANNING AGENCY REVIEW OF PROPOSED HEALTH CARE FACILITY CONSTRUCTION

Approved by American Hospital Association
November 15-17, 1967.

The American Hospital Association affirms its continuing policy of being a responsible participant in the partnership to achieve comprehensive areawide planning for health services, manpower, and facilities, and recognizes that orderly involvement of comprehensive areawide health planning agencies is essential.

As a result of more than two decades of cooperation with the United States Public Health Service and other federal and state agencies, the Association believes that mandatory review of proposed health care facility construction by a comprehensive areawide health planning agency now is necessary to bring about orderly development of needed health programs, avoid unnecessary duplication of facilities, and assure proper assessment of the relationship of proposed health programs to existing health services, manpower, and facilities.

Accordingly, the Association recommends that, henceforth, all legislation providing for construction or renovation of hospital and medical facilities provide for review procedures involving organized comprehensive health care and health planning agencies.

American Hospital Association

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STATEMENT ON THE COORDINATION OF EDUCATION AND TRAINING PROGRAMS*

Approved by American Hospital Association
November 15-17, 1967

The education and training of personnel is an essential element of management in any organization. Leaders in the hospital and health field, recognizing the need for more and better personnel training programs, have seen a fortuitous development recently: At a time when the hospital field is experiencing a shortage of personnel at all levels, technological changes and employer-relocations have caused unemployment in many industries. Displaced industrial workers are now the object of training programs for hospital employment. These programs, designed by educators and governmental leaders, are also being used to upgrade present hospital personnel in a move to keep current employees in step with the rapidly changing advances in medical care. Programs of retraining and upgrading, although historically overdue, are now going forward as a joint effort by all parties concerned, and are to be considered laudable.

Strong in the professional fields of nursing, paramedical, and medical education, hospitals have long lacked organized training programs for personnel in the supportive or nonprofessional fields. The increase in the numbers of persons needed to provide the increasingly complex patterns of hospital care has strained the capacities of existing hospital training programs. They are even more burdened today as the shortage of trained personnel becomes more acute, and the need to train the unemployed grows.

In seeking solutions to their problems of initiating and expanding training programs, hospitals have received assistance from government at the federal, state, and local levels, from voluntary agencies, and from private foundations. Because in most cases this is the first time these interests have come together, there is a pervasive element of unfamiliarity. The hospital field, governmental agencies, and private foundations, all find new ground in each other's operations and environments as first-time ventures proceed.

For example, in industry, training of technological personnel has classically followed the pattern of apprenticeship programs, some of which have been under development for 30 years. Hospitals, because of their unique characteristics, do not as a group fit into many of the classical patterns previously established within governmental and educational agencies. But hospitals are geared to the sharing of research data and experimental information, which is the hallmark of professionalism and the starting point for coordinated programs.

Currently, efforts to educate and train hospital personnel meet with unnecessary delays and cumbersome difficulties. This is undoubtedly due to lack of understanding by all parties concerned. It is also due to a lack

*Originally approved by Council on Administration, March 10-11, 1966.

of coordination of government agencies. Competition among governmental agencies and the various plans now under way under government sponsorship have caught hospitals in a crossfire in many communities.

The need for training programs in the hospital and health field is urgent. Naturally, all plans should be tempered by local needs; there should be scope for variation from one community to the next. This requires the full cooperation of leaders in all appropriate agencies to help coordinate all such efforts in the hospital and health field, so as to produce the most meaningful and productive programs.

American Hospital Association

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STATEMENT ON PLANNING FOR HOSPITAL CONSTRUCTION IN SMALL COMMUNITIES

Approved by American Hospital Association
November 15-17, 1967

Planning for the development and expansion of hospitals, public health centers, nursing homes, rehabilitation centers, and related health care facilities has received, during recent years, increasing attention from community organizations, public agencies, and interested citizens. Objectives and policies have been developed, reevaluated, and adjusted on the basis of experience, as have programs for coordination of facilities and services.

A small community, exhibiting a natural enthusiasm for having its own hospital, may plan to construct a new hospital even though such construction is not in the best public interest. The desire to provide a facility that will attract a physician to, or retain a physician in, the community is frequently given as the primary reason for building a hospital. The belief that a hospital will improve the economic status of the community is usually overemphasized; at best this is difficult to predict. Competition with nearby towns, community pride, and reluctance of patients to travel are frequently used as justification.

Unfortunately concern is likely to focus on availability of beds rather than on the community's ability to produce the scope and quality of services needed, and to secure and retain a competent hospital staff. A hospital can be no better than the quality of its personnel. High-quality hospital care requires trained and experienced personnel in administration, nursing, laboratory, x-ray, anesthesia, dietetics, medical records, physical and occupational therapy, and other specialized services. The business office as well as the service departments, including the power plant, laundry, housekeeping, and maintenance, must also be in capable hands if the hospital is to function effectively and economically. At the same time, the supply of trained personnel for the health field is extremely limited.

Although there is widespread interest in recruitment of young people for health occupations, it will probably be many years before numbers adequate to supply the need will be available. Meanwhile, recognition of the importance of competent personnel to effective service is essential in the best interests of the public.

Hospital planning, therefore, must include careful study of the community and its surrounding trade area, and of all adjacent hospital service areas. In many instances the results of such study will bring about subordination of personal and community pride and acceptance of the fact that traveling a reasonable distance is a small price to pay for high-quality hospital service. Thus an orderly pattern of health care facilities may be planned for the community and the area.

American Hospital Association

840 NORTH LAKE SHORE DRIVE CHICAGO ILLINOIS 60611

TELEPHONE 312 645-0400 CABLE ADDRESS: AMHOSP

STATEMENT ON MEDICAL STAFF MEMBERSHIP AND STATUS OF ALLIED HEALTH PROFESSIONALS AS STAFF AFFILIATES IN HOSPITALS

Approved by American Hospital Association
November 15-17, 1967

1. Hospital medical staff membership should be limited to competent, qualified, and licensed doctors of medicine, doctors of osteopathy, and dentists. Patients should be admitted only by medical staff members.
2. The services of certain allied health professionals may be made available for patient care as medical staff affiliates within the limits of their skills and the scope of their lawful practice. These categories of health professionals include, for example, audiologists, clinical psychologists, podiatrists, and radiation physicists. Whether they carry out their activities as hospital employees or as independent practitioners, eligible professionals are identified in general by all of the following criteria:
 - a. They exercise independent judgment within their areas of competence, the ultimate responsibility for patient care being shared by a member of the medical staff.
 - b. They participate directly in the management of patients.
 - c. They record reports and progress notes on patients' records.
 - d. They write orders to the extent established by the medical staff within the scope of their licenses and applicable statutes.
 - e. They perform consultations on request if authorized by the medical staff.
3. It is the obligation of the medical staff of the hospital to recommend to the governing authority the extent of responsibility that may be assumed by members of these allied health professions. To carry out this obligation, the following procedures should be established and provided for in the medical staff bylaws:
 - a. The medical staff should determine the general qualifications to be required of members of each category of allied professionals.
 - b. Applications for appointment and privileges should be processed through the same channels as those for medical staff membership and privileges.
 - c. Privileges should be considered and specified by the medical staff for each individual, based upon his professional training, experience, and demonstrated competency.

4. Members of these allied health professions should be individually assigned to an appropriate clinical department as staff affiliates and should carry out their professional activities subject to departmental policies and procedures. The bylaws of the medical staff must establish this procedure and relationship. An affiliate or adjunct staff should not be established as an organizational entity.
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American Hospital Association

530 NORTH LAKE SHORE DRIVE, CHICAGO, ILLINOIS 60611

TELEPHONE 312 645-9400 / CABLE ADDRESS: AMHOSP

STATEMENT ON COLLECTIVE BARGAINING IN HEALTH CARE INSTITUTIONS*

Approved by American Hospital Association
August 24, 1959

Revised by American Hospital Association
November 15-17, 1967

Voluntary nonprofit hospitals are exempted from coverage under the Labor-Management Relations (Taft-Hartley) Act of 1947 in this country. The American Hospital Association has consistently supported such exclusion and reaffirms that support at this time.

Meanwhile, some health care institutions have faced aggressive efforts by employee professional groups and labor unions to organize groups of their employees and to represent them in collective bargaining negotiations with management. Although some of these activities have been conducted peacefully, in other instances such activities as strikes, mass resignations, and other occurrences have impeded the proper care of the sick.

The position of the American Hospital Association concerning collective bargaining in health care institutions is as follows:

1. The American Hospital Association believes that voluntary nonprofit health care institutions should be exempt from the provisions of the Labor-Management Relations (Taft-Hartley) Act.
2. The American Hospital Association further believes that such institutions should be exempt from all legislative acts, federal or state, requiring health care institutions to bargain collectively with any unions or professional groups of their employees.

The American Hospital Association reaffirms its advocacy of strong and positive personnel policies in health care institutions that "strive to provide for all employees compensation, working conditions, and personnel practices at least at the levels prevailing for equivalent work in the community."*

*Revision of Statement of American Hospital Association Concerning Collective Bargaining in Hospitals, approved by House of Delegates, August 24, 1959

**Statement on Management-Employee Relations in Health Care Institutions, approved by American Hospital Association, May 8-10, 1967

January 25, 1968

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

MEETING OF THE ~~SOCIETY~~ OF UNIVERSITY HEALTH ^{CENTER} ADMINISTRATORS

January 20 - 22, 1968 New Orleans, Louisiana

Present:

Lewis Rohrbaugh, Vice President for Medical Affairs, Boston University, since 1960
William Willard, Vice President for Medical Affairs, University of Kentucky, since 1966
Joseph Volker, Vice President for Health Affairs, University of Alabama, since 1962
Robert Carter, Director and Dean of Medical Center, University of Iowa, since 1967
Adan Nigaglioni, Chancellor for Medical Sciences campus, University of Puerto Rico, since 1965
Lloyd Elam, President, Meharry Medical College, effective April 1968
George Wolf, Provost and Dean, University of Kansas, since 1966
John Patterson, Executive Director and Dean of Medicine, University of Connecticut, since 1964
Peter Herbut, President, Jefferson Medical College, since 1966
Randolph Batson, Director of Medical Center and Dean, Vanderbilt University, since 1963.
John Sheehan, Vice President and Dean, Loyola University, since 1950
Robert Cadmus, President, New Jersey Medical College, since 1966
Robert Smith, President, Medical College of Virginia, since 1956
Clement St. John, Vice President and Director of Medical Center, University of Cincinnati, since 1961
William McCord, President, Medical College of South Carolina, since 1965
William Knisely, Director, Institute Biology and Medicine, Michigan State University, since 1964
Samuel Martin, Provost, University of Florida, since 1961
Joseph S. Begando, Chancellor, Medical Center Campus, University of Illinois, since 1966
James Dennis, Director, Vice President and Dean, University of Oklahoma, since 1965
Alvin Kuhn, Chancellor, University of Maryland, since 1958
William Frye, Chancellor of the Medical Center, Louisiana State University, since 1965
Carlyle Jacobsen, President, Upstate Medical Center, until 1967
Gordon Scott, Vice President, Wayne State University, since 1965
Wilfred Westerfeld, Acting President, Upstate Medical Center, since 1967
Robert C. Berson, Executive Director, AAMC
Joseph Webster, Dean of the School of Pharmacy, University of Illinois

Carlyle Jacobsen presided. The attached agenda was distributed but not followed, and no precisely-worded alternative agenda was developed.

A. The AAMC Task Force on Allied Health Professions.

Dr. George A. Wolf, Jr. gave a rather complete verbal review of the activities of this task force, particularly its meeting on December 7, and plans for a meeting in March. There was considerable interest in this development and a good bit of discussion. A number of those present expressed interest in being actively helpful but no clear suggestions were made as to how the SUHA as such could play a helpful role.



B. Federal Support for Health Education - Possibilities for 1968.

Robert C. Berson reviewed the recent activities of the AAMC Committee on Federal Health Programs and the main points he believes will be contained in the Administration's proposal this year with some additional comments by Dr. Sam Martin. There was a good bit of interest and discussion and a number of questions about the support of nursing education and education in the allied health professions. All of the men present were keenly interested and would like to learn about the details of the Administration's proposals as soon as possible. Most of them seemed to be in a position to be fairly influential to members of the Congress from their states.

C. Further Development of the AAMC.

Robert C. Berson reviewed the decisions reached at the Annual Meeting of the AAMC, the action of the Executive Council in asking its Committee on Ways and Means to make specific proposals about the reorganization of the AAMC and the plans of the Council to review those proposals at its next meeting. He did not describe the details of the Committee's recommendations. There was a great deal of discussion of many of the services and programs of the AAMC and its evolution in the recent past. There was a high level of interest in what further evolution will take place. A few people expressed the opinion that the AAMC would not broaden itself to such an extent that educators in the other health professions would actively participate in its affairs.

Although Berson and Wolf repeatedly suggested that the AAMC would be keenly interested in suggestions from the SUHA as to what it might do, no clear suggestions were offered.

D. Funds for the Construction and Renovation of Teaching Hospitals.

Dr. Rohrbaugh summarized the study of present and anticipated needs of teaching hospitals for construction funds which has been conducted by a committee of the Council of Teaching Hospitals largely stimulated by individuals in Boston and urged that this group support efforts to get legislation and appropriations to meet these needs. There was general agreement that the problems are urgent and highly important to all of health education as well as to the care of substantial numbers of patients. The discussion was in entire agreement with Dr. Rohrbaugh's viewpoint. No specific strategy or tactics were proposed or decided upon.

E. The Future Role and Composition of SUHA.

A good bit more than half of the discussion on both Saturday and Sunday was devoted to discussion of the future composition, name, organizational pattern and mission of the group itself. Rather early in the discussion, the group elected Dr. Kenneth Penrod as its next chairman. He and the others elected to an Executive Committee met during two periods when the entire group was not in session and then presented fairly specific proposals to the group as a whole.

In the extended discussion, it was clear that a few of the members felt the group should be formally organized and seek an initial foundation grant to develop staff and an action program and attempt to become the spokesman for health education. Most of the members disagreed with this in whole or in part and the eventual decisions reached are summarized in the attached memorandum prepared by Dr. Penrod.

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*Con - (initials) Sam Martin & e
Walker Wolford*

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Director, Bureau of Health and Hospitals
United States Catholic Conference
Washington, D.C.

Howard N. Nemerovski, Attorney
San Francisco, California

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