82D CONGRESS
1st Session

SENATE

REPORT
No. 610

VETERANS' ADMINISTRATION POLICIES AND PRACTICES WITH RESPECT TO MEDICAL CARE

REPORT

OF THE

COMMITTEE ON LABOR AND PUBLIC WELFARE
UNITED STATES SENATE

AUGUST 2 (legislative day, AUGUST 1), 1951.—Ordered to be printed with illustrations

UNITED STATES
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COMMITTEE ON LABOR AND PUBLIC WELFARE

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SPECIAL SUBCOMMITTEE TO INVESTIGATE VETERANS' ADMINISTRATION POLICIES AND PRACTICES WITH RESPECT TO MEDICAL CARE

Mr. HUMPHREY, Minnesota, *Chairman*

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Mr. HUMPHREY, for the Committee on Labor and Public Welfare, submitted the following

REPORT

INTRODUCTION

The medical care program of the Veterans' Administration is one of the largest in the world. Potentially affecting some 21,000,000 veterans, it operates on a budget calling for an expenditure of over $650,000,000 a year. It involves the direct ownership and operation today of 151 hospitals containing 119,400 authorized beds: more than 8 percent of all the hospital beds in the United States. During 1950, Veterans' Administration hospitals provided care for more than 100,000 patients a day. Obviously, a program of this magnitude is one of considerable and continuing interest to the Congress and the people of the United States.

That interest is not based solely on the size and the cost of the program. It is considerably heightened by the fact that during the last few years, the quality of the medical care available to beneficiaries of the Veterans' Administration has been raised to a point where it unquestionably represents the best medical care available anywhere in the world at any time in the world's history.

When one realizes that this program also represents an attempt on the part of the Congress to partially discharge our obligation to the men and women who have offered their lives in defense of our country, it is obvious that anything materially affecting that program should be of immediate concern to the Congress. It is. Just as the Congress when it was informed as to what was needed to assure our veterans the best possible medical care promptly made it available, so too is the Congress quick to respond to any development which threatens the continued rendition of that care. Consequently when, in January of this year, Dr. Paul B. Magnuson, Chief Medical Officer of the VA, was

involuntarily separated from the service and replaced by Admiral Joel T. Boone and when this personnel shift disclosed the existence of a situation which could conceivably return the VA medical care program to the shambles which made it a national scandal in 1945, the Senate's Committee on Labor and Public Welfare, which had jurisdiction in the matter, on motion of Senator Humphrey, of Minnesota, immediately initiated an inquiry into the situation.

In order to understand the nature of the problem confronting the committee and to understand the basis for the subsequent recommendations of this subcommittee, a certain familiarity with those developments which made veterans' medical care in 1951 so much superior to what it had been in 1945 is essential. They may be briefly outlined as follows:

BASIS OF THE "NEW" VETERANS' MEDICAL CARE PROGRAM

When Gen. Omar N. Bradley was appointed Administrator of Veterans' Affairs in 1945, the type and quality of medical care available in VA hospitals was decidedly worse than mediocre; in some institutions it was scandalous. In large measure, this situation had resulted from a complex of factors directly attributable to World War II. Congressional Appropriations Committees of necessity had been compelled to give priority to the needs of our fighting forces; materials and supplies needed to expand VA facilities were unavailable. Physicians, dentists, nurses, and allied medical personnel were in critically short supply. And, concurrently, VA's case load was rising rapidly.

But in no small measure, the low standards of VA medical care could also be attributed to an addiction on the part of the Veterans' Administration to outmoded, rigidly insular, and completely uninspired principles of medical administration. During a period when the principles and practices of both hospital administration and medical treatment had been undergoing profound and beneficial change in private institutions and in other governmental agencies, the Veterans' Administration seems to have taken pains to steer clear of the stream of medical progress. Its lay administrators, both in Washington and in the field, in many cases, seem to have deliberately resisted the introduction of any new ideas. In particular, they insisted on keeping the VA medical-care program completely isolated from medical education and medical research despite the then well-known fact that only insofar as a hospital program is identified with teaching and research can it be considered unusually good. Interns were not even permitted in VA hospitals. Rigid civil-service rules and regulations discouraged the best qualified professional personnel from participating in the program. So too did the fact that for many years the medical-care program had been controlled and operated by lay administrators unwilling to seek and to follow competent professional advice on professional matters.

Confronted with this situation, General Bradley called in Dr. Paul R. Hawley who had done a magnificent job of medical administration in the European theater of operations and appointed him Chief Medical Director of the Veterans' Administration. Dr. Hawley in turn promptly appointed Dr. Paul B. Magnuson, eminent orthopedic surgeon, as his chief aide. Drs. Hawley and Magnuson immediately

planned and promptly put into effect a series of changes in Veterans' Administration medical care policies and practices which in a very short time revolutionized the entire program. That they were able to succeed in such an undertaking is directly traceable to the fact that General Bradley's delegation of authority to his Chief Medical Director went far beyond the usual routine pronouncement couched in generalities. Dr. Hawley was instructed by General Bradley as follows:

> I want a first-class medical service and I want you to give me one. You can come to me at any time for help and advice. I shall support you fully.

And then General Bradley made his instructions really meaningful by giving to his Chief Medical Director the authority to issue orders pertaining to medical service in the name of the Administrator. The result, to quote Dr. Hawley, was that "there was not the slightest doubt, anywhere in the entire Veterans' Administration, as to the channel of control of hospitals—it was through the Chief Medical Director to the Administrator."

The basic principles underlying the Hawley-Magnuson revolution in Veterans' Administration medical care were simple, yet their application is the difference between providing the highest type of medical care or mediocre care. The very great improvement made by Hawley and Magnuson is largely attributable to the introduction of teaching and research into the medical program. The process was also given an important assist by Public Law 293 (79th Cong.) which took the doctors, dentists, and nurses of the Veterans' Administration out from under the restrictions of civil-service rules and regulations.

Medical schools and the VA cooperate

It is an indisputable fact that first-class medical care is possible only in those medical institutions and programs which engage in teaching and research. Good medical care and scientific advances therein are inseparable from medical education. This Nation's great medical institutions have been teaching and research centers. It is obvious to this subcommittee that teaching and research give vitality to a medical institution; they stimulate scientific progress; they keep the medical staff alert, and they are indispensable if the best qualified personnel are to be drawn into the program.

To bring that sort of first-class medical care to our veterans, Drs. Hawley and Magnuson had first to overcome the problem of creating within the VA a medical training program of sufficiently high standards as to be accredited by recognized professional bodies. Without such accreditation the VA hospitals could not offer those internships and residencies needed to attract the best graduates of our medical schools. And to win accreditation good physical facilities were not enough. The new ingredients which had to be added were qualified and competent medical educators. These the VA lacked. In 1945, there were far too few career physicians in the service who could qualify as teachers. Hawley and Magnuson had to find them elsewhere.

Dr. Hawley's conclusion was that the only answer to the problem would be to affiliate as many veterans' hospitals as possible with the Nation's accredited medical schools. Achieving this, however, proved to be anything but a simple undertaking. Most of the Nation's professional men and professional institutions evinced a great reluctance to the idea of associating themselves with a then

discredited Government agency. Their wholly understandable reluctance could be removed only if the medical schools chould be completely sold on the fact that the Veterans' Administration really intended to do an all-out job of revitalizing its medical care program. Effective affiliation between the schools and the Government agency could not be contractual. Of necessity it would have to depend on the development and maintenance of mutual confidence in the complete good faith of both parties. By far the most valuable contribution which Drs. Hawley and Magnuson made to our veterans—and it was only one of many—was the creation on the part of the administrators of our medical schools of a feeling of confidence in the Veterans' Administration.

Any objective analysis of the development of that relationship shows that in no small part it rested on a clear understanding given the schools that when Dr. Hawley or Magnuson entered into agreements with them, those agreements were binding on and would be carried out by all other officials of the VA. The schools learned to their complete satisfaction that while the law held General Bradley responsible for the operations of the entire Veterans' Administration and gave him complete authority over every single phase of its activities, General Bradley, in accordance with sound administrative practices and without ever attempting to evade any responsibility, nonetheless, had delegated to his Chief Medical Director complete authority over every phase of the VA program which in any way affected the rendition of medical care to patients in VA hospitals and clinics. Bradley's demonstration of complete confidence in his Chief Medical Director evoked a corresponding display of confidence on the part of the schools. The resulting program wherein the medical schools working with the VA raised the level of veterans' medical care to the highest possible point was first expressed in an informal agreement set forth in Veterans' Administration Policy Memorandum No. 2, dated January 30, 1946. Under this arrangement, each affiliated school of medicine organized a deans' committee, which assumed responsibility for the schools' functions in the program. The agreement expressly called for the exercise of good faith on the part of both parties and clearly provided for the cooperative solution of difficulties. The complete text of the memorandum follows:

POLICY MEMORANDUM NO. 2

JANUARY 30, 1946.

Subject: Policy in Association of Veterans' Hospitals With Medical Schools

1. General considerations

(*a*) *Necessity for mutual understanding and cooperation.*—The Department of Medicine and Surgery of the Veterans' Administration is embarking upon a program that is without precedent in the history of Federal hospitalization. It would, therefore, be most unusual if numerous problems did not arise for which no fully satisfactory solution were immediately apparent. Such problems frequently can be solved only by trial and error, and, until workable solutions are found, both parties in the program must exercise tolerance if the program is not to fail.

There can be no doubt of the good faith of both parties. The schools of medicine and other teaching centers are cooperating with the three-fold purpose of giving the veteran the highest quality of medical care, of affording the medical veteran the opportunity for postgraduate study which he was compelled to forego in serving his country, and of raising generally the standard of medical practice in the United States by the expression of facilities for graduate education.

The purpose of the Veterans' Administration is simple: Affording the veteran a much higher standard of medical care than could be given him with a wholly full-time medical service.

The purposes of both parties being unselfish, and there being no conflict of objectives, there can be no serious disagreement over methods. It will be recognized that the Veterans' Administration is charged with certain legal responsibilities in connection with the medical care of veterans which it cannot delegate, if it would. Yet the discharge of these responsibilities need not interfere with the exercise by the schools of their prerogatives in the field of education.

All medical authorities of the Veterans' Administration will cooperate fully at all times with the representatives of associated schools and other centers. It is the earnest desire of the Acting Chief Medical Director that our relations with our colleagues be cordial as well as productive.

(*b*) *General division of responsibility.*—The Veterans' Administration retains full responsibility for the care of patients, including professional treatment, and the school of medicine accepts responsibility for all graduate education and training.

2. The Veterans' Administration

(*a*) Operates and administers the hospital.

(*b*) As rapidly as fully qualified men can be had, will furnish full-time chiefs of all services (see par. 5 below) who will supervise and direct the work of their respective staffs, including the part-time attending staff furnished from the school of medicine, insofar as the professional care of patients is concerned. Nominations by deans' committees for such full-time positions will be welcomed; and, unless there be impelling reasons to the contrary, will be approved wherever vacancies exist. These service chiefs are fully responsible to their immediate superior in the Veterans' Administration.

(*c*) Appoint the consultants, the part-time attending staff and the residents nominated by the deans' committee and approved by the Veterans' Administration

(*d*) Cooperate fully with the schools of medicine in the graduate education and training program.

3. The schools of medicine

(*a*) Will organize a deans' committee, composed of senior faculty members from all schools cooperating in each project, whether or not furnishing any of the attending or resident staff.

(*b*) Will nominate an attending staff of diplomates of specialty boards in the numbers and qualifications agreed upon by the deans' committee and the Veterans' Administration (see 6 e.)

(*c*) Will nominate, from applicants, the residents for graduate education and training.

(*d*) Will supervise and direct, through the manager of the hospital and the consultants, the training of residents.

(*e*) Will nominate the consultants for appointment by the Veterans' Administration.

4. Hospital managers

(*a*) Are fully responsible for the operation of their hospitals.

(*b*) Will cooperate with the deans' committee, bringing to its attention any dereliction of duty on the part of any of its nominees.

5. Chiefs of service

(*a*) Are responsible to their superior in the Veterans' Administration for the conduct of their services.

(*b*) Will bring to the attention of their superior, for his action, such cases as they are unable to deal with personally of dereliction of duty or incompetence on the part of any full-time or part-time staffs under their control.

(*c*) Will, together with the part-time attending staff, under the direction of the manager, supervise the education and training program.

(*d*) When full-time employees of the Veterans' Administration, will be diplomates of their respective boards and will be acceptable to the deans' committee and to the specialty boards concerned. It is the urgent purpose of the Veterans' Administration to place full-time fully qualified and certified chiefs of service for all services in each hospital associated with a school of medicine. Except in cases where the chief selected has local affiliations, which might embarrass or prejudice his relations with one or another of the associated schools, his initial assignment

may not be cleared through the deans' committee. In all cases, when it has been conclusively demonstrated that a chief of service cannot cooperate with a deans' committee, he will be transferred (if efficient otherwise) and replaced by another.

Until this purpose can be fully accomplished, however, in order that a hospital may obtain approval for resident training by one or another specialty board, it may be necessary to appoint part-time chiefs of services who meet the requirements of the boards. This will be done; but it will be done with the understanding that the part-time chiefs will be replaced with qualified full-time chiefs as rapidly as they become available. The duties and responsibilities of part-time chiefs will be the same as those of full-time chiefs.

6. Part-time attending staff

(*a*) Will be responsible to the respective chiefs of service.

(*b*) Will accept full responsibility for the proper care and treatment of patients in their charge.

(*c*) Will give adequate training to residents assigned to their service.

(*d*) Will be veterans unless approval in each case has been given by the Chief Medical Director.

(*e*) Will be diplomats of their respective boards and acceptable to such boards for direction of resident training. Exception may be made in the case of a veteran who has completed the first part of his board examination, but whose completion of the examination was interrupted by the exigencies of the military service.

(*f*) Will hold faculty appointments in one or another of the associated schools of medicine, or will be outstanding members of the profession of the caliber of faculty members.

7. Consultants

(*a*) Will be veterans unless approval in each case has been given by the Chief Medical Director.

(*b*) Will be members of the faculty, or professional rank, of one or another of the associated schools of medicine.

(*c*) Will, as representatives of the schools of medicine, direct and be responsible for the educational training of residents.

(*d*) Will afford to the manager and the proper chief of service the benefit of their professional experience and counsel.

(*e*) Will conduct their duties through, and in cooperation with, the manager and the proper chief of service, and also, in matters of education and training, with the part-time attending staff—always, however, coordinating with the chief of service.

Thus began what has been called one of the world's greatest medical programs. Our best medical schools are affiliated. Many of this country's eminent physicians are serving as consultants, bringing their skills and counsel to assist in providing the best possible care for veterans. Residents and interns have been brought into the program, many of whom have sought to make it their career. Policy Memorandum No. 2 remains, as it has from the beginning, the guide to operations which is adhered to by the deans' committees.

Along with development of the deans' program, came an advance in the philosophy of medical care for veterans. The basic emphasis was on the provision of complete care. Such care envisages a hospital system, dynamic and complete in operation, which will result in the application of all techniques necessary to get the patient out of the hospital and back to his home and community. Getting the patient back to his home and community requires not only those services directly involving professional medical, dental, and nursing care, but also such other supporting services as may be necessary for rehabilitation, with a view to enabling the individual to attain a place of respect and self-support in his community. It is evident that the provision of such complete care, if properly carried out, requires a high degree of organization and integration of all the services that affect the care of patients.

The deans' committee program also involved another fundamental concept; namely, identification of the veterans' hospital with the resources of the community in which it is located. The Hawley-Magnuson philosophy called for as flexible a type of hospital system as was possible under the law. These men clearly recognized that the patient is cared for in the hospital—that medical care could not be packaged and mailed from the central office of the Veterans' Administration. They knew that the best medical care in each locality would be made available to veterans only if the outstanding specialists in each community could be prevailed upon by the local deans' committee to serve as visiting physicians or consultants to the VA hospitals. Only to the degree that these men would be willing to be identified with a VA hospital would it command the respect of the profession and attract competent men to its full-time career service.

All of these concepts were translated into realities during Dr. Hawley's tenure as Chief Medical Director of the Veterans' Administration and while Dr. Magnuson served as his chief assistant. Their realization, we reiterate, was not due to contractual relationship, nor to written regulation, nor to legislative enactment. While any one oe all three of these might have, in the past, and can, in the future, givr such a tripartite relationship between deans, medical director, and administrator greater stability and some guaranty of continuity, the fact is that while General Bradley was Administrator of Veterans' Affairs, that delicate but most important relationship rested entirely on the confidence which each of the three parties vested in the others.

Distrust displaces confidence

As far as the public was concerned, it was generally assumed that this new, wholly desirable, and well-publicized veterans' medical care program had been firmly established by Generals Bradley and Hawley. From 1948 to 1951, after they had moved on to other occupations and Gen. Carl R. Gray, Jr., had taken over as Administrator of Veterans' Affairs and Dr. Magnuson as Chief Medical Director, most people were under the impression that the program was being maintained on the same or on an even better basis. Subsequent developments have made it apparent, however, that shortly after General Gray's appointment the relationship of the medical schools and of professional men to the program was characterized by a growing sense of uneasiness and distrust. Not uneasiness as regards their relationship to the Chief Medical Director but rather uneasiness and distrust on their part as to what they considered to be a vastly different relationship between the Administrator and the Chief Medical Director that that which had obtained during General Bradley's regime and on the basis of which they had felt it possible to cooperate with the Veterans' Administration. At any rate, immediately following Dr. Magnuson's departure from the Veterans' Administration in January of this year, this uneasiness on the part of the men whose patriotic time- and energy-consuming cooperation with the VA had made its medical program a matter of pride and satisfaction to the Nation took on terrific impetus and began to crystallize in a manner which unquestionably threatened to destroy completely that tripartite relationship on which, as we have seen, the entire program depended.

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THE INVESTIGATION BEGINS

Inasmuch as the Senate's Committee on Labor and Public Welfare has jurisdiction over matters relating to "veterans' hospitals, medical care and treatment of veterans," Senator Humphrey, of Minnesota, who had maintained a particularly close interest in this program since his training in pharmacy had given him an insight into the deans' point of view almost as compelling as his recognition of our obligation to the veteran, immediately requested that the committee investigate the situation and take appropriate action.

The committee quickly decided that the threat to the continuance of the program was very, very real. Twenty-five medical schools wrote the Association of American Medical Colleges expressing their concern and intimating that perhaps they should discontinue their identification with the program. The Director of Research for the Citizens' Committee for the Hoover Report found that, "These difficulties threaten to disrupt, and might even destroy, the medical service a greateful Nation wants to give the veteran, particularly the disabled veteran." Doctors by the score and even deans' committees threatened to resign and were persuaded to refrain, at least temporarily, only because Dr. Magnuson, despite his feeling that he had been "fired," was so sincerely interested in the continuation of the program that he wrote to every participating doctor urging that he continue to serve the Veterans' Administration wholeheartedly and expressing the conviction that the problem would be settled in such a way as to maintain the same high standards as had been developed under Generals Bradley and Hawley. Dr. Hawley, the man who above all others knows the program which was developed under his direction, felt that the situation was evidence "of a policy of admistration which, in my considered opinion will very shortly destroy one of the finest accomplishments in all history in the fields of medical care and medical education." "I have weighed these words most carefully," Dr. Hawley stated.[1]

While the committee could not tell at that time whether the deans and Dr. Magnuson or the Administrator was in the right, whether the conflict was or was not merely the result of a personality clash, or whether the difficulty rested on nothing more than a temporary misunderstanding, it knew without doubt that a program of great value to our country was seriously endangered. It promptly and unanimously appointed this Subcommittee on Veterans' Administration's Policies and Practices With Respect to Medical Care to investigate the matter and to recommend such remedial action as might be necessary. The subcommittee consists of Senator Humphrey, chairman, Senator Hill, Senator Douglas, Senator Morse, and Senator Nixon.

But the committee also knew that whatever the points at issue might turn out to be, the VA medical-care program which means so much to war-injured veterans had not as yet suffered any serious damage. It was threatened and it might collapse at any moment but, as yet, that delicate relationship between the schools and the agency which had to be maintained if the program was to survive was still in existence. Therefore, the Committee on Labor and Public Welfare instructed this subcommittee to conduct its investigation promptly and thoroughly but through executive sessions which by

[1] See also Dr. Hawley's statement of opinion as the subcommittee's hearings progressed.

avoiding such premature publicity as would involve the release of provocative, headline-making, but unchecked testimony might unnecessarily endanger the continuance of that relationship. It was clearly understood, however, that upon completion of our task, the subcommittee would make its proceedings public in order that everyone concerned might become fully conversant with the situation and aware of the necessity for such action as we might recommend. Therefore, we are setting forth, herewith, our method of procedure, our basic findings, and our recommendations. Concurrently—and, because of its bulk, in a separate volume—we are releasing the entire record of our hearings including exhibits and documents so that the testimony of each witness may be evaluated with the proper perspective and so as to make available to all the basis for our conclusions.

SUBCOMMITTEE PROCEDURE

As the subcommittee made clear after its first planning session and before calling any witnesses, the statutory authority of the Administrator of Veterans' Affairs to choose and change Chief Medical Directors was not questioned and was not a point at issue. Furthermore, it was not intended that the subcommittee inquire into all phases of the VA program or even into all phases of its medical-care program. We have not done so. Our task was to seek out such differences of policy with respect to the operation of a medical-care program as might exist or have existed in the VA and which, if they were not resolved clearly and permanently, would undermine the program no matter what individuals were involved in its operations. The subcommittee made it plain that it was interested in principles and not in personalities. As examination of the testimony will show, we were fortunate in securing such cooperation on this point from all the witnesses who appeared that, although every conflict of reason or rumor, of theory, attitude, or opinion which presented itself was thoroughly investigated, the hearings were marked by a complete absence of personality clashes.

Beginning with testimony from General Gray and Dr. Magnuson, the two men whose differences of opinion had brought the problem to a head, the subcommittee took testimony in a series of 9 hearings from some 25 competent witnesses. In addition and despite the pressure of other work before the Senate, the subcommittee met in five other sessions called to plan its operations, analyze testimony, and formulate its recommendations.

Having heard General Gray and Dr. Magnuson set forth the issues as they saw them, we then sought the assistance of the Association of American Medical Colleges and received extremely valuable cooperation in the form of testimony from Dr. Joseph C. Hinsey, dean of Cornell Medical School and chairman of the association's executive council; Dr. Hugh Wood, dean of the School of Medicine at Emory University and chairman of the association's committee on Veterans' Administration relationships; and Dr. John Truslow, dean of the Medical College of Richmond. The point of view of veterans and of the general public was expressed by representatives of the Veterans of Foreign Wars, the American Veterans' Committee, the Minnesota Department of the American Legion, and the Citizens' Committee for the Hoover Report. Expert and very well-informed testimony was

also provided by Dr. Harold S. Diehl, dean of medical sciences of the University of Minnesota; Dr. Howard A. Rusk, chairman of the department of physical medicine and rehabilitation at New York's Bellevue Medical Center; and by Dr. Paul R. Hawley, director of the American College of Surgeons and former Chief Medical Director of the Veterans' Administration.

After each separate hearing, all the testimony and documentary evidence submitted by that time was analyzed as a whole and that analysis was used as the basis for the next hearing. Throughout the hearings, close liaison was maintained with both the Veterans' Administration and the professional groups involved and as important developments occurred, the reaction of each party thereto was promptly ascertained. As a result of this approach, when all of the testimony presented by the groups and individuals listed above was analyzed, the subcommittee had a quite clear picture of the problems which had arisen in the VA. We found at this point that those problems, while they existed in unique and exacerbated form in the Veterans' Administration program, involved questions of administrative policies and practices which are in no way peculiar to that agency but which are to be found in and which call for clear-cut decision by every agency of Government which operates programs of medical care.

MEDICAL ADMINISTRATION IN OTHER AGENCIES

The subcommittee called for and received a thoroughgoing explanation of the medical administrative practices followed by the services from representatives of the Surgeon General of the Army, the Bureau of Medicine and Surgery of the Navy, and the Surgeon General of the United States Public Health Service of the Federal Security Agency. This testimony was not only very well organized and documented but it proved most pertinent and enlightening as well. Your subcommittee found as a result of this hearing that while the problems which are plaguing the veterans' medical care program could just as easily have arisen in these other agencies, they are in fact conspicuous in the services by their absence. And we found that this is unquestionably due in no small measure to the fact that the services believe in and apply a different philosophy regarding the relationships between the head of the agency, its other divisions, and its chief medical officer than that which now prevails in the Veterans' Administration. In the Federal Security Administration, this pattern is a matter of law. In the Army and Navy it rests on tradition, regulation, and a well-defined theory of administration. In each of these cases it represents a pattern of administration similar to that which prevailed in the VA during the Bradley-Hawley regime but which has undergone considerable change during General Gray's tenure. We shall discuss this pattern in more detail later. It will suffice for our immediate purposes, however, to illustrate it by pointing out that the Federal Security Administrator has never been known to give an order in or to interfere in any way with the operations of a Public Health Service hospital, nor has the Secretary of the Army or the Secretary of the Navy ever been known to personally exercise the authority they unquestionably have over the detailed operation of Walter Reed Hospital or the National Naval Medical Center. In contrast, the present Administrator of Veterans' Affairs most decidedly

CHART I

VA ORGANIZATIONAL PATTERNS RE MEDICAL PROGRAM
1945-1951
(as it existed in theory and as set forth in provisions of VA Manual)

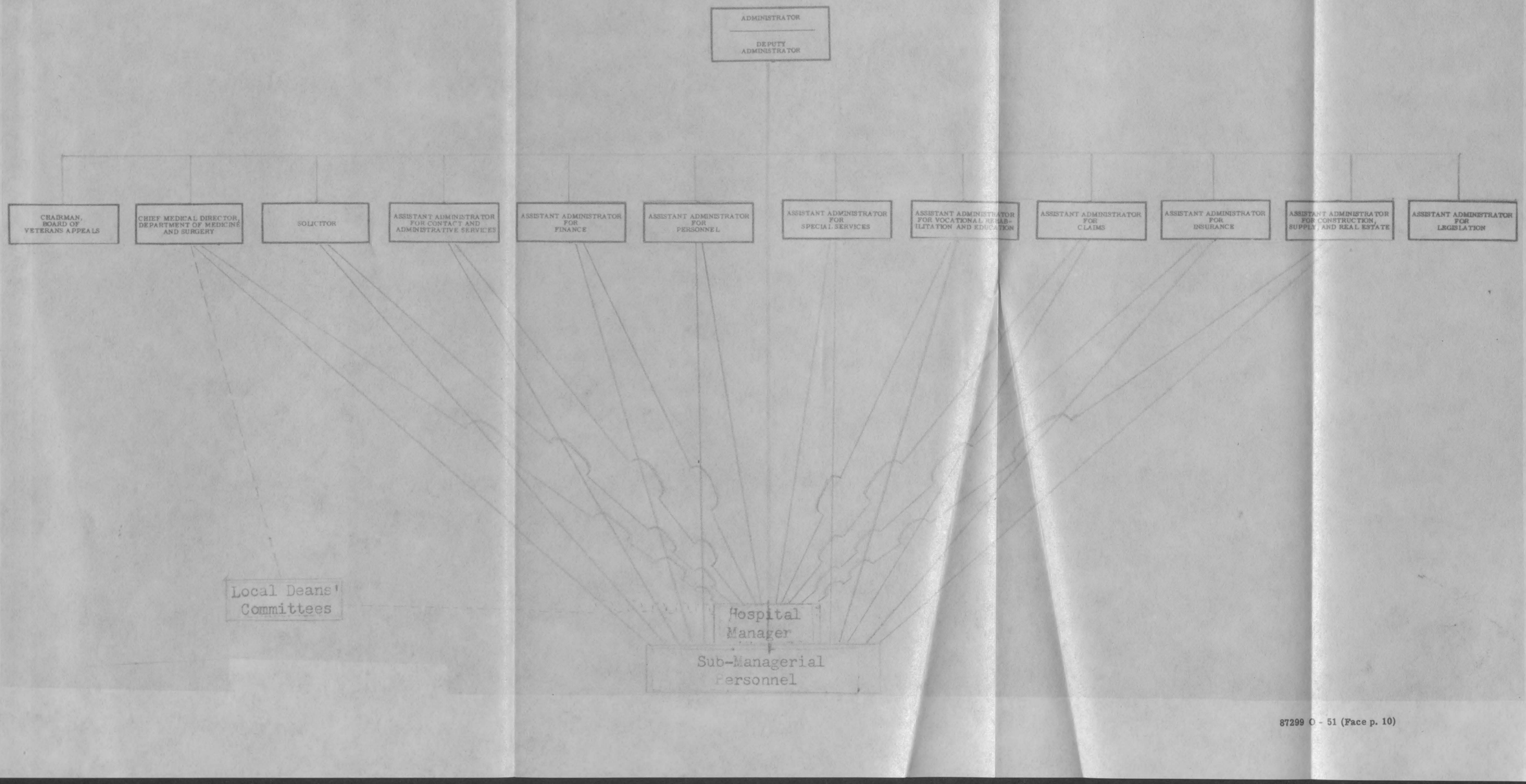

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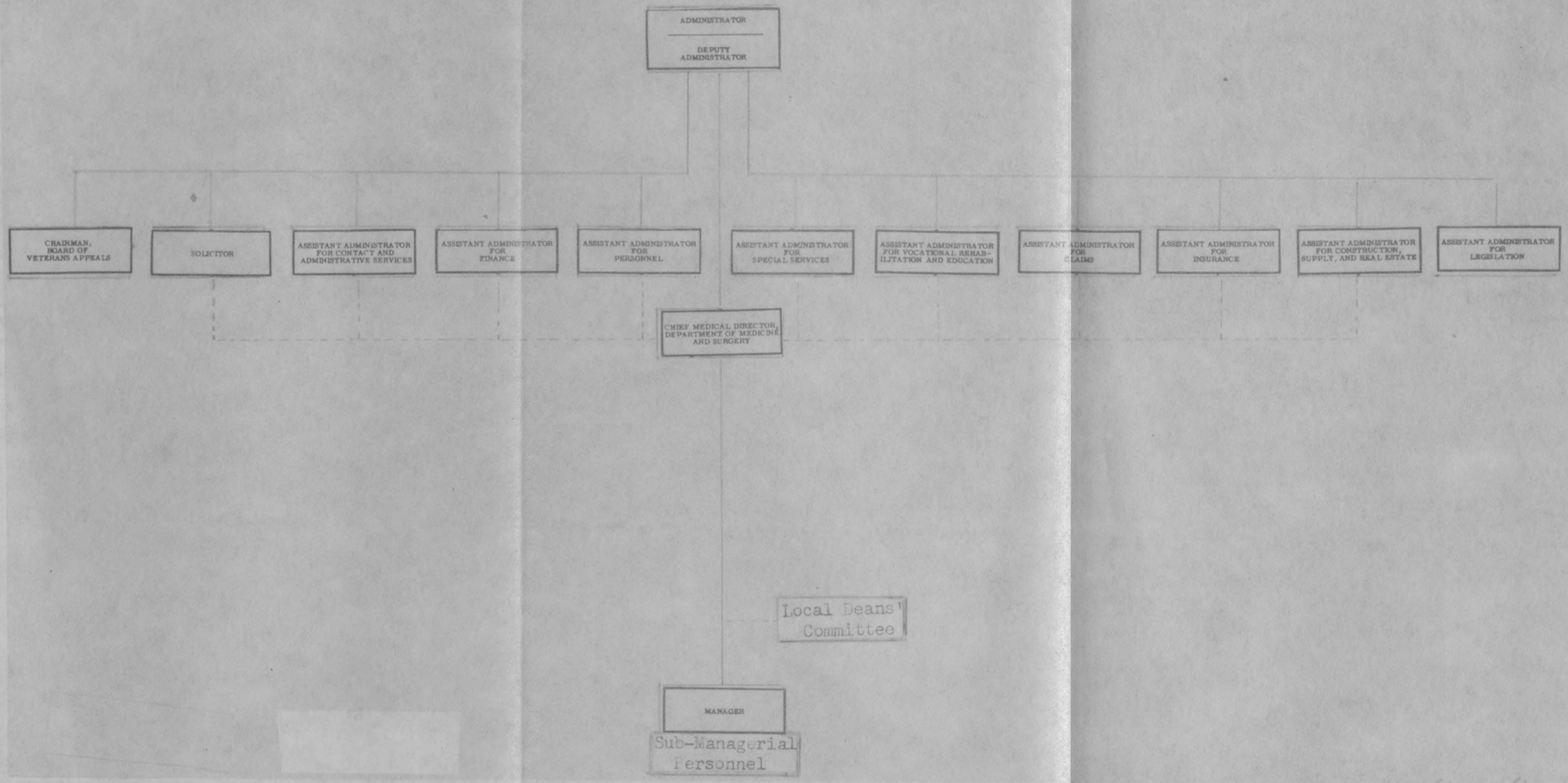
CHART II

VA ORGANIZATIONAL PATTERNS RE MEDICAL PROGRAM
1945-1948
(as it actually operated)



has directly and personally administered local VA hospital affairs although his predecessor, General Bradley, sedulously refrained from so doing.

On the basis of the information gained through the process outlined above, the subcommittee concluded its hearings with a 2-day session with General Gray and Admiral Boone and then, in a series of executive sessions, formulated its conclusions. The subcommittee's findings as regards the points at issue and its recommendations are set forth below.

THE BASIC PROBLEM

Administrative relationships under the Bradley-Hawley regime

We have said that during the course of our hearings it quickly became apparent that the pattern of administrative practices which began to appear in the VA during General Gray's tenure differed markedly from that followed by other agencies and, indeed, from that which had been operative in the VA under General Gray's predecessor. Yet without wanting to sound paradoxical, we must also point out that if one were to chart the administrative relationships theoretically operating within the VA during the Bradley-Hawley regime as against those which were theoretically in effect under General Gray and Dr. Magnuson, they would turn out to be identical in all important respects. In theory and on paper—perhaps, in the minds of both Administrators as well—they were identical. In actual practice they were markedly different. It is in this apparent contradiction that the underlying cause of the crisis in VA medical care is to be found. The three charts prepared by the subcommittee's staff which appear below make this abundantly clear. They are simplified but accurate in all essentials. The first represents administrative relationships affecting the Department of Medicine and Surgery as they existed in theory from 1945 to 1951. The second represents those same relationships as they actually functioned from 1946 to 1948 under General Bradley and the third as they were tending to function under General Gray during the latter part of 1948.

Chart I represents an administrator's nightmare. Yet it does accurately represent the administrative relationships created on paper at least by the men who set forth the functions of each Assistant Administrator's office in the Veterans' Administration Manual. On the basis of this chart no less than nine coequal Assistant Administrators seem to have the authority to move in on the individual hospital manager and exercise influence over his decisions as regards overlapping matters. While some of them are so engaged, still others may be communicating directly with those groups of submanagerial hospital personnel which seem to come under their ill-defined jurisdictions. And to top it all off, the Administrator and his Deputy retain the right to issue orders to any of the hospital personnel without even such formal channeling of their instructions through a suboffice as would at least protect lower echelon personnel from concurrently receiving contradictory orders from above.

Obviously no medical care program worthy of the name could function on this basis without the rapid development of such confusion, frustration, and mismanagement as would quickly wreck morale, drive out competent personnel and rob the program of any possible value to anyone but such selfish incompetents as might be willing to

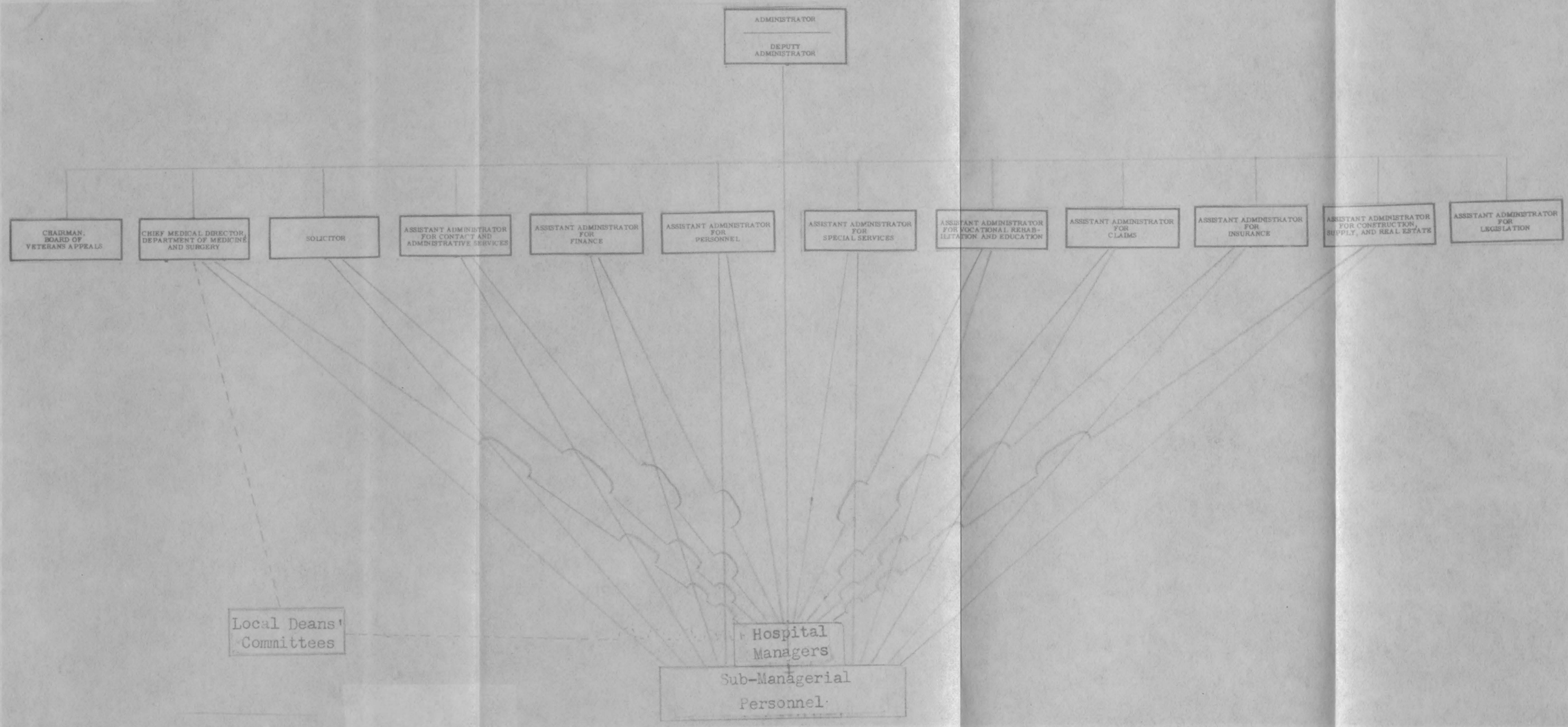
pretend to work in the resulting shambles. Certainly the remarkably fine medical care program developed by Drs. Hawley and Magnuson under General Bradley's leadership could not have grown out of any such administrative morass. And, of course, despite the contents of the Veterans' Administration Manual, it did not. General Bradley determined the policy which he believed should guide the development of the medical care program. But having done so, he made his Chief Medical Director responsible for carrying out that policy and he also delegated to him sufficient authority to enable him to effectively discharge that responsibility. As we have noted previously, General Bradley authorized Dr. Hawley to act in the Administrator's name and with all the Administrator's powers with respect to everything affecting the care of patients in VA hospitals and clinics. And when General Bradley talked of matters affecting the care of patients, he was thinking in modern medical terminology. To Bradley, "everything" meant just that. He knew that hospital planning affected the well-being of the patient as did the choosing of its equipment and the maintenance of its supplies. He knew that the charwoman, the groundskeeper, the recreation officer, and the chaplain each had a degree of influence on the success or failure of the doctor's attempt to help a veteran return to his home, his family, and his job as quickly as possible. This Bradley concept was made known and accepted throughout the VA. The result was that in actual practice, administrative relationships within the VA were far closer to those depicted in chart II than in chart I.

Although there may have been a dozen men with the rank of assistant administrators, there was only one man in charge of the medical-care program. Insofar as his central office colleagues were in command of skills or services which affected that program, those skills and services were made available to the Chief Medical Director and through him to the field. Insofar as they did render direct service to the field, it was in terms of programs and in ways which had been cleared through and approved by the Chief Medical Director or which had originated in his office. Under General Bradley, the title "Chief Medical Director" was a meaningful one.

The deans of our medical schools found it altogether possible and desirable to cooperate in that sort of medical care program. They knew that when they made an agreement with either Dr. Hawley or Dr. Magnuson that agreement would be carried out even though it might involve land acquisition, construction, budgeting, and personnel practices as well as strictly professional matters. Such a relationship would have been an utter impossibility had the VA been administered as shown on chart I. Fortunately whatever its appearance on charts or diagrams, the testimony given us clearly indicates that during this period and insofar as its medical care operations were concerned, the VA was in reality a well-administered, highly integrated organization with clearly defined allocations of responsibility and corresponding delegations of authority. The deans ignored the apparition and extended their cooperation on the basis of the then reality. The result was the unbelievably rapid creation on an enormous scale of a program of medical care characterized by standards so high as to be equaled by a relatively few institutions operating on a very limited scale.

CHART III

VA ORGANIZATIONAL PATTERNS RE MEDICAL PROGRAM
1946 - 1951
(as it began to take form in actual practice)



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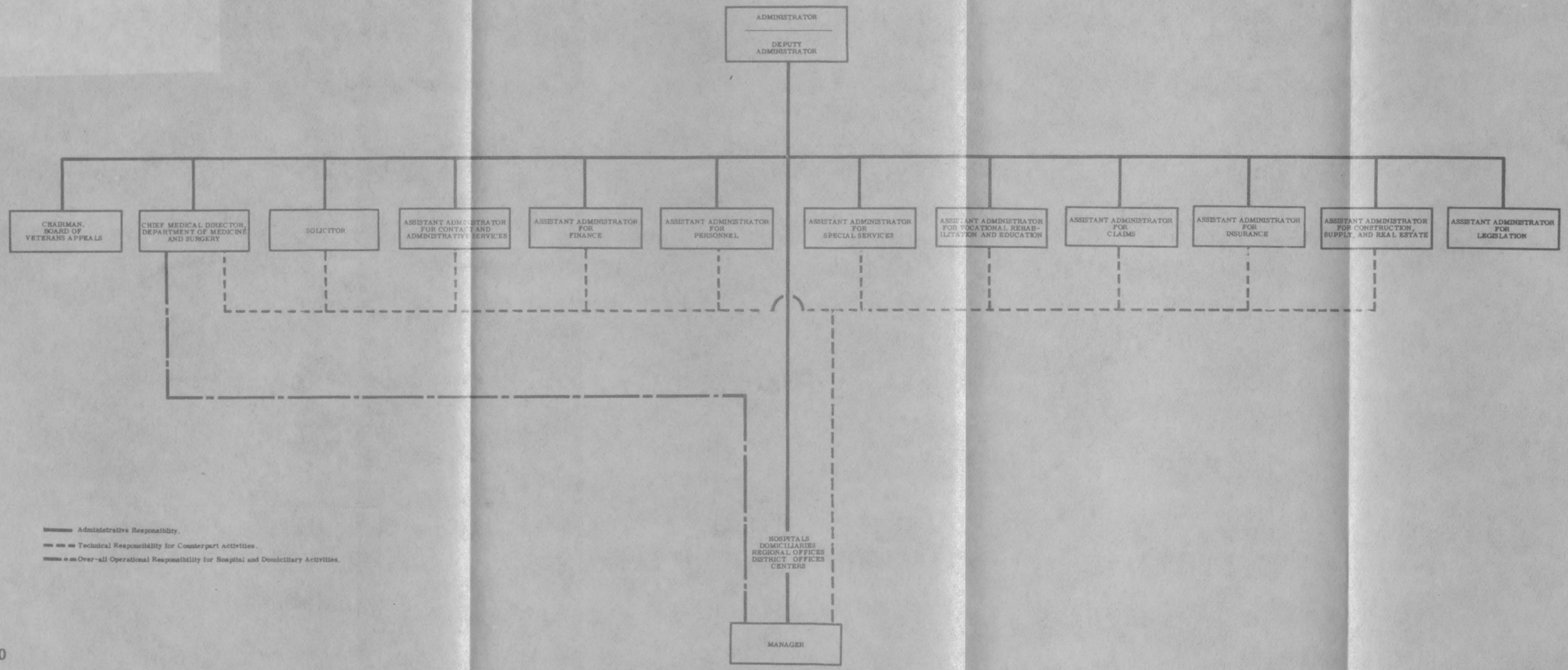
MEC-4
Change 101

CHART IV

VETERANS ADMINISTRATION

March 21, 1951

ORGANIZATION CHART



100.00

87299 O - 51 (Face p. 20) No. 2

Administrative relationships under General Gray

Shortly after General Gray took office as Administrator of Veterans' Affairs and appointed Dr. Magnuson as his Chief Medical Director, the atmosphere surrounding the Veterans' Administration began to undergo a decided change. Although it was not clearly apparent until Dr. Magnuson's departure from the VA in January of 1951, the testimony we have taken shows very clearly that almost immediately after Generals Bradley and Hawley left the Veterans' Administration, the organizational pattern we referred to in the last paragraph as a reality began to fade into a memory and the apparition began to take on flesh.

General Gray has repeatedly informed us that he has made no basic changes in the VA's organizational or procedural pattern affecting the medical-care program except to abolish the district branch offices which were a hindrance to its development. The subcommittee is willing to agree that for the most part the formal relationships and the written understandings between the VA and the medical schools remained the same and that with very few but highly significant exceptions the VA's formalized organizational procedures and regulations relating to medical care also remained the same. But the testimony we have taken proves conclusively that the basically all-important relationship between the deans of the medical schools, the VA's Medical Director, and the Administrator of Veterans' Affairs, which had rested entirely on the confidence which each had expressed in the others, underwent sudden and continuing change. Whereas, the confidence of the deans was immediately transferred to the new Chief Medical Director, that of the new Administrator of Veterans' Affairs apparently was withheld.

Even a cursory glance at the testimony we have been given shows very clearly that Dr. Magnuson was forced to spend most of his 3 years in office trying in vain to secure from the Administrator an approximation of that authority which General Bradley had conferred on Dr. Hawley and which, as we have seen, made possible the development of the medical care program despite the agency's woefully unbalanced formal pattern of organization. Dr. Magnuson seems to have spent the rest of his time trying to repair damages caused the program as a result of this new relationship and persuading the medical schools to continue their cooperation regardless of it.

Whether the conflict between General Gray and Dr. Magnuson had its origin in a clash of personalities or in differing philosophies of medical administration is not readily apparent, nor would it be important save for one thing. As the excerpts from the testimony which we are setting forth immediately below indicate, so long as Dr. Magnuson was Chief Medical Director of the VA, General Gray expressed both in actions and in words a concept of medical care administration vastly different from that which General Bradley, Dr. Hawley, and Dr. Magnuson had followed and the value of which, in the opinions of the deans of the medical schools and the members of this subcommittee, has been proved thoroughly. But General Gray's testimony on the last day of our hearings—a few months after Admiral Boone had become Chief Medical Officer and as the subcommittee's investigation was drawing to an end—conveys a completely different impression and leads the subcommittee to express the hope that the difficulty was

occasioned by a clash of personalities which has now been resolved. If this was the case, however, we must say that to allow such a clash of personalities to continue for 3 years and to so endanger a program which is of incalculable value to the Nation and its veterans is, in our opinion, evidence of remarkably inept administration. And in so saying we want to make it clear that we have nothing but praise for the patience and loyalty with which during those 3 years Dr. Magnuson stood by the program which he had helped bring into being.

DR. MAGNUSON'S POSITION

Dr. Magnuson's interpretation of the differences of opinion between himself and General Gray regarding the manner in which the program should have been operated is apparent in the following excerpts from his testimony: [2]

I want to thank you, gentlemen, for the opportunity to appear before this subcommittee to present my views on the policies and practices of the Veterans' Administration relating to medical care and hospitalization.

I can answer the question on the policies of the Veterans' Administration medical program simply and positively. As you know, my position has always been that of providing the best possible medical care to our veterans, and I have tried never to compromise with anything that I believed might weaken that policy. I know of no one who has ever argued with that position.

This policy, however, means nothing unless the practices of the Veterans' Administration are designed to make it effective. These practices or operations spell the success or failure of this policy. In my 3 years as Chief Medical Director of the Department of Medicine and Surgery, my major concern was to see that this policy was really carried out; that it was not defeated in part or in whole by bad practices.

It makes little difference whether the practices followed are established by law or established administratively. Whichever method is used is of no particular importance provided full recognition and participation are given to medical judgment. In other words, the quality of leadership brought to the positions of both the Administrator of Veterans' Affairs and the Chief Medical Director of the Department of Medicine and Surgery must include the spirit of cooperation or the American veteran will suffer. The care of the veteran at the bedside is always affected by the practices which govern the furnishing of that care, therefore, it is almost impossible to make any complete separation of bedside care and over-all administration. A hospital is not just a building containing a number of departments which provide separate segments of medical care without reference to each other. Rather it is an institution providing on a highly integrated basis a single end product—medical care—which requires an understanding of how the many separate segments must be joined together. The Chief Medical Director with his professional staff is the one best qualified to provide that understanding and join together all the segments needed for the best possible care of the veteran.

I want to say right now that General Gray and I have never disagreed on the broad subject of good medical care, but we have not always agreed on the practices which are needed to provide that good medical care. Such disagreements are not due to any mere question of personality, either between us as individuals or between doctors on the one hand and laymen on the other.

* * * Generals Bradley and Hawley both recognized that medical care and hospitalization consisted of more than just bedside care. They saw to it that the Medical Department participated not only in those matters which directly affected medical care, but also in those which had less direct effect on medical care.

I took office as Chief Medical Director 2 weeks after General Gray assumed the position of Administrator. During a period of several months thereafter, General Gray stated that he was just familiarizing himself with his position and would postpone major decisions until after he had visited every VA installation. About 3 months after assuming office, General Gray left on his extended field trip which lasted for some 9 months, during which time my only contacts with

[2] We again call attention to the fact that all of the testimony given us and all of the documents in support thereof are being made available concurrently with this report.

him were either by letter or for only a few minutes at a time when I met him somewhere in the field or saw him during his infrequent and short visits to the central office. Throughout this period there was no opportunity for the face-to-face discussions so vital to the making of major decisions. At the same time, however, during his extended field trip and without consulting the Chief Medical Director, General Gray began to take actions which directly or indirectly adversely affected medical care.

* * * * * * *

These actions were taken without the prior knowledge of the Medical Department. General Gray took them either on his own initiative or on the advice of some other member of his staff in no way qualified to express an informed judgment on over-all medical policy. * * *

This practice has continued from that day to this. The point is not that these decisions, good or bad, were made, but rather that they were made without the knowledge or participation of the Chief Medical Director, and in most cases I was informed of them only through the back door, frequently long after the action had been taken.

* * * * * * *

Much of my time was spent not in developing the medical-care program but in time-consuming process of correcting arbitrary or unwise decision or decisions based on inadequate information which adversely affected the medical-care program. On the other hand, many decisions which I requested be made were either not made or were postponed for a long period time, causing complete uncertainty as to our position.

* * * * * * *

Senator MORSE. Am I correct in this assumption; that that documentary evidence will show that you did not receive specific instructions as to your responsibilities and jurisdiction and relation to the Administrator either in writing or in spoken orders?

Dr. MAGNUSON. That is right, Senator. And I think it will show also that there was complete confusion between not only the Medical Department and the Administrator but between the Chief Medical Director and his responsibilities and the other departments of the Veterans' Administration. Nobody, so far as I could see, knew what their defined responsibilities were or what the interchange was between them in order to make the thing a good administrative procedure as a whole, as between departments. I said here, in this, that I got my information through the back door. And that is exactly what I meant. Construction things that might have some effect on the care of patients, either the increase of beds or the decrease of beds or the changing of a laboratory or X-ray rooms or what not, would go from the hospital to the Construction Department. I would learn about them if the Construction Department chose to send me a courtesy copy.

* * * * * * *

The Veterans' Administration's excellent medical program has already begun to show signs of deterioration—as reported by the Deans of Affiliated Medical Colleges last week in Chicago. In all frankness, I must say that the progress initiated under General Bradley has not been continued. Nor do I see any hope for progress in the years to come until the administrative leadership of the Veterans' Administration is elevated to a point where an intelligent and cooperative working relationship exists between an able Administrator and a Chief Medical Director who has the confidence and support of the medical profession. The charge that I did not agree with General Gray on how the VA medical program should be run is a true charge: I insisted then, and I still believe today, that the Chief Medical Director must know clearly what his responsibilities are and must have the authority to carry them out. I cannot believe that any administrative process which does not keep the Chief Medical Director informed can ever lead to smooth operation. He, as operating head of the Medical Department, should be responsible to the Administrator for good medical care and proper operation of hospitals with authority to act within the confines of clearly established policies.

* * * * * * *

Dr. MAGNUSON. It was after 30 frustrating months of trying to operate with a complete lack of definition of my responsibilities that I first proposed to the Administrator that possibly the solution to our problem was a revision of Public Law 293, which would definitely spell out the responsibilities not only of the Administrator, but of the Chief Medical Director, for operating the medical

program. That was after 30 months. This lack of definition was a source of concern to the Special Medical Advisory Group, established by law to advise the Administrator. It was under the chairmanship of Dr. Charles W. Mayo of the Mayo Clinic, that this group made specific pertinent recommendations to him in 1948. And I have those recommendations here, which I will submit.

Excerpts from the communication to which Dr. Magnuson referred follow. The point of view expressed therein is very much the same as that held by the many eminent physicians and outstanding medical and hospital administrators who, on numerous occasions during Dr. Magnuson's tenure, addressed similar communications to the Administrator of Veterans' Affairs and subsequently to members of the subcommittee. We believe that point of view to be thoroughly sound.

DECEMBER 7, 1948.

Mr. CARL R. GRAY, Jr.,
Administrator of Veterans' Affairs, Washington, D. C.

DEAR MR. GRAY: The special medical advisory group was in session on December 6, 1948, and, among other items on the agenda, considered certain administrative problems in the Veterans' Administration bearing on its medical activities.

A subcommittee of the group was appointed to study this matter and submit a report to the group. The following report of the subcommittee was approved unanimously by the entire group, with instructions to me as chairman that the report be brought to your early attention for your consideration:

"At the last meeting of the Special Medical Advisory Council 3 months ago, the attention of the Council was called to certain administrative problems in the Veterans' Administration, which appeared to require study of the Council, in order to give proper advice to the Administrator with respect to the program of medical care offered to the veterans of this country. Taking cognizance of this, Dr. Mayo, the chairman, appointed a subcommittee to investigate this problem and report at this meeting. Your committee has done this and, in addition to making a study of the administrative structure of the Department of Medicine and Surgery during the past 3 months, it has spent the past 3 days in Washington in a more intensive study of the problem.

"Your appointed committee consists of Dr. Stewart Rodman, Dr. G. W. Brugler, and Dr. Roy Kracke. During the past 3 days, your committee has held conferences with the Chief Medical Director and other members of the organization pertinent to this problem. Part of the time Dr. Mayo has been in attendance. In consideration of the problem it soon became obvious to the committee that the study could not be confined solely to existing activities of the Department of Medicine and Surgery, but more important, their relationship to other departments.

"First, we would like to record our impression that the veterans of the United States are receiving medical care of a high quality and second to none in this country. Indeed, this is the subject of favorable comment throughout the country. Therefore, we wish to record our confidence in the administrative officials of the Department of Medicine and Surgery, whose policies have resulted in this high level of medical care for the veterans. We note, however, that this has been accomplished not because of existing administrative pattern but, rather, in spite of it. In an over-all survey of the responsibilities of the Veterans' Administration as a whole, it is at once apparent that the Department of Medicine and Surgery is responsible for a major share of administrative activities.

"At this point it became necessary to define what is meant by 'complete medical and hospital service,' for the veteran. In the opinion of this committee this must include not only responsibility for professional care, but also over-all managerial responsibility for all ancillary services including the physical plants in which medical care is offered, and all service facilities in support thereof. We have found that, although the Chief Medical Director is responsible for the medical care of the veteran in all of its phases, he is not cloaked with the necessary authority with which to properly exercise his function. For example, although he is responsible for the quality of medical care, the installations in which medical care is offered are frequently in whole, or in part, under other administrative direction. For example, in the veterans' hospitals throughout the country, the Chief Medical Director is responsible for appointments and the work of doctors, dentists, and nurses. He has virtually little control over the appointment and activities, tenure, and discipline of the large group of auxiliary medical personnel that serve in the

medical installations. This applies even to groups of administrative importance and responsibility, such as the lay managers of veterans' hospitals, who are responsible for administrative direction to the deputy administrators rather than to the Chief Medical Director.

"Furthermore, the Chief Medical Director does not have control over other hospital activities such as purchasing, fiscal matters, recreational facilities, etc., that are a part of the average veterans' hospital. This situation is not good administrative practice. Some one official in the Veterans' Administration should carry the total responsibility for offering good medical care to the veteran. This responsibility should not be spread amongst a large group of people. In any organization this results only in conflicts, irritations, annoyances, disagreements and, ultimately, disintegration of medical staff morale.

"It is the belief of this committee that such disintegration is now beginning to appear in the Department of Medicine and Surgery. Therefore, it is our belief that administrative changes should be considered by the Administrator that would prevent this and, furthermore, strengthen the administrative pattern of the organization.

* * * * * * *

"If some reorganizational plan similar to this is not adopted, it is the fear of this committee that the general level of medical care offered to the veteran may slowly disintegrate and reach a level such as that which existed prior to World War II, when it assumed the aspects of a national scandal.

"The committee has studied the law under which the Administrator conducts the affairs of the Veterans' Administration, and it is our belief that new congressional legislation is not required to effect these changes, but that the Administrator is now sufficiently cloaked with congressional and executive authority to make such changes, if he so desires.

"The committee moves the adoption of this report, and moves that it be transmitted to the Administrator of Veterans' Affairs through the Chief Medical Director."

Sincerely yours,

CHARLES W. MAYO, M. D.,
Chairman, Special Medical Advisory Group.

Incidentally, the subcommittee would like to point out that had the Administrator been required by law to send the Congress copies of the recommendations made to him by his Advisory Committee together with a statement as to how and why he had acted or failed to act on its recommendations, this entire problem might have been cleared up long before it had become as serious as it now is. We shall refer to this again later on.

Six months afterward, the Advisory Committee felt compelled to reiterate its appeal in the letter which follows:

JUNE 13, 1949.

Mr. CARL R. GRAY, Jr.,
Administrator of Veterans' Affairs, Washington, D. C.

DEAR MR. GRAY: The Special Medical Advisory Group, established by congressional action to advise the Administrator of the Veterans' Administration on the care and treatment and other matters pertaining to medical and surgical service to the veteran, believes that it is within its functions to advise the Administrator on matters of administration of hospitals that constitute an implement of medical care. In support of this we quote from the law establishing this Group: " * * * whose duties shall be to advise the Administrator, through the Chief Medical Director, and the Chief Medical Director direct, relative to care and treatment of disabled veterans, and other matters pertinent to the Department of Medicine and Surgery."

We are gravely concerned over the lack of authority of the Chief Medical Director over the control of the hospitals, which we consider to be an integral part of the medical care to the veteran.

We advise and firmly urge the Administrator to delegate more authority to the Chief Medical Director, who is directly responsible to the Administrator for such care.

We strongly recommend that the managers of all Veterans' Administration hospitals be under the supervision of, and be rated by, the Chief Medical Director, who in turn is responsible to the Administrator.

We wish to emphasize that the actions of the Special Medical Advisory Group are solely in the interest of the sick and disabled veteran.

Sincerely yours,

CHARLES W. MAYO, M. D.,
Chairman, Special Medical Advisory Group.

And even 6 months after Dr. Magnuson's ouster from the VA, the Board of Chief Consultants to the central office of the VA felt that the problem was still serious enough in its implications to warrant sending this letter to the chairman of the subcommittee:

MEMORANDUM

JUNE 6, 1951.

To: The Honorable Hubert H. Humphrey, United States Senate, Washington, D. C.

From: Board of Chief Consultants, central office, Veterans' Administration, Washington, D. C.

The Board of Chief Consultants, Department of Medicine and Surgery, Veterans' Administration, at a meeting held June 4 and 5, 1951, voted to have a representative arrange a meeting with you or, failing that, with other members of your Senate subcommittee investigating policies of medical care and practices of the Veterans' Administration for the purpose of conveying the following message which represents the unanimous opinion of the Board.

We appreciate fully the importance of the careful investigation now being made by your subcommittee of the medical organization of the Veterans' Administration. We are confident that the action which will be taken should lead to the early correction of certain serious inadequacies of control to which we have called attention in the past. On January 15, 1951, in a letter addressed to the former Chief Medical Director of the Veterans' Administration, our Board stated its concept of the basic requirements for an effective medical program for the veterans of this country. A copy of this document was sent to you at that time. Briefly, we pointed out and now repeat for emphasis that the Chief Medical Director should be guaranteed adequate authority and support to properly carry out his total responsibility to the Nation as the professional head of the program. Certain important incidents in the past have indicated that such authority either had not existed or had not been exercised.

Since the time at which our letter was written, a new Chief Medical Director has been appointed and from an excellent report which he has given us at this meeting we have been assured that the Administrator has cooperated in giving him an opportunity to exercise full professional leadership during the last 3 months. Moreover, the new Chief Medical Director has expressed the belief that a new organizational chart recently prepared by the Administrator confers on him the authority required to meet his broad responsibility.

The Board is pleased to have this reassurance but we, in the past, have been the unwilling witnesses of a number of jurisdictional disputes between the Administrator and the former Chief Medical Director. We feel that, if the confidence of the whole medical profession and the public in the Veterans' Administration medical program is to be maintained, such disputes must be terminated once and for all by a clear and even more definite statement setting forth the duties and responsibilities of the Chief Medical Director and by giving him a clear channel of authority over the affairs of the Medical Department from the smallest or largest field unit to him in central office. We recommend a statement that the authority and responsibility, legally vested in the Administrator, in regard to medical installations and functions should be exercised only through the Chief Medical Director and not through collateral channels which bypass him. Such safeguards have not been fully incorporated in the present organization of the Veterans' Administration. We are anxious for assurance that Assistant Administrators now of equal rank to the Chief Medical Director in the Veterans' Administration will not be able to influence in deleterious fashion or to nullify the efforts of the Chief Medical Director in planning and maintaining a functioning medical organization, "second to none."

We realize that the best organizational charts will not assure a smoothly functioning Medical Department unless individuals in control and their subordinates are first properly selected and secondly willing to work as a team. The work of your committee has had a salutary influence within the Veterans' Administration. It is our belief that your subcommittee should remain in existence ready to take

appropriate action should need arise. Controversy if it were allowed to continue or should it recur would do inestimable damage.

Respectfully submitted.

RALPH M. TOVELL, M. D.,
Chairman, Board of Chief Consultants, Veterans' Administration.[3]

GENERAL GRAY'S ATTITUDE

General Gray's attitude toward the problem is perhaps best summed up in the following excerpt from his testimony:

I have stated that the difference between Dr. Magnuson and me is the fact that he refuses to accept the present organization and has sponsored and talked about a bill which would set up a Bureau of the Medical Department, self-contained within itself, including all of the agencies. And in the hospital there is personnel work, there is administrative work, there is finance work, there is repair work, construction and repair and maintenance. He wants all of that within the Medical Department.

Senator HUMPHREY. That is as it pertains to a hospital?

Mr. GRAY. As it pertains to a hospital.

Senator HILL. And with the Administrator having no over-all authority, so far as he is concerned?

Mr. GRAY. Sir?

Senator HILL. With the Administrator having no over-all authority?

Mr. GRAY. Only through him.

Senator HILL. Well, when you say "through him," would he be subject to the Administrator's directions, or would he be pretty much on an equal plane with him?

Mr. GRAY. It all depends on what the Administrator found out as to what he was doing and how much he was told of what was going on.

* * * * * * *

It has been charged that I, as a layman, have interfered with the practice of medicine. If by that phrase those who criticize me say that I have attempted to dictate on matters affecting the relationship between the physician and the patient, or the professional relationships between physicians, I have never interfered with the practice of medicine and categorically deny the charge.

It is my job to see that the affairs of veterans are properly administered and when I have found medical men resorting to extravagances or to practices which were administratively bad and which were unrelated to the care of patients, or when any medical men have attempted to take over administrative functions delegated to the Administrator by the Congress and the President, I have stepped in and exercised my duty to correct this condition.

That is what I conceive to be my job as set up by the Congress and approved by the President.

Today, as upon my previous appearance before this committee, I am hopeful that we may avoid any discussion of personalities and keep our consideration on the plane of service to veterans. But I cannot ignore specifics that have been leveled at me by gentlemen who have appeared before this committee, nor can I ignore particulars contained in the letter from the committee asking that I appear before it this morning.

The Veterans' Administration was established as an integrated agency in 1930, following the pattern set by the recommendations of the Dawes committee in 1921. The reason for this was that prior to 1921 the various functions consolidated in the VA had been performed by separate agencies. This system had proved itself a failure and had collapsed of its own weight.

The Veterans' Administration is not a Department of Medicine and Surgery. It is not a Department of Insurance or a Department of Vocational Rehabilitation and Education or a Department of Pensions and Claims. It is a whole in which each and all of these, as well as other departments, are contained. It is my job to see that all function smoothly together to make a harmonious whole. It is my job to see that they function economically and efficiently in the service of the veterans of our Nation.

* * * * * * *

[3] Subsequently, Senator Humphrey met with Dr. Tovell and having reviewed with him the Advisory Group's experiences and subsequent attitudes toward VA administrative procedures, transmitted them to the subcommittee. The subcommittee wishes to express its appreciation to the group for its willingness to thus aid our deliberations.

The managers of hospitals are responsible to the Administrator through the Chief Medical Director for over-all operations in the 137 separate hospitals, 13 hospital-homes, and 3 domiciliary centers of the Veterans' Administration. *The supporting services necessary to operation of a hospital are supervised in connection with technical matters by the various Assistant Administrators particularly concerned with such matters. These supporting services include such "housekeeping" activities as accounting, personnel administration, fire protection, operation of laundries, and such matters. Many of our hospitals have extensive grounds, and in some cases, farming and dairying operations for therapeutic purposes. Engineering divisions in the hospitals operate utility systems, laundries, fire-fighting equipment, heavy-duty mechanical equipment, and automotive equipment. I see no reason why the Chief Medical Director should be burdened with the responsibility for these activities and I have continued to hold the appropriate Assistant Administrators responsible for them—as did my predecessor.*

The manager of a hospital is responsible for the coordination and supervision of the operation of the hospital as an entity. He sees to it that approved policies, regulations, and procedures are carried out. His operations are reviewed periodically by representatives of the Chief Medical Director and, *where technical matters solely under the jurisdiction of particular Assistant Administrators are concerned, by representatives of the Assistant Administrators.* These field supervisors are under orders to work through the managers and to avoid any action which might possibly be construed as interference with the manager's authority.

There may be direct communication between central office and subordinates of the hospital manager on routine matters of technical operations. If any matter of any importance is to be communicated to a hospital, it is communicated to the manager and not to any subordinate. Instructions which establish or change procedures, regulations, or policy, are communicated to the hospital managers over my signature or that of the Deputy Administrator acting for me by direction. When these are more than minor changes of administrative routine, they are initiated by or have been concurred in by the Chief Medical Director before they are issued.

We have italicized certain passages in General Gray's testimony because they so well illustrate the difference in medical administration policy and practices between General Gray and his predecessor. It is our understanding that General Bradley did hold the appropriate Assistant Administrators responsible for the providing of services listed by General Gray but that when they involved hospitals and medical centers, he very definitely held them responsible for carrying them out only along lines approved in advance by his Chief Medical Director.

THE BASIC PROBLEM

Even if it were not completely proved by a wealth of testimony, the statement made by General Gray would indicate that under his supervision and during Dr. Magnuson's tenure, the VA's pattern of administration would undoubtedly show a marked tendency to shift from that outlined in chart II to that depicted in chart III. Chart III, as a glance will show, is identical with chart I except as regards its title. We have included it again because when we were discussing chart I we were dealing with an administrative monstrosity so obviously unworkable that it was absurd to think that any administrator would permit it to find expression in practice. Yet in 1948 VA practices began to conform to it more and more closely. As we have seen, notwithstanding the fact that that pattern on paper reflected provisions scattered through the VA Manual during his terms of office, General Bradley, by informally but effectively vesting what the Army would call line control over the entire medical care program in the Chief Medical Officer and by changing that of the Assistant Adminis-

trator to functional control, [4] molded all those relationships affecting the medical-care program into a new, realistic, and workable administrative plan. But General Gray, on his accession to office, actually permitted the VA to begin functioning in terms of chart III. His different concept of what are the integral parts of a total medical-care picture led him to permit the actual exercise of line control over various factors of importance to medical-care programs by no less than 10 coequal Assistant Administrators as well as by himself and his Deputy. We are confident that General Gray is perfectly sincere when he insists that he made no major changes in the VA's administrative pattern. What General Gray does not seem to realize was that merely by letting all the confused and contradictory and overlapping provisions of the Veteran's Administration Manual have full play; by permitting all his assistants to carry out the roles assigned them by the manual without clearance with or approval of the Chief Medical Director, he had lifted the lid off a veritable Pandora's box; a Pandora's box atop which General Bradley had wisely kept Dr. Hawley ensconsed for over 2 years. It is in this change in the administrative relationships of other offices in the VA to the office of the Chief Medical Director and to hospitals and clinics in the field that we find the basic problem underlying the program's current difficulties.

As soon as they saw the change occurring and the administrative pattern of chart III emerging, the deans, key hospital and medical administrators, and the experienced medical personnel in the VA knew that unless the process was reversed, the VA's medical care program would be left in ruins. They and the members of this subcommittee believe that no program of any sort can operate in terms of chart III for any length of time. Certainly no medical-care program can. Its welter of conflicting lines of authority and the maze it makes of lines of communication cannot but lead to utter confusion, intolerable pressures, bitter rivalries and the eventual destruction of a program to the maintenance of which we know General Gray is wholeheartedly devoted.

Yet more than a month after this investigation got under way and after most of VA's problems had been thoroughly discussed, General Gray had a new and official Veterans' Administration Organization Chart issued for the purpose of clarifying the administrative relationships which he believed should obtain between his various central office groups and a VA hospital. That chart is here reproduced as chart IV.

Chart IV is, in effect, identical with our chart III. The only difference is that we have carried ours one step further down the scale and we have made clear the fact that it is not along three clearly distinguishable and easily handled channels that central office personnel, orders, requests, questions, investigations, and a thousand and one other things strike a hospital manager and the staff which is trying to see to it that veterans get the care they need, but through more than a score. And, of course, those jealously guarded lines work in two directions thus compounding confusion. We repeat our conviction that such a system cannot work.

[4] For a lucid explanation of these management terms, see the introductory remarks of Colonel James T. McGibony, Medical Corps, Office of the Surgeon General (Army) in the testimony he presented on March 13.

We believe that General Gray's inability to realize this until recently is directly traceable to that devotion to the welfare of the veteran which has driven him to spend an overwhelming amount of his time out in the field developing a first-hand knowledge of each of the institutions for which he is responsible; familiarizing himself with their peculiarly local problems and checking on the type and quality of service rendered in each hospital. He has been so deep in the woods, clearing out the underbrush from around individual trees, that he has never had an opportunity to see the forest for the supervision of which he is responsible; he cannot have noticed that the plethora of assistant administrators he leaves behind him swing such lusty axes in their attempts to carve out larger bureaucratic niches for themselves that they are rapidly destroying his forest.

We feel greatly reassured, however, since Admiral Boone, who is thoroughly experienced in medical administration and in whom General Gray has expressed the greatest confidence, has been instructed to analyze the entire complex of relationships within the agency which in any way affects the medical care program and to recommend to the Administrator such changes as he finds to be necessary not only to maintain the program but to further strengthen it as well. We are confident that his findings will parallel ours.

CONCLUSIONS AND RECOMMENDATIONS

Throughout its hearings, the subcommittee consistently sought to unearth the really fundamental issues adversely affecting the veterans' medical-care program and to find practical and permanent solutions to the problems thus disclosed. The testimony we received is filled with illustrations of Dr. Magnuson's determined but unavailing efforts as Chief Medical Director to obtain that clear-cut delegation of primary responsibility for control over the operations of the VA's medical and hospital system which he believed was essential to its successful functioning and in which belief we find him to have been correct. The many examples of lack of administrative coordination and of improper delegation and exercise of authority with which the testimony is replete condemn the VA's organizational pattern and administrative practices as having been unwieldy, inefficient, and confused. The VA's comments on those examples and its attempts to justify the specific practices which had been questioned not only fail to carry conviction but in themselves lend further strength to our conclusions.

Summation of the essential evidence leads to the obvious conclusion that since hospitals are erected and operated for the care and treatment of patients, everything that goes on in a hospital should be efficiently controlled and directed to that end. There is no question whatsoever that the provision of modern, complete hospital care and treatment requires a high degree of integration, coordination, and control over all the many and varied services and functions that affect such care if the program is to be directed efficiently. In the opinion of the subcommittee such necessary integration, coordination, and control has been almost completely lacking in the Veterans' Administration for some 3 years past. Primary authority for the direction of activities affecting the care and treatment of patients was so diffused among Assistant Administrators that it clearly could

not be said that the Chief Medical Director had effective control over the operation of the medical and hospital system.

There is considerable doubt on the part of the subcommittee that the present VA administrative organization ever has operated smoothly and efficiently since its inception. It fairly mushroomed in the wake of demobilization in 1945 but has never been thoroughly overhauled since that enormous deluge of business hit the agency. Despite the great ramifications of the organization and the incessant problems of coordination, confidence in the medical program was maintained under General Bradley's administration because of his willingness to grant carte blanche authority to the Chief Medical Director. Under such conditions, the big administrative job was that of trying to make the system work. During Dr. Magnuson's time in office, however, not only was the Chief Medical Director faced with the ordeal of making the thing work but he had to contend with a completely different conception of his authority to do the job. The refusal of the present Administrator during that period to delegate the authority which would have enabled the Chief Medical Director to control, manage, and operate the medical and hospital system so shook confidence in the program that it was threatened with complete disintegration.

The subcommittee is highly gratified that during its last hearings and after a month's tour of hospitals in the company of Admiral Boone, his new Chief Medical Director, in the course of which the problem was discussed with several local deans committees, General Gray's testimony indicates a willingness to strengthen the hand of the Chief Medical Director and, on the basis of his confidence in Admiral Boone, to let it be known throughout the VA and to the public that he regards his Chief Medical Director in somewhat the same light as General Bradley regarded Dr. Hawley. Because we believe that many of the statements made to the subcommittee on the last day of our hearings will be of considerable interest to professional men affiliated with the VA medical care program and will do much to restore their faith in the program's potentialities, we are setting forth below copious excerpts from that testimony and italicizing the most important commitments made therein.

EXCERPTS FROM THE HEARINGS OF MAY 10–11, 1951

General GRAY. Vice Admiral Boone, Chief Medical Director of the Veterans' Administration, is here today. I am gratified that you have invited him to testify before this committee as to the authority and responsibility with which he is vested.

As the Chief Medical Director he is responsible for the over-all operation of the entire Department of Medicine and Surgery and, through him, each hospital and domiciliary manager is responsible for the entire coordination and over-all operation of the facility within his charge. He has now been in office more than 2 months and has had an opportunity to study the operation of his department and its relationship to other activities in the Administration, both from the central office in Washington and on an extended field trip with me on which he visited and appraised all types of Veterans' Administration installations. *I am confident that he will confirm my opinion that he has been clothed with authority fully commensurate with his responsibility.* Basically, the authority he has is identical with that of his predecessor.

Service to veterans is the all-important function of the Veterans' Administration. It must be effective, efficient, and coordinated. It can only be so with a smoothly operating over-all organization. Anything that interferes with service to veterans, destroys the very purpose of the Veterans' Administration. Personal ambition or departmental ambition cannot be allowed to curtail service, nor

can they be permitted to interfere with the function of the Veterans' Administration as a unified and efficient whole in which every part is related to and dependent upon every other part.

That, gentlemen, is my concept of the job to which the President nominated me and you confirmed more than 3 years ago.

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"6. It is stated that until about a year and a half ago Veterans' Administration doctors designated or assigned to take graduate courses in physical medicine and rehabilitation for a 6-week period were approved by the Chief Medical Director and that such assignments went through routinely in such a manner that the training institution knew long in advance the numbers and names of persons designated for such training. Such advance knowledge enabled the training establishment to make proper plans ahead of actual beginning of the course of training. Now, it is charged, that for the last two classes the training institution has not known sufficiently beforehand who the trainees would be to enable them to make proper plans. This, it is charged, is due to the fact that each individual designated for this training must now be personally approved by the Administrator. In view of the slight degree of contact between the Administrator and these individual doctors and the Administrator's assumed inability to evaluate their professional qualifications for such assignments, the motives underlying such a procedure are questioned. Moreover, such approval by the Administrator, it is charged, has created a bottleneck in the orderly conduct of this training program."

General GRAY. The specific reference to the training of doctors in physical medicine and rehabilitation is not understood. However, without restriction to this particular category, it may be stated that my predecessor took general action which among other things denied authority to the then Chief Medical Director to approve the attendance at courses of training of individuals of the Department of Medicine and Surgery. I refused to change this procedure during the tenure of the former Chief Medical Director. Accordingly, the charge is incorrect by implying that such a delegation did exist until a year and a half ago. It is also unsupported by the facts in asserting that a bottleneck exists in the orderly conduct of the training program by reason of the fact that each individual designated for training must be personally approved by the Administrator. It is true that during the tenure of the prior Chief Medical Director, the procedure was for the Administrator to make final approval of travel for Department of Medicine and Surgery employees to attend courses of instruction. However, no record can be found of a refusal by the Administrator to approve the attendance of any individual at such courses. Although the requirement of final action by the Administrator involved a slight additional period of time, this double check on an activity which entailed a special type of expense did not operate as a retarding factor and any time lag was insignificant.

By Authorization Order No. 373 of March 30, 1951, the Administrator delegated to the present Chief Medical Director authority to take final action on this procedure, without reference to the Administrator.

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Senator HUMPHREY. Let me give you another example. On supplies I was glad to hear you say what you did because you set the record straight on what your prior testimony had been. Have you issued any administrative order to the effect that all supplies, medical supplies, speaking now only of medicinals and drugs for hospitals, must have the concurrence or the approval of the Chief Medical Director or one of his deputies?

General GRAY. To my best knowledge that is and has been the standing order of the Veterans' Administration.

Senator HUMPHREY. Let me ask you a question with reference to that matter.

General GRAY. In other words, the supplies, medical, drugs and supplies, are furnished on requisition by the Medical Department and are furnished under no other manner of handling.

Mr. REIDY. Is the list of supplies they can order prepared under the approval and concurrence of the Chief Medical Director?

General GRAY. Yes, sir.

Mr. REIDY. And that is in writing?

General GRAY. It has been and continues, and there has been no change of any kind under this procedure.

Senator HUMPHREY. Let me ask you with reference to hospital construction. We have had before us in extended hearings representatives of the Public Health

Service, the Surgeon General of the Army, and the Navy, and all the branches of the services. We have gone into their type of hospital management operation.

We received clear-cut unmistakable testimony that not a single hospital is constructed nor are any plans made available for purposes of construction until they are stamped and approved and O. K.'d by the Chief Medical Director or the Surgeon General.

General GRAY. I have said that same thing identically, sir, and it is factual.

Senator HUMPHREY. Is there any order to that effect?

General GRAY. It is standing orders. It has been in effect continuously, and I have not changed one iota of it.

Mr. REIDY. Then there would be no objection to the VA putting in a statement in writing as to its procedure if it does not now exist, and that is what we are concerned with, the statement that the deans of the schools are going to withdraw their cooperation unless they receive certain assurance.

If in writing VA's regulations it is absolutely stated that no VA hospital will be built without the complete approval of the Director of the Medical Division that would resolve that problem. Perhaps it is already in writing.

General GRAY. I cannot say whether it is in that wording or in that specific category.

Mr. REIDY. That is your intent, I believe you said?

General GRAY. *It is not only the intent, but the action.*

Mr. REIDY. Then there would be no objection?

General GRAY. *I have no objection at all* because I rely on the Chief Medical Director to give me full and complete medical advice, and since the construction of a hospital is that in which he has to work to render service, medical care to patients, it is absolutely necessary that he be in complete agreement with the plans as advertised and the building as built, and that is to my best knowledge and belief the exact situation. Whether it is spelled out in just so many words in some of the very multitudinous, shall we say, instructions or bulletins or what not, I am not prepared to say, but that is the action that is being taken, and I am quite confident that it is there somewhere in some form.

Mr. REIDY. But if it would help reassure the deans committee——

General GRAY. I have no objection whatsoever to making a statement, and in fact I have in writing, which I will be perfectly glad to submit as an exhibit, a joint memorandum to the Chief Medical Director and to the Assistant Chief in Charge of Construction that all alterations, plans, and specifications incident to alterations or improvements or betterments or what not in veterans' hospitals will come to me with a joint recommendation of those two departments.

Mr. REIDY. And with the specific statement that no plans would be approved unless the Chief Medical Director had approved them?

General GRAY. That is included in that if it comes to me with the joint recommendation it has to have his recommendation and approval.

Mr. REIDY. I was thinking in terms of phraseology, sir. Everything you have said so far indicates that you are not only prepared to but have always acted on the assumption that the principles the deans say is the basis of their cooperation would be put into effect, so I presume there would be no objection to spelling them out so that they may be reassured that that is going to be continued practice?

General GRAY. Wording sometimes is important, and yet it is at times infinitesimal. The fact of a statement, and I am a rather factual sort of person and not many people misunderstand me, when I say that there is no construction, alterations, additions, or betterments to be had or made in the Veterans' Administration unless it comes to me for final decision and approval by the Congress and the Budget and the rest of it, without the joint recommendation of the Chief Medical Director, who in reality approves the lay-out, as it were, and the Chief of Construction and Supply advises me properly as to the cost of what that facility will be.

Now we have criteria which has been worked up jointly between the Construction Division and the Medical Department in which all general factors of relationship of size and utilization of buildings is a joint recommendation and a joint concurrence. That is already there.

Mr. REIDY. Then can we assume that that same thing would apply, and if it is not clear now you would be willing to clarify it with regard to the professional equipment in a hospital?

General GRAY. That also very definitely applies. There is not a piece and never has been a piece of equipment sent to a hospital except on requisition from the Medical Director.

Mr. REIDY. Presumably, if that is not clear, because it may be scattered throughout existing directives, you would have no objection?

General GRAY. *None whatsoever to spelling it out.*

Mr. REIDY. To the effect that no piece of medical equipment would be sent to a hospital without requisition and approval of the Chief Medical Director or his deputy?

General GRAY. *That is correct.* That is what is in effect and some people have been told that it is not in effect and to that end there is misunderstanding.

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Admiral BOONE. In all this travel with General Gray we would go into a new hospital and he would say, "I think this would be interesting to you in view of some of the things you have heard."

Very properly General Gray would start on the top floor, and he has a procedure which I wish I had adopted as an inspector general many years ago. He goes all the way down the right side of the hall, and then comes back down on the other, and never misses a thing.

I have traveled with inspectors of the Army and Navy for years and have been an inspector general, and I must say, gentlemen, that I have learned a lot from him in these 2 months of inspection. I have never seen a man as thorough an inspecting officer as he is. He has never missed a trick. He looks at the construction work.

Then we go into a hospital that is manned, and the manager starts to walk through the hospital with him. He turns and says to the manager, "This is Admiral Boone's province, you go with him, and I will follow you. I may disappear after a while, and I will meet you in the office later if I do. This is Admiral Boone's office and bailiwick."

We went to the hospital in Oakland, Calif., which is a hotel taken over from the Army, and I might say that we have to do a lot about that place in the way of construction. As soon as we got in the manager started to talk to him, and he said, "This is Admiral Boone's province, you go and tell him. He will make the decision about what we shall do with this hospital."

A few days later I had a memorandum from him listing the things that he suggested to me, he did not tell me, but that we should consider them in this problem. In every matter of construction I deal very intimately with Colonel Dryden, the Chief Administrator for Construction, Real Estate, and Supply. We have a most delightful relationship, and in no instance has he tried to prevail on me to do something which I did not think it was wise to do medically for any hospital alteration, any construction.

General Gray has told me that he will never approve any changes in hospitals, any alterations, without there being a joint statement on there with our signatures, either Colonel Dryden or myself. He will never approve a blueprint for a hospital without seeing my name on it.

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Senator HUMPHREY. I would like to ask a question with reference to this last circular on hospital construction. *Am I to understand, or is the committee to understand, that before any hospital is constructed, before any contracts are let, that the Chief Medical Director must certify the adequacy of the plans, is that correct, Admiral?*

Admiral BOONE. General Gray said that that is right.

General GRAY. *Absolutely right.*

Senator HUMPHREY. We want to get this pinned down.

General GRAY. This is the authentic record of it.

Admiral BOONE. As to the plans which are now in being and the plans are all finished for the construction program, the 1946 program, except four hospitals which were held up due to security matters, those other plans are finished business.

Senator HUMPHREY. But as a matter of policy——

General GRAY. Mr. Chairman, that facility and that operation was in effect for them as well as reiterated in the change that I have just had read.

Senator HUMPHREY. Yes, I understand that.

General GRAY. In other words, it is a continuation of the same policy but the existing record is a little more emphatic and factual.

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General GRAY. That is exactly what we are doing, Senator Hill, is trying to keep abreast of the changes. Just as an illustration I think I mentioned yesterday that the question of the change of the patient load is very definitely reoccurring and constantly a matter before us. The question of how many general medical and surgical beds, how many tubercular beds, how many neuropsychiatric beds shall be had.

We are trying to keep abreast of the percentage of the medical load. I come before you constantly with requests for money for the purpose of making those changes. All of that is a report to me by the Department of Medicine as to the shifting requirements incident to the change in the medical load.

Senator HUMPHREY. You see, General Gray, what I am attempting to do here is that there have been a certain number of charges, as you know, that have been made. All I am attempting to do is to keep those charges in mind and to pinpoint our questioning so that there is not any shadow of a doubt as to what the procedure and policy is in the Veterans' Administration.

When I ask you a question on construction and alteration, what we want is what you are giving us today, the precise policy statement, your administrative regulations and bulletins included into the record as well as your own affirmation.

Admiral BOONE. When we went out to see these new hospitals, I am seeing them now as a new product, but we have bugs in them. We have spent millions of dollars in the Navy to put in grids. Now we do not need grids. In some of these hospitals you have them and probably do not need them.

Senator HUMPHREY. Personally I do not think anybody should be too critical of that kind of technical change. The thing we are interested in is the relationship that exists in the administrative structure of the Veterans' Administration. You have these Assistant Administrators with more or less equal authority in their work. Obviously the Chief Medical Director with the Hospital Management Section is not going to be charged with the building of the hospitals; that is, the actual engineering, you have a Construction Division for that.

The only question that is important, it seems to me, is whether or not there is that close relationship as to the medical advice, whether it is made constantly available to the Construction Division, and that is a definite "Yes".

General GRAY. Unquestionably has been and will be as long as I am here.

Admiral BOONE. Because I foresaw there might be a question, and I wanted to be absolutely sure, so I spent an hour with them and they gave me the assurance that that has been so. Sometimes there might be a section of a thing sent to them, but they always have access to the whole blueprint any time they want it.

When you come to repairs and alterations, Colonel Dryden and the Bureau of the Budget come in, and we sit down and analyze this thing together. I am happy to say that the final decision has been left to me to make the decision.

Senator HUMPHREY. If you felt there was any undue delay, for example, in the Construction Division under the relationships you have in the Veterans' Administration you are empowered to go to the Construction Division and expedite this matter or at least see why the delay?

Admiral BOONE. Yes, sir. This afternoon I have an appointment with Colonel Dryden because he is going out into the field and he said he wanted to have any ideas I have so that he can impart them as he goes around, and he said he would report to me when he gets back. The Administrator has endowed me with this responsibility, it is my responsibility to see that this continued liaison is maintained.

If it is not maintained it is my responsibility.

Senator HUMPHREY. You have the authority?

Admiral BOONE. I have the authority as long as I am given the personnel to do it.

Another point, going to this membership on the committee, the selection of managers has come up. I said to General Gray when I went into that matter, it was new to me to have this procedure, and I have gotten the background and I am perfectly content with the reasons for it, which are sound, but I found that my deputy was a member of that committee.

He has been informed on doing the job, knows the people better than I do, certainly now, *but because of criticism, I felt the position of Chief Medical Director should be the representative on that committee, and I asked to have the committee changed and have me put on.*

General Gray immediately put me on the committee. Then I said I wanted to go beyond that because of the restriction that the Chief Medical Director could not have an alternate, and I asked to have an alternate. He authorized Dr. Frear, my deputy, to be the alternate.

We have the understanding that when both of us are away I designate who will be on the committee. Dr. Frear has told me that as long as he has been on that committee never in one single instance has a manager of a hospital been selected that was not his recommendation. He got his recommendations from the professional staff of the VA, not himself, after screening all the records as to the man's capabilities.

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Senator HUMPHREY. May we just back up for a moment because this was another point that was in controversy and we want to get the record very clear and get our thinking perfectly straight on it. You were stating that the hospital manager is, in military parlance I suppose you would say, an area commander?

General GRAY. He is the unit commander.

Admiral BOONE. The unit commander.

Senator HUMPHREY. In charge of this installation?

General GRAY. Yes.

Senator HUMPHREY. He has all the powers to coordinate all the activities that are channeled through that hospital unit and his immediate superior of course is the Chief Medical Director?

Admiral BOONE. That is right.

Senator HUMPHREY. Any differences of opinion that may exist at the hospital level, any differences that cannot be reconciled there, are channeled through you, and if you cannot handle it, to the Administrator?

Admiral BOONE. The court of last resort is the Administrator.

Senator HILL. But it has to channel through you just as it would in the Navy?

Admiral BOONE. They can deal with the Administrator, but it has to go through the Chief Medical Director. For example, we might take the Philadelphia Navy Yard, where there is a hospital within the yard. There is the base commander, and then there is the commanding officer of the hospital, and he runs the hospital.

Very properly the commanding officer of the hospital does not run the base commander. General Gray, just like the Secretary of the Navy, handles the base commander, but he has the relation with them.

Senator HUMPHREY. Let me ask you this question then, Admiral. Through these hospitals you have the special services working, you have the construction and maintenance, you have supply, personnel, budget, and finance?

Admiral BOONE. Yes. * * *

Senator HUMPHREY. What I am trying to get clear now is whether or not there is any contradiction in statement or policy. You say that the hospital manager is a unit commander or the unit manager of all services being conducted there?

General GRAY. He is the general manager.

Senator HUMPHREY. The general manager of all services in this hospital. One of the services in that hospital is known as special services?

General GRAY. That is right.

Senator HUMPHREY. That covers recreation and so forth. *Am I to understand by your statement then that the Assistant Administrator in charge of special services can conduct that program in that hospital without any control by the general manager?*

Admiral BOONE. No, sir.

General GRAY. Nor without the approval of the Chief Medical Director. *It shows that he can do nothing except as approved by the Chief Medical Director.*

Senator HUMPHREY. I am glad to have that.

Admiral BOONE. May I give a practical application of that? On this trip, because of that situation, every place I went I asked managers, "Is anything conducted in your hospital without your knowledge and approval or desire?"

They said, "Positively, no."

I said, "That is what we want. How about the volunteer service, Red Cross and others?"

They said, "It all has to be programed according to our wishes."

I asked with reference to the library, and it was the same thing. I asked them about the canteen, which is quite independent of them, just like the ships' service and the canteen in the Army, but he still has the relation to them as the over-all man, and they operate with his approval.

Senator HUMPHREY. The special services division or department of the Veterans' Administration is primarily directed—it's not wholly—to your hospital?

Admiral BOONE. Support service.

Senator HUMPHREY. Why is it necessary to have a special services department?

Admiral BOONE. That is a matter that I am giving very careful attention to. I have an open mind on it. General Gray has told me about it, and I might say that General Kerr came and talked to me, a very fine gentleman.

Senator HUMPHREY. Yes, indeed.

General GRAY. He has a fine, long experience in that particular thing.

Admiral BOONE. In the Army. I said to him, "Is this a popular set-up?" He said that the medical advisory group to the VA does not approve it. Dr. Magnuson did at a time, but after a time he did not approve the way it was set up. I said that it was new to me, that I had never lived in this kind of set-up, but that

I would go out and study it and I told him that he and I could discuss it. I said that if it does not seem to meet the best requirements of hospital management I should not have any hesitancy in recommending that it be changed.

General Gray and I discussed it after I saw it in the field. He said to me after we returned to Washington, "At your pleasure if you have ideas that you want to recommend to me as to how this should be modified I am receptive to accepting your recommendations."

Senator HUMPHREY. So in essence it is under review as to its relationship and need to the total medical program?

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Senator HILL. I want to make a statement before we close here, but you go ahead.

Admiral BOONE. Senator, may I add to what I said a moment ago? I feel that the hearing has not been without benefit.

Senator HUMPHREY. I think if we tie this thing down, and we are not anxious to prolong it, we are at the conclusion of the hearing, and as far as I can see this is the final day. I want to thank General Gray for his cooperation. I want him to know that insofar as the subcommittee chairman is concerned he has complete confidence in his ability and more so in his integrity, and as a man and as a Government servant. He is a fellow Minnesotan long before I ever got there with a career and reputation long before I ever was heard of.

It has been a pleasure to work with him. I hope that you know, General Gray, that that has been the spirit of this hearing.

General GRAY. I realize that.

Admiral BOONE. I inquired in New York about General Gray with regard to his reputation as an industrialist. He was said to be one of the greatest industrialists and I do not believe he would have been selected to head these railroads and everything else if it had been otherwise. I see him leave at 7:15 every morning without fail. Most of his week ends are on these inspections and investigations to which he gives up his time. His whole heart and soul and effort are directed to this without any thought of anything else.

Senator HUMPHREY. A friend of mine said to me yesterday: "You know, there are many brilliant and smart men, and sometimes they get by for a long time, but the men who really last and gain position and honor are men of character." I think that is the test here in Government service and service to the country. The people that really produce and produce when the chips are down are those with solidness of character and integrity.

Here are the questions that conclude the hearing. If you will permit me I will read these questions and get your brief and concise answers.

With regard to the fundamental principles governing the provision of veterans' hospital care, the expert witnesses appearing before this committee have been unanimous in their emphasis on the principle, which is called complete care. Under this principle, the basic mission of the veterans' medical program is to provide a system of hospital care, dynamic and complete in operation, which will result in the application of all techniques necessary to get the patient out of the hospital and back to his home and community. Getting the patient back to his home and community under this complete-care concept requires not only those services directly involving professional medical, dental, and nursing care, but also such other supporting services as may be necessary to rehabilitation with a view to enabling the individual to attain a place of respect and self-support in his community.

I want to ask this first of General Gray, and then I would like to get your comment, Admiral Boone.

Question: Do you personally endorse this concept of complete care, and will you tell the committee whether such a principle governs the present administration?

General GRAY. *I endorse it 100 percent, and I can say to you to the best of my knowledge and belief that that is the manner in which it is being conducted.*

Senator HUMPHREY. Admiral Boone?

Admiral BOONE. I wholeheartedly endorse it.

Senator HUMPHREY. Do you think it is a sound principle?

Admiral BOONE. I think it is a very sound principle.

Senator HUMPHREY. It has been very forcefully brought out before this committee that the provision of complete care in veterans' hospitals, if properly and adequately carried out, requires a high degree of organization and integration of all the services that affect the care and treatment of patients. Outstanding

witnesses have strongly emphasized, for example, that the location and construction of hospitals as well as everything that goes on in operation of the hospitals affects the care of patients.

General Gray, do you concur in the general position taken by these witnesses?

General GRAY. *I concur in the statement that anything that has to do remotely with the getting of a sick man or woman well more quickly is a medical determination.*

Senator HUMPHREY. Thank you.

Admiral Boone?

Admiral BOONE. I concur definitely in that statement with General Gray.

Senator HUMPHREY. *Then you agree, since the various functions that go into operating a hospital affect the care of patients, that hospitalization consists of more than just the direct medical and bedside care of patients? Is it your feeling that the management of a hospital, the manager of a hospital, should exercise over-all supervision and coordination of all activities and all functions carried on in said hospital?*

Admiral BOONE. *I think he should, and if does not he avoids his responsibility to execute his responsibility.*

Senator HUMPHREY. General Gray?

General GRAY. *I not only believe it, sir, but I have ordered it.*

Senator HUMPHREY. That is a concise and direct statement.

The next query: In view of the peculiar interrelationship of all the medical and related functions affecting the care and treatment of patients, as brought out before this committee, it has been rather convincingly put to us that the organization and administration of medical facilities cannot successfully be separated from medical policies, programs, and practices. *This implies, I believe, that adequate authority be vested in the Chief Medical Director to assure his effective control over all policy affecting the care and treatment of patients and over the management and operation of the medical and hospital system.*

General Gray, do you agree that the Chief Medical Director should have such authority?

General GRAY. *I not only agree with it, but he has it by my direct order and has had it.*

Senator HUMPHREY. Admiral Boone?

Admiral BOONE. I think he should have it and his policies must be in consonance with the Administrator's policies.

Senator HUMPHREY. *Do you feel that as the Chief Medical Director of the Veterans' Administration you have been given the authority to exercise effective control over all policies affecting the care and treatment of patients, and over the management and operation of hospitals and similar systems?*

Admiral BOONE. I feel that I have. If I did not feel that I would not be there.

Senator HUMPHREY. Thank you.

Expert witnesses have repeatedly stressed before this committee the indisputable fact that the best medical care is possible and is rendered only in hospitals which engage in teaching and research. The record also shows that the very remarkable improvement in the veterans' medical program subsequent to 1945 was very largely the result of the introduction of teaching and research. It is likewise apparent that a teaching program must provide such physical facilities and competent teachers that it will be approved by the various accrediting agencies. This has been accomplished since 1945 only through the affiliation of veterans' hospitals with the outstanding medical schools.

This committee is convinced that should the medical schools and teaching hospitals withdraw from the program accreditation will be lost, residents will not elect to enter the service, the outstanding physician consultants will resign, the better career men will leave, and the entire program will rapidly degenerate into an inferior service.

Question: According to your own testimony before this committee, and this refers particularly now to General Gray you agree, do you not, that the Veterans' Administration could not staff its hospitals with competent personnel unless the Deans' Committee program continues in effect?

General GRAY. Mr. Chairman, I have been making that statement for 3½ years, and I would like to have you look at the notes which were drawn up immediately which shows Deans' Committee, teaching hospitals, and residency programs.

I have constantly, from the very beginning, stressed the desirability of this, the necessity of it, and then I have even gone further than that and said it is a 50–50 proposition at that because by virtue of these we are, with the most concentrated patient load in the world, with a staff of experts and technicians and people that we assemble, that no one else can assemble, and with a hospital that is ideal for its use and with a facility in the shape of equipment that only a rich

Uncle Sam can provide, we are therefore capable of offering residencies the like of which cannot be found anywhere else.

Furthermore, I have gone to analyze and find out that in the use of those residents, ward physicians, and junior surgeons it helps us and makes it possible for us to staff our hospitals. That I have been preaching for 3½ years solid. *I subscribe to that statement; yes, sir.*

Senator HUMPHREY. Thank you.

Admiral Boone?

Admiral BOONE. May I just revert and read two sentences from my statement made at the time I was inducted into office in regard to that point?

I know that the cooperation given to the VA by the American medical profession has been and is magnificent. It is an accomplishment of which it has a right to be proud.

Consequently, the present close-knit association of the VA's Department of Medicine and Surgery and Dean's Committee and teaching medicine has my complete support. Programs for care of veterans in non-Dean's Committee hospitals and in regional offices will receive my support and consideration toward their evolutionary improvement.

I am assuming leadership of the well-conceived and well-established medical program that was brought into being by the combined efforts of the Veterans' Administration and the leading medical schools in the United States. I am comforted and gratified to have been assured that I inherit such relationships.

I would like to say that we are most dependent on this very excellent program and assistance and association with the Deans' Committee and our consultants throughout the country.

Senator HUMPHREY. And it has your unqualified support?

Admiral BOONE. Absolutely my unqualified support, and *I consider them indispensable to the success of the program.*

Senator HUMPHREY. Thank you. Now we have the conclusion.

The Association of American Medical Colleges has recommended to this committee in its testimony the following principles which, in their opinion, should govern the veterans' medical program if it is to continue to provide the best care of patients:

(*a*) The Chief Medical Director should have supervision over the functions of special services in the hospitals.

(*b*) The Chief Medical Director should have full voice in matters relating to hospitals and clinics and all activities having to do with treatment of patients, education, and research.

(*c*) The Chief Medical Director should have authority in the allocation of the various types of hospital personnel to the end that best medical care can be rendered.

(*d*) Control of hospitals and other medical field stations that is exerted by the Administrator should channel through the Chief Medical Director. It is important that this concern the budget, construction, personnel, equipment, and supplies.

That is the end of the four points of the American Association of Medical Colleges and their recommendations.

The deans have strongly emphasized to us that constructive action is required along the lines indicated if staff morale is to be maintained.

Question: In view of the obvious difficulties that have arisen out of the current situation, do you agree with this committee that prompt action is needed if the Deans' Committees are to be given adequate assurances with regard to the maintenance and continuation of the medical program?

General Gray?

General GRAY. Now that is a long, involved question, Senator.

Senator HUMPHREY. Let me withdraw that question and break it down for you.

Senator HILL. Suppose I give you a copy of it?

Senator HUMPHREY. The first question I would like to ask of you, General Gray, is this: The four recommendations of the Association of American Medical Colleges I have read, namely that the Chief Medical Director should have supervision over the functions of special services in the hospitals. Let us stop there.

General GRAY. *There is no question but what the services now utilized in the special services, with the possible exception of the canteen, are a medical matter. As a medical matter he should have, he does have, complete jurisdiction as to what of those services shall be rendered to whom and in what manner.*

Senator HUMPHREY. I think that is very clear.

Admiral Boone, would you give us your observation?

Admiral BOONE. I think going back to my former testimony I still have an open mind as to just exactly where special services fit in in the whole Veterans' Administration organization, whether it is properly placed now or whether there should be modifications to it. I feel that in my association of 2½ months it would not be wise for me to say that I subscribe that special services should be taken out from where it is and placed in the Department of Medicine and Surgery.

Senator HUMPHREY. Do you think that the Medical Director should have supervision?

Admiral BOONE. Nothing should be conducted by the special services in the hospital that does not meet with his approval and sanction.

Senator HUMPHREY. Thank you.

General GRAY. But by the same token under the present regulations he has that control.

Senator HILL. You will notice that this question says, "Chief Medical Director shall have supervision over the functions of special services in the hospitals." As I understand it, you do today have supervision, in fact, further than supervision, you have veto power over special services?

General GRAY. Special services cannot do anything without a doctor's prescription.

Admiral BOONE. With that analysis of it and with that restricted interpretation I would say "Yes" to (*a*).

Senator HUMPHREY. *Item (b) was that the Chief Medical Director should have full voice in matters relating to hospitals and clinics and all activities having to do with the treatment of patients, education, and research.*

General GRAY. *One hundred percent, yes.*

Senator HUMPHREY. Admiral Boone?

Admiral BOONE. *That is the only answer.*

Senator HUMPHREY. *The third question was that the Chief Medical Director should have authority in the allocation of the various types of hospital personnel to the end that best medical care can be rendered.*

General GRAY. There is no question but what that is absolutely true, and he has that.

Admiral BOONE. I accept that; I do have that authority.

Senator HUMPHREY. The final point of the Association of American Medical Colleges recommendation is as follows:

"Control of hospitals and other medical field stations that is exercised by the Administrator should channel through the Chief Medical Director. It is important that this concern the budget, construction, personnel, equipment, and supplies."

General GRAY. All questions relating to the medical care of patients and any activities in the Veterans' Administration must filter through, up and down, as between the Administrator and the Chief Medical Director.

Senator HUMPHREY. Admiral Boone?

Admiral BOONE. That is the interpretation I give to the authority that I have and that is the way my office is to function. I might say in budget we have our own budget in the Department of Medicine and Surgery, and it works up through channels to the Administrator, but I adopt the work of Mr. Press and his staff. It is all coordinated in our office.

Senator HUMPHREY. *So you would say, General Gray, in reference to the fourth point, namely, the control of hospitals and other field stations should channel through the Medical Director?*

General GRAY. *Both up and down; yes, sir.*

Senator HUMPHREY. *And that this control and coordination is particularly important insofar as it refers to the budget in these hospitals?*

General GRAY. *Positively necessary.*

Senator HUMPHREY. And the construction and alterations?

General GRAY. No change is made whatsoever of any major character, has any jurisdiction of being done, except on a medical prescription.

Senator HUMPHREY. You have already answered as to the use and utilization of personnel.

General GRAY. Yes, sir.

Senator HUMPHREY. And we have discussed in great detail the prerogatives and the authority and the responsibility of the Chief Medical Director insofar as equipment and supplies?

General GRAY. That is correct, sir.

Senator HUMPHREY. It is the policy of the Administrator of Veterans' Affairs that equipment and supplies that pertain to the adequate functioning of hospitals and domiciliaries, out-patient clinics, and other medical services must be approved by the Chief Medical Director?

General GRAY. It is not only true but it is a fact and has in the organization and is now in the organization and can only function that way. In other words, if I can sum it up in one sentence, Mr. Chairman, the Veterans' Administration as a whole only acts in accordance with a prescription authorized and written by the Chief Medical Director.

* * * * * * *

Admiral BOONE. *I have made a study of the medical program in which the Veterans' Administration is associated with leading medical schools throughout the Nation.*

I know that the cooperation given to the VA by the American medical profession has been—and is—magnificent. It is an accomplishment of which it has a right to be proud.

I know that top-notch medical care for veterans is basic Veterans' Administration policy—to that policy I wholeheartedly subscribe.

Consequently, the present close-knit association of the VA's Department of Medicine and Surgery and deans' committees and teaching medicine has my complete support. Programs for care of veterans in nondeans' committee hospitals and in regional offices will receive my support and consideration toward their evolutionary improvement.

An interruption or disruption of this program would be a disservice to veterans and to the Nation. I pledge you I shall bend every effort not only to continue the program but to seek ways to strengthen it.

In this purpose, I have the complete assurance of the Administrator of Veterans' Affairs that I will enjoy his full support.

THE ADMINISTRATOR'S CURRENT ATTITUDE

We note with particular interest the following specific points in the testimony set forth above:

(1) General Gray's statement that he endorses "100 percent" the complete-care concept of medical administration.

(2) The general's concurrence in the statement that "anything that has to do remotely with the getting of a sick man or woman well more quickly is a medical determination."

(3) His agreement that the manager of a hospital "should exercise over-all supervision and coordination of all activities and all functions carried on in said hospital."

(4) His agreement that "adequate authority be vested in the Chief Medical Director to assure his effective control over all policy affecting the care and treatment of patients and over the management and operation of the medical and hospital system," and his statement that Admiral Boone has that authority "by my direct order."

(5) The General's agreement that the VA cannot staff its hospitals with competent personnel unless the deans' committee program continues in effect.

(6) Admiral Boone's belief that "nothing should be conducted by the special services in the hospital that does not meet with his (the Chief Medical Director's) approval and sanction, and General Gray's willingness to so interpret existing regulations as to give the Chief Medical Director that control.

(7) General Gray's "100 percent" agreement that "the Chief Medical Director should have full voice in matters relating to hospitals and clinics and all activities having to do with the treatment of patients, education, and research."

(8) General Gray's feeling that "there is no question but what it is absolutely true * * * that the Chief Medical Director should

have authority in the allocation of the various types of hospital personnel to the end that the best medical care can be rendered."

(9) General Gray's agreement that matters involving the control of hospitals should channel through the Medical Director "both up and down" and that this is particularly important as regards hospital budgets.

(10) General Gray's agreement that as regards construction and alterations in hospitals "no change whatsoever of any major character" will be made "except on a medical prescription."

(11) His agreement that it is the Administrator's policy "that equipment and supplies that pertain to the adequate functioning of hospitals and domiciliaries, out-patient clinics, and other medical services must be approved by the Chief Medical Director."

(12) Admiral Boone's insistence that no matter what services are carried out in a hospital "you can have only one head of anything, and that is the manager."

(13) General Gray's and Admiral Boone's concurrence in the belief that the Assistant Administrator in Charge of Special Services can do nothing with respect to the conduct of that program in a hospital "except as approved by the Chief Medical Director."

(14) Their agreement that the continuance of special services as a separate division in the VA should be reviewed by the Chief Medical Director, and General Gray's statement that he would be receptive to such recommendations as might thus be developed.

(15) General Gray's action in restoring the Chief Medical Director to a permanent place on the committee which nominates hospital managers and his delegation of Admiral Boone's deputy as his alternate on that committee, and General Gray's statement that Senator Humphrey was "absolutely right" in interpreting the Administrator's remarks to mean "before any hospital is constructed, before any contracts are let, that the Chief Medical Director must certify the adequacy of the plans."

REASONS FOR RECOMMENDATIONS

We are highly pleased that one result of our efforts has been to make these commitments from the Administrator of Veterans' Affairs to a subcommittee of the United States Senate a matter of public record. We feel that this in itself will do much to restore morale and a spirit of cooperation on the part of VA medical consultants and deans committees. We think it should serve as a guide and a warning to all VA personnel not directly and wholly identified with its medical-care program as to what the Congress and the Administrator believes their relationships to that program should be.

We are gratified that Dr. Hawley, the chief architect of the new VA medical-care program, saw fit to state:

> I do believe very firmly that this investigation here, and the thoroughness with which you have gone into it, will certainly be a guide to any future Administrator of Veterans' Affairs for some years, whether or not it is a matter of law. Here it is before a competent body. Whether you do anything about it other than to publish a report, a sympathetic report—and I am sure it will be sympathetic—it will take a very bullheaded Administrator to operate under any other policies than I think have been shown here by this investigation.

We, too, believe that the principles upon which our expert and responsible witnesses have agreed should most certainly serve as a guide to

any future Administrators of Veterans' Affairs. We hope that the meeting of minds between General Gray, Admiral Boone, and members of the subcommittee as regards those principles is already being reflected in current Veterans' Administration activities.

Nonetheless, we feel that the evidence presented to us makes it incumbent upon us to do more than merely report our findings as regards the principles which should underlie the administration of veterans' medical care.

We believe the testimony makes it quite clear that the current administrative and statutory organization of the Veterans' Administration is such that unless both are changed, its medical-care program may be subjected again and again to the sort of crisis which recently threatened its complete destruction and which is anything but dissipated as yet. We point out that that program is such that should it once be destroyed, it is highly doubtful that it could ever be reestablished. We feel that it is far too important and valuable a program for the Nation to permit its continuance to be conditioned on fortuitous displays of confidence between particular administrators and particular medical directors. Our national interest requires that it rest on a much firmer foundation.

Therefore, we are, herewith, recommending to the Administrator of Veterans' Affairs and to the Congress measures which, in our considered opinion, should be immediately adopted if the problems confronting the veterans' medical-care program are to be resolved and the possibilities of their recurrence minimized.

RECOMMENDATIONS TO THE ADMINISTRATOR OF VETERANS' AFFAIRS

RECOMMENDATION NO. 1: *The Administrator of Veterans' Affairs should formally delegate to the Chief Medical Director such primary authority as may be necessary to assure his effective control over all policy affecting the care and treatment of patients and over the management and operation of the hospital system, and this delegation of authority should be clearly and unequivocably set forth in the Veterans' Administration Manual and in the agency's organizational charts.*

The subcommittee was disturbed to learn that the Chief Medical Director has not always had effective control over the planning, management, and operation of VA hospitals. As we shall show in greater detail later, our inquiry revealed nothing comparable to this inexcusable situation in any of the other Federal agencies which operate hospital systems of any importance. Testimony before the subcommittee was unanimously to the effect that the Surgeon General of the Public Health Service and, as regards comparable medical and hospital programs, the Surgeons General of the Army and Navy have such primary authority and, further, that they are not bypassed by higher administrative authority in the management and operation of these programs.

We believe it essential that this formal delegation of authority be made and that it be made promptly. We are glad that the excerpts from General Gray's testimony set forth above indicate that he feels no reluctance in granting it. However, one phase of Admiral Boone's testimony points to the possible existence of a misconception bearing on this point which we believe we should not pass by without clarification. Admiral Boone volunteered the information that upon his

appointment as Chief Medical Director of the VA, representatives of the press told him that—

> they understood that I was going to require General Gray to put in writing to me his instructions. I replied—

the admiral continued—

> that I had been in the military service 37 years and had served a great many admirals, generals, and Presidents and had never presumed or had the presumption or effrontery to ask my superiors to put in writing their instructions to me. The basis of a firm relationship is a confidence in your superior and not challenging to show that you have no confidence in him. General Gray selected me * * * I feel he must have selected me for a matter of confidence rather than friendship. I would have been unworthy of accepting this position, of taking this position, had I been unable to return that confidence. The basis of our relationship is a mutual confidence to which he referred yesterday.

In so saying, Admiral Boone implies that he does not think it proper, as Chief Medical Director of the VA, to suggest that the Administrator of Veterans' Affairs set forth in writing and without equivocation the statement as to the Medical Director's place in the program and his authority with respect to other VA personnel which this subcommittee now recommends as urgently needed.

The admiral's statement must have been a source of gratification to General Gray. We, too, find such a declaration of faith in General Gray heart warming, and, as illustrative of the relationship existing between two highly placed officials of a most important agency, altogether laudable. However, we insist that General Gray and Admiral Boone must recognize the fact that this program does not operate on the basis of a relationship between two men but, rather, through a multiplicity of relationships involving tens of thousands of VA employees and hundreds of non-VA employees whose cooperation in the program is essential to its success. They and those other millions of Americans who are concerned with the Veterans' Administration—veterans in general and those who are patients in its hospitals; the taxpayers who support it; the doctors who serve it; the schools which cooperate with it; the Congress which appropriates its funds—cannot base their activities and their thinking with respect to the Veterans' Administration on any such personal relationship with the Administrator as Admiral Boone enjoys. This is public, not private and personal business. And the public is without question entitled to publicly given assurance in the form of permanent VA regulations that this medical-care program and all that pertains to it will be run by its Chief Medical Director in accordance with over-all policy regulations decided upon by the Administrator in consultation with the Chief Medical Director and his medical advisory committees.

If, on the basis of either military tradition or close personal relationships, Admiral Boone feels that it would be presumptuous to request a written delegation of authority, then it might well be said that, on that same basis, General Gray should have felt constrained to voluntarily extend it without any request being made. In any case, regardless of subjective interpretations of the proprieties, this is the public's business and, while it requires loyalty and close cooperation amongst those engaged in carrying it on, it also requires that the public know just how it will be managed.

It is, of course, true that when a man in the Army or Navy is ordered to a new post, he does not demand a special statement of his authority and responsibilities from his new commanding officer.

It would never occur to him to do so. But that is not because he is not entitled to know exactly what they are. It is because he doesn't have to ask. They are spelled out quite clearly and definitively in Army and Navy regulations and graphically set forth in tables of organization. As military rather than civilian agencies, the components of the Department of Defense must be prepared to act quickly in emergencies; their personnel must be able to adapt to rapidly changing circumstances and to conduct themselves with confidence in the face of new and perhaps turbulent conditions. Generations of experience have taught such agencies that if they are to be prepared to so function, they must spell out clearly and in advance of any emergency, the exact responsibilities of and relationships among personnel at every level and under all conceivable circumstances. They have done so and it is undoubtedly because of this that, in moving from one to another of the many responsible military and naval positions he has held, Admiral Boone has never felt it necessary to ask a superior officer for such a delegation of authority as we recommend he now be given.

But, although the degree to which such meticulousness in administrative programing should characterize civilian agencies may be subject to debate, there is no question but that it is altogether and woefully lacking in the Veterans' Administration. There is no doubt that Admiral Boone quite honestly and in all sincerity believes his relationship to General Gray confers on him all the authority he needs to properly administer the medical care program and that the contacts he has had with VA's other 11 Assistant Administrators during his short period in office are such as to assure their complete and continuing cooperation. This may or may not be so. We hope it is so. But whether or not Admiral Boone personally needs the formal reassurance that he has the requisite authority and position in the Administration which acceptance of our recommendation would confer upon him, certainly it should be given him in behalf of his subordinates in the Department of Medicine and Surgery, of his hospital managers, of his colleagues in the medical profession, and of his associates in other divisions of the VA. It is particularly essential that it be given the medical schools and those physicians who are not employees of the Veterans' Administration whose cooperation helped bring the medical care program to its present stature and whose continued cooperation must be won. That cooperation was based on a clear-cut understanding as to exactly how the program would be administered given them by Generals Bradley and Hawley through Dr. Magnuson. The understanding having been breached repeatedly, it is now endangered. If they are to continue to grant it, those doctors and the schools they represent have a right to insist that the original understanding be restored intact and that it be so incorporated in the Administration's Manual that it cannot again be undermined.

RECOMMENDATION NO. 2: *That no one shall be appointed manager of a Veterans' Administration Hospital without the prior approval of the Chief Medical Director.*

Managers of VA hospitals are appointed by the Administrator from a list of nominees provided him by a committee of three VA officers. The subcommittee believes this to be an acceptable procedure but only if the Chief Medical Director, or, in his absence, someone per-

sonally delegated by him, is a member of the committee and he or his delegate personally approves of the nominee chosen. While we know of no instance in which a hospital manager has been appointed without such approval, we do know and we deplore the fact that for a period of time the Chief Medical Director was removed from membership on the committee and arbitrarily replaced by his deputy, with the result that altogether unnecessary but thoroughly justifiable suspicion and distrust of the Administrator's motives permeated the entire medical organization. We are pleased that, during the course of our hearings, a directive restoring the Chief Medical Director to membership on the committee was issued. This directive should continue in effect and should be strengthened so as to make it clear that whether the Chief Medical Director is one of three or one of a score serving on the committee, in no case will it recommend a candidate who has not met with his approval. If the Chief Medical Director, who of all VA employees and executives should be the best-qualified judge in this field, cannot be trusted with such responsibility, he should be removed from office.

RECOMMENDATION NO. 3: *All "special services" personnel and activities in VA hospitals must be under the direct control and supervision of the hospital manager and shall operate only in accordance with policies approved by the Department of Medicine and Surgery. In this connection, we also recommend that the Administrator make a thorough investigation into the possibility and desirability of completely abolishing the Office of the Assistant Administrator for Special Services by eliminating all of its functions now duplicated in the Department of Medicine and Surgery and by integrating its other and necessary functions into that Department.*

The subcommittee has refrained from recommending the immediate elimination of special services as such from the VA program only because we have not had opportunity to make a thorough study of its total program. However, we are convinced that, insofar as special services activities are carried on in VA hospitals, they should be completely integrated into the hospital's program and that that in turn should be headed up by a single, responsible administrator whose central office responsibilities flow through a single channel to the Department of Medicine and Surgery. If we could rely entirely on the VA Manual's intimation that the primary mission of the Office of the Assistant Administrator for Special Services is to help patients get well, we would also recommend the immediate abolition of that office as a separate entity. As our previous recommendations imply, there is no question in our minds but that everything which affects the process through which the VA patient may once again return to his community as an independent, employable member of society definitely should be a part of an integrated Department of Medicine and Surgery.

In making this recommendation, we want it distinctly understood that it is made in terms of administrative efficiency and not in terms of personalities. We are insistent that the record clearly set forth the fact that General Kerr, Assistant Administrator for Special Services in the Veterans' Administration, appears time and time again in our records and to our knowledge solely as an intelligent, non-self-seeking, cooperative partner in the total enterprise. Throughout the entire tale of bitterness and rivalry in the upper echelons of the

VA which runs through the testimony we have taken, his name has called forth expressions of respect from all parties.

RECOMMENDATION NO. 4: *The Administrator should initiate a revision of budgetary control procedures, with a view to making the hospital manager responsible for a single budget and to recognizing the special budgetary problems of the hospitals affiliated with the medical schools.*

In the time available the subcommittee has not been able to explore the budgetary control problem in detail. It is clear, however, that the system is faulty. Hospital managers do not operate on the basis of an over-all hospital budget and they have been unable to transfer available funds from one budget category to another where funds are needed. Furthermore, the teaching hospitals have budgetary problems somewhat different from those of other hospitals, particularly as a teaching and consultant program must be planned and carried out on a stable basis. Unanticipated budgetary upheavals wreck the program.[5]

RECOMMENDATION NO. 5: *The Administrator should initiate a revision of personnel ceiling procedures, with a view to giving the Chief Medical Director more flexibility in the allocation of personnel in hospitals.*

The subcommittee is convinced that a hospital cannot be well operated if eternally subjected to the rigidity of many of the rules, regulations, and controls that normally apply to the usual Government agency. Insofar as the law permits, every effort must be made to keep hospital controls flexible and changeable to meet constantly changing conditions and local needs. Illustrations have been given the subcommittee indicating that, owing to the personnel ceiling policy it may not be possible for the hospital to add nurses that are badly needed even though unfilled authorized positions exist in some other category. This is indefensible and action ought to be taken to correct it.[5]

Should it be found that the law prevents the application of such procedures as would accomplish the results sought through recommendations 4 and 5, that fact should be reported to the committee together with an explanation of the procedural changes found to be desirable and the reasons therefor.

ADDITIONAL COMMENT ON NONLEGISLATIVE RECOMMENDATIONS

With respect to the changes in the Veterans' Administration's organizational pattern recommended above, the subcommittee believes that they cannot be carried out on the basis of those word-of-mouth instructions or intimations which apparently sufficed to get the program going in the Bradley-Hawley days. We are glad, as we have said, that General Gray and Admiral Boone seem to have agreed that they should be put into effect. We believe, however, that that can only be done satisfactorily if the acceptance of these recommendations is made evident through a series of clear-cut rules and regulations set forth in one place in the VA Manual, through modification of all other parts of the manual which conflict therewith, and through the issuance of a new organizational chart clearly illustrating the administrative relationships which should apply amongst all VA employees whose activities affect the medical care program.

[5] In this connection, we particularly call the reader's attention to the testimony of Dr. Harold S. Diehl.

It should not be overlooked that, among other things this will involve changing those sections of the VA manual which, in describing the spheres of influence of Assistant Administrators, imply that, as regards anything touching on the medical-care program, they share coequal authority with the Chief Medical Director or that they will have discharged their functional responsibilities to him in those respects by merely "consulting," "collaborating," or "coordinating" on their own terms. Any such terminology must be changed so as to clearly spell out the fact that, as regards matters affecting medical care, they and their personnel will function only in accordance with policies and practices which have been approved in advance by the Chief Medical Director or by his duly authorized representative. They would, of course, retain the right to approach the Administrator or his deputy directly should they disagree with the Chief Medical Director. Arguments could and should be carried up but not down through the organization.

In brief, if these recommendations are to be effectively carried out, it will mean that the functional descriptions of the VA's 11 other divisions as now set forth in the manual should be carefully reviewed and rewritten so that all ambiguous terminology which might lead anyone to believe that any of these offices could take action effecting the medical-care program on a coequal basis with the Chief Medical Director or in any manner save through his office and with his agreement will be stricken. And, by the same token, it should mean that with respect to such VA functions as claims and eligibility, wherein the Department of Medicine and Surgery serves another office in a strictly functional capacity, the organizational chart should show the Department of Medicine and Surgery as operating in those fields only through and in manners approved by the Assistant Administrators in charge of those particular services.

As regards the redrafting of organizational charts, we freely admit that many witnesses have testified that one cannot get good administration through legislation, regulations, or charts. We would point out, however, that these same witnesses almost invariably proceeded to recommend changes in all three. We, too, believe that given intelligent understanding, mutual good faith, and a desire to cooperate on the part of all concerned, a program can operate well despite statutory difficulties, contradictory regulations, and weirdly inoperative organizational charts. As was once the case in the Veterans' Administration, given those characteristics on the part of key personnel, formal barriers can be disregarded and the participants can work out ways to achieve their joint objective.

However, if the time comes, as it did in the VA, when the participants agree only as regards a generalized statement of their objective and are not in agreement as to the methods by which it can be reached, then such things as organizational charts can assume tremendous significance. They become symbols of disagreement. Insofar as they portray the methods which some of the participants favor, they appear as talismans, as sources of righteous justification and symbols of rectitude. Insofar as they outrage the administrative principles of other participants, they become the focal points of emotional attack. In either case instead of being the points of departure for reasoned and reasonable compromise, they become shibboleths.

From 1946 to 1948, VA's organizational charts, faulty as they seem to the subcommittee to have been in their application to the medical care program, were of negligible significance. From 1948 until today, they have assumed more and more disproportionate importance. The one currently in existence depicts relationships so much at variance with the promises and protestations of the Administrator that to professional men it seems to symbolize nothing but double-talk.

It is for this reason that we recommend not only that real authority over the program be vested in the Chief Medical Director but that General Gray's wholehearted acquiescence in that delegation of authority as expressed to this subcommittee be clearly set forth in an organizational chart showing that all lines of service, communication, and authority which impinge on the medical-care program flow through and only through the Department of Medicine and Surgery. For this reason and also so that the chart may serve as a constant guide to any of the all-too-numerous Assistant Administrators of the VA whose understandable interest in their own specialized programs might lead them to forget the Administrator's pledge to the Congress that by his "direct order," the Chief Medical Director will have adequate authority "to assure his effective control over all policy affecting the care and treatment of patients and over the management and operation of the medical and hospital system."

Before setting forth our recommendations to the Congress, we want to restate our strong feeling that those recommendations made above should be made effective immediately. We are fully aware of the management survey of the VA organization which is now under way. That survey will not be completed for many months and there is no guaranty that its recommendations will be adopted whether or not they parallel ours. But the threat to the stability of the medical-care program is a clear and present danger which must be met through prompt action.

RECOMMENDATIONS TO THE CONGRESS

LEGISLATIVE RECOMMENDATION NO. 1: *We recommend that Public Law 293, Seventy-ninth Congress (38 U. S. C. 15) be amended so as to leave no doubt whatsoever that the Congress intends the Chief Medical Director of the Veterans' Administration to be the principal medical authority of the agency with primary authority to control, manage, and operate its medical and hospital program.*

Public Law 293, Seventy-ninth Congress, which established the Department of Medicine and Surgery in the Veterans' Administration, did not spell out the functions of the Department nor did it attempt to itemize the areas of authority to be exercised by the Chief Medical Director. Likewise, the committee reports on H. R. 4717 (H. Rept. No. 1238 and S. Rept. No. 858, 79th Cong.) were silent as to intent. Nevertheless, it is inconceivable that Congress ever did intend that the Administrator of Veterans' Affairs actually function as a Surgeon General or, in VA terminology, a Chief Medical Director. Among other things, Congress did not require that the Administrator be a qualified doctor of medicine, although it did impose such a requirement for the Chief Medical Director (38 U. S. C. 11a and 15b).

Nonetheless, on many occasions, the Administrator of Veterans' Affairs, interpreting quite literally the law which places full responsibility for the agency's many and diverse activities in its administrative chief, has completely bypassed the office of the Chief Medical Director and personally interfered with details incident to the planning and management of particular hospital programs. General Gray has stated that in the eyes of the law he corresponds to the Surgeon General and he has all too often acted as if he were. The results have been extremely detrimental to the entire program.

Medical schools and medical men cooperating with the VA had assumed that the Chief Medical Director was the responsible head of the medical and hospital program and, in accordance with over-all policy determinations made by the Administrator, had full authority over all operating phases of that program. We believe that most Members of the Congress shared that assumption. We know of none who have even intimated that they believed otherwise. And the assumption is certainly implicit in that part of the statute which reads "* * * The Chief Medical Director shall be the Chief of the Department of Medicine and Surgery and shall be directly responsible to the Administrator for the operations of the Department" (38 U. S. C. 15). But insofar as the Administrator personally took over responsibility for some of the Department's operations, he rendered that assumption completely invalid and thereby vitiated the understanding which had led medical schools and professional men to cooperate in the program. When the Chief Medical Director sought to have his responsibilities and authority under the law clarified by the agency's Solicitor, the most cogent part of the answer he received read as follows:

> In short, the answer to the stated questions is that the Administrator is responsible for all functions prescribed by veterans' laws, and the Department of Medicine and Surgery is responsible to the Administrator for all medical functions. There is no well-defined dividing line between medical functions and administration. Some things are obviously the one, some the other. Some things obviously must be decided by trained professional practitioners, others by persons administratively experienced—else the chief executive himself must be a doctor.

Not only did such an answer fail to clarify the picture, but the circumstances surrounding its delivery served to add to the confusion. The Chief Medical Director was actually reprimanded by the Administrator for having asked that the law be clarified and the Solicitor, instead of answering his questions directly, had answered through the Administrator.

We believe that no medical care program can operate successfully for very long in an atmosphere where such uncertainties can be exploited by bureaucratic strivings for power, justification, or personal glorification. Consequently, and on the well-grounded assumption that these difficulties which plague the VA's medical care program do not appear in similar programs run by the Army, the Navy, and the Public Health Service, the subcommittee thoroughly investigated the methods whereby those agencies keep the problem under control. We found that insofar as these three agencies carry on operations similar to those involved in the VA's medical and hospital program, all three agencies have one thing in common: In fact, those programs and everything ancillary to them are completely controlled, at the top, by the Surgeon General of each respective service and, in the field, by a

commanding officer in each hospital or medical center who reports directly to the office of his Surgeon General. In each case, these relationships are clear-cut and definitive. In the Army and Navy they are based on and spelled out in regulations such as those we have urged the Administrator of Veterans' Affairs to promulgate. In the United States Public Health Service, they are based on statutory provisions such as we are, herewith, urging the Congress to apply to the Veterans' Administration.

Fundamentally, the statutory provisions controlling the administration of medical care programs in the Army and Navy are similar to those now applicable to the VA. Complete authority and full responsibility is vested in the Secretary of the Army and in the Secretary of the Navy, respectively. We believe this is as it should be. We would not recommend changes in their statutory authority with respect to medical care programs even if it were within our province. We would not do so for two very good reasons: First, because these are not civilian agencies and the nature of the problems which can at any moment confront military establishments is such that the commanding officer of that establishment must at all times have the authority to utilize every instrumentality in and every person attached to his agency in whatever way an emergency situation may render necessary; secondly, because the medical care programs in these establishments are being operated on an efficient and intelligent basis, and we do not believe in suggesting legislative changes merely to make work for the Congress. Neither of these conditions applies to the Veterans' Administration. Whereas the Secretary of the Army and the Secretary of the Navy have by regulation transferred complete authority over both technical and operational matters affecting such Army and Navy hospitals as are similar to those operated by the VA to their respective Surgeons General,[6] the Administrator of Veterans' Affairs has not seen fit to do so. Moreover, whereas, even if he does promulgate such regulations as we have suggested and as he has indicated he is prepared to do, we see no reason why, as in the case of the Army and the Navy, the administrator of a civilian agency should have the statutory authority to rescind such regulations at will. In view of what has already occurred in the Veterans' Administration, the continued existence of such authority will remain a source of continued uneasiness and distrust on the part of the medical profession in general and the deans of our medical schools in particular.

Turning now to our investigation of the organizational pattern characteristic of the Federal Security Agency, of which the Public Health Service is a part, we find that here the relationship between the Administrator of the Agency and the Surgeon General of the Public Health Service is a matter of statute rather than administrative regulation. We find, too, that the problems which have occasioned so much difficulty in the Veterans' Administration simply do not exist in the United States Public Health Service although it is not only a civilian agency with responsibilities comparable to those of the VA, but one which also operates its hospital-care program on the basis of that same "complete-care concept" which presumably applies in

[6] These are the so-called name hospitals in the Army like Walter Reed and such hospitals in the Navy as the National Naval Medical Center at Bethesda, which are not actually rendering service in a field of active military or naval operations. In this connection we recommend that anyone interested in these problems also read the excellently prepared and comprehensive testimony with respect to medical care administration given the subcommittee by the representatives of the three Surgeons General.

the Veterans' Administration and one which also maintains close and effective liaison between its hospitals and the Nation's medical schools. In connection with this, we find the following excerpts from the testimony given us by Dr. G. Halsey Hunt, Chief of the Public Health Service's Division of Hospitals, of particular interest:

The administration of Public Health Service hospitals is based upon two principles. The first of these is the principle of medical responsibility for administration. The most important person in any hospital is the patient. The basic activity of the hospital is the care of the patient by the doctor. Everything that goes on in a hospital contributes directly or indirectly to this end. Under these circumstances we feel that the top level of decision in a hospital, and in a hospital system, should be in the hands of physicians.

The second principle is that of unified responsibility. At each level of operation there is one individual through whom all of the lines of responsibility and authority flow. Specifically, this means that in any given hospital, all professional and administrative matters head up in the medical officer in charge. His responsibility includes the care of the patients, the research that is carried on, the training programs within the hospital, and the administrative functions of the hospital.

The administrative functions within the hospital are made up of the personnel activities, the budget and fiscal operations, the maintenance operations within the hospital, and the other supporting services, which permit the functioning of the hospital as an administrative unit.

We believe, too, that the following colloquy between Dr. Hunt and members of the subcommittee is particularly enlightening:

Senator HILL. You speak of broad policies. Let me ask this question now. The Federal Security Administrator who is the over-all supreme Administrator, is pretty far removed from down the line where the actual administration takes place. Has he ever sought to issue orders directly himself, to go into a hospital, say, and issue an order that this thing be changed or that thing be done or some other thing not be done?

Dr. HUNT. Such an action has never come to my attention, and I am sure it would have, had it happened.

Senator HUMPHREY. In other words, he has never gone into a hospital, let us say, and ordered the removal of certain patients to another hospital, or the closing of a laboratory, or the opening of a research installation?

Dr. HUNT. That is right.

Senator HILL. Does he ever go beyond the Surgeon General himself insofar as any actions are concerned? Has he ever been known, we will say, to step over the Surgeon General, down to the Bureau of Medical Services, or into a hospital?

Dr. HUNT. Not in any way, as far as issuing orders is concerned. We have relationships with him.

Senator HILL. Oh, surely.

Dr. HUNT. But as far as orders are concerned they all come through the Surgeon General, through the Bureau of Medical Services, to the Division.

Senator HILL. Do you know of any instance where he has issued orders, that have come down to you, where the Surgeon General did not concur?

Dr. HUNT. No, sir.

We find that just as General Gray is the Administrator of a civilian agency which among other functions is responsible for operating a hospital and medical care program, so too is the Administrator of the Federal Security Agency responsible for the over-all supervision of a multiphased program involving similar medical and hospital operations. But the Federal Security Administrator, while he determines over-all policy matters and promulgates regulations which affect the United States Public Health Service, does not ever interfere directly with the management of the medical care program, nor has he ever shown any desire so to do. It may be that even had he authority commensurate with that vested in General Gray, he would never be tempted to act as if he were in fact, as well as in law, "a surgeon general." But neither the Congress nor the people nor the

medical profession need fear that he ever will attempt to act in that capacity because through specific legislative enactment the Congress has seen to it that the Administrator of the Federal Security Agency cannot possibly mistake its intent. Unlike the VA statute which we have quoted above, those which apply to the United States Public Health Service specifically state that—

> The Public Health Service in the Federal Security Agency shall be administered by the Surgeon General under the supervision and direction of the Administrator (42 U. S. C. 202)—

and, in even more detail, that—

> The Surgeon General, pursuant to regulations, shall (a) control, manage, and operate all institutions, hospitals, and stations of the Service, and provide for the care, treatment, and hospitalization of patients, including the furnishing of prosthetic and orthopedic devices; and from time to time, with the approval of the President, select suitable sites for and establish such additional institutions, hospitals, and stations in the States and possessions of the United States as in his judgment are necessary to enable the Service to discharge its functions and duties; * * * (42 U. S. C. 248).

We are confident that the Congress intended the VA medical care program to be operated in the manner which characterizes the program of the United States Public Health Service. General Gray, in his concluding testimony, has indicated a belief that it should operate in that same manner. However, inasmuch as under the present statutes this would remain a matter of administrative whim, we are recommending that the Congress make its intent crystal clear by adopting the recommendation we have set forth above.

LEGISLATIVE RECOMMENDATION NO. 2: *We recommend that the law (38 U. S. C. 15) should be further amended to provide that the Chief Medical Director be appointed by the President, by and with the advice and consent of the Senate.* The subcommittee is of the opinion that the Senate previously erred by acceptance of the provisions resulting in Public Law 293, Seventy-ninth Congress, which, for reasons not clear to the subcommittee, ignored the constitutional prerogative of the Senate. Although the Senate has been empowered to advise and consent to the appointment of a whole host—literally thousands—of lesser Government officials, it does not, under present law, exercise this traditional prerogative with regard to appointment of the Chief Medical Director of the Veterans' Administration. Yet this official presumably is to be the director of one of the world's largest medical enterprises. The subcommittee knows of no other comparable position in the Federal Government which can be filled without senatorial review of the applicant's qualifications and approval of his nomination.

LEGISLATIVE RECOMMENDATION NO. 3: *We recommend that the statute be amended so as to reconstitute and redefine the functions of the special medical advisory group, which was established by Public Law 293 of the Seventy-ninth Congress, along the following lines:*

1. Changing the name of the group to Advisory Commission on Veterans' Medical Care.

2. Appointment of the Commission by the President.

3. A Commission membership consisting of representatives of the public, veterans, and eminent authorities in the respective health professions concerned; this latter representation to include members of the deans' committees.

4. Designation or appointment by the Commission of technical advisory committees in the respective medical specialty fields to advise the Chief Medical Director.

5. Proper organizational provisions and perpetuation of the Commission.

6. Continuing review and evaluation by the Commission of the status, progress, and problems of the medical and hospital program, including all policies and procedures affecting the care and treatment of patients.

7. Reporting the results of the Commission's continuing review and evaluation, including such recommendations as it deems desirable, to the Administrator and the Chief Medical Director, not less often than once each year.

8. Requiring the Administrator to include in his annual report to Congress the evaluations and recommendations reported to him by the Commission, together with his explanation of the action taken or contemplated respecting such recommendations.

As brought out in this report, the special medical advisory group as now constituted warned the Administrator as long ago as December 7, 1948, of the dangers inherent in the situation then developing and recommended that he act to correct the difficulties. This report was not made to Congress and nothing was done about it. Under the present law, the advisory group is not required to report to Congress and it has not always been certain of its proper advisory jurisdiction.

In this regard the subcommittee strongly emphasizes the fact that the subject medical and hospital program is so essential to the well-being—even the very lives—of many of our veterans that it absolutely must be kept dynamic and alert to the continuous scientific advances that are being made in hospital care. Affiliation of hospitals with the medical schools is the only way this can be successfully accomplished. The present arrangement has been based solely on mutual confidence and cooperation, without any contractual basis. The subcommittee does not at this time recommend any change in this principle governing the deans' committee program; it would appear to be unwise to take any steps that might lead to less flexibility in the plan. Nevertheless, the deans' committees should be given a more formalized instrument through which their views, problems, and recommendations might be channeled not only to the Administrator but to the Congress. It is the firm conviction of the subcommittee that Congress should be advised of administrative problems when they arise, not after they have got completely out of control.

In concluding this report, the subcommittee wants to reiterate its earlier statement that its findings and recommendations have not been arrived at through casual investigation. They represent well-considered opinions unanimously arrived at in the course of 6 months during which we took voluminous testimony, carefully checked and rechecked the charges and countercharges made therein, and conferred repeatedly and at every stage of our deliberations with all the key personalities involved. As instructed by the Chairman of the Committee on Labor and Public Welfare, we have constantly kept in mind the fact that we were investigating a program which is of great significance to the Nation and which was in danger of collapse should the delicate relationship between the agency and our medical schools be unduly disturbed. We have attempted to avoid premature and emotion-arousing publicity and to conduct our hearings on such a level

and in such a manner as to produce results rather than headlines. We are pleased that both the representatives of the Veterans' Administration and the deans' committees saw fit to voluntarily express their satisfaction with the manner in which our hearings were conducted. We are very glad that the Association of American Medical Colleges, referring to the conclusions and recommendations set forth in a preliminary draft report and which are paralleled in this final report, saw fit to wire us as follows:

Senator HUBERT HUMPHREY,
Committee on Labor and Public Welfare, United States Senate:

Dr. Harold Diehl and I have studied in detail the conclusions and recommendations contained in the confidential committee draft of the report of the Subcommittee on Veterans' Administration Policies with respect to hospital administration. We wholeheartedly endorse these conclusions and recommendations and urge their adoption by your committee. We believe that the potentiation of these recommendations and conclusions will reestablish confidence and assure continuing progress in the medical program of the Veterans' Administration. We wish to congratulate you and your committee upon the objective and thorough investigation you have made and for your constructive recommendations.

JOSEPH C. HINSEY,
Chairman, Executive Council,
Association of American Medical Colleges.

Despite all this and even though our hearings seem to have brought about a meeting of minds on the part of all involved, we believe the problem is still serious and that it will remain so until our recommendations are adopted. If they are adopted and if General Gray thus vests in his Chief Medical Director the sort of authority he told us he was prepared to grant, we are sure that the deans of our medical schools will be able to evince the same confidence in their official relationships with Admiral Boone as Dr. Magnuson has unequivocally told us Admiral Boone deserves as an individual. The re-creation of such a tripartite relationship on this basis will mean the reestablishing of those same bonds which gave this country a veterans' medical care program second to none. At the same time, it will mean that the maintenance and improvement of that program will be assured regardless of changing personalities. Certainly our obligations to those who have served in our Armed Forces make it incumbent upon us all to lay aside any past differences and to put forth every effort to achieve that goal.

As a final word, we should like to thank those who expressed their confidence in the work of this subcommittee by urging us to recommend that it be continued on a permanent basis. Such a recommendation is unnecessary. Under the Legislative Reorganization Act, the Senate's Committee on Labor and Public Welfare has a continuing responsibility for watching over activities of the Veterans' Administration. It has not and it will not shirk that obligation.

The Committee on Labor and Public Welfare having considered the above report of its subcommittee, adopted same and ordered that it be submitted to the Senate.

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