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The Emergence of a Medical School in Hampton Roads

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THE EMERGENCE OF A MEDICAL SCHOOL
IN HAMPTON ROADS

by
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ABSTRACT

THE EMERGENCE OF A MEDICAL SCHOOL
IN HAMPTON ROADS

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This dissertation documents the early years in the campaign by community leaders in Norfolk and adjacent cities to establish a local medical school as a means to improving the quality of medical education in the Hampton Roads area. Although attention is focused on the period 1959 to 1973, it is not strictly limited to this period of time.

The methodology for this dissertation is based heavily upon oral research. As one historian pointed out, "What better way to learn about a particular time than from the mouths of those who lived it." Approximately forty individuals instrumental in the founding of the medical school were interviewed and their memorable experiences and recollections captured with the use of a tape recorder. The result is a history of the origin of the Eastern Virginia Medical School based largely on the attitudes, beliefs, and perceptions of many of its key founders and supporters.

TABLE OF CONTENTS

LIST OF ILLUSTRATIONS	vii
LIST OF TABLES	viii
PREFACE	ix
ACKNOWLEDGMENTS	xii
 Chapter	
I. INTRODUCTION	1
Statement of the Problem	6
Limitations of the Study	8
Methodology	9
Significance of the Problem	20
Review of Related Literature	24
II. MEDICAL EDUCATION IN HAMPTON ROADS:	
1700s and 1800s	32
Norfolk in the 1700s and 1800s	32
Hospitals in Hampton Roads in the 1700s and 1800s	36
Medical Schools in Virginia in the 1700s and 1800s	43
Medical School Standards in the 1800s	51
The Flexner Report	55
III. MEDICAL CLIMATE AND EDUCATION IN NORFOLK:	
1900-1959	74
Population and Medical Schools	74
Need for Physicians during the First Half of the Twentieth Century	76
Change in Medical School Curriculum and Academic Year	78
Norfolk: Its Concern for Public Health, 1915-1918	78
Recognition of the Need for Medical Education in Norfolk, 1918-1919	81
Norfolk: Its Concern for Public Health, 1918-1940	83
Health Care in Norfolk, 1940-1958	94

Chapter

IV. THE FIRST YEARS, 1959-1964	109
Innovation and Reform in Medical Education	109
Recognition of the Need for a Medical School in Norfolk	113
Support for the Proposed Medical School Expands	133
Planning and Development of the Medical Center	137
Significant Studies	146
Efforts To Gain Support Accelerated	155
V. THE FIRST DECADE OF THE NORFOLK AREA MEDICAL CENTER AUTHORITY	166
The Norfolk Area Medical Center Authority	166
Financial Support	179
Medical School Sponsorship	188
Land Requirement	203
Organization of the Medical Authority	206
Perspectives of State and National Leaders	221
Summary	223
VI. ESTABLISHMENT OF THE EASTERN VIRGINIA MEDICAL SCHOOL OF THE EASTERN VIRGINIA MEDICAL AUTHORITY	239
Opposition to the Establishment of a Medical School in Norfolk	239
Studies Supporting the Need for the Eastern Virginia Medical School	254
Recruitment of Faculty and the First Dean	262
Educational and Curricular Plan	267
A School in Development	272
Regional Elements of the Eastern Virginia Academic Health Network	282
VII. THE IN-VITRO FERTILIZATION AND EMBRYO TRANSFER PROGRAM AT EASTERN VIRGINIA MEDICAL SCHOOL	301
Purpose and Procedure of In-Vitro Fertilization	301
History of In-Vitro Fertilization	302
History of the In-Vitro Fertilization Program at the Eastern Virginia Medical School	306

Chapter

VII. Approval of the First In-Vitro Fertilization Program in the United States by the Ethics Advisory Board . . . 324
Opposition to the In-Vitro Fertilization Program 325
Major Themes of Protest 328
New Ethical Guidelines 331
Public Opinion Polls 339

VIII. AFTERWARD 345

CHRONOLOGY OF EVENTS 348

APPENDICES

1. Need expressed for a written history of the Eastern Virginia Medical School and the Eastern Virginia Medical Authority 355

2. Sample letter of introduction from the president of the Eastern Virginia Medical Authority to a prospective interviewee . . . 357

3. Sample letters sent to 120 U.S. medical schools 359

4. Reprint of Abraham Flexner's evaluation notes on Virginia's three medical schools. . 364

5. Public Health Department: A Few Comparisons of health conditions in Norfolk from 1910 to 1920 369

6. Sanitation inspection facts for the years 1940, 1939, and 1938 373

7. Communicable diseases for the years 1940, 1939, and 1938 376

8. Medical education: Essentials of an acceptable college 378

9. The Joint Committee on House Staff Procurement and Training 389

10. Letters from John S. Thiemeyer, Jr., M.D. . . 393

11. Attendees at the meeting of the Joint Committee on House Staff Procurement and Training, 12 July 1960 397

12. Correspondence on proposals to improve the medical education programs at area hospitals, 1960 399

13. Draft of prepared resolution concerning planning of the medical center complex . . . 405

14. State council's basic considerations for the proposal of a new medical school 407

15. State council's proposed schedule for the development of a new medical school 412

16. State council's summary of conclusions on the proposal for a new medical school 414

APPENDICES

17.	The Norfolk Medical Center Commission	416
18.	The seven principle points constituting basic program objectives of the medical authority recommended by Richardson K. Noback, M.D.	418
19.	List of attendees at the 15 January 1964 meeting of the Norfolk Medical Center Commission	420
20.	Chapter 471, Code of Virginia, 1964	422
21.	Chapter 440, Code of Virginia, 1964	428
22.	Membership of the Norfolk Area Medical Center Authority's Medical Advisory Committee, June 1964	431
23.	By-Laws of the Norfolk Area Medical Center Commission	433
24.	House Resolution 3140	441
25.	List of organizations and businesses financially supporting the proposed medical school, 1969	454
26.	Conclusions of Old Dominion College's 1965 study on the Norfolk Area Medical Center Authority's proposal for an affiliation between the two institutions	456
27.	Letters from Dr. Thomas C. Moore to Dr. Mason Andrews	459
28.	Hospitals in the Tidewater area, 1964	463
29.	Committees of the Norfolk Area Medical Center Authority	465
30.	Termination of the Norfolk Medical Research Foundation	468
31.	Medical Educators Conference, 15-16 June 1967	471
32.	House Bill 1435	477
33.	Summary and Conclusions from the Ethics Advisory Board's Final Report	480
	SELECTED BIBLIOGRAPHY	483

LIST OF ILLUSTRATIONS

1. U.S. Naval Hospital--Portsmouth (1830)	37
2. St. Vincent's Hospital and Sanitarium-- Norfolk (1890)	39
3. Norfolk Protestant Hospital (1900)	40
4. The Leigh Hospital--Norfolk (1903)	42

LIST OF TABLES

1. Health Expenditures for the City of Norfolk-- 1915	80
2. General Government	91
3. Department of Public Welfare	91
4. Ten Principal Causes of Death in Norfolk--1935 .	92
5. Financial Sources for Medical Schools	157
6. Carnegie Commission Goals for New University Health Science Centers by 1980	256
7. Pregnancy Rate by Diagnosis	323
8. Pregnancy Rate by Age	323

PREFACE

This dissertation documents steps taken by civic leaders in Norfolk and the surrounding cities during the 1950s and 1960s to create a medical school in the Hampton Roads area as a means of improving health care services for the citizens of Eastern Virginia. The primary concern of this dissertation will be to trace the origin of the Eastern Virginia Medical School in Norfolk, Virginia, from its inception to its establishment. Created by the Norfolk Area Medical Center Authority (NAMCA), a public, yet corporate, governmental instrumentality, the Eastern Virginia Medical School opened its doors in 1973 as a community-based, three-year medical school.

The thesis of this dissertation focuses on the cooperation and dedication of the citizens of Hampton Roads to promote and create the mechanisms necessary for establishing a medical school in Norfolk. These mechanisms include community and legislative support, the medical authority, the Eastern Virginia Medical School Foundation, and alliances with regional educational institutions and medical organizations. The cooperation demonstrated by prominent area citizens continues today and is responsible for the continuance of the medical school. For this reason, this dissertation will especially explore the cooperation

demonstrated by area leaders and expound upon it with factual evidence.

The Eastern Virginia Medical School is recognized for several of its programs. Among its noted programs is the In-Vitro Fertilization program which has received national and international attention and recognition. This program exemplifies the progressive attitude of the medical school in its persistent goal of excellence in medicine. Therefore, a chapter has been written about this program.

Personal interviews with key individuals having an intimate knowledge of the origin of the medical school serve as the basis for this dissertation. Since the Eastern Virginia Medical School is a relatively young medical school, it has been possible to interview many of the doctors, hospital administrators, lawyers, and business people actively involved in the medical school's origin. Therefore, a significant amount of the research for this dissertation consists of oral material.

Annual reports, board minutes, speeches, minutes of seminars, personal letters and other materials from the archives of various libraries and personal files of local citizens have been examined. Together with the personal interviews of key individuals, valuable insight into the origin of the Eastern Virginia Medical School has been gained.

Since the period after 1973 exceeds the scope of this dissertation, a brief chronology of significant events since

that time is provided. In addition, several significant documents, reports, and papers reflecting the origin of the medical school are provided in the appendices.

It should be noted that the Eastern Virginia Medical Authority, formerly the Norfolk Area Medical Center Authority, was redesignated the Medical College of Hampton Roads in August 1987. Since this latter name change occurred after the major portion of this study was written, the former name is used throughout this study to refer to the medical authority.

The decision to limit this study to the origin of the medical school was a difficult one. However, the goal from the beginning was to document the origin of the medical school and not its development. The origin of the Eastern Virginia Medical School is rich in fine traditions and personalities. It is hoped that this study will help to preserve the early history of this unique educational institution.

ACKNOWLEDGMENTS

Many individuals contributed to this dissertation. To those who shared with me their mornings and afternoons so that I might interview them, please accept my sincere appreciation. I hope this dissertation is worthy of the time you shared with me.

A special thank you is extended to Drs. Mason C. Andrews, R. Bryan Grinnan, and John S. Thiemeyer, Jr. Without their interest and support, many significant details of the Eastern Virginia Medical School's origin would doubtlessly have gone unreported.

Several librarians, archivists, and administrative personnel of the medical authority and other institutions, provided critical assistance. A special debt of gratitude is owed to Anne Cramer and her staff at the Moorman Memorial Library of the Eastern Virginia Medical School; to Anne Richardson and Peggy Haile of the Kirn Memorial Library in Norfolk; to Linda Coppedge of the Norfolk Academy of Medicine; and to Becky Tucker, Gail Kelley, and others at the Medical College of Hampton Roads who so graciously offered assistance when needed.

Many of the recorded conversations were transcribed by Laurel Loving. Her meticulous attention to detail deserves an acknowledgment for a job well-done.

Dr. William Mayer, president of the Medical College of Hampton Roads, was an inspiration from our very first meeting. Without his willing support, it is doubtful that many of the interviews conducted for this dissertation would have been possible.

I would like to express my sincere appreciation to my dissertation committee. Members included Drs. Maurice Berube (chairman), Ray Strangways, and Robert MacDonald of Old Dominion University, and Mr. Joe Greathouse of the Medical College of Hampton Roads. Their constructive comments and guidance throughout the past three years will always be remembered.

A special thanks is offered to Dr. Maurice Berube. He recognized the potential of oral research and its application to this study. Much of the credit belongs to him. Thank you for your guidance, understanding, and patience.

Special thanks are extended to my wife, Carole, for the many sacrifices she endured during the writing of this dissertation. She was a constant source of support and encouragement. The constructive criticism she continually provided has been an immense help to me.

Alas, my son, John V ("Ace"), should be recognized. At the tender age of five, his clandestine activities involving the rearrangement of my notecards and research papers have added new meaning to the writing of the doctoral dissertation. He steadfastly maintains that my personal computer and the doctoral dissertation are not compatible,

and that "duck hunt" is the one and only true justification
for a computer.

John Pierce Flemming IV

CHAPTER I

INTRODUCTION

The Eastern Virginia Medical Authority, under the leadership of its president, Dr. William Dixon Mayer, realized in 1984 the need for a written history of the Eastern Virginia Medical School (see appendix 1). With the approval and guidance of the Eastern Virginia Medical Authority and in conjunction with Old Dominion University, the collection of information and data for the writing of this history was begun in the spring of 1985.

The primary concern of this dissertation will be to trace the history of the Eastern Virginia Medical School in Norfolk, Virginia, from the early 1960s through 1973. Created by the Norfolk Area Medical Center Authority (NAMCA), a public, yet corporate, governmental instrumentality, the Eastern Virginia Medical School opened its doors in 1973 as a community-based, three-year medical school. This dissertation will attempt to examine the years of work and effort that culminated in the founding of the Eastern Virginia Medical School.

The Committee on the Costs of Medical Care emphasized in 1930 the need for 13,000 more physicians¹ for the nation's population of 117 million.² The committee recommended a physician-to-population ratio of 134.7 physicians

per 100,000 population.³

The National Health Assembly convened at the request of President Truman in 1948. The assembly's final report recommended a national physician-to-population ratio of 150:100,000 by 1960.⁴

The Surgeon General's Consultant Group on Medical Education met in 1959 to propose ways of increasing the nation's supply of physicians. The resulting "Bane Report" recommended an increase in the physician output of existing medical schools and the establishment of an additional twenty to twenty-four new schools.⁵

The need for a medical school in Norfolk was recognized several times since early in the nineteenth century. Eastern Virginia, and especially Norfolk, was one of the fastest growing areas in the state. In 1960 the population of Norfolk was 305,000;⁶ the population of Richmond, site of the Medical College of Virginia, was 220,000;⁷ and the population of Charlottesville, home of the University of Virginia School of Medicine, was 29,000.⁸

The physician-to-population ratio for Eastern Virginia was 86:100,000 in 1960, while in Richmond and Charlottesville the ratio was 183:100,000 and 281:100,000, respectively.⁹ The physician-to-population ratio for Virginia, as a whole, in 1960 was 130:100,000.¹⁰ The national ratio was 142:100,000.¹¹ It was obvious that Eastern Virginia, compared to other parts of the state and to the nation, had a serious physician shortage.

National recognition of the need for more medical schools in the 1950s and 1960s provided the stimulus which led to the influx of federal funds for the construction of new medical schools in the 1960s and early 1970s. Norfolk's low physician-to-population ratio in 1960 amid one of the fastest growing areas in the state, and perhaps the nation, indicated that Norfolk was a prime site for a medical school.

A group of Norfolk's leading civic leaders, such as Dr. Mason C. Andrews who was president of the Medical Towers Development Corporation and a leading Norfolk practicing obstetrician and gynecologist, began to lay the groundwork to establish the medical school in 1962.¹² During the next several years, growing support came from many sources. In 1961 the Norfolk County Medical Society endorsed the concept of the medical school and the Committee on Medical Education of the Medical Society of Virginia reported that Norfolk would be a good location for a third medical school in Virginia.¹³

With community and governmental endorsement and the urging from such civic leaders as Dr. Andrews, area legislators prepared legislation calling for a comprehensive study by the Council of Higher Education for the State of Virginia on the feasibility of establishing a private medical school in the Hampton Roads area. The General Assembly of Virginia adopted this resolution in March 1962.¹⁴

A mayor's advisory committee on the establishment of a school of medicine was formed in January 1963 by the Norfolk City Council to study the feasibility, need for, and potential benefits of a medical school in Norfolk. A detailed report was submitted to the Norfolk City Council in June with the recommendation that the report be presented to the State Council of Higher Education's Study Committee.¹⁵ The report listed, among others, the following points in support of a privately supported medical college in Norfolk:

1. Some strong local and growing state support
2. A national, state, and local need for more physicians: the 1962 national ratio was 121 per 100,000 population; Virginia's ratio was 100 per 100,000
3. The low rank of Virginia among the states in terms of young people entering medical college
4. The need for opportunities for Hampton Roads' residents to enter medical college
5. The projected population growth in Virginia and Eastern Virginia, and the need for additional physicians to serve that population
6. The importance of residency training programs at a local level to influence physicians to enter practice in Eastern Virginia
7. The support of the need for a medical school by recognized leaders who had acted as consultants in the survey¹⁶

Additional reasons for supporting this concept were the large population concentration in Eastern Virginia; the expected economic impact of a medical school; the new educational facilities being considered for the Hampton Roads area--several new public and private colleges had been

started; the existence of federal health facilities, including a major United States Public Health Service Hospital, a large Veterans' Administration Hospital, a regional naval hospital; and the expanding transportation system that would soon link all of the other Tidewater cities with Norfolk.¹⁷

The potential impact of a Norfolk medical center on the metropolitan health care system had been pursued by the Health, Welfare, and Recreation Planning Council of Norfolk. It had organized a conference of professional and civic leaders who, together with national authorities, examined how best to proceed.¹⁸ From this conference, a medical center commission evolved with representation from the Norfolk County Medical Society, the Norfolk City Council, the Health, Welfare, and Recreation Planning Council, and the Norfolk Redevelopment and Housing Authority. The result was a resolution passed by the Virginia General Assembly in March 1964 which established the Norfolk Area Medical Center Authority (redesignated the Eastern Virginia Medical Authority in 1975). Companion legislation, also enacted in March 1964, identified the newly formed medical authority as an educational institution.¹⁹

Thus, after several years of planning, the civic and professional leaders had an official mandate from the Commonwealth of Virginia to proceed with development of a medical school, a medical educational system, and health care programs in Eastern Virginia.

Statement of the Problem

The importance of researching and writing a history of the Eastern Virginia Medical School is four-fold. First, the primary stimulus is timeliness; that is, there is the need to record the extensive groundwork that went into the creation of the medical school while many of the principal individuals are available to verify firsthand the motivation and generation of ideas, plans, and actions which led to the establishment and continuance of the medical school in Norfolk.

Second, twenty-five years have elapsed since the Eastern Virginia Medical School's inception. Until now, no comprehensive history of the early years of the medical authority and the pre-establishment of the medical school has been compiled. Thus, the chance that critical details of the early history of the medical school will become irretrievably lost is increasing.

Third, the Eastern Virginia Medical School was created as a community-based medical school having both public and private qualities. As a result, its reliance on state and federal financial support has been small compared to strictly public medical schools whose financial support has come chiefly from state and federal sources. This is particularly important since medical colleges across the nation have been faced with dwindling governmental support in recent years.²⁰ Therefore, a history of the creation and development of a medical school whose existence has been

based on minimal governmental financial support can serve as a model of survival to existing public and private medical schools and for medical schools yet to exist.

Last, several of the clinics, departments, and programs of the Eastern Virginia Medical School and its parent organization, the Eastern Virginia Medical Authority, have received national and international acclaim during the medical school's short existence. A prime example is the medical school's in vitro fertilization program which began in 1978. The importance of reviewing its achievements in medicine and offering a critical examination is worthy of documentation.

The thesis of this dissertation centers on the cooperation and dedication of the citizens of Norfolk and her sister cities to promote and create the mechanisms necessary for establishing a medical school in Norfolk. These mechanisms include community and legislative support, the Norfolk Area Medical Center Authority (redesignated the Eastern Virginia Medical Authority in 1975), the Eastern Virginia Medical School Foundation, and alliances with area educational institutions and medical organizations. The cooperation demonstrated by prominent area citizens continues today and is responsible for the continuance of the medical school. For this reason, this dissertation will especially explore the cooperation demonstrated by Norfolk's leaders and expound upon it with factual evidence.

Limitations of the Study

Quite possibly, the origin of the Eastern Virginia Medical School might be traced, at least ideologically, to the spring of 1812 when Drs. John Hodges, Lewis Hansford, and J. F. Oliverira Fernandes announced their intention to open a private medical school in Norfolk on 1 October 1812. Their plan proposed:

A General Course of Lectures on the different branches of Medicine and Surgery, provided the Applicants should exceed twelve. . . . [They] sincerely wish and earnestly request their Brother Physicians resident in this place to assist them in their laborious task. . . . The plan of Studies will be rendered public as soon as it shall be ascertained whether any assistance is to be expected from their colleagues. . . . The subscribers have reason to expect, that, their assiduity, will encourage the members of the Legislature, to approve the plan, and create an establishment worthy of their wisdom and patriotism.²¹

This advertisement first appeared in the Norfolk Gazette and Public Ledger on 17 July 1812;²² however, no courses were taught nor was a private medical school initiated in Norfolk as hoped.

An attempt will be made to trace the origin of the Eastern Virginia Medical School from 1959 when the Norfolk Ledger-Dispatch reported on Mr. Lawrence M. Cox's address to a Catholic business and professional men's club known as the Ryan Club. As executive director of the Norfolk Redevelopment and Housing Authority, Mr. Cox suggested that the Tidewater Medical Center site plan might include a medical school.²³ This site plan included over thirty-seven acres of land in the Atlantic City redevelopment area which had

been withheld from commercial use.²⁴ Norfolk General Hospital, already situated in the area with three other medical buildings in prospect--the Medical Tower, the Norfolk Public Health Center, and the King's Daughters Health Services Building--should make the area "a natural for a medical college,"²⁵ Mr. Cox insisted.

"We have in our area," Mr. Cox stated on 4 January 1961, at the dedication of the Medical Tower in the Norfolk Medical Center, "one of the largest concentrations of population of any urban area in the nation that does not have a medical college."²⁶ This eventually led to several studies on the feasibility of the establishment of a medical college in the Norfolk area, and subsequently to the creation in 1973 of the Eastern Virginia Medical School in Norfolk.

Because careful and serious groundwork to establish the medical school did not begin until 1959, this study will be restricted primarily to the period 1959 to 1973; therefore, any period before 1959 or after 1973 will not be explored in depth but offered as background information.

Methodology

Historical Method of Research

The historical method of research has been utilized in making this study. It consisted of the following four steps:

1. Conducting firsthand oral interviews with those individuals actively involved in the creation and

development of the Eastern Virginia Medical Authority and the Eastern Virginia Medical School

2. Locating and collecting original, written materials about the Eastern Virginia Medical Authority and the Eastern Virginia Medical School
3. Ascertaining which materials were relevant to this study
4. Organizing the authentic, relevant material into a lucid narrative

Primary Sources

Jacques Barzun and Henry F. Graff state in The Modern Researcher that the difference between a primary source and a secondary source is that the former gives the words of the witnesses or first recorders of an event.²⁷ An attempt has been made to maximize the use of primary sources such as personal letters, board minutes, speeches, minutes of seminars, annual reports, personal memoirs, and chronicles because these are often the most valid sources of information. A major source of information was obtained by personal interviews with principal individuals involved in the creation and development of the Eastern Virginia Medical School. Therefore, a directed effort was initiated to obtain material utilizing the research techniques of oral historians.

Oral Interview

One of the primary methods for obtaining much of the information used in this dissertation was by oral interview. Since the Eastern Virginia Medical School is a young and

ongoing medical school, it was possible to interview many of the doctors, hospital administrators, lawyers, and business people actively involved in the Eastern Virginia Medical School's evolution. The Eastern Virginia Medical Authority offered its assistance by providing a list of over sixty individuals for prospective interview. In addition, Dr. William D. Mayer, the Eastern Virginia Medical Authority's president, wrote a letter to many of the individuals to be interviewed and requested that they contribute their knowledge and viewpoints to the writing of this history (see appendix 2). In all, thirty-nine people were interviewed for this study.

Oral history is the practice of interviewing individuals with the aid of a tape recorder in order to collect valuable source information. As such, this dissertation contains a substantial amount of information based largely on oral history. E. Culpepper Clark defines it more precisely as "the process whereby an historian seeks to create historical evidence through conversation with a person whose life experience is deemed memorable."²⁸ Dr. Louis Starr, former director of the Oral History Research Office at Columbia University in New York City, took this definition a step further by noting that to be oral history the material must add something "to the sum total of the world's available supply of knowledge."²⁹

Clark states that oral history has four recognizable characteristics:

1. It is oral.
2. It is autobiographical.
3. It is the result of memory.
4. It is a joint intellectual product.³⁰

The advantage of interviewing someone who can provide personal perspective is that it helps the researcher validate the historical experience. Clark states:

It is one thing to read about the depression [the Great Depression of the 1930s] through general demographics or government policy; quite another to see it through the eyes of those who experienced it. . . . What better way to learn about a particular time than from the mouths of those who lived it.³¹

A prime reason for recording the interviews used in the collection of information for this dissertation was to prevent the irretrievable loss of important historical information, which in many instances was known only by a few individuals. The idea that much important knowledge is lost forever when it is not recorded on a timely basis from knowledgeable individuals is not new. Professor Wayland D. Hand, former chairman of the Oral History Committee at the University of California Los Angeles (UCLA), once said, "It has always been the eleventh hour in the collecting of folklore."³²

In order to become more familiar with the literature and help facilitate appropriate questioning and interview techniques, a letter was sent to Columbia University requesting source material relating to oral history.³³ Columbia University is well-known for its pioneer work in

the area of oral history. It has an established oral history library and offers graduate courses in oral history.³⁴

Dr. Allan Nevins is credited with the modern development of oral history. He launched the first oral history program in the United States at Columbia University in 1948 and served as the chairman of the Oral History Advisory Committee at Columbia University. In addition to his professorship at Columbia University, Dr. Nevins twice received the Pulitzer Prize for biography and was a Gold Medalist of the National Institute of Arts and Letters and the New York Historical Society.³⁵ His initial impulse to begin an oral history collection came from the perceived urgency to record the recollections of the elite; that is, he felt that the remembrances of leaders in government, industry, science, and the military should be recorded before their recollections vanished forever.³⁶

During the 1950's, oral history made minor progress in its use as an acknowledged branch of research. By the mid-1960s, however, the practice of oral history had become so widespread that the National Colloquium on Oral History was founded to promote and develop its methodology. Noted historians and social scientists, physicians, archivists, librarians, and assorted lay persons attended the first meeting of the National Colloquium on Oral History in 1966 at the University of California's Conference Center at Lake Arrowhead, California, to discuss oral history.³⁷ The

National Colloquium on Oral History soon afterwards became an annual event.

The field of oral history continued to grow in the 1970s and 1980s. In Oral History as a Teaching Approach, John A. Neuenschwander estimates that there were over four hundred oral history projects in existence in 1976 in the United States.³⁸ In 1983 Columbia University alone had collected over four thousand memoirs and accumulated over half a million pages of transcript.³⁹ A pamphlet distributed in 1985 by Columbia University entitled Oral History notes that Columbia University offers graduate courses in the oral history field.⁴⁰

Much has been written on oral history interviewing. In his article "On Oral History Interviewing," Charles Morrissey states that the purpose of oral history interviewing is information gathering. As such, interviewing which poses the same questions to different individuals may not be the best method to use if one is interested in gathering all the information one can.⁴¹

In his book Elite and Specialized Interviewing, Lewis Anthony Dexter extends Morrissey's contention that standardized questions for all interviewees is not always best. According to Dexter, comparability and meaning of responses from an interviewee may actually be lessened when standardized questions are used as the basis of the interview; that is, ". . . interviewer X can raise questions in one way with Y, but if the same techniques are used with Z, the meaning

is altered."⁴² Further, if one wants to test and be able to compare results statistically, then questions should be posed to the interviewee which call for a yes or no response. However, if the purpose of the interview is to discover or gain information, then questions of a moderately general nature which can be interpreted by the interviewee in several different ways should be asked.⁴³

Gary Brannigan, in his review of R. L. Gordon's book Interviewing Strategy, Techniques and Tactics, presents an argument for the unstructured interview. He states that "since interviewing serves two basic functions, discovery and measurement, the unstructured interview is more useful during the discovery phase."⁴⁴

Neuenschwander contends that oral historians often prefer questions which call for a broad general response. Although questions which elicit a yes or no response may be useful at times, Neuenschwander believes that the most successful interviews are those in which the interviewee talks at length about what he thinks is important. The how, what, where, and why queries elicit these types of responses. Neuenschwander states: "Whenever an interview becomes a dialogue, one can be sure that something has gone wrong."⁴⁵

Both Dexter and Morrissey ascribe to and profess Neuenschwander's approach to questioning in the interview. Dexter states that the interviewer should ". . . use some general phrase which the interviewee can interpret for

himself. Do not be any more precise than you absolutely have to be about what you are looking for."⁴⁶ He goes on to say that ". . . it is important to start off with comments or ask questions where the key words are quite vague and ambiguous, so the interviewee can interpret them in his own terms, out of his own experience."⁴⁷

When asked the question "How long do you consider to be the ideal interview in terms of minutes?", Dr. Philip C. Brooks, former Director of the Harry S. Truman Library in Independence, Missouri, noted that this issue must remain somewhat flexible although sixty minutes was usually considered standard because most interviewers and interviewees will become tired.⁴⁸ Clark supports Brook's contention by noting that fatigue usually will result within ninety minutes after initiation of the interview.⁴⁹ The interviews conducted for this dissertation indicated that this estimate is generally true. All the interviews conducted in a single sitting for this dissertation lasted anywhere from thirty minutes to ninety minutes, with the majority approximately seventy-five minutes in length. In some cases, however, the same individual was interviewed on more than one occasion. In such cases, a total of several hours may have been spent interviewing and recording that person.

Clark estimates that it requires ten hours for the transcription of a one-hour tape-recorded interview.⁵⁰ In the case of transcription of tapes for this dissertation, Clark's estimate generally held true. Only minor editing

occurred in the transcription of tapes used in writing this dissertation.

As Clark quotes from David Lovekin's article "Jacques Ellul and the Logic of Technology," "there is a persistence in the illusion that truth is verbatim."⁵¹ Clark goes on to say that the oral historian should intervene as interpreter and write what the conversation really meant. The transcription of the interview tape must be a "joint intellectual product" with a "shared meaning"⁵² for both the interviewer and the interviewee.

In his article "The Research Interview," Gary Brannigan discusses the wide use of questionnaires in social science research. He refers to D. C. Orlich's book entitled Designing Sensible Surveys which addresses eight advantages of the interview, some of which are as follows:

1. The respondent's feelings can be revealed.
2. The cause of problems and the solutions to problems can be discussed.
3. The respondent is given an opportunity for free expression.
4. The respondent may express personal information, attitudes, beliefs, and perceptions that might not have been obtained by a self-administered instrument.
5. The interviewer can follow-up answers or probe for additional information to clarify answers.⁵³

In an attempt to differentiate from the so-called "standard interview" which confronts each interviewee with the same questions, the term "elite interview" was coined. As used by David Riesman, an elite interview is "an

interview with any interviewee--and stress should be placed on the word "any"--who in terms of the current purposes of the interviewer is given special, non-standardized treatment."⁵⁴ According to Riesman, this includes "letting the interviewee introduce to a considerable extent . . . his notions of what he regards as relevant, instead of relying upon the investigator's notions of relevance."⁵⁵

Unlike the standardized survey interview that social scientists have used, the usual oral history interview is an elite or nonstandardized type of interview. The interviewer allows the interviewee to determine the shape of the interview. Thus, the interviewer seeks to draw from the interviewee the fullest possible account of an event or period of time.

During the interview, Clark recommends that the interviewer ask only open-ended questions; that is, questions that do not call for or lead the interviewee into responding with a specific answer or present a specific choice among alternatives. Clark suggests that the interviewee be given the opportunity to do most of the talking and that the interviewer avoid interrupting.⁵⁶ Likewise, Morrissey notes that it is important to leave phrasing of questions open-ended and not lead the interviewee to an expected response. The interviewer should let the interviewee volunteer what he or she thinks is most significant.⁵⁷

The use of statistics in a standardized interview is

often used to help facilitate certain conclusions. The short responses that lend themselves to statistical analysis and such statistical procedures as factor analysis, canonical correlation analysis, t-test, and the Pearson product moment r correlation, would not be readily applicable in elite interviewing. Information gained from each individual is not always equally important nor should it carry the same weight.⁵⁸ Dexter states: "The population cannot be satisfactorily randomized or stratified in advance; and different interviewees make quite different and unequal contributions. . . ."⁵⁹

The techniques of the elite, nonstandardized interview professed by oral historians were used to obtain much of the material presented in this dissertation. The reason several pages have been devoted to its methodology and relatively short history was to establish its credibility as an appropriate and applicable procedure for this study.

Archival Materials

Although much emphasis was placed on interviewing significant individuals who contributed to the creation, development, and continuance of both the Eastern Virginia Medical School and its parent organization, the Eastern Virginia Medical Authority, a large amount of time was devoted to collecting information from archival materials and other original written records. The archives of the medical school's library has proven to be an invaluable

asset and was utilized extensively.

Secondary Sources

Extensive use of secondary sources, such as books and articles, was necessary, and every attempt was made to judge carefully between fact and opinion. Newspaper articles provided another source of information. These were considered secondary sources because they reported an activity at the time the event occurred or recounted information given to them on the occasion of some anniversary or celebration. Where possible, validation of secondary source information, as well as primary source information, has been made with the use of collaborating evidence. Following this, an attempt was made at reconstruction of the history of the Eastern Virginia Medical School.

Significance of the Problem

This study is significant for one basic reason although others will become apparent in the course of this dissertation. Until now, no comprehensive history of the creation of the Eastern Virginia Medical School has been compiled. This deficit of historical documentation has been recognized by the medical community of both the medical authority and the medical school.

The Eastern Virginia Medical School is located in the heart of the City of Norfolk. In 1984 Norfolk had a population of approximately 280,000.⁶⁰ The medical school is surrounded by the seven cities of Eastern Virginia--Norfolk,

Chesapeake, Portsmouth, Virginia Beach, Hampton, Newport News, and Suffolk. The combined Norfolk, Virginia Beach, and Newport News metropolitan statistical area (MSA) was the twenty-ninth largest MSA in the United States in 1984 with a population of approximately 1,261,000.⁶¹

From an economic standpoint, the establishment of the Eastern Virginia Medical School has been likened to the opening of a major industry in the Hampton Roads area. For the fiscal year ending 30 June 1985, the Eastern Virginia Medical School had revenues and expenditures in excess of \$13 million and \$14 million, respectively.⁶² During that same period, municipal subsidies to the medical school totaled \$972,000.⁶³

The Eastern Virginia Medical School was an outgrowth of the Eastern Virginia Medical Authority. The medical authority was established on 25 March 1964 by the General Assembly of the Commonwealth of Virginia, under Chapter 471, Code of Virginia.⁶⁴ Originally called the Norfolk Area Medical Center Authority (NAMCA), it was renamed the Eastern Virginia Medical Authority (EVMA) in 1975 (now the Medical College of Hampton Roads) primarily to emphasize the regional affiliation and allegiance of the seven participating municipalities of Eastern Virginia.⁶⁵ From its inception in 1964, the medical authority was composed of regional community leaders appointed by the respective city councils of the seven surrounding cities.

The Eastern Virginia Medical Authority is a powerful

economic influence on the Hampton Roads area. Over eleven hundred people are directly employed by the medical authority, and hundreds more are indirectly employed because of the ripple effect on the area's patient care system. In the fiscal year 1984-85, the Eastern Virginia Medical Authority's budget totaled \$61.5 million.⁶⁶ Of this amount, \$39.1 million in salaries and fringe benefits went directly into the region's economy. Another \$16.4 million was spent in Eastern Virginia for goods and services.⁶⁷

The opening of the medical school in 1973 created the need for new construction of offices, laboratories, and research facilities. With multi-million dollar construction of such buildings as the Sydney and Frances Lewis Basic Medical Education Building, the Tidewater Rehabilitation Institute, the Elise and Henry Clay Hofheimer II Hall of the Clinical Sciences, and the proposed Howard and Georgeanna Jones Center for research and treatment of infertility problems, the economic impact of the Eastern Virginia Medical Authority on the Hampton Roads area has become even more visible.

The Eastern Virginia Medical School, in conjunction with Norfolk General Hospital, has become internationally recognized for work performed in the areas of open-heart surgery, kidney transplantation, and human in vitro fertilization. Recognition of these programs is another reason for the importance of this study.

The in vitro fertilization program has precipitated

arguments touching on a wide range of ethical issues such as the origins of life, human experimentation, and human sexual intimacy. The last chapter of this dissertation will be devoted to the establishment of the Eastern Virginia Medical School's In-vitro Fertilization program primarily because the first therapeutic, in vitro fertilization clinic in the United States was established in 1980 at Norfolk General Hospital in conjunction with the Eastern Virginia Medical School.⁶⁸ Subsequently, on 28 December 1981 the first baby in the United States conceived by in-vitro fertilization was born at the Eastern Virginia Medical School's in vitro fertilization clinic.⁶⁹ The event received national and international attention.

The task of this study is two-fold. First, to analyze the past in light of the present and of the future which it is bringing forth; and second, to look back into the past for those critical insights necessary to the understanding of the existing situation.

The Eastern Virginia Medical School has enjoyed a successful, although often times difficult, existence since matriculation of its first class in 1973. As of June 1987, over 800 students had graduated with a medical degree from the Eastern Virginia Medical School.⁷⁰ Many of them have dispersed throughout the entire world and are contributing to all aspects of medical education, research, and services.

This dissertation will document chronologically the medical school's early history to include a chronology of

significant events since 1973. In order to present a cohesive history of the medical school, areas such as academic development of the medical school and regional health care development in the Hampton Roads area will intertwine throughout this study. In addition, this dissertation will provide background information against which future plans and changes can be made.

Review of Related Literature

A literature search was initiated to determine what had been written concerning histories of medical schools in the United States. A computer search of the Dissertation Abstracts International data base was performed which covered the period 1861 to February 1986. It indicated that only one doctoral dissertation had been written on a history of a specific medical school.⁷¹ A manual search of the Resources in Education (RIE) Index⁷² and the Current Index to Journals in Education (CIJE)⁷³ since 1975 was conducted to identify journal articles, periodicals, and books which relate to the histories of medical schools. This search revealed that only one book had been written since 1975 concerning the history of a specific medical school.

According to Garrison and Morton's Medical Bibliography--An Annotated Checklist of Texts Illustrating the History of Medicine,⁷⁴ only twelve books were written before 1965 about the history of medicine in the United States. All were published before 1949, and none dealt with

a history of a specific medical school.

Because of this lack of identification of written histories of existing medical schools in the United States and the feeling of dissatisfaction that a more exhaustive literature search should be performed, an inquiry was sent to 120 medical schools in the United States (see appendix 3). As of 15 September 1986, one hundred and six medical schools had replied to this inquiry. Of these medical schools, thirty-eight reported that one or more books had been written about the history of their institution or a segment of it and that each was at least fifty pages in length. Three medical schools responded that a doctoral dissertation had been written on at least a part of the history of their institution. Sixty-five medical schools reported that either nothing had been written about the history of their institution or that the only history written was in the form of commemorative booklets, journal articles, or similar forms of less than fifty pages.

One of the goals of this study is to make maximum use of all relevant literature and to reveal any pertinent comparisons and/or contrasts between the early history of the Eastern Virginia Medical School and its parent organization, the Eastern Virginia Medical Authority (redesignated the Medical College of Hampton Roads in 1987), with that of other medical institutions in the United States. Personal interviews with key individuals having an intimate knowledge of the origin of the medical school, however, serve as the

basis for much of this dissertation.

FOOTNOTES

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³Physicians for the Future, p. 39.

⁴Ibid., pp. 39-40.

⁵Ibid., p. 43.

⁶Virginia, Bureau of the Census, Number of Inhabitants: Virginia, 1980 (PC 80-1-A48), p. 9.

⁷Ibid.

⁸Ibid.

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¹⁰Physicians for the Future, p. 66.

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¹⁴Virginia, General Assembly, House Bill 229 (March 1962).

¹⁵Interview with Richard F. Welton, III, president of Smith and Welton, Inc., Norfolk, Virginia, 28 February 1985.

¹⁶Norfolk, Virginia, Brief of the Mayor's Advisory Committee on the Establishment of a Medical College in the Tidewater Area, 27 June 1963.

¹⁷Virginia, State Council of Higher Education, Physicians for Virginia--Part II, December 1963, pp. 12-13.

¹⁸Margery Loomis Krome, "The History of the Health-Welfare-Recreation Planning Council of the United Committee in Tidewater Virginia: A Case Study in Voluntary Planning" (Masters thesis, Old Dominion University, 1973).

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²⁴Andrews, 28 January 1985.

²⁵Cox, p. 17.

²⁶"First Step toward the Medical College," Norfolk, Va., The Virginian-Pilot, 2 December 1961, p. 4.

²⁷Jacques Barzun and Henry F. Graff, The Modern Researcher (Washington, D.C.: Harcourt, Brace and Jovanovich, 1985), p. 124.

²⁸E. Culpepper Clark, "The Oral History Interview," cited in Effective Interviewing, ed. Alexander Tolor (Springfield, Il.: Charles C. Thomas, 1985), p. 184.

²⁹Elizabeth I. Dixon and James V. Mink, eds., Oral History at Arrowhead: Proceedings of the First National Colloquium on Oral History (Los Angeles, Ca.: The Oral History Association, 1967), p. 19.

³⁰Clark, p. 181.

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³³John P. Flemming IV, to the director of the Oral Research Office of Columbia University, 31 July 1986, Personal Files of John P. Flemming IV, Chesapeake, Virginia.

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³⁵Ibid., p. viii.

³⁶Ibid.

³⁷Ibid., pp. 1-95.

³⁸John A. Neuenschwander, Oral History as a Teaching Approach (Washington, D.C.: National Education Association, 1976), p. 7.

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⁴⁰Oral History Research Office, Oral History (Columbia University, New York: Oral History Research Office, 1985), p. 6.

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⁴²Lewis Anthony Dexter, Elite and Specialized Interviewing (Evanston, Il.: Northwestern University Press, 1970), p. 102.

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⁴⁵Neuenschwander, p. 18.

⁴⁶Dexter, p. 49.

⁴⁷Ibid., p. 55.

⁴⁸Dixon and Mink, p. 26.

⁴⁹Clark, p. 187.

⁵⁰Ibid., p. 185.

⁵¹Ibid., p. 192.

⁵²Ibid., p. 193.

⁵³Brannigan, p. 197.

⁵⁴Dexter, p. 5.

⁵⁵Ibid.

⁵⁶Clark, p. 187.

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⁶²Financial Statement for Year Ended June 30, 1985, Eastern Virginia Medical Authority (Norfolk, Va.: Goodman and Company, Public Accountants, 1985), p. S-2.

⁶³Ibid., p. S-21.

⁶⁴Virginia, Code of Virginia, Chapter 471, 25 March 1964.

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⁶⁶Financial Statement for Year Ended June 30, 1985, p. S-21.

⁶⁷Ibid., p. 17.

⁶⁸Frank H. Marsh and Donnie J. Self, "In Vitro Fertilization: Moving from Theory to Therapy," The Hastings Center Report, 10 June 1980, p. 5.

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CHAPTER II

MEDICAL EDUCATION IN HAMPTON

ROADS: 1700s and 1800s

Norfolk in the 1700s and 1800s

Norfolk was incorporated as a town on 15 September 1736 by a Royal Charter signed by King George II, King of England.¹ The estimated population of Norfolk at that time was less than one thousand.² Situated on the Lafayette and Elizabeth Rivers, Norfolk grew rapidly and prospered through trade and commerce. Because of its large harbor and its proximity to the ocean, Norfolk became a focal point for trade in Eastern Virginia.³ Commodore Matthew Fountaine Maury, a U.S. naval officer and captain in the Confederate Navy during the War between the States, described Norfolk's harbor as "The King's Chamber Among the Great Harbors"⁴ of Virginia.

At the height of the American Revolution in 1776, Norfolk's population was approximately six thousand.⁵ On New Year's Day 1776, the British fleet attacked Norfolk with four warships. The British landing force, under the command of Lord Dunmore, began burning the warehouses along Norfolk's wharves. Fearing total capture of the city, Norfolk's defenders hastily burned stores and houses before

fleeing.⁶ As one reporter stated: "To Norfolk goes the doubtful honor of being the most desecrated community of its size in the American colonies during the [American] Revolution."⁷ Almost immediately, Norfolk's population declined sharply. Norfolk did not recover until around 1800 when its population was estimated at 6,926, of whom 3,850 were white and 3,076 were black.⁸

The need for physicians in Norfolk was demonstrated dramatically in the eighteenth and nineteenth centuries by periodic outbreaks of yellow fever and smallpox. Like other seaports of that time, Norfolk was constantly exposed to these two maladies with the frequent arrival of ships from foreign ports. Quarantining of patients did much to protect the community from smallpox; however, only the approach of cold weather in the fall of the year could stop the spread of yellow fever.⁹

Geoffrey Marks and William Beatty note that the first American writer to draw attention to the yellow fever disease was John Mitchell (c. 1680-1768) of Urbana, Virginia, whose unpublished manuscript, "An Account of the Yellow Fever Which Prevailed in Virginia in 1737, 1741 and 1742," documents early instances of yellow fever epidemics in Virginia.¹⁰

The Duke de La Rochefoucauld Liancourt in the late eighteenth century traveled the continent of North America and kept a journal entitled Travels through the United States of North America. According to Dr. Wyndham Blanton,

the duke visited the City of Norfolk and made the following observation:

Diseases are habitual at Norfolk in summer and autumn, and . . . malignant epidemics are there frequent. Last year [1796] the yellow fever is said to have carried off there five hundred persons from a population of four thousand. Three hundred died at the time the distemper prevailed; the others fell victims to [the disease's] consequences. . . .¹¹

Dr. Blanton notes that little is known of Norfolk's physicians during the second half of the eighteenth century. However, his assessment is that "the need for physicians in Norfolk must have been often acute";¹² nevertheless, the supply of physicians necessary to provide adequate medical care probably kept pace with the demand.¹³

Between 1795 and 1826, three serious outbreaks of yellow fever occurred in Norfolk and claimed hundreds of lives.¹⁴ In 1855 yellow fever again struck Norfolk with devastating results. Like the three previous yellow fever epidemics, its source was traced to a foreign ship docked in Norfolk's harbor.¹⁵

William S. Forrest, author of The Great Pestilence in Virginia, describes the ravages of the 1855 yellow fever epidemic that plagued Norfolk and its bordering city, Portsmouth. "The mysterious, pestilential visitation with Norfolk and Portsmouth were afflicted in 1855, is justly classed among the severest and most terrible calamities that ever desolated any community," proclaimed Forrest.¹⁶ The first death from the ensuing epidemic occurred on 8 July 1855. By 11 August, an estimated one-half of Norfolk's

population had fled the city for fear of contracting the dreaded disease.¹⁷

Historical records indicate that the number of deaths in Norfolk and the surrounding area as a direct result of the 1855 yellow fever epidemic were between six and seven thousand. According to the Norfolk Census of 1850, the resident population of Norfolk was 22,952.¹⁸ Forrest estimates that one-third of the residents of Norfolk and Portsmouth died of the 1855 yellow fever epidemic even though it only lasted for the three-month period of July through early October.¹⁹

There were twenty-eight physicians in Norfolk and Portsmouth in 1855,²⁰ far too few to adequately respond to the yellow fever epidemic that afflicted these two cities. Because of the severity of the yellow fever epidemic and the shortage of physicians in the Norfolk-Portsmouth area in July 1855, forty-four physicians from other parts of Virginia and several other states came to Norfolk and Portsmouth to offer their medical assistance. When the epidemic was finally over in October, ten resident and twenty-five non-resident physicians had died of yellow fever, the very disease they had so desperately tried to eradicate.²¹

Six years later, Virginia was drawn into the War between the States. Norfolk, being a major Southern seaport, was the focal point of naval operations for the Confederacy.²² After the War between the States, the

physician shortage in Norfolk and other parts of the Hampton Roads area began to subside.²³

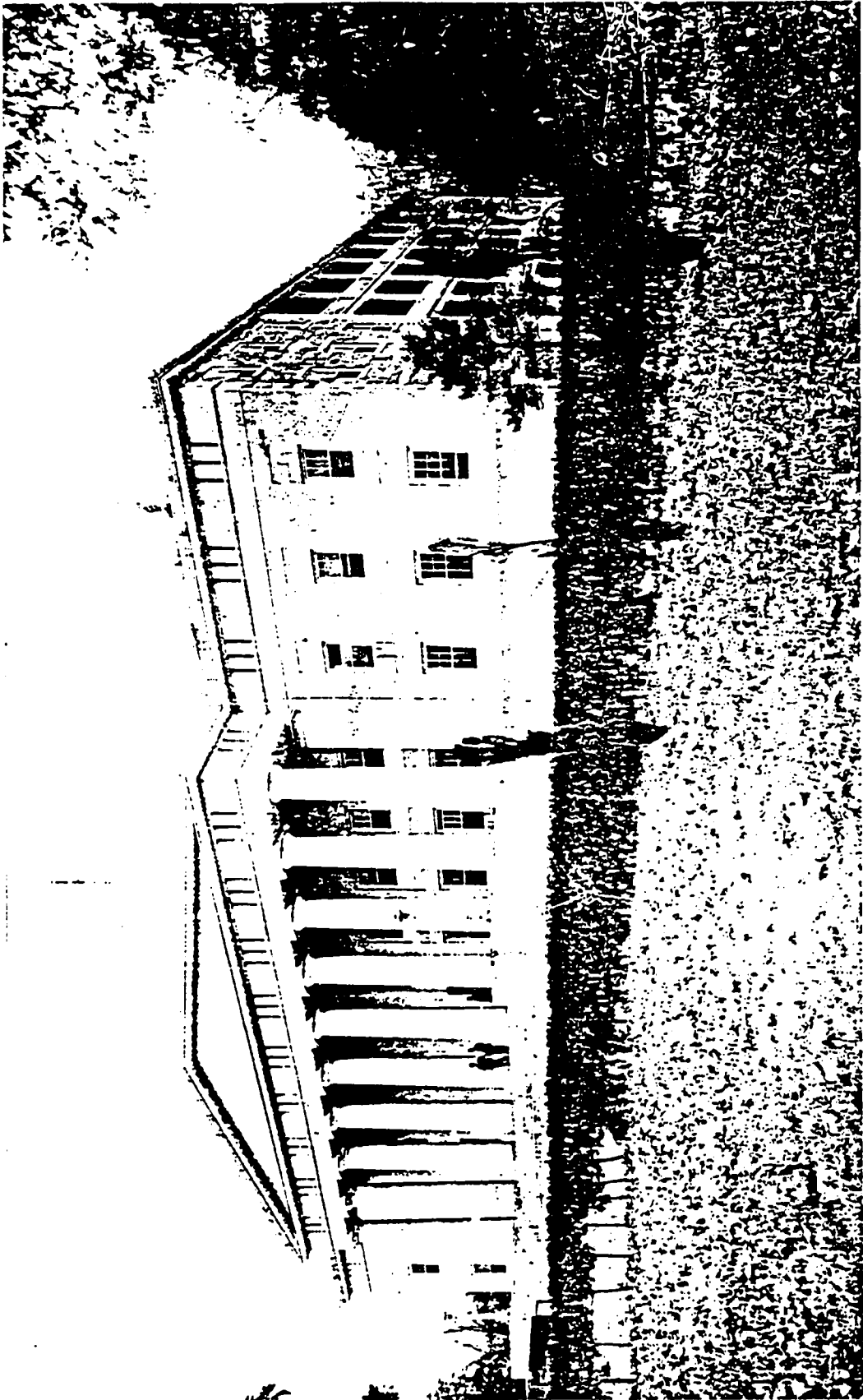
Norfolk's leaders recognized the importance of good medical care for its population and the need for an adequate supply of physicians.²⁴ Many still remembered the suffering and death in Norfolk and the surrounding area earlier in the century as a result of the yellow fever epidemics.

The Norfolk County Medical Society was organized on 3 June 1870 in the City of Norfolk. The members adopted the code of ethics of the American Medical Association at the second meeting.²⁵ This, no doubt, had a positive effect on the local practice of medicine in future years by setting certain minimum standards.

Hospitals in Hampton Roads in the 1700s and 1800s

Norfolk's first hospital was the Marine Hospital. Built in 1787 for the purpose of providing medical care to navy personnel, the Marine Hospital was located in the Berkley section of Norfolk, an area formerly known as Washington.²⁶ Although the Portsmouth Naval Hospital was built in Portsmouth in 1830, it, like Norfolk's Marine Hospital, provided medical care only to military personnel.²⁷

DePaul Hospital, originally known as the Hospital of Saint Vincent de Paul, is the oldest civilian hospital in Norfolk. Located at Church and Wood Streets, the first building was the home of Dr. James H. Behan and his sister,



U. S. NAVAL HOSPITAL—Portsmouth.

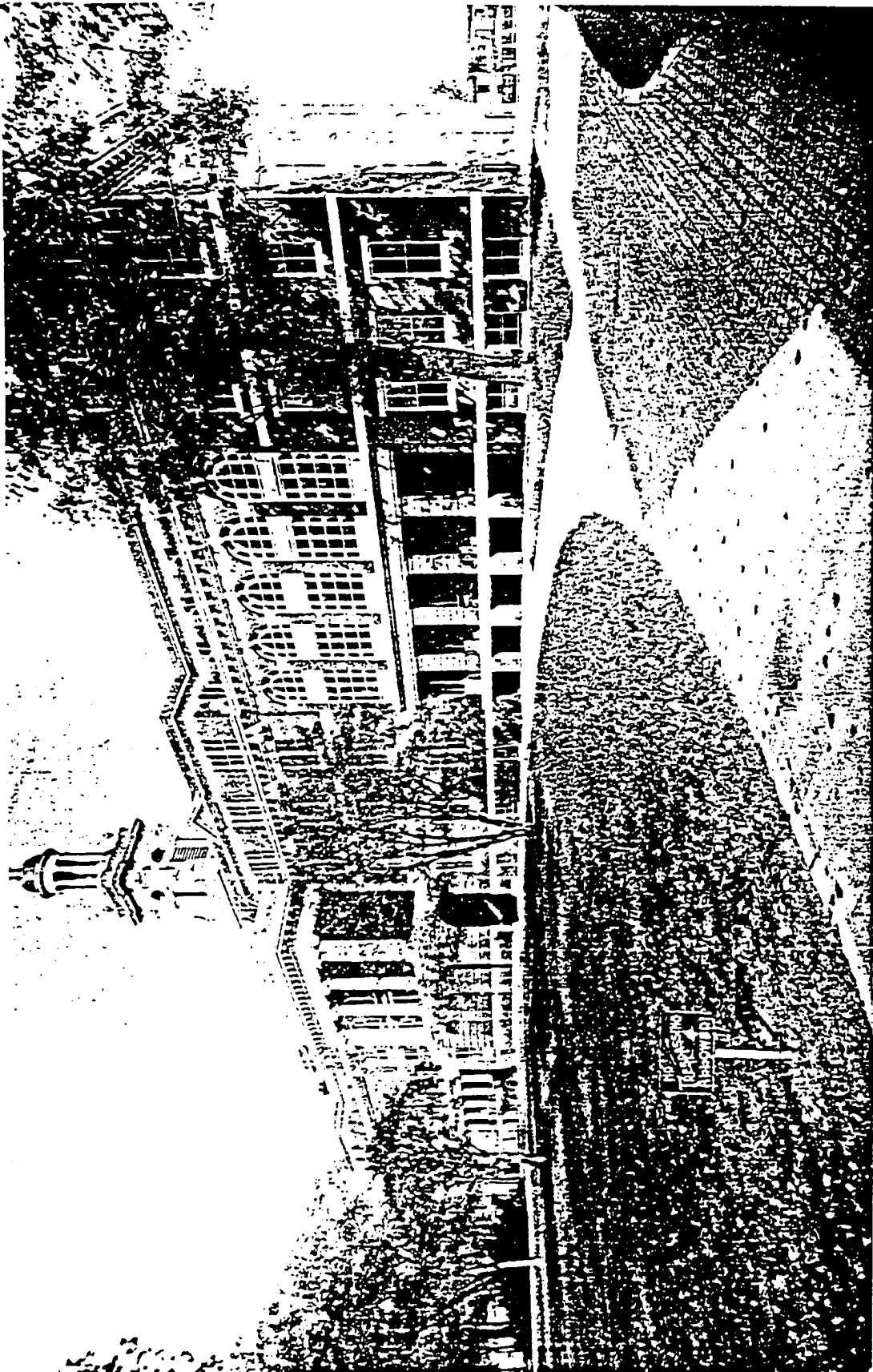
(1902)

Miss Ann Plume Behan Herron. She had died of yellow fever during the 1855 epidemic. Upon her death, the house and land was bequeathed to the Sisters of St. Vincent de Paul to be used as a hospital.²⁸ In 1899, the house was destroyed by fire and in its place, DePaul Hospital was built in 1900.²⁹

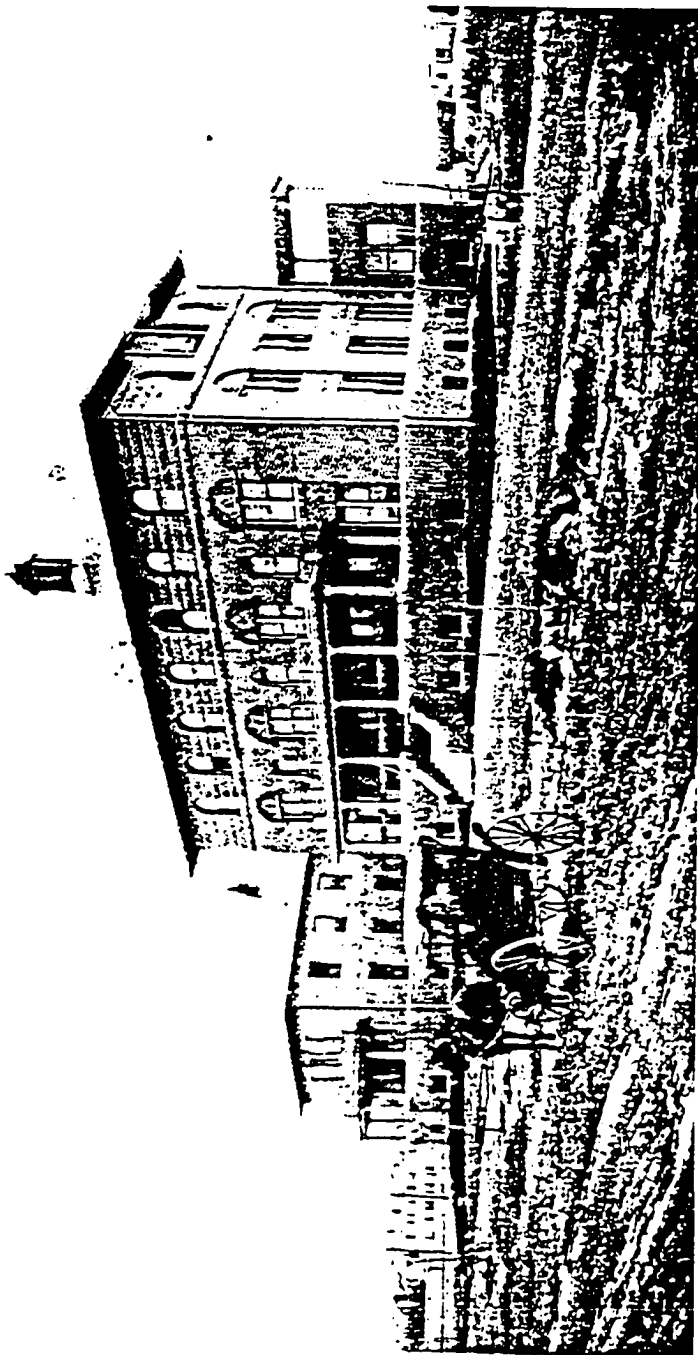
At least seven civilian hospitals were built in the Hampton Roads area between 1888 and 1913. Three of the seven were located in Norfolk. In 1888 the Norfolk Women's Christian Association established the Retreat for the Sick, a twenty-five bed hospital located near Union Station on the corner of Holt and Riley Streets in the old section of Norfolk.³⁰ In 1896 its name was changed to Norfolk Protestant Hospital.³¹ Recognizing the need for more hospital beds and improved facilities, the hospital's board of directors in 1901 purchased forty-two lots in the Atlantic City ward and began construction of the new hospital. Bound by Raleigh, Colley, and Boissevain Avenues and Thetford Street, the building was completed in 1903.³²

In an attempt to broaden the base of financial support for Norfolk Protestant Hospital, the hospital's board of directors changed the hospital's name to Norfolk General Hospital. It was hoped that the city's Jewish and Catholic population, as well as those of other religious faiths, would identify with the hospital and offer their financial support.³³

Sarah Leigh Hospital in Norfolk opened in 1903.



ST. VINCENT'S HOSPITAL AND SANITARIUM—Norfolk.
(1902)



NORFOLK PROTESTANT HOSPITAL.

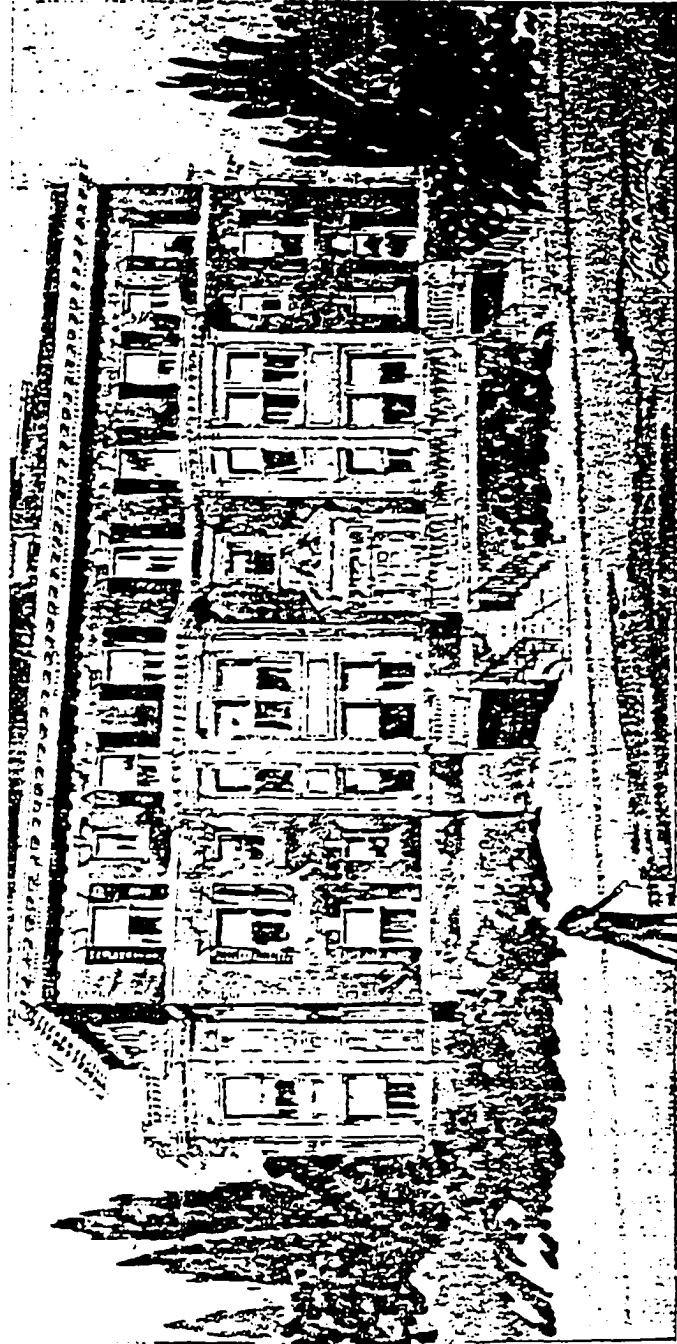
(1902)

Founded by Dr. Southgate Leigh and named in honor of his aunt,³⁴ it was located on Mowbray Arch in the Atlantic City section of Norfolk, not far from Norfolk Protestant Hospital. In 1936 it was reorganized on a non-profit basis and renamed Leigh Memorial Hospital.³⁵ Dr. R. Bryan Grinnan, Jr., a practicing Norfolk physician from 1936 to 1978, made the observation that Leigh Memorial was the first area hospital in which all corners on the inside of the building were rounded. The purpose of rounding all corners was to make them easier to clean, thus insuring total cleanliness of the hospital.³⁶

Four other area hospitals were constructed between 1888 and 1913. It may, at first, seem strange that so many hospitals would be constructed during this short period of time; however, good medical care was recognized as a necessity, and this need was manifested partly in the construction of new and improved medical facilities.

Dixie Hospital in Hampton was founded as an extension to the Hampton Training School for Nurses, which was established in 1891 to train black women in the nursing profession.³⁷ Newport News General Hospital was built in 1902 and was that city's first hospital.³⁸ Suffolk's first hospital, Lakeview Hospital, was built in 1906.³⁹

Although a temporary hospital in the City of Portsmouth was built in 1855 to care for victims of the yellow fever epidemic,⁴⁰ Portsmouth did not have a permanent civilian hospital until 1896.⁴¹ Public interest was



THE LEIGH HOSPITAL,--Norfolk (from Sketch).

(1902)

aroused at the death of a stranger who had become ill and, for lack of a better place, given a bed in the city jail. As a result of public outcry, a small, two-story building on Court Street was set-up as a hospital.⁴² This continued to be Portsmouth's only civilian hospital for seventeen years. In 1913 the King Daughters' Hospital (now Portsmouth General Hospital) was built.⁴³

Medical Schools in Virginia
in the 1700s and 1800s

The need for physicians in Virginia was recognized by Thomas Jefferson in the 1770s.⁴⁴ Dr. Joseph M. Toner, a noted historian on American medicine in the nineteenth century, estimates there were thirty-five hundred to four thousand practicing physicians in the United States at the time of the American Revolution; however, only about two hundred of them had medical degrees from a formal medical school.⁴⁵ Medical apprenticeship was popular and, no doubt, accounted for the large number of physicians in the United States during the eighteenth century through the latter part of the nineteenth century.⁴⁶ During this time, the number of practicing physicians in the United States continued to increase. In 1790, it is estimated that there were five thousand physicians in the United States.⁴⁷ By 1850, the number of physicians in the United States had increased to over forty thousand.⁴⁸ As might be expected, the physician to population ratio increased significantly during this same period. William Barlow and David Powell estimate the

physician-to-population ratio increased from "one in 950 in 1790 to one in less than 650 in 1850."⁴⁹ During this same period, the overall population increased from roughly four million in 1790 to twenty-three million in 1850.⁵⁰

First Medical School in Virginia

Established in 1693, the College of William and Mary is the second oldest college in the United States and the first academic institution to receive a direct charter from the crown of England.⁵¹ From 1730 to 1779, its faculty was composed of a president, six professors, one usher, one sub-usher, and a writing master.⁵²

Thomas Jefferson proposed the establishment of a medical school in 1779 to be located in Williamsburg, Virginia, as part of the reorganization of the College of William and Mary to university status.⁵³ Jefferson drafted the bill for amending the college's constitution and on 18 June 1779 he and George Wythe presented it to the General Assembly for the Committee of Revisors. According to Roy J. Honeywell, author of The Educational Work of Thomas Jefferson, the proposed bill for amending the Constitution of the College of William and Mary stated, in part:

There shall . . . be eight Professorships, to wit, one of moral philosophy, and the laws of nature and of nations, and of the five arts; one of law and police; one of history, civil and ecclesiastical; one of mathematics; one of anatomy and medicine; one of natural philosophy and natural history; one of the ancient languages. . . and one of the modern languages.⁵⁴

The divinity chairs and grammar school of the College

of William and Mary were replaced in 1779 by the professorships of law and medicine.⁵⁵ As a result of the college's reorganization, the college's School of Medicine became the third medical school to be established in the United States and the first in the State of Virginia.⁵⁶

The first formally recognized medical school in the United States was the Medical Department of the University of Pennsylvania in Philadelphia. Established in 1765, it served as a model for subsequent medical colleges in the United States.⁵⁷ The second medical school in the United States was chartered in 1767 as King's College of New York but later changed its name to the Medical Department of Columbia College.⁵⁸

The medical school at the College of William and Mary operated only four years and is seldom mentioned in the medical history of the United States because of its short duration. It ceased to exist in 1783 when its esteemed Professor of Anatomy and Medicine, Dr. James McClung, resigned and moved to Richmond.⁵⁹

A second attempt to introduce medicine at the College of William and Mary occurred in 1824 when its president, Dr. John Augustine Smith, proposed that the college be moved to the state capital in Richmond. Thomas Jefferson vehemently opposed this plan. Jefferson still believed that it was important to have a center for medical education in Eastern Virginia.⁶⁰

In support of medical education in the Hampton Roads

area, Thomas Jefferson wrote a letter in 1824 to his long-time correspondent and friend, Joseph C. Cabell, which stated in part:

But Richmond thinks that it can have a hospital which will furnish subjects for the clinical branch of medicine. The classes of people which furnish subjects for the hospitals of Baltimore, Philadelphia, New York, and Boston, do not exist at Richmond. The shipping constantly present at those places furnish many patients. Is there a ship at Richmond? . . . No, sir, Richmond is no place to furnish subjects for clinical lectures. I have always had Norfolk in view for this purpose. The climate and Pontine country around Norfolk render it truly sickly in itself. It is moreover the rendezvous not only of the shipping of commerce, but of the vessels of the public navy. . . . I had thought, and have mentioned to yourself and our colleagues, that when our medical school [at the College of William and Mary] has got well under way, we should propose to the federal government the association with the establishment, and at our own expense, of the clinical branch of our medical school, so that our students after qualifying themselves with the other branches of the science here [the College of William and Mary], might complete their course of preparation by attending clinical lectures for six or twelve months at Norfolk.⁶¹

Dr. John Augustine Smith's proposal to move the College of William and Mary to Richmond failed.⁶² Thomas Jefferson, who for almost fifty years had tried unsuccessfully to establish a permanent medical center in Eastern Virginia, was unable to persuade the Virginia General Assembly or the United States Congress to provide funds annually for a medical school attached to the College of William and Mary.⁶³ As a result, the medical school at the College of William and Mary lasted only four years and Jefferson's hope that the clinical branch of the medical school be located in Norfolk was never realized.

Early Attempts to Establish a Medical School in Norfolk

Two unsuccessful attempts were made at establishing a medical school in Norfolk during the nineteenth century. The first attempt was in 1812 by Drs. John Hodges, Lewis Hansford, and J. F. Oliverira Fernandes. They had proposed a private medical school in Norfolk and placed an advertisement in the Norfolk Gazette and Public Ledger on 17 July 1812 requesting assistance from local physicians to help get it started.⁶⁴ However, the medical school never materialized.

The second attempt at establishing a medical school in Norfolk came in 1857 when the famous Virginia surgeon, Dr. John Peter Mettauer, recognized the value that a formal medical school would have in Norfolk.⁶⁵ Dr. Mettauer had lived in Norfolk at the outbreak of the War of 1812 but moved to Prince Edward County near Farmville, Virginia. In 1837, he organized the Prince Edward Medical Institute, which was soon recognized and accepted by all the leading Eastern medical universities at that time.⁶⁶ Dr. Mettauer made careful plans to affiliate it with Randolph-Macon College in Ashland, Virginia. On 8 June 1854, the Randolph-Macon Board of Trustees favored a plan which originated with Dr. Mettauer, voting that "On application of Dr. Mettauer permission is granted him to remove the medical department of the College to any place in Virginia as he may think advisable," ⁶⁷

Dr. Mettauer envisioned that the last two years of medical school training for students in the medical department of Randolph-Macon College would be completed in Norfolk. Like Thomas Jefferson before him, Dr. Mettauer believed the students of the medical school, in this case Randolph-Macon College, would have the advantage of many and varied medical cases offered by Norfolk's relatively large population. Not only would this be an advantage to the medical students, but to Eastern Virginia and, in particular, to Norfolk. The Hampton Roads area would reap the benefits of the medical students' labor during their last two years of formal medical training in Norfolk. Additionally, there was the possibility that these medical students might decide to stay in this part of the state after their graduation and practice medicine.

The Prince Edward Medical Institute operated for several years in affiliation with Randolph-Macon College.⁶⁸ However, the second step, that of a medical school in Norfolk, was lost due to the War between the States. Dr. Mettauer's medical school closed for the war and never reopened.⁶⁹

Medical Schools in Virginia during the 1800s

In all, ten attempts were made at establishing medical schools in Virginia during the nineteenth century. The first attempt, as previously noted, was in 1812 in Norfolk. The second attempt was planned for William and

Mary College in 1824 by Thomas Jefferson. Both attempts failed because of insufficient financial and political backing.⁷⁰ Of the subsequent eight attempts, all eight were initially successful; however, only three of those eight medical schools continued to survive into the twentieth century.

The third attempt at establishing a formal medical school in Virginia during the nineteenth century succeeded. Founded in Charlottesville in 1825, the Medical School of the University of Virginia was the twentieth chartered medical school in the United States.⁷¹ It is the oldest medical school in Virginia still in existence.⁷²

The Winchester Medical School was founded in 1825 in the City of Winchester. It was the fourth attempt to establish a medical school in Virginia and operated successfully for thirty-seven years. However, because of the War between the States, it was discontinued in 1862 when General Banks of the Union Army destroyed it by burning it to the ground. The Winchester Medical School closed and never reopened.⁷³

The Prince Edward Medical Institute, founded by Dr. Mettauer in 1837, became the fifth attempt at establishing a medical school in Virginia during the nineteenth century. As previously noted, it was closed during the War between the States and never reopened.

The first medical school chartered in the City of Richmond was the Medical Department of Hampden-Sydney

College. It was the sixth attempt at creating a medical school in Virginia. Founded on 5 November 1838, it was originally located on the corner of Main and Nineteenth Streets in the Union Hotel,⁷⁴ but in 1845 it moved to the Egyptian Building on Academy Square and was renamed the Medical College of Virginia.⁷⁵ The Medical College of Virginia prospered and has become the second oldest surviving medical college in Virginia.

The seventh and eighth attempts at establishing a medical school in Virginia were in Petersburg in the mid-1800s. The Scientific Eclectic Medical Institute was chartered on 8 March 1847.⁷⁶ About five years later, the Petersburg Primary Medical School was founded.⁷⁷ Financial problems caused both the Scientific Eclectic Medical Institute and the Petersburg Primary Medical School to discontinue operations within a few years.⁷⁸

As previously mentioned, an attempt in 1857 by Dr. John Peter Mettauer to establish a medical school in Norfolk failed. This was the ninth attempt during the nineteenth century at establishing a medical school in Virginia.

The University College of Medicine was the second medical school founded in the City of Richmond during the nineteenth century and the tenth and final attempt at establishing a medical school in Virginia during the nineteenth century. Chartered in 1893, it was located in McGuire Hall on East Clay Street in Richmond.⁷⁹ Like many of its predecessors, within a few years financial problems

beset it. In 1913 the University College of Medicine merged with the financially more stable Medical College of Virginia. The union of the two medical colleges retained the name of the larger, financially more stable Medical College of Virginia.⁸⁰

Medical School Standards in the 1800s

During the eighteenth century and midway through the nineteenth century, medical education standards in the United States were practically nonexistent. Most medical schools required less than two years of formal medical training beyond high school. In his book History of Medical Education and Institutions in the United States published in 1851, N. D. Davis reported that in 1850 the University of Virginia had extended from two months to ten months its formal medical training requirement for the degree of doctor of medicine.⁸¹ Such was the norm rather than the exception for most, if not all, medical schools in the United States until the latter part of the nineteenth century.⁸²

Many physicians in the United States were concerned about the low academic standards maintained by a large proportion of this nation's medical schools. In reaction, the first National Medical Convention convened in New York City in 1846.⁸³ Its members developed procedures for a thorough examination of the problems of medical education in the United States and provided the groundwork for the establishment of the American Medical Association (AMA).⁸⁴

At the 1847 National Medical Convention in Philadelphia, it was reported that the survey results of nineteen medical colleges in the United States indicated that there was great variation among medical schools as to the number of faculty members, student requirements, and school standards. For example, of the medical schools surveyed, the number of professors varied from three to eight; the school term extended from three months in some institutions to eight months in others; and clinical instruction was required in some institutions, but not in others.⁸⁵

There is no question that medical education was deficient. Many physicians were practicing medicine without any formal training except what they had learned as apprentices.⁸⁶ Many were poorly educated. In most cases, the blame rested with the medical school. Faced with financial problems, many medical schools needed the student's tuition fee to continue operations. As a result, many medical schools found it financially necessary to lower academic requirements and reduce the duration of the academic term in order to attract more applicants. Many well-trained physicians frowned upon their ill-educated colleagues and called for reform.⁸⁷

Virginia, like many other states, had several medical schools in the mid-nineteenth century. These medical schools were representative of the great variation in the quality of American medical schools alluded to by the

National Medical Convention in 1847.

In 1848 the American Medical Association sent circulars to all the county clerks in Virginia, asking for information on the physicians who were actively practicing medicine in their district. Two-thirds of the county clerks responded. The returns indicated that 678 of the 972 physicians in those counties had received degrees from medical colleges. More than one-fourth of the physicians, 249, practiced medicine without any authority at all; 228 of those had no formal medical training whatsoever. Most of this latter group practiced medicine in the western counties of the state.⁸⁸

The need for reform in medical education on a national scale was evident. In 1849 the AMA Committee on Medical Education recommended that state medical societies be established where none existed. As a first step toward reform, the state medical society was seen as a means of strengthening the AMA's control on medical education in the United States.⁸⁹ As previously noted, the Norfolk County Medical Society was organized in the City of Norfolk on 3 June 1870.⁹⁰

In 1876 Dr. J. S. Billings, assistant to the Surgeon General of the United States Army, published an article on American medical education entitled "A Century of American Medicine, 1776-1876." Speaking of the requirements and standards for admission and graduation at American medical schools, Dr. Billings stated:

Certainly the standard for admission and for graduation at almost all our medical schools is too low, and one-half, at least, of these schools have no sufficient reason for existence; but it is not probable that it would improve matters much to establish a uniform, which must, of course, be a minimum, standard.⁹¹

Dr. Billings' attitude toward medical education in this country was shared by a large proportion of the medical community. Many physicians recognized that there was enormous differences in the quality of medical education among medical schools in the United States; however, only a much smaller proportion of the medical community wanted uniform standards established for physicians or medical schools.

Although a few medical colleges did react favorably to the AMA's proposals on medical education, most did not.⁹² Because of the continued lack of uniformity among state licensing boards, requirements for medical school admission and graduation varied from one state to another. Early in the twentieth century state laws were slowly, but steadily, put into effect to recognize the need for higher medical school standards. State licensing boards raised their academic requirements.⁹³ Many medical schools responded by modernizing their laboratories and clinical facilities and enlarging their libraries. Tuition fees increased.⁹⁴ Within a few years, many of the medical schools had increased their academic year from less than four months to a minimum of six months and the duration of training from less than two years to four and five years beyond high

school.⁹⁵

On 20 April 1905 the AMA held a conference in Chicago to gain support for elevating the standards in American medical education.⁹⁶ Members from state medical societies, the Association of American Medical Colleges, and the Southern Medical College Association attended. As a result of this conference, the AMA's Council on Medical Education was organized and tasked with making suggestions on how to improve medical education and influence the colleges to accept higher standards.⁹⁷ The Council on Medical Education took this issue to the Carnegie Foundation and requested a thorough investigation. The result was the Flexner Report of 1910.

The Flexner Report

The chairperson of the AMA's Council on Medical Education, Arthur D. Bevan, met in 1907 with the president of the Carnegie Foundation, Henry S. Pritchett, and requested that the Carnegie Foundation for the Advancement of Teaching conduct an investigation and study American medical schools.⁹⁸ The intent was to improve the public image of the AMA and to strengthen the hand of the AMA's Council on Medical Education with the medical schools. Unlike the Council on Medical Education, it was believed that the Carnegie Foundation would be viewed by the public as an impartial investigator, thus making their findings more credible and acceptable by both the public and the

medical community.⁹⁹ Moreover, Dr. Bevan believed that because the AMA and its Council on Medical Education represented physicians and medical colleges, it was somewhat unethical for them to publicly condemn other physicians and medical colleges. Any public condemnation of the existing situation had to come from an outside agency with no direct relationship to organized medicine so that any action would be viewed as impartial and moral. It had to be an agency that would not derive any direct benefit from medical reform.¹⁰⁰

The Carnegie Foundation agreed to conduct the investigation of American medical schools. A former headmaster, Abraham Flexner, was hired to supervise the project. Flexner had received his bachelor's degree at Johns Hopkins University, and, no doubt, many of his subsequent findings were influenced by the standards of the medical school at Johns Hopkins.¹⁰¹

Accompanied by N. P. Colwell, the secretary of the AMA's Council on Medical Education, Flexner visited each of the nation's medical schools between January 1909 and April 1910.¹⁰² As a representative of the Carnegie Foundation, administrators for many of the medical schools probably viewed Mr. Flexner's visit as an opportunity to show their need for funds and, in return, receive a handsome endowment from the philanthropist.¹⁰³ In The Social Transformation of American Medicine, Paul Starr states that doors were, most likely, opened to Flexner "that otherwise would have been

closed"¹⁰⁴ to other representatives of the AMA.

Significant Facts Revealed by Flexner's Study
of Medical Schools

Abraham Flexner submitted his final report to the Carnegie Commission in 1910.¹⁰⁵ He attacked the validity of the claims made in the catalogues of many of the financially weak proprietary schools. In his 1910 report to the Carnegie Foundation, Flexner stated:

Low standards give the medical schools access to a large clientele open to successful exploitation by commercial methods. The crude boy or the jaded clerk who goes into medicine at this level has not been moved by a significant prompting from within; nor has he as a rule shown any forethought in the matter of making himself ready. He is more likely to have been caught drifting at a vacant moment by an alluring advertisement or announcement, quite commonly an exaggeration, not infrequently an outright misrepresentation. Indeed, the advertising methods of the commercially successful schools are amazing. Not infrequently advertising costs more than laboratories. The School catalogues abound in exaggeration, misstatement, and half-truths. The deans of these institutions occasionally know more about modern advertising than about modern medical teaching.¹⁰⁶

Paraphrasing Flexner's description of many of the medical schools, Paul Starr states:

Touted laboratories were nowhere to be found, or consisted of a few vagrant test tubes squirreled away in a cigar box; corpses reeked because of the failure to use disinfectant in the dissecting rooms. Libraries had no books; alleged faculty members were busily occupied in private practice. Purported requirements for admission were waived for anyone who would pay the fees.¹⁰⁷

Abraham Flexner's descriptions of the poorer schools were graphic. For the financially stronger schools, however, his comments were much less harsh. He only endorsed wholeheartedly one medical school--his alma mater,

Johns Hopkins University.¹⁰⁸ It should be noted that Johns Hopkins University in Baltimore, Maryland, derived its name from its founder, Johns Hopkins, who was a wealthy banker and merchant. Upon his death in 1873, he bequeathed seven million dollars to establish and divide equally among a university and a coexisting medical school.¹⁰⁹ This was an enormous endowment for any academic institution in the late nineteenth century. Of the Johns Hopkins Medical School, Flexner stated:

This [Johns Hopkins Medical School] was the first medical school in America [established in 1893] of genuine university type, with something approaching adequate endowment, well equipped laboratories conducted by modern teachers, devoting themselves unreservedly to medical investigation and instruction, and with its own hospital, in which the training of physicians and the healing of the sick harmoniously combine to the infinite advantage of both. The influence of this new foundation can hardly be overstated.¹¹⁰

In his 1910 report to the Carnegie Foundation, Abraham Flexner stressed that the four basic areas that medical schools needed to improve upon were:

1. The basis of medicine
2. The importance of research
3. The significance of the scientific method in medical practice
4. The need for university control of hospitals in clinical teaching¹¹¹

On the latter point of a university hospital for clinical instruction, Flexner emphasized:

1. The hospital must be of sufficient size.
2. It must be equipped with teaching and working quarters closely interwoven in organization and

conduct with the fundamental laboratories of the medical school.

3. The school faculty must be the sole and entire hospital staff, appointment to which follows automatically after appointment to the corresponding school position.
4. The teaching arrangements to be adopted must be left to the discretion and judgment of the teachers, subject only to such oversight as will protect the welfare of the individual patient.¹¹²

According to Paul Starr, Flexner recommended that the best medical schools be strengthened and "the remainder, the great majority of schools, ought to be extinguished. America was over-supplied with badly trained practitioners; it could do with fewer but better doctors."¹¹³

Abraham Flexner contended that the nation's large number of medical schools had resulted in an overproduction of physicians of which many were unqualified. He recommended that the number of medical schools in the United States be reduced to between thirty and thirty-six in an effort to reduce the oversupply of physicians. With a reduction in the number of the nation's medical schools, the supply of physicians could be maintained at a feasible level.¹¹⁴ In partial defense of his contention, Flexner offered the following:

Professor Paulsen, describing in his book on the German Universities the increased importance of the medical profession, reports with some astonishment that "the number of physicians has increased with great rapidity so that now there is, in Germany, one doctor for every 2000 souls, and in the large cities one for every 1000." What would the amazed philosopher have said had he known that in the entire United States there is already on the average one doctor for every 568 persons, that in our large cities there is frequently one doctor

for every 400 or less, that many small towns with less than 200 inhabitants each have two or three physicians apiece!¹¹⁵

The excessive number of medical schools in the United States and the inherent oversupply of physicians was generally recognized years before Abraham Flexner's report. In his article "Medical Education and the State," published in the Journal of the American Medical Association in 1902, Dr. Walter A. Wells wrote:

There are . . . according to the Association of American Medical Colleges, 170 schools of medicine in the United States. One-half . . . would more than suffice; indeed, if the number were proportioned to the population as in Germany (the country in which medical education is generally conceded to have attained the summit of organization), there would be but thirty colleges in the entire United States, We have, in fact, the largest number of medical colleges in proportion to the population of any country in the world, it being one to about every 440,000 inhabitants.¹¹⁶

Henry S. Pritchett, president of the Carnegie Foundation at the time of Abraham Flexner's study on American medical schools, wrote the introduction to Flexner's final report which was submitted to the Carnegie Foundation in 1910. In his introduction, Pritchett emphasized five significant points revealed by Flexner's study:

1. For twenty-five years past there has been an enormous over-production of uneducated and ill trained medical practitioners. This has been in absolute disregard of the public welfare and without any serious thought of the interests of the public. Taking the United States as a whole, physicians are four or five times as numerous in proportion to population as in older countries like Germany.
2. Over-production of ill trained men is due in the main to the existence of a very large number of commercial

schools, sustained in many cases by advertising methods through which a mass of unprepared youth is drawn out of industrial occupations into the study of medicine.

3. Until recently the conduct of a medical school was a profitable business, for the methods of instruction were mainly didactic. As the need for laboratories has become more keenly felt, the expenses of an efficient medical school have been greatly increased. The inadequacy of many of these schools may be judged from the fact that nearly half of all our medical schools have [annual] incomes below \$10,000, and these incomes determine the quality of instruction that they can and do offer. . . . Colleges and universities have in large measure failed in the past twenty-five years to appreciate the great advance in medical education and the increased cost of teaching it along modern lines. Many universities desirous of apparent educational completeness have annexed medical schools without making themselves responsible either for the standards of the professional schools or for their support.
4. The existence of many of these unnecessary and inadequate medical schools has been defended by the argument that a poor medical school is justified in the interest of the poor boy. It is clear that the poor boy has no right to go into any profession for which he is not willing to obtain adequate preparation; but the facts set forth in this report [Flexner's 1910 report] make it evident that this argument is insincere, and that the excuse which has hitherto been put forward in the name of the poor boy is in reality an argument in behalf of the poor medical school.
5. A hospital under complete educational control is as necessary to a medical school as is a laboratory of chemistry or pathology. High grade teaching within a hospital introduces a most wholesome and beneficial influence into its routine. Trustees of hospitals, public and private, should therefore go to the limit of their authority in opening hospital wards to teaching, provided only that the universities secure sufficient funds on their side to employ as teachers men who are devoted to clinical science.¹¹⁷

Reform in Medical Education Prior to the Flexner Report

Early in the 1900s before the publication of

Flexner's report, major changes occurred in medical education. For example, the number of medical schools in the United States between the years 1906 and 1910 decreased, not because of the widespread attention received by Abraham Flexner's 1910 report, but for other reasons such as financial problems faced by many medical schools. This was, in large part, due to the steadily rising requirements mandated by state licensing boards. State laws were enacted requiring medical schools to modernize their laboratories and clinical facilities and to enlarge their libraries. In many cases, medical schools were required to increase the period of formal medical training from two to four years beyond high school. As a result, medical schools were forced to increase tuition fees in order to comply with state requirements. Student enrollments dropped, and many medical schools were forced to cease operations.¹¹⁸

According to Dr. Wyndham Blanton, an American historian on eighteenth and nineteenth century medicine in the United States, major reform of American medical colleges began in 1907 when the AMA reviewed existing medical colleges and graded them on the basis of their admission requirements, curriculum, physical equipment, clinical facilities, and number of full-time faculty members. He concluded that the decrease in the number of medical colleges in the United States between 1907 and 1925 was a direct result of the negative publicity leveled at medical colleges by the AMA.¹¹⁹

In 1904 there were 166 medical schools in the United States.¹²⁰ In 1910, the year of the Flexner Report, the number of medical schools had dropped to 131.¹²¹ By 1915, the number of medical schools in the United States had declined to 95.¹²² The decrease continued and in 1925 there were only 80 medical schools in the United States.¹²³ The number of medical schools reached a low of 66 in 1933.¹²⁴

Flexner's Comments on Virginia's Medical Schools

There were only three medical schools in the state of Virginia at the time of Abraham Flexner's visit in February 1909. They were the University of Virginia Department of Medicine in Charlottesville, the Medical College of Virginia in Richmond, and the University College of Medicine in Richmond.¹²⁵ After his visit to each of these medical schools, Flexner indicated that the University of Virginia was one of the better medical schools in the United States.¹²⁶ In his 1910 report, Flexner pointed out that the University of Virginia should possibly consider the City of Norfolk as a site for an extension of its medical department. In one of his two references to Norfolk, Flexner stated ". . . whether it [the University of Virginia] would do better to operate a remote [medical] department at Richmond or Norfolk, the future will determine."¹²⁷ A reprint of Flexner's evaluation notes on the three medical schools in Virginia, as reported to the Carnegie Foundation, is provided in appendix 4.

In his 1910 report to the Carnegie Foundation, Flexner made the following general comments about Virginia's three medical schools:

The destruction by fire of the University College of Medicine at Richmond should precipitate the consolidation of the two independent schools [in Richmond]. Separately neither of them can hope greatly to improve its present facilities, which, weak in respect to laboratories and laboratory teaching, are entirely inadequate on the clinical side. Their present hospitals utilized together, though still unsatisfactory, would at any rate be much more nearly adequate than is either hospital taken by itself; and the combined fees would furnish much better laboratory training than either school now gives. A single independent school of the better type might still have in Virginia a brief term of prosperity,--the more so as the medical department of the University of Virginia is on a considerably higher [educational] basis.

The rapid improvement of the medical department of the University of Virginia in the last three years is one of the striking phenomena of recent medical school history. The limitations of Charlottesville have been acutely felt; the university is pursuing the course calculated to surmount them. It faces indeed a much greater outlay than it has yet made, for larger clinics in internal medicine and obstetrics must be developed. The alternative of a remote department diminishes difficulty of one kind only to create difficulty of another. A remote department at Norfolk or Richmond would of course command abundant clinical material; but could it preserve university ideals? The present resources of the university are not large enough to stand the strain of such liberal support as a remote department needs if it is to be genuinely productive. The experience of a few years warrants the belief that a clinic in most lines, for a school of 200 students, can be developed at Charlottesville if the university can afford it. Graduating classes of 50 easily suffice for Virginia's demand. At any rate, so much is evident: in Virginia, as elsewhere, the teaching of medicine will fall to the universities; and at this writing, the only institution available is the University of Virginia.¹²⁵

Aftermath of the Flexner Report

The effect of the Flexner report, in conjunction with the continuing work of the American Medical Association, the

Association of American Medical Colleges, the Southern Medical College Association, and state medical societies, was a drastic reduction in the number of medical schools and a vast improvement in the quality of medical education. Although the report tried to develop a national system of medical education, it ignored certain local factors. The report blamed the existing medical education situation on the medical schools' professors, who were virtually helpless. Their salaries were paid by the medical school, and most medical schools were operating on budgets that prohibited them from modernizing their facilities as Abraham Flexner had recommended.¹²⁹

Flexner realized that in order to improve the quality of medical school education in this country, a reference point or model was necessary. His reference point was Johns Hopkins University.¹³⁰ Every medical school in the country, by comparison, failed in its attempt to provide modern medical training.¹³¹

In his 1977 article "New Light on the Flexner Report: Notes on the AMA-Carnegie Foundation Background," Howard S. Berliner stated that the Flexner report "has received attention far out of proportion to its actual contribution to medical education [and that] dwelling on the report serves only to mask the real dynamics of the period and the inner reasons for the changes occurring in [American] medical education."¹³² The report "did not, by itself, create change in medical education, rather it was the money

poured into medical education by the large foundations" that provided the impetus for change.¹³³

Nevertheless, the Flexner report of 1910 did establish a specific benchmark against which all programs of medical education could be measured. It did so by advocating that a firm scientific base should be combined with practical clinical experience in a university setting.¹³⁴ A new era in medical education was underway.

FOOTNOTES

¹Thomas J. Wertenbaker, Norfolk: Historical Southern Port (Durham, N.C.: Duke University Press, 1962), p. 8.

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³"Norfolk Virginia," Norfolk Virginian, 1897, p. 7.

⁴Ibid.

⁵Wertenbaker, p. 47.

⁶Ibid., p. 62.

⁷"When All Norfolk Was Burned," The Virginian Pilot and the Portsmouth Star, 6 January 1957, p. C-2.

⁸Wertenbaker, p. 86.

⁹Ibid., pp. 188-97.

¹⁰Geoffrey Marks and William K. Beatty, The Story of Medicine in America (New York: Charles Scribner & Sons, 1973), p. 236.

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¹⁷Ibid., p. 2.

¹⁸City of Norfolk, Virginia, Census of 1850.

- ¹⁹Forrest, pp. 231-32 and 248.
- ²⁰Ibid., pp. 250-58.
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- ²²Wertenbaker, pp. 207-18.
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- ²⁴Blanton, pp. 217-18.
- ²⁵The Norfolk Academy of Medicine, pp. 15-16.
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- ²⁸Ibid.
- ²⁹Ibid., pp. 9-11.
- ³⁰Raymond P. Sloan, Not for Ourselves Alone: The Story of Norfolk General Hospital (Charlottesville, Va.: The Michie Co., 1969), pp. 14-16.
- ³¹Ibid., p. 19.
- ³²Albin Trant Butt, ed., A Century of Service to the Sick--The 100 Year History of the Hospital of St. Vincent De Paul (Norfolk, Va.: n.p., 1957), pp. 9-11.
- ³³Ibid., pp. 20-39.
- ³⁴Interview with R. Bryan Grinnan, Jr., M.D., Norfolk, Virginia, 11 December 1986.
- ³⁵Blanton, p. 218.
- ³⁶Interview with R. Bryan Grinnan, Jr., M.D., 11 December 1986.
- ³⁷Blanton, p. 218.
- ³⁸Ibid.
- ³⁹Holcomb, pp. 161-63.

⁴⁰Mildred M. Holladay, "History of Portsmouth," The Portsmouth Star, Portsmouth, Virginia, 19 January 1936, p. 10.

⁴¹Blanton, p. 217.

⁴²Ibid.

⁴³Ibid., pp. 217-18.

⁴⁴John Franklin, M.D., personal papers, "Jefferson's School of Medicine at the College of William and Mary in Virginia." Moorman Memorial Library (archives), Eastern Virginia Medical School, Norfolk, Virginia, n.d.

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⁵⁶J. S. Billings, "A Century of American Medicine, 1776-1876," in The American Journal of Medical Sciences, ed. Issac Hays (Philadelphia: Henry C. Lea, 1876), pp. 476-77.

⁵⁷Ibid., 475-77.

⁵⁸Ibid.

⁵⁹Blanton, pp. 13-14.

⁶⁰Honeywell, pp. 265-68.

⁶¹Ibid., pp. 266-67.

⁶²Blanton, pp. 13-14.

⁶³Adams, pp. 38-39 and 59-61.

⁶⁴Norfolk Gazette, Norfolk, Virginia, 17 July 1812, p. 1.

⁶⁵Blanton, pp. 31-36.

⁶⁶Ibid., pp. 34-35.

⁶⁷Ibid., p. 33.

⁶⁸Ibid.

⁶⁹Ibid.

⁷⁰Blanton, p. 5; and Adams, pp. 59-61

⁷¹Francis R. Packard, M.D., History of Medicine in the United States (New York: Hafer Publishing Co., 1963), p. 1209.

⁷²Billings, p. 476.

⁷³Blanton, pp. 16-19.

⁷⁴Medical College of Virginia, The First 125 Years, 1838-1963, Bulletin LXI (Richmond, Va.: n.p., Fall 1963), p. 8.

⁷⁵Ibid.

⁷⁶Blanton, p. 8.

⁷⁷Ibid., p. 7.

⁷⁸Ibid., pp. 7-8.

⁷⁹Ibid., pp. 65-66.

⁸⁰Charles M. Caravati, M.D., Medicine in Richmond, 1900-1975 (Richmond, Va.: Richmond Academy of Medicine, 1975), p. XIII.

⁸¹N. S. Davis, History of Medical Education and Institutions in the United States, cited by Francis R. Packard, M.D., History of Medicine in the United States (New York: Hafner Publishing Co., 1963), p. 1208.

⁸²Blanton, pp. 133-44.

⁸³N. S. Davis, History of the American Medical Association from Its Organization up to January 1855 (Philadelphia: n.p., 1855), p. 23.

⁸⁴Ibid., pp. 23-37.

⁸⁵National Medical Convention, Proceedings of the National Medical Conventions Held in New York, May 1846, and in Philadelphia, May 1847 (Philadelphia: n.p., 1847), pp. 63-70.

⁸⁶American Medical Association, Transactions of the American Medical Association, 1848 1 (Philadelphia, n.p., 1848):359-60.

⁸⁷Ibid., 2(1849):40-41.

⁸⁸Ibid., 1(1848):359-64.

⁸⁹Ibid., 2(1849):40-41.

⁹⁰Blanton, p. 97.

⁹¹Billings, p. 480.

⁹²William Pepper, Higher Medical Education (Philadelphia, n.p., 1894), pp. 24-25.

⁹³James R. Parsons, Jr., "Preliminary Education, Professional Training and Practice in New York," Journal of the American Medical Association 26 (13 June 1896):1149-52.

⁹⁴John B. Deaver, M.D., "Medical Education," Journal of the American Medical Association 38 (15 March 1902): 683-85.

⁹⁵Walter A. Wells, M.D., "Medical Education and the State," Journal of the American Medical Association 38 (5 April 1902):861-67.

⁹⁶AMA Council on Medical Education, Report of the First Annual Conference, 1905 (Chicago: n.p., 1905), pp. 7-8.

⁹⁷Ibid.

⁹⁸Paul Starr, The Social Transformation of American Medicine (New York: Basic Books, 1982), p. 118.

⁹⁹Howard S. Berliner, "New Light on the Flexner Report: Notes on the AMA--Carnegie Foundation Background," Bulletin of the History of Medicine 51 (Baltimore: The Johns Hopkins University Press, 1977), p. 606.

¹⁰⁰Starr, p. 118.

¹⁰¹Ibid.

¹⁰²Ibid., p. 119; and Abraham Flexner, Medical Education in the United States and Canada--A Report to the Carnegie Foundation for the Advancement of Teaching, with an Introduction by Henry S. Pritchett (New York City: n.p., 1910; reprint ed., Medicine & Society in America, New York: Arno Press, 1972), pp. 185-319.

¹⁰³Starr, p. 119.

¹⁰⁴Ibid.

¹⁰⁵Ibid., p. 118.

¹⁰⁶Flexner, pp. 18-19.

¹⁰⁷Starr, p. 119.

¹⁰⁸Ibid., p. 120.

¹⁰⁹Encyclopedia Americana, 1983 ed., s.v. "Johns Hopkins."

¹¹⁰Flexner, p. 12.

¹¹¹Ibid., pp. 20-104.

¹¹²Flexner, p. 106.

¹¹³Starr, p. 120.

¹¹⁴Flexner, pp. 151-54.

¹¹⁵Ibid., p. 14.

¹¹⁶Wells, pp. 862-63.

¹¹⁷Ibid., pp. x-xi.

¹¹⁸Ibid., p. 118.

¹¹⁹Blanton, p. 9.

¹²⁰John S. Haller, Jr., American Medicine in Transition, 1840-1910 (Chicago: University of Illinois Press, 1981), p. 228.

¹²¹Starr, p. 118.

¹²²Ibid., p. 120.

¹²³Blanton, p. 9.

¹²⁴Haller, p. 228.

¹²⁵Flexner, pp. 314-16.

¹²⁶Ibid., pp. 109, 111, 314-15.

¹²⁷Ibid., p. 148.

¹²⁸Ibid., p. 316.

¹²⁹Ibid., pp. 126-30.

¹³⁰Ibid., pp. 12.

¹³¹Ibid., pp. 37-38.

¹³²Berlinger, p. 608.

¹³³Ibid.

¹³⁴Flexner, pp. 28-51.

CHAPTER III

MEDICAL CLIMATE AND EDUCATION

IN NORFOLK: 1900-1959

Population and Medical Schools

In 1900 the population of the United States was approximately 76 million;¹ for Virginia it was 1.9 million;² and for Norfolk it was 47,000.³ By 1920, the population of the United States had increased 39 percent to an estimated 106 million,⁴ Virginia's population had increased 21 percent to 2.3 million,⁵ and Norfolk's population had more than doubled to 116,000.⁶

Of the 162 medical colleges in the United States in 1904,⁷ only three were located in Virginia. By 1920 the number of medical schools in the United States had decreased to eighty-six⁸ with only two located in Virginia. Of the eighty-six medical schools, seventy-four were four-year programs, seventy-seven were regular or non-sectarian, five were homeopathic, one was eclectic, and three were classified as "non-descript affairs."⁹

The number of medical schools in the United States continued to decline from 1920 until the late 1940s. It was then that the seriousness of an inadequate number of medical schools providing a less than optimum annual number of

graduates was recognized and a concerted effort begun on a national scale to correct the problem.¹⁰ The number of medical schools did not reach eighty-six again until 1970.¹¹ While several medical schools ceased operations during the fifty years from 1920 to 1970, an equal number were created; therefore, the total number of medical schools in the United States remained at eighty-six in 1970.¹²

In his article "Report of Council on Medical Education" which appeared in the May 1920 issue of the Journal of the American Medical Association, Dr. A. D. Bevan, chairman of the Council on Medical Education, estimated that the United States had over half of the world's supply of medical schools in 1904.¹³ At that time there were 162 medical schools in the United States; however, the number of medical schools dropped drastically during the ensuing two decades.¹⁴

Medical school admission standards increased and state licencing laws became more strict in the early 1900s.¹⁵ As a result, some medical schools were forced to close. Since the remaining medical schools did not appreciably increase their student enrollment, the nation's annual number of medical school graduates steadily decreased over the next twenty years.

In 1904 there were over 28,000 medical students attending the 162 medical schools in the United States.¹⁶ In 1910 American medical schools graduated over 4,400 students.¹⁷ The number of medical schools had decreased to

less than ninety by 1919 with total student enrollment numbering just over 13,000.¹⁸ The annual number of medical school graduates decreased to 3,047 in 1919.¹⁹ Dr. Bevan wrote in 1920:

The trend of medical schools to limit their enrollments of medical students is in the interests of better medical education. . . . With the higher standards adopted during the last sixteen years the requirements for admission to medical schools in the United States are now on par with other leading countries.²⁰

Only four of the 160 medical schools in 1906 required two or more years of college preparation as a prerequisite for admission to medical school. In contrast, seventy-nine of the eighty-six medical schools in 1920 required at least two years of college preparation.²¹

Need for Physicians during the First Half
of the Twentieth Century

For the six decades following 1913, Virginia had only two medical schools--the Medical School of the University of Virginia in Charlottesville and the Medical College of Virginia in Richmond.²² Norfolk's need for physicians in the early 1900s was demonstrated by the lack of physicians to respond to the periodic outbreaks of smallpox and diphtheria that plagued the area as noted in municipal records and the minutes of various meetings of the Norfolk County Medical Society.²³

Dr. Bevan's 1920 report to the Council on Medical Education noted that there was no shortage of physicians in the United States. On the contrary, there was probably an

oversupply of physicians. The problem was that there was a need for a better distribution of physicians.²⁴ As support to his contention, Dr. Bevan offered a comparison of the physician-to-population ratio in the United States versus that of Great Britain. The United States had one physician for every 720 people in 1919 compared to one for every 1500 people in Great Britain.²⁵ The perceived shortage of physicians in the United States in 1919 was due more to the maldistribution of physicians and not to any actual shortage of physicians. Nevertheless, it was viewed by many as a major problem.

Drs. John W. Cline and Vernon W. Lippard reported in 1958 that the number of physicians per 100,000 population in the United States between 1920 and 1955 remained relatively constant.²⁶ Leland S. McKittrick, M.D., in his article "Reason Underlying Conference on Medical Education and Licensure," substantiates the assertion of Cline and Lippard.²⁷ In 1920 the physician-to-population ratio in the United States was 137, decreased to 133 by 1940 and remained at 133 for the next fifteen years, despite a significant increase in the nation's overall population.²⁸

R. Bryan Grinnan, Jr., M.D., retired, was a practicing Norfolk physician from 1936 until 1978. As the author of several articles on the history of local medicine, Dr. Grinnan has noted that in the 1960s the proponents of the Eastern Virginia Medical School stressed the low physician-to-population ratio in Eastern Virginia, and used

this statistic as part of their rationale for a medical school in Norfolk.²⁹ Both state and national statistics support Dr. Grinnan's contention.³⁰

Change in Medical School Curriculum
and Academic Year

In 1920 American medical schools based their course of study on the assumption that after graduation and a year or two of internship, the physician would be prepared to enter general practice and deal with almost any problem that might be encountered, including most major surgery. Consequently, the volume of material to be covered in four years of medical school study became greater and each course inherently more superficial. This led to unrest on the part of many faculty members who felt that important areas of their specialization were not being adequately addressed.³¹ This unrest resulted in two major changes affecting the curriculum at many medical schools. First, the hours devoted to some subjects decreased. Second, the academic year increased.³² Dr. Vernon Lippard noted:

While in the 1920s the program leading to the medical degree occupied four academic years, each of approximately thirty-two weeks, by the end of the 1960s the average year was nearer thirty-six weeks and many schools required the student to be in residence during most of one or two summers.³³

Norfolk: Its Concern for Public Health
1915-1918

Norfolk's concern for the health of its citizens continued after Abraham Flexner's 1910 report on medical

conditions in the United States. In 1910 the general death rate in Norfolk was 18.1 per 1,000 population.³⁴ Both tuberculosis and typhoid fever were serious problems for Norfolk in 1910, accounting for 260.7 and 53.9 deaths per 100,000 population, respectively.³⁵ A partial reprint from a 1920 article in The Virginia Medical Monthly describing health conditions in Norfolk during that period is offered in appendix 5.

As late as 1915 Norfolk employed its health director only on a part-time basis.³⁶ According to city documents, the Norfolk City health director received a salary of \$2,500.00 per year in 1915. To subsidize his salary, he was allowed to maintain a private medical practice. He determined the amount of time he would devote to the service of the City of Norfolk since there was no city ordinance concerning this matter.³⁷

In 1915 the Norfolk City Council recommended that the position of city health director be made a full-time position with an annual salary of at least \$4,000.00.³⁸ In an attempt to obtain the best qualified person, the former requirements that the city's health director be both a physician and a resident of Norfolk were discontinued.³⁹ The new policy for the position of city health director was based on experience and ability.

The per capita cost for Norfolk's health services in 1915 amounted to less than fifty-six cents.⁴⁰ The total appropriation for health conservation for fiscal year 1915

was divided as shown in table 1.

TABLE 1

HEALTH EXPENDITURES FOR THE CITY OF NORFOLK, 1915

Health Department:	
Ordinary	\$38,138.49
Extraordinary	550.00
City veterinarian	2,311.00
Anti-tuberculosis league	1,000.00
Board of quarantine commissioners	240.00
Modified milk	400.00
Salaries for physicians and nurses for inspection of school children and for the City Home	<u>5,350.00</u>
TOTAL	\$49,189.49

SOURCE: Norfolk, Va., Report on a Survey of the City Government (New York, N.Y.: Bureau of Municipal Research, 1915), p. 335.

The City of Norfolk had one of the highest infant mortality rates of southern cities during the early 1900s.⁴¹ According to the report of the New York Milk Committee, the infant mortality rate in 1913 for the City of Richmond, Virginia, was 162.1 per thousand; Birmingham, Alabama, 120.8; Louisville, Kentucky, 129.2; and Nashville, Tennessee, 127.8.⁴² In the 1915 Report on a Survey of the City Government, Norfolk's infant mortality rate was reported to be 191 per thousand.⁴³ Two reasons were noted for Norfolk's high infant mortality rate. First, milk standards were inadequate and often resulted in its victims getting gastroenteritis. Secondly, the health department was inappropriately organized. The latter was considered the chief reason for the high infant mortality rate in

Norfolk.⁴⁴

Recognition of the Need for Medical Education
in Norfolk, 1918-1919

The first public recognition of the need for a medical school in Norfolk in the twentieth century was by Dr. Charles R. Grandy in 1918. He recommended that a medical school should be constructed in Norfolk and that it should be affiliated with Atlantic University in Virginia Beach.⁴⁵

Dr. Grandy's belief that a newly created medical school should affiliate itself with an established university was shared by other medical school authorities during the 1920s.⁴⁶ Dr. Grandy believed that an established university was essential as the basis for a new medical school because it would offer the new medical school advantages such as a stable financial base, existing classrooms and laboratories, and prospective students.

In 1900 Frederick C. Shattuck enumerated the requisites for a modern medical school. He stated:

[It should have] university connection; the control of sufficient clinical material in hospitals; scientific laboratories, each under . . . a competent head undisturbed by the demands of private practice, and a corps of enthusiastic teachers who care more for the work than for its immediate money return.⁴⁷

In his report to the Council on Medical Education in 1920, Dr. A. D. Bevan noted that sixty-six of the eighty-six medical schools in the United States had become departments within universities, and ". . . 52 of these universities

have assumed full control not only of the entrance qualifications of the students admitted but also of the finances and the methods of teaching. . . ."48 As a result, Dr. Bevan noted that the private medical school without university connection was gradually being replaced by the public, university connected, medical school.49

The American Medical Association described the "essentials of an acceptable medical college" in an attempt to set minimum standards and requirements. A reprint from the June 1920 issue of the Virginia Medical Monthly is provided in appendix 6.

On 3 November 1919 Dr. Southgate Leigh, founder of Leigh Memorial Hospital in Norfolk, suggested to the members of the Norfolk County Medical Society that consideration should be given to the creation in Norfolk of a postgraduate medical school.50 He believed that it would draw medical school students primarily from the Medical School of the University of Virginia and the Medical College of Virginia. The population of Eastern Virginia would be the beneficiaries of the increased quality and quantity of medical services as a result of a local post-graduate medical school. The minutes of the 3 November 1919 Norfolk County Medical Society meeting read, in part:

Dr. Southgate Leigh spoke of the need for closer interest in the proceedings of the Society referring to the wide field open for advance in medical matter in the City. He then suggested that the time was opportune for the establishment in Norfolk of a Post Graduate Medical College and moved the appointment of a Committee to consider and report upon the feasibility of such an

enterprise. The motion was favorably discussed by many members and on being approved the following committee was appointed: Drs. Leigh (Chairman), Taliaferro, Collins, P. S. Schuck, Gwathmey and R. C. Williams.⁵¹

The matter of a proposed postgraduate medical school in Norfolk was not discussed again by the Norfolk County Medical Society until nine years later. The minutes of the 1 October 1928 session of the medical society state, in part:

Dr. N. G. Wilson reported some correspondence with the Chamber of Commerce in which the Chamber inquired as to the opinion of the Society on the feasibility of establishing a Post Graduate Medical School in Norfolk. While the Society is on record as believing this to be the most desirable, it was held that until there was a regular teaching body to supervise the instruction it would be impracticable to make it a success.⁵²

Like Dr. Grandy's recommendation for the establishment of a medical school in Norfolk, no further serious consideration was given to Dr. Leigh's proposal for a post-graduate medical school until several decades later. It should be noted, however, that Norfolk's civic leaders in the 1920s recognized the need for quality health care and acknowledged that the medical community should investigate the feasibility of creating a medical school in Norfolk. Correspondence between officials for the City of Norfolk and the Norfolk County Medical Society reflects a mutual recognition of the need for quality health care in the Hampton Roads area.⁵³

Norfolk: Its Concern for Public Health,
1918-1940

Norfolk's physician population grew dramatically

after World War I primarily as a result of former area physicians returning from the war effort to resume their medical practice in Norfolk. In addition, new physicians were attracted to the area as a result of Norfolk's increased emphasis on health care.⁵⁴ Many of the young physicians who settled in the Norfolk area at that time became life-long residents and prominent members of the medical community.⁵⁵

The population of the Norfolk-Portsmouth area increased more than forty-six percent during the period 1910 to 1920, from 164,912 to 241,148.⁵⁶ Most of this growth was attributed to Norfolk's selection in 1917 as a site by the federal government for a naval base.⁵⁷ The construction of the Norfolk Naval Base and the Norfolk Naval Base-Portsmouth created thousands of new jobs, and many of the people who moved to the area in 1917 to fill these jobs made the Norfolk-Portsmouth area their permanent residence.

Contagious Diseases

At the 1 April 1918 meeting of the Norfolk County Medical Society, Dr. Charles R. Grandy moved that a resolution be adopted to create a hospital in Norfolk for contagious diseases.⁵⁸ On 3 June 1918 Dr. Schuck reported to the members of the medical society that construction of a hospital for contagious diseases was underway.⁵⁹

In the book Norfolk: Historic Southern Port, Thomas J. Wertenbaker discussed the health progress of Norfolk

during the 1920s. He stated:

A contagious disease hospital was established, war was declared on mosquitoes and flies, school children were given medical examinations at stated intervals, dental clinics were established. A bacteriological laboratory was erected where milk and meat were daily tested. No restaurant may serve milk dipped from a can. Every glass comes from a sealed bottle. . . . All fresh meats sold are inspected and stamped. Food manufacturing plants and factories are regularly inspected. . . . Bakeries, ice-cream plants, restaurants were supervised. As a result, Norfolk had the lowest mortality rate from typhoid of all South Atlantic cities. . . . Thus the city, so long considered an unhealthful spot, might now point with pride to its splendid health work and to its low mortality rate.⁶⁰

Quacks and Irregulars

The Norfolk County Medical Society in 1922 turned its attention to the problem of "quacks and irregulars." A special committee consisting of Drs. Burnley Lankford (Chairman), Southgate Leigh, N. G. Wilson, W. L. Harris, C. L. Harrell, P. L. Moncure, and James W. Hunter, was appointed to study the problem and make recommendations to help improve the situation.⁶¹

The 1920s was a time when the Norfolk County Medical Society was striving to improve the quality of medical care for the area's citizenry. Thoughts of creating an area medical school were not yet abandoned. Medically uneducated, self-professed healers threatened these goals, not to mention the harm they posed to those individuals who sought their help. The medical society even identified local members of the medical profession whose substandard work negatively affected the ideals and minimum standards

held by the medical society.⁶²

At its 3 April 1922 meeting, the Norfolk County Medical Society proposed a two-page resolution condemning quacks and irregulars and citing action the City of Norfolk should take to prevent such individuals from applying their trade in Norfolk. This resolution was presented in the form of a city ordinance and submitted to Norfolk's mayor and city council for incorporation into the city's existing ordinances.⁶³

At its 1 May 1922 meeting, the members of the Norfolk County Medical Society discussed at length the issue of quacks and irregulars and "unfavorable prognoses given by our profession."⁶⁴ This latter issue stemmed from some of Norfolk's physicians giving their patients "hopeless prognoses."⁶⁵ As a result, many of these patients in desperation sought help from unlicensed, self-proclaimed healers. The committee to investigate quacks and irregulars submitted the following recommendations to the medical society's members:

1. The continuation of the committee on ordinances, of which Dr. Moncure is chairman.
2. That the Secretary of our Society or Chairman of the Committee on Ordinances communicate with the secretary of the State Board of Medical Examiners and the secretaries of the various medical societies in the State with a view of having ordinances adopted such as has been adopted in Norfolk, as it is believed that the advertising quack, being removed from the cities, will be unable to carry on his work in the country districts.
3. That a permanent Publicity Committee be appointed for the purpose of ascertaining the proper pamphlets to

be placed in our offices for perusal by patients, to keep in touch with the work of the A.M.A. and other societies, to censor the newspapers and collect the advertisements of irregulars and to endeavor to educate ministers of the gospel to a proper sense of their responsibility.

4. That the nurses employed by our patients be given to understand that they are to co-operate with the profession and to maintain a dignified sense of their own responsibility and that some member of the Society be delegated to address the local nurses association and to request their cooperation in combating quacks.
5. That it is the sense of the committee that it is unethical for a member of the Society to have any professional dealings with osteopaths, to send patients to osteopaths for any kind of treatment or to patronize them personally, to consent to patients going to osteopaths for treatment or to do anything that could in any way either directly or indirectly be construed as approving of osteopaths or any treatment given by them and that a copy be sent to every member.
6. That the Secretary of the Society be instructed to request the men of the regular profession equipped to do physio-therapy and the ethical masseurs and masseuses to give their names and addresses to him, so that he may include this material in the letter above mentioned.
7. That a committee be appointed to co-operate with the Health Commissioner, to keep in touch with him in regard to the treatment of contagious diseases by irregulars and to aid him in any way that it can.
8. That the Society appropriate fifty dollars (or as much thereof as is necessary) to buy selected pamphlets to be placed upon the tables in the waiting rooms of its members or to be distributed to their patients.⁶⁶

Public Health, 1927-1939

On 3 January 1927 Dr. Grandy recommended to the Norfolk County Medical Society that a tuberculosis hospital be constructed to care for area residents.⁶⁷ Norfolk

already had a tuberculosis clinic, but not a hospital for the specific purpose of caring for tuberculosis patients. A tuberculosis clinic had been organized in 1906 by Dr. Grandy. It was the first tuberculosis clinic in the state of Virginia.⁶⁸

At the 5 May 1930 meeting of the Norfolk County Medical Society a "Special Committee To Cooperate in the Planning for the Proposed Tidewater Tuberculosis Hospital" was appointed.⁶⁹ The following year a hospital for tuberculosis patients was built and named the Charles R. Grandy Tubercular Sanatorium in memory of Dr. Grandy who had died the previous year.⁷⁰

In January 1930 the Norfolk County Medical Society passed resolutions relating to the lack of support for the care of Norfolk's indigent sick in various hospitals within the city.⁷¹ Medical care for the indigent sick was provided by the City of Norfolk at the Truxtun Welfare Center which was constructed in 1930 on a farm consisting of 275 acres in Princess Anne County (now part of the City of Virginia Beach).⁷²

The Welfare Center consisted of the General Booth Prison Farm, the Wise Contagious Hospital, the Grandy Tubercular Sanatorium, several tubercular cottages, and the Municipal Hospital.⁷³ Revenue to support the center came from two sources--the Board of State Prisoners and the Welfare Center's sale of farm and dairy produce to other municipal institutions.⁷⁴

The Norfolk County Medical Society made several requests to the City of Norfolk in 1930 for financial support of the city's indigent sick being cared for at the various hospitals in Norfolk.⁷⁵ Until then, these hospitals and attending physicians were bearing the financial burden for medical care of the city's poor. In its 9 January 1930 letter to Norfolk's mayor and city council, the medical society stated, "This issue [care of Norfolk's indigent sick] . . . will be heard from again, and yet again, if necessary."⁷⁶

The City of Norfolk failed to initiate action in 1930 and 1931 toward alleviating the financial burden on the city's hospitals and local physicians for care of the city's indigent sick. As promised, the Norfolk County Medical Society continued its efforts to have the city accept this financial responsibility. In October 1931 the Norfolk County Medical Society again requested relief for the burden of caring for the city's indigent sick. This time the medical society requested \$2.00 per day for each indigent patient treated at the Welfare Center and at other municipal hospitals within Norfolk.⁷⁷ Provision for medical care of Norfolk's indigent sick at taxpayer expense was not resolved until several years later.⁷⁸

The Grandy Tubercular Sanatorium housed and cared for approximately one hundred patients annually between 1933 and 1935.⁷⁹ The Welfare Center's Municipal Hospital cared for the indigent, aged, and unemployables. The number of

patients admitted between 1933 and 1935 increased 44 percent, from 713 to 1,025.⁸⁰

The Wise Memorial Hospital, named for Dr. Henry A. Wise, was restricted to the care of contagious and communicable disease cases.⁸¹ Most of its patients were children. In 1933 eighty patients were admitted. Admittance increased to 173 in 1935, an increase exceeding one hundred percent in two years.⁸²

Much can be learned by examining municipal reports and documents. In the Annual Report of the City Manager: 1934, statistics concerning Norfolk's operating budget were reported. Tables 2 and 3 depict two important segments of this operation.

An examination of tables 2 and 3 reveals that the number of employees of both the general government and the Department of Public Welfare decreased during the period 1931 to 1934. Revenue of the general government fell dramatically, but increased slightly for the Department of Public Welfare during the same period.

TABLE 2

GENERAL GOVERNMENT

Employees	Year	Revenue	Expenditures
81	1931	\$212,601	\$281,522
77	1933	117,881	215,918
70	1934	116,788	202,471

SOURCE: Annual Report of the City Manager: 1934
(Norfolk, Va.: 1934), p. 10.

TABLE 3

DEPARTMENT OF PUBLIC WELFARE

Employees	Year	Revenue	Expenditures
205	1931	\$149,450	\$438,773
143	1933	145,240	305,431
154	1934	151,652	337,624

SOURCE: Annual Report of the City Manager: 1934
(Norfolk, Va.: 1934), p. 20.

The Great Depression of the 1930s had only a minimal impact on the financial condition of the Norfolk Welfare Center. The Welfare Center reduced its budget primarily by reducing its food expenditures. The prison farm, which had steadily increased its production of crops during the 1930s, supplied large quantities of food to the Norfolk Welfare Center. Thus, the Welfare Center's dependence from outside sources for its food supply was greatly reduced.⁵³

In the Annual Report of the City Manager: 1935, statistics relating to the public health of Norfolk's

citizens was reported. Table 4 lists the ten principal causes of death in Norfolk for 1935.

TABLE 4
TEN PRINCIPAL CAUSES OF DEATH
IN NORFOLK, 1935

Diagnosis	1933	1934	1935
Heart disease	428	474	390
Apoplexy	179	190	206
Pneumonia	124	174	188
Brights disease	96	132	112
Cancer	87	101	106
Tuberculosis	82	59	89
Early infancy	69	89	39
Diabetes	--	21	22
Automobile accidents	29	26	19
Appendicitis	--	--	13
Hernia	20	25	--
Homicide by firearms	19	--	--

SOURCE: Annual Report of the City Manager: 1935
(Norfolk, Va.: 1935), p. 14.

In May 1935 plans were formulated to establish the Norfolk Hospital Association for the purpose of determining the meaning of "indigent" and for distributing medical care funds to the poor.⁸⁴ The Norfolk Hospital Association continued to function until absorbed in 1955 by the Norfolk Welfare Department.⁸⁵

Through the efforts of concerned, local physicians, a venereal disease clinic was formed in Norfolk in 1936.⁸⁶ It, along with the Grandy Tubercular Sanatorium, became a service of the Norfolk Public Health Department in the 1950s.⁸⁷

As prescribed by the United States' Public Health Service, milk inspection procedures were adopted by the Norfolk Bureau of Health in 1939.⁸⁸ Early in 1940 the bureau increased its efforts toward improving the quality of health of the general public. The bureau adopted a new system for inspecting soda fountains, restaurants, and other public places serving food and drink.⁸⁹ (A list of inspections performed by the sanitary force of the Norfolk Bureau of Public Health for the years 1938 through 1940 is provided in appendix 7.)

In 1940 Norfolk had three physicians on its payroll. Although the city employed each of them on a part-time basis, they reported visits to 3,833 of the city's indigent sick that year.⁹⁰

On 1 August 1940 the General Assembly of Virginia passed legislation mandating blood tests as a prerequisite for marriage.⁹¹ Subsequently, the Norfolk Bureau of Public Health was certified by state authorities to perform serologic tests,⁹² which led to the early recognition and treatment of many communicable diseases, especially venereal diseases. With the massive influx of new residents into the area, reported cases of venereal disease increased. For example, there were 2,324 new cases of syphilis and 495 new cases of gonorrhea and chancroid reported to the Norfolk Bureau of Public Health in 1940.⁹³ (A statistical summation of communicable diseases reported to the Norfolk Bureau of Public Health in 1940 is provided in appendix 8.)

Health Care in Norfolk, 1940-1958

Medical Facilities in Norfolk, 1941-1945

Norfolk became one of the country's principal bases for military activities in 1940 primarily because of presidential emphasis of the Hampton Roads area as a defense center.⁹⁴ As a result, the civilian population in Norfolk increased more than 110 percent in less than four years, from 144 thousand in 1940 to 305 thousand in 1943.⁹⁵

The beginning of World War II created new problems for the area's practicing physicians. According to the minutes of the Norfolk County Medical Society, forty-one physicians left their practice in Norfolk and became a part of the war effort. The remaining physicians assumed the medical responsibilities of those who had departed.⁹⁶

In 1940 Norfolk maintained three municipally-operated hospitals for the indigent sick. They were the Municipal Hospital for general illness and for the aged, the Charles R. Grandy Sanatorium for tubercular patients, and the Henry A. Wise Memorial Hospital for contagious and communicable diseases.⁹⁷ Funds to operate these facilities came primarily from the City of Norfolk. Costs were held to a minimum by obtaining surplus food from the General Booth Prison Farm and other necessities from various W.P.A. (Work Projects Administration) projects--a vestige of the Great Depression in the 1930s--ongoing in Virginia.⁹⁸

A special meeting of the Norfolk County Medical Society was called on 26 March 1943. The chairman of the

meeting, Dr. A. Brownley Hodges, stated that the meeting had been called to consider action relative to the provisions by the federal government for additional hospital facilities and expansion of existing hospital facilities in the City of Norfolk.⁹⁹ Dr. R. L. Payne presented the following resolution which stated in part:

The Norfolk County Medical Society, the membership of which includes the members of the medical profession of the City of Norfolk, the City of Portsmouth, the Town of South Norfolk and the remainder of the County of Norfolk, submits the following resolution:

In support of the certification of such need [DePaul Hospital], the Medical Society submits the following data:

The hospitals in the City of Norfolk must provide all hospital facilities for the civilian population of an area which includes Norfolk City, that portion of Norfolk County adjacent to the City, the Town of South Norfolk, the whole of Princess Anne County and the Town of Virginia Beach.

The population of this area based on the number of food ration books No. 2 issued to civilian residents of this area appears to be in excess of 300,000.

The Duke Endowment, administering some 116 hospitals in North and South Carolina, estimates that an urbanized population needs 5 hospital beds per 1000 of population. The Public Health Service figure, we understand, is 4 per 1000. Accepting the lower of these two figures, our need in Norfolk City would be in excess of 1,200 hospital beds. At present the sum of all of the hospital beds here is about 640--a truly dangerous situation.

Agencies of our Federal Government have approved plans and provided grants for 60 additional beds for The Norfolk General Hospital, 60 for the Leigh Memorial Hospital, 60 for The Community Hospital and, in addition, the new hospital on Granby Street [DePaul Hospital] of 300 beds.

This plan, if carried out fully, will bring the total number of hospital beds available in Norfolk

City to approximately 1,120, a figure still below the lowest estimate of need.

This Society wished to record its protest to any thought of abandoning any of the hospital projects, and in the awareness of real and urgent need for all of these additional facilities, to urge that the work on all proceed with the utmost despatch.¹⁰⁰

This resolution was adopted unanimously by the membership of the Norfolk County Medical Society on 26 March 1943.¹⁰¹ A copy was sent to the Norfolk City Manager, Colonel Borland, in hopes that the city's leaders would support any practical plans proposed by the federal government to provide funds for new construction of medical facilities and the expansion of Norfolk's existing hospital facilities.¹⁰²

By the end of 1944, both Norfolk General Hospital and Leigh Memorial Hospital had added a new wing. Saint Vincent's Hospital at Church and Wood Streets (near Talbot Park) was discontinued and a new, three hundred bed facility, DePaul Hospital, was built on Granby Street. The federal government provided \$1,750,000 for construction of this new facility.¹⁰³

In Portsmouth several additions were made to the Naval Hospital.¹⁰⁴ The original Portsmouth Naval Hospital is the oldest hospital in the United States.¹⁰⁵ Spurred by a continued increase in patient load after World War II, in 1952 Congress authorized the construction of a new, eighteen story, eight hundred bed naval hospital in Portsmouth. The new naval hospital was completed in 1959.¹⁰⁶ The original

Portsmouth Naval Hospital is still in operation.

Accelerated Medical School Programs
as a Result of the War, 1942-1945

There was an extreme need for physicians in the military during the early years of World War II. As a result, medical schools in the United States increased their academic year to twelve months during the period of 1942 to 1945. This "accelerated program" decreased the time required for graduation from four years to three years. Medical students and interns were deferred from military service and if qualified, they were enrolled in the Army Specialized Training Corps or the Navy V-12 Program. As compensation to the medical student who enrolled in either of these two programs, the government paid the student's tuition fees.¹⁰⁷

During the period 1930 to 1939, American medical schools graduated 33,202 students. Between 1940 and 1949, the number of medical school graduates increased to a total of 57,013,¹⁰⁸ a 72 percent increase from the previous decade.

At Virginia's two medical schools, the number of medical school graduates increased from a total of 702 during the period 1930-1939 to 1,226 graduates during the period 1940-1949.¹⁰⁹ This represented a 75 percent increase in the number of medical school graduates from the previous decade.

Changes to Norfolk, 1946-1959: The Norfolk
Redevelopment and Housing Authority

In 1946 the Virginia General Assembly passed a law for the redevelopment of slum areas in Virginia's cities.¹¹⁰ That same year the Norfolk Housing Authority changed its name to the Norfolk Redevelopment and Housing Authority.¹¹¹ The legislation was significant because it allowed the authority to acquire and clear land for resale to private investors as well as for public uses.¹¹²

Charles Kaufman served as the first vice-chairman when the Norfolk Housing Authority was formed in 1940. In 1942 he was appointed chairman of the authority and held that position until 1969.¹¹³

Lawrence M. Cox served as the authority's director from 1941 to 1969.¹¹⁴ With Kaufman and Cox continuously at the helm for almost thirty years, a continuity of direction was provided for the Norfolk Redevelopment and Housing Authority.

The Federal Housing Act of 1949 provided federal funds to the nation's cities for construction of new homes.¹¹⁵ Under the direction of Charles L. Kaufman and Lawrence M. Cox, Norfolk was the first city in the United States to complete its application for a loan and grant under the national redevelopment program.¹¹⁶ The federal government readily approved Norfolk's application. Subsequently, Nathan Straus, who as administrator of the United States Housing Authority had inspected the slum sections in

more than one hundred cities, said of Norfolk's slums, "I have traveled all over these United States, from one end to the other, and I have seen all kinds of slums, but this is positively the worst thing I have ever seen."¹¹⁷

The Norfolk Redevelopment and Housing Authority began its first of three slum clearance projects in 1951.¹¹⁸ In 1955 the authority shifted its emphasis to Redevelopment Project Number Two--the redevelopment of 135 acres in the Atlantic City section of Norfolk--the area immediately surrounding Norfolk General Hospital.¹¹⁹ Often referred to as the Atlantic City Project, Redevelopment Project Number Two began in July 1957 with key provisions directed toward the thirty-five acre site of the proposed Medical Arts Center adjacent to Norfolk General Hospital.¹²⁰

Sixty-four percent of the homes in this area were listed as substandard in 1955 by the authority.¹²¹ The goal of the Norfolk Redevelopment and Housing Authority and the Norfolk City Council was to create a new Medical Arts Center around Norfolk General Hospital and a waterfront expressway that would make the Medical Arts Center easily accessible to residents of all of the Hampton Roads' cities.¹²²

Medical Facilities

The Medical Arts Center in Norfolk was completed in the mid-1960s at an approximate cost of \$10 million.¹²³ It included a \$2.3 million Medical Tower with offices for doctors and dentists, a \$5.5 million wing for Norfolk

General Hospital, a \$1.25 million King's Daughters Hospital for children, and a \$1 million Municipal Health Center.¹²⁴ Other major provisions included the construction of a high-rise apartment building adjacent to the Medical Arts Center and a major thoroughfare linking Hampton Boulevard with Brambleton Avenue, Virginia Beach Boulevard, and Waterfront Drive.¹²⁵

In 1959 there were seven hospitals in Norfolk, excluding military hospitals.¹²⁶ In addition to these hospitals, the federal government operated several military, medical facilities in the Hampton Roads' area, the largest of which was the eighteen-story United States Naval Hospital in Portsmouth, commonly referred to as the Portsmouth Naval Hospital. The Portsmouth Naval Hospital was completed in 1959 at a cost of \$15 million.¹²⁷ The seven civilian hospitals in Norfolk included four general hospitals; one children's clinic and hospital; one eye, ear, nose, and throat hospital; and one hospital for the chronically ill, geriatric, and convalescent. Total bed capacity for Norfolk's seven civilian hospitals was 1,344.¹²⁸

What used to be "Atlantic City" is home now to the apartment buildings beside the Hague (the west end of what was formerly called Smith's Creek)¹²⁹ and a medical complex including the Eastern Virginia Medical School, the King's Daughters Children's Hospital, Norfolk General Hospital, Medical Tower, Mental Health Center, Public Health Center,

and Tidewater Rehabilitation Institute. In an article published in 1959 entitled "Rebirth of a City," the Norfolk Chamber of Commerce proclaimed:

The key to Norfolk's success in rapidly accomplishing its ambitious program lies in the spirit of cooperation which exists among its city council, its businessmen and the commissioners and director of its redevelopment and housing authority.¹³⁰

What we have seen in this period of sixty years is an expansion of medical services in Norfolk. Initiated by positive-thinking, motivated individuals, the desire to provide quality medical care to Norfolk's citizenry was a principal goal of Norfolk's medical community and its municipal leaders.

The idea of establishing a medical school in Norfolk, although faded by fifty years, was never fully abandoned. Support for the idea in the late 1950s was carefully planned and methodically executed. The next few years, many of its founders and observers would later say, were marked by individual and collective determination and perservance.

FOOTNOTES

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³Ibid., p. 8.

⁴Statistical Abstract of the United States, 1986, p. 5.

⁵Thomas Jefferson Center for Political Economy, Statistical Abstract of Virginia, 1966, p. 5.

⁶Ibid., p. 8.

⁷A. D. Bevan, M.D., "Report of Council on Medical Education," Journal of the American Medical Association 74 (1 May 1920):1250.

⁸Ibid., p. 1243.

⁹Ibid.

¹⁰Vernon W. Lippard, A Half-Century of American Medical Education: 1920-1970 (New York: Josiah Macy, Jr. Foundation, 1974), p. 6.

¹¹Department of Commerce, Statistical Abstract of the United States, 1986, p. 160.

¹²Ibid.

¹³Bevan, "Report of Council on Medical Education," p. 1250.

¹⁴Ibid., p. 1243.

¹⁵Lippard, A Half-Century of American Medical Education: 1920-1970, pp. 5-6.

¹⁶Bevan, "Report of Council on Medical Education," pp. 1243-44.

¹⁷Lippard, A Half-Century of American Medical Education: 1920-1970, p. 6.

¹⁸Bevan, "Report of Council on Medical Education," p. 1250.

¹⁹Lippard, A Half-Century of American Medical Education, p. 6.

²⁰Bevan, "Report of Council on Medical Education," p. 1250.

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²²Association of American Medical Colleges, AAMC Directory of American Medical Education, Washington, D.C., 1972, pp. 194-96.

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²⁷Leland S. McKittrick, M.D., "Reason Underlying Conference on Medical Education and Licensure," Journal of the American Medical Association 162 (1958):21.

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²⁹Interview with R. Bryan Grinnan, Jr., M.D., Norfolk, Virginia, 11 December 1986.

³⁰State Council of Higher Education, Physicians for Virginia: Part II (Richmond, Va.: December 1963), pp. 4-5, and 22.

³¹Lippard, A Half-Century of American Medical Education, p. 13.

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³³Ibid.

³⁴ "Public Health Department," Virginia Medical Monthly (Richmond, Va.: Medical Society of Virginia, July 1920):177.

³⁵ Ibid.

³⁶ Report on a Survey of the City Government, (Norfolk, Va.: Bureau of Municipal Research, September-December 1915), p. 333.

³⁷ Ibid.

³⁸ Ibid.

³⁸ Ibid., p. 334.

⁴⁰ Report on a Survey of the City Government, Norfolk, Va., September-December 1915, p. 353.

⁴¹ Ibid.

⁴² Ibid.

⁴³ Ibid., p. 354.

⁴⁴ Ibid.

⁴⁵ R. Bryan Grinnan, Jr., M.D., "A Short History of the Norfolk County Medical Society," Virginia Medical Monthly (Richmond, Va.: Medical Society of Virginia, January 1970):410.

⁴⁶ Bevan, "Report of Council on Medical Education," p. 1246.

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⁴⁹ Ibid.

⁵⁰ Grinnan, "A Short History of the Norfolk County Medical Society," p. 410.

⁵¹ Norfolk County (Virginia) Medical Society, Minutes of the Regular Board Meeting, 3 November 1919.

⁵² Ibid., 1 October 1928.

⁵³ Ibid.

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⁵⁷"The Cradle of the Nation," Norfolk, (Norfolk, Va.: Norfolk Chamber of Commerce, March 1959), p. 53.

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⁶⁸"Resolutions on the Death of Dr. Grandy," Virginia Medical Monthly (Richmond, Va.: Medical Society of Virginia, August 1932):322.

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⁸⁰ Ibid., p. 18.

⁸¹ Ibid.

⁸² Ibid., p. 19.

⁸³ Ibid., p. 16.

⁸⁴ Grinnan, "A Short History of the Norfolk County Medical Society," p. 411.

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⁸⁶ Ibid.

⁸⁷ Ibid.

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⁸⁹ "Annual Report of the City Manager," Civic Affairs: 1940 (Norfolk, Va.: 1940), p. 56.

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⁹¹ Ibid., p. 50.

⁹² Ibid.

⁹³ Ibid.

⁹⁴ Ibid.

⁹⁵ "The Cradle of the Nation," Norfolk, p. 53.

⁹⁶Grinnan, "A Short History of the Norfolk County Medical Society," p. 412.

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⁹⁸Ibid., p. 63.

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¹¹⁴Ibid.

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- ¹²³"Redevelopment," New Norfolk (Norfolk, Va.: Norfolk Chamber of Commerce, August 1964), p. 22.
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- ¹²⁷"Norfolk--A Medical Mecca," Norfolk (Norfolk, Va.: Norfolk Chamber of Commerce, September 1958), p. 17.
- ¹²⁸"Information About Norfolk," Norfolk, March 1959, p. 58.
- ¹²⁹Wertebaker, Norfolk: Historical Southern Port, p. 289.
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CHAPTER IV

THE FIRST YEARS, 1959-64

Innovation and Reform in Medical Education

The roots of the Eastern Virginia Medical School can be traced to the early 1960s. As discussed in the first three chapters of this dissertation, several attempts to establish a medical school in Norfolk had occurred, but all had failed. However, the 1960s offered a climate affable to medical educational innovation and reform in the United States. This was particularly true for the Hampton Roads area.

A great deal of literature was written in the 1950s and 1960s about the problems of medical education in the United States. It tended to focus on improvement of the educational process from the standpoint of more effective learning with regard to increased relevance of medical practice to social needs. Although medical schools co-existed with undergraduate and graduate universities, university affiliation was no longer perceived as an absolute necessity. It was also evident that more student experience in community settings was not only desirable but probably necessary. As a result, most of the medical schools established in the 1960s and 1970s demonstrated a

more independent, community-oriented, non-university type of operation. Most of these medical schools were established in urban areas serving large populations. The necessity of a university-hospital affiliation gradually became unnecessary. Primarily due to financial reasons, many urban medical schools became affiliated with several hospitals operating within the urban area.

Dr. Paul Sanazaro, concluding a paper entitled "An Agenda for Research in Medical Education," dealt with the possible conflict between university-based education and community based clinical training. He suggested a flexible experimental program--"creating a new model of socially responsive medical education and molding the combined resources of the university, the hospital, the clinic, and the community into a new standard of excellence."¹

The literature of the late 1950s and 1960s is replete with writings calling for reform in medical education and the need for more physicians and medical schools. Dr. Ward Darley, executive director of the Association of American Medical Colleges, contended that family practice should look to medical needs of the 1980s and 1990s and provide advanced education in continuing, comprehensive care. He listed a number of areas for family practice research: the general biology of the human being, human behavior, the art of medicine, and the effectiveness of medical care. He believed that this field of medicine should be of particular interest to new medical schools.²

Dr. Darley noted the serious shortage of physicians in the United States and the need for expansion of medical education. He stated that the federal government should become a major source of funding and stressed the hazards of partial support. Dr. Darley also emphasized the great need for construction funds and the establishment of new medical schools. He cited the U.S. Surgeon General, who, in 1959, had estimated a need for twenty-one new medical schools by 1970 as support for his contentions.³

According to the Surgeon General's Consultant Group on Medical Education in 1959, there were 133 medical doctors per 100,000 population at that time. The report concluded that the annual number of medical school graduates would have to increase 25 percent by 1975 if this ratio was to be maintained. As a result of this report, public opinion was aroused and Congress took action to increase the capacity of existing medical schools and the overall number of medical schools in the United States.⁵

Over thirty medical schools have been established in the United States since 1960. Some, like the Eastern Virginia Medical School, were created largely in response to the opportunity for innovation and reform. Pressures such as the civil rights movement, student revolt, and the Viet Nam War in the late 1960s and early 1970s, had an impact on the new medical schools. Issues of minority admissions, affirmative action, educational and financial support for disadvantaged students, and medical care for the poor came

to the attention of medical schools and the public. A sudden awareness that accentuated the pitfalls and ethical problems inherent in the traditionally elitist approach to medical care and education emerged.

Whether by choice or due to the unavailability of federal funds for the construction of a university hospital after about 1970, many of the new medical schools operated without association with a university hospital. Many of the new medical schools found it necessary to use community hospitals, which were inexperienced in undergraduate medical education, for clinical training. Furthermore, these medical schools were rarely in the position to develop the traditional, administrative procedures assuring control of patient care in affiliated hospitals.

The medical schools established after 1960 were created in response to a social demand for more physicians. Often, they were motivated by a preoccupation with educational issues and usually funded modestly with federal monies for research. They were almost exclusively dependent upon community facilities for clinical experiences and were forced to rely more than had been customary upon practicing physicians for teaching. Most of the medical schools established after 1960 developed around the need for more family practitioners. Officials of these medical schools tended to espouse a somewhat different set of values than did officials of the established, more traditional medical institutions.

The planning of the Eastern Virginia Medical School grew out of the innovation and reform in medical education that were so characteristic of this period in the United States. Chapter IV of this dissertation will discuss how efforts of local citizens to improve medical education in the Hampton Roads area reflected much of this innovation and reform. It will be devoted to a discussion of the problems encountered and the events that transpired as area leaders came together to propose and build the foundation for the Eastern Virginia Medical School.

Recognition of the Need for a Medical School
in Norfolk

It is debatable as to who first suggested in the 1950s the idea that a medical school should be built in Norfolk. Mr. Charles Kaufman, a Norfolk lawyer, philanthropist, board member of Norfolk General Hospital for several decades, and chairman of the Norfolk Redevelopment and Housing Authority for twenty-eight years, is one of the individuals credited with the idea that Norfolk should consider the possibility of establishing a medical school. Whether he saw the medical school from an economic or social standpoint is not clear, nor is it particularly important. What is important is that other civic leaders followed him and began to explore the implications of establishing a medical school in Norfolk.

Mr. Lawrence M. Cox, executive director of the Norfolk Redevelopment and Housing Authority, suggested in

1959 that the City of Norfolk consider the possibility of including a medical school in the proposed Norfolk Medical Center site plan. The suggestion was presented in Mr. Cox's address to the Norfolk Ryan Club, the membership of which consisted of Catholic business and professional men. Portions of Mr. Cox's speech were subsequently reported in the Norfolk Ledger-Dispatch.⁶

Dr. John S. Thiemeyer, Jr., on 12 July 1960 suggested that the members of the Joint Committee on House Staff Procurement and Education study the feasibility of creating a medical school in Norfolk.⁷ The Joint Committee on House Staff Procurement and Education represented three hospitals in Norfolk--Norfolk General Hospital, DePaul Hospital, and Leigh Memorial Hospital. The committee's membership included members of the board of directors, house staff, and administrators of each of the hospitals. Several prominent, local citizens from the non-medical community were also members of this joint committee.

Dr. Thiemeyer's suggestion of the possible feasibility of a medical school in Norfolk is important because it came from a prominent member of the medical community. Not since 1918 had recognition of the need for a medical school in the Hampton Roads area been made by a physician to members of the medical community. As noted in chapter 3, Dr. Charles R. Grandy in 1918 recommended to fellow members of the Norfolk County Medical Society that they consider the possibility of establishing a medical

school in Norfolk, followed by Dr. Southgate Leigh's recommendation in 1919 to the Norfolk County Medical Society that consideration be given to the creation of a post-graduate medical school in Norfolk.

Experience indicated that in order to succeed in Norfolk, a medical school had to receive extensive support within the community. By 1960 the idea of a medical school in Norfolk was gradually gaining support among local leaders. It already had received favorable recognition from three prominent members of the community--Mr. Charles L. Kaufman, Mr. Lawrence M. Cox, and Dr. John S. Thiemeyer, Jr. It was an opportune time, politically and economically, for the serious consideration of the creation of a third medical college in Virginia and the first permanent such institution for Norfolk.

The Medical Environment in Hampton Roads After World War II

Dr. John S. Thiemeyer, Jr., president of the medical staff at DePaul Hospital in 1959, served as president of the Norfolk County Medical Society (now the Norfolk Academy of Medicine) in the early 1960s.⁸ According to Dr. Thiemeyer, Norfolk was depleted of many of its physicians during World War II. When the war ended, many of these physicians returned to Norfolk as did many young people who had lived in the area before the war. They returned with a "whole new horizon of what was going on in the world."⁹ Provincial, medical attitudes gave way to a more cosmopolitan outlook.

Contentment with obsolete medical methodologies were replaced with a desire to bring to the Hampton Roads area the most advanced medical methodologies and technologies available. Dr. Thiemeyer explained, "They [local physicians and, in a larger sense, the Hampton Roads medical community] wanted something better."¹⁰

The physicians returning to Norfolk after World War II had acquired new medical skills and were acquainted with new technologies not available in Norfolk prior to the war. These physicians were not satisfied with the status quo of medical services in Norfolk. They wanted to associate themselves with high quality medical education programs. They wanted to be in the forefront of the rapid advances being made in medicine. In their search for excellence in medicine, they were confronted with several enormous obstacles such as the lack of strong medical education programs at the hospitals in Norfolk.

Intern and Resident Shortage at Three of Norfolk's Hospitals

Norfolk General Hospital had all of its internships and residencies filled in 1955. Five years later the hospital's vacancy rate for interns and residents was over 50 percent.¹¹ Several reasons were perceived as causes for the hospital's inability to effectively recruit and retain quality medical school graduates.

One principal cause for the high vacancy rate of interns and residents at Norfolk General Hospital was

attributed to the hospital's lack of emphasis on continuing medical education. According to one unidentified hospital administrator, there had even been talk of scraping the hospital's entire medical education program, and word of this had reached the state's two medical schools.¹² An unpublished article dated 1960 from the personal files of Dr. Thiemeyer stated the problem this way:

Norfolk General has discovered in its drive to get more interns and residents . . . the hard way, what it takes these days to attract house staffers to a hospital not affiliated with a medical school. It's had to overhaul its teaching program completely--and in doing so, persuade attending doctors that interns and residents aren't there to serve them, but to learn medicine.¹³

Medical education in Norfolk during the early 1960s was at a low ebb. Most physicians recognized that the lack of medical education facilities and resources were two major reasons why many graduating medical students declined to apply for a residency at a Norfolk hospital. As the problem created by the shortage of interns and residents intensified, talk within the medical community increased. It was not unusual for physicians at Norfolk's hospitals to discuss the medical education problem during lunch gatherings or at meetings of the medical society. As Dr. Charles Horton, a long-time plastic surgeon in Norfolk and one of the key figures in the planning and development of the Eastern Virginia Medical School, noted:

It was difficult to get good people to come to our internships and medical programs. They wanted a medical school environment and we all concluded that we should really be working hard to try to get a medical school started in Norfolk. This talk went on for a long time--

every time we had lunch together at a restaurant. However, nobody did anything about it because nobody knew how to approach it.¹⁴

Another major impediment to the efforts of Norfolk's hospitals in recruiting medical school graduates for its intern and resident posts was the weak affiliation between each of the hospitals in Norfolk and either of the state's two existing medical colleges.¹⁵ Many members of Norfolk's medical community became frustrated. They wanted "to have top-notch medicine in this area and were unable to have all of the components that made it good," Dr. John S. Thiemeyer, Jr., recalled.¹⁶

The student composition at Virginia's two medical schools was perceived by many people in the medical community as another impediment to the recruiting efforts of Norfolk's hospitals. Student enrollment at the state's two medical schools was largely composed of out-of-state students. Upon graduation, many of these non-resident students would return to their home states to practice medicine.¹⁷

The large out-of-state enrollment at Virginia's two medical schools presented a serious problem to Norfolk's recruiting efforts of medical school graduates to fill the intern and resident positions at its hospitals. Two problems were at issue, Dr. Thiemeyer recalled. "First, the Eastern part of Virginia had difficulty getting its students into the state's medical schools because of the high percentage of non-resident students filling their classes

and secondly, the medical schools [in Virginia] would not supply the physicians that we needed."¹⁸ As a result, Norfolk's hospitals were forced to rely heavily upon foreign-trained students to supplement their intern and resident requirements.

Virginia ranked second among all of the states for having the highest percentage of foreign-trained physicians during the late 1950s. New York ranked first.¹⁹ Dr. Thiemeyer remarked, "It was not a wholesome situation for Norfolk."²⁰

Norfolk General Hospital in 1960 had filled only four of its sixteen internships offered through the National Intern Matching Plan, a program designed to place a medical school graduate with a hospital in the United States.²¹ The hospital, hopefully, was one of the medical school graduate's choices, but this was not always the case. The receiving hospital was required to provide a medical education program and an environment conducive to learning for the intern. Many faculty members at Virginia's two medical schools believed that Norfolk General Hospital's medical education program and teaching environment were not as good as they should be. Therefore, these faculty members would not recommend Norfolk General Hospital to their medical school graduates. According to one article, "Word had gotten out among graduating medical students that interning at Norfolk General meant 90 percent scut work."²² In other words, the intern's duties at Norfolk General

Hospital were basically confined to routine assignments with limited exposure to new medical experiences that would increase the intern's medical knowledge.

Mr. Roy Prangle, chief administrator at Norfolk General Hospital, commented in 1960 that "only about 10 percent of the attending staff [of Norfolk General Hospital] actually teach."²³ Very little emphasis was placed on providing a continuing medical education program for the hospital's staff--especially for its interns and residents.²⁴

The absence of the quantity and quality of post-graduate medical education at Norfolk General Hospital, DePaul Hospital, or Leigh Memorial Hospital was perceived as a major obstacle to the hospitals' ability to recruit medical school graduates from either of Virginia's two medical schools or any out-of-state medical school. As public awareness of the problem grew, each of these three Norfolk hospitals initiated efforts to improve the medical education program at their hospital.

Incentives Offered To Induce Medical School Graduates To Come to Norfolk

The Norfolk Foundation, a community trust and charitable organization endowed by contributions from local residents for philanthropic interests designated by its donors, recognized in the 1950s the seriousness of the problem that Norfolk General Hospital, DePaul Hospital, and Leigh Memorial Hospital were having in their ability to

attract medical college graduates to Norfolk. In an attempt to encourage medical school graduates to apply for internships at Norfolk's hospitals, the Norfolk Foundation offered scholarships to medical students at Virginia's two medical colleges in return for their agreement to serve their internship and residency in Norfolk.

The Norfolk Foundation had paid the tuition of over forty medical students at the University of Virginia and at the Medical College of Virginia as of June 1960.²⁵ Even so, the problem of getting medical school graduates to serve their residency in a Norfolk hospital persisted. The Norfolk Foundation's scholarship program for medical school students provided only minor relief to the problem of a shortage of interns and residents at Norfolk's hospitals. It was evident that the scholarship program alone could not solve the problem.

The directors of Norfolk General Hospital also offered other financial incentives as a means to attract more physicians. One incentive was a raise in stipends for interns and residents. "We knew we could not buy our way out of the problem," Mr. Prangley, chief administrator at Norfolk General Hospital, commented, "but we wanted to make our pay adequate for the needs of each."²⁶ The evidence supports Mr. Prangley's supposition. The raise in stipends for interns and residents at Norfolk General Hospital proved to be of marginal benefit only in helping the hospital to attract physicians.²⁷

Steps Toward Reform of Medical Education
in Norfolk

Medical education at Norfolk's hospitals in the late 1950s and early 1960s was in desperate need of reform. Local medical authorities, as well as medical authorities across the state, recognized that serious problems existed in the medical education programs at Norfolk's hospitals. A concerted effort was launched in 1960 by concerned, local physicians to improve these programs to enhance the attractiveness of Norfolk's hospitals to graduating medical students applying for residency.

In an effort to strengthen the medical education program at Norfolk General Hospital, the hospital's board of directors appointed early in 1960 Dr. Donald W. Drew as the hospital's full-time director of medical education. Dr. Drew was tasked to identify problems with the medical education program at Norfolk General Hospital and institute innovative measures, if necessary, to strengthen the program and make it more attractive to medical school graduates applying for hospital residency. The board of directors at Norfolk General recognized the seriousness of the hospital's medical education program and concluded that reform was necessary.

Dr. Drew knew that the medical education program at Norfolk General Hospital possibly involved a multiplicity of problems. Before he could recommend appropriate reform, he had to identify specific areas of weakness. After several

months of investigation, Dr. Drew reported his findings in July 1960. In his report to the hospital's board of directors, Dr. Drew noted several problems with the medical education program at Norfolk General. His report stated, in part, "I saw right away that I had a very unhappy house staff on my hands. They had far too much scut work and an impossible load of clinic patients."²⁸ In support of Dr. Drew's findings, an unidentified third year medical resident recalled:

During my first year I spent ten to twelve hours a day doing admitting histories and physicals on private patients. I learned very little because I didn't participate in these patients' care. The rest of the time I worked in the clinic--usually with no supervision from an attending [physician]. Teaching conferences were held infrequently, and I had almost no time to attend those that were held--or time to study. I was so discouraged I was considering continuing my training at another hospital.²⁹

Realizing that the problem of recruiting and retaining interns and residents was becoming worse, steps were taken in 1960 by Norfolk General Hospital, DePaul Hospital, and Leigh Memorial Hospital to have attending general practitioners take over the out-patient clinics. Fewer routine and follow-up cases were sent to the house staff. Instead, the admitting physician was given full responsibility for the write-up of routine histories on private medical patients, as well as the responsibility for performing routine physical examinations on patients.³⁰ Relieved of these duties, the intern and resident, it was hoped, would have more time to pursue their medical studies,

keep abreast of technological advances in the medical field, and hopefully shed any negative feelings they held toward the hospital. However, these measures offered only temporary relief.³¹

The medical community realized that the medical education programs at Norfolk's three hospitals needed permanent reform. The first step in this direction was the formation of the Joint Committee on House Staff Procurement and Training.

The Joint Committee on House Staff Procurement and Training

Dr. John S. Thiemeyer, Jr., organized the Joint Committee on House Staff Procurement and Training in 1960³² in an effort to formulate a long-term program that would attract interns and residents to Norfolk's hospitals.³³ Representatives on the committee included members of the board of directors, house staff, and administrators of Norfolk General Hospital, DePaul Hospital, and Leigh Memorial Hospital. In addition to these representatives, several prominent, local citizens from the non-medical community were offered membership to the joint committee. (A list of the committee's membership is provided at appendix 9.)

Dr. Thiemeyer sent a letter to members of the Norfolk County Medical Society and to the executive committee of the DePaul Hospital medical staff in April 1960 to arrange a meeting to discuss the need for a post-graduate medical

education program at Norfolk General Hospital, DePaul Hospital, and Leigh Memorial Hospital. His letter stated, in part:

Much interest has been expressed by representatives of Norfolk General, Leigh Memorial and DePaul Hospitals in getting together to discuss some of our mutual problems. I refer specifically to post-graduate medical educational programs in our community hospitals with the concurrent need for adequate house staff coverage of in-patient, clinic and emergency room patient care.³⁴

Dr. Wickham Taylor, president of the Norfolk County Medical Society, subsequently congratulated Dr. Thiemeyer for taking the first step toward solving the problem of an inadequate post-graduate medical education program at Norfolk's hospitals.³⁵ Hoping to attract attention to this increasing problem and gain support to correct it, Dr. Thiemeyer wrote several letters to civic leaders in the community. (Correspondence to this effect is provided in appendix 10.)

The first meeting of the Joint Committee on House Staff Procurement and Education was held in May 1960. It focused on the extensive publicity received by the six hospitals in Jacksonville, Florida, for their innovative efforts toward improving their graduate medical education programs. Several members of Norfolk's city-wide joint committee believed that many of the problems facing the hospitals in Jacksonville might also have similar bearing on problems confronting hospitals in Norfolk.³⁶

The Jacksonville plan identified several problem areas which arose as a result of each of Jacksonville's six

hospitals attempting to conduct fully independent, graduate education programs for their interns and residents. As a result of this study, the six hospitals in Jacksonville elected to participate in one centrally located graduate medical program.³⁷

At the second meeting of the Joint Committee on House Staff Procurement and Education, Dr. Thiemeyer agreed to serve as the committee's temporary chairman. Once the members agreed that the committee should continue to function, Dr. Thiemeyer and other committee members discussed the background and the principal causes of the critical shortage of interns and residents at the hospitals in Norfolk. Several committee members contended that there would be no prospects of improvement unless some plan could be developed and implemented to create a "dynamic Norfolk educational and training program" that would attract interns and residents to the Hampton Roads area.³⁸ (A list of attendees present at this meeting of the Joint Committee on House Staff Procurement and Education is provided in appendix 11.)

The second meeting of the Joint Committee on House Staff Procurement and Education was also significant because the idea of creating a medical school in Norfolk was brought to the attention of the committee members. Dr. Thiemeyer suggested that the committee consider the possibility of creating a medical school in Norfolk as a long-range objective toward solving the problem of an intern and

resident shortage at the city's hospitals. In addition, it was implied that the creation of a medical school in Norfolk would insure the availability of quality medical education in the Hampton Roads area. Several members of the committee agreed with the idea, but some expressed doubts that the Virginia General Assembly would appropriate the necessary funds required to insure the success of a third medical school in the state of Virginia.³⁹ Nevertheless, it was decided that the idea of creating a medical school in Norfolk did merit further study.

Support for Improved, Medical Education Programs
in Norfolk Gains Momentum

The desire to improve the programs in medical education at Norfolk's hospitals was a principal topic among local physicians at medical gatherings in 1960. The members of the Norfolk County Medical Society discussed this issue extensively at their 5 April 1960 regular board meeting. The concensus of the membership was that local hospitals should increase their efforts to improve the intern and resident training programs and that local hospitals should advise the two Virginia medical schools of the intern placement problem facing Norfolk's hospitals.⁴⁰

At the regular board meeting held on 15 November 1960, Dr. George F. Elsasser, Jr., emphasized that "any step furthering medical education is particularly necessary to attract more medical students."⁴¹ Dr. Charles Horton, a long-time plastic surgeon in Norfolk and one of the key

figures in the planning and development of the Eastern Virginia Medical School, had recommended a month earlier that the medical society appoint a committee to investigate the possibility of establishing a medical museum in Norfolk. The members of the Norfolk County Medical Society thought that the presence of a medical museum in Norfolk would be an indication of the high regard the local medical community placed on quality medical education. They approved Dr. Horton's recommendation unanimously.⁴²

The Policy Formulating Committee

The Policy Formulating Committee was formed on 12 July 1960 as a sub-committee to the Joint Committee on House Staff Procurement and Education. Membership of the Policy Formulating Committee consisted of five individuals well-known as business, civic, and medical leaders in Norfolk. They included Mr. Henry C. Hofheimer, II, a local businessman, philanthropist, and member of the board of directors at Norfolk General Hospital; Mr. Roy R. Prangle, chief administrator at Norfolk General Hospital; Dr. Clairborne Fitchett, member of the board of directors at Norfolk General Hospital; Dr. Frank N. Bilisoly, III, member of the Norfolk County Medical Society; and Dr. John S. Thiemeyer, Jr., president of the medical staff at DePaul Hospital.⁴³

Members of the Policy Formulating Committee were concerned with continuing efforts to identify ways to attract more medical school graduates to fill vacant

internships at Norfolk's hospitals. At their 5 August 1960 meeting, they concluded that it would be necessary to increase the amount and improve the quality of graduate medical education programs offered to the hospitals' interns and residents. As a result, the committee recommended the establishment of a teaching faculty composed of physicians from each of the medical staffs of Norfolk General Hospital, DePaul Hospital, and Leigh Memorial Hospital.⁴⁴ In particular, the committee recommended:

This faculty should be set up in all three hospitals with certain fixed standards. Members of this faculty will be required to spend a designated number of months on the clinic services and in the outpatient departments of various hospitals. The assignment of these services would be done by each individual hospital and the departments within the hospitals. Attendance records of physicians would be kept and forwarded to the secretary of this Joint Committee each month. Those physicians who fulfill their requirements would have a certain public recognition and certain services furnished in the hospitals. These services would include assistance in the operating room and house staff help in work up and management of private patients. The non-teaching staff doctors would not have these services.⁴⁵

Local Physicians Encouraged To Participate in Teaching Programs for Interns and Residents

At the 17 September 1960 breakfast meeting attended by the hospital's board members and the administrative staff of Norfolk General Hospital, Mr. Roy R. Prangle presented several of his observations concerning the need for a well-organized medical education program at Norfolk General Hospital.⁴⁶ He remarked that interns and residents of the hospital were overburdened with routine hospital duties which left them little time to devote to their medical

education. The faculty of the two medical schools in Virginia were aware of this problem and therefore often hesitated to recommend Norfolk General Hospital to their medical school graduates. The faculty members did not believe that any of the hospitals in Norfolk offered a good learning environment. A quality graduate teaching program and modern facilities, Mr. Prangley stressed at the hospital's breakfast meeting, were key factors in attracting medical school graduates.⁴⁷

Mr. Prangley emphasized the inability of Norfolk General Hospital to hire either a full-time or part-time faculty as a means to supplement and enhance the hospital's medical education program. The rationale was that sufficient funds were not available to hire a faculty or to maintain a faculty over any extended period of time. Mr. Prangley recommended a plan proposed the preceeding month by the Policy Formulating Committee in which some members of the medical staff of each of the city's hospitals would donate a few hours of their time each week toward teaching the hospitals' interns and residents. In return for their teaching efforts, these medical staff members would receive special privileges at the city's hospitals. Non-teaching staff members would not be afforded these privileges. For example, it was proposed that teaching staff members receive assistance from the hospital's house staff in caring for their patients.⁴⁸

As a result of the proposal to solicit teaching

assistance from the medical staffs of Norfolk General Hospital, DePaul Hospital, and Leigh Memorial Hospital, intra-hospital and inter-hospital correspondence offering guidelines and proposing recommendations followed. In addition, proposals for the improvement of the medical education programs at Norfolk General Hospital and DePaul Hospital were developed. (Principal correspondence to this effect is provided in appendix 12.)

Attending physicians who agreed to devote a few hours each week to teaching in one or more of the medical education programs at Norfolk General Hospital, DePaul Hospital, and Leigh Memorial Hospital were classified as "teaching" attending physicians.⁴⁹ The Joint Committee on House Staff Procurement and Training recommended that the hospitals provide these physicians with certain hospital privileges and hospital staff assistance not provided to "non-teaching" attending physicians.

By-laws Revised at Norfolk General Hospital

Although Norfolk General Hospital revised its by-laws in 1960 to accommodate recommendations proposed by the Joint Committee on House Staff Procurement and Training, a year passed before the hospital's board of directors approved the plan. Dr. Thiemeyer explained the delay this way:

These three hospitals have always had open staffs. Some physicians who used DePaul or Leigh Memorial more than they did Norfolk General were afraid they'd lose their privileges at the latter under the new by-laws. Other physicians who chiefly used Norfolk General but who have never done much teaching saw the proposed changes as

a move to form a ruling clique in the hospital of those who did teach.⁵⁰

Mr. Prangley received attention from the local medical community when he commented that merely discussing changes to the by-laws of Norfolk General Hospital led to a heightened interest in teaching on the part of many of the attending physicians at Norfolk General Hospital. In his remarks to hospital staff members and to the board of directors, Mr. Prangley stated, "During the months we were hashing over the revisions, doctors who'd never taken any interest in the program started showing up at teaching conferences, helping out at clinics, and even volunteering to lecture."⁵¹ Many of the hospital's physicians resented Mr. Prangley's brash, yet candid, remarks. For some, their resentment would become more visible during the next several years.⁵²

Intern Shortage Subsidies

The number of medical school graduates who applied for residency at Norfolk General Hospital increased between 1960 and 1961. For example, in 1960 only four medical school graduates applied for internship at Norfolk General Hospital in spite of the fact that sixteen internship vacancies existed. In 1961, however, the hospital received twelve new interns out of the sixteen it requested through the National Intern Matching Plan. Hospital authorities attributed this increase to strong efforts devoted at improving the hospital's medical education program. As one

hospital official noted, the sharp rise in the number of medical school graduates who chose Norfolk General Hospital in which to serve their internship in 1961 was chiefly attributed to the belief that "satisfied house staffers are your best recruiters."⁵³

Support for the Proposed Medical School Expands

Support for the proposed medical school in Norfolk increased dramatically during 1960 and 1961. Although strong support was voiced by several local leaders, proponents for the medical school were not confined to Norfolk. Several state medical authorities and officials of the American Medical Association believed that a medical school in Norfolk would fill a void for medical services in Eastern Virginia. They believed that a concerted effort by the leadership of Norfolk to establish a local medical school was the first step toward realization of this goal.

The Norfolk County Medical Society Endorses the Concept of a Local Medical School

Support for the concept of creating a medical school in the Hampton Roads area continued to grow throughout the remaining months of 1960. Supporters for the proposed medical school were pleased when the executive board of the Norfolk County Medical Society endorsed the concept and announced that the medical society was behind any positive effort for a "well-conceived and well-planned medical school" for the Hampton Roads area.⁵⁴

The Norfolk County Medical Society officially announced its intent to "investigate and report on the feasibility and the desirability of a medical school in Norfolk" at its 21 March 1961 executive committee meeting.⁵⁵ Executive committee members present included Drs. John Franklin (President), Mason Andrews, John Thiemeyer, Jr., William Hotchkiss, George Elsasser, Jr., Howard Kruger, Harry Taylor, Jr., Alter Laibstain, Harry Frieden, Meyer Drischer, and K. K. Wallace. Dr. Thiemeyer recommended that a special committee be appointed for this purpose, and the committee approved the proposed action. An eighteen-member Medical School Investigation Committee was appointed. Dr. Charles Horton was selected to chair the investigating committee.⁵⁶

Fifty-eight members were present at the 4 April 1961 business meeting of the Norfolk County Medical Society. Dr. John Franklin spoke to the members about establishing a medical school, noting that "the idea has long been held by members of the Norfolk County Medical Society."⁵⁷ He told the society's members about a meeting, called by Dr. Allan Barker of the Virginia Medical Society's Committee on Education, which Mr. Lawrence Cox and he [Dr. Franklin] attended. Several problems regarding the establishment of a new medical school were discussed during the meeting with Dr. Barker and the medical society's Committee on Education. Dr. Franklin noted that Dr. Maloney, medical education member of the faculty at the Medical College of Virginia,

offered the following information for anyone who was considering the establishment of a third medical school in Virginia:

1. The State of Virginia contributes close to 28 percent of costs for the two existing medical schools in Virginia.
2. Tuition supplies less than 25 percent of costs at Virginia's two medical schools.
3. The faculty of a medical school should be composed of nationally prominent medical figures in order to attract grants.
4. The federal government should be considered as a principal source for construction funds.⁵⁸

Dr. Franklin concluded his remarks to the Norfolk County Medical Society by telling them that the Virginia Medical Society's Committee on Medical Education was not very encouraging in its outlook for the successful establishment of a medical school in Norfolk. However, the consensus of the Committee on Medical Education was that supporters for a medical school in Norfolk should continue their efforts.⁵⁹

The Norfolk County Medical Society did continue its efforts in support of establishing a medical school in Norfolk. At a meeting later that year, executive committee members agreed to display an exhibit at the Virginia Medical Society's Annual Convention in October 1961. It was decided that the display would focus on the promotion of a medical school in Norfolk. Drs. Andrews (President), Salley, Grinnan, and Franklin urged the medical society members to financially support this effort.⁶⁰

Medical Society of Virginia Recognizes Norfolk
as a Potential Site for a Medical School

The Medical Society of Virginia, although slow to offer support for the idea of establishing a medical school in Norfolk, did recognize the potential need for additional medical services in Eastern Virginia. In its 1961 annual report, the society's Committee on Medical Education acknowledged receiving strong endorsements for a medical school in Norfolk from both the Norfolk County Medical Society and the Norfolk Redevelopment and Housing Authority. Stating its position, the medical society's Committee on Medical Education remarked, "The committee is in general agreement that there exists nationally a need for more medical graduates and that an unusual and unique opportunity to help meet this need seems to exist in the Norfolk area."⁶¹

Report by the American Medical Association's
Liaison Committee on Medical Education

On 28 February 1962 Drs. Glen Leymaster and Lee Powers of the American Medical Association's (A.M.A.) Liaison Committee on Medical Education visited Norfolk for a preliminary exploration of the needs for a medical school in the Hampton Roads area. At the 6 March 1962 business meeting of the Norfolk County Medical Society, Dr. Charles Horton reported that Drs. Leymaster and Powers concluded their visit by noting that "Norfolk has the potential for a medical school," but "the biggest limiting factor was the

temporary inadequacy of the existing higher education facilities."⁶²

The results of Drs. Leymaster's and Powers' unofficial, preliminary survey of the proposed medical school in Norfolk were published in February 1963. Their report indicated that establishment of a medical school in the Hampton Roads area might be justified. After stressing some of the basic criteria and policies that would have to be considered, they suggested that a broader study of statewide medical education needs in Virginia should be performed.⁶³

Planning and Development of the Medical Center

The Norfolk medical community experienced continued optimism and prosperity in 1961 beginning with the dedication of the Norfolk Medical Tower Building located adjacent to Norfolk General Hospital. The completion of the medical tower marked the first step toward the development of the Norfolk Medical Center Complex. At its dedication on 14 January 1961, Mr. Charles L. Kaufman, a Norfolk attorney and the chairman of the Norfolk Redevelopment and Housing Authority, applauded Dr. Mason C. Andrews by referring to him as a man of vision and the impetus behind the founding of the Norfolk Medical Tower Building.⁶⁴

The Norfolk Medical Tower Building, a ten-story building providing approximately one hundred professional suites for doctors and dentists, also provided laboratory and x-ray facilities, a drugstore, an orthopedic appliance

shop, a beauty parlor, an optical shop, and other related facilities.

At the dedication of the Norfolk Medical Tower Building, Mr. Lawrence M. Cox spoke of the future of Norfolk. He suggested that serious consideration should be given to the possibility of establishing a medical school in Norfolk,⁶⁵ offering several reasons why a medical school should be established in Norfolk. He remarked:

We have in our area one of the largest concentrations of population of any urban area in this nation that does not have a medical college. . . . [We] have on three sides of the [Norfolk Medical] Center, all the land that could be needed for a basic medical science building. . . . We are the only community in the nation with a Public Health Service Hospital that does not have a medical college. . . . We have in the College of William and Mary a made-to-order affiliate for the new medical school--an established and respected institution. . . .⁶⁶

Mr. Cox told the audience at the medical tower's dedication that there was growing support for a medical school in Norfolk. He noted that medical authorities across the state recognized the need for additional medical services in Eastern Virginia and that the establishment of a medical school in the Hampton Roads area was a long-term solution. He stated that "Practicing physicians gravitate to the locale of the medical school. . . . Doctors and dentists like to be close to research facilities and other tools by which they can improve their professional knowledge and keep abreast of the times."⁶⁷

Mr. Cox cited several prominent medical authorities who acknowledged the need for more physicians in Virginia.

Dr. Malcolm H. Harris, a physician from West Point, Virginia, and a former chairman of Virginia's Commission on Medical Education, was one such individual noted by Mr. Cox. In a letter to Mr. Cox, part of which was read at the dedication of the Norfolk Medical Tower, Dr. Harris wrote:

[A] study of population trends and Virginia's medical school output reveals an appalling situation. I cannot in good conscience but offer help that will remedy a situation that is at least ten years behind the times. . . . The American Medical Association will welcome a well-founded medical school and would lend any assistance within its power.⁶⁸

Mr. Cox told the audience that he had consulted with hospital officials on the Surgeon General's staff and that "They tell me that a four-year medical school here, sufficient in size and facilities to graduate fifty students yearly, would cost between eight and nine million dollars-- and that's going first class."⁶⁹ Over the next several years, however, these figures would be revised sharply upward.

Mr. Cox had devoted considerable thought and effort to the possible establishment of a medical school in Norfolk. He had even explored possible financial sources to fund a medical school. In his address, Mr. Cox reported:

Federal grants, as in the Hill-Burton Program, will provide two-thirds of the capital outlay [for construction of a new medical school]. This legislation . . . brings a new school within reach.⁷⁰

In a letter to Dr. John S. Thiemeyer, Jr., Mr. Cox re-emphasized his support for the establishment of a medical school in Norfolk. He stated "It was my personal hope that

a medical college could be established in Norfolk's new medical center. . . . I genuinely believe in the idea strongly and firmly."⁷¹

Proposal for a Medical Center Complex

The Norfolk County Medical Society estimated that 800,000 people in the Hampton Roads area used Norfolk for their health and medical needs in 1962.⁷² The medical society saw the opportunity to build a medical center complex on unused land surrounding the Norfolk Medical Tower Building and Norfolk General Hospital. The medical society gained support for this project from the Norfolk City Planning Commission, the Virginia Tidewater Dental Association, the Norfolk Redevelopment and Housing Authority, and the Health-Welfare-Recreation Planning Council. On 19 February 1962 the executive committee of the Norfolk County Medical Society approved a draft resolution requesting the Norfolk City Council to "appropriate the necessary funds for the cost of a specific study to formulate a comprehensive, overall plan for the Norfolk Medical Complex."⁷³ (A copy of the draft resolution is provided in appendix 13.)

Master Plan for a Medical Center Complex

In 1963 the sixteen-member Norfolk Medical Center Commission began making plans for a medical center complex to be located adjacent to Norfolk General Hospital and the Norfolk Medical Tower Building.⁷⁴ A principal

consideration was the future location of the proposed medical school.⁷⁵ The commission's membership was composed of doctors, businessmen, and other prominent members of the community. (A list of the commission's membership is provided at appendix 14.)

Architectural Subcommittee

In mid-1963 the Norfolk Medical Center Commission appointed a four-member architectural subcommittee composed of Mr. Pretlow Darden, Captain Fred Ray, Dr. John Franklin, and Dr. Mason Andrews.⁷⁶ The subcommittee was tasked to assemble a list of architectural firms which would be considered for the task of designing a master plan for the evolution of a metropolitan medical center. After having reviewed the credentials of several national architectural firms, the subcommittee contacted Mr. Al Murrow, executive director of Community Studies, Inc., in Kansas City.⁷⁷ His firm was preparing a master plan for the Kansas City Medical Center Authority. The Kansas City Medical Center was considered one of the leading examples of medical center development in the United States.⁷⁸

Mr. Murrow's firm had interviewed seventeen architectural firms for the role of coordinating, architect planner. The planner's job was the overall supervision and guidance of the principal architect.⁷⁹

As a result of the architectural subcommittee's meeting with Mr. Murrow, the subcommittee arranged a meeting

with Mr. Vincent G. Kling of Philadelphia on 16 October 1963 to discuss the preparation of a master plan for the Norfolk medical center. Mr. Kling told the subcommittee that the coordinating architectural costs would be in the range of \$25,000 to \$50,000. After several hours of discussion, the subcommittee decided to hire Mr. Kling as the coordinating, architect planner. The minutes of the subcommittee's meeting state, in part, "[Vincent Kling] has extensive experience in the field of health facilities, of area planning, and . . . [has received] many national awards."⁸⁰

On 10 January 1964 the architectural subcommittee of the Norfolk Medical Center Commission met with Mr. Warren Phelaps, Regional Director of the Housing and Home Finance Agency in Philadelphia, to discuss the financing of the medical center.⁸¹ At the 15 January 1964 meeting of the Norfolk Medical Center Commission, Dr. Andrews told the members of the commission that the architectural subcommittee had met with Mr. Phelaps and that the medical center might qualify as a public works project; however, the commission decided to defer the question of financing the medical center until a more thorough review could be conducted. Dr. Andrews recommended, and the commission approved, that \$10,000 in local funds be used in the interim to defray the initial cost of a contract proposal from the firm of Vincent Kling.⁸²

Appointment of Dr. Vernon E. Wilson

Dr. Charles Horton, a well-known plastic surgeon in Norfolk, was acquainted with Dr. Vernon E. Wilson, dean of the University of Missouri School of Medicine. Dr. Wilson had expertise in the planning and development of medical centers. Dr. Horton noted that Dr. Wilson came to be associated with the proposed medical center and medical school in Norfolk as a result of a discussion between the two of them in 1963. Dr. Horton recalled:

When I was a visiting professor of plastic surgery at the University of Missouri School of Medicine, I began talking to their dean--Dr. Vernon Wilson. I told him that we wanted a medical school in Norfolk, but that we really didn't know how to start it. I asked him to come here and look the situation over. He agreed to come to Norfolk, and was later invited to return to Norfolk by a very informal group of people who had a great desire for a medical school here. I introduced him to Mason Andrews and some of the town leaders.⁸⁴

Dr. Andrews discussed the proposal for the Norfolk Medical Center Complex with Dr. Wilson on numerous occasions after Dr. Wilson's first visit to Norfolk. Dr. Wilson agreed to offer his services without fee except for actual travel expenses.⁸⁵ At the 15 January 1964 meeting of the Norfolk Medical Center Commission, Dr. Andrews proposed that Dr. Wilson be appointed as a consultant on the technical development of the proposed medical center complex. Dr. John Franklin strongly supported Dr. Andrew's proposal and the commission unanimously passed the motion. Dr. Horton would later say of Dr. Wilson, "He became our chief consultant and plans-maker. He told us how to go about

starting a medical school step-by-step."⁸⁶

Architectural Master Plan Developed

The Norfolk Medical Center Commission held a series of meetings in February 1964 to discuss development of the area medical center. In addition to the commission's members, the meetings were attended by Mr. Vincent Kling, Dr. Vernon Wilson, and representatives from the Norfolk Cardiac Diagnostic Clinic, the Norfolk Mental Health Center, the Norfolk Research Foundation, the Proprietary Psychiatric Hospital in Norfolk, and the Southeastern Tidewater Rehabilitation Center. At the last February 1964 meeting of the Norfolk Medical Center Commission, it was concluded that the development of an area medical center would be a monumental task and that present hospital facilities were not particularly suited for teaching medical and para-medical personnel.⁸⁷

News of the proposed medical center complex rapidly spread throughout the Hampton Roads area. At the medical center commission's 27 February 1964 meeting, Rabbi Malcolm H. Stern of the Norfolk Jewish Community Council requested that the commission provide a building site within the proposed medical center complex for the construction of a home for the aged. Mr. Richard F. Welton, III, a local businessman and member of the medical commission, recommended that Rabbi Stern's request be forwarded to the coordinating architect, Mr. Kling, for possible

incorporation into the master plan. The commission unanimously approved the motion.⁸⁸

By the end of March 1964, the Norfolk Medical Center Commission had received over \$10,000 in donations: \$500 from S. L. Nusbaum, \$5,000 from the Norfolk County Medical Society, and \$5,000 from the Norfolk Foundation.⁸⁹ The commission proceeded to contract Mr. Kling to begin preliminary work on the draft architectural master plan for the medical center complex.⁹⁰

Several non-members attended the 11 April 1964 meeting of the Norfolk Medical Center Commission. They included: Vincent G. Kling of the American Institute of Architecture; Richardson Noback, M.D., medical consultant; Joseph Marzella, associate of Vincent Kling; Elizabeth Chambers, Norfolk Ledger-Dispatch newspaper; and William Stevens, Virginian-Pilot newspaper.⁹¹ Dr. Noback emphasized the need to develop a major research facility within the medical center complex. He believed that a major research facility would attract high caliber professional personnel in terms of teaching and community practice. In his concluding remarks, Dr. Noback noted that while the ratio of medical staff-to-patients in teaching hospitals was generally 2-to-1, the ratio of medical staff-to-patients at Norfolk General Hospital was 1-to-2.⁹² (A list of the seven principal points Dr. Noback recommended is provided in appendix 15.)

After Dr. Noback's address to the medical commission,

Dr. Vernon Wilson presented a scale model of the proposed Norfolk Medical Center. It represented an estimated land area requirement of 130 acres. Dr. Wilson noted that the medical center commission should determine whether the commission or the individual facilities would hold the land title and ownership to the property. He concluded his remarks by suggesting that all component facilities of the medical center be oriented toward a medical-teaching objective.⁹³

At the medical commission's 2 May 1964 meeting, Mr. Kling offered two potential architectural designs for the proposed medical center complex:

1. A campus-type center incorporating a large land area
2. A compact unit-type center (This plan was designed like a two-story mall with service entrances to the medical facilities and parking areas.)⁹⁴

Mr. Kling recommended that the medical center complex be conceived and planned as a total unit and not as a group of autonomous facilities. The unit approach would ensure effective programming and the elimination of duplication.⁹⁵

Significant Studies

Several studies were made to determine the feasibility of establishing a medical school in Norfolk. The first study was initiated by the Norfolk City Council in 1961. The second significant study was House Bill 229 in which the state legislature in 1962 directed the Virginia Council of Higher Education to study the feasibility and

advisability of establishing a medical school in the Hampton Roads area. The third significant study was made by the Mayor's Advisory Committee on the Establishment of a Medical School in Norfolk. This latter study was especially significant because it brought together local leaders from different segments of the community to forge a unified community effort for the establishment of a local medical school.

City of Norfolk Studies the Feasibility
of a Medical School

On 28 January 1961 the Norfolk Ledger-Dispatch reported that "upon the well-timed suggestion of Councilman Roy B. Martin, Jr., Council [of the City of Norfolk] has directed City Manager Thomas F. Maxwell to study and report on the steps the city should take in seeking a medical college."⁹⁶ Councilman Martin's suggestion was heavily influenced by the growing public support for a medical school in Norfolk.⁹⁷ Many local citizens perceived a medical school in Norfolk as a potential economic and social asset to the city and for this reason offered their support.

The results of the city manager's report were favorable. The report suggested that proponents for the medical school prepare a sound foundation and identify sources of financial support.

Virginia Legislature Studies the Feasibility
of a Third Medical School in Virginia

Several events occurred in 1962 to strengthen the

cause of establishing a medical school in Norfolk. The most significant of these events was the passage of two state legislative acts. The Virginia General Assembly, pursuant to Senate Joint Resolution (S.J.R.) No. 44 and House Bill (H.B.) 229, directed the State Council of Higher Education to undertake two studies on medical education in Virginia. Specifically, H.B. 229, approved by the Virginia General Assembly on 31 March 1962, directed the Virginia State Council of Higher Education to "make a careful and comprehensive study of the feasibility and advisability of establishing a private school of medicine in the Tidewater area."⁹⁸ S.J.R. No. 44 directed the state council to study medical education across the state. Since both studies were directed at somewhat similar concerns, the State Council of Higher Education treated them as parts of a general, comprehensive study. Both studies were completed in December 1963.

Report to the Governor and General Assembly of
Virginia on the Feasibility of Establishing
a Private Medical School in the
Hampton Roads Area

The State Council of Higher Education, as directed by the Virginia General Assembly in March 1962, submitted in December 1963 two reports on medical education to the Virginia General Assembly and to Governor Albert S. Harrison. The two reports were submitted as Physicians for Virginia--Part I and Physicians for Virginia--Part II. Part I of the comprehensive study was in response to Senate Joint

Resolution No. 44 directing a statewide study of medical education.⁹⁹ Part II was in response to House Bill 229 which directed the State Council on Higher Education to "make a careful and comprehensive study of the feasibility and advisability of establishing a private school of medicine in the Tidewater area."¹⁰⁰

Physicians for Virginia--Part II reported the State Council's findings and recommendations along with a presentation of supporting data for the establishment of a medical school in the Hampton Roads area. The twenty-four page report was highly favorable toward the proposed medical school. The report recognized several factors that favored the Hampton Roads area as a site for the development of a new medical school. It also recommended that certain considerations for a new medical school be analyzed. These considerations included sponsorship, community and government endorsement, financial requirements, student resources, and patient resources. As a prelude to each of these considerations, a statement prepared by the Association of American Medical Colleges and the Council on Medical Education and Hospitals of the American Medical Association was offered. (The state council's discussion of each of these five considerations is provided in appendix 16. The report's "Proposed Schedule for Development of a New Medical School" is provided in appendix 17, and a summary of the state council's conclusions is provided at appendix 18.)

The State Council of Higher Education offered three

recommendations on the feasibility of establishing a private medical school in the Hampton Roads area. The first recommendation was addressed to the General Assembly of Virginia, and the second and third recommendations were addressed to the citizens of Hampton Roads. The State Council's recommendations stated:

1. The General Assembly should be encouraged to look with favor upon the proposed development of a new, private, four-year medical project short of financial obligation in recognition that the construction and operation of such a school would make a substantial contribution to the State's increasing need for physicians.
2. If citizens of Hampton Roads, after careful review of the challenge involved in the construction and operation of a private medical school, should decide to implement their plan for such a school, the citizens of Virginia should give every type of support to the project because of the inherent benefits that can be derived for all Virginians.
3. If citizens of Hampton Roads should proceed with plans to construct and operate a private medical school, it is recommended that its development be continued under the guidance and leadership of representatives of the American Medical Association and the Association of American Medical Colleges.¹⁰¹

Although the state council's study did not recommend state subsidies for the proposed medical school in Norfolk, it did recommend legislative support. Norfolk's legislative constituency in the state legislature was small, but persistent and effective regarding the proposed medical school.

(A more thorough discussion of Norfolk's legislative support is provided in Chapter V.) Most important of all, the state council's report provided supporters of the proposed medical

school the impetus to continue their efforts.

Mayor's Advisory Committee on the Establishment
of a Medical School in Norfolk.

Dr. John S. Thiemeyer, Jr., proposed to the Norfolk City Council early in 1963 the establishment of a mayor's committee to study the issue of creating a medical school in Norfolk. Roy B. Martin, Jr., the mayor of Norfolk, was "a good friend of mine,"¹⁰² Dr. Thiemeyer recalled.

The Norfolk City mayor's office sent a letter on 19 April 1963 to six prominent citizens in the city advising them of their appointment to the Mayor's Advisory Committee on the Establishment of a Medical School in Norfolk. One of the appointees, Mr. Barron F. Black, later commented that he found out about his appointment by "reading my name in the newspaper."¹⁰³

The members of the committee represented diverse, but important segments of the community. In addition, each individual was considered to be an influential member in the community who would work diligently to produce a quality, comprehensive study. The committee's membership included:

Barron Black, Chairman	Norfolk attorney
Mason Andrews, M.D.	President, Norfolk Medical Tower Corporation
Lawrence M. Cox	Director, Norfolk Redevelopment and Housing Authority
Hon. Walter A. Page	Norfolk judge
John Thiemeyer, Jr., M.D.	President, Norfolk County Medical Society
J. Hoge Tyler, III	President, Seaboard Citizens National Bank
Lewis W. Webb, Jr.	President, Old Dominion College
Hon. J. Warren White, Jr.	Virginia House of Delegates, Norfolk representative

Dr. Thiemeyer, president of the Norfolk County Medical Society, was requested to convene the first meeting of the mayor's advisory committee.¹⁰⁴ The meeting was subsequently scheduled for 17 May 1963 in Dr. Thiemeyer's office at the Norfolk Medical Tower.¹⁰⁵ The committee's membership elected Mr. Barron F. Black, a Norfolk attorney and former Chancellor of the University of Virginia, as chairman of the advisory group.

From the first meeting in Dr. Thiemeyer's office, the committee members vigorously pursued making contacts and gathering information for the study. Community organizations were encouraged to financially support the proposed medical school. By the end of June 1963, the committee had received twenty-two resolutions from organizations in the Hampton Roads area endorsing and offering their financial support for the proposed medical school.¹⁰⁶

In addition to communicating with such local people as Dr. Charles Horton, a prominent plastic surgeon; Toy Savage, board of directors, Norfolk General Hospital; and Henry Shriver, a noted individual in higher education, experts and agencies across the country were solicited for advice and support. Mr. Thomas C. Boushall, chairman of the State Council of Higher Education's Committee on Medical Education, offered the mayor's advisory committee valuable advice on how to develop its study and present it to the State Council on Higher Education in a favorable manner. Dr. Richard Prindle of the U.S. Public Health Service in

Washington, D.C., provided extensive statistical data which the mayor's advisory committee would later use. Dr. Vernon E. Wilson, dean of the University of Missouri School of Medicine and an authority on medical education, offered advice on how to get a new medical school started.¹⁰⁷

At the request of the mayor's advisory committee, the Norfolk City Council appropriated one thousand dollars for the committee's operating expenses. On 4 June 1963 the mayor's office, somewhat reluctantly, sent a check to Mr. Black, the committee's chairman.¹⁰⁸

Dr. Andrews Presents the Medical School Proposal
to the Committee on Medical Education

On 27 June 1963 the mayor's advisory committee presented a thirty-six page brief to the State Council of Higher Education's Committee on Medical Education. It addressed the need for a medical school in the Hampton Roads area from a local, state, and national perspective. In addition, attention was directed to the problem of how the private medical school should be financed. The report concluded:

The need for additional medical education facilities is apparent. The real questions are where they should be located and how they can be provided within the public and private resources available. The facts set forth here impel the conclusion that Tidewater Virginia is the only feasible location [in Virginia] for this facility.¹⁰⁹

As a result of dialogue early in 1963 between Dr. Mason Andrews and Mr. James W. Bailey, assistant director of the State Council of Higher Education, and a presentation by

Dr. Andrews to the State Council of Higher Education's Committee on Medical Education, it was suggested that Dr. Andrew's briefing should be compiled into a printed version and submitted to the Committee on Medical Education for the committee's evaluation.¹¹⁰ Subsequent dialogue between Mr. James Bailey and Mr. Thomas Boushall indicated that it would be advisable to publish a brochure highlighting the need and feasibility of establishing a medical school in Norfolk.¹¹¹ With the approval of the members of the mayor's advisory committee, it was decided that Dr. Andrews should be in charge of producing the brochure and that support from Mr. Bailey and Mr. Boushall would be requested as needed. The brochure, entitled "A New MEDICAL SCHOOL in Norfolk," was published in August 1963 and subsequently submitted to the state council's Commission on Medical Education and to the Norfolk City Council.¹¹² In the interim, Mr. Black sent a letter to the members of the mayor's advisory committee citing one of the findings by the state council's Committee on Medical Education in its investigation into the need for a third medical school in Virginia. The Medical Education Committee's unfinished report, Mr. Black noted with enthusiasm, stated:

In light of the relatively serious situation that is developing in Virginia with regard to the probable demand for more physicians in the years ahead and the limitations that appear to be likely in providing many more medical school graduates through state-supported medical schools in the foreseeable future, it is a most opportune time to review the proposal of a group of citizens from the Hampton Roads area to develop a private medical school. A combination of resources and circumstances in

the Hampton Roads area provides an opportunity to attract a private medical school that would substantially assist the State in meeting its growing needs for physicians beginning in 1975. Such a school could yield important medical, economic and cultural benefits to the entire State.¹¹³

Efforts To Gain Support Accelerated

Mr. Lawrence M. Cox was still gathering information in support for the medical school two years after his speech at the dedication of the Norfolk Medical Tower in which he voiced strong support for the establishment of a medical school in Norfolk. At his request, the Department of Health, Education, and Welfare (HEW) in Washington, D.C., supplied him with tables, charts, and other data relevant to the supply of physicians in Virginia. In a 21 May 1963 letter to Mr. Cox from HEW, the following points were emphasized:

1. In relation to population, Virginia has only about 85 percent as many physicians as the national average.
2. The highest ratios of physicians to population are found in the Charlottesville and Richmond trade areas. . . . The relative lack of physicians in the Norfolk and surrounding trade areas is apparent.
3. The Norfolk SMSA [standard metropolitan statistical area] has 42 percent more population than Richmond, but 14 percent fewer physicians.
4. Virginia ranks 41st among the states in the proportion of young people who enter medical school.
5. In all of Virginia, young people from the Richmond area attend medical school at the highest rate. Next highest is the Charlottesville area. Of the 19 trade areas in the state, the Norfolk area ranks 13th in the proportion of young people attending medical school.
6. Medical school graduates tend to settle and practice

in the area in which they take their residency training. In relation to its population, the number of residencies offered in Virginia hospitals is . . . only 64 percent of the national average. An increase in the number of good residencies offered in Virginia would in itself attract more physicians to practice in the State. An increase in Norfolk could be expected to attract more physicians to Norfolk.¹¹⁴

Financial Considerations

The first serious consideration given to financial funding of the proposed medical school in Norfolk was in 1963. In a 27 December 1963 letter to the Norfolk City Manager, Mr. Barron Black stated that the Mayor's Advisory Committee on the Establishment of a Medical School in Norfolk had not recommended that the state legislature be approached for financial support. The committee's rationale was:

1. The General Assembly probably would not provide funds.
2. The state should not be asked to support a third medical school. A request from the state at this time for financial support might jeopardize any attempts at establishing a medical school in Norfolk.¹¹⁵

The Journal of the American Medical Association (JAMA) reported in 1963 that there were eighty-seven approved medical schools in the United States. Of these, forty-six were private and forty-one were public medical schools.¹¹⁶ Financial support for these medical schools came from the sources listed in table 5.¹¹⁷

TABLE 5

FINANCIAL SOURCES FOR MEDICAL SCHOOLS

Source	Percent of Expenditures
Tuition and fees	6.4
Endowment income + Unrestricted gifts & grants	6.7
Payment for medical services + Services & facilities provided by teaching hospitals & clinics.	7.4
State appropriations	15.6
Grants for research projects + Grants for research training programs.	53.9

The JAMA article reported that the federal government was the principal source of money for supporting research projects and research training programs of the medical schools. In all, the federal government provided an estimated 40 percent of all money expended by medical schools in 1960 and 1961.¹¹⁸

The mayor's advisory committee was aware of the 1963 JAMA article in which eight categories of funding sources for medical schools and the overall financial contribution each source made to the medical schools were identified. This knowledge would later influence the direction the committee would take in their search for financial backing.¹¹⁹

Turning Point

The period 1959 to 1964 is important because a handful of local, civic-minded citizens saw the need for expanded medical services in Eastern Virginia. They

believed that the establishment of a medical school in Norfolk would be a long-term solution to a problem that had existed for several decades in Eastern Virginia.

There was no one leader, but several leaders. They came from diversified occupations, but were able to come together as a group and exert a concerted effort to gain public support for a local medical school. The passage of state legislation in 1964 to create the Norfolk Area Medical Center Authority was a significant milestone in their efforts. From that point on, the idea of a medical school in Norfolk was no longer just an idea--it was an embryo waiting to be born.

FOOTNOTES

¹Paul J. Sanazaro, M.D., "An Agenda for Research in Medical Education," Journal of the American Medical Association 197 (September 1966):979-84.

²Ward Darley, M.D., "Family Practice of the Future: Fact or Fiction?" Journal of Medical Education 32,2 (December 1961):142-49.

³Ward Darley, M.D., "Physicians for the Future," Journal of Medical Education 40 (November 1965):1086-96.

⁴Vernon W. Lippard, A Half-Century of American Medicine: 1920-1970 (New York: Josiah Macy, Jr., Foundation, 1974), p. 117.

⁵Ibid.

⁶Lawrence M. Cox, "New Medical School?," Norfolk Ledger-Dispatch, 19 February 1959, p. 17.

⁷Joint Committee on House Staff Procurement and Education, Minutes of the Organizational Meeting, DePaul Hospital, Norfolk, Virginia, 12 July 1960.

⁸Interview with John S. Thiemeyer, Jr., M.D., Hampton, Virginia, 13 February 1985.

⁹Ibid.

¹⁰Ibid.

¹¹Ibid.

¹²"How to Rebuild a Dwindling House Staff," Norfolk General Hospital, 30 October 1960, Personal Files of John S. Thiemeyer, Jr., M.D., Norfolk, Va.

¹³Ibid.

¹⁴Interview with John S. Thiemeyer, Jr., M.D., 13 February 1985.

¹⁵Ibid.

¹⁶Ibid.

¹⁷ Ibid.

¹⁸ Ibid.

¹⁹ Ibid.

²⁰ Ibid.

²¹ "How to Rebuild a Dwindling House Staff," 30 October 1960, Personal Files of John S. Thiemeyer, Jr., M.D.

²² Ibid.

²³ Ibid.

²⁴ Ibid.

²⁵ Barron F. Black, chairman of the Distribution Committee of the Norfolk Foundation, to Sister Mary Elizabeth, administrator of DePaul Hospital; John Merritt, administrator of Leigh Memorial Hospital; and Roy L. Prangley, administrator of Norfolk General Hospital; 9 June 1960, Personal Files of John S. Thiemeyer, Jr., M.D.

²⁶ "How to Rebuild a Dwindling House Staff," 30 October 1960, Personal Files of John S. Thiemeyer, Jr., M.D.

²⁷ Interview with John S. Thiemeyer, Jr., M.D., 13 February 1985.

²⁸ "How to Rebuild a Dwindling House Staff," 30 October 1960, Personal Files of John S. Thiemeyer, Jr., M.D.

²⁹ Ibid.

³⁰ Ibid.

³¹ Interview with John S. Thiemeyer, Jr., M.D., 13 February 1985.

³² John S. Thiemeyer, Jr., M.D., president of the DePaul Hospital Medical Staff, to Roy R. Prangley, administrator of Norfolk General Hospital, and John Merritt, administrator of Leigh Memorial Hospital, 13 April 1960, 19 April 1960, and 24 May 1960, Personal Files of John S. Thiemeyer, Jr., M.D.

³³ Ibid., 24 May 1960.

³⁴John S. Thiemeyer, Jr., M.D., president of the DePaul Hospital Medical Staff, to members of the Norfolk County Medical Society, the Executive Committee of the DePaul Hospital Medical Staff, Judge Walter Page, and Messrs. Prieur and Stokley, 19 April 1960, Personal Files of John S. Thiemeyer, Jr., M.D.

³⁵Wickham Taylor, M.D., President of the Norfolk County Medical Society, to John S. Thiemeyer, Jr., M.D., 13 May 1960, Personal Files of John S. Thiemeyer, Jr., M.D.

³⁶Joint Committee on House Staff Procurement and Education, Minutes of the Organizational Meeting, 12 July 1960.

³⁷Ibid.

³⁸Ibid.

³⁹Ibid.

⁴⁰Norfolk County (Virginia) Medical Society, Minutes of the Regular Board Meeting, 5 April 1960.

⁴¹Ibid., 15 November 1960.

⁴²Ibid., 4 October 1960.

⁴³Joint Committee on House Staff Procurement and Education, Minutes of the Organizational Meeting, 12 July 1960.

⁴⁴Policy Formulating Committee, subcommittee of the Joint Committee on House Staff Procurement and Education, DePaul Hospital, Norfolk, Va., 5 August 1960.

⁴⁵Ibid.

⁴⁶Roy R. Prangle, presentation to the Medical Staff Officers and Board of Directors, Norfolk General Hospital, Norfolk, Virginia, 17 September 1960.

⁴⁷Ibid.

⁴⁸Ibid.

⁴⁹"How to Rebuild a Dwindling House Staff," 30 October 1960, Personal Files of John S. Thiemeyer, Jr., M.D.

⁵⁰Ibid.

⁵¹Ibid.

⁵² Ibid.

⁵³ Ibid.

⁵⁴ Lawrence M. Cox, speech delivered at the dedication of the Norfolk Medical Tower Building, Norfolk, Virginia, 14 January 1961, Personal Files of John S. Thiemeyer, Jr., M.D.

⁵⁵ Norfolk County (Virginia) Medical Society, Minutes of the Executive Committee Meeting, 21 March 1961.

⁵⁶ Ibid.

⁵⁷ Norfolk County (Virginia) Medical Society, Minutes of the Regular Board Meeting, 4 April 1961.

⁵⁸ Ibid.

⁵⁹ Ibid.

⁶⁰ Norfolk County (Virginia) Medical Society, Minutes of the Executive Committee Meeting, 3 October 1961.

⁶¹ Medical Society of Virginia, Annual Report--1961 (Richmond, Va., 1961), p. 7.

⁶² Norfolk County (Virginia) Medical Society, Minutes of the Regular Board Meeting, 6 March 1962.

⁶³ Physicians For Virginia--Part II, A Report from the State Council of Higher Education to the Governor and the General Assembly of Virginia, Richmond, Va., December 1963, p. 12.

⁶⁴ Ibid.

⁶⁵ Ibid.

⁶⁶ Ibid.

⁶⁷ Ibid.

⁶⁸ Ibid.

⁶⁹ Ibid.

⁷⁰ Ibid.

⁷¹ Lawrence M. Cox to John M. Franklin, M.D., 27 January 1961, Franklin papers, Moorman Memorial Library (archives), Eastern Virginia Medical School, Norfolk, Va.

⁷²Norfolk County (Virginia) Medical Society, Minutes of the Regular Board Meeting, 19 February 1962.

⁷³Ibid.

⁷⁴Interview with Mason C. Andrews, M.D., 28 January 1985.

⁷⁵Ibid.

⁷⁶Norfolk Medical Center Commission, Minutes of the Architectural Subcommittee, Norfolk, Virginia, 16 October 1964.

⁷⁷Ibid.

⁷⁸Ibid.

⁷⁹Ibid.

⁸⁰Ibid.

⁸¹Norfolk Medical Center Commission, Minutes of the Regular Board Meeting, Norfolk, Virginia, 15 January 1964.

⁸²Ibid.

⁸⁴Interview with Charles E. Horton, M.D., professor of Plastic Surgery, Eastern Virginia Medical School, Norfolk, Virginia, 7 February 1985.

⁸⁵Ibid.

⁸⁶Interview with Charles E. Horton, M.D., 7 February 1985.

⁸⁷Norfolk Medical Center Commission, Minutes of the Regular Board Meeting, 27 February 1964.

⁸⁸Ibid.

⁸⁹Ibid.

⁹⁰George F. Rice, secretary/treasurer of the Norfolk Medical Center Commission, to members of the Norfolk Medical Center Commission, 19 March 1964, Franklin papers, Moorman Memorial Library (archives), Eastern Virginia Medical School.

⁹¹Norfolk Medical Center Commission, Minutes of the Regular Board Meeting, 11 April 1964.

⁹²Ibid.

⁹³Ibid.

⁹⁴Ibid., 2 May 1964.

⁹⁵Ibid.

⁹⁶"A Medical College: A Challenge," The Norfolk Ledger-Dispatch, 28 January 1961, p. 4.

⁹⁷Interview with John S. Thiemeyer, Jr., M.D., 13 February 1985.

⁹⁸Virginia, General Assembly, H.B. 229, 31 March 1962.

⁹⁹Virginia, General Assembly, S.J.R. No. 44, 31 March 1962.

¹⁰⁰Virginia, General Assembly, H.B. 229, 31 March 1962.

¹⁰¹Physicians for Virginia--Part II, December 1963, p. 19.

¹⁰²Interview with John S. Thiemeyer, Jr., M.D., 13 February 1985.

¹⁰³Barron F. Black, chairman of the Mayor's Advisory Committee on the Establishment of a Medical School in Norfolk, to members of the Mayor's Advisory Committee, 29 May 1963, Personal Files of John S. Thiemeyer, Jr., M.D.

¹⁰⁴Mary M. Randolph, Deputy City Clerk of Norfolk, to John S. Thiemeyer, Jr., M.D., 10 April 1963, Personal Files of John S. Thiemeyer, Jr., M.D.

¹⁰⁵J. Warren White, member of the Mayor's Advisory Committee on the Establishment of a Medical School in Norfolk, to members of the mayor's advisory committee, 8 May 1963, Personal Files of John S. Thiemeyer, Jr., M.D.

¹⁰⁶Barron F. Black, chairman of the Mayor's Advisory Committee on the Establishment of a Medical School in Norfolk, Brief of the Mayor's Advisory Committee on the Establishment of a Medical College in the Tidewater Area, (Norfolk, Virginia, 27 June 1963), appendix D.

¹⁰⁷Interview with Charles E. Horton, M.D., 7 February 1985.

¹⁰⁸Roy B. Martin, Jr., mayor of the City of Norfolk, to Barron F. Black, 4 June 1963, Personal Files of John S. Thiemeyer, Jr., M.D.

¹⁰⁹Black, Brief of the Mayor's Advisory Committee, 1963, appendix D.

¹¹⁰James W. Bailey, assistant director of the [Virginia] State Council of Higher Education, to Mason C. Andrews, M.D., 16 April 1963, Personal Files of John S. Thiemeyer, Jr., M.D.

¹¹¹Thomas C. Boushall, chairman of the Bank of Virginia, to Barron F. Black, chairman of the Mayor's Advisory Committee on the Establishment of a Medical School in Norfolk, 17 April 1963, Personal Files of John S. Thiemeyer, Jr., M.D.

¹¹²Norfolk County (Virginia) Medical Society and the Norfolk Redevelopment and Housing Authority, A New Medical School in Norfolk, 1963.

¹¹³Barron F. Black, Chairman, Mayor's Advisory Committee on the Establishment of a Medical School in Norfolk, to members of the mayor's advisory committee, 14 October 1963, Personal Files of John S. Thiemeyer, Jr., M.D.

¹¹⁴Margaret D. West, assistant chief of the Division of Public Health Methods, Department of Health, Education, and Welfare, Washington, D.C., to Lawrence Cox, director of the Norfolk Redevelopment and Housing Authority, 21 May 1963, Personal Files of John S. Thiemeyer, Jr., M.D.

¹¹⁵Barron F. Black, chairman of the Mayor's Advisory Committee on the Establishment of a Medical School in Norfolk, to Thomas F. Maxwell, Norfolk City Manager, Norfolk, Virginia, 27 December 1963, Personal Files of John S. Thiemeyer, Jr., M.D.

¹¹⁶William D. Willard, M.D., "The Widening Gap Between Two Extreme Groups of Medical Schools," Journal of the American Medical Association (3 August 1963):105.

¹¹⁷Ibid.

¹¹⁸Ibid.

¹¹⁹Barron F. Black to John S. Thiemeyer, Jr., M.D., 5 November 1963, Personal Files of John S. Thiemeyer, Jr., M.D.

CHAPTER V

THE FIRST DECADE OF THE NORFOLK AREA MEDICAL CENTER AUTHORITY

The Norfolk Area Medical Center Authority

The establishment of a medical school and medical center in Norfolk was perceived by many prominent, local physicians in the early 1960s as a means to improving medical education in the Hampton Roads area. As support from community leaders increased, it became apparent that it was vital to have an effective means for the definition of objectives for area medical growth, general program direction, land use, encouragement of joint planning, and a framework conducive to orderly growth and development. Development and growth would have to be focused not only on the proposed medical school, but attention would have to be given to the medical center as well.

Proponents for the medical school realized that public support was necessary if there was to be a medical school in Norfolk. They also knew that the state legislature would not on its own initiative establish and support a medical school in Norfolk. Proponents believed that it had to be initiated by the private sector, yet authorized by public legislation. With this in mind, the

idea of establishing a medical authority was first discussed at the 15 January 1964 meeting of the Norfolk Medical Center Commission, a municipal agency organized to identify the medical needs of the city's population.¹ Officials of the medical commission agreed that the primary purpose of establishing a medical authority was to create a public agency that could work with the metropolitan area, the respective Hampton Roads communities, and state health agencies in regard to overall community health and medical needs.² Mr. Toy D. Savage, the commission's chairman, discussed three methods by which the Norfolk Medical Center Commission could be established as a medical authority. They were:

1. An amendment to the Norfolk City charter
2. A general legislative bill making it permissible for any city or county to create a medical center authority
3. A specific action of the state legislature to create a medical authority³

The members of the medical center commission discussed at length Mr. Savage's remarks. (A list of the attendees at the 15 January 1964 Norfolk Medical Center Commission meeting is provided in appendix 19.) Several actions were recommended and approved such as:

1. Mr. Lawrence Cox recommended that a medical center authority be established through a specific action of the state legislature. Mr. Roy Charles seconded Mr. Cox's motion.
2. Dr. John Franklin recommended that the proposed medical center authority be named the Norfolk Area Medical Center Authority (NAMCA). Mr. Clifford Adams seconded Dr. Franklin's recommendation.

3. Mr. John L. Roper II recommended that the medical authority be composed of seven commissioners, two of whom were to be from the medical profession.
4. Capt. Fred C. Ray (U.S. Navy Ret'd), assistant to the Norfolk City Manager, recommended that the appointment of the seven medical authority commissioners be vested in the Norfolk City Council. Captain Ray's recommendation was seconded by Mr. Philip Steadfast, director of the Planning Department for the City of Norfolk.
5. Mr. Roy R. Charles recommended that the Norfolk City resident requirement be waived in the appointment of commissioners to the medical authority.
6. Dr. John S. Thiemeyer, Jr., recommended that each commissioner be appointed for a three-year term, and that the maximum number of terms be set at two.⁴

Mr. Savage told the members of the Norfolk Medical Center Commission that the recommendations approved by the commission would be presented to the Norfolk City Council with the request that the council have the city attorney's office prepare a legislative bill for consideration by the Virginia General Assembly.

TOY D. SAVAGE, JR.: We realized in the early 1960s that we needed a local medical school if we were to have quality medical care in this area. There were many problems we had to solve, such as how to get political support from all the cities in the Hampton Roads area, how to get financial support from the state, and how to get the General Assembly of Virginia to approve the concept of a medical school to be located in Norfolk.

We knew it would be necessary to have the Virginia State Council of Higher Education investigate the need for another medical school for Virginia--a medical school that would serve the people of Eastern Virginia. The state council subsequently did a study which endorsed the concept of a medical school in this area. After that, the Norfolk Medical Center Commission concluded that the best way to get a medical school was to first establish a medical authority. So, Sam McGann, the assistant Norfolk City Attorney, and I drafted the necessary legislation

for presentation to the General Assembly.⁴

A public hearing was subsequently scheduled for 21 January 1964.⁵ A few days later a bill incorporating the recommendations of the Norfolk Medical Center Commission was prepared and submitted to the Virginia General Assembly. Area legislators of the Virginia House of Delegates who endorsed the bill included Messrs. J. Warren White, James W. Roberts, Theodore C. Pilcher, William H. Hodges, Robert E. Gibson, William P. Kellam, Pressley B. White, Henry E. Howell, Bernard Levin, Donald H. Sandie, Virgil J. Cox, Willard J. Moody, J. Lewis Rawls, James B. Fugate, and Arthur H. Richardson.⁷

Although several area legislators played significant roles in the creation of the Norfolk Area Medical Center Authority and eventually the Eastern Virginia Medical School, one of the first and perhaps most significant legislators was Del. J. Warren White, who was elected to the Virginia House of Delegates in 1961 and served for the next eighteen years.⁸ During this time, he maintained his position as president and treasurer of Old Dominion Paper Company in Norfolk.⁹

Delegate White was perhaps best known for his conciliatory manner and perserverance.¹⁰ Dr. John S. Thiemeyer, Jr., former chairman of the Mayor's Advisory Committee on the Establishment of a Medical School in Norfolk; Dr. Mason C. Andrews, professor and chairman of the Department of Obstetrics and Gynecology at the Eastern

Virginia Medical School; and Mr. Toy Savage, former member of the Virginia House of Delegates, worked closely with Delegate White to bring a medical school to Norfolk. Excerpts of their recollections regarding Delegate White's role are as follows:

JOHN S. THIEMEYER, JR., M.D.: It is important to understand the political difficulty we had in getting the Virginia Legislature to consider our proposal for a medical school in Norfolk. This is where J. Warren White, a member of the House of Delegates, came in. His political maneuvering in the House to help us get state approval is probably underestimated and little understood.

J. Warren White had been a delegate from Norfolk for a couple of years when we asked him for his support. His family ties to Norfolk went back several generations. Once we convinced him of the advantages of having a medical school here, he became one of the medical school's most ardent supporters. He was appointed to the Mayor's Advisory Committee [on the Establishment of a Medical School in Norfolk] and was asked to help us get approval from the state legislature on the idea of a medical school along with state financial support. We also asked for his assistance in getting the state council's Committee on Medical Education to take a look at our proposal for a medical school.

Warren just would not give up on the idea of a medical school here in Norfolk. He was confronted with tremendous political opposition in the state legislature stemming from the state's other two medical schools. They were opposed to a third medical school in the state because they feared it would mean less state funds for them. Generally speaking, the Tidewater area traditionally did not have a lot of political pull in the state legislature and this made our task even more difficult.¹¹

MASON C. ANDREWS, M.D.: It was Warren's idea to create a medical authority. The idea of a medical authority had the stigma of another government agency and another level of bureaucracy. Virginia is a very conservative state and, as a result, people criticized him for backing the medical authority. Warren was convinced that an essential step to getting a medical school in Norfolk was the creation

of a medical authority. He believed it would be a good thing for our people and he worked hard for its support. He was instrumental in getting the state legislature to approve it.¹²

JOHN S. THIEMEYER, JR., M.D.: With J. Warren White's political maneuvering and backroom negotiations, the Commission on Medical Education reviewed our proposal and publicly announced their endorsement. Less than a year later, the state legislature gave their approval for us to establish a medical authority.

The problem of getting state funds seemed insurmountable. State legislators wouldn't go along with it. Warren, as time passed, helped convince the legislature to provide some state subsidy, although it was small compared to that received by the other two medical schools. J. Warren White was a tremendous asset in our efforts and not enough can be said about him.¹³

MASON C. ANDREWS, M.D.: His skill, coupled with his happy, comfortable relationship with others helped persuade people to his point of view.¹⁴

TOY D. SAVAGE: He was one of the most effective legislators and businessmen that Norfolk has had in a number of years. One reason was that he was one of the most enjoyable companions. It was amazing what he could get done.¹⁵

Guy Friddell, a local newspaper reporter and author, noted that Del. White's final plea for state approval to establish the Eastern Virginia Medical School was "Aw, c'mon fellows, this is a good thing."¹⁶ As a result of the efforts of Delegate White and other local legislators, chapters 471 and 440 of the Code of Virginia were passed by the Virginia General Assembly on 25 March 1964¹⁷ and signed by the Governor of Virginia on 31 March 1964.¹⁸ Chapter 471 provided a mandate to establish a private school of medicine in Hampton Roads.¹⁹ Chapter 440 pertained specifically to the inclusion of the medical authority as an educational

institution.²⁰

In addition to creating the Norfolk Area Medical Center Authority, Chapter 471 provided for the appointment and terms of office of members of the medical authority and for the election of certain officers. It prescribed the powers and duties of the medical authority including the power to borrow money and issue bonds. It also authorized the cities in Hampton Roads the right to exercise certain powers in cooperation with the medical authority.²¹

Specifically, sections 3, 4, and 5 of Chapter 471, Code of Virginia--1964, stated:

Section 3. The Authority shall be deemed a public instrumentality, exercising public and essential governmental functions to provide for the public health and welfare, and is hereby authorized to exercise the powers conferred by the following sections.

Section 4. The Authority may identify, document and evaluate needs, problems and resources relating to health and medical care; to plan, develop and implement programs to meet such needs on both an immediate and long range basis.

Section 5. The Authority may plan, design, construct, remove, enlarge, equip, maintain and operate medical educational institutions, medical and paramedical facilities, together with related and supporting facilities and to do all things necessary and convenient to carry out any of its purposes.²²

A copy of Chapters 471 and 440 of the 1964 Code of Virginia are provided in appendices 20 and 21, respectively.

In May 1964 the Norfolk Medical Center Commission held an informal conference to select the initial seven commissioners of the medical authority. The following individuals were appointed for the terms listed:

Hon. Walter A. Page	April 1964 - April 1965
R. R. Richardson, Jr.	April 1964 - April 1965
Roy R. Charles	April 1964 - April 1966
Lawrence M. Cox	April 1964 - April 1966
John M. Franklin, M.D.	April 1964 - April 1967
Mason C. Andrews, M.D.	April 1964 - April 1967
Toy D. Savage, Jr.	April 1964 - April 1967 ²³

It was agreed that regular business meetings of the Norfolk Area Medical Center Authority would be open to the press; however, executive board meetings would meet in closed session.²⁴

The last meeting of the Norfolk Medical Center Commission was held on 25 May 1964. Representatives of the news media attended. The chairman, Mr. Toy Savage, noted that the commission's files, records, financial accounts and obligations, and contracts had been transferred to the Norfolk Area Medical Center Authority. He suggested that the Norfolk Medical Center Commission be dissolved since the medical authority had been approved, its commissioners selected, and its first meeting scheduled for 2 June 1964. The motion was seconded by Mr. Clifford Adams, and the Norfolk Medical Center Commission was adjourned for the last time.²⁵

The commissioners of the newly formed Norfolk Area Medical Center Authority met almost weekly during June, July, and August 1964. Most of these meetings dealt with organizational matters such as the formation of committees and sub-committees and individual appointments to these groups. The first meeting of the medical authority met at the Kings' Daughters Children's Hospital. Dr. John M.

Franklin, chairman of the Nominating Committee, recommended the following individuals to the office noted: Mason C. Andrews, M.D.--Chairman, Toy D. Savage, Jr.--Vice-chairman, and George F. Rice--Secretary/Treasurer. It was agreed that each officer would be appointed for a term of at least one year.²⁶

The commissioners of the medical authority realized that citizen participation and support from across the Hampton Roads area would be needed if the medical authority was to attain all of its objectives.²⁷ Those objectives included:

1. Serving as a coordinating and stimulating influence and agency in the assembling of a regional comprehensive medical complex (The resources of this complex would be concerned with such services to health facilities and physicians throughout the area as may be sought and capable of achievement.)
2. Planning for the development and coordination of health facilities and programs in the area
3. Exploring ways to implement the expressed desire of the medical, civic, and business community that a school of medicine be established in this area²⁸

At the second meeting of the medical authority on 8 June 1964, it was agreed that Mr. Vincent G. Kling, a well-known Philadelphia architect, would be appointed as executive architect to the medical authority and that Dr. Richardson K. Noback, executive director of the Kansas City General Hospital and Medical Center and the associate dean of the University of Missouri School of Medicine, pending his approval, would be appointed as an executive medical consultant.²⁹ Consultation would come from many sources

during the ensuing years; however, Mr. Kling and Dr. Noback were considered national experts in architecture and medical education, respectively, and therefore regarded by officials of the medical authority as chief consultants.

From the time of its establishment in 1964, the medical authority formulated plans to establish a clinical base upon which to build a strong, medical education program. "Its ultimate goal," contended Dr. Mason C. Andrews, "was the establishment of a medical school."³⁰ The commissioners of the Norfolk Area Medical Center Authority believed that the medical authority's existence was predicated on three overall goals:

1. Planning health services and facilities on a regional basis
2. Assembling an area medical center to fulfill regional health needs
3. Establishing a medical school in the Medical Center³¹

At the 17 June 1964 meeting of the medical authority, Judge Walter Page recommended a resolution to establish an advisory committee to the medical authority. The resolution, subsequently approved by the medical authority, stated:

Be it resolved that the Norfolk Area Medical Authority hereby creates a Medical Advisory Committee to assist and advise the Authority in the matters of planning, development, and organization of this Medical Center and its component facilities; which Committee shall be composed of not less than 15 or more than 21 members. . . .³²

(A list of the members appointed to the medical advisory committee is provided in appendix 22.)

On 12 June 1964 the General Counsel of the medical authority submitted for adoption a draft of suggested by-laws.³³ The medical authority approved them at their 29 June 1964 regular business meeting.³⁴ In essence, the by-laws described the duties of the medical authority's commissioners and prescribed a guide for the conduct of business. (A copy of the medical authority's by-laws is provided in appendix 23.)

The most difficult problem encountered by the medical authority in 1964, recalled Dr. Mason Andrews, was the determination of what the relationship between the proposed medical center and medical school would be with the existing hospitals in the area.³⁵ There was general agreement that the establishment of a medical school in Norfolk would require an expansion of existing hospital facilities. After several months of study and consultation, the medical authority's medical advisory committee concluded that the best interests of all concerned would be a close affiliation and physical connection between the proposed medical school and the city's largest hospital--Norfolk General.³⁶

Dr. Mason Andrews was supported by his brother, Dr. William Andrews, and other staff members of Norfolk General Hospital in helping to establish a medical school in Norfolk adjacent to the medical center and Norfolk General Hospital. Their proposal was endorsed on 31 March 1966 by Norfolk General Hospital's board of directors and written in the form of the following resolution:

WHEREAS the Norfolk Area Medical Center Authority has proposed the establishment of a medical college in the medical center in close proximity to Norfolk General Hospital, the two institutions to be physically connected and their operations to be coordinated in such respects as may be mutually advantageous; and

WHEREAS in the judgment of the Board of Directors of the hospital, patient care will be improved and the local community benefitted through the establishment of a close working relationship between the two institutions;

THEREFORE BE IT RESOLVED:

1. That the Board of Directors of Norfolk General Hospital does hereby declare its approval in principle of the establishment of a medical college in close proximity to and the physical connection between the two institutions and the integration of their operations in such respects, to such extent and on such basis as the governing boards of the two institutions may deem practical and mutually beneficial after carefully considering all aspects of the matter;

2. That a committee of not less than five and not more than seven members be appointed by the president with authority and instructions to make a comprehensive and careful study of all facets of the proposed affiliation, to conduct such discussions and negotiations with the Norfolk Area Medical Center Authority as the committee may deem desirable, and to make a report of the committee's findings and recommendations regarding the matter of the physical connection which should be established between the two institutions and the respects in which, the extent to which and the basis on which the operations of the two institutions should be integrated;

3. That pending the establishment of such a relationship with the college the hospital's primary purpose must be to meet the ever-growing hospitalization needs of the community.³⁷

Plans were developed in 1963 to enlarge Norfolk General Hospital. By 1966, phase three of construction was underway. Mr. R. R. Richardson, Jr., former hospital president and presently chairman of the hospital's Building Committee, explained that phase three would include a three-story addition adjoining Wing A, plus a four-story unit.³⁸

In all, the patient capacity for emergency room facilities would be doubled. The dietary department, originally designed to serve three hundred patients, would be increased to serve one thousand patients. The out-patient department and hospital pharmacy would be enlarged as well as central supply installations. Two operating rooms for open-heart surgery and a coronary care unit would be added. The result would be 150,000 square feet of new floor space, plus 36,000 square feet of renovated space.³⁹

Meanwhile, Dr. Noback, consultant to the medical authority, studied the planning needs for the proposed medical center and medical school in Norfolk. In July 1964 he told the commissioners of the medical authority that "the importance and potential of the medical development in Norfolk requires ambitious and bold planning. This is not to argue for foolish wishes but rather to argue for high objectives."⁴⁰

Many ambitious and bold recommendations concerning the proposed medical school and medical center were offered in 1964. The proposals included the retention and use of the existing staff and the department structure of Norfolk General Hospital. The medical authority agreed that the individuals involved in the teaching and research programs on a full-time basis would be represented through their dean and the medical authority.⁴¹

The medical authority moved rapidly in 1964 toward its ultimate objective--the establishment of a medical

school.⁴² Chapter 471 of the 1964 Code of Virginia had empowered the medical authority to "plan, design, construct, remove, enlarge, equip, maintain and operate medical educational institutions, medical and paramedical facilities, together with related and supporting facilities and to do all things necessary and convenient to carry out any of its purposes."⁴³ The medical authority was given the right to eminent domain, to charge and collect fees for services and facilities, to accept loans, grants, or assistance, and the right to borrow money and issue bonds.⁴⁴

The medical authority and its several committees were composed of individuals with long careers encompassing voluntary public service in medicine, education, community fund-raising, hospital board memberships, planning councils, and other civic and social service organizations. It organized committees of physicians and other interests to obtain information on the area's most critical health needs and on ways these needs could be structured for future use by the medical school. During the first two years of its existence, it also initiated several major projects which would complement and help to support a medical school.

Financial Support

While the General Assembly of Virginia created the Norfolk Area Medical Center Authority in 1964 when it approved Chapter 471, Code of Virginia--1964, state funds, however, were not allocated for implementation of this

mandate. Local proponents of the medical center and medical school realized that the municipalities within the Hampton Roads area would have to contribute several million dollars for the construction and operation of the local medical school.⁴⁵

Medical authority officials knew that construction of a university hospital was financially prohibitive although a university hospital was perceived by many as a necessity for a quality medical education program. They realized that the only alternative to a university hospital was to use existing medical facilities and resources. The initial seed money came from the City of Norfolk, which authorized \$231,000 for the medical authority during the medical authority's first three years of development and operation.⁴⁶

Several individuals with an intimate knowledge of the financial issues facing the medical authority during the planning and development of the medical center and the medical school were interviewed between 1985 and 1987. Mr. Richard F. Welton III, president of Smith and Welton, Inc.; Dr. Mason C. Andrews, professor and chairman of the Department of Obstetrics and Gynecology at the Eastern Virginia Medical School; Mr. Harry B. Price, Jr., president of Price's, Inc.; and Dr. Robert J. Faulconer, professor and chairman of the Department of Pathology at the Eastern Virginia Medical School, provided their insight and perspective. Excerpts of their recollections of the events that

transpired in efforts to raise money for the establishment of a medical school in Norfolk are as follows:

RICHARD F. WELTON III: I was drafted by Mason Andrews around 1963. He organized a small group of us (Harry Price--a local businessman, Larry Cox--director of the Norfolk Redevelopment and Housing Authority, George Rice--a member of the Norfolk Planning Commission, and others). We met on a regular basis for lunch at the Blue Room in the old Monticello Hotel on Granby Street to discuss the need for a medical school in Norfolk. Mason sought our advice on how to raise enough money to get the medical school started.

Mason and others were instrumental in getting financial support from the City of Norfolk. The Norfolk City Council certainly deserves a lot of credit. Together with financial support from the Oscar Smith Foundation, early seed money was provided without which I don't think we could have started a medical school.⁴⁷

MASON C. ANDREWS, M.D.: We needed advice from people experienced in starting a medical school, so we brought in Dr. Vernon E. Wilson, Dr. Richardson K. Noback, Mr. Vincent Kling, and others to work with us on a continuing basis. Vernon Wilson was the dean of the University of Missouri Medical School and Richardson Noback was the associate dean of the medical school and the executive director of the Kansas City Medical Center. Dr. Wilson suggested that we raise \$50 million as an endowment for the medical school, but we knew that we couldn't raise that much money. We agreed that if we could raise \$15 million, we could start a medical school.

Dr. Egleberg, a former dean at UCLA, was one of the top doctors in Washington. He said that we could do it and should do it, and we believed that we could.⁴⁸

HARRY B. PRICE, JR.: We hired Ketchum and Ketchum of Pittsburg, professional fund-raisers, to tell us how we could raise \$15 million to start a medical school. They were one of the best fund-raising organizations in the United States. They came to Norfolk and interviewed people in the community. The result was that they told us we couldn't raise \$15 million within the Hampton Roads area. They thought the most we could raise locally was \$4 million to \$5 million. So we paid them their fee of \$7,500, sent them on their way, and decided to continue to look for other

ways of raising \$15 million.

RICHARD F. WELTON III: After getting the report from Ketchum and Ketchum, our small group met in the Blue Room [of the Monticello Hotel] to discuss what we needed to do. We decided to hire a public relations expert to obtain advice on how to raise enough start-up money for a medical school. He told us that we needed to get 100 individuals and have each of them contribute \$30,000 to \$50,000.⁵⁰

ROBERT J. FAULCONER, M.D.: The problem of how to finance the medical school was perhaps our biggest obstacle. The area immediately surrounding Norfolk General Hospital and the Norfolk Medical Tower Building was in need of redevelopment and slum-clearance. Medical facilities were needed to help support the medical school, and we didn't have the money to build them.⁵¹

The Norfolk Area Medical Center Authority's Board of Commissioners decided in February 1965 to arrange a meeting with U.S. Congressman Porter Hardy, Jr. This meeting was subsequently held in March 1965. Congressman Hardy suggested that officials of the Norfolk Area Medical Center Authority schedule a conference with Mr. Oren Harris, the administrative secretary of the U.S. House of Representatives.⁵² In January 1965 Mr. Harris had introduced House Resolution (H.R.) 3140 before the Committee on Interstate and Foreign Commerce.⁵³ (A copy of H.R. 3140 is provided in appendix 24.) H.R. 3140 authorized \$50 million for regional medical complexes within the United States. Members of the medical authority hoped that Mr. Harris would equate the Norfolk Area Medical Center Authority with a regional medical center so that it could qualify for federal funds under H.R. 3140.⁵⁴

MASON C. ANDREWS, M.D.: Once we got money [\$235,000 between 1964 and 1966] from the City of Norfolk,

things started to move. The Oscar F. Smith Foundation and the Roy R. Charles Foundation made large contributions. Around Thanksgiving [1964] it was concluded that someone needed to lead a fund-raising drive. No one person would do it. We decided to get Porter Hardy, a congressman from our district who was about to retire.⁵⁵

RICHARD F. WELTON III: A group of about twelve of us had a luncheon meeting at the Harbor Club [in 1965]. Charles Kaufman, Mason Andrews, Harry Price, Bobby Payne, Larry Cox, Porter Hardy, and a few others were present. We agreed that Porter Hardy, who was a U.S. Congressman from our area, would be the ideal person to head a fund-raising drive. We told him of our need for a medical school in this community and what our consultants had advised. We asked him for his guidance in helping us raise \$15 million--\$10 million for an endowment and \$5 million for the construction of medical facilities.

Porter was reluctant to chair the fund-raising campaign, but Charles Kaufman helped persuade him to support it, telling him how important it was for the community. We finally convinced Porter Hardy to chair the first fund-raising campaign. Porter looked around the room and said, 'I'll take this job as chairman as long as you all understand you are co-chairmen and that I am counting on each of you.'

A few days after our luncheon at the Harbor Club, we all met in Mr. Kaufman's office, in the big conference room. Porter Hardy looked around the table and said, 'I don't know much about fund-raising, but what little I've learned is that the people who are going to raise the money are going to have to give first and here's my pledge.' I can't remember the amount, but it was a very generous pledge. He asked each of us to contribute and those of us who had corporations had to go back and discuss it with our board of directors. Porter wanted a prompt commitment. He did not expect anyone to attempt to raise money until they first made their own personal commitment or that of the corporation they represented. This was the beginning of the fund-raising campaign for the first \$15 million.

Porter Hardy worked more than forty hours a week to help us raise the money. He gave generously of his time for several years until the goal of \$15 million was achieved. He did a super, outstanding job. Everybody in the community rallied around him; everyone supported him. He was a great help to us,

to this community, and to the Hampton Roads area.

For many years, the City of Norfolk was the only Tidewater city to financially support our efforts to bring a medical school to Norfolk. After Virginia Beach contributed \$250,000, however, the other cities in Hampton Roads pledged their support. The fund-raising efforts among the area cities was phenomenal and unheard of. We've raised around \$35 million locally.⁵⁶

ROBERT J. FAULCONER, M.D.: Mason Andrews and Larry Cox were the spark plugs, and others like Harry Price, Jr., Roy Charles, and Charles Kaufman were instrumental. Congressman Porter Hardy was asked to help initiate the first fund-raising campaign. Since then, the Eastern Virginia Medical School Foundation was formed and Henry Clay Hofheimer has guided the fund-raising efforts.⁵⁷

MASON C. ANDREWS, M.D.: Henry Clay Hofheimer was one of the very fine people throughout the area who helped us raise money for the medical school. Others included Lloyd Nolan of Newport News, Sam Lyles in Virginia Beach, Lucius Kellam on the Eastern Shore, and Judge Johansen of Portsmouth. These people took care of the money raised for the medical school.⁵⁸

JOHN S. THIEMEYER, Jr., M.D.: Financing the medical school was a terrific job. Many people were involved. It was a community project that eventually involved all the people and city councils in Hampton Roads. This was one of the few regional efforts where support has been unanimous. Several people led this effort, among them Henry Clay Hofheimer. He was the financial rock.⁵⁹

Mr. Henry Clay Hofheimer II, a local businessman well-known for his philanthropic work, was instrumental in helping the medical authority raise money for the proposed medical school. He discussed the issue of fund-raising and reminisced about the times during the 1960s when he solicited contributions from personal friends, businesses, and philanthropic foundations. "One such time," Mr. Hofheimer recalled, "was when I requested a contribution from the

Mellon Foundation. Paul Mellon of New York later contributed \$1 million."⁶⁰

Another time, Mr. Hofheimer recalled, was when he was walking his two dogs along the shoreline at Virginia Beach and encountered two friends, Mr. and Mrs. Sidney Lewis, of Richmond. They were staying at the beach for the weekend, and as they talked, Mr. Hofheimer directed the conversation toward local efforts to raise money for the establishment of a medical school in Norfolk. Before their brief conversation ended, Mr. and Mrs. Lewis had offered to contribute \$300,000 toward the construction of facilities for the proposed medical school.⁶¹

Believing that Mr. and Mrs. Lewis might be willing to contribute more than their offer of \$300,000, Mr. Hofheimer requested they consider a larger contribution and suggested that they let him know of their decision before they returned to Richmond. The following day Mr. and Mrs. Lewis notified him that they had decided to contribute \$1.5 million toward the construction of the proposed medical school in Norfolk.⁶²

Mr. Roy R. Charles was another Norfolk resident who provided a generous financial contribution to help establish the medical school in Norfolk. He described his role in the establishment of the medical school as "of minor significance."⁶³ A resident of Norfolk since 1932, Mr. Charles stated that his ties with the Eastern Virginia Medical School were primarily financial in that "I

contributed \$1.5 million toward the medical school's endowment."⁶⁴

Many local citizens, organizations, and foundations contributed generously to help financially support the medical authority's efforts. For example, the year after the medical authority was organized, the Norfolk Foundation contributed over \$30,000, the Oscar F. Smith Foundation contributed \$150,000, and the Norfolk County Medical Society contributed \$27,000. (A list of organizations and businesses financially supporting the establishment of the medical school and its related activities is provided in appendix 25.)

Mr. Charles F. Burroughs, Jr., a former commissioner and interim president of the medical authority, recalled a conversation he had with Mr. Colgate Darden, a former governor of Virginia from Norfolk.

CHARLES F. BURROUGHS, JR.: I talked with Colgate Darden after his term as Governor of Virginia. He told me that somebody had asked him, since he was from Tidewater, 'What was the difference between Tidewater and the rest of the state?' And he said that it was by far the most generous part of the state. He said that they haven't got as much money down there as the rest of the state, but they're much more willing to give it for the public good of its citizens. I think that's perfectly true.⁶⁵

In addition to contributions from local citizens, organizations, and foundations, the Norfolk Area Medical Center Authority looked to federal sources in the mid-1960s, as it does today, for financial support of the medical center's activities and the medical school. Dr. Joseph A.

Gallagher, deputy director of the federal government's Bureau of Health Manpower, wrote a letter in April 1967 to officials of the medical authority in which he provided information regarding the availability of federal funds for new and existing medical schools and the bureau's policy on its disbursement.⁶⁶

The Health Professions Educational Assistance Act of 1963 provided federal funds for the construction of facilities to establish new medical schools and to expand existing ones. New medical schools were eligible to receive federal grants equal to two-thirds of the cost for the construction of medical facilities and basic equipment for essential teaching facilities.⁶⁷ In addition to information on direct assistance for operating expenses, Dr. Gallagher provided the medical authority information on special improvement grants available from the federal government.⁶⁸ It was not unusual during the 1960s for articles to appear in local newspapers or in national medical journals about congressional funding for medical schools, medical facilities, and medical research.

Shortly after fund-raising efforts began, another financial issue, the medical authority's tax status, arose. The tax status of the Norfolk Area Medical Center Authority was not officially resolved until April 1965. As the recipient of millions of dollars from fund-raising campaigns, federal programs, and other sources, officials of the medical authority became concerned about the legality of

their tax exempt status. As a result, Robert R. MacMillan, legal counsel for the medical authority, contacted the state tax commissioner in 1965 regarding the medical authority's tax status. In a letter to the medical authority's commissioners in April 1965, Mr. MacMillan reported that the medical authority was not subject to Virginia state income taxation and that it need not file a Virginia income tax return.⁶⁹

Medical School Sponsorship

The question of which agency or group would be the appropriate sponsor for the proposed medical school came to the attention of the Norfolk City Council in 1961. The city council appointed City Manager Thomas F. Maxwell to prepare a report on steps that might be taken to determine the feasibility of a medical college in Norfolk. The Norfolk City Council assumed that the sponsor would be either the proponent doctors, the Norfolk Division of the College of William and Mary, the City of Norfolk, or the State of Virginia.⁷⁰

University Affiliation

Old Dominion University

Old Dominion University was a two-year college known as the Norfolk Division of the College of William and Mary from 1930 to 1955. Four-year programs were started in 1955 and the Norfolk Division was redesignated as the Norfolk College of William and Mary in 1960. The Norfolk Division

changed its name to Old Dominion College in 1962 and became an independent, state-supported college.⁷¹

In its 1963 report, the State Council of Higher Education expressed the "probable need for an affiliation between the proposed medical school in Norfolk and a four-year college or university."⁷² The State Council's report recommended:

1. That a mutually satisfactory contractual arrangement between Old Dominion [College] and the local interests promoting the medical school be arrived at
2. That Old Dominion's graduate programs be strengthened by 1968-69 in order to support such a school⁷³

Representatives of the Norfolk Area Medical Center Authority met with the Board of Visitors of Old Dominion College on 4 March and 15 March 1965 to discuss the possible affiliation between the two institutions. As a result of these two meetings, it was decided that Judge Walter A. Page and Mr. Toy D. Savage, commissioners of the medical authority, should contact Col. James Roberts and Sen. Edward Breeden, Norfolk representatives to the Virginia Legislature along with Mr. J. Hoge Tyler III, a member of the State Council of Higher Education, to discuss the needs of Old Dominion College in the development of basic science courses and graduate programs. The attendees at the 15 March 1965 meeting decided that once these needs were reviewed with Lewis Webb, president of Old Dominion College, a full report should be developed and presented to the Virginia General Assembly.⁷⁴

Officials of Old Dominion College subsequently conducted a study in 1965 to determine the long-range building needs of the college. The study was completed in September 1965. As part of that study, consideration was given to the possible affiliation between Old Dominion College and the Norfolk Area Medical Center Authority as it related to the medical authority's goal to establish and operate a medical school in Norfolk.⁷⁵

The 1965 study by Old Dominion College offered several conclusions regarding the medical authority's proposal for an affiliation between the two institutions. Primarily, the study concluded that the proposed medical school should be affiliated with Old Dominion College as opposed to other state colleges.⁷⁶ (A list of the study's conclusions is provided in appendix 26.)

The study by Old Dominion College recommended that the college "should be receptive to an affiliation with the Norfolk Area Medical Center Authority in the development and operation of a medical school."⁷⁷ It also offered several conditions and steps in its plan of action for this affiliation. These requirements included:

1. The medical school, once established, should be administratively integrated as another unit of Old Dominion College.
 - a. If it is essential for the medical school to be completely self-supporting, then appropriate overhead charges should be established for such overhead services as administration, accounting, purchasing, student records, etc.
 - b. The Commonwealth's fiscal authorities should be

asked to provide the controlling fiscal policies which should apply.

2. With integrated operations, there should be one governing board in control of operations, and this should be the College's Board of Visitors.
 - a. The Board of the Norfolk Area Medical Center Authority could be designated an Advisory Council on Medical Education to the Board of Visitors and could play an advisory role in such matters as medical education standards, medical school administration appointments, goals and objectives, etc.
 - b. The Medical Center Authority Board should be responsible for seeing that all needed operating or capital funds are secured, and that operating funds are budgeted to the College for the medical school operation each year.
3. To benefit to the fullest extent from educational and administrative integration, the medical school should be located on or adjacent to Old Dominion's Campus.
4. To guide the negotiations from this point forward, the following steps are recommended.
 - a. The Board of Visitors should approve of the idea of affiliation in principle, and appoint a small committee of not more than three of its members as a Medical School Development Committee.
 - b. The medical authority should be urged to take a similar step, with the two groups then constituted as a Joint Committee for Study and Negotiation.
 - c. As soon as possible, the medical authority should develop financing to provide a budget to the College for appointing a Dean of the Medical School, with the medical authority Board concurring on the person nominated for appointment.⁷⁹

Several high-ranking officials at Old Dominion College did not look favorably upon an affiliation between the college and the proposed medical school. Frank Batten, head of Old Dominion College's Board of Regents and chairman of the Board of Norfolk Newspapers, Inc., and Lewis Webb,

president of Old Dominion College, foresaw several complications involving an affiliation between the college and the proposed medical school. The lack of financial support was viewed as the most significant problem. "Lew Webb brought Old Dominion College a long way and did not want to take on the responsibility for a medical school; that was because medical schools, for the most part, do not support themselves, and Lew Webb believed that Old Dominion College already had enough financial problems and obligations," remarked Dr. John S. Thiemeyer, Jr.⁷⁹

Joint Liaison Committee

A Joint Liaison Committee between Old Dominion College and the Norfolk Area Medical Center Authority was established in 1965. Its membership included:

Old Dominion College

Frank Batten
James A. Howard
John B. Johnson, M.D.
W. Peyton May
A. K. Scribner
Lewis Webb

NAMCA

Mason C. Andrews, M.D.
Roy R. Charles
John M. Franklin, M.D.
Harry H. Mansbach
Hon. Walter A. Page
Robert L. Payne, M.D.
Harry B. Price, Jr.
Richard F. Welton III⁸⁰

Mr. Toy Savage, Dr. Mason Andrews, and Adm. Page Smith (U.S.N. ret'd) met with the Board of Visitors and administrative officials of Old Dominion College on 17 September 1965 to discuss the possible affiliation between the proposed medical school and Old Dominion College. Officials of the college emphasized that the development of

a full graduate curriculum in the sciences precluded early consummation of such an affiliation; however, such an affiliation could be achieved in the late 1970s. Officials of the Norfolk Area Medical Center Authority did not want to delay establishment of the medical school in Norfolk beyond 1972. In this regard, and in recognition of Old Dominion College's commitment to its undergraduate programs, officials of the medical authority declared that they would explore affiliation potential with other institutions of higher education, specifically the College of William and Mary and the University of Virginia.⁸¹

The College of William and Mary

The possibility of re-activating the William and Mary Medical School was addressed in a 26 April 1965 letter from Dr. Thomas C. Moore to Dr. Mason C. Andrews. In his three-page letter, Dr. Moore discussed six steps to establishing a medical school at the College of William and Mary.⁸² (A copy of Dr. Moore's 26 April 1965 letter to Dr. Andrews is provided in appendix 27.) As part of step five, Dr. Moore suggested that the two public instrumentalities, the Norfolk Area Medical Center Authority and the College of William and Mary, "Obtain state legislative action (1966 session) creating a Norfolk Campus of William and Mary University in lieu of Old Dominion College.--This step is not indispensable but would facilitate development of Norfolk General Hospital as 'University Hospital, Norfolk.'"⁸³

In a 6 May 1965 letter to Dr. Mason Andrews, Dr. Vernon E. Wilson, medical consultant to the medical authority, suggested that medical authority officials seek an affiliation of the proposed medical school in Norfolk with the College of William and Mary. Dr. Wilson believed that the College of William and Mary, with its existing graduate programs and relative proximity to Norfolk, would welcome an affiliation with the proposed medical school in Norfolk.⁸⁴ However, very little progress toward an affiliation between the two institutions was achieved during the ensuing months.

University of Virginia

A meeting between officials of the Norfolk Area Medical Center Authority and the University of Virginia School of Medicine was scheduled for 15 October 1965 to discuss the possibility of an affiliation between the University of Virginia School of Medicine and the proposed medical school in Norfolk.⁸⁵

MASON C. ANDREWS, M.D.: We didn't have a lot of money. We arranged a meeting with the president of the University of Virginia. He offered to support us in the state legislature. It seemed too good to be true. However, there was one caveat--we would have clinical years only and no basic science. It sounded good, but to have a medical school, basic science is a necessity.⁸⁶

Dialogue between the two institutions continued through 1969.

Dr. Kenneth R. Crispell, dean of the University of Virginia School of Medicine, wrote two letters to Dr. Mason

Andrews between January and April 1966 in which he submitted tentative proposals for an association between the two institutions. Among his recommendations and concerns, Dr. Crispell stated:

1. The President and the Board of Visitors of the University of Virginia will create a University of Virginia Department of Continuing Medical Education (Norfolk Division) to be directed by an Associate Dean of the University School of Medicine who will be physically based in Norfolk. . . . Financial support for the department will be furnished by the Norfolk Medical Authority. . . .
2. The University of Virginia cannot assist in or encourage the Norfolk Medical Authority to seek State funds for [a] third medical school. The present State financial support of the existing State medical schools is precarious and they would be seriously weakened if funds were provided by the State for a third school. . . . The University of Virginia is willing to continue the dialogue with the Norfolk Medical Authority as to the best plan for the development of a third medical school in the State in the Tidewater Area be it as planned now, a private school associated with Old Dominion College or the possibility of the University of Virginia School of Medicine (Norfolk Division).³⁷

Many proponents for the establishment of a medical school in Norfolk did not want a division of another medical school. They wanted a separate, independent medical school. They knew the problems the Hampton Roads area faced with medical education and services during the two preceding decades and they wanted a voice in changing it. An independent medical school in Norfolk would be the vehicle for this change. In a 10 January 1969 letter to Dr. Mason Andrews, Dr. William G. Thurman, professor and chairman of the Department of Pediatrics at the University of Virginia School of Medicine, noted that "some of the individuals here

feel that . . . no progress [regarding affiliation has been made] over the past three years, but I feel strongly that the attempt [at the affiliation of the University of Virginia School of Medicine and the Norfolk Area Medical Center Authority] has been made and that we are now meeting the contingencies at the moment."⁸⁸ Nevertheless, discussions with the University of Virginia School of Medicine became passive in nature soon afterwards and by the end of 1969 the chances of a possible affiliation between the two institutions were practically nonexistent.

Results of Efforts at University Affiliation

In an April 1966 meeting between Dr. Richardson Noback, medical consultant to the medical authority, and officials of Old Dominion College, the proposal for an affiliation between the two institutions was discussed again. Representatives for Old Dominion College included President Lewis Webb, Provost Dean Johnson, and Vice-Rector Peyton May. The problems of affiliation were discussed, and it was concluded that an affiliation between the Norfolk Area Medical Center Authority and Old Dominion College should be pursued.⁸⁹

In July 1966 Dr. Mason Andrews told the Norfolk City Council that the Norfolk Medical Center Complex offered the most feasible location for the proposed medical school because medical facilities already existed in the medical center. He also noted that unencumbered land was available

adjacent to Old Dominion College. However, since the college was only a short distance from the medical center, it should be considered an alternative site to the medical center.⁹⁰

Speaking of the Norfolk Medical Center Complex and proposed medical school, Dr. Andrews told the Norfolk City Council:

The possibility of assembling here an unfragmented site of suitable size, conveniently accessible to the people of the area, the heart of the city and the future University, which could be designed efficiently and attractively to meet the needs and opportunity of tomorrow, is a major element in the potential achievement here. . . . Granted vision, access, and effort, the type of function here referred to can be developed to strengthen not only the core city but the entire area.⁹¹

In an appearance before the Norfolk City Council on 11 October 1966, Mr. Frank Batten, chairman of the Board of Advisors of Old Dominion College, spoke of the college's position on the proposal to establish a medical school in Norfolk. He stated that after a good deal of consideration and study by independent consultants hired by the college it was concluded that Old Dominion College should not be the site of a medical school. The rationale was that it would be economically unfeasible for Old Dominion College. However, the Board of Advisors unanimously adopted a resolution stating that the college wholeheartedly endorsed the development of a medical school in Norfolk and would enter into an affiliation agreement with the Norfolk Area Medical Center Authority to help develop plans for the establishment of a medical school. He also noted that Old Dominion

College had already taken steps to develop its science programs toward the type of graduate work needed in order to support a medical school.⁹²

Efforts to effect an appropriate affiliation between the Norfolk Area Medical Center Authority and Old Dominion College continued into 1967. Representatives of the Norfolk County Medical Society and the medical authority met in January 1967 to discuss development of the medical center and establishment of the medical school. Drs. Frank N. Bilisoly and Charles E. Davis represented the medical society and Mr. Lawrence M. Cox and the Hon. Walter A. Page represented the medical authority. As a result of their meeting, it was decided that the two groups should work together to study "feasible means of effecting an affiliation between Old Dominion College, the Medical School, Norfolk General Hospital, and the Authority."⁹³

Discussions between the two institutions continued during the next four years. Then, in a meeting with the president and staff of Old Dominion University (ODU) on 6 January 1971, Dr. Elmer Ellis, a consultant for the university, commented, "In discussing our [ODU's] position with the State Council of Higher Education, it was the consensus that we [ODU] can meet with the representatives of the Norfolk Area Medical Center Authority in their efforts to persuade the State Council to endorse their plan." At the end of the meeting, Dr. Ellis concluded:

There is need for the Medical School, there is strong

area support and Old Dominion must approve [of an affiliation]. It appears that the need for NAMCA to promptly employ a dean will accelerate our [ODU's] considerations of certain aspects of the arrangements. For this reason, it is doubtful that we can wait until April [1971] before we discuss further with NAMCA the possibilities of an affiliation.⁹⁴

After four years of discussion and negotiation with officials of Old Dominion College, the College of William and Mary, and the University of Virginia, officials of the Norfolk Area Medical Center Authority realized that the task of formulating an acceptable affiliation with one of these institutions and the proposed medical school was an extremely difficult task. However, the chances of an affiliation between the medical authority and Old Dominion College were believed to be more feasible and acceptable than with either of the other two institutions.

Hospital Affiliation

Dr. Mason Andrews' article "Report from the Medical Center Authority," published in the May 1965 issue of the Norfolk County Medical Society's The Bulletin, emphasized that the most difficult issue faced by the Norfolk Area Medical Center Authority in 1965 was "the exact form of affiliation between the proposed medical center (and ultimately Medical School) with the existing hospitals. There is unqualified agreement that the establishment of a School of Medicine will require the construction of a new 400-bed hospital."⁹⁵ Dr. Andrews noted that the dean of the proposed medical school and the Norfolk Area Medical Center

Authority would represent full-time faculty members of the medical school. However, these full-time faculty members would have to apply for hospital privileges at affiliated hospitals and be governed by the rules and regulations of each hospital accordingly.⁹⁶

Norfolk General Hospital

The board of directors of Norfolk General Hospital appointed Dr. Howard Kruger to chair a special committee for the purpose of defining the relationship between Norfolk General Hospital, the medical center, and the proposed medical school. In a 17 March 1966 letter to Dr. George Rector, secretary of the medical staff at Norfolk General Hospital, Dr. Kruger noted six recommendations of the hospital's committee.⁹⁷ All six recommendations were adopted by the medical staff of Norfolk General Hospital at a special meeting held on 19 April 1966.⁹⁸ Dr. Kruger's recommendations stated in part:

1. . . . the Medical Staff of Norfolk General Hospital welcomes affiliation with the proposed medical school and medical center.
2. . . . the Norfolk General Hospital should retain the organization of its Medical Staff, as outlined in the By-Laws.
3. . . . the medical school faculty members should be encouraged to become members of the Medical Staff of the Norfolk General Hospital; but, that only full-time private practitioners shall be eligible to hold elective offices on the Staff (all members of the Executive Committee, all Directors of Departments, and Chiefs of Services).
4. The Norfolk General Hospital and the medical school hospital shall be connected physically.

5. . . . the joint utilization of house staff and of common facilities, such as emergency room and out-patient departments should be encouraged, wherever practical.
6. . . . the Board of Directors of Norfolk General Hospital should retain its organization according to its Constitution; and share the concern of the Medical Staff with reference to protecting the present privileges of the practicing physicians of this community.⁹⁹

In the interim, the board of directors of Norfolk General Hospital had met to discuss the possible relationship between the hospital and the proposed medical school. The result was a resolution that stated in part, ". . . the Board of Directors of Norfolk General Hospital does hereby declare its approval in principle of the establishment of a medical college in close proximity to and the physical connection between the two institutions and the integration of their operations. . . ." ¹⁰⁰

In a January 1967 letter to Dr. Mason C. Andrews, chairman of the medical authority, Dr. Robert B. Gahagan, president of the medical staff at Norfolk General Hospital, discussed the future relationship of the planned medical school and hospital with Norfolk General Hospital. Dr. Gahagan stated that "the Executive Committee [of Norfolk General] was . . . pleased to know that . . . there will be, or that there are plans for, a 400-bed 'university hospital' to be used as a teaching hospital for the forth-coming medical school."¹⁰¹ He also stated that "the Executive Committee of the Medical Staff of Norfolk General Hospital is behind the plans of the Norfolk Area Medical Center

Authority to form a medical school in this area and stands ready to cooperate in any way that it can to help facilitate this great undertaking."¹⁰²

Norfolk General Hospital, as noted earlier, had initiated in 1963 a plan to enlarge its physical facilities to accommodate more patients and additional medical services. As a result, a new wing to the hospital was opened in 1967. This addition contained 217 patient beds and intensive care space. With a total of 670 patient beds, Norfolk General Hospital was the largest civilian hospital in the Tidewater area.¹⁰³ (A list of the ten private hospitals and the three government hospitals in the Tidewater area in 1964 is provided in appendix 28.) Another wing containing operating rooms and other medical service departments was opened in 1968.¹⁰⁴ This expansion, local medical authority officials believed, would potentially preempt the necessity for construction of a university hospital.

On 25 November 1968 Dr. Mason Andrews told members at the medical authority's regular board meeting that a close relationship between Norfolk General Hospital and the proposed medical school was assured as a result of successful efforts by the liaison committee to bring the two institutions together.¹⁰⁵ Drs. Bilisoly, Fitchett, Devine, and Horton represented Norfolk General Hospital on the liaison committee. Representatives for the medical authority included Drs. Payne, Thomson, Franklin, and

Andrews.¹⁰⁶

Dr. Clairborne W. Fitchett, president of the medical staff at Norfolk General Hospital, in a 20 January 1969 letter to hospital staff members, recognized the need for an affiliation between the Norfolk General Hospital and a medical school. Since the proposed medical school in Norfolk was still in the planning stages, he emphasized the need for a close relationship between Norfolk General Hospital and one of the two existing medical schools in the state. He stated:

The Norfolk General Hospital should affiliate itself in its teaching program with an existing medical school. . . . In order to attract good residents to our hospital we must have an educational environment. This education environment today means you must have medical students going through your hospital. The good resident today is not willing to put himself in an institution that does not include medical students and full-time faculty to teach them. . . . We will have to have some type of direct affiliation with one of the two State schools.¹⁰⁷

Land Requirement

Officials of the medical authority realized in 1965 that the planning of the medical center complex should be farsighted and should include sufficient land for patient care activities, as well as major education and teaching facilities. Meetings were initially held with local and out-of-state architectural firms to discuss the planning and development of the medical center complex.

Mr. Vincent G. Kling of Philadelphia was selected as the coordinating, architect planner for the design of the

medical center complex. He reviewed the schematics for the medical center complex and recommended the re-routing of Colley Avenue, the construction of a pedestrian overpass across Brambleton Avenue, and preferred locations for proposed medical facilities within the medical center complex. His recommended design was the determining factor for the amount and configuration of the land requirement.¹⁰⁵

Dr. Mason C. Andrews, chairman of the Norfolk Area Center Medical Authority, wrote a letter to the Norfolk City Council in July 1966 in which he outlined the medical authority's need for additional land in the vicinity of the medical center complex. Architectural plans by Mr. Kling and his associates were attached to the letter. These plans represented an additional 17.69 acres immediately east and north of the 33.68 acres occupied by the five components of the medical center complex (Norfolk General Hospital, King's Daughters Children's Hospital, the Norfolk Public Health Department, the Tidewater Rehabilitation Institute, and the Norfolk Medical Tower Building). As chairman of the medical authority, Dr. Andrews requested that the city council approve the transfer of 17.69 acres from the Atlantic City Redevelopment Project to the medical authority.¹⁰⁹

Mr. Kling had incorporated two important variables in his design of the medical center complex. First, he recognized that high-rise development required relatively less acreage than did a lower and more spread-out type of construction. Second, attention was given to the number of

educational programs which the medical authority contemplated and the predicted number and proportion of medical students who resided in the community as compared to those students who did not reside in the community and who therefore required living quarters.¹¹⁰

Alternative sites for the construction of medical facilities were acknowledged. However, Dr. Andrews emphasized that each of the alternative land sites as less feasible than the 17.69 acres requested.¹¹¹ He noted that "the greatest benefit to the people of this area is most likely to occur if this center is built around the existing medical center development which now includes the Norfolk General Hospital (700 beds including present construction), the King's Daughters Hospital (100 beds), the City Health Department building, the Rehabilitation Institute, and the Medical Tower building,"¹¹² The goal of the medical authority was to centralize the medical center development surrounding the existing five medical facilities. The five-year plan included the construction of medical facilities within the medical center complex, a comprehensive mental health center, a research institute, a second doctor's office building, an extended-care facility, enlargement of the King's Daughters Children's Hospital, a regional office and lab for public health and, ultimately, a medical school.¹¹³

The primary site for the construction of the medical school was designated within the boundaries of the medical

center complex. Medical authority officials agreed that the most feasible alternative location to the medical center was the campus of Old Dominion College. Although unencumbered land was readily available at Old Dominion College, medical authority officials believed that the one-mile distance between the campus of Old Dominion College and the medical center made it less desirable. Complementary medical facilities already existed in the medical center.¹¹⁴

Mr. Lawrence Cox, executive director of the Norfolk Redevelopment and Housing Authority, informed officials of the medical authority in 1968 that the redevelopment and housing authority was in a position to sell to the medical authority all the remaining land in the Atlantic City Redevelopment Project (approximately 27.5 acres). The cost was approximately \$21,000 per acre payable over a three-year period.¹¹⁵ At the 30 December 1968 regular board meeting of the medical authority, the seven-member board of commissioners agreed to the purchase.¹¹⁶

Organization of the Medical Authority

An organizational outline for the Norfolk Area Medical Center Authority was introduced at the 3 August 1964 regular board meeting of the medical authority. It included operating institutes in the areas of research, dentistry, geriatrics, nursing, and education and training. The latter area was meant to include the proposed medical school and para-medical schools. Specific operating institutes

included the Southeastern Virginia Rehabilitation Institute, Cardio-Pulmonary Institute, and the Tidewater Area Mental Health Institute.¹¹⁷ The medical authority appointed committees to plan and develop each of the institutes. (A list of the committees and their members is provided in appendix 29.)

Service Facilities

Several service facilities were formed in 1964 by the Norfolk Area Medical Center Authority. The medical authority worked to relate these facilities physically and administratively in such a way as to be complementary to the proposed medical school and medical center. In 1967 the medical authority established in succession the Cardio-vascular Center at Norfolk General Hospital, the Cardio-Pulmonary Laboratory at King's Daughters Children's Hospital, the Research Institute, and the Tidewater Rehabilitation Institute. The medical authority, in cooperation with Norfolk General Hospital and other municipal and state agencies, established in 1970 the Department of Pediatric Neurology, a Renal Dialysis Center, and three Mental Health Outreach Centers in Norfolk. The Eastern Virginia Inter-Hospital Medical Education Committee (EVIMEC) was formed on 9 March 1971. The Community Mental Health and Psychiatric Institute was completed in 1973. On 6 June 1973 the Eastern Virginia Medical School was accredited for medical education in the United States by the Liaison

Committee of the American Medical Association and the Association of American Medical Colleges.¹¹⁸

Cardiac Surgery Program

A liaison among the Norfolk Area Medical Center Authority, Tidewater Heart Association, and Norfolk General Hospital was responsible for bringing to Norfolk a comprehensive cardiac surgery program in 1967. Until 1967 only two cardiac surgery programs existed in Virginia, and both were located at the state's two existing medical schools.¹¹⁹

The Norfolk Area Medical Center Authority worked for two years to establish a Cardiac Surgery Program in Norfolk. It was believed that a cardiac surgery program would strengthen area training programs and provide future benefits to the development of medical progress in the Hampton Roads area.¹²⁰

A search committee of nine representatives from Norfolk hospitals and the medical authority interviewed five candidates for the position of director of the cardiac surgery program. Chaired by Dr. Robert L. Payne, Jr., the committee consisted of Drs. Charles E. Davis, Jr., W. Andrew Dickinson, Clairborne W. Fitchett, George A. Harkins, Oswald W. Hoffler, Joseph D. Lea, Eugene L. Lowenberg, and Levi Old, Jr. Early in 1967, the search committee selected Dr. Norman B. Thomson, Jr., of Buffalo, New York, to head the Cardiac Surgery Program at Norfolk General Hospital.¹²¹

Dr. Thomson was credited with several accomplishments. He had been president of his medical class at the Columbia University College of Physicians and Surgeons, served as an associate professor of surgery at the State University of New York--Buffalo School of Medicine, and in 1967 was serving as the director of the Heart Surgery Program at the Children's Hospital in Buffalo.¹²² Dr. Thomson accepted the offer to head the Cardiac Surgery Program at Norfolk General Hospital and relocated to Norfolk in mid-1967 along with part of his cardiac surgery team.¹²³

MASON C. ANDREWS, M.D.: Dr. Norman Thomson was a pioneer in heart surgery. We wanted him and knew that if he came to Norfolk, he would be a future faculty member of the medical school.

Wyndell Winn and Warren White were board members of Norfolk General Hospital who supported the idea of a heart surgery program in Norfolk. Since then, both of them have undergone heart surgery operations at Norfolk General Hospital.¹²⁴

On 14 April 1967 the medical authority's liaison committee met to discuss the details concerning the personnel who would be involved in the open heart surgery program. In addition to its head surgeon, Dr. Thomson, the liaison committee hired Dr. I. G. Montes, a fellow in cardiovascular surgery; Thomas Mullen, a chemist; and William Marshall, a pump technician. The medical authority initiated a search for an associate surgeon, two open-heart operating room nurses, and two nurse anesthetists.¹²⁵ Dr. Bruce Innes was hired as an associate cardiologist shortly after Dr. Thomson's arrival in Norfolk.¹²⁶ Dr. A. A.

Douglas Moore, a pediatric cardiologist and director of the cardio-pulmonary diagnostic laboratory at King's Daughters Children's Hospital, had arrived in Norfolk earlier in the year.¹²⁷

The prospect of being a part of the creation and development of a medical school was very appealing to Drs. Thomson, Innes, and Moore. The climate for a medical school was becoming increasingly favorable. Marked advances in medical and surgical techniques were winning wide acclaim. The work of Dr. Thomson and his associates in open-heart surgery had already gained national recognition. "We would not come to Norfolk solely to perform surgery without the opportunity to teach or do research," Dr. Thomson exclaimed. "The country is in desperate shape. There is a severe shortage of doctors, nurses, and para-medical personnel. This is because medical educational facilities are inadequate."¹²⁸ Dr. Mason Andrews later commented that "the future medical school was the magnet which attracted Drs. Thomson, Innes, and Moore to come to Norfolk."¹²⁹

Cardio-Pulmonary Laboratory

The Norfolk Area Medical Center Authority appointed Drs. Samuel M. McDaniel, Eugene F. Potasse, Clairborne W. Fitchett, and R. Bryan Grinnan to the medical authority's Special Committee on Establishing a Cardio-Pulmonary Laboratory.¹³⁰ On 3 July 1964 the four-man committee sent a letter to Dr. John Vann, president of the medical staff at

Norfolk General Hospital. They recommended that Norfolk General Hospital and Kings' Daughters Children's Hospital establish an independent department of cardio-pulmonary physiology on 1 January 1965. The committee also recommended that the proposed cardio-pulmonary department be chaired by a recognized authority in the cardio-pulmonary field.¹³¹

At the 1 October 1964 Medical Advisory Committee meeting, it was recommended that the proposed cardio-pulmonary laboratory be incorporated into the medical center master plan.¹³² The medical authority approved this recommendation at its next meeting.¹³³

Representatives from Norfolk General Hospital, the Tidewater Heart Association, and Kings' Daughters Children's Hospital were appointed to the Cardio-Pulmonary Laboratory Committee. The committee's membership included Drs. William F. Murphy, George A. Harkins, Samuel M. McDaniel, and Eugene Potasse; Messrs. Leighton P. Roper II and C. Wiley Grandy; and Mrs. Thomas G. Johnson. By the end of November 1964, the Tidewater Heart Association had pledged \$20,000 per year for five years to the Cardio-Pulmonary Laboratory. Soon afterwards, the Kings' Daughters Children's Hospital and Norfolk General Hospital each pledged \$10,000 per year for five years to the Cardio-Pulmonary Laboratory.¹³⁴

The Cardio-Pulmonary Laboratory was established in April 1967 at King's Daughters Children's Hospital. Its purpose was to detect heart defects in patients of all ages.

Dr. A. A. Douglas Moore, a pediatric cardiologist and a former co-worker of Dr. Norman Thomson in Buffalo, New York, was appointed to the position of director of the laboratory.¹³⁵

A. A. DOUGLAS MOORE, M.D.: I came from a teaching institution in London--Saint Mary's Hospital Medical School. I spent three and a half years at Children's Hospital in Boston, then on to Buffalo, New York. While in Buffalo, I heard that Norfolk General Hospital was looking for someone in cardiology and renal dialysis. I was a pediatric cardiologist. The Hampton Roads area was in desperate need of cardiologists in the mid-1960s. Very little secondary or tertiary medical care was available in this area.

I came to Norfolk on January 1, 1967, and became the first full-time faculty member when the medical school opened. The people here were enthusiastic about the medical school.

Several people played significant roles in helping to get the Cardio-Pulmonary Lab started. With the help of Drs. Bobby Robinson and Andrew Dickinson of Virginia Beach General Hospital, Dr. Jack Dempsey at the Portsmouth Naval Hospital, and a generous contribution from Mrs. Tazewell Taylor, the Cardio-Pulmonary Lab opened around June 6, 1967.¹³⁶

Official records from the Norfolk Area Medical Center Authority and the Tidewater Heart Association indicate that Mr. Harry Mansbach and Mr. Tazewell Taylor, Jr., were instrumental in obtaining financial support for the Cardio-Pulmonary Laboratory. At their urging, the Tidewater Heart Association in 1967 contributed \$125,000 to help equip the laboratory and \$25,000 for its construction.¹³⁷

A. A. DOUGLAS MOORE, M.D.: We received quite a lot of publicity when we went to schools in the area and tested the children for heart problems. About thirteen to fifteen children were identified with heart murmurs, and we operated on four or five of them. In 1969 we received funding from the State for the indigent children. The program lasted about five

years.

The volunteer assistance was tremendous. Faithful volunteers like Mrs. Clay, Frank Batten's wife--Jane Batten, and Dr. Patterson, now on the Board of Trustees at Norfolk General Hospital, were a great help in making the lab a success.

The Norfolk Area Medical Center Authority brought in several people to help pave the way for the medical school. Norman Thomson, a cardiac surgeon, was from Buffalo, New York. He stayed here for about three or four years. Bruce Innes came from a fellowship program and stayed until about 1980. Dr. James Etheridge was recruited primarily as a pediatric neurosurgeon. Dr. Womble was recruited to help start the Renal Dialysis Program. He stayed until around 1975.¹³⁸

Research Institute

The Research Institute was planned by the Norfolk Area Medical Center Authority to complement the Cardiac Surgery Program and the Cardio-Pulmonary Laboratory. It opened in 1967 in the old Levy building of Norfolk General Hospital at a cost of slightly over \$2 million.¹³⁹ The Research Institute was designed to study a wide range of medical needs and to attract high caliber medical personnel to the Norfolk area.¹⁴⁰ According to Dr. Bruce Innes, "It will be a place where anybody in the medical community who has a bona fide project can carry out research. Specific projects for the cardiovascular program will be undertaken but the laboratory is not to be governed by or used exclusively for the cardiovascular program. . . . It will be used also as part of the facilities for continuing medical education of the area's private physicians in conjunction with nursing schools, and for interns and

residents."¹⁴¹

In addition to Hill-Burton funds, contributions from local agencies, foundations, and individuals were received toward the construction and operation of the Research Institute. In 1967 the Oscar F. Smith Foundation contributed \$125,000 toward the construction costs of the Research Institute.¹⁴² The Tidewater Heart Association, through the bequest of Mr. Tazewell Taylor, Jr., contributed another \$125,000.¹⁴³

In a 14 February 1967 letter to Mr. Robert R. MacMillan, legal counsel for the medical authority, Mr. Alfred N. Hilton, secretary of the Board of Trustees of the Norfolk Medical Research Foundation, informed Mr. MacMillan of the Research Foundation's intention to dissolve all of its assets and transfer the proceeds to the Research Institute. The seven member board of trustees of the Research Foundation included Drs. Charles E. Horton (Chairman), Mason C. Andrews and Patrick C. Devine; Messrs. E. T. Gresham, Sr., Edward D. Levy, Robert K. Maddock, and Alfred N. Hilton. Approximately \$70,000 was transferred from the Norfolk Medical Research Foundation to the Research Institute.¹⁴⁴ It should be noted that each of the Research Foundation's members were also members of either the Norfolk Area Medical Center Authority or one of its committees or sub-committees. (A copy of the legal document dissolving the Norfolk Medical Research Foundation is provided in appendix 30.)

Tidewater Rehabilitation Institute

The placement of a comprehensive rehabilitation facility on land designated for the Norfolk Medical Center Complex was recognized by medical authority officials as an important contributing factor to the medical center concept. The first step in this direction was when Mr. Toy Savage, vice-chairman of the medical authority, met with federal and state health department officials on 23 January 1964 to discuss the possibility of obtaining a grant for the construction of a rehabilitation center in Norfolk.¹⁴⁵ At the 27 February 1964 regular board meeting of the Norfolk Medical Center Commission, he told the members that federal funds in the Hill-Burton Program did not allow for grants in the actual developmental planning of medical centers. However, grants were available to study and document the need, size, and scope of facilities and activities necessary in medical and health care to meet the requirements of the area served. The representatives from the Federal Public Health Service noted that they would recommend that a demonstration grant for area planning be approved for the proposed Norfolk Medical Center and that these funds would become available after 1 July 1964.¹⁴⁶

During the latter half of 1964 federal authorities with the Hill-Burton Program offered to match locally raised capitation funds for the construction of the rehabilitation center.¹⁴⁷ Dr. John Thiemeyer, Jr., recommended that the planning and construction of the Southeastern Tidewater

Rehabilitation Center proceed without delay. It was emphasized that the center's site plan should be submitted to federal authorities of the Hill-Burton Program not later than the program's 15 October 1964 scheduled deadline.¹⁴⁸

In a 8 September 1964 letter to Mr. Roy Prangley, chief administrator at Norfolk General Hospital, Mr. A. Whitney Murphy, an architect in Washington, D.C., discussed his long-range plan for the development in Norfolk of the proposed rehabilitation center, expansion and redevelopment of Norfolk General Hospital, and construction of a medical school.¹⁴⁹ At the 18 September 1964 meeting of the medical authority, it was agreed that close coordination between Messrs. Murphy, Kling, and Stedfast, director of the Norfolk City Planning Department, should be maintained to insure appropriate re-routing of streets around the medical center complex during its construction.¹⁵⁰

A contract was signed in 1965 with Fox-Sandler Company of Virginia Beach to begin construction of the Tidewater Rehabilitation Institute.¹⁵¹ At the May 1966 meeting of the medical authority's medical advisory committee, Dr. Robert L. Payne announced that the Kiwanis Club of Norfolk and the Oscar F. Smith Foundation had each pledged \$200,000 for the construction of the Tidewater Rehabilitation Institute.¹⁵² The Tidewater Health Foundation, Inc., a charitable corporation and agent of the Norfolk Area Medical Center Authority, assumed responsibilities of operating the Tidewater Rehabilitation

Institute.¹⁵³ The United Communities Fund agreed to underwrite the financial operations of the rehabilitation institute to the extent that cash expenses exceeded cash revenues.¹⁵⁴

The rehabilitation institute was built on a plot of land designated for the Norfolk Medical Center Complex at a cost of approximately \$1.1 million, of which \$543,000 came from Hill-Burton funds.¹⁵⁵ Construction was completed in January 1967.¹⁵⁶ An editorial in Norfolk's Ledger-Star acknowledged the regional cooperation, noting: "It [the Tidewater Rehabilitation Institute] holds a lesson in cooperation that many communities could take to heart, and it is especially gratifying to find such an example being offered to the nation by the people of Tidewater, an area whose full potential will be realized only through close liaison and shared endeavor."¹⁵⁷

Mental Health Center

The need for a modern, comprehensive mental health center was recognized by medical authority officials in 1965. The Community Mental Health Center and Psychiatric Institute, originally known as the Norfolk Mental Hygiene Clinic, was established in 1923 by a grant from the state. This was the first mental hygiene clinic in Virginia,¹⁵⁸ but by 1964 there were twenty-seven mental hygiene clinics in the state.¹⁵⁹ The Norfolk clinic continued to function until 1928 when funding was terminated. It was reactivated

in 1946 and was renamed the Norfolk Mental Health Center in 1958.¹⁶⁰

According to its 1958 constitution, the Norfolk Mental Health Center's objectives were:

1. To establish a service for the study and treatment of adults and children having nervous, mental, or emotional diseases
2. To conduct research into the causation of such problems as affect the mental health of adults and children in the community
3. To cooperate and collaborate with social agencies concerned with the welfare of the citizens of the community
4. To cultivate an interest in mental health and an understanding of the mentally ill¹⁶¹

In 1964 Dr. Dietrich W. Heyder, director of the Norfolk Mental Health Center, noted that three events occurred in 1963 to help bring about the realization of a regional comprehensive mental health center. They were:

1. Discussions were initiated concerning the professional, financial, and territorial location of a mental rehabilitation center.
2. The Community Health Center Act of 1963 was enacted. It promised to eliminate some of the barriers to construction of a mental health center in Norfolk.
3. Efforts to establish a medical school in the medical center complex were intensified.¹⁶²

Dr. Heyder and Dr. Frederick Woodson wrote a letter to the medical authority in September 1964. They requested that plans be implemented for an area mental health center and that the medical authority appoint an area mental health advisory committee to the medical authority.¹⁶³ The medical authority approved their request and appointed the following

individuals to the Advisory Committee on Mental Health Services: Drs. Dietrich Heyder, Frederick Woodson, Hanai J. Rittner, and H. William Fink; Messrs. Edward L. Breeden (Chairman) and Leighton Roper II; Mrs. Foster I. Gilbert and Mrs. John E. Krome.¹⁶⁴

Dr. Robert H. Barnes, executive director of the Greater Kansas City Mental Health Foundation and a consultant to the medical authority's Committee on Area Mental Health Services, visited Norfolk in June 1965. After examining Norfolk's mental health facilities and services for two days, Dr. Barnes filed a seven-page report.¹⁶⁵ He noted that the Tidewater area over the succeeding decade, with perceived population growth and the establishment of a medical school, would require a "comprehensive, broadly conceived conceptual model [for mental health services that could] adequately serve [its] requirements."¹⁶⁶ The thrust of his report was a recommendation that the Norfolk Area Medical Center Authority arrange a contract in which the newly expanded Norfolk comprehensive mental health center would replace the Norfolk and Chesapeake Mental Health Center and four clinics (Portsmouth, Lower Peninsula, Williamsburg, and Atlantic).¹⁶⁷ Dr. Barnes believed that the primary obstacle the medical authority would face in effecting this would be the unwillingness of the other clinics to participate in such an agreement. He believed that local jealousies would evolve because the "current Norfolk Clinic and its staff would undoubtedly become the

nucleus for the proposed Regional Comprehensive Center."¹⁶⁸ One advantage of building a comprehensive regional center in Norfolk was that the medical authority would become eligible for federal construction funds under Public Law 88-164 (Title II, the Community Mental Health Centers Construction Act).

The Virginia General Assembly provided \$325,000 to the medical authority in 1966 to be used as partial matching funds under Public Law 88-164 for the construction of a comprehensive community mental health center in the Norfolk area.¹⁶⁹ Upon Mr. Harry Manbach's motion at the 12 November 1968 board meeting of the medical authority, it was agreed that the mental health center would be built at a cost not to exceed \$2.2 million.¹⁷⁰ The Norfolk Redevelopment and Housing Authority subsequently conveyed additional land along Fairfax Avenue (within the medical center site plan) to the medical authority for the construction of the mental health facility.

Controversy arose in late 1968 when cost projections for the mental health facility were amended to \$2.35 million as a result of revised construction plans involving more space than originally planned. Nevertheless, the medical authority approved the revised floor plan.¹⁷¹ The federal Hill-Burton Program provided approximately \$1.1 million and the state contributed \$325,000. Over \$730,000 was raised locally.¹⁷² The 63,000 square-foot, eighty-bed Community Mental Health Center and Psychiatric Institute was

completed in 1973.¹⁷³

Perspectives of State and National Leaders

At the February 1967 dedication of a new hospital wing for Norfolk General Hospital, Gov. Mills E. Godwin spoke of the rapid growth of the Norfolk Medical Center Complex and strides made toward the establishment of a medical school in Norfolk. He urged caution regarding future growth of the medical center and efforts to establish a medical school, stating "I'd suggest that all ramifications of the project both in respect to costs and the number of doctors to be graduated have the most careful scrutiny. There are already two State supported medical schools."¹⁷⁴ However, he concluded his remarks by noting the initiative and determination of Norfolk's leaders to go forward on this project, and stated that "The State stands ready to adequately assist in the development of the Medical Center of which the school would be a part."¹⁷⁵

A month earlier a breakfast meeting attended by Drs. Mason Andrews, Robert Slater, Vernon Wilson, and Adm. (U.S.N. Ret'd) H. P. Smith was held to discuss the most appropriate way to organize a conference which would set directions for establishment of the Norfolk Medical Center and the medical school.¹⁷⁶ The group concluded that a meeting should be scheduled and several national leaders in medical education invited. The purpose of the meeting would be to examine the development of a medical center and

medical school and to consider national, state, and local problems as they might affect the medical center and the medical school. It was suggested that the results of the proposed conference be published in order to influence state and national thinking.¹⁷⁷

As a result, a two-day conference was held on 16 and 17 June 1967 in Virginia Beach. In addition to being attended by nationally-recognized authorities in medical education, deans from several medical schools and leaders in the local community also attended the two-day conference. (A list of the conference's participants is provided in appendix 31.) The conference was aimed at identification and discussion of specific catalyses for medical developments in Norfolk.

Discussion at the conference included topics such as the availability of federal financial support, characteristics of medical schools and their impact, the role of the medical school within the framework of institutions of higher learning, and the medical school's relationship to community health programs. Since the conference was designed to identify appropriate steps in developing the medical center and creating a medical school, no action was sought on how to solve each of the potential problems identified.¹⁷⁸ The result of the conference was a better understanding of the problems to be encountered in developing the medical center and in creating a medical school, and the potential advantages for the Hampton Roads

area.¹⁷⁹

The most significant issue identified during the two-day conference was how the medical authority should approach the problem of obtaining the necessary funds, conservatively estimated at \$25 million to \$30 million, to finance a medical school. It was concluded that the medical authority's emphasis should be directed at foundation grants and private gifts.¹⁸⁰ As was noted in Chapter IV, the Mayor's Advisory Committee on the Establishment of a Medical School in Norfolk had arrived at the same conclusion four years earlier.¹⁸¹

Summary

The climate for a medical school in Norfolk became increasingly favorable with each succeeding year during the 1960s. Significant developments in heart surgery, renal dialysis, organ transplantation, and other areas of medical service helped to stimulate recognition of the need for an effective, continuing medical education program in the Hampton Roads area. Local community leaders, many of them physicians, believed that the best way to insure long-term quality medical education was the creation of a medical school. As a result, the Norfolk Area Medical Center Authority was established as the vehicle to strengthen medical education in the Hampton Roads area. It focused on the creation of a medical school as its primary goal. Defined as an institution of higher education that was a

public entity and a government instrumentality, the medical authority was created as a public instrument to permit private sector action. In this regard, it was unique among institutions of higher education in Virginia.

Having identified medical education as the general goal and the creation of a medical school as the specific goal, the Norfolk Area Medical Center Authority directed its attention toward methodically attaining these two goals. Renowned medical consultants, planners, fund-raisers, architects, and others were consulted on how the medical authority should proceed toward creating a medical school. Land was purchased from the Norfolk Redevelopment and Housing Authority and additional land was acquired as part of the Atlantic City Redevelopment Project, existing medical facilities were expanded, and new facilities were erected.

Nationally-recognized physicians were hired to direct the services of these new medical facilities and programs. Encouraged by the idea of creating a medical school, they saw the opportunity to be an integral part of the future medical school and the opportunity to continue their research.

Norfolk experienced a boom in construction and renovation in the late 1950s and 1960s. Acres of slum areas across the city were cleared and many of its residents relocated to newly constructed subsidized housing in other parts of the city. Multi-story office buildings were erected in the downtown area. The Kirn Memorial Public

Library, the Norfolk Cultural and Convention Center (which includes SCOPE, the Chrysler Theater, an exhibition hall, and underground parking facilities), a multi-story hotel, Seaboard Citizens National Bank, and the twenty-one-story Virginia National Bank (SOVRAN) building were a few of the city's significant developments. The Maritime Tower replaced the old City Market. Apartment towers rose high above the Hague.

Improved traffic arteries such as Virginia Beach Boulevard, Brambleton Avenue, Tidewater Drive, and Saint Paul's Boulevard were in use, and Waterfront Drive was being planned. Redevelopment provided space for growth and further development and expansion of Norfolk General Hospital, construction of several new medical facilities, and the establishment of a medical school.

Despite the fact that the groundwork for the medical school had been years in planning and developing, proponents of the medical school were confident as the 1960s came to a close that the establishment of a private medical school in Norfolk was only a matter of time. The medical school was planned as the axis around which the various medical facilities of the medical center complex would operate. Dr. Mason Andrews, in a letter to the Norfolk City Council, expressed his aspirations and those of his associates, for the area's future when he stated: "Granted vision, access, and effort, the type of function here referred to [the Norfolk Medical Center Complex and the medical school] can

be developed to strengthen not only the core city but the entire area."¹⁸²

The development of the Norfolk Medical Center Complex was a significant and vital part of Norfolk's growth which continued into the 1970s and 1980s. Beyond that, as community leaders had realized in the early 1900s, the success of any community is often measured by its health standards. The Norfolk Area Medical Center Authority's plans were rapidly becoming realities. As early as 1970, the Norfolk Medical Center Complex was viewed as the medical center for Eastern Virginia and the northeastern section of North Carolina. The next logical step was establishment of the medical school.

FOOTNOTES

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¹⁰Ibid.

¹¹Interview with John S. Thiemeyer, Jr., M.D., Norfolk, Virginia, 29 May 1987.

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¹³Interview with John S. Thiemeyer, Jr., M.D., 29 May 1987.

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⁴² Ibid.

⁴³ Acts and Joint Resolutions of the General Assembly of Virginia, Chapter 471, p. 737.

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⁴⁵ Interview with Mason C. Andrews, M.D., 28 January, 1985.

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⁴⁸ Interview with Mason C. Andrews, M.D., 28 January 1985.

⁴⁹ Interview with Harry B. Price, Jr., president of Price's, Inc., Norfolk, Virginia, 17 January 1985.

⁵⁰ Interview with Richard F. Welton III, 28 February 1985.

⁵¹ Interview with Robert J. Faulconer, M.D., professor and chairman of the Department of Pathology, Eastern Virginia Medical School, Norfolk, Virginia, 12 April 1985.

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CHAPTER VI

ESTABLISHMENT OF THE EASTERN VIRGINIA MEDICAL SCHOOL OF THE EASTERN VIRGINIA MEDICAL AUTHORITY

The Eastern Virginia Medical Authority (EVMA) was created on 31 March 1964 as the Norfolk Area Medical Center Authority (NAMCA) with the passage of House Bill (H.B.) 444 by the Virginia General Assembly.¹ H.B. 444 subsequently became Chapter 471 of the 1964 Code of Virginia.² On 19 March 1975 the Virginia General Assembly passed H.B. 1435 which significantly revised and updated the initial legislation. This bill changed the name of the medical authority to the Eastern Virginia Medical Authority and increased to seven the number of Hampton Roads' cities represented on the board of commissioners.³ (A copy of H.B. 1435 is provided in appendix 32.) Throughout this period, the medical authority faced opposition to its principal goal--the establishment of a medical school.

Opposition to the Establishment of a Medical School in Norfolk

Opposition to the establishment of a medical school in Norfolk was voiced almost immediately after the idea was suggested in 1958. Resistance came principally from five

groups: (1) local residents whose land and homes would be taken to provide space to build the medical school and complementary facilities; (2) local physicians who feared a loss of influence and power in the community; (3) regional medical groups who feared that regional medical planning would not be appropriately represented throughout the Hampton Roads area; (4) officials of the two existing medical schools in the state; and (5) legislators in the Virginia General Assembly.

Local Residents

An extensive study was conducted in 1965 and 1966 by the Norfolk Area Medical Center Authority (NAMCA) in conjunction with various advisory committees and authorities in the field of medical care, medical education, and medical center operation. It was concluded that for the greatest benefit to the people of the area the medical center should be constructed around the existing medical center development which included Norfolk General Hospital, the Public Health Department, the Rehabilitation Institute, and the Norfolk Medical Tower Building. Future construction, however, would be contingent upon the availability of sufficient land to accommodate projected facilities essential to the concept of a comprehensive medical center complex.⁴

In 1966 consultants for the medical authority recommended that an additional seventeen acres of land be

acquired by the medical authority. This land was east of the existing 33.68 acres already occupied by medical facilities of the medical center. It was proposed that the medical authority acquire this land as part of the Ghent Neighborhood Conservation Project.⁵

Opposition to this proposal came from many local residents, especially those residing in the East Ghent area. It was upon this seventeen acres of land that the medical authority proposed the construction of the medical school and other complementary medical facilities. The establishment of a medical school meant relocation for many residents some of whom had lived in the East Ghent area all of their lives.

On 11 October 1966 the Norfolk City Council held a two-and-a-half hour public hearing to discuss NAMCA's proposal to acquire 17.68 acres of land adjacent to the Norfolk Medical Center in East Ghent. Approximately 165 property owners affected by this proposal attended the public hearing.

Dr. Mason C. Andrews, chairman of the medical authority, pointed out arguments to the Norfolk City Council in favor of the medical authority's plans for expansion of the medical center.⁶ He was followed by several local business and civic leaders who endorsed the medical authority's request for the land acquisition. Speaking to the city council in favor of the proposal were Mr. Frank Batten, chairman of the Board of Advisors of Old Dominion

College; Dr. Robert L. Payne, Jr., chairman of the medical authority's Medical Advisory Committee; Mr. Hunter Hogan and Mr. V. H. Nusbaum, local realtors; Mrs. J. H. Godwin, Jr., chairperson of the Building and Planning Council of the Kings' Daughters Children's Hospital; Mr. Harvey Lindsay, chairman of the Citizen's Advisory Committee; Reverend Peyton Williams, a Norfolk minister; Mr. W. Fred Duckworth, a local businessman and former mayor of Norfolk; Mr. C. E. Thurston, a local businessman; Mr. Preston Blake, Jr., a representative of the Health, Welfare, and Recreation Planning Council; and Mr. Samuel R. Ames, president of the Norfolk Chamber of Commerce.⁷

Token opposition to the medical authority's land acquisition proposal was offered by Mr. Harry W. Keeling, representing the Ghent Civic League, and Mr. J. Hume Taylor, representing the Concerned Citizens' Committee of Norfolk. Mr. Keeling told the members of the city council that the Ghent Civic League had held a meeting in which 250 members attended. A vote was taken on the medical authority's proposal to acquire an additional seventeen acres of land in their neighborhood. The result was that only twelve of the 250 members present opposed the plan. The majority of attendees believed that the medical center and medical school were good for the City of Norfolk and in the best interests of all of its citizens. As a result, the decision was made by members of the Ghent Civic League to support the medical authority's land acquisition proposal.⁸

The Norfolk City Council voted on the medical authority's land acquisition proposal after hearing from approximately twenty speakers. The result was unanimous approval of the proposal.⁹

MASON C. ANDREWS, M.D.: The original plans of the medical school went all the way to Stockley Gardens and Redgate Avenue. However, this was not to be. If things had gone according to our plans, it would have been an impressive facility. There were houses and apartments that would have to have been demolished to make room for the medical school. Opposition to our proposal from the community immediately surrounding this area was great, so we settled for less than we wanted. They were going to go to Washington to stop us. It would have cost us several hundred thousand dollars to please these people, so we gave up on the original plan. You can't win them all.¹⁰

Local Physicians

Many prominent Norfolk physicians favored the idea of establishing a medical school in Norfolk. The majority of the physicians who worked in Norfolk's hospitals, including the house staff and faculty of the hospitals' medical education program, favored the idea of a medical school. They were interested in research and training, and the presence of a local medical school was highly appealing to them. A medical school would attract research grants and the attention of officials at other medical institutions. Unlike many private, office-based physicians, especially general practitioners, the physicians engaged in training and research did not require their patients' goodwill for the success of their businesses. Their careers depended largely on the opinion of their colleagues and the

administrators at other medical institutions.¹¹

On the other side of the issue were the private, office-based physicians, many of whom vehemently opposed the idea of a local medical school. They had a privileged and somewhat dominant role in the community's hospitals. Unlike their counterparts who identified more closely with area hospitals and leaned toward research and training, this second group of physicians depended on the goodwill of their patients and on patient referrals from their colleagues.¹²

Mr. Toy D. Savage, Jr., a commissioner of the Norfolk Medical Center Commission from 1964 to 1966 and a board member of Norfolk General Hospital in the 1960s, stated:

TOY D. SAVAGE, JR.: There was unrest among some of the area physicians regarding plans to establish a medical school in Norfolk. Much of the discontent was a result of a lack of understanding regarding what rights they would have at area hospitals versus the rights of the medical school's faculty. Partly because of this lack of understanding, negotiations were constantly underway between Norfolk General Hospital and the medical authority to reach some type of agreement.¹³

Many older physicians perceived the presence of a medical school in Hampton Roads as an economic and political threat. They became angry and bitter at the thought of a local medical school. For one thing, the medical school would require their teaching assistance. They did not want to be part-time instructors and donate their time to the medical school.¹⁴ As discussed in Chapter IV, many of these physicians were not interested in medical education programs for local hospitals. Many medical authorities considered

this lack of interest the root of the problem that plagued the medical education programs at Norfolk's hospitals in the late 1950s and early 1960s when these hospitals had difficulty in attracting medical school graduates to fill their vacant internships and residencies.

TOY D. SAVAGE, JR.: I was closely associated with Norfolk General Hospital and the problems it was having in providing quality health care in the late 1950s and early 1960s. During this period of time, Norfolk General had difficulty in recruiting English-speaking interns and residents.

We realized that Norfolk General Hospital would not be able to provide first-rate medical care without the presence of a local medical school. Others associated with Norfolk General, like Charles Kaufman, were strong supporters of the idea of a local medical school. Our need for quality medical care was the driving force behind our support for a medical school.¹⁵

Many older physicians who had private practices believed that the medical school's faculty would dominate the hospitals in the local area and that they would be denied the hospital privileges enjoyed prior to the establishment of the medical school. These physicians resented their possible loss of influence and prestige in the community and at hospitals and medical facilities in Hampton Roads.

Mr. Glenn R. Mitchell was chief administrator at Norfolk General Hospital from 1971 to 1984 and is currently president of SENTARA Health Systems, a corporation involving several hospitals, urgent care centers, nursing homes, and other related health activities. He recalled the conflict among area physicians as to plans for a local medical

school.

GLENN R. MITCHELL: I accepted an administrator position with Norfolk General Hospital in January 1971. At that time, there was a question as to whether or not the medical school could really be started. There were some doctors who wanted the medical school and others who didn't. There was real fear and concern.

There was discontent among the doctors who were established in their practices. They made a decision that they were not going to stay on the faculty of the medical school nor were they going to be a part of a university hospital. All of a sudden a medical school was being thrust upon them. It was a question of changing the status quo. They became very concerned and opposed to the idea of a medical school in Norfolk.

On the other side of the issue, the physician leadership, the leading physicians on our staff, were the biggest advocates of the medical school. They had well-established, successful practices and were self-confident.¹⁶

Regional Resentment

The third faction who opposed the establishment of a medical school in Norfolk consisted of physicians in other geographic areas of Hampton Roads. One such group consisted of physicians in the City of Hampton. In 1965 the Hampton Medical Society sent a letter to the Department of Health, Education, and Welfare in Washington, D.C. The letter stated, in part:

Recognizing the possible need for a new medical school in the Norfolk area, the Hampton Medical Society would like to voice strong objection to the usurpation of area-wide medical planning responsibilities by any group not adequately representative of the entire area. Specifically, the Hampton Medical Society feels that the Norfolk Area Medical Center Authority (NAMCA), being a body chosen by the Norfolk City Council and therefore responsible only to Norfolk interests, should not attempt to plan medical facilities for the surrounding areas, including the Virginia Peninsula. If such planning is

necessary, it should be done by a group whose members would be chosen by the areas affected in proportion to the population in those areas.¹⁷

The commissioners of the Norfolk Area Medical Center Authority recognized the need for the medical school to be a regional institution in which all the cities in the Hampton Roads area would participate. A concerted effort toward this goal was initiated in the early 1970s.

Existing Medical Schools

The establishment of a medical school in Norfolk presented two serious threats to the two existing medical schools in Virginia--the University of Virginia School of Medicine in Charlottesville and the Medical College of Virginia in Richmond. First, it would have created more competition for students. Second, it would have meant that public monies allocated for the state's medical schools would have to be divided three ways instead of two. As a result, the University of Virginia School of Medicine and the Medical College of Virginia would be getting fewer state dollars than previously received, a situation neither medical school was willing to accept gracefully.

Dr. Joseph L. Yon (Rear Admiral U.S.N. Ret'd), associate dean of the Eastern Virginia Medical School since 1972, recalled the sensitivity demonstrated by the state's two existing medical schools when they learned that the Norfolk Area Medical Center Authority might seek financial support from the state for the proposed medical school in

Norfolk.

JOSEPH L. YON, M.D.: The founders of this school went to the Medical College of Virginia and to the University of Virginia to get their thoughts on the opening of a medical school branch in Norfolk. The University of Virginia might have followed through, except the governor stopped it.¹⁸

As support for the establishment of a medical school in Norfolk gained support in the Hampton Roads area, opposition to the idea intensified at the two existing medical schools. Dr. Mason C. Andrews recalled, "As soon as we started to build a case for a medical school in Norfolk, the state's two existing medical schools started to increase their student enrollments."¹⁹ In other words, officials at these medical schools were trying to persuade state legislators and others that their institutions could supply Virginia's demand for more medical doctors and thereby meet the medical needs of the state. Thus, the need for a third medical school in the state would be unnecessary.

The Virginia Legislature

Many Virginia legislators opposed the idea of establishing a third medical school in Virginia. Many of them were alumni of the University of Virginia or Virginia Commonwealth University. Others had strong ties to these two institutions.

Local proponents of the Norfolk medical school sought advice from Mr. Colgate W. Darden, Jr., a former governor of Virginia and past president of the University of Virginia. Mr. Darden was a resident of Norfolk and an individual

considered by many as the most influential political figure in Virginia.

Mr. Barron F. Black, chairman of the Mayor's Advisory Committee on the Establishment of a Medical School in Norfolk, approached Mr. Darden in April 1963 in an attempt to assess "his attitude toward the [proposed] Medical College."²⁰ Mr. Darden had recently served on President Eisenhower's Commission on National Goals, and one of the recommendations of this commission was that medical school enrollments in the United States should be increased at least fifty percent by 1970.²¹ Therefore, it was thought that Mr. Darden might look favorably upon the proposal for the establishment of a medical school in Norfolk and offer his support. However, this was not the case. In a letter to the members of the Mayor's Advisory Committee, Mr. Black wrote of his meeting with Mr. Darden, "Our conversation [about the proposed medical college] ended up somewhat argumentatively."²² It gradually became evident to proponents of the medical school that Mr. Darden was steadfast in his opposition to a third medical school in the state.²³

Nevertheless, efforts to obtain Mr. Darden's support continued. An extremely influential political figure in Virginia, he was considered by many to be Virginia's elder statesman.²⁴ He was elected to the Virginia House of Delegates from Norfolk in 1929. A few years later he was elected to the U.S. House of Representatives from the Second

Congressional District, served one term as governor of Virginia, was appointed chancellor of the College of William and Mary, and subsequently served as president of the University of Virginia from 1947 to 1959.²⁵ Throughout this time, he maintained his home in Norfolk.²⁶ Gov. Lindsay Almond appointed Mr. Darden to the State Board of Education in 1960. He was co-chairman of the state board in 1963 when the Norfolk Mayor's Advisory Committee on the Establishment of a Medical School in Norfolk sought his advice and support for the proposed medical school.²⁷

Mr. Darden was an individual with an immense knowledge of what the financial and political repercussions might be in establishing a third medical school in Virginia. "Any support from Colgate Darden," recalled Dr. Thiemeyer, "would have greatly increased the chances that the state legislature would have approved the establishment of another medical school in the state."²⁸

Mr. Darden's wife, Constance Darden, was from one of the wealthiest families in the United States--the duPont's. Hence, it was believed that strong support from her husband quite possibly might have resulted in a large endowment from the duPont Foundation for the proposed medical school.²⁹

Mr. Darden basically opposed the idea of a third medical school in Virginia because he believed that the state could not financially afford another medical school. As a former governor of Virginia and past president of the University of Virginia, he was aware of the financial burden

that a medical school would have on the state's treasury.³⁰ Virginia was already heavily subsidizing the University of Virginia School of Medicine and the Medical College of Virginia.

JOHN S. THIEMEYER, JR., M.D.: [Mr. Darden had] traumatic experiences with the finances of the medical school at the University of Virginia. . . . His experiences were such that he thought it [the proposal for a medical school in Norfolk] was an unwise thing, that it couldn't be done financially or physically. He didn't intentionally block us by any means, but if he had been with us, everything would have been so much easier. . . . He had his opinions and experiences . . . which were probably valid. . . .³¹

Dr. Robert L. Payne, Jr., was a member of the Norfolk Area Medical Center Authority's Joint Liaison Committee. This committee, consisting of Norfolk General Hospital, the Norfolk Area Medical Center Authority, Old Dominion College, and the Norfolk County Medical Society, was formed to help establish a medical school in Norfolk. Regarding the medical authority's request to Mr. Colgate Darden for state funds for the medical school in Norfolk, Dr. Payne recalled that Mr. Darden opposed the idea of the medical school because he "believed it would drain away finances from Old Dominion College which he felt was the more important task."³²

Mr. Guy Friddell, a well-known Norfolk newspaper reporter and author, spent two years interviewing Mr. Darden. The result was an oral history published in 1978 entitled Colgate Darden: Conversations with Guy Friddell. Mr. Friddell supports the recollections of Dr. Thiemeyer and

Dr. Payne regarding Mr. Darden's steadfast opposition for support of the proposed medical school by concluding, "He [Mr. Darden] never hesitated to follow his convictions."³³

Mr. Darden was not alone in his belief that the State of Virginia could not afford another medical school. Many members of the state legislature shared his belief, as did many authorities in the medical field. Dr. Vernon Wilson, dean of the University of Missouri School of Medicine and medical consultant to the Norfolk Area Medical Center Authority, noted in 1963, "There are currently two schools of medicine being operated by the State of Virginia, neither of which is receiving adequate state support."³⁴

Unable to obtain Mr. Darden's political support, the Mayor's Advisory Committee looked to other influential and well-known individuals to direct and procure the political and financial backing for the proposed medical school. During the next several years, considerable attention was focused on identifying appropriate individuals for these tasks.

Political support, although slow in coming, did gain momentum. For instance, the medical authority had encountered resistance from the governor's office since steps were first taken to gain state approval in the early 1960s. On 13 October 1968, however, it appeared that this resistance might be weakening. Attending a dinner of the Virginia Medical-Political Action Committee were three candidates for the Democratic Primary nomination for

governor of Virginia. They were Lt. Gov. Fred G. Pollard of Richmond; State Sen. Harry E. Howell of Norfolk; and former U.S. Ambassador to Australia, William C. Battle.³⁵ Each of the candidates endorsed the plan for a privately financed medical school in the Hampton Roads area. Lieutenant Governor Pollard stated, "If the people of that area have enough determination to build a private medical school, the least the state can do is to provide the necessary graduate programs at Old Dominion College."³⁶

JOSEPH L. YON, M.D.: The medical authority could not get the governor to sponsor a third medical in the state. Since they [the commissioners of the medical authority] couldn't get state funds or state approval to start a public medical school, they decided to establish a private medical school without outside support.³⁷

As was the case in the latter 1960s, the governor's office continued in the early 1970s to oppose state support of a private medical school in Eastern Virginia. Dr. Robert J. Faulconer, professor and chairman of the Department of Pathology of the Eastern Virginia Medical School, was a member of several medical authority committees during this period. He recalled some of the political obstacles to establishing a medical school in Norfolk.

ROBERT J. FAULCONER, M.D.: Politics was a big problem. Gov. Linwood Holton [Governor of Virginia from 1970 to 1974] was adamantly opposed to a medical school in Norfolk. He thought it would ultimately become a ward of the state because of the huge costs to operate a medical school and the fear that it would not continue to receive adequate support from the people and cities of Hampton Roads.³⁸

This opposition from the governor's office did not

stop proponents of the medical school from lobbying for support in the Virginia General Assembly. Subsequently, the Appropriations Committee voted in March 1972 to provide state funds for the Eastern Virginia Medical School and the governor did not veto the measure. The result was a provision in the Code of Virginia which provided a yearly \$4,000 student capitation subsidy to the Eastern Virginia Medical School.³⁹

Studies Supporting the Need for the Eastern
Virginia Medical School

The Norfolk Area Medical Center Authority struggled between 1964 and 1973 to obtain its principal goal--the establishment of a medical school. During this period, several studies were conducted to investigate the feasibility and practicality of establishing a medical school in Eastern Virginia. Three studies conducted in the early 1970s that supported the need for another medical school in Virginia were the Carnegie Commission's report Higher Education and the Nation's Health, the Olson Report (also referred to as the Eastern Virginia Medical School--Financial Plan for the First Ten Years, and The Shortage of Family Physicians--Report of the Virginia Advisory Legislative Council.

The Carnegie Commission Report

The Carnegie Commission on Higher Education published in 1970 a special report, Higher Education and the

Nation's Health, which helped to provide additional credibility for the effort to establish a medical school in the Hampton Roads area. The report dealt with medical education in the United States. It identified specific geographical areas where more doctors were needed and suggested policy changes that would enable federal and state agencies to meet this need.⁴⁰ The report recognized the Norfolk-Portsmouth area of Virginia as the second largest population center in the United States that was without a university health center (Table 6).⁴¹ The report inferred that if the population of the Hampton-Newport News area had been included, then the Hampton Roads area with an estimated population of 930,000 would have been the largest population center in the United States that was without a university health center.⁴²

TABLE 6

CARNEGIE COMMISSION GOALS FOR NEW UNIVERSITY
HEALTH SCIENCE CENTERS BY 1980

Standard Metropolitan Area	Estimated Population, 1 July 1967 (1,000)
Phoenix, Arizona	859
Norfolk-Portsmouth, Virginia . . .	646
Springfield-Chicopee- Holyoke, Mass.	557
Jacksonville, Florida	505
Wilmington, Del.-N.J.-Md.	481
Tulsa, Oklahoma	451
Fresno, California	416
Wichita, Kansas	396
Duluth-Superior, Minn.-Wis. . . .	273

SOURCE: Higher Education and the Nation's Health, Policies for Medical and Dental Education, A Special Report and Recommendations by the Carnegie Commission on Higher Education (New York: McGraw-Hill Book Co., 1970):Table 4, p. 55.

The Carnegie Commission's report recognized "that local initiative is desirable and usually essential in planning for a new university health science center."⁴³ In this regard, it applauded the proponents of the Eastern Virginia Medical School for their initiative, enthusiasm, and tenacity in efforts to establish a medical school in Eastern Virginia.

The Olson Report

The 1971 report Eastern Virginia Medical School--Financial Plan for the First Ten Years of Operation, often referred to as the Olson Report, was initiated by the Norfolk Area Medical Center Authority to help justify state support for a medical school in Norfolk. It evolved as a

result of a request in 1969 by Dr. Mason C. Andrews, chairman of the medical authority, to Gov. Mills E. Godwin, Jr., for state funds to assist the medical authority in its planning of the proposed medical school.⁴⁴ Before any legislative action could be taken, however, Linwood Holton was elected governor of Virginia in 1970. Governor Holton, like his predecessor, did not favor the idea of a third medical school in Virginia. Dr. Andrews' request was presented to the Virginia General Assembly, and, as a result, the Appropriations Committee granted the Norfolk Area Medical Center Authority \$100,000 in 1970 for the study of the feasibility of a medical school in Norfolk. The medical authority, in requesting this appropriation, stated that the objective would be to test the soundness of past proposals for the construction and operation of the medical school within specified financial limits.⁴⁵

On 4 September 1970 Gov. Linwood Holton wrote a letter to Mr. Harry H. Mansbach, the newly appointed chairman of the medical authority, which outlined the procedures for obtaining the \$100,000 in state appropriations.⁴⁶ Gov. Holton restated the conditions and concerns set forth in the appropriations act of the General Assembly, and asked that a report be submitted by 1 April 1971 in order that the results could be incorporated into the 1972-74 state budget.⁴⁷ These conditions included:

1. Buildings should be built entirely with local private resources and federal matching funds.

2. Affiliated area hospitals should provide clinical facilities at no cost to the state.
3. Legacies to the medical school should be developed.
4. Student subsidy from the state should not exceed \$4,000 per student or \$1 million, whichever is the lesser.
5. The total of endowment funds, local appropriations, and student subsidy from the state should be sufficient to the satisfaction of the governor for an accredited school of medicine.
6. Project operating costs and fund sources for the initial ten years of operation should be identified.
7. Resources required for the basic sciences component of the medical instructional program should be identified. The facilities where these resources would be located should also be identified.⁴⁸

The medical authority requested the services of three consultants to study and address the seven conditions and concerns of the appropriations act. The three consultants were: Stanley W. Olson, M.D., president of the Southwest Foundation for Research and Education; Thomas J. Campbell of the Association of American Medical Colleges; and Lawrence Prehn, Jr., of the Southwest Research Institute.⁴⁹

Dr. Olson and his colleagues visited Norfolk in early 1971 and spoke to the commissioners of the medical authority and to local medical and municipal officials. Their report, delivered on 1 April 1971, summarized the group's findings as follows:

1. Construction of buildings for the proposed Eastern Virginia Medical School will be accomplished with local and federal matching funds. Sufficient local funds have already been committed for this purpose and steps are being taken to meet federal requirements for matching funds.

2. A sound basis has been established for affiliation and agreement among the various area hospitals to provide the requisite clinical facilities to support the Eastern Virginia Medical School. This will be done at no cost to the state. Within the past decade, \$23 million has been expended for new facilities within the medical center itself.
3. A distinguished group of citizens has established the Eastern Virginia Medical School Campaign, whose purpose is to raise sufficient private funds to meet the needs of the new medical school. To this end, legacies of more than \$3 million have been identified and it appears feasible that legacies in the amount of \$10 million or more will be identified by the time the new school accepts its first students.
4. Examination of the proposed operating budget and sources of income reveals them to be adequate and attainable. The budget plan is sound and the \$1 million annual contribution from the state of Virginia represents the maximum amount required to insure the operation of the medical school.
5. The leadership vested by the citizens of the Tidewater area in the Eastern Virginia Medical School Foundation has taken steps to provide operating funds for the Eastern Virginia Medical School. Over \$7 million from local sources has been committed for an endowment fund. The fund campaign will be directed by national organizations. The leaders are confident they will be able to raise the remainder required to provide \$5 million to match federal funds for construction of the additional facilities for the medical school and establish a \$10 million endowment fund. The City of Norfolk will provide \$500,000 per year. Federal funds are available for medical education, but President Nixon is asking Congress to make money available to the medical schools at the rate of \$1,500 per student per year. These items, together with other fund sources identified, demonstrate the soundness of the financial operations of Eastern Virginia Medical School.
6. Examination of a cash flow projection for the first ten years operation of the Eastern Virginia Medical School shows that there will be a small but healthy cumulative surplus for the entire period.
7. The basic sciences part of the medical instructional program represented by the facilities for the faculty, student learning space, and facilities for research will be included as an integral part of the

Eastern Virginia Medical School at the medical center campus.⁵⁰

In conclusion, the Olson Report stated:

The significance of Eastern Virginia Medical School for the health care of all citizens in the Tidewater region goes beyond the direct contribution of the new physicians to be educated there, important as that aspect may be. The medical school will be the nucleus from which a university health science center will evolve. The effect will be improved training programs in affiliated hospitals; incentives for additional physicians to practice in Virginia; new emphasis on family care; increased opportunity for the training of nurses, therapists, and technologists; all to the end that each person in each community may have a full range of health services.⁵¹

Report of the Virginia Advisory Legislative Council

The Virginia Advisory Legislative Council, a group of twelve state legislators, published in December 1971 the report The Shortage of Family Physicians. The purpose of the report was to advise the governor and the General Assembly of the need for more physicians in Virginia and to recommend possible solutions for this problem.

The report noted that one-fourth of the state's population lived in Eastern Virginia and was not receiving minimal health care primarily because of the shortage of physicians in that part of the state.⁵² The report also noted that the number of physicians graduating with medical degrees in the field of primary care at Virginia's two medical schools had gradually decreased between 1950 and 1965. During the period 1950 to 1955, the combined annual total of new physicians graduating with medical degrees in

primary care was eighty-seven; from 1955 to 1960 it had decreased to seventy per annum; and from 1960 to 1965 it had dropped to fifty-six per annum.⁵³

Dr. Mason C. Andrews addressed the legislative council of the Virginia General Assembly in 1971 during their investigation of the physician shortage in Virginia. He offered support for the establishment of a medical school in Norfolk and told the council members that the proposed medical school in Norfolk would serve the health needs of Eastern Virginia. He told them that the medical school by 1976 would be able to graduate sixty-four physicians annually. In addition to fostering better health care for the citizens of Eastern Virginia, the medical school also would provide a long-term economic return to the area's economy by attracting professionals to fill new jobs generated by the establishment of a medical school.⁵⁴

After studying the issue for about a year, the legislative council commented favorably upon the idea for the establishment of a medical school in Norfolk. Their report concluded:

We would like . . . to commend the efforts of those in the Tidewater area who are participating in the establishment of this institution which has as a primary goal the creation of more primary physicians, including family practitioners. The family practice program being developed at the proposed medical school is to be praised as it could act as a potential future source of family practitioners. Therefore, the Council feels that the General Assembly should be encouraged to look with favor upon the development of a new medical school in the Tidewater area, and should provide financial support through appropriations based on a per in-State student basis only. Such appropriations should be earmarked for

educational purposes only and should not be used for capital outlay and school maintenance. It is also recommended that State medical scholarships should be offered to EVMS students when the school is established. This would represent a minimal investment for the benefits to be accrued to the people of the Commonwealth.⁵⁵

Several factors influenced the council's recommendation for state support of the Eastern Virginia Medical School. Two principal factors were the growing scarcity of primary care physicians and the state's responsibility to provide minimal medical care to all of its citizens. Thus, the Virginia Advisory Legislative Council's support for the proposed medical school in Eastern Virginia, together with the prestigious Carnegie Commission and Olson Reports, helped validate the need for the establishment of the Eastern Virginia Medical School.

Recruitment of Faculty and the First Dean

The medical school's first faculty members were recruited in 1967 with the appointments of Drs. A. A. Douglas Moore, Norman B. Thomson, Jr., and Bruce Innes. They established the cardio-pulmonary laboratory and the cardiac surgery program at Norfolk General Hospital.⁵⁶ In 1969 Dr. James E. Etheridge was appointed as the director of pediatric neurology, and subsequently became the chairman of the medical school's Department of Neurology.⁵⁷ Dr. Patricia Bell Williams was the first full-time basic science faculty member, having been appointed in pharmacology in August 1971.⁵⁸

Several basic issues had been resolved by the end of 1970. For instance, the medical authority had decided not to construct a new university hospital primarily because of financial reasons. It was concluded that such a venture would have been too expensive and one in which the medical authority did not have the financial resources to carry to completion. Instead, it was decided that the medical school would use the existing resources of area hospitals, community and federal, for its educational programs. The existing postgraduate residencies at Norfolk General Hospital, King's Daughters Children's Hospital, and DePaul Hospital would be linked to the medical school's educational programs to maintain the continuum of learning for health professionals, including continuing education for local practicing physicians. Allied health education programs would be developed in association with existing institutions of higher education, especially Old Dominion University.

A nation-wide search for the medical school's first dean was initiated in November 1970.⁵⁹ The thirty-three member search committee consisted of distinguished Tidewater citizens from the medical, educational, cultural and business communities.⁶⁰ Several highly qualified and experienced individuals were considered. The medical authority wanted an individual "highly respected and among the most knowledgeable people so far as administrative capacities, the potential for sound innovation, and the presumed ability to dream and consummate," commented Dr.

Mason C. Andrews.⁶¹

In April 1971 the medical authority selected Dr. Robert T. Manning to be the Eastern Virginia Medical School's first full-time dean. Dr. Manning resigned from his posts of professor of internal medicine and associate dean at the University of Kansas School of Medicine to come to Norfolk on 1 June 1971.⁶²

As the new dean of the medical school, Dr. Manning faced a problem not encountered by most other deans of medical schools. He was tasked to organize and develop a medical school that had neither a university base nor a major teaching hospital of its own. Thus, Dr. Andrews' recommendation that the new dean of the medical school possess "the potential for sound innovation"⁶³ was most applicable. Because of the circumstances upon which the Eastern Virginia Medical School would be established and developed, it would be unique among the existing medical schools.

Dr. Manning approached his new job with two priorities in mind. First, he had to recruit and organize the medical school's faculty. Second, he had to formulate an educational curriculum for the medical school.⁶⁴ Dr. Charles E. Horton, a well-known plastic surgeon in Norfolk and a member of the medical authority's Medical Advisory Committee when Dr. Manning was selected as dean, recalled Dr. Manning's strategy to accomplish these two urgent needs.

CHARLES E. HORTON, M.D.: Dr. Manning came to Norfolk to

help us start the medical school. There was no faculty and no base upon which to start this school. He began by recruiting many of the basic faculty members, some of whom are still here.

Dr. Manning tried to develop a new concept in medical education--a three-year academic program. It was envisioned that students would attend classes all year round. The school would focus on training primary care physicians and specialists. He suggested that the faculty be primarily composed of local physicians who would donate a part of their time to the teaching services of the medical school.⁶⁵

Dr. Joseph L. Yon (Rear Admiral U.S.N. Ret'd) was the commanding officer of the Portsmouth Naval Hospital when Dr. Manning was appointed to the deanship of the Eastern Virginia Medical School. He had been a member of the medical authority's Search Committee for the Dean in 1970,⁶⁶ and recalled the events surrounding Dr. Manning's appointment.

JOSEPH L. YON, M.D.: I was a member of the authority's Search Committee for the dean and as such, often times entertained members of the search committee for breakfast and dinner at the Naval Hospital [in Portsmouth]. Officials in the navy strongly believed that the Naval Hospital should be a part of the medical school.

Dr. Robert Manning was selected as the dean in 1971. He came over to the Naval Hospital and we talked about the status of the proposed medical school, its relationship to area hospitals, needed facilities for the medical school, and so forth.

I retired from the navy on March 1, 1972, and came aboard the medical school on June 1, 1972, as the associate dean for Administrative and Interhospital Relations. My job was solely administration of the medical school; that is, to negotiate contracts with the thirteen or so hospitals as it pertained to our students, to promote hospital involvement with the medical school, and so forth.⁶⁷

Formal recruitment and organization of the faculty

began in 1972 with the appointment of Dr. Richard E. Davis as the associate dean for Academic Affairs.

JOSEPH L. YON, M.D.: Dr. Richard Davis was hired as the associate dean for faculty development and curriculum. He was given the title of Professor of Psychiatry and my title was Professor of Surgery. Recruitment of faculty members was just beginning.⁶⁸

Faculty membership was offered to all members of the practicing medical profession in Eastern Virginia who expressed a desire to participate in teaching at the new medical school. Full-time faculty members were recruited from the local community and from other medical and graduate schools and research institutes. During 1972 and 1973, eight individuals were appointed to chair departments at the medical school. They were: Drs. Donald J. Merchant in microbiology and immunology; David D. Michie in physiology; Desmond R. H. Gourley in pharmacology; Edward J. Morrison in anatomy; Paul J. Fink in psychiatry and behavioral sciences; Karl A. Schellenberg in biochemistry; Daniel F. Cowan in pathology; and Mason C. Andrews in obstetrics and gynecology.⁶⁹ Each of these department chairmen was charged with the recruitment of faculty members needed to conduct the teaching duties and other responsibilities of his respective department.

JOSEPH L. YON, M.D.: Dr. Davis spent most of his time traveling around the country to recruit qualified people in the basic sciences. The first two years of medical school is primarily basic science. In order to become accredited, we needed a strong faculty in the basic sciences. This was our first priority.⁷⁰

Educational and Curricular Plan

Soon after Dr. Manning assumed the position as the Eastern Virginia Medical School's first dean in 1971, he and the medical authority began to formulate an innovative approach for the organization and development of the medical school. Specific concepts of a health care system and an educational system were articulated for the eastern part of Virginia. Attention was focused on the interrelatedness of community and family health centers, medical group practices, private medical practices, and regional hospital services linking urban and rural resources into one comprehensive, regional educational and health care network. Describing the medical school's philosophy, Dr. Manning stated:

This medical school will not create its own university hospital and withdraw within ivy-covered walls away from the surrounding community. It is our philosophy that health profession students should learn in multiple, real environments like those in which they will spend the rest of their professional lives; that is, in community health and medical care facilities.⁷¹

It was envisioned that the Eastern Virginia Medical School would be a private institution that would operate on minimal, government financial assistance. The private sector would be the primary financial source. Within the private sector, the communities of the Hampton Roads area would be the financial base.⁷² The medical school would have limited numbers of full-time faculty, place heavy reliance on volunteer faculty, and use existing local hospitals rather than have its own hospital for clinical

teaching experiences.

The medical school was conceived as the nucleus of a regional network of medical institutions. Dr. Manning envisioned that it would provide the basis for medical education in the eastern part of Virginia, offer research programs, and provide expanded health care services to all citizens in Eastern Virginia. Its primary mission, stated Dr. Manning in 1972, was "to train physicians for medical practice and to provide health and medical services to the citizens of the eastern part of Virginia, to the state, and to the nation."⁷³ In light of this mission, Dr. Manning proposed an innovative educational program for the Eastern Virginia Medical School. Basically, the instructional process would be highly structured. He called it "education by design."⁷⁴

Dr. Manning believed that chance and circumstance often entered into the educational process and that such uncontrollable variables should be eliminated as much as possible. Emphasis should be given to measurable behavioral objectives. In the past, learning had been considered the variable and time the constant. Dr. Manning believed that this needed to be reversed to where learning was the constant and time the variable. He believed that the core science courses were not obsolete. It was the medical school's educational approach toward teaching them that was obsolete. The completion of "X" courses or "X" credit hours was inconsequential. Achievement and performance were the

real goals, and it was these, and not the number of courses or credit hours, that the medical school should emphasize.⁷⁵

Overview of the Education Plan

Dr. Manning formulated an educational plan for a thirty-six month instructional program that would lead to the degree of Doctor of Medicine. The initial curriculum for the medical school was organized into three phases of continuous study with vacation breaks scheduled for July and December of each year. Each academic phase was approximately one-year in length. By the fall of 1973, an instructional curriculum had been formulated and approved by officials of the medical authority.⁷⁶

There were several reasons for designing a three-year medical curriculum as opposed to the traditional four-year program. First, it was believed that the students could complete all the stated objectives for the medical degree in a three-year period of time. Second, it was believed that the target date for graduating the first class in 1976 could be met. Other reasons for a three-year program as opposed to the traditional four-year program included the lower costs to the medical student and better utilization of the medical school's equipment and space.⁷⁷

During Phase I, students would acquire the fundamentals of the basic sciences and physical diagnosis. These subjects formed the foundation of medical practice and prepared students for clinical responsibilities in Phase II.

Students would acquire skills and the main principles of medical practice in Phase II. The educational experiences in this phase were designed to help students apply basic science concepts to medical practice. Phase III was more flexible and was devoted to educational opportunities for students to study the advanced and detailed aspects of various branches of basic and clinical sciences as they related to patient care.⁷⁹

Behavioral sciences were to be stressed throughout each of the phases because it was believed that compassion and understanding of the patient and the family were important aspects in the physician's training. Therefore, Phase I included an eight-week neuro-emotional segment. In addition, a series of seminars and group discussions on behavioral science subjects were offered. During Phases II and III, members of the Department of Psychiatry and Behavioral Science were to participate in clinical rounds of each clerkship and demonstrate behavioral aspects of patient care.⁷⁹

Phase I

The first three months were devoted to an introduction to a medical sciences course consisting of basic instruction in anatomy, biochemistry, human behavior, microbiology, pathology, pharmacology, and physiology. The remaining nine months were arranged in segments related to body organ systems in which basic science subjects were to

be taught in an integrated fashion and sequence. The sciences basic to medical practice would stress normal structure and function, followed by abnormal structure and function and the principles of treatment.³⁰

A course introducing students to clinical medicine ran concurrently with the basic science curriculum during Phase I. It emphasized interviewing, history-taking, and physical examination. It complemented the other aspects of Phase I instruction by demonstrating the clinical relevance of the sciences basic to the practice of medicine. Students had the opportunity to participate in two elective programs: a clinical office-based preceptorship each Saturday morning for the first six months and broad electives during the remainder of this phase.³¹

Phase II

Upon satisfactory completion of Phase I, students began the twelve-month second phase. This phase consisted of six required clinical clerkships, each of eight weeks duration: family medicine, internal medicine, obstetrics and gynecology, pediatrics, psychiatry, and surgery. The fundamentals of diagnosis, pathogenesis and treatment were presented. Students developed medical practice skills by interviewing and examining patients and by assisting in the delivery of medical care. In essence, Phase II was designed to provide students opportunities to apply knowledge and skills gained in Phase I and facilitate the transition from

classroom to clinical experience.⁵²

Phase III

Upon successful completion of Phase II, students would have developed an understanding of both the sciences basic to medicine and the knowledge and clinical skills required to practice medicine. They were to use Phase III to design, with the approval of faculty advisors, an individualized educational program that reflected their career interests. This program would be selected from among several planned courses in the basic and clinical sciences. It was required that at least eight weeks of this phase be spent in basic science selectives.⁵³

Phase III also consisted of an eight-week family medicine clerkship. This clerkship provided the student an opportunity to participate in the activities of a discipline totally devoted to primary medical care.⁵⁴

A School in Development

Having recruited full-time faculty members and departmental chairmen and developed an educational plan consistent with the needs of the Eastern Virginia Medical School, the Norfolk Area Medical Center Authority sought accreditation from the American Medical Association. This proved to be a formidable task.

Road to Accreditation

A medical school seeking accreditation from the

American Medical Association (AMA) must first obtain approval from the AMA's Liaison Committee on Medical Education (LCME). Hence, the Norfolk Area Medical Center Authority requested early in 1971 that the LCME provide a site visit of the Eastern Virginia Medical School. As a result of this request, the LCME first visited Norfolk in May 1971. In late January 1972 the committee published its report which referred to the Eastern Virginia Medical School as a "school in development."⁵⁵ It recommended that the medical school be granted provisional membership in the Association of American Medical Colleges (AAMC).⁵⁶ However, the committee also recommended that accreditation be withheld and that the medical school not admit students in 1972.⁵⁷

Accreditation would mean that the medical school had successfully attained certain standards recognized by the American Medical Association deemed to be essential for quality medical education. It required the approval of not only the LCME, but also the Executive Council of the AAMC and the Council on Medical Education. The medical authority realized that there was little chance of getting federal developmental assistance for the Eastern Virginia Medical School without prior accreditation approval from the American Medical Association.

The LCME's rationale for recommending the denial of accreditation and the delay in student enrollment was predicated on several concerns expressed in their report.

Dr. Gerald A. Holman, appointed in January 1975 as the medical school's second dean of student affairs,³⁸ reported that among the committee's concerns were:

the [in]adequacy of budget projections; the conditions under which community hospitals would become affiliated with the medical school; the lack of any state and federal financial support; the process by which departmental heads were to be recruited; the absence of a coordinated plan for the development of the academic medical center; insufficient administrative support in the dean's office; the nonexistence of a university academic base; the need for a regional residency training program; and the rate of growth of the medical library.³⁹

During the ensuing summer months of 1972, the medical authority initiated efforts to overcome the negative findings of the LCME's January 1972 report. Applications for federal funds were filed and efforts to hire needed faculty and departmental chairmen were increased. Physicians within the community became more actively involved in developing the medical school's curriculum and long-term medical educational plan. The dean's staff was increased and a chief librarian was hired. Steps were taken to develop graduate educational programs in the sciences at area colleges and universities. A plan was devised for sharing specific faculty members between Old Dominion University and the Eastern Virginia Medical School through joint appointments. Norfolk General Hospital and Leigh Memorial Hospital merged to form Medical Center Hospitals. Both hospitals voiced their support for and commitment to the proposed medical school. Residency programs at area hospitals were further developed and in some cases combined.

The result was a higher quality of medical education at the hospitals in Hampton Roads.⁹⁰

Facilities for the Medical School

Plans were made to purchase Leigh Memorial Hospital and the adjacent Smith-Rogers Hall. The latter was a ten-year old, four-story dormitory and teaching facility used for a Licenced Practical Nurse program. Medical authority officials planned to convert Smith-Rogers Hall into an interim medical school facility.⁹¹ Construction of a permanent facility would begin in a few years when, it was hoped, financial resources would not be so scarce.

JOSEPH L. YON, M.D.: Dr. Richard Davis and I traveled to San Diego and to New York to see what other new medical schools had done in the way of facilities. We needed ideas to help us get the medical school accredited. We met with Al Davis. He had experience in developing a big medical school complex in New York and he later became our consultant to help us with accreditation.

It was a very traumatic period. We were worried about what the LCME wanted in the way of classrooms, laboratories, offices, etc. The contract for Smith-Rogers Hall permitted the reconstruction of the interior to accommodate laboratories, a library, and an auditorium on the first floor. It also permitted the removal of walls and light fixtures on other floors to make room for study areas, faculty offices, lounges, etc.

I got a crew together and we worked day and night for about nine months. Sometimes we worked on Saturdays and Sundays in an effort to be ready for the first class of students.⁹²

Contributions and gifts for the construction and operation of the medical school continued to come in from individuals, organizations, and foundations. It appeared

that all of the LCME's concerns soon would be satisfactorily addressed as progress continued into the summer of 1972.⁹³

Setbacks

The medical authority experienced several setbacks during the summer and fall of 1972. Among them was the disapproval by the Department of Health, Education, and Welfare of the medical authority's grant request for \$958,538 in renovation funds for Smith-Rogers Hall. The application was rejected primarily because too few non-federal funds had been committed to the medical school, thus giving rise to the question of the medical school's financial stability.⁹⁴

In September a \$240,000 request for start-up funds from the federal government was denied because several concerns expressed in the LCME's 1971 report were deemed not to have been adequately addressed, especially the committee's concern regarding the financial stability of the medical school.⁹⁵ Without the necessary start-up funds, the medical authority looked to the Eastern Virginia Medical School Foundation to provide approximately \$1.16 million for the purchase and renovation of Smith-Rogers Hall. Since the medical school facility was a requirement for accreditation, the Foundation provided the \$1.16 million at the expense of other needed facilities and equipment.⁹⁶

Efforts to Regroup and Move Forward

Dr. Robert T. Manning, interim president of the medical authority and dean of the proposed medical school since June 1971,⁹⁷ recommended to the medical authority in the late summer of 1972 that the medical school withdraw its request to the LCME for an accreditation visit in the fall of 1972 and that the opening of the medical school be postponed until the fall of 1974.⁹⁸ In addition, he requested that he be relieved of his position as interim president of the medical authority so that he could devote more of his time to the development of the medical school's curriculum and long-range educational goals.⁹⁹

The commissioners of the medical authority agreed with Dr. Manning's suggestion that the LCME re-schedule their fall visit. However, they believed the psychological impact of another delay in opening the medical school would jeopardize all efforts to establish a medical school in Norfolk. With this conviction and the decision to "mount every effort to obtain approval for the enrollment of a charter class in the fall of 1973,"¹⁰⁰ the medical authority actively pursued efforts to obtain funds, departmental chairmen, faculty, equipment, and other needed resources. In addition, it was decided that the LCME should be periodically apprised of progress made by the Eastern Virginia Medical School.

Several progress reports were submitted to the LCME during the fall of 1972. Having reviewed these reports, the

LCME in January 1973 once again recommended denial of accreditation for the Eastern Virginia Medical School.¹⁰¹ This time the committee expressed serious reservations about the medical school's ability to be ready for the enrollment of a class in 1973 although significant progress had been achieved since the LCME's 1972 visit. The LCME's 1973 report noted that before accreditation would be granted to the medical school, more full-time faculty had to be hired in the basic sciences, departmental chairmen and other faculty members had to be under contract, and the curriculum needed to be revised from "faculty-oriented" to "student oriented."¹⁰² However, the most critical need identified by the LCME was the need for an appropriate instrument to measure the academic quality of the medical school's curriculum.¹⁰³

After receiving the LCME's negative accreditation report in January 1973, the medical authority took steps immediately to overcome the deficiencies identified by the LCME. For example, several nationally recognized medical educators were invited to Norfolk in March "to review the quality of the departmental chairmen already appointed and the credentials of those under consideration."¹⁰⁴ The group included Dr. John Rose, dean of Georgetown University; Dr. E. B. Brown, Jr., chairman of physiology, University of Kansas Medical Center; Dr. Kenneth Brinkhous, chairman of pathology, University of North Carolina; and Dr. Hayden Nicholson, dean emeritus of the University of Miami. They

concluded after three days of talks and investigation that more full-time faculty and departmental chairmen in the basic sciences were needed and should be appointed by June 1973 if the medical school was to receive accreditation by the fall of 1973.¹⁰⁵

The Norfolk Area Medical Center Authority appointed Dr. Richard MaGraw, a distinguished medical educator and administrator, in late January 1973 as the first full-time president of the medical authority. Although he did not formally accept his new appointment on a full-time basis until April 1973, he and other administrators of the medical school and medical authority took immediate action in February to correct all of the deficiencies identified by the LCME's January report. His initial energies were directed at obtaining the LCME's approval for the accreditation of the medical school.¹⁰⁶

Mr. Richard F. Welton III was the chairman of the Search Committee for the President which recommended Dr. MaGraw to the medical authority.

RICHARD F. WELTON III: Dick MaGraw came on board as the first president of the medical authority. He was aggressive, worked long hours, and did a super job. He was the first one who put the finger on the General Assembly for monies to care for the indigent people of this area. Monies to care for the health needs of the indigent were going to Charlottesville and to Richmond. He pointed out the fact that our hospitals were providing a lot of indigent care and that no state funds were going to the Hampton Roads region for indigent care.

Dick MaGraw was ahead of his time. He moved rapidly. He was aggressive. Unfortunately, he irritated some of the doctors and supporters of the medical school.

After a period of five years, there was a parting of the ways and Dick McGraw resigned as president of the medical authority. He hated to leave. He was a professional and did a lot in a short period of time to help establish the Eastern Virginia Medical School.¹⁰⁷

As soon as Dr. McGraw was appointed president of the medical authority, Dr. Manning shifted his efforts toward development of the medical school's curriculum and the formulation of an instrument to measure the quality of the medical school's educational program. As noted earlier, he took action to create an innovative curriculum approach for the Eastern Virginia Medical School in which student achievement and performance were emphasized and the number of required courses and credit hours de-emphasized. The result was a thirty-six month instructional program that would lead to the degree of Doctor of Medicine.

The medical authority sent an interim progress report to the LCME in March, but no official response was rendered on the status of the medical school. Extraordinary efforts were expended in April and May to recruit full-time faculty members and departmental chairmen. Fund-raising efforts continued. By early June additional faculty and departmental chairmen were appointed and under contract. At that point, the medical authority immediately notified the LCME and requested a site visit.¹⁰⁵

Between February and September 1973, the medical authority emphasized efforts toward the planning and developing of health programs cooperatively with area

colleges and universities. Although talks between Old Dominion University and the Eastern Virginia Medical Authority regarding a possible affiliation had been ongoing for several years, concern on the part of the governor of Virginia and hesitation by officials of Old Dominion University resulted in no formal relationship being reached between the two institutions. Dr. McGraw negotiated tentative agreements with several institutions of higher education between March and September 1973, including the College of William and Mary, Norfolk State College, Hampton Institute, Old Dominion University, Virginia Polytechnic Institute and State University, and Virginia Wesleyan College. As a result of his efforts, a formal affiliation between the medical authority and each of these institutions had been reached by September 1973. The overall result helped to strengthen the regional character of the Eastern Virginia Medical School and the Norfolk Area Medical Center Authority.¹⁰⁹

Accreditation is Approved

The LCME met in mid-June 1973 and reviewed the progress made by the Eastern Virginia Medical School since its January visit. Because several major deficiencies had been corrected, the committee granted the medical school provisional accreditation for one year and permission to accept students in the fall of 1973.¹¹⁰ A registration date was scheduled and notices were mailed to twenty-four of the

twelve hundred applicants. The charter class of the Eastern Virginia Medical School, composed of twenty in-state students and four out-of-state students, matriculated in late September 1973.¹¹¹

Regional Elements of the Eastern Virginia
Academic Health Network

The commissioners of the Norfolk Area Medical Center Authority realized in the 1960s that the establishment of a local medical school would require the participation of all the cities in the Hampton Roads area. As a result, the Board of Commissioners was expanded to include members appointed by each of the seven city councils in the Hampton Roads area. Participation was encouraged and financial support expected from each of the cities. Membership on the board was generally based upon the amount of financial support provided by the respective city. Since Norfolk's contribution to the medical school's development and operation (\$500,000 annually during the early 1970s) was twice as much as that of any of the other cities, it was permitted to have four board members. Virginia Beach, with a \$250,000 annual contribution, had two members. Each of the other five cities had one board member.¹¹²

Mr. Charles F. Burroughs, Jr., a former commissioner and interim president of the Eastern Virginia Medical Authority, discussed the regional nature of the medical school.

CHARLES F. BURROUGHS, JR.: The medical school is a

regional thing. It just happens to be located in Norfolk. The people that work and tend to it and teach there are from all around Tidewater. The medical benefits go to the whole area. I've never seen any indication that it ought to be here or there. It's for all the citizens of Tidewater.¹¹³

The medical authority, together with the medical school, created, administered, and participated in several health care activities for the citizens of the Hampton Roads area. These activities have included providing physicians for the area through the M.D. degree program, residency program, residency training programs, clerkships, continuing education programs in health care, and the development of several regional health programs.

The Eastern Virginia Medical School Foundation

The concept of using regional resources was perhaps best exemplified by the formation of the Eastern Virginia Medical School Foundation on 11 December 1969.¹¹⁴ The name of the foundation signified a broader geographical relationship than that of the Norfolk Area Medical Center Authority and its membership reflected participation from citizens throughout both urban and rural Eastern Virginia. Its purpose was to receive and distribute funds for the development and operation of the medical school.

Mr. Henry Clay Hofheimer II has been the president of the Eastern Virginia Medical School Foundation since its founding in 1969. He was also the vice chairman of the original fund-raising committee established in 1963.

HENRY CLAY HOFHEIMER II: We had the idea for a medical

school in the 1950s when I was president of Norfolk General Hospital because we could not seem to attract interns, residents, or bright young doctors to the area due to the fact that we did not have a medical school. When we first came up with the idea everyone thought we were crazy, including myself, but we decided to give it a try.¹¹⁵

The trustees of the foundation initiated the Eastern Virginia Medical School Campaign on 15 January 1970. Top leadership was recruited in the person of former Virginia Congressman Porter Hardy, Jr., as campaign chairman, assisted by thirty-five civic leaders as co-chairmen. Congressman Hardy agreed to serve only if those who had recruited him agreed to financially support the campaign. Nearly \$1 million was pledged that same afternoon.¹¹⁶

It was the foundation's mission to build the financial base for the medical school. Medical authority officials had concluded that \$15 million was needed although a private consultant's study had indicated that no more than \$5 million could be raised in the Hampton Roads area. Nevertheless, the campaign committee members were determined to raise its goal of \$15 million.

HENRY CLAY HOFHEIMER II: We were fairly successful in the early months, but \$15 million was a lot of money to raise in the 70s, particularly for this area, and our funds plateaued several times. In October 1972 we had reached the \$12 million mark and that last three million seemed so far away. One evening I was walking along Virginia Beach when I saw the couple that I knew had donated nine million to Washington [and] Lee College for the construction of the law school. I introduced myself to Frances and Sydney Lewis and our families cultivated a friendship. The Lewises agreed to donate a challenge grant of \$1.5 million to the school with the stipulation that we raise the same amount by December 31, 1972. Well, we raised more than that amount and in fact, ended up

with a total of \$17.5 million to begin construction of our medical school. We named the school Frances and Sydney Lewis Hall, of course.¹¹⁷

The Eastern Virginia Medical School Foundation has raised over \$40 million since its inception in 1969.¹¹⁸ The last three annual fund drives have netted \$1.2 million, \$1.7 million, and \$2.6 million, respectively.¹¹⁹ The foundation currently has net assets valued in excess of \$27.3 million.¹²⁰ Resources of the foundation have been used to construct Lewis Hall (the basic science building) and Hofheimer Hall (the clinical science building).¹²¹

The Eastern Virginia Inter-hospital Medical
Education Committee

The NAMCA decided in the late 1960s not to establish a university hospital. In lieu of its own teaching hospital, the medical authority decided to pursue an affiliation with regional hospitals to secure the necessary medical facilities and resources for an appropriate teaching and learning environment for the students of the medical school.

Initial discussions to form the Eastern Virginia Inter-hospital Medical Education Committee (EVIMEC) began in 1969 and the formal operating policy involving fifteen hospitals was signed in 1971. The committee representation included hospital board members, administrators, and physicians.¹²²

The committee was originally organized to help facilitate the medical student and graduate educational

activities in the fifteen hospitals. However, the role of the EVIMEC changed over the years. The committee now consists of thirty area hospitals, the Eastern Virginia Medical Authority, and the Eastern Virginia Medical School.¹²³

The EVIMEC hospitals form a consortium to jointly develop and maintain the resources, programs, and facilities which are necessary to develop the clinical skills essential for medical practice. A system of joint faculty appointments, affiliation agreements, teaching responsibilities, and research undertakings bind these medical institutions to the medical school and medical authority.¹²⁴

The Eastern Virginia Health Education Consortium

The Eastern Virginia Health Education Consortium (EVHEC) is similar to the Eastern Virginia Inter-hospital Medical Education Committee (EVIMEC) in that it involves several institutions concerned with health education in Eastern Virginia. It is an association between the Eastern Virginia Medical Authority and several regional institutions of higher education.¹²⁵

During the early days of the Eastern Virginia Medical School's accreditation process, the need for an academic relationship with an established university was recognized by medical authority officials as a necessity for accreditation. In September 1973 representatives from the Eastern Virginia Medical Authority met with representatives

from six regional institutions of higher education to discuss possible joint educational relationships. The six institutions included Christopher Newport College, Hampton Institute, Norfolk State College, Old Dominion University, the College of William and Mary, and Tidewater Community College.¹²⁶

A commitment by the institutions was achieved in which they would work jointly to plan and develop health educational programs, share faculty with specialized skills, and pool their resources to obtain the optimum medical benefits for the citizens of Tidewater. It was anticipated that most of the joint programs would be at the master's or Ph.D. level.

As a result of this planning, several programs were approved by the State Council of Higher Education. The graduate degree programs presently offered are: the M.S. in Art Therapy; the Ph.D. in Biomedical Sciences, which is a joint program of Eastern Virginia Medical School and Old Dominion University; and the Psy.D. program of the Virginia Consortium for Professional Psychology which is sponsored by the Eastern Virginia Medical Authority, the College of William and Mary, Norfolk State University, and Old Dominion University.¹²⁷

The Eastern Virginia Area Health Education Center

The Area Health Education Center (AHEC) concept was formulated by the Carnegie Commission of Higher Education in

1969 and implemented by the federal government in 1972. Its mission was to address the problems of the geographic maldistribution of primary care physicians and other health care personnel throughout the nation. The establishment of the AHECs was proposed as a solution to the maldistribution problem.¹²⁸

The Eastern Virginia Medical Authority first agreed in 1979 to sponsor and coordinate several AHECs in the Hampton Roads area. The goal was basically educational. The Eastern Virginia Area Health Education Center (EVAHEC) program would join the resources of health care professionals and institutions to train students in the health professions, especially in the rural and urban areas of Eastern Virginia where there was a scarcity of health care professionals.¹²⁹

The EVAHEC multi-disciplinary approach consists of regional affiliation agreements between the Eastern Virginia Medical School and Hampton University, Norfolk State University, Old Dominion University, and the Medical College of Virginia. Areas of Hampton Roads that are served by the program include the inner cities of Hampton, Newport News, and Norfolk; the rural areas of Chesapeake, Suffolk, and Franklin; and the counties of Southampton and Isle of Wight.¹³⁰

The Eastern Virginia Graduate School
of Medicine

Graduate medical education in Eastern Virginia had

been an ambition of many local physicians for several decades. With the likelihood of a medical school opening in Norfolk, serious attention was once again focused on the possibility of establishing a graduate medical program in the Hampton Roads area.

Gov. Linwood Holton expressed doubts in July 1971 as to the possibility of the state appropriating funds for a regional, medical education program in Eastern Virginia. Local support for the program continued to increase, however, especially when the Liaison Committee on Medical Education noted in the fall of 1972 that consideration should be given to the establishment of a regional, graduate medical education program in the Hampton Roads area. Once the Eastern Virginia Medical School was established in 1973, efforts to create a graduate medical program were vigorously advanced.¹³¹

The Board of Commissioners of the medical authority created the Eastern Virginia Graduate School of Medicine (EVGSM) in 1974 as a partnership between the Eastern Virginia Medical Authority and participating hospitals and health professionals in the Hampton Roads area. The graduate school's mission was to organize a regional system of graduate medical education in Eastern Virginia.¹³²

The Eastern Virginia Graduate School of Medicine currently manages eighteen residency programs in thirteen regional hospitals. Under the aegis of the graduate school, the residency programs include: Diagnostic Radiology;

Emergency Medicine; Family and Community Medicine; General Surgery; Internal Medicine; Neurological Surgery; Neurology; Obstetrics and Gynecology; Ophthalmology; Orthopedics; Otolaryngology; Pathology; Pediatrics; Physical Medicine and Rehabilitation; Plastic Surgery; Psychiatry and Behavioral Sciences; Radiation Oncology and Biophysics; and Urology.¹³³

Graduate Programs

Master of Science in Art Therapy

The Eastern Virginia Medical School and the Tidewater Community Mental Health Center and Psychiatric Institute worked together in 1973 to establish an Art Therapy program. The result was the creation of an eleven-month training program which led to a Certificate in Art Therapy.¹³⁴

During the succeeding three years, increased emphasis in the mental health field encouraged the two participating institutions to extend the academic curriculum to two years and to offer a Master of Science degree in Art Therapy.¹³⁵ As of September 1987, sixty students had graduated from the program.¹³⁶

Ph.D. Program in Biomedical Sciences

The Eastern Virginia Medical Authority and Old Dominion University began efforts in the early 1970s to jointly develop a doctoral program in the biomedical sciences. In August 1978 the State Council of Higher Education approved the Ph.D. Program in Biomedical Sciences.¹³⁷

The program utilizes faculty and resources from the Department of Biological and Chemical Sciences at Old Dominion University and the basic science departments at the Eastern Virginia Medical School. The eleven biomedical tracks include: biological chemistry; cancer biology; cardiovascular; cellular endocrinology; general biomedical sciences; clinical chemistry; neurosciences; immunology; molecular vector-borne diseases and environmental health.¹³⁸

Four students have graduated in this joint program since the first students were admitted in 1979. As of September 1987, there were ten Old Dominion University students and seventeen Eastern Virginia Medical School students in the program.¹³⁹

Ph.D. Program in Clinical Psychology

Planning and development of the Ph.D. Program in Clinical Psychology (Psy.D.) began in the early 1970s. With the approval of the State Council of Higher Education, the program enrolled its first students in September 1978. It was the first multi-institutional doctoral program in clinical psychology in the United States.¹⁴⁰

This advanced degree is granted jointly by the Eastern Virginia Medical School, the College of William and Mary, and Norfolk State University. It is administered by the Virginia Consortium for Professional Psychology. The program uses seven Eastern Virginia Inter-hospital Medical Education Committee hospitals and fifteen other health care

facilities in the Hampton Roads area for the training of the program's students.¹⁴¹

Approximately thirty-one new students matriculate in the Psy.D. program each year. As of September 1987, the program had graduated forty-three students.¹⁴²

FOOTNOTES

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⁶Norfolk City Council, Minutes of the public hearing on the proposed Land Use Plan of the Norfolk Area Medical Center Authority, 11 October 1966. (Typewritten.)

⁷Ibid.

⁸Ibid.

⁹Ibid.

¹⁰Interview with Mason C. Andrews, M.D., professor and chairman of the Department of Obstetrics and Gynecology, Eastern Virginia Medical School, Norfolk, Virginia, 28 January 1985.

¹¹Interview with Jock R. Wheeler, M.D., professor of Surgery, Eastern Virginia Medical School, Norfolk, Virginia, 28 February 1985.

¹²Ibid.

¹³Interview with Toy D. Savage, Jr., Willcox and Savage Professional Corporation, Norfolk, Virginia, 26 August 1986.

¹⁴Interview with Glenn R. Mitchell, president of SENTARA Health Systems, Norfolk, Virginia, 7 February 1985.

¹⁵Interview with Toy D. Savage, Jr., 26 August 1986.

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¹⁷Jess P. Miller, M.D., secretary-treasurer of the Hampton Medical Society, to the Department of Health, Education, and Welfare, Bureau of State Services (Community Health), Washington, D.C., 2 November 1965.

¹⁸Interview with Joseph L. Yon, M.D. (Rear Admiral U.S.N. Ret'd), associate dean of the Eastern Virginia Medical School, Norfolk, Virginia, 13 February 1985.

¹⁹Interview with Mason C. Andrews, M.D., 28 January 1985.

²⁰Barron F. Black, chairman of the Mayor's Advisory Committee on the Establishment of a Medical School in Norfolk, to members of the mayor's advisory committee, 19 August 1963, Personal Files of John S. Thiemeyer, Jr., M.D.

²¹Lawrence M. Cox, executive director of the Norfolk Redevelopment and Housing Authority, speech given at the dedication of the Norfolk Medical Tower Building, Norfolk, Virginia, 14 January 1961.

²²Barron F. Black to members of the mayor's advisory committee, 19 August 1963.

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²⁴Guy Friddell, Colgate Darden: Conversations with Guy Friddell (Charlottesville, Va.: University Press of Virginia, 1978), preface.

²⁵Colgate W. Darden, Jr., The Reminiscences of the Honorable Colgate W. Darden, Jr.: An Oral History (Annapolis, Md.: U.S. Naval Institute, 1984), preface.

²⁶Friddell, Colgate Darden: Conversations with Guy Friddell, preface.

²⁷Interview with Dr. John S. Thiemeyer, Jr., 13 February 1985.

²⁸Ibid.

²⁹Ibid.

³⁰Ibid.

³¹Ibid.

³²Interview with Robert L. Payne, Jr., M.D., Virginia Beach, Virginia, 12 February 1985.

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³⁴Vernon E. Wilson, M.D., dean of the University of Missouri School of Medicine, to Mason C. Andrews, M.D., 9 July 1963, Personal Files of Dr. Mason C. Andrews.

³⁵"Three Candidates Endorse Tidewater Medical School," Richmond, Va., Richmond Times Dispatch, 14 October 1968, p. B10.

³⁶Ibid.

³⁷Interview with Joseph L. Yon, M.D., 13 February 1985.

³⁸Interview with Robert J. Faulconer, M.D., professor and chairman of the Department of Pathology, Eastern Virginia Medical School, Norfolk, Virginia, 12 April 1985.

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⁴⁸Ibid., pp. 2-4.

⁴⁹Ibid., pp. 7-8.

⁵⁰Ibid., pp. 3-5.

⁵¹Ibid., p. 6.

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⁵⁴Ibid., p. 18.

⁵⁵Ibid.

⁵⁶Eastern Virginia Medical School--The First Decade, Eastern Virginia Medical Authority, Norfolk, Virginia, 19 November 1983, pp. 11-12.

⁵⁷Ibid., p. 12.

⁵⁸Ibid.

⁵⁹"Chronological Summary--Years 1958-1969," Eastern Virginia Medical School, Norfolk, Virginia, n.d.

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⁶⁴Eastern Virginia Medical School--The First Decade, p. 12.

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⁷¹Robert T. Manning, M.D., Eastern Virginia Medical School, Norfolk, Virginia, n.d., p. 2.

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⁷³Ibid.

⁷⁴Ibid., pp. 4-15.

⁷⁵Ibid., pp. 4-6.

⁷⁶Ibid., pp. 18-20.

⁷⁷Ibid., pp. 18-21.

⁷⁸Student Handbook: 1974-1975, Eastern Virginia Medical School, Norfolk, Virginia, 1975, pp. 7-8.

⁷⁹Holman, "Eastern Virginia Medical School of the Eastern Virginia Medical Authority," pp. 16-17.

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⁸¹Ibid.

⁸²Ibid., pp. 16-17.

⁸³Ibid.

⁸⁴Ibid., p. 17.

⁸⁵Ibid., p. 19.

⁸⁶Ibid.

⁸⁷Ibid.

⁸⁸Ibid., p. 23.

⁸⁹Ibid., p. 19.

⁹⁰Ibid.

⁹¹Ibid.

⁹²Interview with Joseph L. Yon, M.D., 13 February 1985.

⁹³Holman, "Eastern Virginia Medical School of the Eastern Virginia Medical Authority," p. 20.

⁹⁴Ibid., pp. 20-21.

⁹⁵Ibid.

⁹⁶Ibid., p. 20.

⁹⁷Interview with A. A. Douglas Moore, M.D., 9 September 1986.

⁹⁸Holman, "Eastern Virginia Medical School of the Eastern Virginia Medical Authority," p. 21.

⁹⁹Ibid.

¹⁰⁰Ibid.

¹⁰¹Ibid.

¹⁰²Ibid.

¹⁰³Ibid., p. 22.

¹⁰⁴Ibid., p. 22.

¹⁰⁵Ibid.

¹⁰⁶Ibid., pp. 21-24.

¹⁰⁷Interview with Richard F. Welton III, president of Smith and Welton, Inc., Norfolk, Virginia, 28 February 1985.

¹⁰⁸Holman, "Eastern Virginia Medical School of the Eastern Virginia Medical Authority," p. 22.

¹⁰⁹Ibid.

¹¹⁰Ibid.

¹¹¹Ibid.

¹¹²William D. Mayer, M.D., president of the Eastern Virginia Medical Authority, 1979-1984: A Five Year Report to the Board of Commissioners of the Eastern Virginia Medical Authority, Norfolk, Virginia, September 1984.

¹¹³Interview with Charles F. Burroughs, chairman of the Development Committee, Eastern Virginia Medical Authority, Norfolk, Virginia, 12 February 1985.

¹¹⁴Holman, "Eastern Virginia Medical School of the Eastern Virginia Medical Authority," p. 9.

¹¹⁵Lorraine Hudson, "Henry Clay Hofheimer, II," Praxis Quarterly 2 (Summer 1986):3-4.

¹¹⁶Holman, "Eastern Virginia Medical School of the Eastern Virginia Medical Authority," p. 10.

¹¹⁷Hudson, "Henry Clay Hofheimer, II," p. 4.

¹¹⁸State Council of Higher Education for Virginia, Report to the General Assembly on the Eastern Virginia Medical Authority (Richmond, Va.: 11 September 1987), p. 15.

¹¹⁹Ibid.

¹²⁰Ibid.

¹²¹Ibid.

¹²²Eastern Virginia Medical School, Office of Public Affairs, Eastern Virginia Medical Authority, Norfolk, Virginia, p. 30.

¹²³Ibid.

¹²⁴Ibid.

¹²⁵"What is EVMA and What Does It Do," Eastern Virginia Medical Authority, Norfolk, Va., 25 June 1980, p. 6.

¹²⁶Holman, "Eastern Virginia Medical School of the Eastern Virginia Medical Authority," p. 24.

¹²⁷Eastern Virginia Medical School, Office of Public Affairs, Eastern Virginia Medical Authority, p. 29.

¹²⁸Ibid., p. 28.

¹²⁹Ibid.

¹³⁰Ibid.

¹³¹Gerald A. Holman, M.D., et. al., The Regional Academic Health Network in Eastern Virginia (Norfolk, Va.: Eastern Virginia Medical School, October 1978), appendix VI-3.

¹³²Eastern Virginia Medical School, Office of Public Affairs, Eastern Virginia Medical Authority, Norfolk, Va., p. 41.

¹³³Ibid., p. 42.

¹³⁴Master of Science in Art Therapy, Community Mental Health Center and Psychiatric Institute, Norfolk, Va., n.p., n.d.

¹³⁵Ibid.

¹³⁶State Council of Higher Education for Virginia, Report to the General Assembly on the Eastern Virginia Medical Authority, pp. 39-40.

¹³⁷Gerald A. Holman, M.D., et. al., The Regional Academic Health Network in Eastern Virginia, appendix VI-3.

¹³⁸Ph.D. Program in Biomedical Sciences, Eastern Virginia Medical School, Norfolk, Va., n.d., pp. 2-5.

¹³⁹State Council of Higher Education for Virginia, Report to the General Assembly on the Eastern Virginia Medical Authority, p. 39.

¹⁴⁰Ibid., p. 40.

¹⁴¹Ibid.

¹⁴²Ibid.

CHAPTER VII

THE IN-VITRO FERTILIZATION AND EMBRYO TRANSFER PROGRAM AT EASTERN VIRGINIA MEDICAL SCHOOL

Purpose and Procedure of In-Vitro Fertilization

The original reason for attempting in-vitro fertilization, which means the exposure of the egg and sperm outside the body in laboratory glassware, was to by-pass damaged or blocked fallopian tubes where their function was inadequate to produce a normal pregnancy. Originally, the aim of in-vitro fertilization was to replace tubal function by bringing the sperm into contact with the egg in-vitro and then transferring the embryo into the uterus. Implantation and pregnancy resulting from this technique is identical with that of a pregnancy conceived by normal sexual intercourse.¹

It has been estimated that 15 percent of American couples are infertile. Of the remaining 85 percent of couples that are fertile, planned pregnancy occurs only about 25 percent of the time with sexual intercourse.² The In-Vitro Fertilization Program at the Eastern Virginia Medical School was established to help couples with infertility problems, a significant segment of society, bear children.

The five general steps of the in-vitro fertilization process are, in sequence:

1. Daily hormone injections that stimulate egg production. After about seven days, an injection of the hormone hCG is given to trigger the release of eggs.
2. Step two involves either a laparoscope or ultrasound. If the former is used, then doctors insert the laparoscope at the naval to view the ripening egg-holding follicles. The eggs are then retrieved by means of a hollow needle.
3. Each egg is placed in a petri dish filled with a culture medium duplicating that found in the uterine cavity. Incubation follows while sperm is collected.
4. When the egg has matured (generally after five or six hours), sperm are added to each dish containing an egg.
5. After about forty-eight hours of maturation, the fertilized eggs are transferred to the uterus.³

America's first in-vitro fertilization baby was born on 28 December 1981 in Norfolk, Virginia.⁴ Since then, the Norfolk clinic has been responsible for the births of over 350 babies conceived by in-vitro fertilization.⁵ Although the first in-vitro baby was born less that a decade ago, the concept of in-vitro fertilization can be traced to the nineteenth century. The Norfolk clinic has its roots in this history.

History of In-Vitro Fertilization

The Director advanced into the room . . . and . . . continued with some account of the technique for perserving the excised ovary; passed on to a consideration of optimum temperature, salinity, viscosity . . . actually showed them . . . how the eggs . . . were inspected for abnormalities, counted and transferred to a porous receptacle immersed in a warm bouillon containing free-swimming spermatozoa. . . .⁶

This excerpt is taken from Aldous Huxley's 1932 book, Brave New World. It demonstrates that the idea of human in-vitro fertilization, sometimes referred to as test-tube baby-making, is not a new concept. In fact, some nineteenth century scientists foresaw the possibility of this phenomenon.

The literature states that in 1882 Francis M. Balfour, a biologist at the University of Cambridge in Great Britain, supervised a laboratory course in embryology; the class experimented with the preimplantation developmental stages of rabbits.⁷ Balfour died later that year; however, his work was continued by his close associate, Walter Heape. In 1890 Heape, with the assistance of Samuel Buckley, performed the first successful transfer of embryos between two different species of rabbits.⁸ During the next several decades, successful embryo transplants in mice and rats continued to be performed by such scientists as J. S. Nicholas,⁹ Ann McLaren,¹⁰ and Donald Michie.¹¹

Scientists talked for many years about fertilizing the human egg in-vitro. While a small number of scientists claimed to have successfully accomplished this feat, the scientific community expressed doubt. In the 1940s Dr. John Rock, a Boston gynecologist and pioneer in the development of the birth control pill, reported that he and his colleagues had managed to fertilize a human egg in-vitro. His claim was disputed by many scientists who argued that the few cell divisions observed were caused by incidental

stimulation of the ovum without any involvement of a sperm.¹² Scientists were similarly skeptical of claims by Shettles in the 1950s that he had brought an externally fertilized human egg into the sixth day of cell division.¹³ Doubt was also expressed when the Italian scientist, Daniele Petrucci, announced a few years later that he had kept alive a human embryo in a test tube for twenty-nine days. The embryo was destroyed, Petrucci said, because it was growing monstrous.¹⁴ He terminated the work entirely after it was condemned by the Roman Catholic Church.¹⁵

Gregory Pincus, an American scientist known for his work in the development of the contraceptive pill, noted in the 1940s that human eggs would ripen outside the body and become ready for fertilization.¹⁶ About fifteen years passed with little or no work being performed in this area until Dr. Robert Edwards, an animal genetist in Great Britain, decided to see if he could be as successful with in-vitro fertilization of human eggs as he had been with in-vitro fertilization of mice eggs. For a while, he conducted his research at Cambridge University. In 1965 university officials raised serious ethical issues regarding his research and directed him to immediately cease further experimentation with in-vitro fertilization of human eggs.¹⁷ When he could not persuade university officials to allow him to continue his research with human eggs, he decided to continue his research elsewhere.¹⁸

Dr. Edward's wife Ruth, who also had a Ph.D. in

animal genetics, suggested that he write to Dr. Victor McKusick, a genetist at Johns Hopkins Hospital in the United States. Dr. McKusick had studied inherited human disorders for several years, and Dr. Edwards believed that he might be able to help him obtain some human eggs for experimentation.¹⁹

Dr. McKusick offered to assist Dr. Edwards and suggested that he consider working with the husband and wife team of Drs. Howard and Georgeanna Jones at Johns Hopkins Medical School. With funding from the Ford Foundation, Dr. Edwards came to the United States for six weeks during the summer of 1965 and worked with Drs. Howard and Georgeanna Jones on fertilization research using human eggs.²⁰ In his book, Dr. Edwards stated:

I flew off to Baltimore excited at the prospect of six weeks' research and guilty that I had left Ruth alone in Cambridge. . . . The first night Victor had arranged a dinner party, and of course he had invited my new collaborators--to-be, Georgeanna and Howard Jones. Victor had warned them what I was up to. Yet, as I outlined my ideas in more detail to all three, I once again witnessed the dubious countenance, the pursed lips. They rallied at last, with relief I heard Howard Jones say, 'We'll do all we can to help.'

And they did. . . . Those weeks in Johns Hopkins were decisive for me. Although we had failed to fertilize one single human egg, I was not deterred. I felt confident I could solve the problem eventually.²¹

Dr. Edwards first began working with Dr. Steptoe in 1968.²² Their work led to the world's first in-vitro fertilization baby--Louise Brown born on 25 July 1978 in Great Britain.²³ Dr. Edwards wrote:

We know that our work is opening new horizons in

human reproduction--indeed, it has already opened some. We are aware, too, that it introduces the possibility of genetic engineering or embryological engineering in one form or another, as feared by those correspondents ten years ago when we first began our work. Now that we have demonstrated that human conception can occur outside the human body, many investigations can be done which were impossible before. These are challenges which we should not fear, though we must be on our guard against abuses. . . .

Science moves haphazardly and often unpredictably. Yet what is merely a gleam in the eye of a research scientist today may be familiar to everyone tomorrow.²⁴

Since Great Britain's successful birth of an in-vitro baby in 1978, Australia became the second country about two years later to successfully perform this recent medical breakthrough. The United States became the third country in 1981 to succeed at human in-vitro fertilization.²⁵ Dr. Edward's belief that human in-vitro fertilization might one day become commonplace was rapidly becoming a truism.

History of the In-Vitro Fertilization Program at the Eastern Virginia Medical School

At Dr. Mason Andrews' request, Drs. Howard and Georgeanna Jones accepted faculty positions at the Eastern Virginia Medical School in 1978.²⁶ Although there was no intention of establishing an in-vitro fertilization program, the birth in Great Britain of the world's first in-vitro baby prompted support for an in-vitro fertilization program in Norfolk as part of the five-year old Eastern Virginia Medical School. Without Dr. Andrews' encouragement and efforts, it is doubtful that an in-vitro fertilization program would have been established in Norfolk, much less

become the first in-vitro fertilization program in the United States.²⁷

Over five hundred women applied to the Norfolk In-Vitro Fertilization Program between January 1979 and March 1979--one year before the program was established.²⁸ On 4 December 1979 the State Health Coordinating Council recommended that the State Health Commissioner, Dr. James P. Kenley, approve the pending Certificate of Need for the In-Vitro Fertilization Program at the Eastern Virginia Medical School.²⁹ Dr. Kenley authorized approval of the program on 8 January 1980.³⁰

The controversy and opposition to the Norfolk In-Vitro Fertilization Program received national attention even before Virginia's health commissioner authorized the Certificate of Need for the program. Many opponents to the program were enraged at the commissioner's decision. Right-to-life organizations and various religious groups voiced fears of destruction of life and of doctors playing God. They believed abortion would become an accepted solution to unwanted pregnancies and that doctors who performed abortions were interfering with God's Will. This negative outcry produced a surprising result. People who probably never would have become aware of the In-Vitro Fertilization Program in Norfolk did so because of media attention.

Thousands of couples unable to bear children perceived the In-Vitro Fertilization Program in Norfolk as what one magazine called "Last Chance Babies."³¹ Within a

few days after Virginia's approval of the required Certificate of Need for the program, thousands of inquiries from interested women flooded the medical school.³² Dr. Mason Andrews, chairman of the Department of Obstetrics and Gynecology at the Eastern Virginia Medical School, noted that his office alone had received about one thousand telephone calls from interested women during the two days following approval of the program.³³

Since the establishment in 1980 of the In-Vitro Fertilization Program in Norfolk, approximately 121 in-vitro fertilization clinics, private and public, have opened in the United States.³⁴ However, none of these clinics, nor any of the estimated eighty in-vitro fertilization clinics world-wide, have been able to match the Norfolk clinic's success rate for pregnancies.³⁵ As a result, the current waiting list of applicants exceeds ten thousand.³⁶

The number of staff members at the In-Vitro Fertilization Program in Norfolk increased between 1980 and 1987 from about 12 to about 125.³⁷ The program is chaired by Dr. Howard Wilbur Jones, Jr., a gynecological surgeon. He and his wife, Dr. Georgeanna Seegar Jones, a pioneer in the field of reproductive endocrinology, are the founders of the program. They currently hold the positions of president and vice-president respectively of the Jones Institute for Reproductive Medicine at the Eastern Virginia Medical School. Other distinguished members of the staff include: Dr. Zev Rosenwaks, director of the Jones Institute; Mrs.

Lucinda Veeck, director of the In-Vitro Fertilization Laboratory and the chief medical laboratory technician at the Jones Institute; Dr. Gary D. Hodgen, scientific director of the Pregnancy Research Division of the Jones Institute; and Dr. Mason C. Andrews, chairman of the Department of Obstetrics and Gynecology at the Eastern Virginia Medical School.

The following interview with Dr. Howard Jones provides a first-hand account of the establishment and development of America's first human in-vitro fertilization program.

QUESTION: What were the reasons that prompted you to come to Norfolk?

DR. JONES: This was entirely through our friendship with Mason Andrews. He and I trained together at Johns Hopkins immediately after World War II. We continued our friendship after he returned to Norfolk. As he worked on getting the medical school here, he raised the question of our coming to Norfolk. We considered it even before we retired but didn't want to disrupt our work at Johns Hopkins. But, then I became emeritus in 1976 and my wife became emeritus in 1978. At that time Dr. Andrews renewed his invitation for us to come to Norfolk. We felt that he was being more than polite.

We were anxious to come here because it offered a new opportunity. The alternative was to stay in Baltimore and go into private practice. At Hopkins the retirement age was strictly enforced. So, we were glad to accept Dr. Andrews' invitation.

At that time the only other full-time member of the department was Anibal Acosta who we had recommended to Dr. Andrews when he was looking for faculty. Dr. Acosta was a former graduate student of ours at Hopkins. He had returned to Argentina and written to me that it was very difficult for him to remain in Argentina because of the political situation. He asked if I might know of a place that might be interested in his talents. I recommended him to Dr.

Andrews. So, he came. Later, when we retired, the two of them renewed the invitation for us to come to Norfolk. We were glad to accept it. We did not come with the idea of setting up an in-vitro fertilization program. That was an afterthought. We came simply to help Dr. Andrews with the new department here and to give him sort of instant senior faculty and to help him establish the division of reproductive medicine within the department.

QUESTION: How did the in-vitro fertilization program get started?

DR. JONES: That's an interesting story. We happened to move here in July 1978. We arrived in Norfolk about two days after Louise Brown was born in Great Britain. Dr. Andrews received a telephone call from a reporter at the Ledger-Star asking him to comment on the event that had taken place in Great Britain. I think that he told her that he thought it was a remarkable development. However, she might want to talk to two people who had just arrived in town. They might know a little more about it.

The reason that he thought we might know more about it goes back a number of years. In 1965 Dr. Robert Edwards, who at that time was a young biologist working with in-vitro fertilization on mice, was anxious to get some human eggs and he couldn't do this in Great Britain for a variety of reasons. One reason was that in Cambridge where he worked there was no medical school.

Dr. Edwards was put in touch with me by Dr. Victor McKusick [of Johns Hopkins University] who was a genetist at Hopkins and who knew about Edwards. Bob came with the notion that we would furnish him with some human eggs from operative material that we had. So, Bob came and we furnished him with a fresh supply of human eggs. We attempted in-vitro fertilization at that time. That was in 1965. The system didn't work. He returned to Cambridge. We went on with other things. Later he and Dr. Steptoe began working together. He continued his work which succeeded in having the first in-vitro fertilization baby in 1978.

We had kept in touch with Dr. Edwards through the years and became more familiar with the process. For that reason Dr. Andrews referred the reporter to us. While the moving people were moving our furniture into the house we had just purchased, the reporter came to our house. The girl who interviewed us wrote a story which appeared in the Ledger-Star the next

day. I told her what I knew about the process and that I thought it was an exceedingly important development. As she was about to leave, she asked if this could be done in Norfolk. Well, I thought it was kind of a flip question and I gave her a flip answer. I said, 'Oh, sure.' She then asked what would it take. And I said, 'The only thing it would take would be a little money.' The next day the newspaper headline read 'Doctor Says All It Takes Is Money.'

The curious follow-up to that was that a woman in Norfolk who knew my wife, Georgeanna, telephoned Georgeanna. About three years before, this woman had gone to Johns Hopkins with an infertility problem and was seen by Georgeanna. She later was rewarded with a child. She said that she didn't know that we were coming to Norfolk and was delighted that we were here. Her baby at that time was probably a year or two old. She said that we are delighted to have you and all the proper things. She said that she had seen the newspaper article which reported that money was the only obstacle preventing us from work on in-vitro fertilization. She said that she had access to a foundation and asked how much money we needed. This led to further conversations with this woman and eventually Mr. Henry Clay Hofheimer participated. As a result of that conversation, a small amount of money [about \$20,000] was given anonymously. We did decide to go ahead after some meetings. So the notion of starting an in-vitro fertilization program was a chance occurrence. It took us some months to determine if we had the resources, particularly manpower, to make the attempt. We did and it worked out.

QUESTION: What problems did you have in the early years?

DR. JONES: Well, we had problems entirely of an unforeseen nature. When we started with the program, the main problem was gathering together the personnel to do it. In-vitro fertilization is an extraordinary complex process that requires a lot of different talents. You have to have a good endocrinology lab, embryology lab, andrology lab, and clinical gynecologists. We kind of had all those people on hand, but they needed to be interested and coordinated. Dr. Acosta had special interests in andrology, so that solved that problem. We were able to solicit the interest of Dr. George Wright, who is presently the medical school's chief of microbiology, to provide the necessary endocrine services. We had with us Dr. Jack Rary, who is a cytogenetist. He

expressed some interest in becoming involved in the embryology lab. But, the most important person was a clinician, Mrs. Lucinda Veeck, who was the chief technician in Dr. Rary's lab. She became interested and worked with us from the very first.

We had these various talents and we would have weekly meetings in which we would try to figure out what needed to be done to set the thing up. You need to remember that at that time there had been only two groups in the world working on in-vitro fertilization and embryo transfer--the English group of Steptoe and Edwards and an Australian group led by Dr. Carl Wood. I knew both of these groups through personal contacts. I had worked with Robert Edwards and had visited Australia and knew Professor Carl Wood quite well. I had the benefit of being able to write to these people and to talk to them on the telephone as we went along. There was very little published information in the normal sense. We therefore devised in our own mind with the information we could get from them what we wanted to do.

It was not until 1980 that we actually began a series of clinical trials. When it became known that we were to do this, we ran into opposition from a completely unexpected source.

When we talked to the hospital authorities about providing facilities to carry out this procedure, they were interested and glad to do it. But, almost at the last minute, the hospital administrator said that this required a Certificate of Need. A Certificate of Need is a statement which is issued by the state authorities, the Commissioner of Health the person ultimately responsible, which indicates that there is a need for a new medical service. I think the law that was in effect at that time said that the Certificate of Need was for any medical service that required a capital outlay of over \$100,000 or \$125,000. The equipment needed for in-vitro fertilization really isn't very expensive, or at least it wasn't at that time. According to the regulations [for a Certificate of Need], certain announcements had to be made. At the time, the hospital administrator said that we didn't need to worry about it, that it was a routine thing, and that they would take care of it.

It happened that on the day the hearing was to be held, we were scheduled to be out of town. He [the hospital administrator] said that it didn't make any difference at all, that we didn't need to be there.

As it turned out, to the surprise of everyone, there was a large group of people who came to protest the issuing of the Certificate of Need for this new procedure. These were people from the right-to-life group who consisted of conservative, religious individuals from various denominations--Protestant, Catholic, Jewish. There was no one denomination represented. Because of the interest that the first hearing created, it was decided to postpone any decision. A more formal hearing was scheduled for Halloween Day of 1979. This was held in the Health Center down the street. This was a controversial issue which the media thrived on.

When this hearing was held, the various national television networks were here. The hearing began at two o'clock in the afternoon and continued until about eight o'clock that night. It was soon after Bill Mayer became president of the authority. This was almost the first thing that hit him after he arrived in town.

When I became aware of the controversy being stirred up, I asked to appear before the board of directors of Norfolk General Hospital and before the commissioners of the authority. I said to each of these bodies prior to this hearing that I was surprised at the controversy that had occurred, that I didn't want to do anything to embarrass the institution, and that I could very easily discontinue our efforts at that time without any embarrassment to anybody. I would be pleased to do that if they wished me to do it. But, I also said that if the decision was made to go forward, I would expect the full backing of the boards through thick and thin. Each board voted unanimously to support the effort to go forward. If that had not been the case, I would have been very reluctant to continue in the midst of what proved to be a public controversy about the procedure.

With the rear secure so-to-speak, we pushed ahead with it. The hearing lasted for six hours. The opposition was quite organized. They brought in large numbers of people from out-of-town. We had had an opportunity to understand the magnitude of their effort. We invited the professor of physiology at Harvard, Dr. John Beers; the president of the American College of Obstetricians and Gynecologists, Dr. Roy Parker, who was professor of OB-GYN at Duke at that time; a Jewish rabbi from Norfolk; and a Catholic bishop from western Virginia. They testified in favor of the program. There were many other people who testified against it.

There was a side-light to the hearing. It was scheduled to be held in the auditorium of the Norfolk Health Department at two o'clock. At about one o'clock, most of the medical students in the medical school marched to the auditorium and occupied most of the seats in the auditorium. This was completely unorganized on our part, and I don't know who among the students was responsible for doing this. The result was that when the bus loads of opposition came the people didn't have any place to sit. There was a lot of hoopla about that with people standing around the sides of the auditorium and an overflow outside. So, it was quite a day.

In the course of time and after due process and after subsidiary hearings that were required, the State Commissioner of Health issued a Certificate of Need. I think it was around January of 1980. We got started around the first of March in our actual effort.

QUESTION: What role did the state government play?

DR. JONES: The state issued a Certificate of Need. The only other time we were involved with the state was when I went to Richmond to appear before the State Legislature. I think the issue revolved around a bill someone had introduced that might have prohibited the In-Vitro Fertilization Program. Our informants told us that this wasn't likely to get anywhere. I testified, but I don't think the bill [to prohibit the operation of the In-Vitro Fertilization Program in Norfolk] ever got out of committee. This was around 1980 or 1981. We had had no contact with the state government in any way, shape, or form since that time.

QUESTION: What about the federal government?

DR. JONES: The federal government never really had any role because there were never any federal funds involved. The Department of Health, Education, and Welfare [HEW] had an attitude about in-vitro fertilization which was triggered by a grant application from Dr. Pierre Soupart of Vanderbilt University. In about 1974 Dr. Soupart sent a grant request to the National Institutes of Health [NIH] to permit him to fertilize some human eggs in-vitro, to then study the chromosomes of the fertilized egg and to determine whether the in-vitro process was likely to cause any abnormalities in the resulting pre-embryo.

That grant request was deferred pending an evaluation of its ethical aspect. The secretary of HEW was requested, I'm not sure by whom, to appoint an ethics committee. After the authorization, he did not appoint a committee. It would be interesting to verify the ins and outs of this. He sat on his hands for a couple of years after the opportunity to appoint the committee. The only reason that he did was because Louise Brown [the world's first in-vitro fertilization baby] was born. Then there was some interest in in-vitro fertilization and as a result of that, he did appoint an ethics committee to evaluate the request of Pierre Soupart which had been submitted four or five years before that.

That committee made a report in 1980 after we had gotten started. In the Ethics Advisory Report of the Department of HEW, they said there was nothing unethical about in-vitro fertilization, but that any grant request that should be considered by HEW would have to be referred to an ethics committee. About that time, this committee [the Ethics Advisory Committee] went out of existence. No other ethics committee was ever appointed. So, there was a de facto prohibition against processing grants in this area because there wasn't any mechanism for doing it. That's existed to the present day. So, there's no federal money available for the in-vitro fertilization program.

QUESTION: Where does the money come from for people who participate in this program?

DR. JONES: People who go through this program pay for it themselves. It is considered elective surgery.

QUESTION: What about health insurance?

DR. JONES: Health insurance has been very spotty. Some insurance companies have paid for it; others have not. The largest carriers such as Blue Cross/Blue Shield have not participated except in certain special policies they offer.

QUESTION: Are the right-to-life groups still fighting the in-vitro fertilization program?

DR. JONES: They have kind of given up, I think. They surface now and again.

QUESTION: How do they justify their position?

DR. JONES: They have some objections which are quite

trivial and based on a lack of understanding of what we are trying to do. Others are more fundamental and confused with the abortion issue. Clearly we are at the other end of the spectrum. We are trying to get people pregnant. We're not trying to interrupt pregnancies. But, they use such arguments as not all of the preembryos that are transferred develop. Indeed, that is true. Therefore, you are causing abortion of the ones that don't develop. The problem with that argument is that this occurs in nature, that human reproduction is extraordinarily inefficient. Only a minimal number of eggs that are fertilized in the natural process actually implant and develop. Most of them do not develop and are aborted.

On a more serious theological level, the opposition such as illustrated by the official position of the Roman Catholic Church as exemplified by the instruction recently issued by the Congregation of Faith, has to do with the unnaturalness argument. They hold that reproduction must be inevitably associated with sexual intercourse and anything that separates reproduction from intercourse is immoral and therefore unethical. It is my belief that this is a minority point-of-view and a minority point-of-view among Christian and Catholic theologians. It is, nevertheless, the traditional view of the Roman Catholic Church as exemplified by the instruction.

QUESTION: What is the present success rate of the Norfolk In-Vitro Fertilization Program compared to its first-year success rate?

DR. JONES: That is a very interesting subject. The success rate now is of course better than when we first started. But, the success rate within the first year or so quickly got up to around 25 percent but it hasn't gone much over the 30 percent mark. It is our belief that the reason for this is that we are dealing with what I previously described as the inefficiency of human reproduction, namely that there is a limit to reproductive potential--the eggs and sperm that are produced have a large percent of genetically incompatible matings. The fall-out rate is an expression of these mismatches, and it requires a large number of attempts in order to get suitable matchings that will develop and go on. The reason that the reproduction process works at all is that in the human there are thirteen times a year to try it. In fact, in human reproduction the success rate in any one month, menstrual month, of exposure is approximately the same as it is with in-vitro

fertilization. We are equaling nature, but we're not exceeding it. We are able to do that by a maneuver which allows us to use more than a single egg in each cycle, whereas nature uses only one egg.

QUESTION: How many eggs do you use?

DR. JONES: We did use up to six. We've reduced that to five, and we're trying to reduce it to four because of the danger of multiple births. We're dealing with a matter of chance which exists in normal reproduction. We are able to see and study that up close in the in-vitro process in a way that's never been possible before.

QUESTION: What does the future look like? Will the success rate go up?

DR. JONES: I think that we are now unraveling some of the reasons for the inadequacies relating to the inefficiency of human reproduction. As we identify them, it will be possible to take steps to overcome them. So, I'm very optimistic about the future in terms of the normal mating situation. But, there are certain auxiliary things that are coming along. For instance, if we do have a patient that happens to produce an extra large number of eggs and we want to transfer a limited number for fear of having multiple pregnancies, we can now preserve the excess pre-embryos by cryopreservation, by freezing them. We have some frozen babies by frozen preembryos. This will add a little bit to the success rate because otherwise those eggs would not have been fertilized at all.

We have certain options with regard to treating people who have no eggs at all. These extra eggs that some people have, some people don't want to freeze them, but are perfectly happy to give them to other people. So, we have a donor egg program whereby women can have normal pregnancies from eggs that have been donated, just like sperm have been donated for many years to overcome male infertility. Now we can do the same with eggs and there's a very large demand for this but the supply is very limited because most people with the option of freezing them will elect to do that rather than give them away.

QUESTION: Under what circumstances would this be done?

DR. JONES: This would come up for a person who may have had a premature menopause. Some women undergo a change of life, no menstruating, as early as in their

early twenties and they just run out of eggs. Menopause is an exhaustion of the egg supply. That's called premature menopause. Or, you can have a patient who is without ovaries. Or, you can have a patient who had a bilateral ovarian tumor and had to have them surgically removed as a life-saving step. So, if she recovered from the operation and had no evidence of reoccurrence of the tumor, we could offer her a donor egg. We also have an experimental program which is designed to help infertile males who have too few sperm whereby we can pick up an individual sperm and inject it into the egg rather than have it have to get there on its own steam.

QUESTION: Can sperm be frozen, like the egg, and used at a later time?

DR. JONES: Yes, and it is being done here. It's kept in Lewis Hall where there's a sperm bank. Say, for instance, a male is going to have testicular surgery, and is going to lose his testicular function. We collect a specimen from him, freeze it, and use it later. That's been going on for some time.

QUESTION: How about freezing the egg?

DR. JONES: Eggs do not freeze very well. We're working on that. The fertilized egg seems to freeze better than the unfertilized egg.

QUESTION: How many births have there been at the Norfolk In-Vitro Fertilization Program?

DR. JONES: Over 350 births so far, and 400-500 pregnancies including present pregnancies.

QUESTION: How are couples selected for this program?

DR. JONES: The application rate is very high and we do our best to take them in rotation. There are certain factors that make it very rigid. Age is one factor. There's an age above which you don't go, so we like to squeeze people in while it's still possible to do, and yet we have great uncertainty as to the appropriateness of that.

QUESTION: Do you take in anyone over age forty?

DR. JONES: Our oldest mother is forty-three. We counsel older women because we now have enough information to say that the pregnancy rate, the success rate above age forty, is much less than it is otherwise. The success rate is very much related to the age of the

patient. We discourage people coming in above the age of forty.

QUESTION: Is there any geographic criteria for acceptance to the program?

DR. JONES: Not really. We try to give some preference to the people in the Tidewater area.

QUESTION: What was the application rate like when the program was first established?

DR. JONES: That's interesting because there were a lot of applications before we ever got started. Most of them were a result of the publicity about it. If it hadn't been for the media, no one probably would have known what we were doing. Our first successful patient, Judy Carr, came here as a result of the hearing that was held on Halloween Day 1979. She had had one tube removed because of ectopic pregnancy. She had had a second ectopic pregnancy on the opposite tube, and they had taken the pregnancy out and left the tube in. She then had a third pregnancy, and the doctor at that time had to take the last tube out. So, she had no opportunity of getting pregnant. Media coverage of the hearing in Norfolk appeared in the Boston area. She was from Massachusetts.

Her doctor saw an article in the newspaper [about the controversy]. He had been in the navy and had been assigned to the Portsmouth Naval Hospital so he knew about Norfolk. When he went in to see her to tell her that he had to take her last tube out, he also told her that in Norfolk they just might have something to overcome her problem.

She immediately wrote to us when she got home from the hospital to see if there was anything to this. Well, that was before we ever got started, but at least her name was on the list. So, when we got around to looking at those people, her name was at the top. That's how she got in early on the deal.

The right-to-life people, the people who were trying to suppress the thing, also succeeded in disseminating information about it. If they had never posed it, Judy Carr may never have known what we were doing.

QUESTION: How many in-vitro fertilization clinics are there now?

DR. JONES: I wish I could answer that. I suspect there are more than a hundred, but I really don't have a handle on that.

QUESTION: How much does it cost to go through the In-Vitro Fertilization Program in Norfolk?

DR. JONES: About \$5,000. That includes the program and hospital costs. The program costs are about \$3,300 and the hospital costs are about \$1,700. That's for one try.

QUESTION: How many in-vitro fertilization attempts does it normally take for a woman to get pregnant?

DR. JONES: Chance has no memory. You have an equal chance each time. In some cases, ten attempts have been made.

QUESTION: What does the surgical process involve?

DR. JONES: The method of harvesting eggs has changed a good bit since we first started. We can do it either by laparoscopy which is a minor operating procedure. We can now harvest the eggs by ultra-sound guidance without making an incision by inserting a needle through the vagina into the ovaries. We don't like to do this process more than two or three times a year.

QUESTION: How has your staff changed since the In-Vitro Fertilization Program was first begun?

DR. JONES: We started with about twelve people. We now have about one hundred and twenty-five people.

QUESTION: You earlier said that Dr. Edwards left England and came here [Johns Hopkins] in 1965 to get some human eggs. Where was the in-vitro fertilization process done, in England or the United States?

DR. JONES: We tried this in Baltimore [at Johns Hopkins]. The eggs won't keep. You've got to use them right then and now.

QUESTION: What was the result?

DR. JONES: We were unable to make the system go then. We couldn't get fertilization. We couldn't get the eggs fertilized?

QUESTION: What was the problem?

DR. JONES: We now know what the problem was, but we didn't then. The eggs were not mature. We just took any old eggs; we didn't realize that you had to have a mature egg.

QUESTION: Weren't there any laws against this in 1965?

DR. JONES: Well, there never have been any laws against it. There were no laws then and there are none now, for or against it.

QUESTION: When is construction of the Jones Institute scheduled to begin?

DR. JONES: We had a meeting yesterday about that. The thing that's holding it up at the moment is an agreement among the members of the staff of how big the building will be. It's about 10 percent over-budget in terms of square feet. The architect has been selected. We have got to come to a meeting of the minds among ourselves about how we are going to reduce the size about 10 percent. I hope we can come to an agreement sometime next week.

We were told that it will take eight months after the architect starts the detailed drawings that will be put out to bid. It will take about four months after the drawings are put out to bid before construction can start. So, I think the earliest will be the fall of 1988, more realistically the spring of 1989.

QUESTION: Where will it be located?

DR. JONES: Next to Lewis Hall, the medical school building. It will be a separate building but attached to Lewis Hall.

QUESTION: Is there any state or federal assistance for its construction?

DR. JONES: No. All the money is coming from private sources. About a third of the money has been identified so far.³⁸

Doctors at the Jones Institute for Reproductive Medicine believe that human in-vitro fertilization should be accepted as standard clinical therapy for infertile couples. Data gathered at the Institute over a five-year period supports their position. The data gathered on 775 women who

participated in the In-Vitro Fertilization Program at the Eastern Virginia Medical School between 1 January 1981 and 31 December 1985 indicates that there is essentially the same expectancy rate for pregnancy whether the egg and sperm are united through sexual intercourse or by an in-vitro process. However, the in-vitro pregnancy rate has been shown to increase dramatically with the transfer of multiple eggs.

The data indicates that a successful pregnancy is achieved about 20 percent of the time with the in-vitro fertilization of one egg; with two eggs it increases to about 28 percent; with three eggs the pregnancy rate is about 35 percent. The pregnancy rate does not increase with the transfer of more than three eggs.³⁹

The pregnancy rate in normal reproduction (sexual intercourse) is about 20 percent. Normally, only one egg is exposed. Since an average of 2.5 eggs were transferred per patient in the Eastern Virginia Medical School In-Vitro Fertilization Program between 1981 and 1985, there were significantly more multiple births than would be expected by normal reproduction. Twins accounted for about 25 percent of the births and triplets accounted for about 4 percent of the more than two hundred children born as a result of in-vitro fertilization. There were no multiple pregnancies greater than triplets.⁴⁰

The 1,078 cycles of egg transfer on the 775 participants in the In-Vitro Fertilization Program yielded some

interesting results. Table 6 depicts the in-vitro fertilization pregnancy rates by diagnosis.⁴¹

TABLE 7
PREGNANCY RATE BY DIAGNOSIS

<u>Diagnosis</u>	<u>No. of Egg Transfers</u>	<u>% Pregnancy/Transfer</u>
Tubal disease	725	26.5
Endometriosis	143	25.2
Male (low sperm count)	46	26.1
Idiopathic (cause unknown)	60	36.7
Tranvesical	26	26.9
DES exposure	59	25.4
Cervical (sperm immobilized)	10	10.0
Immunological (antisperm antibodies)	5	40.0
Anovulation	4	50.0

The pregnancy rate by age for the 775 participants in the In-Vitro Fertilization Program is shown in Table 7.⁴²

TABLE 8
PREGNANCY RATE BY AGE

<u>Age</u>	<u>No. of Egg Transfers</u>	<u>% Pregnancy/Transfer</u>
Less than 25	6	0.0
26-30	22	25.0
31-35	549	26.6
36-39	251	29.9
Over 40	60	25.0

Analysis of the data indicates that in-vitro fertilization is a useful procedure for overcoming infertility. In the case of patients over age 35 with tubal disease or endometriosis, doctors at the Jones Institute recommend that it should perhaps be considered in lieu of surgical

treatment or endocrine therapy. In any case, additional experience should result in improved in-vitro fertilization procedures and an even higher pregnancy rate than attained by the In-Vitro Fertilization Program at the Eastern Virginia Medical School during its first five years of operation.

Approval of the First In-Vitro Fertilization
Program in the United States by the
Ethics Advisory Board

The Department of Health, Education, and Welfare (HEW) banned in 1975 all federal funding for human in-vitro embryo research not approved by the Ethics Advisory Board.⁴³ The board first discussed the ethics of in-vitro fertilization research in September 1978. The thirteen-member board, composed of seven physicians, two lawyers, one businessman, a member of a philanthropic organization, a philosopher, and a religious ethicist announced their conclusions and recommendations in March 1979 to Joseph Califano, secretary of HEW. In general, the board concluded that research in the areas of human in-vitro fertilization and embryo transfer were ethically acceptable.⁴⁴ (The summary and conclusions of their final report are provided in appendix 33.)

The Ethics Advisory Board of HEW disbanded in 1980 when funding wasn't renewed. Since then, Mr. Califano and all of his successors have failed to take action on the approval or disapproval of the board's recommendations. As

a result, there has been a de facto moratorium on government funding of research involving human in-vitro fertilization and embryo transfer research.⁴⁵ Without the ethics advisory board's recommendations, HEW would not take action toward federal funding of this research.

Opposition to the In-Vitro Fertilization Program

National right-to-life organizations succeeded in the mid-1970s in creating a moratorium on any federal participation relating to human in-vitro fertilization research. It was even illegal to discuss the procedures at federally supported conferences.⁴⁶

A major objection to human in-vitro fertilization was based on the destruction of human embryos. Some believed that scientists would fertilize dozens of human eggs and then destroy all but the one selected for reimplantation. Right-to-life supporters argued that this was abortion and therefore should be banned. Religious fundamentalism was at the root of most arguments.

There was very little support for in-vitro fertilization from religious groups. Right-to-life supporters made it a religious issue with connotations of killing unborn fetuses and therefore against God's Will. However, there were a few proponents in the religious community who did not condemn human in-vitro fertilization as a means to helping infertile couples to have children. One such person was Father Richard A. McCormick, a Catholic priest from

Georgetown University and a member of HEW's Ethics Advisory Board in the early 1980s. He complimented the doctors and scientists who worked for the In-Vitro Fertilization Program at the Eastern Virginia Medical School, stating "they're reimplanting every embryo that is fertilized. Sometimes the process isn't successful, but if it fails, it fails. That's not discarding embryos."⁴⁷ Nevertheless, his opinion was a minority opinion among religious leaders.

Bishop Walter Sullivan of the Catholic Diocese in Richmond, Virginia, stated in November 1978 that the proposed In-Vitro Fertilization Program in Norfolk was a "misuse of priorities that could lead to things like cloning, sperm banks, and experiments with the fetus."⁴⁸ He called the process "experimenting with life,"⁴⁹ and condemned the doctors for "playing God."⁵⁰

Dr. Joseph Stanton, a Tufts University medical professor, voiced strong opposition to the opening of the In-Vitro Fertilization Program in Norfolk. As one of the founders of the Boston-based Value-for-Life Committee, he stated, "If we are casual about human life at the beginning, it will erode our entire moral structure."⁵¹ Speaking to a group of about two hundred people at St. Matthews School in Virginia Beach, he told the audience that "test-tube baby projects and research are a danger to civilization and may destroy the family concept."⁵²

The Virginia Society for Human Life was an ardent opponent to human in-vitro fertilization. Their members

believed that the rights of the unborn child would be disregarded. Abortion of the unborn fetus was the basis of much of their argument.⁵³

Mr. Charles D. Dean of Portsmouth, president of the Tidewater Chapter of the Virginia Society for Human Life, believed that the doctors and scientists at the Norfolk clinic were motivated by "arrogant curiosity" and not the interests of infertile couples. He argued:

The real motivation here has nothing to do with having babies. What's going on in there is just scientific inquiry. What they really want to do is experiment on the human embryo. All those women and their babies are expendable. . . . It may take a real human tragedy over there before people realize what's going on. But I'll tell you one thing--we're determined. Sooner or later, we're going to close that place down.⁵⁴

On 11 February 1980 the Tidewater Chapter of the Virginia Society for Human Life sent a letter to Virginia's Attorney General, Marshall Coleman, requesting that he "initiate injunctive proceedings" against the proposed In-Vitro Fertilization Program in Norfolk.⁵⁵ However, Mr. Coleman dismissed the charges later that month because he believed that the state had no authority to initiate court action in this case.⁵⁶

Opponents of the In-Vitro Fertilization Program in Norfolk began in December 1980 to circulate a petition asking public officials to cut-off tax monies for the Eastern Virginia Medical School. City Council members of each of the Tidewater cities were contacted. Opponents hoped that their efforts would encourage medical school

officials to abandon further action to establish an in-vitro fertilization program in Norfolk.⁵⁷

Major Themes of Protest

The issue of in-vitro fertilization opened the door to controversy and ethical debate. Many people feared the unknown and others thought that the newly gained knowledge would be abused.

The major themes of the protest directed toward the In-Vitro Fertilization Program at the Eastern Virginia Medical School involved several issues: the moral status of the embryo, consent, sexual ethics, the family, the cost, the newly created individual, surrogate motherhood, and the possibility of human cloning and hybridization.

Status of the Embryo

The most vehement opposition came from those who believed that a new human being was born as soon as the egg and sperm were united. They proclaimed that human in-vitro fertilization involved the disposal of human embryos and therefore the taking of innocent human life.

Consent

The issue of consent revolved around the belief that it was wrong to experiment on human beings unless the subjects of the experiments had given their consent. The real ethical issue about consent in this kind of research related to the embryo and the future individual it would

become. Obviously, it was not possible to obtain the consent of the embryo and still less chance of obtaining the consent of the individual the embryo would become. The question then was: Does this make the research unethical?

Sexual Ethics and the Family

Critics argued that in-vitro fertilization resulted in the separation of sexual intimacy and procreation. They believed that the intrusion of technology into the act of procreation would result in a devaluation of sexual intimacy and ultimately the destruction of marriage and family. The stress of in-vitro fertilization, especially if the results were unsuccessful, could be disastrous on the family relationship.

The Cost

Some critics raised the question: Is in-vitro fertilization worth the cost? Their argument was based on the premise that medical resources are limited. To give money to one area of medicine is to withhold money from another area. If medical spending is to be rational rather than haphazard, they argued, then medical priorities should be identified. In so doing, the question was raised: What is in-vitro fertilization's priority on the medical scale?

The Newly Created Individual

Concern was expressed that in-vitro fertilization could result in an increased number of foetal abnormalities.

Therefore, it should be abandoned. Aside from physical abnormalities, critics argued that there was always the chance that the newly created individual would be subject to an inordinate amount of psychological and emotional suffering.

Surrogate Motherhood

If the in-vitro fertilization process were successful, then the next step was embryo transfer. If the woman from whom the egg was obtained could not carry the child, then a surrogate mother would be needed.

Critics offered several objections to surrogate motherhood. For example, the door would be open for the financial exploitation of the surrogate mother as well as the person who sought the surrogate's services. Also, there would be the danger of emotional trauma to the mother bearing the child when she had to pass it over to the would-be parents, or the emotional trauma to the would-be parents if the surrogate refused to give up the child. The legal ramifications were enormous.

Human Cloning and Hybridization

A few critics of human in-vitro fertilization argued that it would open the medical and scientific doors to human cloning and hybridization. Medical authorities at the Eastern Virginia Medical School disclaimed this possibility and stated that this type of research definitely was not one of their goals. In addition, they discounted this argument

because they believed that the ethical issues against it far outweighed any practical gain.

New Ethical Guidelines

The American Fertility Society decided in 1987 to fill the void created by the 1980 disbanding of HEW's Ethics Advisory Board. Dr. Edward E. Wallach, president of the 10,000-member society said, "There was no organization in the United States that was willing to take a stand on guidelines. We felt that the technologies were getting ahead of us."⁵⁸

Dr. Gary Hodgen, scientific director of the Jones Institute for Reproductive Medicine in Norfolk, was a member of the society's eleven-member ethics committee that issued ethical guidelines for research in human in-vitro fertilization and related areas. He had worked at the National Institutes of Health from 1969 to 1984 before joining the Jones Institute. As a member of the ethics committee, Dr. Hodgen was asked to provide insight into the ethical issues of human in-vitro fertilization and on other issues that have arisen as a result of it.

QUESTION: What effect will the ethics committee report have on the work of you and your colleagues at the Jones Institute?

DR. HODGEN: This report is not a perspective singularly of the physicians working with these patients. This, in fact, came from a broad base of understanding, of curiosity, and of discussion and debate. It allowed for dissension, and the rationale is offered along with the recommendations that are made so that dissent is clearly shown where it occurred.

How it affects us is very important because we now have a basis for proceeding with our research in in-vitro fertilization and the other technologies. And we have guidelines to hold beside our own policies and procedures that suggest to us that we have, in fact, acceptable undertakings. There's an ethical basis for approving what we had planned to do.

QUESTION: The guidelines covered a number of new reproductive technologies. Can you discuss some of the techniques that have or have not been pursued at the Jones Institute?

DR. HODGEN: Certainly in-vitro fertilization has been used. In-vitro fertilization is a proven entity. It works in good hands. We know the rate at which it works. And these children are wonderful, beautiful children.

We have also used artificial insemination by husband, artificial insemination by donor, the use of donor eggs in in-vitro fertilization, and cryopreservation [freezing] of sperm.

We have not yet had an instance where the embryo from one couple is . . . donated to another couple. We have had donated eggs, we have used donated sperms, but not a donated preembryo. Because we already have a donor-egg program, we have not had extra embryos to freeze. We have asked those couples who have provided . . . large numbers of eggs to contribute the extra eggs voluntarily to other couples. They have on some occasions given consent to do that. Because we do this, we have not needed cryopreservation of preembryos because there haven't been any to cryopreserve.

In some ways, you either have egg donation or pre-embryo cryopreservation. Probably one of those two is essential, in fact, ethically required, to justify the program because some patients have more eggs than you would dare put into their uterus as embryos. When one adds more than about five preembryos to the uterus, one increases dramatically the risk of multiple pregnancy. We would not like to have very many cases of triplets or quadruplets or even higher.

QUESTION: Although the Jones Institute hasn't pursued cryopreservation of eggs or preembryos, what benefits might derive from that technology?

DR. HODGEN: If we could store eggs, we could avoid 95 percent of the social conflicts that we feel about

freezing embryos because the egg by itself has no developmental potential--it would have to be fertilized.

There are about sixteen children born in the world from thawed embryos. That some preembryos from other programs around the world have been successfully frozen, thawed, transferred, and normal children have been born, suggests that something is known about how to do it. What we have no idea [of] is whether we are near the optimal conditions. Some data would suggest that we are not, since many of the preembryos that were frozen by techniques used in Australia and Europe were not successful.

QUESTION: What has been the position of the Jones Institute concerning basic research on human pre-embryos?

DR. HODGEN: Never in the lifetime of the in-vitro fertilization program at the Jones Institute has there been a human embryo discarded or destroyed in study. There has never been one. We are not doing it here, and I know of no site in the United States where it is being done.

We wanted a full examination of this issue by a national body, as this report represents. The other reason is that we have a high personal regard for the human preembryo. We have not proceeded with pre-embryo research on human preembryos because we do not yet have sufficient results that we are ready to apply them to patients. But, it is our wish in the near future to achieve that level of success.

One of the basic studies now under way using animal eggs and sperm is called micromanipulation for sperm injection. [This research is being done on the embryos of monkeys, mice, and hamsters.] It perhaps would be a way to treat infertile men by placing one of his sperms into the egg through this microsurgical technique. Simply put, it is a way to do surgery on an egg under a microscope and to move the sperm, a single development. That fertilizes the egg and causes the events that lead to pregnancy. But right now, all of that work is in the development phase.

Should it be successful and we find that the offspring, that the animals born, are normal, whether they be mice or hamsters or rabbits or monkeys, we would eventually be at a place where we would be enthusiastic about using this for humans for obvious reasons. These men need help and they are not able

to impregnate their wives without assistance. And even the normal in-vitro fertilization procedures are not sufficient. So this is an additional technology that we hope to develop.

QUESTION: How would you justify doing research on human preembryos, and under what guidelines would you proceed?

DR. HODGEN: The human preembryo is held in high esteem, high respect, but it does not have the same position in the ethical committee's view as a person. It is not just a blob of tissue, it's not just a few cells. It's worth much, much more than that. But, it's also not given the value of a person.

Now, whereas we must hold a high ethical regard for the human preembryo, we would not seek to begin research there with only a frivolous or mediocre rationale. It would require an extraordinary justification, where the potential for gain is so great that we would consider then performing preclinical basic research on the embryo. In the latter case, there is a declaration from the beginning that if such preembryos were used in preclinical basic research, there would be no intention whatsoever of transferring them to the uterus, either because the study itself would destroy the preembryo or we would have concern about its normalcy--would a normal child develop if it were transferred?

You eventually reach the point in all animal research where you cannot go further because the animal can only teach you so much. Even the monkey, being a primate as we are, is still not a human, and there are conditions that exist in humans that do not exist in any other species. So one reaches a point where learning, if it is going to be applied for human care, must eventually move into the human realm. If the gain for mankind was so extraordinarily great, if the expectation for a study was so great, one might then see that using a small number of preembryos in research might be warranted.

QUESTION: You have been quoted as saying that research on human preembryos could provide the key for understanding the development of cancer. Can you explain?

DR. HODGEN: It's already clear that the genes that operate, that work and perform in the early human embryo, [are] some of the same controlling genes that work in cancer growth. The difference is that in the

normal human embryo, the phase of growth and development which every one of us as individuals went through also had controls that kept us from behaving . . . like a tumor.

The hormones that are made in normal pregnancy and other proteins special to the pregnancy, almost unique to the pregnancy--do you know when else they are often made? When we have cancers.

The point I'm trying to make is that if we were doing cancer research, it might be incredibly important to humankind to learn what controls normal embryonic growth and development because very similar systems are at work, and have lost control in metastatic cancer. If in learning how the human preembryos divide and differentiate, if the regulation and control of those genes that come from the mother and father operate very similarly to the operation of cancers, we may learn through studying embryos how to turn off the metastatic cancer at the level of the DNA [the principal component of chromosomes and the carrier of genetic information]--not using surgery, not using radiation and not using chemotherapy. And if we can turn those switches off, that's the ultimate therapy. So some of the justification for using preembryos for research and not for pregnancy are tied to issues as large as a cure for cancer.

If what I just described were to become reality in the next ten or twelve years, if it happened, this would be perhaps the largest, most important development in medicine since Pasteur and others came to understand the immune system sufficient enough that we could inoculate millions of people against disease--polio, smallpox, diphtheria--the scourges of humanity that went on in the era before human immunology was developed.

QUESTION: Are there other potential benefits from pre-embryo research besides curing cancer?

DR. HODGEN: There's a whole list, of course, a very long list. The others would include the testing of compounds that are either medications, foods or products we use in cosmetics. These are the things that we apply to our bodies that affect us directly, or, in the case of a pregnant woman, the embryo or fetus she is carrying.

We think it may be possible in the decade just ahead to grow in culture embryonic cells--not embryos; make that distinction--which would be exposed to tested

substances. The response of the growth of those cells might tell us whether this [tested substance] would be a toxin or a teratogen [an agent that causes malformation of a fetus]. We have used animal experimentation to try to interpret human vulnerability, and that's a very helpful system. But it's a very imperfect system as well because at some point one wants to know what the vulnerability of a human is. So, by using human embryonic cells in culture, not human embryos, we may be able to determine whether enzymes or proteins produced are altered by the presence of a substance that is added to the medium in which they are growing, and directly infer by that the impact of these substances on human embryos.

Another value is to be able to determine genetically caused birth defects even before there is a pregnancy. In-vitro fertilization may some day be useful not only to infertile couples, but couples who know [they] are carriers of a serious genetic disorder. Example: sickle cell anemia. Neither of them manifests the disease, but they both carry the genes for the disease. Therefore, there's a risk that any child they would bear would be affected.

What does this all have to do with preembryo research? The day is not far away perhaps when one can take a biopsy from a human embryo. There is a technique now being used . . . on animal embryos in which we can remove a few cells from the embryo without harming its developmental capabilities. By examining those cells, we can determine whether the DNA is normal or abnormal. We don't even need to wait until growth and differentiation occur. We can already see into the future what would happen if the embryo is transferred and grows into a child. We will know whether it will be normal.

It is also possible in the far distant future to repair the DNA. The feasibility of this is suggested in the rudimentary experiments that have been done in microorganisms and in lower mammals. The rudiments of understanding already suggest that it may one day be feasible to not only diagnose the genetic defect but to repair it.

Other spinoffs would include studies of aging. When do we start aging? Maybe before we're even born. We probably begin aging if not at the time the two gametes [cells that unite in pairs] are fertilized to cause development, then certainly before we are born. [Before birth] there is a destiny already proclaimed to some degree; there are boundaries put on our

potential, and our potential longevity is one of them. So, understanding the aging process may be, as paradoxical as it seems, enlightened by studying the initiation and development of life.

QUESTION: Can you comment on the federal government's role or lack of role regarding the development of these new reproductive technologies?

DR. HODGEN: I think the federal government behaved very responsibly and very helpfully to society as a whole, to infertile couples, and to those of us working in science and medicine in reproductive issues, through the time that its ethics advisory board report appeared in 1979.

I felt that those were very laudable actions and activities--caution but progress. Let's go forward, but go forward carefully.

But then the government withdrew entirely, did not implement the recommendations of the committee, did not continue to monitor technical developments, and update and revise. So, the gap got wider and wider and wider.

Suddenly then, the role of the scientist is curtailed, truncated, because we have to be not free from the rules of society, but free to learn. I'm saying that if you're going to learn the truth about biology and about humankind and medicine, and apply it in such a way to prevent and treat disease, you must not be impaled upon a policy that prevents you from going into an area where that knowledge exists. The government was in effect declaring that in the reproductive technologies it would not only not help --they'd been withholding funding since 1974--it would not even allow its own investigators to participate.

In 1980 the ethics advisory board expired because there was no longer congressional appropriation to keep it in being. So now there is no vehicle in existence to submit a grant to NIH [National Institutes of Health, the agency within the Department of Health and Human Services that is the federal government's principal biomedical research arm] and have it reviewed and even considered for funding. It is as though you go out to some place where no one is there and attempt to talk to people. It's ludicrous. That moratorium placed on the issue of the new reproductive technologies in 1974 has remained now more than twelve years with no sign of

action.

QUESTION: What effect has that had on research in America?

DR. HODGEN: Louise Brown was born in 1978 in Great Britain, the first in-vitro baby in the world. It is my expectation that she would have been the first anyway. The second baby was born in Melbourne, Australia. I think it is not likely that that would have been the second. I think the second one would have been born here.

But, far more importantly, we would have been on a line to develop the technology far more rapidly. The research that would have been done because grants to the NIH would have been funded, some of them very relevant to this technology, would have gone forward, and the work would have been done better and would have been done sooner.

So, the birth of Elizabeth Carr, the third in-vitro baby in the world, from the Norfolk program, and the first in the United States, probably would have occurred sooner and would have been joined by more vigorous and scholarly effort in the field as a whole if research grants had been allowed.

I think the number and quality of the clinics we have now would be improved. And I think the quality assurance, the reporting of data and the followup, would have evolved far better.

We as a country, the scientists working in reproductive medicine, were definitely discouraged by these governmental actions and policies. It was a very suppressing influence. It dampened the excitement of young people to enter the field. It dampened the enthusiasm of hospital administration boards and medical schools to support the evolution. They didn't want the criticism that might come with it. They wouldn't take the risk of supporting it because of public resistance and that sort of thing.

And yet, when you look at the data, there are now more than three thousand in-vitro conceived babies in the world. The number and kinds of birth defects are at or below, apparently, the rate that occurs in natural conception. These are what I call real babies. The government's action discouraged the evolution of all of this and delayed its development and qualitatively suppressed it.⁶¹

Dr. Hogden and many doctors involved in human in-vitro fertilization emphasize the need for more research. Additional research would perhaps determine why there is a 75 percent chance in nature, as well as under laboratory conditions, that a fertile couple will not succeed in pregnancy under optimal conditions on any given occasion. The reasons for frequent miscarriages is also a question that additional research might help answer. In addition, if it could be determined which egg is the most viable, then maybe only that egg would be fertilized. As it is now, several eggs are fertilized and transferred to the uterus. However, this procedure has its drawbacks, namely a higher rate of multiple births than expected with normal reproduction. Nevertheless, the ten thousand applicants to the In-Vitro Fertilization Program in Norfolk apparently believe it is a risk worth taking.

Public Opinion Polls

Opinion surveys were taken in the United States in August 1978, one month before the world's first test-tube baby was born, by both the Gallop and Harris organizations. Although both surveys were based on samples of approximately fifteen hundred people, the Gallop poll included males and females, whereas the Harris poll interviewed women only.⁶²

The polls indicated that a majority of Americans approved of the in-vitro fertilization procedure. The Gallop poll indicated that 60 percent of Americans approved

of the method, 27 percent opposed it, and the remaining 13 percent were undecided.⁶³

The Harris poll gave rise to some curious findings. For example, on a general question about "approval of the procedure," 52 percent approved of the procedure, 24 percent disapproved of it, and 24 percent were undecided. However, 85 percent of the sample agreed that the in-vitro fertilization procedure should be available to married couples who were unable to have children.⁶⁴ This suggests that the inclusion of the word "married" and a reference to the inability to have children prompted a more favorable response.

The majority of the women (49 percent) believed that a married couple should be allowed to use the sperm donor program when the husband was unable to provide the quantity or quality of sperm needed. Forty percent of the women disagreed.⁶⁵

Finally, those surveyed were asked if they would allow doctors to remove several eggs from a woman, fertilize them all, then discard all but the one to be inserted for development. Forty-five percent said they would allow this, 40 percent said they would not, and 14 percent were undecided. Disapproval of discarding of the fertilized eggs was higher among Catholics (48 percent).⁶⁶ This result suggests that the Catholic Church has a significant influence over its members' attitude toward in-vitro fertilization.

FOOTNOTES

¹Michael Kramer, "Last Chance Babies," New York (12 August 1985):36-37.

²"Virginia Medical Editorial--Keeping Up with the Jones," Virginia Medical 113 (Richmond, Va.: April 1986): 232.

³Interview with Howard W. Jones, M.D., president of the Jones Institute for Reproductive Medicine of the Eastern Virginia Medical School, Norfolk, Virginia, 27 August 1987.

⁴"Virginia Medical Editorial--Keeping Up with the Jones," p. 232.

⁵Interview with Howard Jones, M.D., 27 August 1987.

⁶Aldous Huxley, Brave New World (New York: The Modern Library, 1932), pp. 3-4.

⁷F. M. Balfour, A Treatise on Comparative Embryology, vol. 2, eds. Luigi Mastroianni, Jr., and John D. Biggers, Fertilization and Embryonic Development In Vitro (New York: Plenum Press, 1981), p. 1.

⁸Walter Heape, Preliminary Note on the Transplantation and Growth of Mammalian Ova Within a Uterine Foster Mother, vol. 48, eds. Luigi Mastroianni, Jr., and John D. Biggers, Fertilization and Embryonic Development In Vitro (New York: Plenum Press, 1981), pp. 1-5.

⁹J. S. Nicholas, Development of Transplanted Rat Eggs, vol. 30, eds. Luigi Mastroianni, Jr., and John D. Biggers, Fertilization and Embryonic Development In Vitro (New York: Plenum Press, 1981), pp. 5-6.

¹⁰Ann McLaren and Donald Michie, Studies on the Study of Fertilized Mouse Eggs to Uterine Foster Mothers, vol. 33, eds. Luigi Mastroianni, Jr., and John D. Biggers, Fertilization and Embryonic Development In Vitro (New York: Plenum Press, 1981), pp. 6-7.

¹¹Ibid.

¹²"A Bum Rap for Dr. Steptoe," TIME, 31 July 1978, p. 62.

- ¹³ Ibid.
- ¹⁴ Ibid.
- ¹⁵ Ibid.
- ¹⁶ Robert Edwards and Patrick Steptoe, A Matter of Life (New York: William Morrow and Co., 1980), p. 40.
- ¹⁷ Ibid., pp. 48-49.
- ¹⁸ Ibid., p. 49.
- ¹⁹ Ibid., p. 53.
- ²⁰ Ibid.
- ²¹ Ibid., pp. 53-54.
- ²² Ibid., p. 15.
- ²³ William A. W. Walters and Peter Singer, eds., Test Tube Babies (Melbourne: Oxford University Press, 1984), p. 19.
- ²⁴ Edwards and Steptoe, A Matter of Life, pp. 187-88.
- ²⁵ Walters and Singer, eds., Test Tube Babies, p. 19.
- ²⁶ Kramer, "Last Chance Babies," p. 39.
- ²⁷ Interview with Howard W. Jones, M.D., 27 August 1987.
- ²⁸ Ibid.
- ²⁹ "Test-Tube Clinic," Newsweek, 5 March 1979, p. 102.
- ³⁰ "Test-Tube Baby Clinic Gets OK From Health Panel," Norfolk, Va., The Ledger-Star, 5 December 1979, p. A8.
- ³¹ Kramer, "Last Chance Babies," cover story.
- ³² "Queries Flood Test-Tube Baby Clinic," Richmond, Va., Richmond Times Dispatch, 10 January 1980, p. 66.
- ³³ Ibid.
- ³⁴ Ibid.
- ³⁵ Kramer, "Last Chance Babies," p. 37.
- ³⁶ Ibid., p. 41.

³⁷"Virginia Medical Editorial--Keeping Up with the Jones," p. 232.

³⁸Interview with Howard W. Jones, M.D., 27 August 1987.

³⁹Ibid.

⁴⁰"The Indications for In-Vitro Fertilization," Virginia Medical 113 (Richmond, Va.: April 1986):220.

⁴¹Ibid., pp. 219-20.

⁴²Ibid., pp. 218-19.

⁴³Ibid., p. 217.

⁴⁴"Va Med School to Start First In-Vitro Clinic," Health Cure Week, 18 December 1978, p. 21.

⁴⁵Margaret O'Brien Steinfelds, "In-Vitro Fertilization Ethically Acceptable Research," The Hastings Center Report 9 (June 1979):5-8.

⁴⁶"Va Med School to Start First In-Vitro Clinic," p. 21.

⁴⁷William Tucker, "In Vitro Veritas," New Republic (28 October 1981):14.

⁴⁸Ibid., p. 15.

⁴⁹Julia Wallace, "Test-Tube Births Sought Despite Ethics Questions," Norfolk, Va., The Ledger-Star, November 1978, Personal Files of Charlotte Schraeder, Ph.D., Eastern Virginia Medical Authority.

⁵⁰Ibid.

⁵¹Ibid.

⁵²"Test-Tube Clinic," p. 102.

⁵³Julia Wallace, "Test-Tube Fertilizations Defended," Norfolk, Va., The Ledger-Star, 6 February 1979, p. B1.

⁵⁴Interview with Howard W. Jones, M.D., 27 August 1987.

⁵⁵Tucker, "In Vitro Veritas," p. 15.

⁵⁶Sandy Baksys, "Injunction Sought to Halt In Vitro Lab," Norfolk, Va., The Ledger-Star, 11 February 1980, p. C4.

⁵⁷"Court Action Ruled Out in In Vitro Fight," 1 March 1980, Personal Files of Charlotte Schraeder, Ph.D., Eastern Virginia Medical Authority.

⁵⁸"Test-Tube Baby Foes Abandon Legal Battle," Roanoke Times, Roanoke, Virginia, 3 January 1981, Personal Files of Charlotte Schraeder, Ph.D., Eastern Virginia Medical Authority.

⁵⁹Stacey Burling, "Blue Shield Rejects Bids For In-Vitro Insurance," Norfolk, Va., The Virginian-Pilot, 21 February 1980, p. D1.

⁶⁰Joseph Cosco, "Questions of Ethics," Norfolk, Va., The Virginian-Pilot, 28 September 1986, p. C1.

⁶¹Ibid., pp. C1 and C7. Reprinted with the permission of Rosemary Bradley Jones, public relations officer for the Eastern Virginia Medical Authority, and Joseph Cosco, staff writer for The Virginian-Pilot, Norfolk, Virginia, 21 September 1987.

⁶²HEW Support of Research Involving Human In Vitro Fertilization and Embryo Transfer, Ethics Advisory Board of the Department of Health, Education, and Welfare, Washington, D.C., 4 May 1979, appendix.

⁶³Ibid.

⁶⁴Ibid.

⁶⁵Ibid.

⁶⁶Ibid.

AFTERWARD

The State Council of Higher Education for Virginia (SCHEV) prepared in August 1987 a report to the General Assembly on the Eastern Virginia Medical Authority. The purpose of the report was to provide the General Assembly with information upon which it could assess its responsibility to assist the medical authority in future biennia. The report focused exclusively on the medical education aspect of the medical authority.

The 1987 SCHEV Report noted the findings in the various reports of the 1970s and 1980s by the Liaison Committee on Medical Education (LCME). The LCME's reports indicated that the Eastern Virginia Medical School had made progress but also had continuing curricular, programmatic, financial, and faculty problems. Accreditation continued to be granted for short periods of time. The medical school changed to a four-year program in 1983 and added emphasis to research in the basic sciences in response to the LCME's concerns about a three-year curriculum and limited faculty research. These two actions, while bringing the medical school more in line with traditional medical schools, exacerbated its financial problems.

Most of the recurring problems revolve around the lack of a continuing stable funding source for the medical

school. The Eastern Virginia Medical School began as a non-traditional medical school with heavy dependence upon volunteer faculty, minimal emphasis on research, and great reliance on the use of existing, regional hospital facilities for its educational programs. The format was designed to make the school less costly to operate.

As the medical school modified its non-traditional nature in the early 1980s, it became apparent that more funds would be needed to operate its programs. Additional full-time faculty, greater emphasis on research in the basic sciences, expanded laboratories and additional support staff increased the requirement for additional long-term funding sources.

The LCME has never granted the Eastern Virginia Medical School its maximum ten-year period of accreditation. With the exception of the four-year accreditation period granted in 1987, accreditation for the medical school has been limited to no more than two-year periods. The SCHEV Report noted that the medical school still had not reached a satisfactory level of stable funding acceptable to the accrediting agency. The report's findings note that these short accrediting periods, along with the medical school's financial problems, have kept the institution in a state of uncertainty.

The July 1986 LCME report addressed many of the same issues as earlier reports. Principal among these concerns was continuous stable funding. The LCME reasoned that

without a solid financial base the medical school would be unable to place emphasis on research, obtain more and better equipment, hire additional full-time faculty in the basic and clinical sciences, or provide adequate job security for faculty.

The LCME revisited the Eastern Virginia Medical School in March 1987. The site committee was impressed with the development of an effective faculty governance system, the research cooperation between basic science departments, the establishment of centers of excellence in reproductive biology, radiation oncology, and otolaryngology, and the plans for future centers of excellence in diabetes, neurosciences, geriatrics, and oncology. Consequently, a full accreditation for a period of four years was granted.

The SCHEV Report concluded by recommending that the medical authority seek a long-term stable funding base for the medical school. Although no details were offered on how to do this, it was recommended that the Commonwealth of Virginia, the local governments in Hampton Roads, and the Medical College of Hampton Roads work together to arrive at a viable solution.

CHRONOLOGY OF EVENTS

- 1973 Dr. Richard McGraw is appointed as the first full-time president of the medical authority.
- The Community Mental Health Center and Psychiatric Institute opens.
- On 28 September the medical school matriculates its charter class of twenty-four students.
- The Eastern Virginia Health Education Consortium (EVHEC) is formed in collaboration with the College of William and Mary, Hampton Institute, the Norfolk Area Medical Center Authority, Norfolk State College, Old Dominion University, and Virginia Wesleyan College. (Christopher Newport College joins the consortium in 1976). This leads to the development of several educational programs in the health professions.
- Mr. Richard Peters is appointed as the vice president for Administration and Services.
- 1974 EVMS receives an accreditation visit in February from the LCME.
- The Eastern Virginia Graduate School of Medicine is established.
- Class enrollment increases to thirty-six students for the fall of 1974 although the LCME does not formally approve this decision until January 1975.
- Dr. Robert L. Cassidy is appointed chairman of the Department of Family Practice.
- 1975 Dr. Robert T. Manning, dean of the medical school since June 1971, resigns to become the first chairman of the Department of Internal Medicine.
- Dr. Gerald H. Holman, chairman of the Department of Pediatrics, succeeds Dr. Manning as the dean of the medical school.

EVMS receives accreditation visits in February and September from the LCME.

The LCME approves EVMA's request for permission to increase the medical school's class enrollment to forty-eight students in July.

The Norfolk Area Medical Center Authority (NAMCA) is renamed the Eastern Virginia Medical Authority (EVMA) to reflect participation from the other cities in the Hampton Roads area. The number of board members is increased to ten--four from Norfolk, two from Virginia Beach, and one each from Chesapeake, Portsmouth, Suffolk, and Hampton. Newport News joins the other Tidewater cities in about a year.

The Eastern Virginia Inter-hospital Medical Education Committee (EVIMEC) is established in the fall. It is a hospital system composed of thirty-one area hospitals tasked with providing regional, continuing medical education.

Dr. Francis E. Rosato, the first chairman of the Department of Surgery, and Dr. Donald J. Merchant, chairman of the Department of Microbiology, establish the Tidewater Regional Cancer Network. It provides educational and informational services on cancer.

1976 A fire in Smith-Rogers Hall on 1 April is discovered by students. Although the fire lasted for about forty-five minutes, damage is minimal.

The LCME grants EVMS full accreditation for two years (April).

The Department of Radiation Oncology and Biophysics is established with Dr. Anas M. El-Mahdi as chairman. This is the first fully-staffed and hospital-based clinical department of the medical school operating with a new physical plant provided by the Medical Center Hospitals.

EVMS graduates its first students in September.

1977 The LCME approves a request for an enrollment increase in the medical school's class size to eighty students in 1978 and ninety-six students in 1979.

EVMS is reaccredited for three years by the LCME.

The Immunology Program is established.

The medical school is relocated in the newly completed Lewis Hall.

The educational goals of the medical authority are restated.

The evaluation system for improvement of the medical school's educational program is reviewed by medical authority officials.

Small curricular planning groups are restored as subcommittees of the Committee on Instruction.

An interpersonal skills curriculum is initiated.

A committee interphase between medical students and residents is established.

Thirty-three students graduate on 24 August with the remaining three students to graduate after completion of their educational requirements.

Chairmen are appointed for the Departments of Anatomy, Internal Medicine, Pathology, Physiology, and Psychiatry and Behavioral Science.

1978 Lewis Hall is dedicated in February. Modern laboratories for pharmacology, biology, anatomy, pathology, microbiology, immunology, physiology, and biophysics become operational.

The Virginia Consortium for Professional Psychology is created as an inter-institutional graduate program leading to the degree of Doctor of Psychology. Eastern Virginia Medical School, the College of William and Mary, Norfolk State University, and Old Dominion University provide faculty, laboratories, and clinical resources. The first degree is awarded in 1982.

1979 Dr. William Dixon Mayer is inaugurated in December as the second full-time president of the Eastern Virginia Medical Authority.

1980 Efforts are initiated to transform the curriculum to a four calendar year cycle which contains the prescribed thirty-six months of formal instruction and allows for independent study during the months when classes are not in session.

The first in-vitro fertilization clinic in the United States is dedicated in Norfolk.

Dr. Ashton B. Morrison becomes the Eastern Virginia Medical School's third dean.

Mr. Joe S. Greathouse, Jr., is appointed to head the newly established Office of Vice President for Planning and Development.

The Surgical Assistant Program is established.

The Emergency Physician Program is established within the Eastern Virginia Graduate School of Medicine.

The Vascular Research and Service Laboratory is established.

The Eastern Virginia Family Therapy Institute is established. A primary goal is to provide comprehensive family therapy training for clinicians.

The first Area Health Education Center (AHEC) in Virginia is founded in Western Tidewater (Western Chesapeake, Suffolk, Franklin, and the counties of Isle of Wight and Southampton). EVMA received its first AHEC contract from the Department of Health, Education, and Welfare in 1979.

1981 A master's degree program in Art Therapy is created. Its first graduating class is in 1982.

The Mission and Goals Document is approved. It provides broad parameters for the roles and directions of the medical authority and its component parts.

The EVMA Board of Commissioners approve the conversion of the undergraduate medical school program from a three-year to a four-year curriculum. This decision becomes effective with the class matriculating in June 1983.

The Center for Microsurgical Research is established. It permits the expansion and practice of a new methodology for the suturing of minute nerve and blood vessels.

EVMS receives its sixth LCME site visit (14-16 October).

The first in-vitro fertilization baby born in the United States (Elizabeth Jordan Carr) is delivered in Norfolk on 28 December.

- 1982 The medical school matriculates its maximum class enrollment of ninety-six students in July.

The Department of Physical Medicine and Rehabilitation is established with Dr. Charles R. Peterson as chairman.

Interim financing of \$15 million is approved for the construction projects of the medical center parking garage, the Norfolk and Portsmouth Family Practice units, and the clinical sciences building.

The Ad Hoc Committee on Strategies for the Future is formed. It is tasked to formulate plans for future developments of the medical school in order to achieve fiscal and faculty stability in succeeding years.

- 1983 Dr. Ashton B. Morrison resigns in April as the third dean of the medical school. Dr. James P. Baker becomes the interim vice president for Academic Affairs/Dean.

The Ghent Family Practice Center is dedicated on 20 May.

The Eastern Virginia Medical School-American Red Cross (EVMS-ARC) Research Laboratory is established. Dr. Stein Holme is appointed to head the laboratory as scientific director.

The medical school's four-year curriculum replaces its three-year curriculum. It becomes effective with students matriculating in 1983 (the Class of 1987).

The Howard and Georgeanna Jones Institute for Reproductive Medicine is established in September. It becomes a part of the medical school's Department of Obstetrics and Gynecology.

Andrea Peck, Ph.D., is appointed director of the Office of Public Affairs.

- 1984 Beverley Rowley, Ph.D., joins the medical authority as the executive assistant to the president. Together with the four vice presidents and the director of Public Affairs, the President's Advisory Group is established.

Dr. Richard G. Lester is appointed dean of the medical school on 1 May.

The medical authority's board of commissioners approve the establishment of the Office of Vice President for Development. On 1 September Mr. Lee Kitchin is appointed to head this department.

Mr. Richard C. Peters resigns as the vice president for Administration and Services.

Gary D. Hodgen, Ph.D., is appointed scientific director of the Howard and Georgeanna Institute of Reproductive Medicine.

The Dementia Center of Hampton Roads is established.

1985 Mr. Tom Campbell is appointed as the vice president for Administration and Services.

The Elise and Henry Clay Hofheimer II Hall of the Clinical Sciences (informally referred to as Hofheimer Hall) is dedicated.

EVMS receives a site visit from the LCME (1-4 April). Accreditation for one year is approved.

"Operation Smile: Fellowship in the Philippines" is established. A team of forty physicians and health care personnel, many from the medical school's Department of Plastic Surgery, take a ten-day trip to the Philippines. Reconstructive facial surgery is provided at no cost.

Smith-Rogers Hall, the former Leigh Memorial Hospital, the Triangle Building, and the former Planned Parenthood Building are declared to be surplus real estate. Since the properties are owned by the medical authority and are surplus, the medical authority can begin negotiations on either their sale, lease, or exchange of each of them.

A \$3 million bond resolution is approved to pay for the cost of acquiring the Hague Club Apartment Complex Project. The facility will provide housing for medical students, residents, and other medical center health care professionals.

Mr. Tom Campbell resigns as the vice president for Administration and Services.

1986 An Architectural Selection Committee is formed to recommend an architectural firm to design: (1) an addition to Lewis Hall for those functions which comprise the Jones Institute for Reproductive Medicine and (2) an office facility to replace EVMA's functions in Smith-Rogers Hall.

The LCME grants EVMS accreditation for two years as a result of its April site visit. The Contraceptive Research and Development (CONRAD) program of the Jones Institute for Reproductive Medicine is awarded a \$28 million grant from the United States Agency for International Development (USAID). These funds will be used for a five-year research program in family planning technologies.

The Diabetes Education Center is established. Donald E. Moore, Jr., Ph.D., is appointed its director.

1987 EVMS receives a site visit from the LCME. Accreditation is granted for a period of four years. The LCME requests the medical school submit in December 1988 a progress report regarding noted concerns in its report.

Dr. William D. Mayer resigns in October as president of the medical authority.

Mr. W. Ashton Lewis is appointed as acting president of the medical authority.

APPENDIX 1

NEED EXPRESSED FOR A WRITTEN HISTORY OF
THE EASTERN VIRGINIA MEDICAL SCHOOL
AND THE EASTERN VIRGINIA
MEDICAL AUTHORITY



356

Ph.D. in Urban Services
Office of the Coordinator • (804) 440-3073 • Norfolk, VA 23508-6506

September 14, 1984

TO: Ms. Karen Bosch
Ms. Johnnie Bunch
Mr. Brian Collins
Mr. John Flemming
Ms. Elva Hunt
Ms. Lea Pellett

FROM: Lindsay Rettie, Lucy R. Wilson
Coordinator Ph.D./US

RE: Possible Research for Dissertation: History of the
Eastern Virginia Medical Authority

The staff of Eastern Virginia Medical Authority is interested in having one of our PH.D./US students write a comprehensive history of Eastern Virginia Medical Authority and Eastern Virginia Medical School. Since each of you is at or near the stage of selecting a dissertation topic, you may wish to consider this project as a possible area of research. I am attaching an abbreviated history of EVMS for your information and with the hope that your interest in the project may be stimulated.

If you would like to pursue this research, it is entirely possible that we can negotiate with EVMA for some financial assistance for you. Also, I am sure that the staff would be most cooperative in supplying information and records for developing and documenting the research. In considering the prospect, you should keep in mind that well-researched histories of institutions such as EVMA/EVMS are often published for archives, alumni, friends, students, staff etc. The prospect of having your dissertation published is a perquisite that should not be overlooked.

In any event, please let me know within the next week or ten days whether you have interest in this project.

Best wishes and kind regards as you continue the final stages of your work.

LRW/wa
cc: Dr. Lindsay Rettie
Dissertation Chairs
Enclosure

APPENDIX 2

SAMPLE LETTER OF INTRODUCTION FROM THE PRESIDENT
OF THE EASTERN VIRGINIA MEDICAL AUTHORITY
TO A PROSPECTIVE INTERVIEWEE



EASTERN VIRGINIA MEDICAL AUTHORITY
POST OFFICE BOX 1980
NORFOLK, VIRGINIA 23501

OFFICE OF THE PRESIDENT

TELEPHONE (804) 446-5200

January 9, 1985

Mr. Richard F. Welton III
Smith and Welton, Inc.
300 Granby Street
Norfolk, Virginia 23510

Dear Dick,

This letter is to introduce John Flemming who will be calling you for an appointment in the near future. A doctoral student in urban studies at Old Dominion University, Mr. Flemming is going to complete a history of EVMA as his thesis project. We are quite excited about this undertaking and hope you will be able to contribute your special perspective to his efforts. If you have any questions please feel free to call.

Sincerely,

William D. Mayer, M.D.
President

WDM/ag

cc: Mr. John P. Flemming IV

APPENDIX 3

SAMPLE LETTERS SENT TO 120 U.S. MEDICAL SCHOOLS

412 Shell Road
Chesapeake, Virginia 23323

March 6, 1986

Dear Sir:

In fulfillment of my dissertation requirement for my Ph.D. at Old Dominion University in Norfolk, I am writing a history of the Eastern Virginia Medical School. A literature search of medical school histories in the United States has revealed only a handful of books and dissertations written on the matter.

If a history of your medical school has been written, would you please provide me the following:

1. Title of the work
2. Author
3. Number of pages of the work
4. Date of publication
5. Means by which I might obtain a copy

If a history of your medical school has not been written, I would appreciate it if you would please advise me of this.

Sincerely,

John P. Flemming, IV

412 Shell Road
Chesapeake, Virginia 23323

March 6, 1986

Health Sciences Center Library
Temple University
Broad & Tioga Streets
Philadelphia, PA 19140

Dear Sir:

In fulfillment of my dissertation requirement for my Ph.D. at Old Dominion University in Norfolk, I am writing a history of the Eastern Virginia Medical School. A literature search of medical school histories in the United States has revealed only a handful of books and dissertations written on the matter.

If a history of your medical school has been written, would you please provide me the following:

1. Title of the work
2. Author
3. Number of pages of the work
4. Date of publication
5. Means by which I might obtain a copy

If a history of your medical school has not been written, I would appreciate it if you would please advise me of this.

Sincerely,

John P. Flemming, IV
John P. Flemming, IV

*rec history
Temple University
School of Medicine
3/12/86*

412 Shell Road
Chesapeake, Virginia 23323

March 6, 1986

Health Sciences Library
Creighton University
2500 California Street
Omaha, NE 68178

Dear Sir:

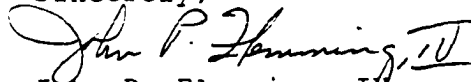
In fulfillment of my dissertation requirement for my Ph.D. at Old Dominion University in Norfolk, I am writing a history of the Eastern Virginia Medical School. A literature search of medical school histories in the United States has revealed only a handful of books and dissertations written on the matter.

If a history of your medical school has been written, would you please provide me the following:

1. Title of the work
2. Author
3. Number of pages of the work
4. Date of publication
5. Means by which I might obtain a copy

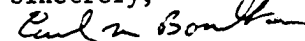
If a history of your medical school has not been written, I would appreciate it if you would please advise me of this.

Sincerely,


John P. Flemming, IV

SPEED REPLY: See attached for what we have. Your library should be able to request an interlibrary loan.

Sincerely,



Earl M. Boulton
Head, Ref/Online Services

History
 Medicine
 Creighton University. Health Sciences
 Library.
 A collection of biographical
 information about alumni and faculty
 of the Creighton University School of
 Medicine / compiled by Creighton
 University health sciences staff. --
 Omaha : Creighton University, 1984.
 5 v. (loose leaf) : ill. ; 29 cm.
 Includes photocopies of information
 taken from various professional
 journals.
 1. Faculty, Medical--biography
 2. Current Biog-Obit 3. Schools,
 Medical--Nebraska 4. History of
 Medicine--Nebraska I. Creighton
 University School of Medicine
 II. Title

DOC 11 NOV 85 127803R2 OCMAsc

P.S. If you have any problems with the UMKC
 Arden Library or Medicine, I do know that
 there is a source for a free copy of their historical
 historical work!
 Ernst

* 6/11/1986

APPENDIX 4

REPRINT OF ABRAHAM FLEXNER'S EVALUATION NOTES
ON VIRGINIA'S THREE MEDICAL SCHOOLS

VIRGINIA

Population, 2,032,567. Number of physicians, 2215. Ratio, 1:918.

Number of medical schools, 3.

CHARLOTTESVILLE: Population, 7307.

- (1) UNIVERSITY OF VIRGINIA, DEPARTMENT OF MEDICINE.
Organized 1827. An organic department of the university.

Entrance requirement: One year of college work in sciences.

Attendance: 89, 53 per cent from Virginia.

Teaching staff: 31 teachers, of whom 12 are professors, 19 of other grade, take part in the work of the department. The laboratory branches are taught by 8 instructors who give their entire time to them.

Resources available for maintenance: The budget of the department calls for \$52,195, including hospital deficit; it is met out of the funds of the university. The income in fees amounts to \$10,060.

Laboratory facilities: Up to three years ago the department was a didactic school. Since then it has been revolutionized: good teaching laboratories in all necessary branches, with increased provision for research, have been equipped and put in charge of enthusiastic teachers of modern training and ideals. The main present lack is a suitable building and an adequate medical library.

Clinical facilities: The University Hospital of 100 beds (80 of them ward beds) is the laboratory of the clinical teachers. [A recent gift of \$50,000 is now available for the extension of the hospital.] Its relation to the medical school and its organization for teaching purposes leave nothing to be desired. Though the material has not yet reached proper proportions, it is increasing and is skilfully and effectively used to train the student body in the technique and methods of scientific medicine. The surgical side is in this respect more highly organized than the medical.

There is a small dispensary.

Date of Visit: February, 1909.

RICHMOND: Population, 111,078.

(2) MEDICAL COLLEGE OF VIRGINIA. Organized 1838.

Entrance requirement: Less than a four-year high school education. The registration office is most systematically conducted.

Attendance: 206.

Teaching staff: 61, of whom 16 are professors, 45 of other grade. There are no teachers giving their entire time to medical instruction.

Resources available for maintenance: Fees, amounting to \$22,490, and an annual state appropriation of \$5,000.

Laboratory facilities: The school occupies an imposing building with ordinary laboratories for pathology, histology, bacteriology, physiology, and chemistry. The dissecting-room is in poor condition. There is a fair museum and an attractive library with some recent books, in charge of a librarian.

Clinical facilities: These are inadequate. Close by is the Memorial Hospital, with about 40 beds available for teaching. Supplementary facilities are enjoyed in the City Hospital and elsewhere.

The dispensary occupies an excellent suite of rooms and has a fair attendance.

Date of Visit: February, 1909.

(3) UNIVERSITY COLLEGE OF MEDICINE. Organized 1893. An independent institution.

Entrance requirement: Less than a four-year high school education.

Attendance: 121, 63 per cent from Virginia.

Teaching staff: 74, of whom 22 are professors, 52 of other grade.

Resources available for maintenance: Fees, amounting to \$14,975.

Laboratory facilities: The school was recently destroyed by fire and now occupies temporary laboratory quarters.

Clinical facilities: These are inadequate. The school

adjoins its own hospital, with less than 50 beds available for teaching. Supplementary facilities are enjoyed elsewhere. An out-patient obstetrical service is well organized.

The dispensary has a fair attendance.

Date of visit: February, 1909.

General Considerations

The destruction by fire of the University College of Medicine at Richmond should precipitate the consolidation of the two independent schools. Separately neither of them can hope greatly to improve its present facilities, which, weak in respect to laboratories and laboratory teaching, are entirely inadequate on the clinical side. Their present hospitals utilized together, though still unsatisfactory, would at any rate be much more nearly adequate than is either hospital taken by itself; and the combined fees would furnish much better laboratory training than either school now gives. A single independent school of the better type might still have in Virginia a brief term of prosperity,--the more so as the medical department of the University of Virginia is on a considerably higher basis.

The rapid improvement of the medical department of the University of Virginia in the last three years is one of the striking phenomena of recent medical school history. The limitations of Charlottesville have been acutely felt; the university is pursuing the course calculated to surmount them. It faces indeed a much greater outlay than it has yet made, for larger clinics in internal medicine and obstetrics must be developed. The alternative of a remote department diminishes difficulty of one kind only to create difficulty of another. A remote department at Norfolk or Richmond would of course command abundant clinical material; but could it preserve university ideals? The present resources of the university are not large enough to stand the strain of such liberal support as a remote department needs if it is to be genuinely productive. The experience of a few years warrants the belief that a clinic in most lines, for a school of 200 students, can be developed at Charlottesville if the university can afford it. Graduating classes of 50 easily suffice for Virginia's demand. At any rate, so much is evident: in Virginia, as elsewhere, the teaching of medicine will fall to the universities; and at this writing, the only institution available is the University of Virginia.

SOURCE: Abraham Flexner, Medical Education in the United States and Canada--A Report to the Carnegie Foundation for the Advancement of Teaching, with an Introduction by Henry S. Pritchett (New York City: n.p., 1910; reprint ed., New York; Arno Press, Medicine & Society in America, 1972), pp. 314-16.

APPENDIX 5

PUBLIC HEALTH DEPARTMENT: A FEW COMPARISONS
OF HEALTH CONDITIONS IN NORFOLK FROM
1910 TO 1920

PUBLIC HEALTH DEPARTMENT: A FEW COMPARISONS
OF HEALTH CONDITIONS IN NORFOLK FROM
1910 to 1920

DEATHS

The general death rate for 1910 was: White population, 14.4 per 1000 per annum. Colored population, 29.1 per 1000 per annum. Total death rate, white and colored, 18.1 per 1000.

The general death rate for 1919 was: White population, 7.6 per 1000 per annum. Colored population, 18.2 per 1000 per annum. Total death rate, white and colored, 11.6 per 1000. . . .

TYPHOID FEVER

In 1910 the death rate from typhoid fever was 53.9 per 100,000.

In 1919 the death rate from typhoid fever was 5.2 per 100,000.

TUBERCULOSIS

The death rate from tuberculosis for 1910 was 260.7 per 100,000.

The death rate from tuberculosis for 1919 was 112.3 per 100,000.

INFANT DEATH RATE

335 babies under one year of age died in 1910, and the population was 67,452.

217 babies under one year of age died in 1919, and the population was 115,777.

DEATHS FROM CAUSES DUE TO THE
PUERPERAL STATE

In 1910 there were 19, population 67,542.

In 1919 there were 17, population 115,777. A gain of approximately 100%.

DIARRHEA AND ENTERITIS UNDER 2 YEARS OF AGE

In 1910, the death rate was 135.9 per 100,000.

In 1919, the death rate was 56.0 per 100,000.

ACTIVITIES OF THE DEPARTMENT OF HEALTH

Persistent distribution of educational propaganda, using as a slogan that good health is to a great degree purchasable, not alone with money, but by an obedience to the laws of nature, by a due regard to public and personal hygiene, by a definite understanding that disease and death is primarily a matter of cause and effect, and that the cause is in a majority of instances preventable; that health is the result of conservative, sensible, temperate living; that disease is the result of a violation of the laws of nature and outrages committed against our bodies.

A comparison of the fields of activity covered by the Department of Health for 1910 and 1920 is interesting:

In 1910 we had no district visiting nurse force, nor did we have medical inspection of schools.

In 1910 all cases of contagious diseases, except small-pox, were quarantined in their homes, boarding houses, hotels, etc.

Now we have a modern, well-built and equipped Contagious Disease Hospital with a capacity of one hundred cases. We employ an epidemiologist, who supervises all contagious diseases in the city, and nurses who investigate, under the epidemiologist, all cases, visit the homes, distributing literature and teaching the inmates how to avoid these diseases.

We operate the largest Venereal Clinic in the State.

We have systematic inspection and scoring of all food establishments, particularly restaurants, soda fountains, bakeries, bottling plants, etc.

We have four men devoting their entire time to meat, milk and food inspection.

In our Bacteriological Department, laboratory analyses

are made daily of the city's public water and milk supply.

Milk is graded in
Certified Milk.
Grade A Raw Milk.
Grade A Pasteurized Milk.
Grade B Pasteurized Milk.

All milk sold in Norfolk is highly standardized and comes from tuberculin tested herds.

Anti-and post-mortem inspections are made and stamped of locally killed meats by a veterinarian.

Regular daily sanitary inspections of the city are made by eight sanitary officers in the detecting and abatement of nuisances detrimental to the comfort and health of the city.

A medical and surgical staff of five physicians, elected to the Department of Health, rendered medical and surgical aid to the city poor.

A Free Dispensary, where medical and surgical aid and free medicines are dispensed to the poor, is operated daily. . . .

The public for the past several years have been in a receptive mood, and never before in the world's history have the people been so eager to learn and practice the principles and precepts of hygiene and health.

SOURCE: P. S. Schenck, Commissioner of Health of Norfolk, Virginia Medical Monthly (Richmond, VA.: Medical Society Virginia, July 1920), pp. 177-78.

APPENDIX 6

SANITATION INSPECTION FACTS FOR THE YEARS
1940, 1939, AND 1938

SANITATION INSPECTION FACTS

FOR THE YEARS 1940, 1939, and 1938

	1940	1939	1938
FOOD ESTABLISHMENTS:			
Bakeries	41	56	169
Barbecue Stands	29	33	18
Bacterial Analysis of Eating and Drinking Utensils	1,009	1,083	0
Beer Taverns	201	381	757
Candy and Confectionery Stores . .	85	132	306
Drug Stores	138	235	213
Grocery Stores	6,265	5,715	6,325
Hot Dog Stands	42	31	32
Ice Cream Plants	40	13	22
Ice Cream Stores	140	138	242
Oyster and Fish Stands and Markets	21	43	78
Open Air Markets	7	0	0
Restaurants, Delicatessens, Lunch Counters	1,051	968	1,399
Soda Fountains	477	534	875

BUILDING CONDITIONS:

Buildings	51	0	0
Cisterns	14	26	12
Cellars	51	106	9
Choked Sewers	969	750	915
Garbage Cans	258	251	426
Gutters and Roofs	31	22	14
Hotels and Rooming Houses	58	96	101
Miscellaneous Inspections	784	0	0
Merchandise and Furniture Stores .	17	0	0
Nuisances Referred to Sewer Division	397	0	0
Slaughter Houses	8	4	9
Stables	8	11	12
Sinks, Waste and Water Pipes, Sewers	495	288	318
Septic Tanks	195	159	120
Schools	22	58	0
Sewers Connected on Notices Served	180	158	248
Sewers Ordered Connected	233	242	0
Septic Tanks Ordered Cleaned and Repaired	50	31	24
Theatres	28	0	0
Toilets Inspected	35,918	36,491	43,549
Trailers	179	14	0

	1940	1939	1938
Vacant Lots Investigated for			
Gardens	79	0	0
Water Ordered on Premises	121	35	29
Yards and Alleys Inspected	28,606	31,295	38,487

SOURCE: Norfolk, VA., Civic Affairs: 1940, (Annual Report of the City Manager, 1940), p. 57.

APPENDIX 7

COMMUNICABLE DISEASES FOR THE YEARS

1940, 1939, AND 1938

COMMUNICABLE DISEASES

FOR THE YEARS 1940, 1939, and 1938
(Cases Reported/Deaths)

	1940	1939	1938
Chicken Pox	172/0	422/0	170/0
Chancroid and Gonorrhoea	495/0	436/1	447/0
Dysentery	0/0	0/1	0/1
Diphtheria	16/2	38/2	23/3
Diarrhea	85/12	127/9	0/10
Encephalitis	0/0	1/6	0/1
Epidemic Cerebral Meningitis	3/0	1/1	4/0
Erysipelas	5/0	0/0	1/0
Influenza and Lagrippe	775/1	611/2	39/1
Measles	482/0	347/0	685/0
Mumps	56/0	538/0	228/0
Ophthalmia	1/0	0/0	0/0
Psittacosis	1/0	0/0	1/0
Poliomyelitis	8/0	5/0	1/0
Pneumonia (All types)	272/160	317/127	92/161
Malaria	0/0	12/1	4/0
Syphilis	2,324/3	2,752/4	2,079/5
Scarlet Fever	114/0	101/0	211/0
Septic Sore Throat	2/0	14/0	0/0
Typhus Fever	2/0	4/0	0/1
Typhoid Fever	14/2	5/0	6/1
Typhoid (Para)	0/0	14/0	0/0
Tuberculosis (All types)	197/47	173/63	147/65
Tetanus	0/0	2/2	2/4
Undulant Fever	0/0	2/0	0/0
Whooping Cough	115/1	76/0	101/4

SOURCE: Norfolk, VA., Civic Affairs: 1940 (Annual Report of the City Manager, 1940), p. 46.

APPENDIX 8

MEDICAL EDUCATION: ESSENTIALS OF AN
ACCEPTABLE COLLEGE

MEDICAL EDUCATION: ESSENTIALS OF AN
ACCEPTABLE MEDICAL COLLEGE

(From "Choice of a Medical School,"
issued by the American Medical Association)

The minimum requirement for admission to an acceptable medical college is a four-year high school education or its full equivalent and two years of work in a college of arts and sciences approved by the Council on Medical Education are as follows:

1. HIGH SCHOOL REQUIREMENTS

(a) For admission to the two-year premedical college course, students shall have completed a four-year course of at least fifteen units in a standard accredited high school or other institution of standard secondary school grade, or have the equivalent as demonstrated by examinations conducted by the College Entrance Examination Board, or by the authorized examiner of a standard college or university which has been approved by the Council on Medical Education. A detailed statement of attendance at the secondary school, and a transcript of the student's work, should be kept on file by the college authorities. This evidence of actual attendance at the secondary schools should be obtained, no matter whether the student is admitted to the freshman or to higher classes.

(b) Credits for admission to the premedical college course may be granted for the subjects shown in the following list and for any other subject counted by a standard accredited high school as a part of the requirements for its diploma, provided that at least eleven units must be offered in Groups I-V:

SCHEDULE OF SUBJECTS REQUIRED OR ACCEPTED FOR
ENTRANCE TO THE PREMEDICAL COLLEGE COURSE

Subjects	Units	Req'd
Group I, English--		
Literature and composition	3-4	3
Group II, Foreign Languages--		
Latin	1-4	
Greek	1-3	
French or German	1-4	2
Other foreign languages	1-4	
Group III, Mathematics--		
Elementary algebra	1	1
Advanced algebra	1/2-1	

	Units	Req'd
Plane geometry	1	1
Solid geometry	1/2	
Trigonometry	1/2	
Group IV, History--		
Ancient history	1/2-1	
Medieval and modern history	1/2-1	
English history	1/2-1	1
American history	1/2-1	
Civil government	1/2-1	
Group V, Science--		
Botany	1/2-1	
Zoology	1/2-1	
Chemistry	1	
Physics	1	
Physiography	1/2-1	
Physiology	1/2-1	
Astronomy	1/2	
Geology	1/2-1	
Group VI, Miscellaneous--		
Agriculture	1-2	
Bookkeeping	1/2-1	
Business law	1/2	
Commercial geography	1/2-1	
Domestic science	1-2	
Drawing, freehand and mechanical	1/2-2	
Economics and economic history	1/2-1	
Manual training	1-2	
Music: Appreciation or harmony	1-2	

2. PREMEDICAL COLLEGE COURSE

(c) The minimum requirement for admission to acceptable medical schools, in addition to the high school work specified above, is sixty semester hours of collegiate work in a college approved by the Council on Medical Education. The subjects included in the two years of college work should be in accordance with the following schedule:

SCHEDULE OF SUBJECTS OF THE TWO-YEAR PREMEDICAL COLLEGE COURSE

Sixty Semester Hours Required	Semester Hours
Required Subjects:	
Chemistry (a)	12
Physics (b)	8
Biology (c)	8
English composition and literature (d)	6
Other nonscience subjects (e)	12
Subjects Strongly Urged:	

	Semester Hours
A modern foreign language (f)	6-12
Advanced botany or advanced zoology . . .	3-6
Psychology	3-6
Advanced mathematics, including algebra and trigonometry	3-6
Additional courses in chemistry	3-6
Other Suggested Electives:	
English (additional), economics, history, sociology, political science, logic, mathematics, Latin, Greek, drawing	

SUGGESTIONS REGARDING INDIVIDUAL SUBJECTS

(a) Chemistry.--Twelve semester hours required of which at least eight semester hours must be in general inorganic chemistry, including four semester hours of laboratory work. In the interpretation of this rule work in qualitative analysis may be counted as general inorganic chemistry. The remaining four semester hours may consist of additional work in general chemistry or of work in analytic or organic chemistry. After Jan. 1, 1922, organic chemistry will be required.

(b) Physics.--Eight semester hours required, of which at least two must be laboratory work. It is urged that this course be preceded by a course in trigonometry. This requirement may be satisfied by six semester hours of college physics, of which two must be laboratory work, if preceded by a year (one unit) of high school physics with laboratory work.

(c) Biology.--Eight semester hours required, of which four must consist of laboratory work. The requirement may be satisfied by a course of eight semester hours in either general biology or zoology, or by courses of four semester hours each in zoology and botany, but not by botany alone. This requirement may also be satisfied by six semester hours of college biology, including three semester hours of laboratory work, if preceded by a year (one unit) of high school biology or zoology with laboratory work.

(d) English Composition and Literature.--The usual introductory college course of six semester hours, or its equivalent, is required.

(e) Nonscience Subjects.--Of the sixty semester hours required as the measurement of two years of college work, at least eighteen, including the six semester hours of English, should be in subjects other than the physical, chemical or

biologic sciences.

(f) Foreign Language.--A reading knowledge of a modern foreign language is strongly urged. French and German have the closest bearing on modern medical literature. If the reading knowledge in one of these languages is obtained on the basis of high school work, the student is urged to take the other language in his college course. It is not considered advisable, however, to spend more than twelve of the required sixty semester hours on foreign languages.

Recognition.--This two-year premedical course in both quantity and quality must be such as to make it acceptable as the equivalent of the first two years of the course in reputable, approved colleges of arts and sciences leading to the degree of Bachelor of Science.

3. APPROVED COLLEGES OF ARTS AND SCIENCES.

A tentative list of colleges of arts and sciences approved by the Council on Medical Education has been prepared, and revisions of this list will be published from time to time. By an approved college (of arts and sciences) is meant one whose standing has been vouched for by some standardizing agency in whose methods the Council has confidence. To be recognized a college must have sufficient scientific equipment and maintain laboratories in the premedical sciences. It must have ample endowment to maintain a sufficient corps of teachers. Membership in some national organization or association of colleges will be favorably regarded by the Council and, in the absence of such membership, careful investigation will be made of the causes of exclusion. It must also maintain national standards for admission to its freshman class. Students must be required to complete a four-year high school course, and the requirements for admission to the premedical course must be no less than the requirements for admission to the regular B.S. course of the college.

Particular attention will be given to the character of high schools from which certificates are received. Colleges should recognize only certificates from high schools approved by commissions or boards of associations of colleges and secondary schools or other agencies approved by the Council. When such endorsement is lacking the college should be slow in accepting certificates without the support of entrance examinations. Undue liberality in the acceptance of certificates from secondary schools unendorsed by approved standardizing agencies will be registered by the Council as a failure to comply with its requirements and the college will be dropped from the approved list.

PREMEDICAL COURSES IN MEDICAL COLLEGES--
JUNIOR COLLEGES

Premedical college courses given in or by medical schools, or advance years taken in high schools, will not be considered as acceptable unless they have been investigated and approved by some association of colleges and secondary schools or other approved agency having to do with the standardizing of liberal arts colleges, and unless they are found to be a full equivalent of the first two years of the course leading to the Bachelor of Science degree.

4. THE MEDICAL SCHOOL ADMINISTRATION
OF ENTRANCE REQUIREMENTS

2. The admission of students to the medical school must be in the hands of responsible committee or examiner whose records shall always be open for inspection. Documentary evidence of the student's preliminary education should be obtained and kept on file. When the medical school is an integral part of the university, this work usually devolves on the university examiner. Unless the university examiner and his records are closely accessible, however, some officer at the medical school should obtain and keep on file documentary evidence of each student's preliminary education, including both high school and collegiate work. It is particularly important that the records show that the required amount of work in the premedical sciences, including laboratory exercises, has been completed.

OTHER MEDICAL SCHOOL REQUIREMENTS

3. The college should require that students be in actual attendance in the college within the first week of each annual session and thereafter.

4. Actual attendance at classes should be insisted on except for good cause, such as for sickness, and no credit should be given for any course where the attendance has been less than 80 per cent of the full time.

5. (a) Full advanced standing may be granted to students only for work done in other acceptable medical schools and in granting advanced standing there should be no discrimination against the college's full course students. Official verification of the student's previous medical work should be obtained by direct correspondence with the college previously attended, and his preliminary qualifications should also be verified and recorded the same as for freshman students. (b) In exceptional cases, students who possess the required premedical qualifications and who have

completed three or more years of work in Class B medical schools may be given advanced standing, but not higher than entrance to the third year (junior) class, and no credit should be given in any subject except on recommendation of the head of the department teaching that subject. (c) In exceptional cases also students who possess the required premedical qualifications and who have completed three or more years of work in Class C colleges may be given advanced standing but not higher than entrance to the second year (sophomore) class, and then only after thorough examinations in all first year subjects have been passed.

SOURCE: "Essentials of an Acceptable Medical College," Virginia Medical Monthly (Richmond, VA.: Medical Society of Virginia, May 1920), pp. 80-82.

** Continued from May 1920 issue of the
Virginia Medical Monthly

SUPERVISION, EQUIPMENT, TEACHERS.

6. There should be careful and intelligent supervision of the entire school by the dean or other executive officer who holds, and has sufficient authority to carry out fair ideals of medical education as determined by the present-day knowledge of medicine.

7. There should be a good system of records showing conveniently and in detail the credentials, attendance, grades and accounts of the students, by means of which an exact knowledge can be obtained regarding each student's work. Records should also be kept showing readily the attendance of patients at the teaching hospitals and dispensaries; the maternity cases attended by students, and the postmortem cases used in teaching.

8. The college curriculum should be fully graded and should cover four sessions of at least thirty-two weeks each, exclusive of time required for matriculation and holidays, and at least thirty hours per week of actual work. The courses offered in the various subjects should be set forth by departments (anatomy, physiology, etc.) in the annual announcement showing for each course its number, subject content, character (lecture, recitation, laboratory or clinic), length of time, when, where, and by whom given, and the amount of credit allowed. The courses for each class should also be clearly set forth in a printed class schedule, for the guidance of the students.

(a) The college should give two years of work consisting largely of laboratory work in well equipped

laboratories of anatomy, histology, embryology, physiology, physiologic chemistry, bacteriology, pathology, pharmacology, therapeutics and clinical diagnosis. Present-day medical knowledge makes it essential that these subjects be in charge of full-time, well-trained teachers.

(b) Two years of clinical work, largely in hospitals and dispensaries, with courses in medicine (including physical diagnosis, pediatrics, nervous and mental diseases), surgery (including surgical anatomy and operative surgery on the cadaver), obstetrics, gynecology, laryngology, rhinology, ophthalmology, otology, dermatology, hygiene and medical jurisprudence. With the higher entrance requirements, time is now available in the latter part of the second year for beginning courses in physical diagnosis and the principles of surgery.

(c) As soon as conditions warrant, relations should be established with a number of approved hospitals so that a fifth undergraduate year may be required to be spent by the student as an intern under the continued supervision of the medical school.

FACULTY

9. (a) The college should provide at least eight expert thoroughly trained professors in the laboratory branches, salaried so that they may devote their entire time to instruction and to that research without which they cannot well keep up with the rapid progress being made in their subjects. For colleges having sixty students or less in each class there should be at least one full-time salaried assistant each in the departments of (1) anatomy, (2) physiology, (3) pathology and bacteriology, and (4) physiologic chemistry and pharmacology. There should be also one additional assistant provided in each of these departments for each additional thirty students enrolled. This represents a low average of the full-time assistants already employed by the acceptable medical colleges.

(b) The faculty should be made up of graduates of institutions recognized as medical colleges and who have had a training in all departments of medicine. Nonmedical men should be selected as teachers in medical schools only under exceptional circumstances and only when medical men of equal special capacity are not available. The faculty should be organized, each department having its head professor, its associate professor, assistant professor, instructor, etc., each having his particular subjects for the teaching of which he is responsible to the head of the department.

CLINICAL FACILITIES AND INSTRUCTION.

10. (a) The college should own or entirely control a hospital in order that students may come into close and extended contact with patients under the supervision of the attending staff. This hospital should be in close proximity to the college and have a daily average (for senior classes of 100 students or less) of not less than 200 patients who can be utilized for clinical teaching, these patients to be of such character as to permit the students to see and study the common variety of surgical and medical cases as well as a fair number in each of the so-called specialties. In the use of this material bedside and ward clinics should be developed for sections of from five to ten students, and for the seniors, a certain number of patients in medicine, surgery and the specialties should be assigned to each student under a well supervised clinical clerk system. The treatment and care of these patients should be particularly observed and recorded by the student under the strict supervision of the intern, or the attending staff of the hospital.

(b) The college should also have ample hospital facilities for children's diseases, contagious diseases and nervous and mental diseases.

(c) The college should own or control a dispensary, or out-patient department, the attendance to be a daily average of 100 patients (visits) (for senior classes of 100 students or less), the patients to be carefully classified, good histories and records of the patients to be kept and the material to be well used. The attending staff should be made up of good teachers, should be well organized and be prompt and regular in attendance.

(d) At least six maternity cases should be provided for each senior student, who should have actual charge of these cases under the supervision of the attending physician. Careful records of each case should be handed in by the student.

(e) Facilities should be provided for at least thirty necropsies (for senior classes of 100 students or less) during each college session which are attended and participated in by senior students. These, as a rule, should be in the teaching hospital controlled by the medical school and performed by the professor of pathology. The so-called clinical-pathological conferences should be more widely developed in connection with the postmortems.

OTHER TEACHING FACILITIES AND FINANCES

11. The college should have a working medical library, to include the more modern text and reference books with the Index Medicus, the Surgeon-General's Index and other serviceable indexes. The library should receive regularly

thirty or more leading medical periodicals, the current numbers of which should be in racks or on tables easily accessible to the students. At the end of each year these periodicals should be bound and added to the files of bound periodicals. The library room should be properly lighted and heated, and open during all or the greater part of the day; it should be equipped with suitable card indexes as well as with tables and chairs, and have a competent librarian in charge.

12. There should be a working medical museum having its various anatomic, embryologic, pathologic and other specimens carefully prepared, labeled and indexed so that any specimen may be easily found and employed for teaching purposes. It is suggested that so far as possible with each pathologic specimen coming from postmortems there also be kept the record of the postmortem, the clinical history of the patient on whom the necropsy was held and microscopic slides showing the minute structures of the disease shown in gross specimen. The museum furnishes an excellent means of correlating the work of the department of pathology with that of the clinical departments.

13. There should be sufficient dissecting material to enable each student individually to dissect at least the lateral half of the human cadaver, to provide cross-sections and other demonstration material and to allow of a thorough course for each senior in operative surgery on the cadaver.

14. For the modern experimental laboratory work in physiology, pharmacology and bacteriology as well as for medical research, a supply of animals--frogs, turtles, rabbits and guinea-pigs, if not also cats and dogs--is essential. Proper provision, also, is necessary for the housing and care of such animals. In any use made of animals every precaution should be taken to prevent needless suffering, and work by students should be carefully supervised.

15. Each college should have a supply of such useful auxiliary apparatus as a stereopticon, a reflectoscope, carefully prepared charts, embryologic or other models, manikins, dummies for use in bandaging, a roentgen-ray and other apparatus now so generally used in medical teaching.

16. The college should show evidences of thorough organization and of reasonable modern methods in all departments, and evidences that the equipment and facilities are being intelligently used in the training of medical students.

17. A clear statement of the college's requirements for admission, tuition, time of attendance on the classes,

sessions, courses offered and graduation should be clearly set forth, together with complete classified lists of its matriculants and latest graduating class in regular catalogues or announcements.

18. Statistics show that modern medicine cannot be acceptably taught by a medical school depending solely on the income from students' fees. No medical school should expect to secure admission to, or be retained in Class A, therefore, which does not have an annual income of a least \$25,000 in addition to the amount obtained from student's fees.

SOURCE: "Essentials of an Acceptable Medical College," Virginia Medical Monthly (Richmond, VA.: Medical Society of Virginia, June 1920), pp. 131-33.

APPENDIX 9

THE JOINT COMMITTEE ON HOUSE STAFF
PROCUREMENT AND TRAINING

June 17, 1960

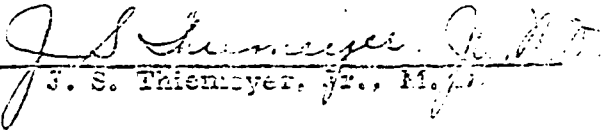
Dear Committee Member:

Enclosed is a list of the representatives and their alternates from the Boards, Medical Staffs and Hospital Administration of De Paul, Norfolk General and Leigh Memorial Hospitals for the Joint Committee on House Staff Procurement and Education.

There will be a meeting of this committee on Tuesday, July 12, 1960 at 7:30 p.m. in the Conference Room at De Paul Hospital. It is requested that both members and alternates be present for this meeting.

Thanking you for your interest, I am,

Sincerely,


J. S. Thieneyer, Jr., M.D.

JST, Jmsst

Enc.

REPRESENTATIVES AND ALTERNATES COMPOSING THE
Joint Committee on House Staff Procurement and Education . . .

For DE PAUL HOSPITAL:

7/12/40

Board Representative:	Hon. Walter A. Fago	✓
Board Alternate:	Mr. Clyde H. Jacob, Jr.	✓
Medical Staff Representative:	J. S. Thiemeyer, Jr., M.D.	✓
Medical Staff Alternate:	Patrick C. Devine, M.D.	
Hospital Administration:	Sister Mary Elizabeth	✓
Administration Alternate:	Sister Juliana	

For NORFOLK GENERAL HOSPITAL:

Board Representative:	Mr. Frank M. Miles	✓
Board Alternate:	Mr. Henry Clay Hofheimer	✓
Medical Staff Representative:	Claiborne Fitchett, M.D.	✓
Medical Staff Alternate:	M. K. King, M.D.	
Hospital Administration:	Mr. Roy R. Prangley	✓
Administration Alternate:	Mr. Robert A. Cranner	✓

For LEIGH MEMORIAL HOSPITAL:

Board Representative:	Mr. Frank D. Beale	✓
Board Alternate:	Mr. Allan J. Hofheimer	✓
Medical Staff Representative:	George F. Eisasser, M.D.	
Medical Staff Alternate:	R. B. Henry, Jr., M.D.	
Hospital Administration:	Mr. J. E. Merritt	✓

for NORFOLK COUNTY MEDICAL SOCIETY

Representative : Dr. Frank N. Bilisdy ✓
 Alternate : Dr. Robert. Faulconer.

For LEIGH MEMORIAL HOSPITAL: (per Mr. J. B. Merritt 6-16-60)

Board Representative:	Mr. Frank D. Beale
Board Alternate:	Mr. Allan J. Hofheimer
Medical Staff Representative:	George F. Elsasser, M.D.
Medical Staff Alternate:	R. B. Henry, Jr., M.D.
Hospital Administration:	Mr. J. B. Merritt

/Muj



Chamman Thunjin

APPENDIX 10

LETTERS FROM JOHN S. THIEMEYER, JR., M.D.

This letter sent to each member of the Medical Staff Executive Committee and Judge Page and Messrs. Prieur and Stokley.

✓ Dr. P.C. Devine.

Also invited 4-26-60: (from N.C.M.S.)

Dr. Wickham Taylor, President
 Dr. John Franklin, Incoming President
 Dr. Wm. Andrews, Spring Clinic Chmn.
 Dr. C. J. Devine, Jr., Chairman, Coordinating Committee
 Dr. Robert J. Faulconer, ~~Intern Procurement Committee~~ *Chairman*
 Dr. Charles E. Horton, *Chairman, Clinical Lectureship Committee*

April 19, 1960

*pro tem of
 joint
 committee on
 Scientific
 Activities
 N.C.M.S*

A. L. Shelton, M. D.
 110 Maycox Avenue
 Norfolk, Virginia

Dear Doctor Shelton:

Much interest has been expressed by representatives of Norfolk General, Leigh Memorial and De Paul Hospitals in getting together to discuss some of our mutual problems. I refer specifically to post-graduate medical educational programs in our community hospitals with the concurrent need for adequate house staff coverage of in-patient, clinic and emergency room patient care.

We have invited representatives of the Governing Boards, Medical Staff Executive Committees and any other interested parties of these hospitals to attend a meeting toward this end. You are invited to attend this meeting also, which will be held on Wednesday, April 27th at 7:30 p.m. in the Conference Room at De Paul.

Sincerely,

J. S. Thiemeyer, Jr., M.D.,
 President, Medical Staff

muj

April 13, 1960

**Mr. Roy R. Prangley, Administrator
Norfolk General Hospital
Norfolk, Virginia**

Dear Mr. Prangley:

Much interest has been expressed by representatives of Norfolk General, Leigh Memorial and De Paul Hospitals in getting together to discuss some of our mutual problems. I refer specifically to post-graduate medical educational programs in our community hospitals with the concurrent need for adequate house staff coverage of in-patient, clinic and emergency room patient care.

The Medical Staff Executive Committee of De Paul Hospital wishes to invite you to attend a meeting held for this purpose on Wednesday, April 27th, at 7:30 p.m. in the De Paul Hospital Conference Room. Will you kindly extend this invitation also to Dr. Haislip as well as representatives of your Governing Board and Medical Staff Executive Committee and any other interested parties who may wish to attend?

Sincerely,

**J. S. Thlemeyer, Jr., M. D.,
President, Medical Staff**

JST, Jr:muj

April 13, 1960

Mr. J. B. Merritt, Administrator
Leigh Memorial Hospital
Norfolk, Virginia

Dear Mr. Merritt:

Much interest has been expressed by representatives of Norfolk General, Leigh Memorial and De Paul Hospitals in getting together to discuss some of our mutual problems. I refer specifically to post-graduate medical educational programs in our community hospitals with the concurrent need for adequate house staff coverage of in-patient, clinic and emergency room patient care.

The Medical Staff Executive Committee of De Paul Hospital wishes to invite you to attend a meeting held for this purpose on Wednesday, April 27th, at 7:30 p.m. in the De Paul Hospital Conference Room. Will you kindly extend this invitation also to representatives of your Governing Board and Medical Staff Executive Committee and any other interested parties who may wish to attend?

Sincerely,

J. S. Thieme, Jr., M.D.,
President, Medical Staff

JST, Jr:muj

APPENDIX 11

ATTENDEES AT THE MEETING OF THE JOINT COMMITTEE

ON HOUSE STAFF PROCUREMENT AND TRAINING,

12 JULY 1960

STAFF
 JOINT COMMITTEE ON HOUSE PROCUREMENT AND EDUCATION

MINUTES - TUESDAY, JULY 12, 1960

The organizational meeting of the Committee was held at DePaul Hospital at 7:30 P.M., July 12, 1960, with the following members present:

For DePaul Hospital:

Hon. Walter A. Page
 Mr. Clyde H. Jacob, Jr.
 Dr. J. S. Thiemeyer, Jr.
 Sister Juliana
 Sister Veronica

For Norfolk General Hospital:

Mr. Frank M. Miles
 Mr. Henry Clay Hofheimer, II
 Dr. Claiborne Fitchett
 Dr. M. K. King
 Mr. Roy R. Prangley
 Mr. Robert A. Cramer

For Leigh Memorial Hospital:

Mr. Alan J. Hofheimer
 Mr. Frank D. Beale
 Dr. George F. Elsasser
 Dr. R. B. Henry, Jr.
 Mr. J. B. Merritt
 Mr. W. A. Oliver

For Norfolk County Medical Society:

Dr. F. N. Bilisoly, III

Absent:

Sister Mary Elizabeth
 Dr. Patrick C. Devine
 Dr. R. J. Faulconer

Dr. Thiemeyer called the meeting and acted as Temporary Chairman. Dr. Thiemeyer expressed the opinion at the outset that those present should first determine if the Committee should continue to function or if it should be dissolved. Mr. Frank D. Beale suggested that several present were not at the initial meeting held on April 27th and were not adequately informed as to the intents and purposes of the Committee to make this decision. Dr. Thiemeyer and others reviewed some of the background relative to the critical shortage of interns and residents in the Norfolk area. Opinion was expressed that there were no prospects of improvement unless some plan could be formulated to create a dynamic Norfolk educational and training program of such dimensions that we could attract interns and residents to the area.

The initial meeting of April 27th grew out of interest created

APPENDIX 12

CORRESPONDENCE ON PROPOSALS TO IMPROVE THE MEDICAL
EDUCATION PROGRAMS AT AREA HOSPITALS, 1960

NORFOLK GENERAL HOSPITAL

September 10, 1960

TO: MEDICAL EDUCATION EXPLORATION COMMITTEE

Each of the following men have been appointed to an Exploration Study Committee to develop a better future medical education program at our hospital. Specifically the Committee is requested to explore and study the proposal and recommendation of the city-wide Joint Committee to develop a teaching faculty in each of three hospitals; the Norfolk General Hospital, the DePaul Hospital, and the Leigh Memorial Hospital.

Since each hospital is expected to develop it's own teaching faculty this Committee is being appointed to make recommendations to the Executive Committee of the Medical Staff, the administration of the hospital, and the Executive Committee of the Board of Directors.

The doctors appointed to the Committee are as follows: Dr. Donald W. Drew, Director of Medical Education; Dr. C. W. Fitchett, representing House Staff Committee; Dr. R. L. Payne, Jr., representing Surgery; Dr. R. B. Grinnan, Jr., representing Medicine; Dr. R. B. Nicholls, representing Obstetrics and Gynecology; Dr. Harry Taylor, representing General Practice, and Dr. H. C. Meredith, representing Outpatient Department Committee, and Dr. M. K. King, ex-officio.

It is expected that the Committee will elect their Chairman at their first meeting.

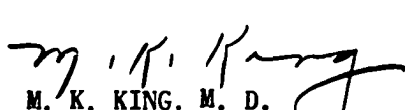
From the Board of Directors Mr. H. C. Hofheimer, II, first Vice President, Mr. R. R. Richardson, second Vice President, and Mr. Frank M. Miles, President, ex-officio.

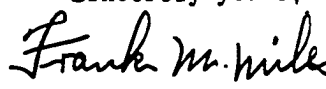
From the hospital administration Mr. Roy R. Prangley, administrator, and Mr. R. A. Cramer, assistant administrator, and Mr. William Goldsmith, Director of Outpatient Department.

It is respectfully suggested that this Committee meet for at least an hour, or more, once each week until their recommendations are finalized. It is further suggested that the first meeting be called for 7:30 breakfast meeting on Saturday, September 17, 1960, in the northeast corner of the private dining room. It is hoped that each Committee member will attend this first meeting promptly at 7:30, going through the cafeteria breakfast line and meeting in the back dining room for privacy. The Committee members may wish to choose a different time and place for future meetings, according to the majority wishes of the Committee.

Our City-wide Joint Committee representing the three hospitals believe that there is an urgency to implementing within each private hospital their recommendations. We will very much appreciate your serving on this Committee.

Sincerely yours,


M. K. KING, M. D.
President of Medical Staff


FRANK M. MILES
President Board of
Directors


ROY R. PRANGLEY
Administrator

RRP:s

September 7, 1960

Dear Doctor:

The Joint Committee on House Staff Procurement and Education met August 18, 1960 at De Paul Hospital. The following recommendations were adopted for presentation to the Medical Staff and Lay Board of each hospital - Norfolk General, De Paul and Leigh Memorial - and to the Executive Committee of the Norfolk County Medical Society as a program to be instituted in this community. The recommendations are as follows:

1. The Joint Committee coordinate the Visiting Lecture Program for the Norfolk hospitals and the Norfolk County Medical Society.

2. The Joint Committee recommends the establishment of a teaching faculty of physicians for the Norfolk hospitals. This faculty should be set up in all three (3) hospitals with certain fixed standards. Members of this faculty will be required to spend a designated number of months in the clinic services and in the out-patient departments of the various hospitals. The assignment of these services would be done by each individual hospital and the departments within the hospitals. Attendance records of physicians would be kept and forwarded to the Secretary of the Joint Committee each month. Those physicians who fulfill their requirements would have certain public recognition and certain services furnished in hospitals. These services would include assistance in the operating room and house staff help in work up and management of private patients. The non-teaching staff doctors would not have these services.

These recommendations are submitted to your Executive Committee for review and consideration. If the general principles of these recommendations are approved by all concerned, then this Committee will proceed with the detailed planning of the proposed program.

Will you please notify the Secretary of your decision on these recommendations at your earliest convenience.

Sincerely,

/s/ J. B. Merritt, Secretary
Joint Committee on House Staff
Procurement and Education

PROPOSALS FOR IMPROVEMENT OF THE MEDICAL EDUCATION PROGRAM

AT NORFOLK GENERAL HOSPITAL AS DEVELOPED BY THE PHYSICIAN

MEMBERS OF THE MEDICAL EDUCATION EXPLORATION COMMITTEE

- (1) All members of the hospital staff will be required to serve in the Out-Patient Department for a period of ten years as assigned by directors of various services. This will be retroactive, and will be a requirement for hospital privileges.
- (2) At all times Outpatient clinics will be covered by members of the hospital medical staff.
- (3) (a) Each senior resident of the three major services will be required to participate in the presentation and publication of a scientific paper during the tenure of his residency.
(b) The House Staff of each hospital service will be required to submit one paper for publication in each quarterly issue of the Hospital Medical Bulletin. Assignments are to be made by each service director.
- (4) More adequate supervision of surgical and gynecological procedures in the Operating Room will be required.
- (5) Creation of separate floors for the care of surgical patients should be carried out, if possible.
- (6) Medical inpatient rounds shall be made five days per week including the Wednesday morning Conference.
- (7) Ward rounds on surgery and gynecological services shall be held at least twice each week.
- (8) There shall be required staff participation in all teaching conferences.
- (9) There shall be didactic teaching conferences at least once each week on each service.
- (10) There shall be a required C.P.C. each month organized and carried out by the Pathology Department.

- (11) There shall be a quarterly combined medical-surgical conference.
- (12) There shall be twice a month psychiatric conferences on the ninth floor by a psychiatrist on major psychiatric problems. This should include outpatient care. Consideration should be given for the organization of a separate and distinct department of psychiatry.
- (13) An intravenous team shall be developed in order to expedite this aspect of patient care and relieve House Staff of excessive demands on their time.
- (14) Attending physicians who do not fulfill their teaching assignments should be dropped from the Attending Staff and placed in courtesy status.
- (15) Private histories and physicals may be done for members of the Attending Staff in such a way as to benefit the teaching program and not to overburden the House Staff. The amount of such work on any one service is to be decided by the Director of the Service, the Chairman of the House Staff Committee, and the Director of Medical Education.
- (16) The major responsibility of the Department of General Practice should be to their own outpatient clinic and should not have assignments to any other clinic except at their own request. Sixteen physicians should be assigned to this clinic each week to serve for a period of up to 6 - 12 months.
- (17) All new appointees to the Medical Staff must have served at least two years of hospital training following graduation from medical school.
- (18) A faculty shall be appointed by the lay board upon recommendations of various departments of the Medical Staff. Recommendations for appointment to the teaching faculty shall be made by the director of each service and the number should be proportional to the Department's participation in the total teaching program.

Appointments should be made voluntarily from members of the Attending Staff.

The total faculty should not be less than 20 nor more than 30 members. Annually

the faculty will elect a chairman. The Director of Medical Education will be a permanent member and serve as Secretary. The faculty shall be responsible for the total teaching program in the hospital.

Suggested Break-Down of the Teaching Faculty:

Medicine - Director and four members	5
Surgery - Director and four members	5
OBS-GYN - Director and three members	4
General Practice - Director and two members	3
Pediatrics - Director and one member	2

Ex-Officio Members

Director of Medical Education	1
Administrator	1
Chairman of House Staff Committee	1
Chairman of Outpatient Department Committee	1
Pathologist	1
Clinical Pathologist	1
Radiologist	1
Total	26

APPENDIX 13

DRAFT OF PREPARED RESOLUTION CONCERNING PLANNING
OF THE MEDICAL CENTER COMPLEX

DRAFT OF PREPARED RESOLUTION CONCERNING
PLANNING OF MEDICAL CENTER COMPLEX

WHEREAS there is common agreement among health organizations, professional groups and physical planning bodies that Norfolk City now has a unique opportunity to plan a medical complex of health facilities and services for a metropolitan population of 100,000 who use Norfolk for their health and medical needs, and

WHEREAS there exist many potential land use applications in the Medical Center Complex, and

WHEREAS realistic planning requires local coordination, technical analysis and the exercise of sound economic judgment, and

WHEREAS the maximum yield in usefulness and attractiveness, from whatever resources are invested, is most likely to result from expert and coordinated planning.

BE IT HEREBY RESOLVED THAT: The Health-Welfare-Recreation Planning Council; the Norfolk County Medical Society; the Norfolk City Planning Commission; the Norfolk Redevelopment and Housing Authority; and the Virginia Tidewater Dental Association recommend that the Norfolk City Council appropriate the necessary funds for the cost of a specific study to formulate a comprehensive, overall plan for the Norfolk Medical Complex. It is noted that this can be initiated as a "crash program" with a completion date not later than October 1, 1963.

Approved by Exec. Council of the NS
2/19/62
J.H.L.

Mr. Robert A. Versprille, Executive Secretary
Norfolk County Medical Society

APPENDIX 14

STATE COUNCIL'S BASIC CONSIDERATIONS FOR THE
PROPOSAL OF A NEW MEDICAL SCHOOL

1. Sponsorship of a Medical School.--The American Medical Association and the Association of American Medical Colleges believe that "the establishment of new medical school programs should occur within the environment of universities or liberal arts colleges with strong graduate degree programs in the sciences and humanities."

While most modern medical schools are so affiliated with university-type institutions, there are exceptions. The Medical College of Virginia has existed for some time as a health center without many of the university-related functions and programs. A new medical school in New York is being proposed by Mt. Sinai Hospital and not by a university, although university affiliation is being sought.

Although the proposed new medical school in Norfolk has been proposed by a group of citizens, physicians and public officials, it is hoped that some affiliation may be developed with Old Dominion College. Indeed, if the above stated principle is carried out, that college is the most logical selection for affiliation. Old Dominion College was formerly the Norfolk College of William and Mary. It has been an independent accredited institution for a little more than two years. The college awarded its first degrees in 1956 and as of last year, it awarded three hundred or more degrees during the year. The current enrollment for Old Dominion College is about 5300 students evenly divided between full-time and part-time. At its present rate of growth, it is likely to have over 10,000 full-time and part-time students by 1975.

Up to this time Old Dominion College has not had any graduate programs. During the current year, graduate programs in business and education will be started. Since the College is basing its development on gradual growth in appropriate areas of strength, it is likely to be four to six years before any extensive graduate work in basic biological sciences can be developed in support of a medical school program. There are, however, other ways in which the College could support a medical education program and the future development of the College appears to be very good in terms of quantity and quality of students and program.

While it would be unusual for a State-supported college to be affiliated with a private medical school, it is not an altogether unique arrangement in American higher education. With proper safeguards incorporated into any basic affiliation agreement, it is possible for both institutions to benefit from the association. Careful negotiation and complete understanding would be necessary in the arrangement, to avoid committing State funds to the operation of the medical school.

SOURCE: Physicians for Virginia--Part II, A Report from the State Council of Higher Education to the Governor and the General Assembly of Virginia, December, 1963.

- 15 -

2. Community and Governmental Endorsement.--"It is important to the success of a new medical school that it have the enthusiastic support of all individuals, agencies and professional groups which can logically be expected to participate or have active interest in its development and the maintenance of the program."

Considerable enthusiastic support appears to be evident on the part of all individuals and groups concerned with the proposed medical school. The local medical society seems to have a realistic understanding of both the potential and the problems involved. Local hospital administrators and trustees have exhibited considerable support for the proposal.

The Norfolk City Council has given complete support to the proposal even to the point of appointing an Advisory Committee on the Establishment of a Medical School. The Norfolk Redevelopment and Housing Authority is most interested in the development of a medical school as an integral part of the total Health Center now under construction.

A number of civic groups, non-professional and professional organizations have endorsed the idea of a medical school. (Appendix C contains a list of such organizations.)

Although the actual development of a private medical school in the Hampton Roads area will require tangible evidences of support from local government and other groups and agencies, there is no reason to feel that such support would not be forthcoming.

3. Financial Requirements.--"Any serious initial consideration of the establishment of a new medical school, whether a two-year basic medical science program or a full four-year program, should incorporate a realistic appraisal of likely sources for the capital expenditures and operating funds at a level to provide and maintain facilities and faculties necessary for sound educational and research endeavors."

It is estimated that construction costs for a basic medical education building would be approximately \$8 million. The new Federal medical aid program could provide up to \$5,333,000 of this requirement with local sources responsible for \$2,667,000. Although later capital improvements would be necessary, it would be feasible to begin the operation of a medical school with this planned facility plus the use of the Norfolk General Hospital as a teaching hospital.

It is estimated that a new medical school, even with relatively small first-year classes, should have not less than \$1,500,000 for annual operating funds, exclusive of those funds which would come from patient

care, student fees, research grants and other such gift sources. This requirement would involve approximately \$35 million in capital endowment funds by the time the institution was in operation (1971). Appendix D shows the amounts required for capital construction.

4. Student Resources.--"There should be available an adequate pool of able students who have been well prepared for the study of medicine. There should be assurance that contemplated admission policies would be designed primarily to attract the most capable students without excessive concern for state of residence."

Although the number of Virginia students seeking medical education has not kept pace with college enrollments over the last ten years, there have been signs recently that more students are applying to medical schools in Virginia and the nation. As long as two years ago, the situation with regard to medical students in Virginia looked foreboding. Today the situation looks better:

- (1) The total student population in Virginia will increase from 65,000 in 1962 to approximately 115,000 by 1975. If there is a proportional increase in the number of qualified students seeking medical education, there should be an adequate number of Virginia students to enter three schools of medicine.
- (2) As an increasing number of well-qualified out-of-state students seek medical training in Virginia, some of these students would provide a pool of applicants for a new medical school.
- (3) If educational opportunities are increased substantially in Virginia over the next decade, there could well be a much larger increase in the number of college students and qualified medical students.
- (4) Student enrollments in the Hampton Roads area are growing at a more rapid rate than for the rest of Virginia. While there were more than 10,000 students in the area last year, this could grow to 25,000 by 1975.
- (5) Since medical education is costly, some local students might be able to attend medical school if they can live at home.
- (6) Increased interest in medical education throughout the nation will probably provide more financial assistance for those students who would like to study medicine but cannot afford it.

The net effect of some of the above factors should result in more qualified students seeking medical training in one of Virginia's existing medical schools or in the proposed new school in Hampton Roads.

5. Patient Resources.--"The contemplated school should have access under circumstances suitable for a teaching institution to an adequate number of patients. So as to provide a well-rounded clinical experience with both hospitalized and ambulant patients, the patient load should balance as to clinical entity, age distribution, sex, and socio-economic status."

Although it is the primary intention to develop Norfolk General Hospital as a teaching hospital for the new medical school, there are numerous other resources available. There are three community general hospitals in Norfolk and one community pediatric hospital. The municipally-owned hospital is a chronic disease and geriatrics hospital. Altogether, there are six private general hospitals in the Hampton Roads area each exceeding 200 beds and each with teaching programs in varying degrees of development. Appendix E provides a summary of hospital facilities in the area.

In addition to the civilian hospitals in the area, there are three major Federal hospitals: a U.S. Naval Hospital; a Veteran's Administration Hospital, and a U.S. Public Health Service Hospital. All of these facilities could be enhanced by a medical school in this area and these hospitals could, in turn, contribute to the operation of the school.

It is worth noting that 273 of the 468 approved residencies now operating in Virginia are in the two existing medical schools. If a medical school is established in Hampton Roads, there could be a sizeable increase in the number of residencies as part of the medical school operation. This, in turn, could attract more able physicians and retain them to practice in Virginia.

There is a potential wealth of clinical facilities and patients available in the Hampton Roads area for teaching materials in a new medical school. It will be necessary, however, to make satisfactory arrangements with the several hospitals for use of beds and facilities for teaching purposes.

Although there is a shortage of qualified faculty members in basic medical sciences throughout the country at present, it is possible to recruit able faculty members to work in a new and challenging situation, provided the necessary funds are available. As more teachers are prepared the shortage will be less critical in the future.

APPENDIX 15

STATE COUNCIL'S PROPOSED SCHEDULE FOR THE
DEVELOPMENT OF A NEW MEDICAL SCHOOL

Proposed Schedule for Development of a New Medical School

At present, it is proposed that a new four-year medical school begin its first year of operation in 1971 and graduate its first class in 1975. Before a class of 64 students can be admitted in 1971, it will be necessary to follow a general time schedule of development such as the following:

1. Develop sufficient capital endowment with or without other commitments to yield an annual income of \$1,500,000 by 1970.
2. Develop mutually satisfactory arrangements with the Norfolk General Hospital, King's Daughters Hospital, DePaul Hospital, and/or other suitable teaching hospitals to provide at least 500 general beds by 1971, committed to the teaching program of the medical school.
3. Agreement to provide at least \$2,667,000 (from local sources) for capital outlay and commitment for Federal participation to the balance of the \$8,000,000 required for a basic medical education building. Funds should be raised at an early date.
4. Acquiring suitable land adjacent to the proposed teaching hospital for development of medical school at an early date.
5. Develop mutually satisfactory contractual arrangements with the Board of Visitors of Old Dominion College and/or the State of Virginia relating to the development of suitable academic policies for the medical school.
5. Development and implementation of plans for a strengthened graduate program at Old Dominion College by 1968-69.
7. Development of satisfactory working liaison with representatives of the American Medical Association and the Association of American Medical Colleges to determine the satisfactory completion of various requirements to comply with criteria and policies for new medical schools.

The financial support required for successful construction and operation of a new institution is regarded as the most crucial issue in the proposal of a new medical school in Hampton Roads. If this problem can be solved, and it is believed that it can be solved, then most other problems should be amenable to appropriate solutions.

SOURCE: Physicians for Virginia--Part II, A Report from the State Council of Higher Education to the Governor and the General Assembly of Virginia, December 1963.

APPENDIX 16

STATE COUNCIL'S SUMMARY OF CONCLUSIONS ON THE
PROPOSAL FOR A NEW MEDICAL SCHOOL

A SUMMARY OF CONCLUSIONS

1. There is a growing demand for increased medical services in Virginia and throughout the United States, caused by population growth and change, increased use and changing patterns of medical service and new medical knowledge.
2. The ratio of physicians to population in Virginia is below that of the nation (by 18 per cent), although both ratios have been fairly stable over a period of years. Physician shortages in some areas, in some specialties and in a number of hospitals, together with population increases and increasing demands for medical services make it imperative that more physicians be graduated in Virginia in the years ahead.
3. Virginia cannot hope to meet the increasing demands for more physicians beyond 1975, even through the expansion of existing schools to optimum size. Therefore, it appears that there will be a need for a new four-year medical school.
4. Since the State, through General Tax Funds, must provide increasingly adequate support for current and expanded programs in the existing medical schools, it is unlikely that there will be sufficient tax funds available for the construction and operation for a third school of medicine.
5. Since Virginia already provides tax support for two public medical schools (out of 42 such institutions in the total of 87 medical schools in the U.S.), it is appropriate that the proposed medical school in Hampton Roads be constructed and operated with private funds (with Federal assistance in construction).
6. The Hampton Roads area now has approximately one-fourth of the total population of the state. With over 1 million people in the area, it could provide valuable support for a medical school in terms of patients, students and faculty.
7. Since it generally takes ten years from initial planning until a medical school can graduate students, the proposed schedule for the development of such an institution in Hampton Roads is feasible.
8. The development of a private school of medicine could be the focal point of a third major health center in Virginia, attracting physicians to the state, providing more educational opportunities for Virginia students and elevating standards of health care throughout the state.

SOURCE: Physicians for Virginia - Part ^{iv} II, A Report from the State Council of Higher Education to the Governor and the General Assembly of Virginia, December 1963.

APPENDIX 17

THE NORFOLK MEDICAL CENTER COMMISSION

LIST OF THE MEMBERS OF THE NORFOLK MEDICAL
CENTER COMMISSION, 1963

Toy D. Savage, Jr. Chairman

Clifford Adams

Mason C. Andrews, M.D.

Barron Black

Roy Charles

Lawrence Cox

Pretlow Darden

Paul Decker

H. William Fink, M.D.

John Franklin, M.D.

John M. Huff, M.D.

Capt. Fred C. Ray

John L. Roper, II

Philip A. Stedfast

John Thiemeyer, M.D.

R. F. Welton, III

George F. Rice Secretary

SOURCE: Letter from George F. Rice, Secretary of the
Norfolk Medical Center Commission, to Alter
Laibstain, M.D., 24 January 1964, Personal
Files of John S. Thiemeyer, M.D.

APPENDIX 18

THE SEVEN PRINCIPLE POINTS CONSTITUTING BASIC
PROGRAM OBJECTIVES OF THE MEDICAL AUTHORITY
RECOMMENDED BY RICHARDSON K. NOBACK, M.D.

SEVEN PRINCIPLE POINTS CONSTITUTING BASIC PROGRAM OBJECTIVES OF THE AUTHORITY

recommended by
Richardson K. Noback, M.D.
Medical Consultant

- 1) The Medical Center Authority will direct its attention and activity to developing educational programs in the health and life sciences in cooperation with those organizations now carrying them out on the Medical Center site. In this regard, the Medical Center Authority expresses a specific intent to establish a College of Medicine which can accept its entering class by 1971.
- 2) Since research is of vital importance to provide new knowledge, stimulate the environment of learning, and improve the excellence of patient care which is a first requirement of a medical unit, the Medical Center Authority will direct its attention to continued development of research. Further, the Medical Center Authority will implement research programs at the earliest practical date.
- 3) The Medical Center Authority will proceed with consideration of the appointment of full time clinical professors whose major responsibilities will include fostering the clinical programs, fostering the development of research activities, and fostering the development of such educational programs as may be deemed appropriate and desirable before the Medical College enrolls its first class.
- 4) The Medical Center Authority will assume the responsibility for further staff development and will employ full time faculty members and define the scope of their responsibilities.
- 5) The Medical Center Authority recognizes the need to have available competent assistance in the further development of its plans and will appoint a Consulting Architect and a Medical Consultant to advise it and work with other individuals, groups, and organizations interested in fostering the development of the Medical Center.
- 6) In order to extend its ability to become familiar with pertinent topics and work with interested organizations, groups, and individuals, the Medical Center Authority will use advisory committees and groups to help identify areas of interest, program elements of mutual advantage, and possible interrelationships. In general, these advisory committees will be asked to explore and define the following major topics: objectives, program policies, major procedures, the potential mutual advantages of affiliations between existing Medical Center activities and those of the activity under consideration, the possible relationships between the activity and those already established, and the present and possible resources available to support the activity.
- 7) The Authority will withhold any decision upon new program elements or major realignments within existing program elements until there has been an opportunity to consider the recommendations of its chief administrative officer (when one is available) and its Consulting Architect and Medical Consultant.

Personal Files of Dr. John S. Theinayer, Jr.

APPENDIX 19

LIST OF ATTENDEES AT THE 15 JANUARY 1964 MEETING
OF THE NORFOLK MEDICAL CENTER COMMISSION

M E D I C A L C E N T E R C O M M I S S I O N

January 15, 1964

PRESENT

Toy D. Savage, Jr., Chairman
 Clifford Adams
 Mason C. Andrews, M. D.
 Roy Charles
 Pretlow Darden
 Paul Decker
 H. William Fink, M. D.
 John Franklin, M. D.

Capt. Fred C. Ray
 John L. Roper, II
 Phillip A. Stedfast
 John Thiemeyer, M. D.
 R. F. Welton, III
 George F. Rice
 Robert A. Versprille
 Guest: Sam McGann, Ass't Norfolk City Attorney

MINUTES: The minutes of the December 12, 1963 meeting were approved as submitted by mail.

ARCHITECTURAL COMMITTEE REPORT: Dr. Andrews summarized the January 10, 1964 conference with Warren Phelan, Regional Director, Housing and Home Finance Agency, Philadelphia, Pennsylvania noting:

- A master plan for the Medical Center might qualify as a public works project; but a final decision in this matter was deferred until a meeting could be held with Sidney Woolner, Federal Director.
- Funds were available for the continuing of resident facilities for medical or para-medical personnel as well as homes for the aging.
- A recently inaugurated academic facilities program might provide financing for the construction of medical and para-medical teaching facilities.

On the basis of information to date, and the present necessity to develop a master plan for the Medical Center, the Architectural Committee recommended that local funds be used to defray the initial cost in the development of such a plan. A contract proposal (copy attached) was read to the Commission from the architectural firm of Vincent G. Kling. After a discussion, it was moved by Mr. Welton that the Commission and Architectural Committee, respectively, be authorized to sign such contract with the firm of Vincent G. Kling providing funds were on hand to cover the costs as follows:

Phase #1	\$2500
Phase #2	2500
Phase #3	2500
Consultation fee	2500
Total	<u>\$10,000</u>

The motion was seconded by Dr. John Franklin and carried.

APPENDIX 20

CHAPTER 471, CODE OF VIRGINIA, 1964

CHAPTER 471

An Act to create the Norfolk Area Medical Center Authority; provide for appointment and terms of office of members of the Authority and for election of certain officers; to prescribe the powers and duties of the Authority including the power to borrow money and issue bonds; and to authorize certain cities to exercise certain powers in cooperation with the Authority.

[H 444]

Approved March 31, 1964

Be it enacted by the General Assembly of Virginia:

1. § 1. There is hereby created a public body politic and corporate to be known as the "Norfolk Area Medical Center Authority" hereinafter referred to as "The Authority", with such public and corporate powers as are hereinafter set forth. The Authority may sue and be sued, plead and be impleaded, and shall have the power and authority to contract and be contracted with and to exercise and discharge all the powers and duties imposed and conferred upon it, as hereinafter provided.

§ 2. The Authority shall be composed of seven members, two of whom shall be licensed members of the medical profession, who shall be appointed by the city council; three of the members first appointed shall be appointed for terms of three years, two for terms of two years, and two for terms of one year. Thereafter the terms of the members shall be three years. Any such member appointed for a three year term may be reappointed for one additional three year term. Thereafter, no member shall be reappointed until at least one year after the expiration of his second full three-year term. Members shall receive no salaries but shall be entitled to reimbursement for necessary traveling and other expenses incurred while engaged in the performance of their duties. Each member shall continue to hold office until his successor has been appointed and qualified. The council shall have the right to remove any member or officer, for malfeasance or misfeasance, incompetency or gross neglect of duty. Vacancies shall be filled by appointment of the council for unexpired terms. Members shall take an appropriate oath of office and same shall be filed with the city clerk. Members shall elect on an annual basis one of their number as chairman and another as vice-chairman and shall also elect a secretary and treasurer for terms to be determined by them, who may or may not be one of the members. The same person may serve as both secretary and treasurer. The members shall make such rules, regulations and by-laws for their own government and procedure as they shall determine; they shall meet regularly at least once a month and may hold such special meetings as they deem necessary.

§ 3. The Authority shall be deemed to be a public instrumentality, exercising public and essential governmental functions to provide for the public health and welfare, and is hereby authorized to exercise the powers conferred by the following sections.

§ 4. The Authority may identify, document and evaluate needs, problems and resources relating to health and medical care; to plan, develop and implement programs to meet such needs on both an immediate and long range basis.

§ 5. The Authority may plan, design, construct, remove, enlarge, equip, maintain and operate medical educational institutions, medical and paramedical facilities, together with related and supporting facilities and to do all things necessary and convenient to carry out any of its purposes.

§ 6. The Authority may acquire property, real or personal, by purchase, gift, devise or by the exercise of the power of eminent domain, on such terms and conditions, and in such manner as it may deem proper, and such rights, easements or estates therein as may be necessary for its purposes, and sell, lease and dispose of the same, or any portion thereof or interest therein whenever it shall become expedient to do so. The exercise of the right of eminent domain shall be in accordance with chapter 1.1 of Title 25 of the Code of Virginia. The power shall be exercised only within the corporate limits of the city of Norfolk. No property of any corporation itself having the power of eminent domain may be condemned hereunder.

§ 7. The Authority may fix and revise from time to time and charge and collect rates, rentals, fees and other charges for the services and facilities furnished by the Authority, and establish and revise from time to time regulations, in respect to the use, occupancy or operation of any such facility or part thereof, or service rendered.

§ 8. The Authority may accept loans, grants, or assistance from the federal government, the State, any municipality thereof, or from any other sources, public or private, to carry out any of its purposes and may enter into any agreement or contract regarding or relating to the acceptance or use or repayment of any such loan, grant or assistance.

§ 9. The Authority may borrow money and issue bonds as hereinafter provided.

§ 10. In addition to the powers granted by general law or by its charter, any city located in the general section of the State to be served by the Authority is empowered to cooperate with the Authority as follows:

(a) To make such appropriations and provide such funds for the operation and carrying out the purposes of the Authority as the council may deem proper, either by outright donation or by loan, or the council may agree with such Authority to take such action.

(b) To dedicate, sell, convey or lease any of its interest in property, or grant easements, licenses or any other privileges therein to any such Authority.

(c) To cause parks, playgrounds, recreational, community, educational, water, sewer or drainage facilities, or any other works which it is otherwise empowered to undertake, to be furnished adjacent to or in connection with property of or any facility of such Authority.

(d) To furnish, dedicate, close, pave, install, grade or regrade, plan or replan streets, roads, roadways, alleys, sidewalks or other places which it is otherwise empowered to undertake.

(e) Plan or replan, zone or rezone any part of such city in connection with the use of any property of such Authority or any property adjacent to the property of such Authority or any of its facilities which it is otherwise empowered to undertake, in accordance with general laws.

(f) To cause services to be furnished to the Authority of the character which such city is empowered to furnish.

(g) To purchase any of the bonds of such Authority or legally invest in such bonds any funds belonging to or within the control of such city and exercise all the rights of any holder of such bonds.

(h) To do any and all things necessary or convenient to aid or cooperate in the planning, undertaking, construction or operation of any of the plans, projects or facilities of such Authority.

(i) To enter into agreements with such Authority respecting action to be taken by such city pursuant to any of the above powers.

§ 11. The Authority is hereby authorized to issue bonds from time to time in its discretion for the purpose of paying all or any part of the cost of acquiring, purchasing, constructing, reconstructing, improving or extending any project and acquiring necessary land and equipment therefor. The Authority may issue such types of bonds as it may determine, including (without limiting the generality of the foregoing) bonds payable as to principal and interest: (a) from its revenues generally; (b) exclusively from the income and revenues of a particular project; or (c) exclusively from the income and revenues of certain designated projects, whether or not they are financed in whole or in part from the proceeds of such bonds.

Any such bonds may be additionally secured by a pledge of any grant or contribution from a participating political subdivision, the Commonwealth or any political subdivision, agency or instrumentality thereof, any federal agency or any unit, private corporation, copartnership, association, or individual, or a pledge of any income or revenues of the Authority, or a mortgage of any project or other property of the Authority.

Neither the members of the Authority nor any person executing the bonds shall be liable personally on the bonds by reason of the issuance thereof. The bonds and other obligations of the Authority (and such bonds and obligations shall so state on their face) shall not be a debt of the Commonwealth or any political subdivision thereof and neither the Commonwealth nor any political subdivision thereof other than the

Authority shall be liable thereon, nor shall such bonds or obligations be payable out of any funds or properties other than those of the Authority. The bonds shall not constitute an indebtedness within the meaning of any debt limitation or restriction. Bonds of the Authority are declared to be issued for an essential public and governmental purpose.

§ 12. Bonds of the Authority shall be authorized by resolution and may be issued in one or more series, shall be dated, shall mature at such time or times not exceeding forty years from their date or dates and shall bear interest at such rate or rates not exceeding six per centum (6%) per annum, as may be determined by the Authority, and may be made redeemable before maturity, at the option of the Authority at such price or prices and under such terms and conditions as may be fixed by the Authority prior to the issuance of the bonds. The Authority shall determine the form of the bonds, including any interest coupons to be attached thereto, and the manner of execution of the bonds, and shall fix the denomination or denominations of the bonds and the place or places of payment of principal and interest, which may be at any bank or trust company within or without the Commonwealth. In case any officer whose signature or a facsimile of whose signature shall appear on any bonds or coupons shall cease to be such officer before delivery of such bond, such signature or such facsimile shall nevertheless be valid and sufficient for all purposes the same as if he had remained in office until such delivery. Notwithstanding any of the other provisions of this act or any recitals in any bonds issued under the provisions of this act, all such bonds shall be deemed to be negotiable instruments under the laws of the Commonwealth. The bonds may be issued in coupon or registered form or both, as the Authority may determine, and provision may be made for the registration of any coupon bonds as to principal alone and also as to both principal and interest, and for the reconversion into coupon bonds of any bonds registered as to both principal and interest. The Authority may sell such bonds in such manner, either at public or private sale, and for such price, as it may determine to be for the best interests of the Authority, but no such sale shall be made at a price so low as to require the payment of interest on the money received therefor more than six per centum (6%), computed with relation to the absolute maturity or maturities of the bonds in accordance with standard tables of bond values, excluding, however, from such computation the amount of any premium to be paid on redemption of any bonds prior to maturity.

Prior to the preparation of definitive bonds the Authority may, under like restrictions, issue interim receipts or temporary bonds, with or without coupons, exchangeable for definitive bonds when such bonds shall have been executed and are available for delivery. The Authority may also provide for the replacement of any bonds which shall become mutilated or shall be destroyed or lost.

Bonds may be issued under the provisions of this act without obtaining the consent of any commission, board, bureau or agency of the Commonwealth or of any political subdivision, and without any other proceedings or the happening of other conditions or things than those proceedings, conditions or things which are specifically required by this act.

§ 13. In the discretion of the Authority any bonds issued under the provisions of this act may be secured by a trust indenture by way of conveyance, deed of trust or mortgage of any project or any other property of the Authority, whether or not financed in whole or in part from the proceeds of such bonds, or by a trust agreement by and between the Authority and a corporate trustee, which may be any trust company or bank having the powers of a trust company within or without the Commonwealth or by both such conveyance, deed of trust or mortgage and indenture or trust agreement. Such trust indenture or

agreement, or the resolution providing for the issuance of such bonds may pledge or assign fees, rents and other charges to be received. Such trust indenture or agreement, or resolution providing for the issuance of such bonds, may contain such provisions for protecting and enforcing the rights and remedies of the bondholders as may be reasonable and proper and not in violation of law, including covenants setting forth the duties of the Authority in relation to the acquisition of property and the construction, improvement, maintenance, repair, operation and issuance of any project or other property of the Authority, and the rates of fees, rents and other charges to be charged, and the custody, safeguarding and application of all moneys of the Authority, and conditions or limitations with respect to the issuance of additional bonds. It shall be lawful for any bank or trust company incorporated under the laws of the Commonwealth which may act as depository of the proceeds of such bonds or of other revenues of the Authority to furnish indemnifying bonds or to pledge such securities as may be required by the Authority. Such trust indenture may set forth the rights and remedies of the bondholders and of the trustee, and may restrict the individual right of action by bondholders.

In addition to the foregoing, such trust indenture or agreement or resolution may contain such other provisions as the Authority may deem reasonable and proper for the security of the bondholders. All expenses incurred in carrying out the provisions of such trust indenture or agreement or resolution may be treated as a part of the cost of a project.

§ 14. The Authority is hereby authorized to fix, revise, charge and collect fees, rents and other charges for the use of any project and the facilities thereof. Such fees, rents and other charges shall be so fixed and adjusted, as to provide a fund sufficient with other revenues to pay: first, the cost of maintaining, repairing and operating the project, and second, the principal of any interest on such bonds as the same shall become due and payable and third, to create reserves for such purposes and for other purposes of the Authority. Such fees, rents and charges shall not be subject to supervision or regulation by any commission, board, bureau or agency of the Commonwealth or any such participating political subdivision. The fees, rents and other charges received by the Authority, except such part thereof as may be necessary to pay the cost of maintenance, repair and operation and to provide such reserves therefor as may be provided for in the resolution authorizing the issuance of such bonds or in the trust indenture or agreement securing the same, shall be set aside at such regular intervals as may be provided in such resolution or trust indenture or agreement in a sinking fund which is hereby pledged to, and charged with, the payment of and the interest on such bonds as the same shall become due, and the redemption price of the purchase price of such bonds retired by call or purchase as therein provided. Such pledge shall be valid and binding from the time when the pledge is made. The fees, rents and charges so pledged and thereafter received by the Authority shall immediately be subject to the lien of such pledge without any physical delivery thereof or further act, and the lien of any such pledge shall be valid and binding as against all parties having claims of any kind in tort, contract or otherwise against the Authority, irrespective of whether such parties have notice thereof. Neither the resolution nor any trust indenture by which a pledge is created need be filed or recorded except in the records of the Authority. The use and disposition of moneys to credit of such sinking fund shall be subject to the provisions of the resolution authorizing the issuance of such bonds or of such trust indenture or agreement. Except as may otherwise be provided in such resolution or such trust indenture or agreement, such sinking fund shall be a fund for all such bonds without distinction or priority of one over another.

§ 15. All moneys received pursuant to the authority of this act, whether as proceeds from the sale of bonds or as revenues, shall be deemed to be trust funds to be held and applied solely as provided in this act.

§ 16. Any holder of bonds, notes, certificates or other evidence of borrowing issued under the provisions of this act or of any of the coupons appertaining thereto, and the trustee under any trust indenture or agreement, except to the extent of the rights herein given may be restricted by such trust indenture or agreement, may, either at law or in equity, by writ, action, injunction, mandamus or other proceedings, protect and enforce any and all rights under the laws of the Commonwealth or granted by this act or under such trust indenture or agreement or the resolution authorizing the issuance of such bonds, notes or certificates, and may enforce and compel the performance of all duties required by this act or by such trust indenture or agreement or resolution to be performed by the Authority or by any officer or agent thereof, including the fixing, charging and collection of fees, rents and other charges.

§ 17. The exercise of the powers granted by this act shall be in all respects for the benefit of the inhabitants of the Commonwealth, for the promotion of their safety, health, welfare, convenience and prosperity, and as the operation and maintenance of any project which the Authority is authorized to undertake will constitute the performance of an essential governmental function, no authority shall be required to pay any taxes or assessments upon any project acquired and constructed by it under the provisions of this act; and the bonds, notes, certificates or other evidences of debt issued under the provisions of this act, their transfer and the income therefrom including any profit made on the sale thereof, shall at all times be free and exempt from taxation by the Commonwealth and by any political subdivision thereof.

§ 18. Bonds issued by the Authority under the provisions of this act are hereby made securities in which all public officers and public bodies of the Commonwealth and its political subdivisions, all insurance companies, trust companies, banking associations, investment companies, executors, administrators, trustees and other fiduciaries may properly and legally invest funds, including capital in their control or belonging to them. Such bonds are hereby made securities which may properly and legally be deposited with and received by any State or municipal officer or any agency or political subdivision of the Commonwealth for any purpose for which the deposit of bonds or obligation is now or may hereafter be authorized by law.

§ 19. This act shall constitute full and complete authority, without regard to the provisions of any other law, for the doing of the acts and things herein authorized, and shall be liberally construed to effect the purposes hereof. The provisions of this act are severable, and if any of its provisions shall be held unconstitutional by any court of competent jurisdiction, the decision of such court shall not affect or impair any of the other provisions of this act.

2. An emergency exists and this act is in force from its passage.

APPENDIX 21

CHAPTER 440, CODE OF VIRGINIA, 1964

CHAPTER 440

An Act to amend and reenact §§ 23-14 and 23-31, as amended, of the Code of Virginia, relating to educational institutions and scholarships thereat and declaring certain educational institutions to be governmental instrumentalities.

[H 347]

Approved March 31, 1964

Be it enacted by the General Assembly of Virginia:

1. That §§ 23-14 and 23-31, as amended, of the Code of Virginia be amended and reenacted as follows:

§ 23-14. The College of William and Mary in Virginia, at Williamsburg; the Medical College of Virginia, at Richmond; the board of visitors of the Virginia State School, at Newport News; * *Longwood College*, at Farmville; the Mary Washington College of the University of Virginia, at Fredericksburg; the Madison College, at Harrisonburg; * *Old Dominion College*, at Norfolk; the Richmond Professional Institute, at Richmond; the Radford College, * at Radford; the rector and visitors of the University of Virginia, at Charlottesville; the Virginia Military Institute, at Lexington; the Virginia Polytechnic Institute, at Blacksburg; the Virginia School for the Blind, at Charlottesville; the Virginia School for the Deaf and Blind, at Staunton; the Virginia State College, at Petersburg; and the Woodrow Wilson Rehabilitation Center, at Fishersville, *and the Norfolk Arca Medical Center Authority, in Norfolk*, are hereby classified as educational institutions and are declared to be public bodies and constituted as governmental instrumentalities for the dissemination of education. The powers of every such institution derived directly or indirectly from this chapter shall be vested in and exercised by a majority of the members of its board, and a majority of such board shall be a quorum for the transaction of any business authorized by this chapter. *Wherever the word "institution" is used in this chapter it shall be deemed to include "authority" and the word "board" shall be deemed to include the members of the Authority.*

§ 23-31. (a) The corporate authorities of the University of Virginia; the Virginia Military Institute; the Virginia Polytechnic Institute; the College of William and Mary in Virginia; the Medical College of Virginia; the * *Longwood College* at Farmville; the Mary Washington College of the University of Virginia, at Fredericksburg; the Madison College at Harrisonburg; *the Richmond Professional Institute*; the Radford College, * at Radford, *Old Dominion College, at Norfolk*, and the Virginia State College, may establish scholarships, hereafter to be designated as unfunded scholarships, in their respective institutions under such regulations and conditions as they may prescribe, but subject to the following limitations and restrictions:

(1) All such scholarships shall be applied exclusively to the remission, in whole or in part, of instructional charges, which charges and fees except for laboratory fees shall be included in a single item designated as tuition.

(2) The number of such scholarships awarded in any one institution for any year to Virginia students therein shall not be in excess of twenty per centum of the enrollment of Virginia students in undergraduate studies in such institution for the preceding year or in lieu thereof the total value of all scholarships awarded in any one institution for any year to Virginia students shall not be in excess of any amount arrived at by multiplying * three hundred dollars by twenty per centum of the enrollment of Virginia students in undergraduate studies in such institution for the preceding year; the number of scholarships awarded in any one institution for any year to non-Virginia students in such institution shall not be in excess of twenty per centum of the enrollment of non-Virginia stu-

dents in undergraduate studies in such institution for the preceding year, and the total value of all scholarships so awarded to such non-Virginia students shall not exceed in any year the amount paid during such year by non-Virginia students in undergraduate studies for instructional services in excess of the actual cost of instruction of such non-Virginia students.

(3) Such scholarships shall be awarded only to undergraduate students in the first four years of undergraduate work, and shall not be renewed for any subsequent year after the first unless the holder thereof maintains a high scholastic standard.

(4) Such scholarships shall be awarded by the governing boards of the respective institutions on a selective basis to students of character and ability who are in need of financial assistance.

(5) Each scholarship awarded shall entitle the holder thereof to the remission of not less than one-half of the annual tuition charge to non-scholarship holders at such institution, provided that no such remission shall exceed in value the sum of * three hundred dollars.

(b) No educational institution named herein shall award any scholarship, or remit any special fees or charges, to any student at such institution except as authorized in this section. *Each educational institution named herein shall make an annual report to the State Council of Higher Education showing the number and amount of scholarships awarded under this section.*

(c) Nothing in this section shall be construed to prevent or limit in any way the admission of certain students, known as State cadets, at the Virginia Military Institute or to affect the remission of fees or charges to such State cadets as permitted under existing law.

(d) Nothing in this section shall be construed to affect or limit in any way the control of the governing bodies of the respective institutions over any scholarships provided or established under the provisions of §§ 23-33 to 23-35; or over any gifts or donations made to such institutions for scholarships or other special purposes; or over any funds provided by the federal government or otherwise for the purpose of vocational education or vocational rehabilitation in this State; or over any funds derived from endowment or appropriations from the federal government for instruction in agriculture and mechanic arts in land grant colleges.

(e) Nothing in this section shall be construed to prevent the governing bodies of the respective institutions from fixing a reasonably lower tuition charge for Virginia students than for non-Virginia students.

APPENDIX 22

MEMBERSHIP OF THE NORFOLK AREA MEDICAL CENTER
AUTHORITY'S MEDICAL ADVISORY COMMITTEE,
JUNE 1964

MEDICAL ADVISORY COMMITTEE

R.L. Payne, Jr., M.D., Chairman

Daniel N. Anderson, M.D.	Howard I. Kruger, M.D.
George H. Carr, Jr., M.D.	Alter Laibstain, M.D.
Patrick C. Devine, M.D.	Joseph D. Lea, M.D.
W.A. Dickinson, M.D.	Alexander Martone, D.D.S.
Donald Drew, M.D.	William F. Murphy, M.D.
Robert J. Faulconer, M.D.	James E. Newby, Jr., M.D.
H. William Fink, M.D.	W. Wickham Taylor, M.D.
Clarborne W. Fitchett, M.D.	John S. Thiemeyer, M.D.
Charles E. Horton, M.D.	John A. Vann, M.D.
Jack C. Kanter, D.D.S.	Frederick Woodson, M.D.
Arthur A. Kirk, M.D.	

SOURCE: Norfolk Area Medical Center Authority, Minutes of the Regular Board Meeting, 17 June 1964 and 16 July 1964.

APPENDIX 23

BY-LAWS OF THE NORFOLK AREA MEDICAL
CENTER COMMISSION

EDWARD L. BREEDEN, JR.
 JAMES A. HOWARD
 ROBERT R. MACMILLAN
 BERRYMAN GREEN, III
 JAMES H. FLIPPEN, JR.

WILLIAM E. BAGGS
 EDWARD L. BREEDEN, III
 JULLAN W. WALKER, JR.
 E. LESLIE COX

LAW OFFICES

BREEDEN, HOWARD & MACMILLAN

612 VIRGINIA NATIONAL BANK BUILDING

NORFOLK 10, VIRGINIA

TELEPHONE
627-6225

June 12, 1964

Mr. Lawrence M. Cox
 Executive Director
 Norfolk Redevelopment & Housing Authority
 1306 Virginia National Bank Building
 Norfolk, Virginia

Mr. Roy R. Charles
 Leigh Memorial Hospital
 358 Howbray Arch
 Norfolk, Virginia

Dr. John Franklin
 400 Gresham Drive
 Norfolk, Virginia

Mr. Walter A. Page
 Judge, Court of Law & Chancery
 Court House Square
 Norfolk, Virginia

Mr. George F. Rice
 400-A Royster Building
 Norfolk, Virginia

Mr. R. E. Richardson, Jr.
 Hall-Hodges Co., Inc.
 1344 Ballentine Boulevard
 Norfolk, Virginia

Dr. Mason C. Andrews
 400 Gresham Drive
 Norfolk, Virginia

Mr. Toy D. Savage
 Attorney at Law
 Virginia National Bank Bldg.
 Norfolk, Virginia

Gentlemen:

Attached please find rough draft of suggested By-Laws to be used by the Authority. These are relatively simple and to the point and should serve as a beginning to guide the relationship of the members to one another.

Yours very truly,



Robert R. MacMillan

RRM/bjr
 Enclosure

BY-LAWS OF THE
NORFOLK AREA MEDICAL CENTER AUTHORITY

Adopted June , 1964

ARTICLE I

Name of the Authority

The name of the Authority shall be "Norfolk Area Medical Center Authority" as provided by Chapter 471, Acts of Virginia, 1964.

ARTICLE II

Seal of the Authority

The Authority shall have a seal in the form of a circle, which shall contain the name "Norfolk Area Medical Center Authority * 1964", a facsimile of which seal is impressed in the margin hereof opposite this Article.

ARTICLE III

Office of the Authority

The office of the Authority shall be in the City of Norfolk, State of Virginia, and the Authority may hold its meetings at such place or places in the City of Norfolk as may, from time to time, be designated by resolution, or at such other convenient place as may be specified in the notice or call of the particular meeting.

ARTICLE IV

Officers

Section 1. The officers of the Authority shall be a Chairman,

a Vice-Chairman, a Secretary, and a Treasurer; provided, however, the office of Secretary and Treasurer may be combined in the same person and such Secretary-Treasurer may or may not be a member of the Authority.

Section 2. Chairman and Vice-Chairman. The Chairman and Vice-Chairman shall be a member of the Authority and shall be elected for a term of one (1) year, beginning on the 1st day of July following his election and shall serve until his successor has been duly elected and qualified. The Chairman shall be the chief executive officer of the Authority, shall preside at all meetings of the Authority and sign all contracts, deeds and bonds and other instruments and obligations of the Authority. He shall make reports and recommendations concerning the business affairs and policies of the Authority.

The Vice-Chairman shall perform the duties of the Chairman in the absence or incapacity of the Chairman or when authorized by resolution of the Authority and, in case of resignation or death of the Chairman, the Vice-Chairman shall perform such duties as are imposed upon the Chairman until such time as the Authority shall elect a new Chairman.

Section 3. Secretary-Treasurer. The Secretary and Treasurer shall be elected by the Authority for such term or terms of office as the Authority may determine and such Secretary-Treasurer may be a member of the Authority or some other person, as the Authority may determine. The Secretary-Treasurer shall keep the records of

the Authority, shall act as Secretary of the meetings of the Authority, and record all votes, and shall keep a record of the proceedings of the Authority in a journal to be kept for that purpose. He shall keep the seal of the Authority and shall attest all documents of the Authority. He shall have the care and custody of all funds and securities of the Authority and shall deposit such funds in the name of the Authority in such bank or banks as the Authority may select. He shall, unless otherwise provided by resolution of the Authority, sign all orders and checks for the payment of monies of the Authority, and shall disperse such money under the direction of the Authority. Whenever required by the Authority, he shall render a statement of his accounts and shall at all reasonable times exhibit his books and accounts to any member of the Authority during business hours. He shall give such bond for the faithful performance of his duties as the Authority may determine.

Section 4. The officers of the Authority shall perform such other duties and functions as may from time to time be required by the Authority.

Section 5. Employment of personnel. The Authority may from time to time employ such personnel as it deems necessary to exercise and perform its powers, duties and functions, including a Director, and shall prescribe their duties and fix their compensation. The power to employ personnel may be delegated by the Authority to one of its officers or to its Executive Director.

ARTICLE V

Meetings

Section 1. Regular Meetings. Regular meetings of the Authority shall be held without notice on the third Monday of each month, and in the event that such day shall fall upon a legal holiday, such meeting shall be held on the next succeeding day which is not a legal holiday. When circumstances require, the regular meeting day may be changed by the Chairman or Vice-Chairman on giving two (2) days notice to each member of the Authority of such change.

Section 2. Special Meetings. Special meetings of the Authority shall be held whenever called by the Chairman or Vice-Chairman or by any three (3) members of the Authority. The Secretary shall give notice of all special meetings by causing a copy thereof to be delivered to each member or to be mailed to the business or home address of each member of the Authority at least two (2) days before the meeting. Such notice, however, may be waived by any member in writing before or after such meeting and the presence at any special meeting of a member shall constitute a waiver of notice by him. At a special meeting, no business shall be considered other than matters designated in the call, but if all members of the Authority are present at a special meeting, any and all business may be transacted at such special meeting.

ARTICLE VI

Quorum

At all meetings of the Authority four (4) members shall consti-

tute a quorum for the purpose of transacting business but any number less than a quorum at a meeting may adjourn the meeting from time to time until a quorum be present. When a quorum is present, action may be taken by the Authority upon a vote of the majority of the members present.

ARTICLE VII

Order of Business

At the regular meetings of the Authority the following shall be the order of business:

1. Roll call
2. Reading and approval of minutes of previous meeting
3. Bills and communications
4. Reports of officers
5. Reports of committees
6. Unfinished business
7. New business
8. Adjournment

All resolutions shall be in writing and shall be copied in the journal of the proceedings of the Authority.

ARTICLE VIII

Manner of Voting

The voting on all questions coming before the Authority shall be by roll call and the ayes and nays shall be entered in the minutes of each meeting unless the vote of the members present is unanimous, in which case the minutes shall so indicate.

ARTICLE IX

Amendments

The By-Laws of the Authority shall be subject to amendment or

repeal upon the vote of not less than five (5) members of the Authority at any regular or special meeting called, provided such call gives notice of the proposed amendment to be acted upon at such regular or special meeting.

APPENDIX 24

HOUSE RESOLUTION 3140

89TH CONGRESS
1ST SESSION

H. R. 3140

IN THE HOUSE OF REPRESENTATIVES

JANUARY 19, 1965

Mr. HARRIS introduced the following bill; which was referred to the Committee on Interstate and Foreign Commerce

A BILL

To amend the Public Health Service Act to assist in combating heart disease, cancer, stroke, and other major diseases.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*
3 That this Act may be cited as the "Heart Disease, Cancer,
4 and Stroke Amendments of 1965".

5 SEC. 2. The Public Health Service Act (42 U.S.C., ch.
6 6A) is amended by adding at the end thereof the following
7 new title:

I

1 "TITLE IX—REGIONAL MEDICAL COMPLEXES
2 FOR RESEARCH AND TREATMENT IN HEART
3 DISEASE, CANCER, STROKE, AND OTHER
4 MAJOR DISEASES

5 "PURPOSES"

6 "SEC. 900. The purposes of this title are—

7 "(a) Through grants, to encourage and assist in the
8 establishment of regionally coordinated arrangements among
9 medical schools, research institutions, and hospitals for re-
10 search and training and for demonstrations of patient care
11 in the fields of heart disease, cancer, stroke, and other major
12 diseases:

13 "(b) To afford to the medical profession and the medi-
14 cal institutions of the Nation, through such coordinated
15 arrangements, the opportunity of making available to their
16 patients the latest advances in the diagnosis and treatment
17 of these diseases; and

18 "(c) To accomplish these ends without interfering with
19 the patterns, or the methods of financing, of patient care or
20 professional practice, or with the administration of hospitals.

21 "AUTHORIZATION OF APPROPRIATIONS

22 "SEC. 901. (a) There are authorized to be appropriated
23 \$50,000,000 for the fiscal year ending June 30, 1966, and
24 such sums as may be necessary for each of the next four
25 fiscal years, for grants to assist public or nonprofit private

3

1 universities, medical schools, research institutions, and other
2 public or nonprofit private institutions and agencies in
3 planning, establishing, and operating regional medical com-
4 plexes for research, training, and demonstration activities
5 for carrying out the purposes of this title. Sums appro-
6 priated under this section for any fiscal year shall remain
7 available for making such grants until the end of the fiscal
8 year following the fiscal year for which the appropriation
9 is made.

10 “(b) A grant under this title shall be for part or all
11 of the cost of the planning or other activities with respect
12 to which the application is made, except that any such
13 grant with respect to construction of, or provision of built-in
14 (as determined in accordance with regulations) equipment
15 for, any facility may not exceed 90 per centum of the cost
16 of such construction or equipment.

17 “(c) Funds appropriated pursuant to this title shall
18 not be available to pay the cost of hospital, medical, or
19 other care of patients except to the extent it is, as determined
20 in accordance with regulations, incident to research, train-
21 ing, or demonstration activities.

22 “DEFINITIONS

23 “SEC. 902. For the purposes of this title—

24 “(a) The term ‘regional medical complex’ means a
25 group of public or nonprofit private institutions or agencies

1 each of which is engaged in research, training, diagnosis,
2 and treatment relating to heart disease, cancer, or stroke and,
3 at the option of the applicant, any other disease found by
4 the Surgeon General to be of major significance to the health
5 of the Nation; but only if such group—

6 “(1) is situated within a geographic area, com-
7 posed of any part or parts of any one or more States,
8 which the Surgeon General determines, in accordance
9 with regulations, to be appropriate for carrying out the
10 purposes of this title;

11 “(2) consists of one or more medical centers, one
12 or more categorical research centers, and one or more
13 diagnostic and treatment stations; and

14 “(3) has in effect arrangements for the coordination
15 of the activities of its component units which the Sur-
16 geon General finds will be adequate for effectively carry-
17 ing out the purposes of this title.

18 “(b) The term ‘medical center’ means a medical school
19 and one or more hospitals affiliated therewith for teaching,
20 research, and demonstration purposes.

21 “(c) The term ‘categorical research center’ means an
22 institution (or part of an institution) the primary function
23 of which is research (including clinical research), training
24 of specialists, and demonstrations and which, in connection

1.5 Therewith, provides specialized, high-quality diagnostic and
2.2 treatment services for inpatients and outpatients.

3.3 (d) The term 'diagnostic and treatment station' means
4.4 a unit of a hospital or other health facility, the primary
5.5 function of which is to support and augment local capability
6.6 for diagnosis and treatment by providing specialized, high-
7.7 quality diagnostic and treatment services to outpatients and
8.8 inpatients.

9.9 " (e) The term 'nonprofit' as applied to any institution
10.10 or agency means an institution or agency which is owned
11.11 and operated by one or more nonprofit corporations or asso-
12.12 ciations no part of the net earnings of which inures, or may
13.13 lawfully inure, to the benefit of any private shareholder or
14.14 individual.

15.15 " (f) The term 'construction' includes construction and
16.16 initial equipment of new buildings, expansion, remodeling,
17.17 and alteration of existing buildings; including architects'
18.18 services, but excluding off-site improvements and the acqui-
19.19 sition of land.

20.20 "GRANTS FOR PLANNING AND DEVELOPMENT

21.21 "SEC. 903. (a) The Surgeon General, after consulta-
22.22 tion with the National Advisory Council on Medical Com-
23.23 plexes established by section 905 (hereinafter in this title

1 referred to as the 'Council'), is authorized to make grants
2 to public or nonprofit private universities, medical schools,
3 research institutions, and other public or nonprofit private
4 agencies and institutions to assist them in planning the devel-
5 opment of regional medical complexes.

6 " (b) Grants under this section may be made only upon
7 application therefor approved by the Surgeon General. Any
8 such application may be approved only if it contains or is
9 supported by reasonable assurances that—

10 " (1) Federal funds paid pursuant to any such
11 grant will be used only for the purposes for which paid
12 and in accordance with the applicable provisions of this
13 title and the regulations thereunder;

14 " (2) the applicant will provide for such fiscal con-
15 trol and fund accounting procedures as are required by
16 the Surgeon General to assure proper disbursement of
17 and accounting for such Federal funds;

18 " (3) the applicant will make such reports, in such
19 form and containing such information as the Surgeon
20 General may from time to time reasonably require, and
21 will keep such records and afford such access thereto
22 as the Surgeon General may find necessary to assure the
23 correctness and verification of such reports; and

24 " (4) the applicant will provide for the designation
25 of an advisory group, to advise the applicant (and the

1 resulting regional medical complex and its component
2 units) in formulating and carrying out the plan for the
3 establishment and operation of such regional medical
4 complex, which includes representatives of organizations,
5 institutions, and agencies concerned with activities of
6 the kind to be carried on by the complex and members
7 of the public familiar with the need for the services
8 provided by the complex.

9 "GRANTS FOR ESTABLISHMENT AND OPERATION OF
10 REGIONAL MEDICAL COMPLEXES

11 "SEC. 904. (a) The Surgeon General, after consultation
12 with the Council, is authorized to make grants to public or
13 nonprofit private universities, medical schools, research in-
14 stitutions, and other public or nonprofit private agencies and
15 institutions to assist in establishment and operation of
16 regional medical complexes, including construction and
17 equipment of facilities in connection therewith.

18 "(b) Grants under this section may be made only upon
19 application therefor approved by the Surgeon General. Any
20 such application may be approved only if it contains or is
21 supported by reasonable assurances that—

22 "(1) Federal funds paid pursuant to any such grant
23 (A) will be used only for the purposes for which paid
24 and in accordance with the applicable provisions of this
25 title and the regulations thereunder, and (B) will not

11. . . . supplant funds that are otherwise available for establish-
2 . . . ment or operation of the regional medical complex with
3 . . . respect to which the grant is made;

4 . . . " (2) the applicant will provide for such fiscal con-
5 . . . trol and fund accounting procedures as are required by
6 . . . the Surgeon General to assure proper disbursement of
7 . . . and accounting for such Federal funds;

8 . . . " (3) the applicant will make such reports, in such
9 . . . form and containing such information as the Surgeon
10 . . . General may from time to time reasonably require, and
11 . . . will keep such records and afford such access thereto as
12 . . . the Surgeon General may find necessary to assure the
13 . . . correctness and verification of such reports;

14 . . . " (4) the applicant has designated or will design-
15 . . . ate an advisory group, described in paragraph (4) of
16 . . . section 903(b), to advise in carrying out the plan for
17 . . . the regional medical complex; and

18 . . . " (5) any laborer or mechanic employed by any
19 . . . contractor or subcontractor in the performance of work
20 . . . on any construction aided by payments pursuant to any
21 . . . grant under this section will be paid wages at rates not
22 . . . less than those prevailing on similar construction in the
23 . . . locality as determined by the Secretary of Labor in ac-
24 . . . cordance with the Davis-Bacon Act, as amended (40
25 . . . U.S.C. 276a—276a-5) ; and the Secretary of Labor shall

1 have, with respect to the labor standards specified in this
2 paragraph, the authority and functions set forth in Re-
3 organization Plan Numbered 14 of 1950 (15 F.R.
4 3176; 5 U.S.C. 133z-15) and section 2 of the Act of
5 June 13, 1934, as amended (40 U.S.C. 276c).

6 "NATIONAL ADVISORY COUNCIL ON MEDICAL COMPLEXES

7 "SEC. 905. (a) The Surgeon General, with the ap-
8 proval of the Secretary, may appoint, without regard to the
9 civil service laws, a National Advisory Council on Medical
10 Complexes. The Council shall consist of the Surgeon Gen-
11 eral, who shall be the chairman, and twelve members, not
12 otherwise in the employ of the United States, who are lead-
13 ers in the fields of the fundamental sciences, the medical sci-
14 ences, or public affairs. At least one of the appointed mem-
15 bers shall be outstanding in the study, diagnosis, or
16 treatment of heart disease, one shall be outstanding in the
17 study, diagnosis, or treatment of cancer, and one shall be
18 outstanding in the study, diagnosis, or treatment of stroke.

19 "(b) Each appointed member of the Council shall hold
20 office for a term of four years, except that any member ap-
21 pointed to fill a vacancy prior to the expiration of the term
22 for which his predecessor was appointed shall be appointed
23 for the remainder of such term, and except that the terms of
24 office of the members first taking office shall expire, as desig-

1 nated by the Surgeon General at the time of appointment.
2 four at the end of the first year, four at the end of the second
3 year, and four at the end of the third year after the date of
4 appointment. An appointed member shall not be eligible
5 to serve continuously for more than two terms.

6 “(c) Appointed members of the Council, while attend-
7 ing meetings or conferences thereof or otherwise serving on
8 business of the Council, shall be entitled to receive compen-
9 sation at rates fixed by the Secretary, but not exceeding \$100
10 per day, including travel time, and while so serving away
11 from their homes or regular places of business they may be
12 allowed travel expenses, including per diem in lieu of sub-
13 sistence, as authorized by section 5 of the Administrative
14 Expenses Act of 1946 (5 U.S.C. 73b-2) for persons in
15 the Government service employed intermittently.

16 “(d) The Council shall advise and assist the Surgeon
17 General in the preparation of regulations for, and as to policy
18 matters arising with respect to, the administration of this
19 title. The Council shall consider all applications for grants
20 under this title and shall make recommendations to the
21 Surgeon General with respect to approval of applications
22 for and the amounts of grants under this title.

23 “REGULATIONS

24 “SEC. 906. The Surgeon General, after consultation with
25 the Council, shall prescribe general regulations covering the

1 terms and conditions for approving applications for grants
 2 under this title and the coordination of programs assisted
 3 under this title with programs for training, research, and
 4 demonstrations relating to the same diseases assisted or au-
 5 thorized under other titles of this Act or other Acts of
 6 Congress.

7 "REPORT

8 "SEC. 907. On or before June 30, 1969, the Surgeon
 9 General, after consultation with the Council, shall submit
 10 to the Secretary for transmission to the President and then
 11 to the Congress, a report on the activities under this title
 12 together with (1) a statement of the relationship between
 13 Federal financing and financing from other sources of the
 14 activities undertaken pursuant to this title, (2) an appraisal
 15 of the activities assisted under this title in the light of their
 16 effectiveness in carrying out the purposes of this title, and
 17 (3) recommendations with respect to extension or modifi-
 18 cation of this title in the light thereof."

19 SEC. 3. (a) Section 1 of the Public Health Service Act
 20 is amended to read as follows:

21 "SECTION 1. Titles I to IX, inclusive, of this Act may
 22 be cited as the 'Public Health Service Act'."

23 (b) The Act of July 1, 1944 (58 Stat. 682), as
 24 amended, is further amended by renumbering title IX (as
 25 in effect prior to the enactment of this Act) as title X, and

1 by renumbering sections 901 through 914 (as in effect prior
2 to the enactment of this Act), and references thereto, as
3 sections 1001 through 1014, respectively.

79TH CONGRESS
1st Session

H. R. 3140

A BILL

To amend the Public Health Service Act to assist in combating heart disease, cancer, stroke, and other major diseases.

By Mr. Harms

JANUARY 10, 1965

Referred to the Committee on Interstate and Foreign
Commerce

FROM
PORTER HARDY, JR.
MEMBER OF CONGRESS
2ND DISTRICT, VIRGINIA

APPENDIX 25

LIST OF ORGANIZATIONS AND BUSINESSES FINANCIALLY
SUPPORTING THE PROPOSED MEDICAL SCHOOL, 1969

APPENDIX C

RESOLUTIONS SUPPORTING THE ESTABLISHMENT OF A SCHOOL
OF MEDICINE IN THE TIDEWATER AREA*

Kiwanis Club of Suffolk, Inc.	Norfolk Retail Merchants Association
Tidewater Virginia Development Council	Virginia Pilot Association
The Kiwanis Club of Norfolk	Virginia State Ports Authority
The Kiwanis Club of Warwick	The King's Daughters Children's Hospital
Downtown Norfolk Association, Inc.	Norfolk Chamber of Commerce
Chamber of Commerce of Suffolk & Nansemond County	The Cosmopolitan Club of Norfolk
Young Men's Christian Association of Norfolk	Phoebus Civic Association
Women's Division, Norfolk Chamber of Commerce	League of Women Voters of Norfolk
Suffolk-Nansemond Junior Chamber of Commerce	Norfolk Ministers' Association
Norfolk Society of Arts	Norfolk Executives Club
Wards Corner Lions Club	Rotary Club of Norfolk
Virginia Tidewater Dental Association	Junior League of Norfolk
Hampton Roads Maritime Association	Womens Club of South Norfolk
	The Pyramid Club
	Virginia Society of Professional Engineers
	Exchange Club of Midtown Norfolk

APPENDIX D

ESTIMATED COST OF NEW MEDICAL SCHOOL FACILITIES IN ADDITION TO
EXISTING TEACHING HOSPITAL

<i>Square Feet Requirements*</i>	
A. Basic Science Facilities:	B. Clinical Science Facilities:
Department facilities 62,970	Departmental facilities, lec- ture rooms, etc. 73,000
Common teaching, & res & support area..... 61,890	
Administration and student activities 16,560	
Total Net141,510	Add Gross for Basic Science.....218,000
Sub total gross (add 35 per cent)218,000	Grand Total Square Feet.....261,000

Cost of Facilities

Cost at \$25 sq. ft.....	\$7,275,000
Architects Fee, 6%	436,500
Movable Fixtures & Cont.....	278,500
TOTAL ESTIMATED COST	\$8,000,000

*Based on entering class of 64 students.

APPENDIX 26

CONCLUSIONS OF OLD DOMINION COLLEGES'S 1965
STUDY ON THE NORFOLK AREA MEDICAL CENTER
AUTHORITY'S AFFILIATION PROPOSAL

CONCLUSIONS ON AFFILIATION

- The medical college would be a major asset to education in the Norfolk area and, if such a college is developed, it logically should be affiliated with the primary institute of higher education in the area - Old Dominion College.
 - An affiliation of a private institution with a state-supported college poses many problems, but none of these appears insurmountable and there are a number of precedents for such an arrangement.
- Old Dominion College does not at present have the science undergraduate and graduate programs necessary to support a medical school, but it would probably develop most of these programs as part of its normal long-term development even without a medical school.
 - In view of past trends, Old Dominion would probably develop these science programs over a 10- to 15-year period, and while this development can be speeded, the five-year schedule to meet the medical school proposed timing seems impractical.
 - Old Dominion would require substantially increased financial support from the State to develop the necessary research and teaching programs in graduate science study, as well as additional funds for development of its science library holdings.
 - A medical school affiliation would, therefore, aid Old Dominion in its development of science programs, provided this did not drain off any of the institution's already short funds to give emphasis to one field of study.
 - Old Dominion's emphasis on science study would be in the State's and the nation's interest because of the predicted severe shortage of scientifically trained manpower in the future.

CONCLUSIONS ON AFFILIATION (Cont'd)

- While the terms of any affiliation agreement will be difficult to devise and operate under, the problems seems soluble with clear objectives and good will on both sides, and the benefits to be gained by adding a medical school seem well worth the effort involved in securing a satisfactory agreement.
- The costs of developing and operating a medical school are great, and there should be some assurance that it will be possible to raise these large sums from private sources before negotiations are carried too far with possible embarrassment to the College.

APPENDIX 27

LETTER FROM DR. THOMAS C. MOORE
TO DR. MASON C. ANDREWS

To: Mason C. Andrews, M.D.
Chairman, Norfolk Area Medical Center Authority

From: Thomas C. Moore, M.D.

Subject: Possible Course of Action for Re-activating the William and Mary Medical School, founded in 1779 by Thomas Jefferson:

Date: April 26, 1965

First Step:

Liason and negotiations between the Administration and Board of Visitors of the College of William and Mary and the Norfolk Area Medical Center Authority toward the cooperative reactivation of the William and Mary School of Medicine, originally established in 1779 by Thomas Jefferson. Joint announcement by these two public instrumentalities of the interest to re-establish the William and Mary School of Medicine. More than enough authority currently resides in these two organizations to effect this reactivation without additional legislative action:

- 1.) When William and Mary was reorganized in 1779 by Jefferson and made into the nation's first University, a School of Medicine was established in addition to a Law School and a School of Modern Languages.
- 2.) In 1922-23, the Law School was reactivated after a long period of inactivity.
- 3.) Three graduate schools are currently functioning at William and Mary--Law, Education, and Marine Science (located at Point Gloucester).
- 4.) The 1962 Act of the Virginia General Assembly which dis-established the Colleges of William and Mary recommended that the ancient College of William and Mary be encouraged to strengthen its program in the liberal arts and sciences and to develop the advanced professional and graduate programs appropriate to its traditions and competence. A School of Medicine is clearly a part of William and Mary traditions. A competence to carry out responsibility in medical

education would be strengthened considerably by liason with the Norfolk Area Medical Center Authority.

- 5.) The Norfolk Area Medical Center Authority, by law, (1964 session of the General Assembly of Virginia) is "a public instrumentality exercising public and essential governmental functions to provide for the public health and welfare" with power to "identify, document and evaluate needs, problems and resources relating to health and medical care; to plan, develop and implement programs to meet such needs on both an immediate and long range basis" and to "plan, design, construct, remove, enlarge, equip, maintain and operate medical educational institutions, medical and paramedical facilities, together with related and supporting facilities, and to do all things necessary and convenient to carry out any of its purposes." The Authority may acquire property by purchase or gift and may accept loans, grants or assistance from the federal government, the state, any municipality or any other public or private source. It may borrow money and issue tax-exempt bonds. It may exercise the power of eminent domain within the corporate limits of the city of Norfolk. "Any city located in the general section of the state to be served by the Authority is empowered to cooperate with the Authority" in a wide range of activities.

Second Step:

The appointment of a Dean of the School of Medicine with academic rank deriving from William and Mary.

Third Step:

Submission of grant requests to leading national foundations concerned with health (Commonwealth, Rockefeller, Kellog, etc.)
For funds to:

- 1.) Carry out a study of a program, curriculum and philosophy of medical education that will enable the re-activated school of William and Mary to achieve an influence in the meeting of current problems in medical education which would be comparable in effect to the role played by Johns Hopkins in the last part of the last century and in keeping with the high traditions of academic innovation and excellence which characterized Jefferson's establishment of the original School of Medicine in his reorganization of William and Mary in 1779.
- 2.) Initiate a national campaign for funds to support expansion of William and Mary programs, including Medicine, as a "living memorial" in anticipation of the commemoration of the Bicentennial of 1776.

Fourth Step:

Establishment of National Advisory Council of leading national educators and distinguished citizens to participate in discussions and give advice relating to the development of the William and Mary medical education program.

Fifth Step:

Initiation of political action to:

- 1.) Secure major federal construction and operational funds as part of anticipated 1776 Bicentennial celebration in recognition of the role of William and Mary and its alumni in the founding of the nation and the shaping of its democratic institutions and in recognition of the tragedy of the college as a casualty, physically and spiritually, of two major wars which raged across its campus. A sort of William and Mary "G.I. Bill of Rights."
- 2.) Obtain state legislative action (1966 session) creating a Norfolk Campus of William and Mary University in lieu of Old Dominion College.--This step is not indispensable but would facilitate development of Norfolk General Hospital as "University Hospital, Norfolk."

Sixth Step:

Implementation of medical education program with community liason appropriate to program, faculty recruitment, construction of physical plant and selection of student body.

APPENDIX 28

HOSPITALS IN THE TIDEWATER AREA, 1964

HOSPITALS IN THE TIDEWATER AREA, 1964

Private Hospitals	Number of Beds
Norfolk General	521
DePaul	350
Riverside	323
Portsmouth General	250
Maryview	242
Dixie	226
Leigh Memorial	185
Norfolk Community	115
King's Daughters	85
Virginia Beach	60
Total Bed Capacity	2,357
Government Hospitals	
Veteran's Administration	1,820
Portsmouth Naval	1,450
U.S. Public Health Service	231
Total Bed Capacity	2,501

APPENDIX 29

COMMITTEES OF THE NORFOLK AREA MEDICAL
CENTER AUTHORITY

NORFOLK AREA MEDICAL CENTER AUTHORITY
DIVISIONS

FINANCE

Harry H. Mansbach, Chairman	Edmund S. Ruffin, Jr.
Pretlow Darden	J.H. Tyler
Charles Horton, M.D.	William P. Woodley
R. Cosby Moore	E.T. Gresham
Harry B. Price, Jr.	

PLANNING AND DEVELOPMENT

Walter A. Page, Chairman	James E. Newby, Jr., M.D.
Lawrence M. Cox	John F. Rixey
Robert J. Faulconer, M.D.	T. Lane Stokes, M.D.
John Franklin, M.D.	George Ware
Robert C. Goodman	

COMMERCIAL SERVICES

R.R. Richardson, Jr., Chairman	Stanley Waranch
Toy D. Savage, Jr.	Richard R. Welton, III
M. Lee Payne	

REHABILITATION

John Franklin, M.D., Chairman	Frank Kellam
M. Lee Payne, Vice-Chairman	Mrs. John F. Rixey
George A. Duncan, M.D.	

RESEARCH

Roy Charles, Chairman	Frank Moore
Lyman Brooks	R. L. Payne, Jr., M.D.
Patrick Devine, M.D.	Eugene F. Poutasse, M.D.
Aubrey Graham	Lewis Webb
Anexander Martone, D.D.S.	

DENTISTRY

Jack C. Kanter, D.D.S., Chair	Gladstone M. Hill, D.D.S.
Lawrence M. Cox	Judge Lawrence I'Anson
Edwin Chittum	Alexander Martone, D.D.S
W.B. Costenbader, D.D.S	Mrs. Webster

EDUCATION AND TRAINING

Barron F. Black, Chairman	John Thiemeyer, Jr., M.D.
Lyman Brooks	James H. Tyler, III
Mrs. Virgil F. Lewis	Lewis Webb
Joseph D. Lea, M.D.	J. Warren White, Jr.

MENTAL HEALTH

Toy Savage, Jr., Chairman	Hanai Rittner, M.D.
H. William Fink, M.D.	Leighton P. Roper
Mrs. Foster I. Gilbert	Frederick Woodson, M.D.
Dietrich Heyder, M.D.	

SOURCE: Letter from George F. Rice, Secretary-Treasurer of the Norfolk Area Medical Center Authority (NAMCA), to NAMCA Commissioners, 26 October 1964, Personal Files of Dr. John Franklin.

APPENDIX 30

TERMINATION OF THE NORFOLK MEDICAL RESEARCH
FOUNDATION

I, Rex A. Bradley, Secretary of The Norfolk Rotary Club, certify that at a regular meeting of The Norfolk Rotary Club held on February 7, 1967, at which time a quorum of the Club was present, the Club approved the action and resolution of the Norfolk Medical Research Foundation taken at its meeting on December 30, 1966 in terminating the Norfolk Medical Research Foundation effective December 31, 1966 and transferring the assets and funds of said Foundation to the Norfolk Area Medical Center Authority on condition that said assets and funds be used solely for medical research.

Rex A. Bradley
Secretary, The Norfolk Rotary Club

Subscribed and sworn to before me this 15th day of February, 1967.

Alvin J. Brewster
Notary Public

My Commission expires:

January 25, 1970.

RESOLUTION FOR THE ESTABLISHMENT
OF A MEDICAL RESEARCH DEVELOPMENT PROJECT

WHEREAS, the Norfolk Area Medical Center Authority has determined to proceed with the establishment of a School of Medicine in the Norfolk Medical Center; and

WHEREAS, a research institute is an indispensable element of a School of Medicine; and

WHEREAS, the Norfolk Research Foundation agrees to merge its program into the activities of the Norfolk Area Medical Center Authority as the Research Center of the Authority with direction by the Authority's Chief Executive Office (when designated); and

WHEREAS, the progressive augmentation of research programs to a high level in Medical Center is necessary and desirable to attract personnel in various talent categories who contribute importantly to the quality of patient care and teaching, and is prerequisite to Federal assistance in establishing and operating a Research Institute; and

WHEREAS, the inauguration of an open heart surgery service will require greatly expanded facilities in the existing animal laboratory in the Medical Center,

BE IT HEREBY RESOLVED that the Norfolk Area Medical Center Authority creates a Department of Research as a major component of the Authority to be headed by a Director of Research, who will be directly responsible to the Chief Executive Officer of the Authority, and

BE IT FURTHER RESOLVED THAT the Norfolk Area Medical Center Authority accepts transfer of the Norfolk Research Foundation with its staff and program of activities to the Department of Research of the Authority as an element of the Medical Center.

BE IT FURTHER RESOLVED that the Norfolk Area Medical Center Authority assigns to its Research Advisory Committee the responsibility of supervising the policies and activities of the Research Department, and making appropriate recommendations to the Authority.

BE IT FURTHER RESOLVED that the Norfolk Area Medical Center Authority hereby agrees to expend up to \$12,000 per year for the activities of the Department of Research for the purpose of development and expansion of research programs in the Norfolk Medical Center.

APPENDIX 31

MEDICAL EDUCATORS CONFERENCE,

15-16 JUNE 1967

PANEL OF MEDICAL EDUCATORS FOR CONFERENCE
 MARINER MOTOR HOTEL, VIRGINIA BEACH
 JUNE 15-16, 1967

- Dr. Merlin K. DuVall, Dean, College of Medicine, University of Arizona, Tucson
- Dr. Robert Q. Marston, Associate Director for Regional Medical Programs, National Institutes of Health, Department of Health, Education and Welfare
- Dr. Robert J. Slater, President, Association for the Aid of Crippled Children, New York City; formerly Dean, College of Medicine, University of Vermont
- Dr. Cheves Smythe, Associate Director, Association of American Medical Colleges, Evanston, Illinois
- Dr. Nils Y. Wessell, President, Institute for Educational Development, New York City; formerly President, Tufts University
- Dr. Vernon E. Wilson, Executive Director for Health Affairs, University of Missouri, Columbia

PANELISTS FROM VIRGINIA UNIVERSITIES AND MEDICAL SCHOOLS

- Dr. Kenneth R. Crispell, Dean, School of Medicine, University of Virginia, Charlottesville, Virginia
- Dr. Frank L. Hereford, Jr., Provost and Professor of Physics, University of Virginia
- Dr. Thomas Harrison Hunter, Chancellor for Medical Affairs, University of Virginia
- Dr. Kinloch Nelson, Dean, School of Medicine, Medical College of Virginia, Richmond
- Dr. R. Blackwell Smith, Jr., President, Medical College of Virginia
- Dr. Davis Y. Paschall, President, College of William and Mary, Williamsburg

LOCAL PARTICIPANTS IN CONFERENCE OF MEDICAL EDUCATORS
June 15 and 16, 1967

Batten, Frank	Publisher, VIRGINIAN PILOT/LEDGER STAR Rector, Old Dominion College Board of Directors, Norfolk General Hospital Former President, United Communities Fund Former President, Norfolk Chamber of Commerce
Birdsong, Harvard R.	President, Birdsong Storage Company, Suffolk
Black, Barron F.	Attorney-at-Law Former Rector, University of Virginia Chairman of Mayor's Advisory Committee on the Establishment of a Medical School in Norfolk
Blake, Preston	President, Preston Blake Insurance Company President, Health-Welfare-Recreation Planning Council
Breeden, Edward L., Jr.	Attorney-at-Law Chairman of the Board, Southern Bank of Norfolk State Senator Board of Directors, Norfolk General Hospital
Camp, James L., Jr.	Chairman of the Executive Committee, Union Camp Corp. Franklin, Virginia and New York, New York
Darden, Colgate W.	Former Governor of Virginia Former President of the University of Virginia Former United States Congressman, Virginia Second District
Darden, Pretlow	President and Owner, Colonial Chevrolet Former Mayor, City of Norfolk Commissioner, Norfolk Redevelopment and Housing Authority Board of Directors, Norfolk General Hospital Former President, Health, Welfare, Recreation Planning Council Former President, United Communities Fund Former President, Norfolk Chamber of Commerce
Davis, Charles E., Jr., M.D.	Surgeon President-elect, Norfolk County Medical Society
Fitzpatrick, William H.	Editor, LEDGER-STAR
Hofheimer, Henry Clay, II	President, Southern Materials Company, Inc. Former President, Board of Directors, Norfolk General Hospital Former President, Norfolk Chamber of Commerce Executive Committee, Lone Star Cement Corp.

Kaufman, Charles L.	Attorney-at-Law Chairman, Norfolk Redevelopment and Housing Authority Former President, Board of Directors, Norfolk General Hospital Former President, United Communities Fund
McNeal, Horace P.	President, Empire Machinery and Supply Company Board of Directors, Norfolk General Hospital
Magann, W. F.	President, W. F. Magann Corporation Former President, Portsmouth Chamber of Commerce
Martin, Roy B., Jr.	Mayor, City of Norfolk
Mason, Robert H.	Editor, VIRGINIAN-PILOT
Moore, R. Cosby	Chairman of the Board, Virginia National Bank Board of Directors, Norfolk General Hospital Former President, United Communities Fund Former President, Norfolk Chamber of Commerce
Page, Walter A.	Judge, Court of Law & Chancery, City of Norfolk Former NAMCA Commissioner Former Chairman, Lay Advisory Board, DePaul Hospital Member, Mayor's Advisory Committee on the Establishment of a Medical School in Norfolk
Prangle, Roy R.	Administrator, Norfolk General Hospital
Price, Harry B., Jr.	President, Price's Inc. Joint Liaison Committee Former President, United Communities Fund Former President, Norfolk Chamber of Commerce
Rawls, Sol W.	President, Sol W. Rawls Company, Franklin, Va. Former Chairman, State Council of Higher Education Chairman, Governor's Commission to Study Nursing Shortage in Virginia
Roper, John L., II	President, Norfolk Shipbuilding and Drydock Corporation Commissioner, Norfolk Redevelopment and Housing Authority Board of Directors, Norfolk General Hospital
Savage, Toy D., Jr.	Attorney-at-Law President of the Board, Norfolk General Hospital Former NAMCA Commissioner Former Representative, Virginia House of Delegates

Wallace, K. Kenneth, M. D.	Physician President, Medical Society of Virginia
Webb, Lewis W., Jr.	President, Old Dominion College Board of Directors, Norfolk General Hospital Member, Mayor's Advisory Committee on the Establishment of a Medical School in Norfolk
Ware, George H.	President, Ware Insurance Company Former President of the Board, Norfolk General Hospital
Welton, Richard F., III	President, Smith and Welton's, Inc. Board of Directors, Norfolk General Hospital Joint Liaison Committee Former President, United Communities Fund President, Norfolk Academy

COMMISSIONERS OF THE NORFOLK AREA MEDICAL CENTER AUTHORITY
PARTICIPATING IN CONFERENCE OF MEDICAL EDUCATORS

- Andrews, Mason C., M. D. Obstetrics--Gynecology
Chairman, Norfolk Area Medical Center Authority
Past President, Norfolk County Medical Society
Member, Governor's Advisory Comm. on Regional
Medical Programs
Former Member, City Planning Commission
- Charles, Roy R. Vice-Chairman, Norfolk Area Medical Center Authority
Former Member, Board of Visitors, College of William
and Mary and Old Dominion College
Former President, Board of Directors, Leigh Memorial
Hospital
Former President, Board of Directors, Tidewater
Chapter of the American Red Cross
- Cox, Lawrence M. Executive Director, Norfolk Redevelopment and Housing
Authority
Member, Mayor's Advisory Committee on Establish-
ment of a Medical School in Norfolk
Board of Directors, Norfolk General Hospital
President, American Society of Planning Officials
- Franklin, John M., M. D. Physician - Internal Medicine
Chairman, Metropolitan Health Division, Health, Welfare,
Recreation Planning Council
- Mansbach, Harry H. Attorney-at-Law
Former President and Owner, THE HUB Clothing Stores
Former President, Health, Welfare, Recreation Planning
Council
Former President, United Communities Fund
Former President, Norfolk Chamber of Commerce
- Richardson, R. R., Jr. President, Hall-Hodges Company, Inc.
Past President, Norfolk General Hospital Board of
Directors
Trustee, Virginia Foundation for Independent Colleges
- Woodley, William P. President, Columbian Peanut Company
Board of Directors, Norfolk General Hospital
Former President, Health, Welfare, Recreation Planning
Council
Former President, United Communities Fund

APPENDIX 32

HOUSE BILL 1435

CHAPTER 396

An Act to amend and reenact §§ 1 and 2 of Chapter 471 of the Acts of Assembly of 1964, which act created the Norfolk Area Medical Center Authority, the amended sections relating to creation and composition of the Authority; and to amend and reenact § 23-14, as amended, of the Code of Virginia, relating to declaring certain educational institutions governmental instrumentalities.

[H 1435]

Approved March 19, 1975

Be it enacted by the General Assembly of Virginia:

1. That §§ 1 and 2 of Chapter 471 of the Acts of Assembly of 1964 and § 23-14, as amended, of the Code of Virginia are amended and reenacted as follows:

§ 1. There is hereby created a public body politic and corporate to be known as the "~~Norfolk Area~~ Eastern Virginia Medical Center Authority" hereinafter referred to as "The Authority", with such public and corporate powers as are hereinafter set forth. The Authority may sue and be sued, plead and be impleaded, and shall have the power and authority to contract and be contracted with and to exercise and discharge all the powers and duties imposed and conferred upon it, as hereinafter provided.

§ 2. ~~The terms of the members of the Authority in office on the effective date of this act shall expire on such date. Thereafter~~ the Authority shall be composed of ~~seven-ten~~ members, two of whom shall be licensed members of the medical profession, who shall be appointed by ~~the city council~~ their respective city councils as follows: one member for the city of Chesapeake, one member for the city of Hampton, one member for the city of Portsmouth, one member for the city of Suffolk, two members for the city of Virginia Beach, four members for the city of Norfolk; ~~three~~ four of the members first appointed shall be appointed for terms of three years, ~~two-three~~ for terms of two years, and ~~two-three~~ for terms of one year. ~~The members who shall serve one, two and three-year terms shall be agreed upon by the city councils.~~ Thereafter the terms of the members shall be three years. Any such member appointed for a three-year term may be reappointed for one additional three-year term. Thereafter, no member shall be reappointed until at least one year after the expiration of his second full three-year term. Members shall receive no salaries but shall be entitled to reimbursement for necessary traveling and other expenses incurred while engaged in the performance of their duties. Each member shall continue to hold office until his successor has been appointed and qualified. ~~The~~ Each city council shall have the right to remove any member ~~or officer~~ appointed by it, for malfeasance or misfeasance, incompetency or gross neglect of duty. Vacancies shall be filled by appointment of the council for unexpired terms. Members shall take an appropriate oath of office and same shall be filed with the city clerk. Members shall elect on an annual basis one of their number as chairman and another as vice-chairman and shall also elect a secretary and treasurer for terms to be determined by them, who may or may not be one of the members. The same person may serve as both secretary and treasurer. The members shall make such

rules, regulations and bylaws for their own government and procedure as they shall determine; they shall meet regularly at least once a month and may hold such special meetings as they deem necessary.

§ 23-14. Certain educational institutions declared governmental instrumentalities; powers vested in majority of members of board.—The College of William and Mary in Virginia, at Williamsburg; the board of visitors of the Virginia School at Hampton; the Virginia Institute of Marine Science, at Gloucester Point; Longwood College, at Farmville; the Mary Washington College, at Fredericksburg; Clinch Valley College of the University of Virginia, at Wise; George Mason University, at Fairfax; the Madison College, at Harrisonburg; Old Dominion University, at Norfolk; the State Board for Community Colleges, at Richmond; the Virginia Commonwealth University, at Richmond; the Radford College, at Radford; the rector and visitors of the University of Virginia, at Charlottesville; the Virginia Military Institute, at Lexington; the Virginia Polytechnic Institute and State University, at Blacksburg; the Virginia School for the Blind, at Charlottesville; the Virginia School for the Deaf and Blind, at Staunton; the Virginia State College, at Petersburg; *Norfolk State College, at Norfolk*; and the Woodrow Wilson Rehabilitation Center, at Fishersville; and the ~~Norfolk Area-Eastern Virginia Medical Center Authority, in Norfolk~~, are hereby classified as educational institutions and are declared to be public bodies and constituted as governmental instrumentalities for the dissemination of education. The powers of every such institution derived directly or indirectly from this chapter shall be vested in and exercised by a majority of the members of its board, and a majority of such board shall be a quorum for the transaction of any business authorized by this chapter. Wherever the word "institution" is used in this chapter it shall be deemed to include "Authority" and the word "board" shall be deemed to include the members of the Authority.

APPENDIX 33

SUMMARY AND CONCLUSIONS FROM THE ETHICS
ADVISORY BOARD'S FINAL REPORT

From the Ethics Advisory Board's Final Report

SUMMARY

... In its deliberations on human *in vitro* fertilization, the Board confronted many ethical, scientific and legal issues.

A. After much analysis and discussion regarding both scientific data and the moral status of the embryo, the Board is in agreement that the human embryo is entitled to profound respect; but this respect does not necessarily encompass the full legal and moral rights attributed to persons. . . .

B. The Board is concerned about still unanswered questions of safety for both mother and offspring of *in vitro* fertilization and embryo transfer; it is concerned, as well, about the health of the children born following such a procedure and about their legal status. Many women have told the Board that in order to bear a child of their own they will submit to whatever risks are involved. The Board believes that while the Department should not interfere with such reproductive decisions, it has a legitimate interest in developing and disseminating information regarding safety and health. . . .

C. A number of fears have been expressed with regard to adverse effects of technological intervention in the reproductive process. . . .

Although the Board recognizes that there is an opportunity for abuse in the application of this technology, it concluded that a broad prohibition of research involving human *in vitro* fertilization is neither justified nor wise. . . .

D. The question of Federal support of research involving human *in vitro* fertilization and embryo transfer was troublesome for the Board in view of the uncertain risks, dangers of abuse and because funding the procedure is morally objectionable to many. In weighing these considerations, the Board noted that the procedures may soon be in use in the private sector and that Departmental involvement might help to resolve questions of risk and avoid abuse by encouraging well-designed research by qualified scientists. . . .

CONCLUSIONS

CONCLUSION 1: The Department should consider support of carefully designed research involving *in vitro* fertilization and embryo transfer in animals, including nonhuman primates, in order to obtain a better understanding of the process of fertilization, implantation and embryo development, to assess the risks to both mother and offspring associated with such procedures, and to improve the efficacy of the procedure.

CONCLUSION 2: The Ethics Advisory Board finds that it is acceptable from an ethical standpoint to undertake research involving human *in vitro* fertilization and embryo transfer provided that:

A. if the research involves human *in vitro* fertilization without embryo transfer, the following conditions are satisfied:

1. the research complies with all appropriate provisions of the regulations governing research with human subjects (45 CFR 46);
2. the research is designed primarily: (A) to establish the safety and efficacy of embryo transfer and (B) to obtain important scientific information toward that end not reasonably attainable by other means;
3. human gametes used in such research will be obtained exclusively from persons who have been informed of the nature and purpose of the research in which such materials will be used and have specifically consented to such use;
4. no embryos will be sustained *in vitro* beyond the stage normally associated with the completion of implantation (14 days after fertilization); and
5. all interested parties and the general public will be advised if evidence begins to show that the procedure entails risks of abnormal offspring higher than those associated with natural human reproduction.

B. in addition, if the research involves embryo transfer following human *in vitro* fertilization, embryo transfer will be attempted only with gametes obtained from lawfully married couples.

CONCLUSION 3: The Board finds it acceptable from an ethical standpoint for the Department to support or conduct research involving human *in vitro* fertilization and embryo transfer, provided that the applicable conditions set forth in Conclusion 2 are met. However, the Board has decided not to address the question of the level of funding, if any, which such research might be given.

CONCLUSION 4: The National Institute of Child Health and Human Development (NICHD) and other appropriate agencies should work with professional societies, foreign governments and international organizations to collect, analyze and disseminate information derived from research (in both animals and humans) and clinical experience throughout the world involving *in vitro* fertilization and embryo transfer.

CONCLUSION 5: The Secretary should encourage the development of a uniform or model law to clarify the legal status of children born as a result of *in vitro* fertilization and embryo transfer. To the extent that funds may be necessary to develop such legislation, the Department should consider providing appropriate support.

to say, when you begin to restrict freedom of inquiry, you had better go very carefully.

The Board's final resolution of this deep-lying tension appears in the arduous formulation of Conclusions 2 and 3.

Reverting to the language of Secretary Califano's mandate, the Board found that "it is acceptable from an ethical standpoint to undertake research involving human in vitro fertilization and embryo transfer" under certain conditions (Conclusion 2); in addition the Board found "it acceptable from an ethical standpoint" for HEW to support such research (Conclusion 3).

"Acceptable from an ethical standpoint," in light of the Board's semantic clarifications, may mean both more and less than the words themselves suggest. The Board says: "This phrase is broad enough to include at least two interpretations: (1) 'clearly ethically right' or (2) 'ethically defensible but still legitimately controverted'. . . . the Board is using the phrase in the second sense; . . . [and] wishes to emphasize that it is *not* finding that the ethical considerations against such research are insubstantial."

What does the Board mean by "ethically defensible"? Erudite treatises may ultimately clarify the matter. In the meantime, only questions can be raised about it. Does the Board mean that it has weighed the ethical arguments pro and con and found on balance that arguments in favor of in vitro research outweigh those against? It does not say so. What are the ethical considerations that make in vitro research ethically defensible? Is it protection of risk-assuming couples? The preponderance of the Board's deliberations would suggest so, but in concluding remarks, the Board writes, "where reproductive decisions are concerned, it is important to guard against unwarranted governmental intrusion into personal and marital privacy." But doesn't such a claim argue against both a protective and prohibitive role for government? Finally, has the Board, in using the phrase "ethically defensible," introduced a new criterion for analyzing ethical considerations in research—one that will be clarified only with further application?

These definitional problems, notwithstanding, the Board went on in Conclusion 2 to set certain limiting conditions on human in vitro fertilization: (A) without embryo transfer; that is, when research could be done with A and B with embryo

transfer (that is, when therapeutic application would be primary). These limiting conditions take account of the Board's view that "the human embryo is entitled to profound respect; but this respect does not necessarily encompass the full legal and moral rights attributed to persons." Thus such research must comply with the appropriate regulations governing research with human subjects and "no embryo will be sustained in vitro beyond the stage normally associated with the completion of implantation (14 days after fertilization)." When research on in vitro fertilization is to include embryo transfer the Board recommends that "embryo transfer . . . be attempted only with gametes obtained from lawfully married couples."

Conclusion 3 repeats the language of Conclusion 2: federal funding is acceptable from an ethical standpoint. However, the Board explicitly draws back from suggesting what level of funding, if any, such research should receive. By this stratagem, the Board joined two concerns and left both to the political process: (1) the appropriateness of government funding in the face of ethical objections to in vitro fertilization research and (2) the priority in vitro fertilization research should hold when measured against competing needs. Yet having approved the research in the first place, the Board's thinking in Conclusion 3 seems to signal hesitation. But perhaps it is not so much hesitation as a political compromise by which the Board hopes to satisfy both proponents and opponents of the research. Proponents—researchers, physicians, and interested couples—can move ahead with the procedure; opponents will be satisfied with restrictions on government funding. The adoption of "Hyde amendment" strategies to avoid public conflict is certainly problematic, since it has not worked in the original instance; whether the Board was wise to do so with in vitro fertilization research remains to be seen.

Conclusion

The Board's task was not easy; nor are its conclusions likely to receive any award for cutting the Gordian knot of moral opposition to in vitro fertilization, government involvement in such research, and the strong desire for genetic offspring. Those who believe that in vitro fertilization and transfer is the first step toward

human production in place of procreation are probably right in seeing nothing in the Board's conclusions or arguments that prevents the ultimate justification of surrogate mothers and the commercial banking of ova and, at some future date, of embryos. They are unlikely to share the Board's sanguine view that such development "may be contained by regulation or legislation. Other abuses may be avoided by the use of good judgment based upon accurate information. . . ."

On the other hand, those who believe that in vitro fertilization with embryo transfer is a logical and appropriate extension of medical therapy in the treatment of infertility will be unhappy about the Board's reluctance to endorse the procedure wholeheartedly and to urge federal support forthrightly, not only for research, but for therapeutic application in government-funded medical care programs. In the absence of funding, particularly for the poor, they will raise questions about the equal availability of a possibly useful therapy.

But, in addition to these substantive problems with the Board's conclusions, there is also a procedural issue. Is it appropriate for boards, such as the Ethics Advisory Board, when they are reviewing medical research, to be structured so that more than half of the members represent the medical and research community? The deliberations of this Ethics Advisory Board suggest that the "ethical questions" will be focused narrowly on those ethical issues that overlap with the concerns of researchers—in this case the problem of risk—to the exclusion of ethical or value issues that may be of concern to those outside the research community, for example, the "soft ethical issues" mentioned above or the increasing interventions in the process of human conception, gestation, and birth. Particularly if they are in the majority, the researchers' and physicians' ethical imperative—protect research subjects and patients from nonvalidated therapies—is likely to become the dominant imperative of the Board. But in the larger view, such an imperative is only one of many ethical considerations. Thus, one must ask whether a Board constituted largely of researchers and oriented to their ethical concerns can be relied upon to say "no" to research or whether they may not be overwhelmingly disposed to judge research as "ethically defensible" in the confusing way the Board has used that term.

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