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ABSTRACT

The book discusses the current problems of arranging clinical experiences for allied health personnels which will meet student needs as well as the interdependent objectives of educational and clinical institutions. Chapter 1 reviews general trends in the education of health practitioners with particular consideration of the status of physical therapy. Chapter 2 concerns the results of a questionnaire survey and a workshop, two aspects of a study conducted by the Division of Physical Therapy, School of Medicine, University of North Carolina at Chapel Hill. Questionnaires were mailed to 51 educational administrators in physical therapy programs and to a sampling of clinical supervisors and clinical faculty members providing physical therapy clinical education for students. The survey showed mutual agreement on four of the five top concerns ranked by educators and clinical faculty. The following two chapters discuss the form and function of interinstitutional agreements from the legal point of view, interdependence of educational and clinical institutions, and basic steps in drafting agreements. Chapter 5 consists of guidelines to assist in negotiating affiliation contracts--both university and clinical center rights, responsibilities, and obligations. A 14-page appendix consists of supplementary workshop information and a reading list. (EA)

Form and Function of Written Agreements in the Clinical Education of Health Professionals

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PREFACE

There is major concern the world over, and especially in the United States, with the need to enlarge the supply of manpower to provide health services. This concern is manifested in terms of efforts to develop more health service personnel of a classical type, such as physicians, dentists, and nurses, and more health service personnel of a more recent but well-recognized vintage, such as physical therapists and hospital administrators. A salient feature of the current and continuing interest in increasing manpower is the expansion of some traditional provider roles (quite evident in nursing, for example) and the proliferation of some quite new types of manpower. Allied health personnel of many professional and technical types are being developed to implement new knowledge and new technology, and to extend the traditional functions of the well-established providers, so that health services can be provided that meet the twin objectives of effectiveness and efficiency.

Training for all types of health manpower must include practical experience in the work setting — not only to develop clinical or technical skills but also to learn roles, relationships, and responsibilities in the practice settings. The diversity of these settings has increased dramatically in response to the health services demands of a changing society. Thus it is no longer just the hospital with which an educational institution must deal in planning the clinical education of students in the health fields.

And it is no longer just the university with traditional professional schools which has responsibility for the basic education of these students. Another feature of the burgeoning developments in our society is that other institutions, such as community colleges, are playing an ever-increasing role in the development and conduct of the curricula leading to degrees or certificates, particularly in the allied health professions.

Hence, this book is of great value at this time because it discusses the problems of how to arrange clinical experiences which will meet student needs and a number of mutually interdependent objectives of the educational and clinical institutions at the same time. Basically, the principles involved

in the arrangements for all the various professions and technologies are similar, but there are important differences which need attention. Therefore, as emphasized in these pages, there is no single set of arrangements which can be set forth as being best for all purposes. The principles, procedures, and basic steps in the affiliation process which are discussed herein can be expected to serve a most important need — a need that is felt by educational programs, by hospitals and other clinical programs, and by the educators, practitioners, and students themselves.

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ACKNOWLEDGMENTS

This book is based in part on a dissertation on interinstitutional agreements for clinical education completed by one of us while a graduate student in the Department of Education of Duke University in Durham, North Carolina. The book developed because of the increasingly evident need for better understanding of relationships between educational and clinical institutions in general and of the interinstitutional agreement process in particular.

In the allied health fields, the need has become especially urgent with the growing number and variety of students and the increasing complexity in educational designs of the curricula through which these students are educated. Furthermore, the Bureau of Health Manpower Education of the National Institutes of Health, United States Public Health Service, has recently indicated that in order for an educational institution to be eligible for federal financial support, written agreements must be available for all clinical education or field experience assignments for students in the allied health professions. Despite such practical considerations as eligibility for federal funding, the writing of agreements by the institutional allies in education is considered a wise expenditure of time and effort.

Thanks are due to many, for no study of this magnitude could be done by a limited number of people. The physical therapists throughout the United States are especially in our debts for the fine response they made to requests for information and for their participation in the workshop originally associated with this project. Special appreciation is extended to the Physical Therapy Fund, Incorporated, associated with the American Physical Therapy Association, for the financial support which made much of this project possible. The senior author of our book was also aided by a leave of absence from the University of North Carolina at Chapel Hill and by a graduate traineeship awarded by the Committee on Graduate Education of the American Physical Therapy Association with funds from the Social and Rehabilitation Service of the Department of Health, Education, and Welfare.

The three of us extend our sincere appreciation to our colleagues with whom we work who made this project possible by their understanding of the heavy commitment of our time necessary for its production. It is our hope that this is a relevant and helpful document for this time in the affairs of the education of the allied health students.

Chapel Hill, North Carolina
January 1972

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CONTENTS

TABLES AND FIGURE

Introduction

BACKGROUND AND APPROACH

Realignments of educational responsibility for the health professions within the higher education community are focusing new attention on arrangements for the practical phases of education. New and emerging fields are looking to established fields for guidelines on relationships between degree-granting institutions and outside agencies for the clinical education of students. At the same time the established fields are taking a new look at their own affiliation arrangements, so they can better cope with the forces of a changing society that demands adequate diversified and coordinated health care services for the people. The study reported in these pages represents such a new look.[1]

The beginnings of this study go back to the fall of 1969, when 11 faculty members of the Division of Physical Therapy, School of Medicine, University of North Carolina at Chapel Hill, together with 26 clinical supervisors from those centers cooperating with the University's educational program, met for an annual supervisors' conference in Raleigh, North Carolina. A portion of the conference was devoted to a workshop session in which the participants brainstormed areas of concern in the agreement process. Through this procedure the groups identified their diverse, but not divergent, interests.

The second step was based on the results of that 1969 workshop session. A questionnaire was prepared and mailed to the 51 educational administrators in the programs of physical therapy which at that time were approved by the American Medical Association in collaboration with the American Physical Therapy Association. Copies of written agreements in use by the educators were requested.

A similar questionnaire was constructed from the point of view of clinical supervisors and faculty. It was mailed to 91 selected physical therapists nationwide who had been identified as clinical faculty in the basic types of clinical facilities utilized in the clinical education of students. Copies of written affiliation agreements were also requested from these respondents.

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[1] The study is presented in somewhat different form in a dissertation submitted in partial fulfillment of requirements for the degree, Doctor of Education, Department of Education, Graduate School, Duke University: Moore, Margaret L. *Interinstitutional Agreements for Clinical Education in Physical Therapy*, 1971.

The results of the questionnaire survey are reported in Chapter 2, along with highlights from a workshop on interinstitutional agreements held in June 1970.

The documents acquired from the physical therapy clinical educators and educational administrators, and from other sources in medicine and nursing, totaled 60 written interinstitutional agreements. An analysis of these documents provided a basis for many of the materials developed and utilized in the June 1970 workshop on interinstitutional agreements. A study of contracts and other legal aspects of affiliation was also undertaken prior to the workshop (see Chapter 3).

The workshop itself was held in Chapel Hill, North Carolina, June 22-24, 1970. The participants were educators and clinical faculty, physical therapists and other allied health professionals, from 44 universities and clinical centers nationwide. There were 12 participants representing the law, public health, hospital administration, and clinical center administration. Other attendees were from community colleges; the Association for the North Carolina Regional Medical Program; the American Hospital Association; and the Bureau of Health Manpower Education of the National Institutes of Health, United States Public Health Service, Department of Health, Education, and Welfare.

Formal presentations, general discussions, panel discussions, and four simultaneous small-group sessions were featured at the two-and-one-half-day workshop. The outcomes are reported in Chapter 2; some of the materials appear in Appendix A.

The final phase of the study that resulted in this book was really not final at all, but rather a transition point to further study and testing. To meet the resounding demand for guidelines in developing interinstitutional agreements, an attempt was made to set forth some tentative guidelines, which appear as a checklist in the final chapter of this book. It should be emphasized that these are not presented as gospel, and a model contract is definitely not recommended.

The basic conclusions of the study, reiterated throughout these pages, are that affiliation agreements should be jointly developed by both parties in light of their mutual goals and that they should be documented in writing. Most importantly, the documents must be clear, simple, broad (but not superficial), and flexible. Only with built-in flexibility and continual review of affiliation arrangements can the complete education of the health professional student adapt to the accelerating pressures of our changing society.

Chapter 1

EDUCATIONAL TRENDS IN THE HEALTH PROFESSIONS

The continuing proliferation of health professions and semiprofessions has become a fact of life in the national effort to meet public demands for adequate health care services. However, education and training patterns for the newer professions have not emerged clearly or consistently. And, for the established professions, there have been pressures for changes in traditional patterns to accommodate greater numbers, new involvements in communities, and new interprofessional relationships.[1]

Whatever the ultimate outcomes of current change, and whatever the differences in the character and degree of specialized knowledge and skill required, all of the health professions have in common the concern with health and the need for practical experience as part of the total educational program. The agreements between educational and clinical institutions for the clinical education of students, particularly in the allied health professions, are the focus of this book. This chapter reviews some of the discernible trends in the education of health practitioners in general and considers in more detail the status of one field, physical therapy.

COMMONALITIES AND DIFFERENCES

All the health professionals — from those in established fields like medicine and dentistry, with all their specialties, to emerging personnel like family nurse practitioners and health evaluation specialists — have been affected by, and in some cases created by, the accelerating changes in modern society. Patterns of practice and patterns of education have both been influenced, but the latter have not kept pace with the former. This gives particularly timely importance to education in general and the clinical phases of education in particular.

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[1] Many of the current trends are documented and discussed in the influential report, *Higher Education and the Nation's Health* by the Carnegie Commission on Higher Education (Hightstown, N. J.: McGraw-Hill Book Company, 1970).

The shifting emphasis of national policy from biomedical research and traditional specialization to the effective distribution of high-quality comprehensive health services has resulted in pressures for increased numbers and kinds of health manpower, and consequently for increased enrollments in educational institutions. The recruitment of minorities especially has been encouraged. There have been pressures for curriculum change in the direction of relevance to practice, with greater integration of theory and clinical experience, and there have been pressures for acceleration. The internship may at last become a thing of the past in the clinical education of the physician.

The need for responsiveness to student desires in developing and modifying effective educational programs is an important trend that affects all education today, particularly professional education in the human services fields. Students are the great proponents of relevance and social awareness. Student demands for joint educational opportunities involving students in several different health fields may force the coordination of educational experiences recognized by many leaders as an ideal.[2] It is an ideal far from realized for the whole spectrum of health professions students. Even those fields theoretically brought together under the allied health sciences umbrella have been in some cases slow in developing coordinated efforts.

Nonphysician Health Professions

For the allied health people, many of whom used to be trained in hospitals, the trend is toward educational responsibility based in university health sciences centers or in colleges or junior colleges. This places a new kind of emphasis on arrangements and affiliations for a diversity of clinical experiences. For the basic scientific and general education, the trend is toward commonality, a core curriculum. The idea is to encourage educational mobility so that students can move upward from one career choice to another.

There are many ways to categorize the health professions, none completely satisfactory for a variety of reasons. One framework is the primary established fields (medicine,

[2] Atwell, Robert J. "Interdependence of Medical and Allied Health Education," and Kirkland, John S. "The Medical Student as a Loner." *JAMA* 213, July 13, 1970, pp. 276-79. Although articles like these may be interpreted by some as arguments for placing allied health education under the dominance of medicine, they also illustrate that physicians have a lot to learn from other health fields, both "allied" and "primary," and that medical students do not want to be loners during their educational period.

dentistry, nursing, public health, pharmacy) vs. the fields "allied" with them. Another is by level of education, which might define a profession as a field requiring the baccalaureate degree as a minimum, which becomes confusing when for some fields the professional organization and licensing laws give equal recognition to two three, and four years of education beyond high school. Attempts to differentiate technologists and technicians are equally clumsy.[3]

For purposes of this text, a more meaningful classification would be by type of practical experience required. Basically this breaks down into (1) laboratory experience in a hospital-based, dental, or other laboratory; (2) field experience in a state or local health agency, a community health center or hospital, or a variety of other grass-roots locales; and (3) clinical experience involving patient care in a hospital (both inpatient and outpatient services), a private practice setting, or other health care facility.

Medical technology is a good example of a field not only requiring a minimum of a baccalaureate degree and laboratory experience at its responsible levels, but also an affiliation between the degree-granting institution and the laboratory-based medical technology program. In 1972 the Board of Schools of the American Society of Clinical Pathologists and the Council on Medical Education of the American Medical Association (AMA) will require "written evidence of the affiliation and of its provisions."[4] Medical technology is also a good example of a health profession that has been traditionally more closely allied with medicine than some of the others, because medical technologists have worked closely with pathologists. This is broadening to include chemists, microbiologists, bacteriologists, and others.

Pharmacy is another health profession requiring laboratory experience. Pharmacy also illustrates the impact of continuing change that affects even the long-established professions. The clinical pharmacy trend is now exposing more students of pharmacy to patients and patient care.

The field experience type of practical training for students is characteristic of social work and the public health specialities like health administration, health education, epidemiology, and public health nursing. These field sites are extremely varied and

[3] National Advisory Health Council, *Education for the Allied Health Professions and Services* (Washington: PHS pub. no. 1600, 1967), pp. 10-11. Table 6 is a helpful categorization.

[4] "Confirmation of Affiliation," Newsletter No. 8 (Chicago: The American Society of Clinical Pathologists Board of Schools, undated).

can range from an urban office situation to a decentralized rural locale. The field experience usually involves working with a variety of people in communities.

Some emerging health professions are still struggling with curriculum development and functional definitions of the profession at the same time. An example is the emergence of evaluation as a new speciality, an effort prompted by the federal government. During 1971 four universities were awarded contracts by the Health Services and Mental Health Administration to conduct feasibility studies toward the development of a new university program in education, training, research, and development in evaluation.[5] The contracts specifically called for the development of field experiences and identification of field sites for students of evaluation with a diversity of backgrounds.

Direct patient-care experience is of course an integral part of the education of future practitioners in the patient-care professions. This book is concerned mostly with the non-M.D. professions, but most of the experience in organizing clinical education and negotiating affiliation agreements for its implementation has been in medical education. Much of what has been learned is applicable to other professions. The study by Cecil G. Sheps and his associates on medical school-teaching hospital relationships remains a valuable resource, in spite of recent trends toward integrating, shortening, and diversifying clinical education: it is referred to frequently in this book.[6]

Professional education in nursing also has long experience in planning clinical education. Newer professions, like the family nurse practitioner, are still in developmental stages and the appropriate clinical experiences are still being worked out. Certainly they will include, at least for some students, work with patients in community health centers and innovative health care delivery units not yet off the drawing boards.

Physical therapy is an allied health profession with a well-established clinical role and a history of informally arranged but mutually beneficial affiliations for clinical education between

[5] University of North Carolina, Harvard, Yale, and UCLA were the four universities awarded contracts in 1971 from the Health Services and Mental Health Administration, United States Public Health Service, for feasibility studies toward a new university program in education, training, research, and development in evaluation of health programs. In 1972, the University of North Carolina at Chapel Hill was the one chosen to conduct the new program.

[6] Sheps, Cecil G., Clark, Dean A., Gerdes, John W., Halpern, Ethelmarie, and Hershey, Nathan, *Medical Schools and Hospitals: Interdependence for Education and Service, J. Med. Educ* 40, September 1965, part 2; reprinted 1971.

educational and clinical institutions and agencies. To the extent there can be a prototype amidst the great diversity, physical therapy can perhaps come closest. The concluding section of this chapter reviews the history and educational philosophy of this patient-oriented profession.

In closing this first section of Chapter 1, it is appropriate to mention some of the current problems affecting the nonphysician (and nondentist) health professions — the changing established fields, the multidisciplinary specialists, the emerging professions, the new crops of assistants, and those professions typically grouped in the schools of allied health sciences developing or already functioning at many universities.

One problem involves the uncertainties of professional identity and some highly charged issues surrounding territorial rights. This is reflected in interpretations of the word, "allied" — often used as "allied with medicine" or "allied with dentistry," and often implying subservience.[7] Some, but not all, health professionals do work under the direction of the elite professions. Others have developed an independent body of expertise, or have arisen in response to a limited but highly specialized need. It would be desirable to think of all as allied toward the goal of a healthy citizenry.

Another problem is the danger of fragmentation posed by the rapid proliferation of new fields and complicated by competitive attitudes that thwart coordination. This is further complicated in many cases by the still-evolving status of an identifiable body of knowledge and skills. Frequently, there is not only a lack of educational leadership, but an acute shortage of faculty.

The problems are recognized and studies are in progress. A Study of Accreditation of Selected Health Educational Programs is under way during 1971 under the direction of William K. Seldin. It is directed toward the delineation of some basic principles as a common base for what currently is an uncoordinated welter of accrediting agencies and organizations.[8]

Also under way are efforts to compile national inventories of allied health occupations education programs. The Association

[7] In the annual education numbers of *JAMA*, data are reported on "Educational Programs in Areas Allied with Medicine," the 15 allied programs the American Medical Association accredits jointly with 18 other professional organizations. The 1970 education number of *JAMA* appeared November 23, 1970; pages 1530-33 contain the report on allied programs.

[8] Some tentatively proposed basic principles of accreditation appear in a paper presented by William K. Seldin in July 1971 at the Conference on Organization convened by the Joint Commission on Accreditation of Hospitals.

of Schools of Allied Health Professions, incorporated in 1967, is developing a continuing inventory for four-year college programs, and the American Association of Junior Colleges is doing a similar inventory for two-year community college programs. Other studies are directed toward providing information for legislative planning, curriculum construction, and cost analysis. Much more information is needed, but first steps are under way.[9] It is hoped the study on interinstitutional relations for clinical education, reported in these pages, will contribute its share.

EDUCATION IN PHYSICAL THERAPY

Physical therapy, unlike many of the more than 100 other health fields, is well established with a developed body of theoretical and practical knowledge and traditions of its own. This concluding section describes the history and current status of the profession and the basic and clinical educational preparation of its practitioners.

Historical Development

The roots of physical therapy in the United States go back to World War I, when orthopedic surgeons and others concerned with the wounded serviceman were influential in organizing a Reconstruction Aide Corps in the United States Army to perform physical therapy in military hospitals.[10] The first United States training program was established in 1918 at Reed College in Oregon by a female British-trained physical therapist who had served with the United States Army.

In 1925 the American Physiotherapy Association, later to become the American Physical Therapy Association (APTA), assumed responsibility for the identification of approved physical therapy educational programs, for establishing the qualifications of graduates, and for publishing a list of the approved courses of instruction. Approval was based on limited criteria, and data were furnished originally by written report. The institutions were first surveyed in 1929 by physical therapy site visitors. When the job of survey and accreditation became

[9] Chase, Helen C. "Some Current Research for the Allied Health Professions," *Physical Therapy* 51, July 1971, pp. 771-78.

[10] The content of this section is based on Beard, Gertrude, "Foundation for Growth: A Review of the First Forty Years In Terms of Education, Practice and Research," *Physical Therapy Review* 41, December 1961, pp. 843-66. As a World War I Reconstruction Aide, retired School Director, and a Mary McMillan Lecturer, she is well qualified to present as complete a story as is available in any one publication.

too difficult for the organization, which then had no national headquarters, no adequate source of income, and no adequate experience in accreditation, the APTA asked the American Medical Association (AMA) to assume this responsibility. In 1936 the Council on Medical Education and Hospitals of the American Medical Association took over the task of accreditation of educational programs in physical therapy.

Until the late 1930s most physical therapy education in the United States had been organized in hospitals and in colleges. Graduates of nursing programs were welcomed into the curriculum, but the primary emphasis was on students with physical education backgrounds.

During World War II, when the demand for physical therapists was so great, nine- and twelve-month emergency courses were established throughout the United States. Other notable influences which have increased the need for physical therapists over the years have been the poliomyelitis epidemics, the growth of the physical rehabilitation movement, the prevalence of chronic disease, the increased trauma from an industrial society, and the more recent concerns for the mentally ill and the mentally retarded and increasing attention to child growth and development problems.

In 1955 the American Physical Therapy Association recommended that all programs of physical therapy be located in universities with four-year medical schools — not under or in a medical school, but with proximity to a medical school with its rich resources in the basic sciences and its medical and clinical facilities, so important to the physical therapy curriculum.[11] The statement developed and stood for a long time, in spite of the fact that both prior to and after 1955 physical therapy programs were being organized on campuses without either two-year or four-year medical schools. In 1955 also, with the assistance of physical therapists and physicians interested in physical therapy education, the then current *Essentials of an Acceptable School of Physical Therapy* was redrafted by the Council on Medical Education and Hospitals of the American Medical Association.[12]

In 1965, with joint planning by the Council of Physical Therapy School Directors (CPTSD), a four-year study of basic physical

[11] Dickinson, Ruth, Dervitz, Hyman L. and Meida, Helen M. *Handbook for Physical Therapy Teachers* (New York: American Physical Therapy Association, 1967), p. 11. Also Committee on Basic Education, *Education for Physical Therapy* (New York: American Physical Therapy Association, 1967).

[12] Council on Medical Education and Hospitals, *Essentials of an Acceptable School of Physical Therapy* (Chicago: American Medical Association, 1955).

therapy education was undertaken by the staff of the American Physical Therapy Association. All 42 approved programs existing at that time participated in the study directed by Catherine A. Worthingham, Ph.D., who was Director of Physical Therapy at Stanford University and later Director of Professional Education for the National Foundation (of Infantile Paralysis). The results of the Worthingham study, which have appeared in seven articles, have given the profession an excellent reservoir of information for self-study and planning.[19] Statistical data in this section come from the published reports.

The Worthingham study, begun in 1965, analyzed the educational programs as they existed in 1965. Of the 42 programs, 35 offered the baccalaureate degree. Two of the 35 accepted students at the junior level only, and two others accepted students at the senior year only. Two programs offered the master's degree for the basic preparation of the physical therapist. Fourteen of the 35 degree-granting institutions also offered a course of study for students who had attained a baccalaureate degree in another subject-matter area. Students who completed this course were offered a certificate of proficiency. Only two hospital-based programs offered the certificate course, which was at least 12 months in length.

Four programs were not able to offer a degree, but credit earned in these institutions was utilized by students in one or more colleges with which the programs were associated. In this way a degree could be granted by the parent university while the student obtained his physical therapy education from an affiliated program of physical therapy. These degree arrangements offered a variety of credit hours and were usually involved with only the final year of study, which concentrated on physical therapy content.

Most educational programs in physical therapy were then, and

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[19] The seven articles in the series on basic physical therapy education were written by Catherine A. Worthingham. All appear in *Physical Therapy*, Journal of the American Physical Therapy Association. They are "Curriculum Patterns for Basic Physical Therapy Education: Compared with Six Selected Undergraduate Fields," 48, January 1968, pp. 7-20; "The Environment for Basic Physical Therapy Education, 1965-1966: The Academic or Theoretical Phase," 48, September 1968, pp. 935-62; "The Clinical Environment for Basic Physical Therapy Education, 1965-1966: Part 1: Facilities," 48, November 1968, pp. 1195-215; "The Clinical Environment for Basic Physical Therapy Education, 1965-1966: Part II: Staff," 49, May 1969, pp. 476-99; "The 1961 and 1965 Graduates of the Physical Therapy Schools: Part 1: 1961 Graduates, Part II: 1965 Graduates," 49, May 1969, pp. 476-99; "Request (Prescription or Referral) for Physical Therapy," 50, July 1970, pp. 989-1031; and "Findings of the Study in Relation to Trends in Patient Care and Education," 50, September 1970, pp. 1315-32.

still are, part of a university academic structure. Forty-two percent of the schools were administratively located in schools of medicine. Twenty-two percent were in schools of the allied health professions; two were autonomous. Only six programs were hospital-based, and one was at the Medical Field Service School of the United States Army. The remainder were in a variety of academic locations.

Some educational programs have a primary teaching hospital available both physically and administratively in their own university structure. Others must rely on clinical facilities under some other administrative control. The proximity and availability of clinical centers determine in part whether clinical education is offered concurrently with classroom instruction or is arranged on a block-time basis.

The Worthingham study found that 255 individuals occupied faculty positions in 42 institutions; of these 172 were full-time and 78 were part-time. Twenty percent of the faculty members were men, and 80 percent were women. Forty percent of those in degree-granting curricula had less than two years of teaching experience, and in certificate programs 33 percent had less than two years of academic experience.

The academic load for faculty in physical therapy was difficult to assess because many had mixed professional responsibilities, including service to patients. The classroom teaching load for faculty in physical therapy can be considered low in comparison with other university faculty with academic appointments outside of the health professions. The schedule of many physical therapy faculty members, however, if evaluated in terms of patient-care commitments, coordination of multiple instruction courses, and the usual factors computed in faculty load, can be considered excessively heavy.

Of the 2,453 physical therapists identified as having clinical faculty appointments, 2,402 participated in the Worthingham study. Seventy-six percent of these were women, 29 percent were under 25 years of age, and 9 percent were over 50 years of age. Eleven percent had academic teaching experience with 7 percent having between one and five years of experience, and 4 percent from 6 to 21 years of teaching experience.

Because of the variation in design of the curricula, it is difficult to determine a true count of the number of students "enrolled" in programs of physical therapy. Majors are selected at the freshman, sophomore, junior, senior, or certificate level in a variety of patterns, which makes an inventory of capacity and enrollment difficult, if not impossible. In the 1965 study, out of 1,033 students enrolled in the "final year" of a physical therapy

curriculum, only 308 were certificate students, and 21 were candidates for the master's degree. In 1965, 856 students graduated from 42 programs of physical therapy.

Several universities offer the master's degree to the qualified physical therapist who has baccalaureate-degree preparation in physical therapy or a certificate in physical therapy. The master's degree program in this instance is for advanced preparation and not basic preparation. Students in these courses were not counted in the group listed above.

In 1965 the current plan of collaboration between the American Physical Therapy Association and the American Medical Association was initiated, whereby review of educational programs in physical therapy would be more frequent and the procedures for evaluation more formalized. The important role of the physical therapist in the accreditation process had been increasingly notable over the years, and in 1963 the National Commission on Accreditation (NCA) recognized the collaborative efforts of the two associations, and both names now appear jointly as accreditation agencies.[14] As this book goes to press, there are 52 or more approved educational programs in physical therapy, and others are in early formative stages or in the stage of provisional approval.

The early 1970s are a time of change in physical therapy education, as they are in so many other fields. In 1967 the Committee on Basic Education of the American Physical Therapy Association published comprehensive guidelines for the establishment of an educational program in physical therapy and recommendations for preparing an official survey visit; in October 1971 a draft of new standards for basic education in physical therapy was distributed for information and study.[15] These standards recognize flexibility, diversity, and the need for continuing evaluation — trends of the times.

Clinical Education

Clinical education in physical therapy is a necessary component of the curriculum since physical therapy is a helping or serving profession involving direct patient care. The clinical

[14] *Procedures of Accrediting Education in the Professions: A Series of Reports* (Washington, D. C.: National Commission on Accrediting, March 1964), and Rogers, Sarah A. "A Salutary Process in Education for Physical Therapy," *Physical Therapy* 47, July 1967, pp. 608-13.

[15] Committee on Basic Education, *Education for Physical Therapy, op. cit.* Also American Physical Therapy Association, "Standards for Basic Education in Physical Therapy" and supplemental materials, 1971.

education of students is the most meaningful part of their educational experience; physical therapy educators believe that clinical education in increasing degrees of involvement should begin early and progress through the entire curriculum.[16] Students assigned to clinical settings can easily be exploited, but effective relationships between physical therapy educational and clinical institutions have assured recognition that the clinical education phase is offered for the primary purpose of teaching the student. Clinical education must be organized and administered as any other clinical laboratory course. It must be created, studied, evaluated, and governed by objectives, criteria, and learning experiences in all of its components as skillfully and as thoughtfully as any other course offering.[17]

The Council of Physical Therapy School Directors stated in 1968 that the primary challenges of clinical education are "to assist the student; to correlate clinical practice with basic sciences; to acquire new knowledge, attitudes and skills; to develop ability to observe, to evaluate, to develop realistic goals and to plan effective treatment programs; to accept professional responsibility, to maintain a spirit of inquiry and to develop a pattern for continuing education." [18] This charge is interpreted by faculty in individual schools and is expressed in their own phraseology and philosophies and through the individual curricula. Curricula should be modified constantly in order for students to have opportunity for educational experiences relevant to changing health needs and the dynamic health care systems they will face as graduates. Curriculum modification implies new types of clinical facilities in which the student would affiliate, new kinds of patients, new methods of treating and serving patients, and new roles for physical therapists in teaching, consulting, administration, and supervision.

The design of the clinical education phase of the curriculum basically should be determined by the philosophy of the school, but in many instances this is molded by available resources or facilities, talents of the faculty, and the type of institution of

[16] Callahan, Mary E. *et al. Physical Therapy Education: Theory and Practice* (Council of Physical Therapy School Directors, April 1968) pp. 9-10, and Schulz, Beatrice F. "Developing Objectives for Physical Therapy Education," *Clinical Education for Physical Therapy* (New York: American Physical Therapy Association, 1961) pp. 7-18.

[17] Whitcomb, Beatrice, "Methods of Clinical Instruction in Physical Therapy," *Physical Therapy Review* 31, April 1951, pp. 129-34.

[18] Callahan *et al., op. cit.*, p. 38.

higher education in which the school is located. Health professions curricula are usually composed of three units that deal with the basic and social sciences, professional theory and application, and full-time clinical education. The sequence affects, but does not control, the relationship among parts of the curriculum.

Experiences usually are planned from less to more complex functions throughout the didactic content and clinical content. The educational experience is, therefore, a continuum. If a curriculum has continuity, sequence, and integration, it generally is considered to be well-formed.[19] An ideal way to build the curriculum, particularly in the area of clinical education, is to plan around the student's needs, society's needs, the subject-matter specialties available, and the professional standards of practice in each area.[20]

In physical therapy much of the design depends on whether the professional phase of the curriculum is concentrated in a one-year certificate program, or blended throughout four years of education. Generally, didactic and laboratory courses comprise the professional curriculum, with some time devoted to early introduction to learning in a clinical environment. Then the three units of laboratory, didactic, and clinical education continue through the curriculum with the clinical aspect increasing, while the didactic and laboratory aspects decrease. The curriculum should conclude with a full-time assignment devoted to clinical education; this period usually lasts from two to four months.

Computed on a basis of a seven-hour day and a five-day week, schools offer their students clinical education from 12 to 65 weeks. In 1965, 10 schools out of 42 offered 20 weeks or 700 hours. Only one school reported more than 27 weeks, and one had less than 14.[21]

Students have assignments with patients in different age groups with acute diseases and chronic diseases; assignments involve hospital inpatient and outpatient services and out-of-hospital programs, such as home care, nursing homes, extended-care facilities, rest homes, and public health clinics. In addition, students are educated in special facilities, related specifically to disease or injury categories. Nurse educators and physical

[19] Dickinson, Dervits, and Moida, *op. cit.*, pp. 193-94.

[20] Schwoer, Joan E. *Creative Teaching in Clinical Nursing* (St. Louis: C. V. Mosby Company, 1968) p. 87.

[21] Worthingham, "Curriculum Patterns for Basic Physical Therapy Education," *op. cit.*, p. 80.

therapy educators utilize the same general plan. Over the years actual assigned time to clinical education has been reduced, but more emphasis has been placed on high-quality educational design of the experience.

Clinical education in the health professions, as a necessary part of the total curriculum, is considered in various ways in the accreditation process, which for many fields is currently undergoing change. Each of the health professions has its own special goals for the clinical phase of its curriculum, but each reiterates as a matter of policy that a balance should exist between the didactic and the practical and that no one curriculum pattern is necessary or desirable. Increasing emphasis is being laid on the establishment of objectives and on evaluation of the clinical learning experience, beginning with self-evaluation by the institutional faculty, and covering the student involved in the experience.[22]

For physical therapy, the currently emerging standards for basic education emphasize the nature and quality of the end product. The accompanying process guidelines, distributed in draft form by the American Physical Therapy Association in October 1971, do not specify minimum hours of clinical experience.[23] They do stress early integration of clinical and academic work and a variety of service settings. These guidelines also state that even when a clinical facility is readily available as part of the parent institution, additional clinical affiliations are essential. Each of these affiliations should be recorded in writing, and the document should be dated and periodically reviewed.

ALLIES IN EDUCATION

Whether a profession requires a laboratory, field, or patient-care setting — or various combinations thereof — for the practical phases of education, there is a need for agreements between educational institutions and clinical institutions. The same principle applies even when both are part of the same university. The same principle applies whether the training period is of long or short duration and whether it involves few or many students.

Chapter 2 presents the results of a questionnaire survey of physical therapy educational directors and clinical center supervisors, and it reports the outcomes of a workshop on

[22] Rogers, *op. cit.*, pp. 608-13.

[23] American Physical Therapy Association, "Standards for Basic Education in Physical Therapy," *op. cit.*

interinstitutional agreements in which a nationally selected group of physical therapy and other health professionals, both academic and clinical, participated. It is a basic conclusion of this study that the interinstitutional agreements should be carefully developed by both parties and documented, clearly and simply, in writing.They should be flexible to accommodate continual adaption to changing trends.

It is also a basic conclusion of this study that those in the educational institution and those in the clinical institution have a common stake in the production of highly qualified practitioners. Both share basic goals in varying degrees. These allies in the education of health professionals are truly dependent on one another, whether the field is newly emerging and still undocumented or as firmly established as physical therapy.

Chapter 2

PRINCIPLES AND PARTICIPANTS IN INTERINSTITUTIONAL AFFILIATIONS

Whatever the field of professional study requiring clinical or field site experience, there are three groups of participants involved in the educational process. These are the students, the institutional educators, and the clinical educators. The study on which this book is based was initiated from the university's point of view, but throughout careful attention was given to the views of the other groups. This is basic, for unless common goals are recognized, and unless the mutuality of obligation is accepted, there can be no effective agreement between educational institution and clinical institution for the clinical education of students.

This chapter presents facts and opinions from various viewpoints. It is based chiefly on two aspects of the study described in the Introduction: (1) a questionnaire survey of physical therapy educational programs and of clinical centers and (2) a workshop on interinstitutional agreements held in June 1970.

QUESTIONNAIRE RESPONSE

The Respondents

A questionnaire on current practice with respect to interinstitutional agreements for clinical education was mailed to the 51 educational administrators in programs of physical therapy approved by the American Medical Association in collaboration with the American Physical Therapy Association. A similar questionnaire was mailed to selected clinical supervisors and clinical faculty members in a sampling of the more than 500 institutions utilized by educational programs of physical therapy for clinical education of students. The quite satisfactory response is summarized in Table 2.1.

The selection of recipients of the clinical institution questionnaire, from among the many centers and agencies affiliating with physical therapy programs for clinical education

TABLE 2.1

QUESTIONNAIRE RETURNS FROM PHYSICAL THERAPY EDUCATIONAL PROGRAMS AND CLINICAL CENTERS

	Questionnaires			
	Returned		Not Returned	
Recipient	N	%	N	%
Programs (N=51)	50	98%	1	2%
Centers (N=91)	79	87%	12	13%

TABLE 2.2

CHARACTERISTICS OF RESPONDING PHYSICAL THERAPY EDUCATIONAL PROGRAMS (N=50)

Characteristic	N	%
Type of support		
Public	30	60%
Private	19	38%
Mixed	1	2%
Administration of program's primary clinical center		
Same as program	22	44%
Separate from program	17	34%
Other	5	10%
No response	6	12%

of students, was accomplished by seeking cooperation from the 15 educational administrators invited to the June 1970 workshop. This quite representative group was chosen on the basis of interest in the subject of interinstitutional agreements, geographic distribution nationwide, and type of curriculum directed (Bachelor of Science, Certificate of Proficiency, and Master of Science).

Each of these 15 educational directors was asked to submit the names of two clinical faculty members in affiliating centers representing the basic types of clinical facilities utilized in physical therapy education (Table 2.3). The clinical institution questionnaire was mailed to these 91 clinical faculty members.

Characteristics of the educational institutions responding to their questionnaire, and of the clinical institutions responding to the clinical questionnaire, are shown in Tables 2.2 and 2.3.

Some idea of the large numbers of affiliations each institution is involved with just for physical therapy education is shown in Table 2.4. The educational programs average almost 20 different affiliations per program. From the clinical center's viewpoint, there are fewer affiliations to cope with, about two or three educational institutions per center, but one center reported as many as 38.

Form and Content of Affiliation Agreements

The questionnaire results were intended to serve as background material for the June 1970 workshop on interinstitutional agreements, and several questions were directed to the form and content of current agreements. Tables 2.5-2.9 report these results.

Signed written agreements are evidently not a firm requirement at the present time on the part of either universities or clinical centers. When there is a requirement, the educators encounter it more frequently from the center than from the university; only six reported a university requirement (Table 2.5). However, there is some evidence that signed written agreements are used more frequently than required and that the desirability of a written contract (a conclusion of the present study) is under consideration in various places.

Table 2.6 reports the forms of agreement used by physical therapy educational programs and affiliating centers. It is clear there is a great deal of variety from one affiliation to another, and a multiplicity of forms are used. Educators report the business letter as the most frequently used mechanism, with formal contracts, memorandums, and verbal agreements used

TABLE 2.3

CHARACTERISTICS OF RESPONDING CLINICAL CENTERS*
(N=79)

Characteristic	N	%
Type of agency		
Rehabilitation center	16	20%
Public health agency	8	10%
Children's center	9	11%
Hospital	32	40%
Federal hospital	10	13%
Self-employed	2	3%
Other	2	3%
Type of support		
Public	40	51%
Private	39	49%

*Of the responding centers, 10 are primary clinical centers for programs of physical therapy; 5 are public institutions and 5 are private; 5 are under the same administration as the educational program.

TABLE 2.4

NUMBER OF AFFILIATIONS REPORTED BY PHYSICAL THERAPY EDUCATIONAL PROGRAMS AND CLINICAL CENTERS

			Mean per center*	
Affiliation	Range	Mean per program	Public	Private
Number of centers reported by programs (N=49)	3-50	19.8	--	--
Number of programs reported by centers (N=79)	1-38	.....	2.9	1.9

*The public-private breakdown refers to the type of support of the clinical centers.

TABLE 2.5

REQUIREMENTS FOR
SIGNED STATEMENTS OF AFFILIATION
REPORTED BY
PHYSICAL THERAPY EDUCATIONAL PROGRAMS
AND CLINICAL CENTERS

Signed statement	Yes		No		No response	
requirement	N	%	N	%	N	%
Program report (N=50)						
Required by university	6	12%	43	86%	1	2%
Required by at least some clinical centers	28	56%*	20	40%	2	4%
Center report (N=79)						
Required by center	13	24%	57	72%	3	4%

*Eleven educational administrators said these centers were mostly federal institutions, but some were state, community, private, and county institutions.

TABLE 2.6

FORMS OF AGREEMENT
USED BY
PHYSICAL THERAPY EDUCATIONAL PROGRAMS
AND CLINICAL CENTERS
(Multiple Response)

Form	Mentions by programs*	Mentions by centers*
Business Letter	33	39
Letter of Agreement	19	16
Verbal	18	41
Formal Contract	16	7
Other	1	1

*Of the 50 programs, 48 responded; of the 79 centers, all responded.

less frequently. The centers report verbal agreements and business letters in almost equal proportion as their most frequently used mechanisms of agreement; there were only seven mentions of formal contracts. About half of the centers who occasionally use written documents include the same content for all affiliation agreements. A smaller proportion of educational programs attempt to standardize content (Table 2.7).

TABLE 2.7

STANDARDIZATION OF CONTENT IN AGREEMENTS BETWEEN PHYSICAL THERAPY EDUCATIONAL PROGRAMS AND CLINICAL CENTERS

Content	Programs		Centers*	
	N	%	N	%
Same in all agreements	14	28%	32	52%
Varies with agreements	33	66%	29	48%
No response	3	6%	--	--
TOTAL using written agreements	50	100%	61	100%

*Of the 79 centers, 61 reported using written agreements; 22 of the 32 reporting the same content in all agreements are public institutions.

Table 2.8 presents physical therapy educational directors' reports of signatures appearing on the written agreements. These directors are the most frequent signers for the educational institution, and often they are the only signers. There is more variety with the clinical centers, as might be expected.

There was a question on review procedure in both questionnaires. There was a large "no response" from the clinical institutions, but of the one third that did respond annual review of agreements was cited by almost all. The educators were split about half and half between biennial and annual review.

There was also an item in the questionnaires on the number of health professions covered in a single affiliation agreement for clinical education. There are some but not many multidiscipline agreements. Only seven of the 48 physical therapy educators responding to the question reported that their university had

agreement with a single center covering clinical education in other fields as well as in physical therapy. Of the 64 clinical centers responding to the question, only 19 reported an agreement covering more than one group of students from the same university.

There is a high degree of satisfaction with current practices, particularly on the part of the clinical centers. This should not be interpreted as complacency, however, for 42 percent of the

TABLE 2.8

SIGNATURES TO AGREEMENTS BETWEEN PHYSICAL THERAPY EDUCATIONAL PROGRAMS AND CLINICAL CENTERS

Signatures	Number of mentions	% of 50 programs
Program reports of university signers		
Signed by program director	35	70%*
One additional signature	14	28%
Three or more additional signatures	2	4%
No response	6	12%
Program reports of clinical center signers		
Signed by clinical faculty	22	44%**
Signed by hospital or agency administrator	31	62%
Signed by directors of medical or clinical services	16	32%
Other signatures	7	14%
No response	6	12%

*In more than half these cases, the program director's signature was the only one required. Additional university signatures mentioned were: 2 comptrollers, 5 presidents, 5 department chairmen, 10 deans, and 8 other officials.

**Nineteen programs report clinical faculty to be the sole signature from the clinical institution.

educational programs and 29 percent of the clinical centers indicated some changes would be desirable (Table 2.9). The keen interest in discussions at the June 1970 workshop bears this out, and it is fortunate that exploration of improvements starts on a firm base of mutual satisfaction and mutual concern.

TABLE 2.9

OPINIONS ON ADEQUACY OF CURRENT AGREEMENTS BETWEEN PHYSICAL THERAPY EDUCATIONAL PROGRAMS AND CLINICAL CENTERS

	Programs		Centers	
Opinion on adequacy	N	%	N	%
Current situation satisfactory	25	50%	50	63%
Changes needed	21	42%	23	29%
No response	4	8%	6	8%

Areas of Primary Concern

Both of the allies in education, the physical therapy educational directors and the clinical faculty in affiliating centers, were given the opportunity to list five areas of primary importance and concern in the affiliation relationship. Selection of five topics was solicited from a list of 14, with open-ended option; these are items amenable, if not to direct inclusion in a contract, at least to influence by the inclusion of specific provisions.

The results are notably similar from both respondent groups. The rank order for the educators is as follows: (1) quality of supervision, (2) evaluations, (3) availability of sufficient learning experiences in a given center, (4) legal problems, and (5) schedules for assignments.

The rank order of prime concerns for the clinical faculty is as follows: (1) availability of sufficient learning experiences, (2) role of clinical center and staff, (3) evaluations (especially of students), (4) quality of supervision, and (5) schedules for assignments.

It is notable that four of the top five concerns are shared by both the educational programs and the centers. This bodes well for mutual accomplishments.

WORKSHOP HIGHLIGHTS

In order to explore in a person-to-person setting the current practices and concerns of educators and clinicians on the subject of interinstitutional agreements for the allied health professions, a two-and-one-half-day workshop was held on June 22, 23, and 24, 1970, in Chapel Hill, North Carolina, under the auspices of the Division of Physical Therapy of the School of Medicine of the University of North Carolina at Chapel Hill.[1] The complete program appears in Appendix A.

The Participants

The group was primarily composed of physical therapy educators and clinical faculty, although one occupational therapist and two medical technologists also participated. It had been hoped that several more health fields would be represented, for workshop emphasis was on issues common to all disciplines. Altogether, allied health protessionals from 44 universities and clinical centers were present, as well as 12 participants who represented the law, public health, and hospital and clinical center administration. Other attendees represented the North Carolina community colleges, the Association for the North Carolina Regional Medical Program, the American Hospital Association, and the Bureau of Health Manpower Education, National Institutes of Health, United States Public Health Service.

The participants from educational institutions came from 14 universities. Participants from clinical institutions came from eight different types of settings where students in the allied health professions receive clinical education (see Table 2.10). A cross-section of settings, geographical representation, and interest in the subject were factors in selecting participants. The number of participants was purposely restricted in order to provide opportunity for interpersonal reaction. Sixty persons participated in the sessions over the two-and-one-half-day period.

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[1] Funded primarily by the Physical Therapy Fund, Inc., of Washington, D. C., with some additional assistance from the Association for the North Carolina Regional Medical Program and the Maternal and Child Health Service, Health Services and Mental Health Administration, Department of Health, Education, and Welfare, through projects funded to the Division of Physical Therapy, School of Medicine, University of North Carolina, Chapel Hill.

TABLE 2.10

TYPES OF CLINICAL INSTITUTIONS REPRESENTED AT THE JUNE 1970 WORKSHOP

Institution	Number of participants
General hospital	10
Public health agency	2
Rehabilitation center	4
Center for mentally retarded	2
Veterans Administration hospital	1
Public Health Service hospital	2
Children's center	1
University teaching hospital	4

The Speakers

A variety of experience and expertise relevant to the study of interinstitutional relationships was represented by the speakers at the June 1970 workshop. On the first day, Cecil G. Sheps, Director of the Health Services Research Center at the University of North Carolina, spoke on the background of the medical school-hospital study which he directed when he was with the University of Pittsburgh.[3] That study, often referred to as the Sheps Report, remains the basic reference on affiliation agreements for clinical education in medicine. It was undertaken with the belief that medical education and research were more interrelated with patient care than either medical school or hospital administrators appreciated. Four common goals were identified: education, research, patient care, and community service. After reviewing over 150 contracts, Dr. Sheps and his colleagues came to the conclusion that the most satisfactory relationships existed when a simplified contract existed. When very detailed agreements existed, a lack of trust or understanding about shared goals was often present. From his vantage point as a former hospital administrator, he favors written agreements because they inform the hospital director of the extent of the involvement of his hospital with other agencies. Written agreements provide orderly maintenance of regular relationships so that the routine does not have to be handled on a crisis basis.

Joseph Kadish spoke as an educator and as a representative of the Bureau of Health Manpower Education, National Institutes of Health. He urged the participants to focus on the real purposes of clinical education. He also reviewed the federal government's interest in manpower development as

demonstrated by the Allied Health Professions Personnel Training Act of 1966, since amended.

In a presentation of legal aspects, a lawyer, David G. Warren of the Institute of Government, University of North Carolina, carefully defined a contract and its functions (see Chapter 3). Emphasis on the possible involvement of lawyers for both parties brought concern from the next speaker, E Martin Egelston of the American Hospital Association. He expressed the desire for the development of national guidelines on agreements, accreditation, and licensure which he felt would help to avoid an increase in local grievance problems involving employers, employees, the unions, and professional associations.

After a presentation of highlights from the preworkshop questionnaires, discussed at the beginning of this chapter, a panel of four active professionals spoke from various vantage points on interinstitutional relationships and agreements. A physical therapy educational administrator from a large city university, Samuel Feitelberg, spoke first on this panel. The complexity of directing and administering a clinical educational program in New York City for a physical therapy program with a large enrollment encouraged him to become well versed on legal issues. He urged the development of a basic contract form which can easily be modified for the variation in levels of sophistication of clinical centers and for the rapidly changing programs, staff, and educational needs of both parties. He urged that parents of students receive more information on the clinical education phase of the curriculum. Feitelberg was also concerned about possible problems with unions on the relationship of students to supportive personnel in health care facilities.

The next speaker, Rae Litaker, is a chief physical therapist in a large community hospital system in South Carolina which is affiliated with four educational programs of physical therapy and a community college program for physical therapy assistants. He reviewed the clinical department chief's mixed responsibilities to hospital, patients, staff, five different educational institutions, and a variety of affiliating students. He expressed concern over the heavy concentration of students on affiliation assignments from May through August, which results in inadequate utilization of the educational resources of the

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[1] Sheps, Cecil G., Clark, Dean A., Gordes, John W., Halpern, Ethelmarie, and Hershey, Nathan, *Medical Schools and Hospitals: Interdependence for Education and Service*, *J. Med. Educ.* 40, September 1935, part 2; reprinted 1971.

hospital and staff during the remainder of the year. He expressed the desire of clinical faculty for a greater role as participating university faculty members.

The third panelist was Sara Schoppenhorst, coordinator of a department of physical medicine and rehabilitation in a large city hospital in Ohio. Her department has allied health students from a variety of programs, including hospital-, college-, and university-based curricula and college and high school cooperative workstudy programs initiated by federal agencies and labor organizations. The administrative and legal entanglements are many and complex, as are the purposes and goals of the multiple groups involved. Difficulty in sustaining meaningful communications has been identified as the major problem area. Other areas that require considerable attention are costs and assignment scheduling. Patient care is and must remain the primary concern of the hospital and educational needs must not obstruct that need, only complement it.

The last panel speaker was the director of a community hospital in western North Carolina, William Lowrance; he is now associated with the Association for the North Carolina Regional Medical Program. He described the changing role of the community hospital in becoming the hub of the health care delivery system in an entire geographic area, and the hospital's need to have a close working relationship with local colleges and training institutes. He pointed to poor discourse between the large university medical centers and hospitals and other health agencies in the state. He urged that realism be included in educational designs by giving students learning experiences in smaller community hospitals and agencies and not restricting assignments to the big teaching hospitals. He described the broad affiliation, involving several health professions, which a hospital can have with a university in contrast to the more limited one involving one discipline and one school.

Most of the workshop time on the second and third days was devoted to small-group discussion, summarized in the next section. There was one speaker on the third day, Ralph H. Boatman, Jr., at that time director of the program on continuing education and field experience in the School of Public Health at University of North Carolina and now Dean, Allied Health Sciences. He emphasized the central importance of the clinical or field phase of education and the need to plan the experience so it is effective for the individual student. He spoke of the joint educational responsibilities of the educational and clinical institutions, the need to expose students to working relationships

with other disciplines, and the importance of evaluation. He spoke also of the high and rising costs of education.

The Discussion Groups

On the second day, the participants in the workshop broke up into the four essentially balanced groups to which they had been preassigned. The charge given to each group had been formalized in advance, so that the roles of all participants in the affiliation relationship would receive attention. These charges were: Group I: Mutual rights and responsibilities of universities and clinical centers for the education of allied health professional students; Group II: Rights and responsibilities of universities concerned with the education of their allied health professional students in clinical settings; Group III: Rights and responsibilities of clinical centers concerned with and participating in education of allied health professional students; and Group IV: Concerns of university students in the allied health professions who receive part of their education in clinical centers.

Each group had a previously identified leader, recorder, and resource person, but the groups developed their own individual mechanisms for fulfilling their charges. At the end of the second day participants reconvened in general session and reports of the four groups were given orally; a question and answer session followed. David G. Warren, a lawyer from the Institute of Government, received most of the inquiries. Questions to him related to liability, health, and travel insurance; how to use a lawyer; who signs contracts; areas of legal responsibility; what structure is desirable for a contract; and whether a written document is a requirement in all cases.

The preworkshop questionnaire category, "legal problems," was not identified among the top five concerns of the clinical faculty who responded, although it was among the top five for the educational administrators. However, the discussions held on all three days of the workshop indicated that the legal implications of affiliation agreements are of deep concern to educators and clinical faculty members alike. Most participants eagerly entered into the open discussion.

Time did not allow the participants to accept or reject any or all of the suggestions expressed in the reports of the individual workshop groups. The reports were duplicated and made available to all participants for their later use.

On the third day, the groups chose to establish their own independent charges for the day based on their activities of the

preceding day. Each group was at a different level of development on the charges originally undertaken. Primarily, the groups focused their deliberations on process, form, and documentation, and to a lesser extent on content of an agreement. One universal charge was given to all groups, and that was to decide on how to make the best use of the information obtained and developed at the workshop, and to make recommendations for implementing their suggestions.

Reports of the Wednesday morning workshop sessions were presented orally to the full group. The workshop ended following discussion of the expected outcomes, including the possibility of developing and field testing some basic guidelines for affiliation agreements.

Proceedings of the entire workshop, recorded and transcribed by a court reporter, were important resource for this book. Actually much of the outcome of the workshop parallels closely what can be learned in the readings referred to in the Reading List (Appendix B), but it was a most thorough and productive session in the interest of all the allied health professions for which clinical education is a major concern.

An analysis of the general workshop discussions and materials developed by the four groups indicates five primary areas of concern:

1. Contracts are not clearly understood and are frightening to educators and clinicians, but most of the workshop participants agreed that they were needed in written form and that they should be bilaterally developed.
2. Legal questions are at the base of many issues in clinical education and further dialogue with lawyers who specialize in health issues would be wise.
3. The role of the student in drafting and maintaining agreements is not clearly understood and will take further study.
4. The availability of adequate clinical education facilities in relation to staff, programs, quality, and distances is a growing issue and will become more complex.
5. Rising costs for education at the university and in the clinical center are of increasing concern; yet neither group, the educators nor the clinicians want to see a fee set for an affiliation assignment.

The five issues identified above, and those previously identified from the response of educational administrators and clinical faculty from the preworkshop questionnaires, are intrinsically involved in the drafting of interinstitutional

agreements between universities and clinical centers, whether expressed in a gentlemen's agreement or in a written document. The attitudes, philosophies, fears, and desires of university faculty and clinical center faculty on these and other issues can be expressed in many ways by what is included or omitted in an agreement. For example, "quality of supervision" is a primary concern to all parties involved, but superior supervision cannot be demanded or assured by the written words of a contract. Quality of supervision might be encouraged in other ways — say, by requiring in writing that clinical faculty have educational preparation at a predetermined level, have experience of a predetermined number of years and type, have time allowed for teaching and supervision of students, and are active in professional activities and organizations.

Desires for learning experiences, legal coverage of students and staff, evaluation of programs and people, as well as a host of other topics are provided for in agreements in innumerable ways, but the manner in which provision is made for them varies from one situation to another. There is great diversity, which makes the attempt to establish guidelines generalizable to all situations a very difficult task indeed. Some first steps are suggested in the following section.

PROFILE OF A CONTRACT

Information from the two preworkshop questionnaires, an analysis of the 60 written agreements acquired during the study, and a synthesis of the materials included in the full proceedings of the June 1970 workshop indicate that a contract or agreement should be developed after a discussion of many issues. The items included in the profile below recurred frequently in the resource materials, thus indicating some level of acceptance of the items for inclusion in many contracts. The material presented here is not given as a model for or outline of a contract; it is simply a compilation of topic areas that might be discussed by representatives of both parties before an agreement is drafted, which agreement would include provisions for those issues on which both parties concur. All items in the profile appeared in the reports of the workshop groups. The inclusion of statements in any one contract on all of the items listed below would be unlikely.

1. The purpose of the affiliation from the point of view of both cooperating parties.
2. The objectives of the affiliation which are shared by the parties while each agency maintains its autonomy and

certain inherent rights. The basic and complementary objectives and rights may be itemized.

3. Exchange of basic promises or joint responsibilities which may cover such topics as:
   a. a nondiscrimination clause
   b. frequency of and provisions for meetings of supervisors
   c. visits of university faculty, including those required for accreditation
   d. visits of clinical faculty to the university
   e. rules and holidays of the center and the university; uniforms; department activities
   f. student involvement in research activities
   g. the ownership and use of equipment
   h. the exclusive use of clinical center by the university or willingness for shared use with other schools
   i. the information on students to be sent to the center, such as the number, dates, length of time, level of education, part-time or full-time, and how these items are determined
   j. the mechanism for curriculum changes and modification
   k. provisions for the student relative to: (i) his insurance coverage for travel to and from the center; travel in connection with this assignment at the center in his own car, in the agency's car, or in a supervisor's car; (ii) health conditions, including pregnancy, the health insurance requirements or lack of requirements of the two agencies; and (iii) liability insurance
   l. the use of facilities, space, and equipment with mutual obligations
   m. faculty appointments with rights and responsibilities, including university faculty who are assigned or visiting in the clinic, and the clinical faculty who are visiting or assigned to the university
   n. publication rights and restrictions
   o. costs
   p. removal or dismissal of students from the clinical centers
   q. role of the student

4. Responsibilities of the university may include:
   a. curriculum design with or without participation of the clinical faculty
   b. the quality of students enrolled; records and reports of students

c. the acceptance, promotion, dismissal of students
d. the educational philosophy of the university's program with or without contribution from the clinical faculty
e. benefits to be extended to the clinic and the clinical faculty
f. the number of students to be assigned — who they are and their assignment schedules
g. evaluation of the curriculum and of the clinical education aspects of it, with feedback to the clinical center
h. assignment of faculty, full-time or part-time
i. coordinator of clinical education, role and costs
j. cost in dollars and how provided
k. legal responsibilities of the student and the university

5. Responsibilities of the clinical center may include:

a. availability of patients for treatment by students
b. provision for instruction and supervision
c. provision for learning experiences within the department and within the institution and all of its component parts, such as the outpatient department, wards, laboratories, and home-care programs
d. the students' benefits — housing, meals, laundry, stipends
e. the availability and use of the library, lounges, lockers, cafeteria, restrooms, office, parking, employees health service, and emergency medical care

6. Rights, responsibilities, and benefits of students, if not provided for in items 4 and 5 above might include:

a. whether or not they are to be included in discussions on the agreement prior to their assignment
b. what their mechanisms are for functioning in an assignment
c. their obligations for travel insurance, sick leave, health insurance, and liabliity insurance
d. rules and regulations of dress, uniforms, and conduct

7. Mechanics for maintaining and modifying the agreement and for arbitrating disputes might include:

a. joint cooperation with two, supervisors or a joint committee meeting on a regular basis, and provisions for visits between the two institutions or agencies

b. arbitration of disputes involving students or programs, with the right of appeal
c. financial matters of an ongoing nature
d. review, evaluation, modification, renewal, and cancelation of the contract
e. timing

8. Signatures of those signing and the date of signing

Chapter 3

FORM AND FUNCTION OF INTERINSTITUTIONAL AGREEMENTS

When representatives of the educational institution and the clinical institution decide that they wish a cooperative relationship for the clinical education of students, they then must negotiate and agree on the terms and conditions of a contract. The preceding chapter ends with the profile of a contract, as synthesized from the June 1970 workshop and the results of two preceding questionnaire surveys. The purpose of this chapter is to discuss the form and function of a contract from the legal point of view.[1] First the legal rules for contract formulation and interpretation are set forth. Then the particular requirements for affiliation agreements are discussed, including the necessity for written documents.

DEFINITION OF A CONTRACT

Throughout this book, the word "agreement" is used more frequently than the more formal term, "contract." Technically, any agreement, oral or written, is according to law a contract — recognized by the courts and enforceable by legal means. The standard definition of a contract as stated in *Black's Law Dictionary* is: "A promissory agreement between two or more persons that creates, modifies, or destroys a legal relationship."

To qualify as promissory, there must be mutuality of obligation, the intention to do or not to do a particular thing,

[1] The content of this chapter is based on two primary sources: Warren, David G. "The Lawyer Speaks of Contracts" (Address at Workshop on Interinstitutional Agreements in the Education of the Allied Health Professions, University of North Carolina, Chapel Hill, June 22, 1970, Reporter's Transcription) and Burby, William E. *Law Refresher — Contracts* (3rd ed.; St. Paul, Minnesota: West Publishing Company, 1963).

based on an exchange of promises. The exchange of promises, obligations, or payments which creates the necessary mutuality of obligation is called consideration. Thus consideration is the tie that binds an agreement. Consideration can be anything that is a benefit to the promisor or a loss or detriment to the promisor, but it is a *sine qua non* for an enforceable contract. Payment for a service is a simple example of consideration; another is the promise to render a service for a promise to refrain from making a charge for another service.

The term agreement in the definition of a contract means mutual assent. There must be a concurrence of understanding of the terms among the parties involved in the negotiations. Put another way, there must be a meeting of the minds. When the terms of the agreement are clear and certain, then this mutual assent is objectively demonstrated by a clear and definite offer by one party and an unequivocal acceptance by the other.

The phrase "between two or more persons" in the definition is relevant to any discussion of contracts involving institutions. The question might be raised: "Is X institution a 'person' for purposes of this contract?" Although varying from state to state, in most states "person" is very broadly defined to mean almost any kind of recognizable body or association or group. An individual is a legal "person," as is a corporation, whether profit or nonprofit. Any governmental unit is recognized as a person for the purpose of the law, whether it is a municipality, hospital authority, county or municipal hospital, community college, state university, or state agency.

In order for these persons to make a legally enforceable contract, they must be legally competent both mentally and physically to negotiate contract terms. Legally competent also means that the individual must not be a minor; the age of majority is either 18 or 21, depending on state law. Further, if some individual is representing an institution in contract negotiations, he must be authorized either expressly or by implication to bind that institution. Also the articles of government of that institution must state the authority for it or its agents to make contracts.

For a contract to be legally enforceable it must modify or destroy a legal relation. It must provide for a legal relation that is new and different. This legal relationship that is created by contract must not be a pre-existing one; it must incorporate a change of status, unless it is a formalization of a status. Thus when an educational institution and a clinical institution begin to consider contractual relationships for the clinical education of

students in a health profession, each should be sure that no previous contracts are continued between them which already cover the intent of the new relationship, or else there will be duplication. Confusion may arise over applicability.

The contract, to be enforceable, cannot conflict with the law and policy of the state; it must be lawful. For example, one could not contract to evade the law for various benefits. When a university and another agency form a contractual relationship, they must be sure that the intent of state or federal law is not violated in such areas as stipulations of union contracts or the provisions of workmen's compensation and unemployment benefits.

The contract cannot be against public policy. It cannot contain any terms which are grossly unfair to one or the other party, and it should not be overwhelmingly more favorable to one party. Occasionally courts will characterize a contract as "unconscionable" because agreement to its terms was obtained through fraud or misrepresentation or simply because it is overly one-sided. In such a case the court would find it blatantly unfair or against public policy to enforce the terms of the contract. Other examples of contracts that would not be enforced as against public policy are those in restraint of trade or creating monopolies.

TYPES OF AGREEMENTS

Contracts or agreements can take many forms — formal or informal, detailed or brief, legalistic or simple in expression. They may be written or oral, and entered into with or without the assistance of attorneys.

Gentlemen's Agreement: Individuals in the health professions frequently rely on the "gentlemen's agreement" in making arrangements for the clinical education of students. Such an agreement implies trust, based on shared interests and goals, and a meeting of minds; it develops out of conversations, correspondence, and visits of the parties, but ordinarily no formal written document exists. The gentlemen's agreement can avoid the time-consuming steps necessary in formulating a written document, but the existence of only an oral agreement can also foster misunderstanding. Even within the "university family," there can be a lack of appreciation of the activities of one unit by other and higher authorities, unless there is written documentation. It has been said that "...it is apparent that *gentlemen* can function under and abide by agreements regardless of their form," but a gentlemen's agreement "depends

on the continued existence of the gentlemen" and that condition is not assured.[3]

The Business Letter: The business letter is another form of agreement, one that is relied on heavily by physical therapy program administrators and other health profession educators in arranging clinical education experiences. A review of sample letters of agreement from educational administrators reveals that typically much is left unsaid, so that some elements of the oral or gentlemen's agreement must supplement the contents of such a letter. The legal problem here is the rule that whatever is left out of a written agreement is considered legally ineffective if it is inconsistent.

Other forms of agreements combine the letter with a form for one or both parties to complete. Some forms of this kind are considered universal documents, useful in many situations. However, a form blindly followed can raise inconsistencies. A form can be used as a checklist or a model form for inserting information in order to complete the documentation package.

Memorandum of Agreement: One common type of more specific written agreement is called a memorandum of agreement. It may be a thoughtfully developed document, arranged in sections by topical headings and written in legal or in common language. The memorandum is frequently developed by the involved parties without early utilization of attorneys in the writing process, but attorneys may and should review and advise on its content, completeness, and legality.

The Contract: The most complete and comprehensive agreement is the formal written contract, usually (but not always) drafted and written with the aid of attorneys. The layman tends to be alternately impressed and intimidated by legal phraseology, but he need not be. Paragraphs beginning with "whereas" and action clauses written in the stilted form of resolutions characterize the general perception of a formal contract. The stereotype is unfortunate, for legal language is not necessarily incompatible with simplicity. In fact the goals of legal drafting are clarity, conciseness, and self-execution, and these are usually better achieved by employing an attorney for drafting a contract.

Any of the above-discussed forms of agreements are considered contracts by the courts, if indeed such a question

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[3] As quoted in Sheps, Cecil G. et al. *Medical Schools and Hospitals* (Evanston, Illinois: Association of American Medical Colleges, 1965), p. 127. The entire Chapter 10, "Affiliation Agreements," pp. 124-45, is good reference on the form and function of agreements.

comes to the end point of having to be answered in a judicial proceeding. It should be remembered that good contracts usually do not reach the courts; they take care of themselves.

METHODS OF ENFORCEMENT

Self-Enforcement

Contracts are usually self-enforcing. The parties intend to carry out the stipulations of the mutual agreement because to do so is of mutual advantage. The purpose of putting something into an agreement is to aid understanding, and not to bring suit one against the other later on. If a contract reaches the state where it is not self-enforcing, it has ceased to be effective as a contract, or as a reflection of the intentions of the parties.

Contract Provisions Aiding Self-Enforcement

Provisions for enforcement may be provided in a contract itself. A provision for enforcement may be included that would require a specified monetary sum as a forfeiture or a penalty for breach of contract (termed a "liquidation for damages").

Provision may be made for interpretation by reference to a code or standard of operation. Reference to standards of the Joint Commission on Accreditation of Hospitals, to essentials of educational programs in the health professions as published by the Council on Medical Education of the American Medical Association, to guidelines on educational programs and personnel, or to membership qualifications of the professional associations are examples of standards through which contracts can be interpreted.

Provisions for arbitration are often included in order that any otherwise unresolvable matter of dispute involving the contracting parties, the financial arrangements, or the students can be referred to a designated person or to a group of persons for nonreviewable resolution. Arbitration groups should always include a neutral person. State law must be consulted prior to the inclusion of an arbitration clause, since the law in some states may prohibit a public agency from arbitrating in labor relations or other specific fields.

Contract provisions should indicate ways or methods by which the contract can be changed. A review procedure should be specified — for example, a joint committee, a time period, or a process by which the contract can be re-evaluated periodically for revision or modification. A contract need not be a permanent document but should be subject to review and alteration as issues change, without disruption of normal relations.

Provisions are also often included for refinement of details of the contract consistent with the body of the originally written text. Besides general references to "existing standards," the desired refinement might mean, for example, specifying that a committee or designated individual could negotiate on further details of an agreement. The contract is not required to be completely detailed or specific; complicated matters are explainable by reference to custom and practice or to express documentation. For example, a separate schedule of fees or timetable could be attached to the contract to state necessary details that might change frequently.

Legal Enforcement

A valid contract can ultimately be enforced by the filing of a lawsuit and obtaining a favorable judgment by the court. For a lawsuit to be instituted on a contract, it must be brought within the statute of limitations (usually three years) for breach of a contract. If a dispute requires legal action, the parties are probably so polarized that the agreement has failed its objectives. Nevertheless, the law books are filled with vain good intentions.

There are remedies available to a party to the contract when the other party fails to meet his obligations under the contract. The most usual of these remedies for breach of contract is a request for monetary damages commensurate with the loss proved in court to be suffered by the plaintiff. This type of enforcement, expensive both in time and money, is not always the most desirable but often the only recourse available.

As one rather rare alternative to damages, the court may request specific performance from the parties through a court injunction by which it mandates that certain provisions of the contract be carried out. Although judgments of this sort have usually involved a unique piece of property, it is a remedy that may be appropriate in some affiliation agreement settings.

In some cases, the remedy may be recision of the contract, which in effect is a cancelation of the contract. Still another alternative is a declaratory judgment where (sometimes in a friendly suit) the court is asked to specify the respective rights and obligations of the parties to the contract — without assessing monetary damages or requiring the performance of the obligations.

It should be noted that if no written contract exists and problems arise, a court can find a contract implied from its understanding of the situation. This may result in a satisfactory

resolution for one or all parties, but it seems far better to avoid the sometimes arbitrary judgment of a court of law based on implicit intentions by documenting a clear and happy understanding in a written contract.

Although no relevant cases have been found in the literature dealing with contracts or agreements associated with clinical education, it should not be assumed that the absence of litigation means either that all is well or that problems cannot reach the stage of legal dispute.

NEED FOR A WRITTEN CONTRACT

Both legal and nonlegal reasons make written contracts advisable, regardless of the terms of the contract. A perfect and fully detailed document may be unnecessary, but a carefully prepared written expression of the parties is essential for numerous reasons.

Nonlegal Reasons

First, the written agreement strengthens the relationships between the two parties by clarifying situations, improving understanding, and solidifying arrangements so that there is a better blend or exchange of promises and more synthesis in the inherent activities covered by the written agreement.

Second, the written agreement more clearly defines the duties of each party and under what conditions they are to be fulfilled — thus serving as a guide.

Third, where services are purchased, or money changes hands, or properties are bought and sold, a written contract is most helpful in clarifying the legally binding relationship between the parties and avoiding misunderstandings.

Fourth, the written contract provides the mechanism for administration, evaluation, review, modification, and cancelation; these need not be re-established each time an issue arises.

Fifth, the spirit of cooperation and the process of arriving at a clear understanding may often be more important than the contract itself, for documents are not developed in written form because those involved do not trust each other. Good practice dictates that items on which agreements are based should be in writing and not merely orally expressed, since the original drafters of the agreement are not the only ones involved in implementing and interpreting the contract. The written contract, therefore, clarifies the understanding that has been agreed to; it makes possible the handling of difficult situations when they

arise by having provided for them in advance. The contract informs people in each agency of arrangements which have been made by a limited number of people; it is a mechanism for informing a larger group of people in both agencies.

Legal Reasons

The primary legal reason for having a written contract or agreement is to have proof of the agreement. People and events change, and depending on issues, times, and points of view, situations are subject to reinterpretation. The written agreement remains a basic point of reference; oral agreements can be difficult to substantiate. The written statement may simplify the settlement of problems if they arise, and may help the courts to come to a just and equitable decision if such issues are placed before them.

Under the statute of frauds, an agreement in writing is frequently required by most state laws if there is an exchange of property, especially an exchange of land. The statute of frauds is similar but not identical in all states. For example, if at least $5000 is involved in any transaction, a written contract may be required according to the law of some states.

MINIMUM ESSENTIALS OF AN AFFILIATION AGREEMENT

The foregoing discussed contracts in general. This section considers affiliation agreements specifically. First, remember that an affiliation agreement is in fact a contract. The minimum essentials of an affiliation agreement are its form, its substantive provisions, and the provisions it makes for procedures or mechanisms involved in its maintenance and modification. These three essentials, relevant to the affiliation agreement between an educational and clinical institution, are discussed briefly below.

The form of the agreement could be any of those previously referred to — letter, memorandum of agreement, formal contract, and so forth. No precise form is required; the important point is that some writing be involved which is accurately reflective of the content. It is important that a lawyer be involved in the drafting process so that the relevant legal requirements of the state and the agency are observed. The form in no way requires seal and ribbon, special size and color of paper, or quaintly formal wording. But other legal requirements which may be overlooked without a lawyer may prove fatal to the contract and terminal to the relationship.

An interinstitutional agreement between a university with educational programs in many health professional fields and a single clinical facility, such as a hospital, may cover only one discipline or it may be a core agreement for several professional student fields. In the latter case, an appendix or supplemental agreement may be added for the specifics of the arrangements for each of the individual disciplines. Common denominators are found in contracts that are applicable to several situations, but it is the rare occasion where an identical contract would be appropriate for all situations or for multiple affiliations. The document may be in outline form or it may follow a model, but the content should be developed separately for individual situations.

The substantive provisions of an agreement should include first of all a statement of purpose as to why the two institutions are agreeing, and on what they agree. Why are they joining forces in an agreement? This might be a simple statement: "To provide clinical education for students," but generally it should be more explicit as to the unique reasons a specific affiliation is desired by the school and by the facility.

The second part of the substantive provisions is the section on obligations which includes the promissory statements that have been determined between the two parties involved. These obligations would be expressed as those involving the two parties jointly, plus those specific for the clinical center and the educational institution in relation to the students.

The third essential of an affiliation agreement is the procedural section. Procedural provisions usually cover the arbitration arrangement by which grievances can be handled and the review arrangement whereby the contract can be evaluated, modified, terminated, or otherwise changed. Such a procedure for evaluation and modification is especially important in an affiliation agreement, because this type of contract should remain reflective of what the institutions are actually doing and what they want to do in the future. Another procedure might be a coordinating mechanism by which the contract could be kept appropriate and responsive. There might be a mechanism for handling recognized problem areas, not necessarily grievance or arbitration problems, but those dealing with emergencies, illness, schedules, and special needs.

AUTHORIZATION FOR THE AGREEMENT

The authority for entering into an affiliation agreement is usually vested in the governing body of the institution, such as

the board of trustees or the board of directors. These boards generally delegate to high administrative officers the responsibility for cooperating with other agencies. Thus, delegation frequently flows downward to the administrator of a hospital or health agency, and to the president or chancellor of a university or college. These individuals may in turn delegate this authority down the line to others in the hierarchy. Frequently delegations of authority to enter into agreements is not in writing but is implied in job titles and job descriptions and therefore assumed by department chairmen, deans, and administrators. A contract negotiator is not always sure where authority resides until an issue is raised and the matter is pursued up through the administrative structure of the organization.

Letters and other written agreements may have one signature for each of the two agencies or more than one. At least one of the signers must be an "authorized individual." The presence of the signatures of such representatives of both parties constitutes acceptance by the agencies involved. A recommendation of the American Hospital Association indicates that high administrative officials in the clinical facilities should participate in the formulation of the document and in its signing.[3]

The size and complexity of the organization is a factor in determining who signs the agreement. How high in the organization one wishes to go for a signature depends on how easily an agreement is managed, since lesser agreements are more apt to get delayed the higher in the hierarchy the proposal travels. The exchange of large sums of money or property may in some instances determine the necessary officials who must sign the agreement.

Today, boards of directors and boards of trustees are more active in the performance of their assigned duties, and their positions are less honorary than previously was true; therefore, authorized board members may be involved in contractual agreements.

In dealing with state agencies particularly one should be sure that the proper signature is obtained, regardless of who may have been engaged in the negotiations.

A FINAL WORD

A basic conclusion of the study on which this book is based is that agreements between educational and clinical institutions for

[3] *Statement on Role and Responsibilities of the Hospital in Providing Clinical Facilities for a Collaborative Educational Program in the Health Field* (Chicago: American Hospital Association, 1967).

the clinical education of professional students should be bilaterally developed and documented in written form. This becomes increasingly important in view of the trends toward diversity in educational patterns and diversity in clinical settings, as discussed in Chapter 4.

Some readers may be hoping for a model contract that might be adapted to any affiliation situation in any health field. This would imply a false standardization, for each interinstitutional agreement — even within the same field, even between one university and different clinical institutions — is unique. The report by Cecil G. Sheps and his colleagues, *Medical Schools and Hospitals: Interdependence for Education and Service*, reached a similar conclusion.

Still, it may be possible to develop some guidelines that might be flexible enough to be helpful without suggesting inappropriate uniformity. Some tentative guidelines, therefore, are presented as the concluding chapter of this book.

Chapter 4

PROSPECTS FOR THE FUTURE

The purpose of this chapter is to reiterate some highlights of the preceding chapters, to present the basic conclusions of the study on which this book is based, to emphasize the interdependence of the allies in education, and to present some basic steps in the affiliation process between educational and clinical institutions.

CONCLUSIONS

The rapid proliferation of new health professionals and semiprofessionals, all requiring some kind of field or clinical educational experience, is a trend that is likely to continue. The changing patterns in the delivery of health services and the increasing numbers and diversity of clinical settings used for education of both new and traditional health care providers are also ongoing trends. The prospect is for continual change.

Interinstitutional relationships for clinical education are effective now on a generally informal basis in most fields, but the prospect of continual change and complexity suggests the desirability at this time of planning more formal documentation of affiliation agreements. The need for this is recognized, mostly by educational directors of health professional programs like physical therapy, which may have as many as 50 different affiliations with clinical institutions — each one different. There is in fact some pressure for standardization to the point of an all-purpose model contract. This is not a realistic hope, nor is it desirable, for patterns vary so with respect to timing, duration, distance, and many other details; each affiliation really is different.

Tentative guidelines may be possible however, if subject to continual review and revision. A series of such tentative guidelines is set forth in Chapter 5. These were developed during the course of the study, but they have not yet been field tested or reviewed by experts in any of the health professions.

Excessive detail in an affiliation agreement is not desirable. The basic conclusion of this study is that the need for simple written contracts is present and will increase in importance in the years ahead. They should be developed bilaterally by university and clinical center personnel and agreed to by both with protection of the rights and responsibilities of each and of the students who are the benefactors of the cooperation. A separate individually prepared contract should be designed for each affiliation, reviewed periodically, and kept as flexible as possible. The language of the contract should be clear and understandable in order that a respected, useful, and workable document results in each case.

Another basic conclusion is that the educational institution and the clinical institution share commonality of purpose and are interdependent. Regardless of the motivating factors that bring a university and a clinical center together to pool their resources, interests, and energies for the education of students in the health professions, there should always be the recognition that the two institutions exist primarily for the improvement of health care of the public. By assisting each other, the two agencies are fulfilling their common major purpose for being, as well as positively affecting their other purposes.

INTERDEPENDENCE OF EDUCATIONAL AND CLINICAL INSTITUTIONS

Health care, education, community service, and research are the basic shared concerns of the educational institution and the clinical institution. These shared goals, identified in the 1960s, have not changed.[1]

A university, for its part, must acknowledge that it cannot perform its educational and research functions alone. The educational offerings for health science students are incomplete without clinical education; facilities and clinical faculty are needed for this phase of the educational process. Research in many facets of health depend on the availability of subjects — e.g., community groups or patients, including ambulatory patients — and of hospitals and other health care facilities. The university scientist needs access to these resources for his research efforts.

Many demands on the modern university require it to become increasingly service-oriented in communities. Service is not the

[1] Sheps, Cecil G., Clark, Dean A., Gerdes, John W., Halpern, Ethelmarie, and Hershey, Nathan. *Medical Schools and Hospitals: Interdependence for Education and Service. J. Med. Educ.* 40, September 1965, part 2, reprinted 1971.

exclusive province of the hospital or clinic. The skills and knowledge of a university staff and faculty are enhanced by being able to work through and with other agencies, such as those with which a school affiliates for clinical education. The university which is interested in helping a community must acknowledge that it is difficult to serve a group without first assisting individuals. A neighborhood health clinic established or supported by the university and the outpatient department of a teaching hospital serve individuals, and therefore have impact on the community from which the individuals come. The necessity of affiliations for clinical or field experience thus assist the university in fulfilling its community service obligations.

The clinical center, for its part, is dependent upon the university both directly and indirectly. It certainly depends on the university to produce the professional staff it employs, and these practitioners are themselves clinical faculty. The center should know and appreciate the entire process of health professional education in the universities with which it affiliates. It can thus, through its professional staff members, influence the educational process so that graduates will be able to function effectively in the practice setting.

The clinical institution can and should rely on the university for enrichment of its service functions to its patients and to the community. Health facilities increasingly rely on universities for the continuing education of their staff members. The clinical center is frequently, and should increasingly be involved in research, either as support to a university investigative effort or as primary research center with original studies emanating from its own staff. Without an appreci' 'on of the university and its contributions, and without an association with a college or university, the clinical center may be limited in its effectiveness.

More and more the two types of institutions are recognizing the strengths and benefits they bring to each other, while preserving their individual primary and secondary objectives, missions, and identities. Both agencies are involved in service, education, and research in varying degrees of emphasis as they each pursue their primary mission, the improvement of health care of the public.

This spirit of interdependence can be documented in the interinstitutional agreement developed by an educational and a clinical institution. The agreement performs several functions: (1) it facilitates joint efforts and actions; (2) it facilitates the achievement of common objectives; and (3) it facilitates

appreciation and understanding of each other's separate and individualized goals and strengthens the relationship of the two parties as they participate together in mutual programs. The written agreement provides proof of what the original negotiators have agreed to; others will later use the document as a reference for action or information on the obligations and conditions to be fulfilled. The contract informs the administration and trustees of both parties of the extent of the agency's involvement with others, and the impact of the services of the two agencies on a broader community.

Parallels exist between the interdependence of clinical institutions and educational institutions for the education of health professional students, like physical therapy students, and the interdependence of hospitals and schools of medicine for the clinical education of medical students.[2] Differences exist also, however, above and beyond the basic similarity of mutual goals and the interdependence in achieving them. These should be recognized when agreements are being contemplated, discussed, or drafted. Very detailed agreements between schools of medicine and hospitals in the interest of education of medical students, for example, are inappropriate in their detail for the needs of education in hospital administration, nursing, clinical pharmacy, occupational therapy, or physical therapy. Medical school classes are larger, affiliations are fewer, and the medical students work in the clinical setting for longer periods of time.

This does not mean that different kinds of health professional students should not work together in the clinical setting, for such experience is highly desirable. Nor does it mean that a university should not negotiate an agreement with a hospital or other clinical center that covers more than one discipline. The basic agreement should in such case be supplemented by appendices that accommodate the differing needs of specific disciplines.

BASIC STEPS IN DRAFTING AGREEMENTS

The contract should provide for: (1) the specific purposes of an affiliation between the two parties; (2) the objectives of the individual parties in the agreement, such as the university's primary objectives and the clinical center's primary objectives in entering into the affiliation; (3) those issues that are of mutual concern and on which both parties agree; (4) the rights as well as the responsibilities of the university; (5) the rights as well as the responsibilities that remain with the clinical center; (6) the rights as well as the responsibilities of the students in whose interest

[2] *Ibid.*

the agreement is initially drafted; (7) the mechanisms for seeing that the agreement remains a workable and meaningful document serving its intended purpose; (8) official acceptance by both parties by appropriate signatures.

Figure 4.1 presents a simple basic model for developing an interinstitutional agreement for clinical education of students in the health professions. Some commentary on the drafting process appears below.

1. Discussion of the issues involved is the most important aspect of drafting an agreement. Regardless of what finally appears in the written document, all possible aspects of involvement should be identified. Some are easily and quickly dispensed with, found inappropriate or unnecessary for inclusion in the agreement, but the act of making the decision to omit is a valuable process.
2. Agreements between any university and a single clinical center should be individualized in each instance. No single form or model is wise. Units from one agreement may be utilized in a second one, but an entire agreement should not be utilized for more than one situation.
3. The contract should be in writing, but it does not have to be in formal legal language. The document may be a memorandum of agreement or letter of agreement, but it should be developed through participation by both parties, and it should be signed by both parties. The business letter, unilaterally developed and signed, is not recommended.
4. Development of an agreement should begin with the staff in each agency, where members of each group can identify items of concern to themselves that need to be discussed with the staff in the other agency. Then discussions of the two sets of issues should be held by representatives of both agencies, who may then compose the initial draft in their own words.
5. The issues should be stated in the positive. The negotiators should basically agree on what to include or exclude, in what manner the items should be included, and the extent of coverage of the items or issues involved. The representatives should agree on the form that the document may take and should identify which individuals in both agencies should be involved in future steps in formalizing the written agreement.
6. The basic agreement should be as short as is practical. It should be flexible and general enough to endure for several years and yet complete enough to offer guidance and

clarification of roles and responsibilities. It should be as free of detail as possible.

7. Difficult issues should be faced by the negotiators and effective solutions, or the mechanism for solution, should be provided for in the agreement. Problem situations should not be avoided; they should in fact be anticipated.
8. After the negotiators have expressed in their own words the basic issues and agreements, they then should ask university and clinical center lawyers and administrative officials to review their draft before final copy is prepared for appropriate signatures. The advice and counsel of a lawyer at this stage is advisable to ensure that state and federal laws are not violated by the provisions of the contract, and to determine if the rights of all parties have been adequately protected. A lawyer should determine that the three minimum essentials of a contract — form, substantive provisions, procedural provisions — are covered and that the document is a clear and workable paper.
9. Generally two officials from each agency should agree to and sign the dated document. Two of those signing should be the highest ranking professionals from each agency, and the other two should be administrative officials from each agency. The magnitude of the issues agreed to, the legal involvements, and the cost factors vary so considerably in agreements that the level of the administrator who is authorized to sign for the university and the agency may vary with the degree of the involvement of the two parties and the size of the two institutions.
10. Regardless of the extent of the agreement, copies of the final document should be shared with others at both agencies who occupy positions at higher administrative levels.
11. Provision for the development of an appendix should be included in the text of the agreement. Although not considered to be an inherent part of the agreement, it is advisable that an appendix be developed each year, or on a need basis, by responsible individuals from each institution who can provide the details as to specific dates, number of students, length of assignment, and other essentials of agreements that vary from year to year.

The foregoing analysis outlines the recommended basic process of developing agreement and negotiating the terms and conditions of a contract between educational and clinical institutions for the clinical education of students. It is perhaps as far as one should go in a publication of this kind toward codifying affiliation agreements. Whether or not the tentative

guidelines in the following chapter can become generally useful, only careful testing and experience can determine. The very human desire for the neat dependable formula too often proves unrealistic in our changing society.

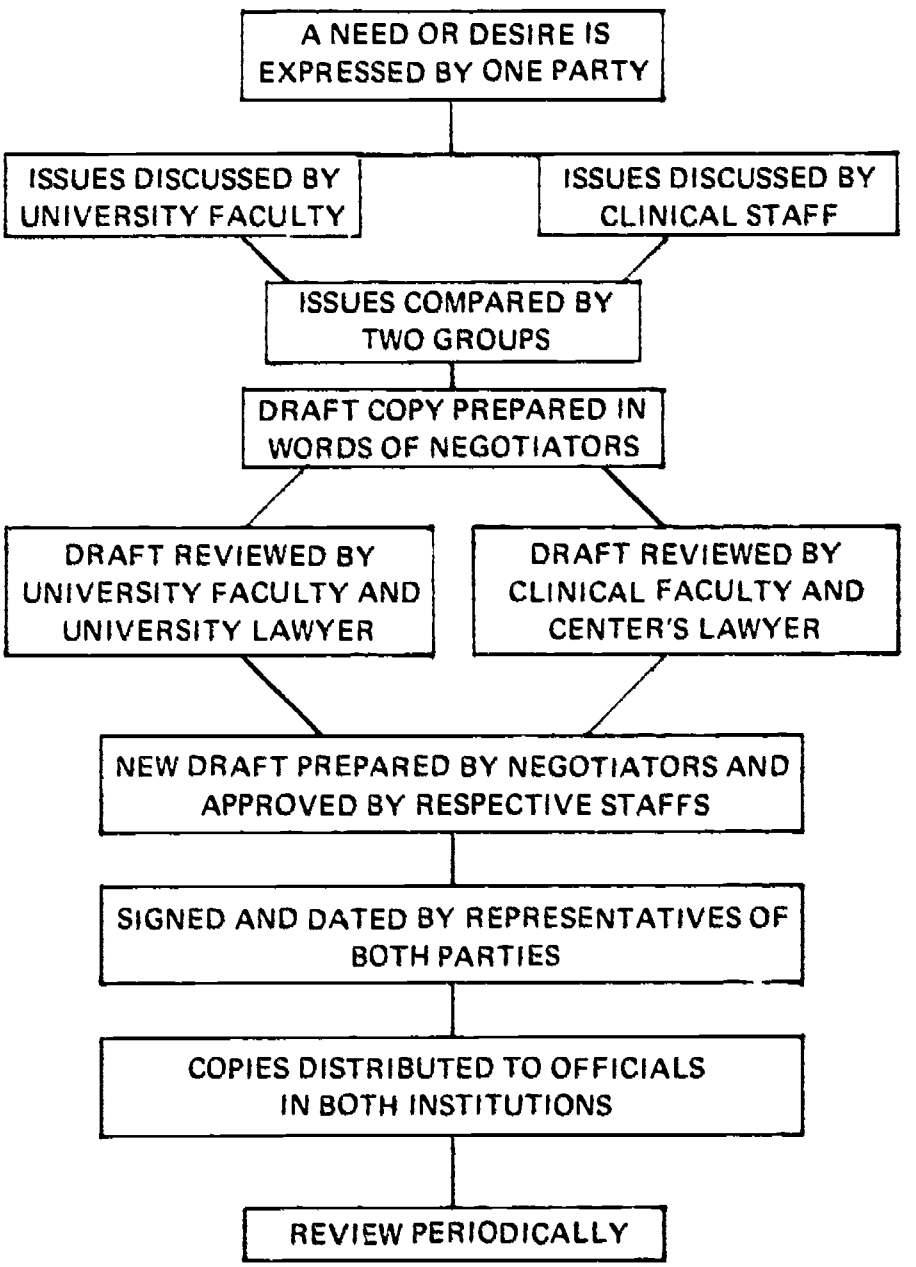

FIG. 4.1. – Model for developing an interinstitutional agreement for clinical education.

Chapter 5

GUIDELINES

The following guidelines include items that might be considered by negotiators from both educational and clinical institutions in negotiating affiliation contracts for clinical education of students in the health professions. The guidelines are intended as a master check list of alternatives, grouped by six major topical areas for convenience — a presentation that is not meant to suggest that agreements should be written in outline form utilizing six major headings. The wording of the alternatives is not intended to be recommended for final usage, and several approaches to the same or related issues are intentionally provided in order to indicate the range of possible interests and alternatives. The guidelines do not constitute an exhaustive list of alternatives but are suggestions only. They should be subjected to expert review and field tested to determine general applicability to the needs of many disciplines. Some items, particularly those subject to frequent change, might better appear in an appendix than in the contract proper.

PURPOSE AND OBJECTIVES OF THE COOPERATIVE AFFILIATION: SHARED OR COMPLEMENTARY FUNCTIONS

The parties agree that by working together they will be contributing to the alleviation of health manpower needs of the nation, or they will be contributing to the development of an increased supply of health manpower personnel.

Mutual cooperation may be expressed in order to promote and develop the best in patient care now and in the future, to develop excellence in education and research, and to provide maximum utilization of community resources. The primary areas of concern included here may be further elaborated by either party depending on its own major interests and emphasis, be it education, research, service to patients, or community service.

The parties agree to cooperate in accomplishing common objectives, furthering mutual understanding and programs of

mutual interest. The contract formalizes pre-existing less formal agreements, including verbal ones. The two parties enter into an understanding with full appreciation that the basic autonomy of each is maintained and that both have inherent rights that are not altered by the cooperative agreement. They acknowledge that the affiliation may supplement patient care and otherwise benefit and enrich the clinical center through the stimulus of association with the university, its faculty, and students. The two acknowledge that the affiliation is needed by the university for the completeness of the curriculum and the professional competence of the students; the educational program also needs the affiliation in order to benefit its accreditation prospects and to promote the licensure of its graduates.

A statement may be included that the facility has the staff and other resources for specific learning experiences in special areas or programs. If opportunities exist in public health, rehabilitation, mental retardation, chronic illness, acute care, or other areas, they may be specified. Additional learning experiences can be arranged in organization, supervision, and administration. Opportunities exist for learning more about the structure and function of the agency and how it meets its public commitment.

MUTUAL PROMISES, JOINT, RESPONSIBILITIES, AND SUBSTANTIVE PROVISIONS

This category really covers most of the substantive understandings of the agreement. Coverage might include the following.

Nondiscrimination clause. A nondiscrimination clause with respect to race, religion, sex, creed, or national origin should be provided documenting admissions policy of the university, employment in both institutions, and those served by both institutions.

Visits of university staff. Visits by university faculty to the center are acceptable, welcomed, or encouraged to plan for the affiliations, accreditation or survey visits by outside groups, observation of students, and for conferences with supervisors during the time the students are present.

Visits of clinic center staff. Visits of the clinical center staff to the university are welcomed, acceptable, or encouraged to plan affiliations, use the library and other facilities of the educational department, observe, audit, or participate in the teaching of courses in the university, or to attend continuing education offerings.

Rules and holiday schedules. The students may be required to adhere to the rules and holiday schedules of the center, as well as to other regulations of the center. The students will be required to appear in uniform which is prescribed by or acceptable to the center, to observe the hours of work, and to participate in departmental activities, including after-hours and inservice education programs, and continuing education opportunities. Permission may be included for the students to attend meetings or conferences at the university if the center is close enough to the university to allow such an arrangement. Clarification will be needed regarding the students' observing the university holidays in addition to or in place of the center's holidays. Uniform requirements should be clearly indicated as to who specifies or prescribes the uniform to be worn by students while affiliating. Many of the details of the items in this section can be included in an appendix to the contract.

Involvement in research activities. The students are allowed to pursue or are encouraged to participate in research activities in the clinical center.

Equipment exchanges. Equipment may be loaned to the clinical center by the university or vice versa, but provisions of the loan should be clarified. If equipment is given to the clinical center by the university, ownership should be stated.

Exclusive agreement. The affiliation agreement may be exclusive between the two centers, or the center may reserve the right to enter into similar agreements with other schools of the same discipline.

Schedules and their details. The determination of the numbers of students, their types, the schedules, and the availability of the facility shall be made by mutual agreement between the officially designated representative of the university and the officially designated representative of the clinical center. Regardless of the wording for this important part of the agreement, some provision, preferably in the appendix to the contract, should be made for the numbers of students involved, the specific academic level of the students who are acceptable to the center, the time of notification of schedules from the university to the center, the information which can acceptably be conveyed in writing or by phone, and whether or not full- or part-time students are allowed.

Curriculum construction and change. Both agencies are obligated to inform one another of changes in the curriulum or changes in the availability of learning opportunities prior to affiliation assignments, or as early or as far ahead of time as is feasible.

Staff changes. Changes in staff affecting preparation of students or clinical teaching of students should be noted to the other party as soon as possible.

Health. Prior to his assignment, the student may be required to have vaccinations for poliomyelitis and smallpox, chest x-ray, test for tuberculosis, or other health screening. Provisions should be made for the sick student to be returned to the student health center of the university, or hospitalization should be arranged at the clinical center in keeping with his insurance coverage, or as provided by the center. These provisions will need to be identified in the agreement. To be eligible for assignment, students should be free and clear of all communicable diseases and physically able to perform all requirements of the affiliation.

Insurance requirements. Should insurance be required or provided for covering health, liability, and automobile? Shall each be required or recommended? What type of insurance is required or recommended and who shall pay for it? Decisions on these matters will depend frequently on what student travel is required on assignment, and what is available to the student in the clinical facility or in the university for his health coverage and his liability coverage.

Health insurance may be provided by a university student policy, Blue Cross-Blue Shield, or equivalent private coverage. In some situations, the student is covered by Workmen's Compensation, Social Security, unemployment compensation, or none of these.

Negligence and liability insurance may be required or recommended, or it may not be considered desirable in any form. If it is required, should a specific policy or company be identified? What limits of coverage should be required or recommended? Some agreements provide for the payment of liability insurance either by the university or the clinical center; other contracts require that the student provide his own insurance.

Automobile insurance may be required by an agency if the student is required to drive as part of his assignment. Some government agencies set specific standards for the use of student-owned automobiles, e.g., on a federal government post, reservation, or property.

Mutual use of facilities. Staff of either cooperating agency is entitled to use the facilities and equipment of the other. This can be individually arranged. There may be a desire to identify which facilities in the university are available to a clinical faculty appointee, and which facilities in the center are available to a university faculty appointee.

Joint appointments. Staff of either agency can be appointed as staff of the other. University faculty can be assigned to the clinic as staff, special staff, or supervisors of students who are affiliating. There should be clear delineation of the faculty member's duties and responsibilities as well as his rights while he is assigned. Staff from the clinical center can be appointed to the university with a clear understanding of their duties, responsibilities, and rights.

Publication rights. Some agencies will require a provision that students, faculty, or staff members be prohibited from publishing any material relative to the clinical education experience unless it has been approved for publication by the appropriate officials within the agency. Others do not consider this a necessary item to be included in an agreement.

Costs of affiliation. No costs are involved and no financial obligation exists on the part of either party in many affiliation agreements. The cost of affiliation is most often borne by the student. The university may agree to pay the center, or the supervisor, a certain fixed fee per student, per time period of affiliation or annually.

Withdrawal and dismissal. Withdrawal of the student from an assignment can be requested by the center, the university, or the student, but only the university can dismiss the student for performance or conduct not justifying continuance in professional education.

Role of student. Students shall not be used in lieu of professional or nonprofessional staff; they shall be supervised at all times.

UNIVERSITY'S RIGHTS, RESPONSIBILITIES, AND OBLIGATIONS

Autonomy. The autonomy of the university will be observed at all times.

Planning. The university assumes full responsibility for the planning and execution of the educational program, including programming, administration, curriculum content, faculty appointments, faculty administration, requirements for matriculation, promotion, graduation, and awarding of degrees. The university is responsible for the curriculum, its design and delivery, its quality and modification. It may solicit the comments and suggestions of the clinical faculty in making timely revisions, on a formal or informal basis. The university is responsible for preparing students for the clinical education phase of their education.

Records and reports. The university agrees to provide and maintain the personal records and reports of students necessary for conducting the trainee's clinical education. The university faculty in arranging for students will be governed by the same policies as govern other students at the same academic level. The students pay tuition and fees; they may be required to provide for their own living expenses during the clinical affiliation assignment.

Withdrawal. The university agrees to withdraw any student from the clinical area when the student is unacceptable to the agency for reasons of health, performance, or any other reasonable causes.

Discipline. The university educational administrator shall be responsible for the discipline of students willfully violating rules and regulations of the agency or of the university, but while the student is assigned to the center the immediate discipline is the responsibility of the clinical supervisor in the center.

Rights and privileges of clinical faculty appointees. The university may appoint as clinical faculty selected supervisors from the center who shall enjoy all the rights and privileges of other clinical faculty of the university. Privileges include use of the professional library, the university library, or other facilities on the university campus. It may include permission to audit courses, to observe or participate in the activities of the university hospital or special clinics, and to attend a credit course each semester during the time the student is assigned (either tuition free, or with tuition reduced). Permission can be limited to only day courses, night courses, or correspondence courses. The university sometimes provides for a cash stipend to selected clinical supervisors. Clinical faculty are normally nonvoting faculty in the university, but some have special privileges and responsibilities in the departmental structure.

Coordination. The university agrees to appoint a person or persons to coordinate the clinical teaching program at the agency through a position on the clinical faculty of the university's program. The university reserves the right to review the qualifications of other persons in the department who may assist in the clinical instruction of students. The university may require that each clinical instructor have membership in a particular professional association, be legally practicing in the state, be active professionally, or have other attributes.

Books and equipment. The university agrees to loan equipment or books to the center during the time of student affiliation or for a specified time period. The right to borrow

books or equipment is granted an affiliating center for any time of the year when materials are needed or desired.

Planning. The university is held responsible for arranging schedules for assignments in cooperation with the clinical center, and in providing the clinical center with the necessary information on the names of students, their sex, date of assignment, and hours of assignment. The university may also agree to present a resume on each student covering level of training, previous clinical education, the clinical education experience which is desired for him, abilities, special interests, and personality. All of this information is provided, or none of it may be made available, depending on the philosophy of the parties involved. Additional material submitted can include personal data on each student, home address, parents emergency phone numbers, and so forth. Much of this material can be in an appendix to an agreement.

Attendance and conduct. The university will submit to the clinical center a statement of its policy on illness and injury, time lost for special events, class attendance requirements, and any other policy on dress, uniform, smoking, or conduct. The university may be held responsible for providing material to the agency which it deems necessary for the planning or learning experiences to achieve the objectives of this phase of the educational experience.

Evaluations. The university is required to provide forms for evaluating students, or the university may agree to solicit the cooperation of the clinical faculty in the development of evaluation tools for student performance and for the clinical education phase of the curriculum.

Assignment of faculty. Where indicated, and upon mutual agreement, the university will provide faculty or staff members to assume responsibility both in instruction and in supervision of the student's clinical learning experiences. This may be on a part-time or full-time basis, or for selected activities. During the time of assignment the university faculty member will become a staff member of the center and be responsible to the clinical chief.

University coordinator. The university agrees to appoint a faculty member as coordinator of clinical education who shall act as liaison between the university, the facility, and the students. He will plan appropriate visits, consultation conferences, planning sessions, and be available by phone, letter, or visit.

Costs. The university agrees to pay a laboratory fee per student per period of time of assignment, a stipend of a certain amount

to a clinical supervisor, or expenses of the clinical supervisors to special meetings called by the university. There may be no financial obligations of any type incurred by either party.

Insurance. Clarification is needed of the legal responsibility of the university to the student and the specifics of what the university requires of the student for health, liability, and automobile insurance coverage. Clarification will need to be made on whether or not the university can accept the responsibility for the student while assigned to an agency in the event of misdemeanor, malpractice, or unethical conduct.

CENTER'S RIGHTS, RESPONSIBILITIES, AND OBLIGATIONS

Autonomy. The autonomy of the clinical center will be observed at all times.

Availability of patients for students. Written provision may be necessary to indicate that all patients, or that some patients from selected services or units in the center, are available for student learning experiences. A statement might be wise that the center will provide clinical education in the care of the chronically ill, or of any other special group of patients. This section of the agreement can include a general statement granting the student the privilege of being assigned selected patients, and participating in their care as determined by departmental policies.

Provisions for instruction and supervision. The center will designate a chief clinical supervisor acceptable to the university for primary responsibility in coordinating and directing the students' learning program. This individual will be involved in planning with the university faculty or center staff for the assignment of the students, including their attendance at special conferences. The statement can be quite general and brief, and simply say that the agency shall provide a planned supervised program of clinical experience. The agency may even make a statement that it will provide a well-administered facility with adequate professional supervision of students in the clinical phase of education. The center may also agree to provide professional and personal guidance and counseling to students.

Provision of learning experiences. The planning and implementation of a meaningful and appropriate learning experience is aimed at achieving the objectives of this phase of clinical education. Another general statement might be that the center agrees to make available clinical and related facilities

needed for the clinical learning experience. The center can specify that certain units in the facility, or associated with it, such as the rehabilitation unit, the chronic disease ward, or the home-care program, will be made available to the students for learning experiences. It might also be specified that students have opportunities for learning experiences in ward rounds, staff meetings, inservice education programs, clinics, special lectures, and similar activities at the discretion of the clinical supervisor. Provision may be made in this section for student experience in administration, record keeping, departmental planning, teaching, consultation, supervision, and other management activities at the discretion of the clinical supervisor. A general statement could be that there should be an environment conducive to the learning process of the student as intended by the terms of the agreement.

Equipment and supplies. The center will provide the necessary equipment and supplies for the student's learning experience and will provide instructional materials and supplies for any associated learning, such as classroom presentations.

Student benefits related to cost factors. This section may deal with a number of items, the details of which might wisely be placed in an appendix. Housing can be furnished to students free, at a nominal price, or under some other arrangements. All or some meals can be provided free, at a fixed price, or at a prevailing rate. Laundering of uniforms may be provided at a price or free, but there may also be limitations as to numbers allowed per week, or per affiliation period. Reference to a student stipend should be included only if it is available from the clinical center. Emergency care may be provided free, at a fixed cost, on a basis similar to that enjoyed by employees, or under some special arrangement. Clarification is sometimes necessary on whether or not medication is provided free with emergency care, at a cost, or on the same basis as employees. A statement can be included in this section which states that the student or the trainee is or is not considered an employee subject to the rights and privileges of employee status. This status might be associated with the availability of stipends or it might be determined on a completely separate basis.

Availability and use of other facilities at the center. The center agrees to make available clinical and related facilities needed for the clinical learning experience of the student. Provisions should relate to the availability and the use of the library, cafeteria, lounges, rest rooms, lockers, office or work space, parking, conference rooms, classrooms, dressing rooms, hospitality shop, and post commissary.

Evaluation of students and the program with provisions for feedback. The agency agrees to keep the university informed regarding the type of education each student has received and his level of performance. The agency usually agrees to evaluate each student's performance, and to report the same to the university on forms provided by the university and at the time specified by the university. Evaluations may be specified to be completed at mid-term, at a final date, or at any time indicated, either on an informal or formal basis. The center usually agrees to notify the university of any emergency situation or problem which may threaten the student's successful completion of the assignment.

Adequacy of staff in quality and quantity. The institution is responsible for the supervision of the students by licensed and qualified clinicians who are acceptable to the university. Clinical instruction will be planned, organized, and taught by designated supervisors employed by the agency. Persons assuming educational responsibility in the center will be selected by mutual consent. The center agrees to inform the university of any change in staff which may affect the clinical education plans for the assignments.

The center agrees to employ only persons with specified professional memberships. The center agrees that only people on the staff who meet particular qualifications should be involved in the education of students, and staff members who do not have these qualifications, while present, would not have key responsibilities in the students' educational experience.

Orientation of a professional and personal nature. Provision will be made for professional orientation both orally and in writing. Provisions will be made for orientation, both orally and in writing, to the community and the area in which the student will live and work during his time of assignment.

Rejection or dismissal of a student by the clinical center. The center reserves the rights to reject any student selected by the university for placement except under terms of the discrimination clause. The center can request the university to withdraw from an assignment any student whose performance is unsatisfactory or whose personal characteristics prevent desirable relationships within the institution.

Timing of schedules. A statement may be included specifying that students at different academic levels are acceptable under the terms of the agreement. The time of the affiliation, the length, and the composition of experience may differ for students at different academic levels. Details of these arrangements can be placed in an appendix to the contract.

MECHANISMS FOR CONTINUED COOPERATION, REGULATION, REVIEW, OR TERMINATION

Time period covered. The agreement shall be effective when executed by both parties or for the period from _____ to _____, or the agreement may be of indefinite duration and can be terminated by either party by 30 days' written notice to the other delivered by registered mail.

Liaison. The parties agree to maintain liaison, to promote a coordinated effort by evaluating the program annually, by planning for its continuous improvement, by making such changes as may be deemed advisable within the terms of the agreement, and by discussing problems as they arise concerning this affiliation. Some agreements indicate that contracting parties will confer at specified times.

Arbitration of disputes involving students, staff, and components of the basic agreement. Provisions for arbitration may be handled through a coordinating mechanism established by the center and the university, such as through the two coordinators appointed by each of the agencies, or by a committee on clinical education appointed by each of the agencies. Lay representation on the committee is wise. Most often arbitration can begin at the level of the two coordinators and then, depending on the degree of involvement, may involve an educational committee in both agencies. Provisions should be made for the right of appeal of either party to higher authorities in the department of each agency, and then to higher authorities in the administrative structure of each agency.

Arbitration of financial disputes can be handled separately, or they can be handled by the same or similar mechanism identified previously. More direct involvement with the fiscal officers of the two institutions involved may be desirable.

Renewal. A simple statement may suffice that arrangements will be made for future students under these terms without renewal of contracts if mutually agreeable and desired by both parties. It may be understood that the parties may revise and modify the agreement by written amendments whenever the same shall be agreed upon.

A joint conference can be provided for each year prior to the expiration of the agreement period, by a faculty representative of the university and a clinical staff member of the agency for the purpose of evaluation. The center and the university agree to review their understanding annually and they may wish to set the renewal date to be at a specific time, such as a period of months prior to the admission of students for affiliation.

Revision. The agreement is subject to revision as occasion demands to insure continuing satisfaction, and may be terminated by either party on due notice of reasonable length. Both parties agree that no major changes will be made without representatives of both participating agencies reviewing the agreement.

Termination. Termination of the agreement can be provided for by statements relating to mutual consent at any time, at the request of any party, by written notice with a certain time period being specified, or prior to an affiliation period. If termination is considered necessary, such termination should not adversely affect the rights and privileges of any students actually enrolled in the program as long as they are making normal progress toward the completion of the program.

SIGNATURES AND DATES

Two persons from both agencies should sign the completed agreement. This action gives acceptance to the document and culminates the discussions and negotiations which have taken place.

University Official	Clinical Center Official
Educational Director	Clinical Director
Date of Signing	

Appendix A

WORKSHOP PROGRAM AND PARTICIPANTS

This section presents the program, participants, and other items from the workshop discussed in Chapter 2. Names and titles are as they were at the time of the workshop.

PROGRAM
WORKSHOP ON INTERINSTITUTIONAL AGREEMENTS IN THE EDUCATION OF THE ALLIED HEALTH PROFESSIONS

University of North Carolina at Chapel Hill
Division of Physical Therapy, School of Medicine
June 22, 23, 24, 1970
Carrington Hall, School of Nursing, Columbia Street

Monday, June 22

8:00 A.M	REGISTRATION—Ground Floor Lobby
	GENERAL SESSIONS—Room 308
9:00 A.M.	WELCOME AND OPENING REMARKS *Margaret L. Moore*
9:15 A.M.	THE ADMINISTRATOR SPEAKS *Cecil G. Sheps, M.D., M.P.H.* Questions and Answers
10:00 A.M.	AN EDUCATOR'S VIEW—from the Bureau of Health Manpower, Department of Health, Education, and Welfare *Joseph Kadish, Ed.D.* Questions and Answers
10:30 A.M.	BREAK
11:00 A.M.	THE LAWYER SPEAKS OF CONTRACTS *David Warren, LL.B.* Questions and Answers
11:30 A.M.	PRESENTATION OF BACKGROUND DATA *Margaret L. Moore* Questions and Answers
12:00 noon	LUNCH—Refer to Restaurant List for Facilities

1:30 P.M. CURRENT STUDIES AND PROJECTS—The American Hospital Association's and the American Medical Association's Study of the Allied Health Professions. Clinical Education.
E. Martin Egelston

1:45 P.M. WORDS FROM WHERE THE ACTION IS—Panel Discussion
Moderator —*Mabel M. Parker*
Educational Administrator—*Samuel Feitelberg*
Clinical Department Chief—*Rae Litaker*
Coordinator of Clinical Facility—*Sara Schoppenhorst*
Hospital Administrator—*William Lowrance*

2:45 P.M. BREAK

3:00 P.M. QUESTIONS AND ANSWERS—Written and from the Floor

Participation urged from all Allied Health Disciplines, and from Official and Voluntary Agencies.

4:00 P.M. PLANS FOR TUESDAY AND WEDNESDAY
Margaret L. Moore

6:30 P.M. SOCIAL HOUR—The Ranch House, Airport Road

7:30 P.M. DINNER—The Ranch House

Tuesday, June 23

9:00 - 9:15 A.M. PREPARATION FOR WORKSHOP SESSIONS
Margaret L. Moore

9:15 - 2:45 P.M. Participants divided into four representative Groups. Leaders and Recorders have been assigned for each Group.

Group 1— Room 202; Miss Schoppenhorst, Resource Person
"Mutual Interests, Rights, and Responsibilities"

Group 2— Room 204; Mr. Feitelberg, Resource Person
"University Rights and Responsibilities"

Group 3— Room 310; Mr. Litaker, Resource Person
"Clinical Center Rights and Responsibilities"

Group 4– Room 312; Miss Shaffer,
Resource Person
"The Students' Concerns"

3:00 - 4:30 P.M.	REPORTS OF WORKSHOPS *Margaret L. Moore and Mabel M. Parker* Questions and Discussions with Mr. Warren and Resource People
EVENING FREE	Materials will be duplicated for Wednesday morning.

Wednesday, June 24

9:00 A.M.	NEW CHARGE TO WORKSHOP GROUPS *Margaret L. Moore*
9:15 A.M.	WORKSHOP SESSIONS
11:00 A.M.	RECONVENE: REPORTS Suggestions for Format of Report
11:45 A.M.	LOOKING AHEAD *Ralph Bostman, Ph.D.*
12:30 P.M.	ADJOURN

OBJECTIVES OF THE WORKSHOP

1. To identify and discuss concerns related to clinical education involving the university and the clinical facility.
2. To discuss the legal implications and responsibilities in clinical education on the part of the student, the university, and the clinical facility.
3. To identify what situations determine the need for a written agreement for a university or clinical facility.
4. To determine what factors influence the selection of a specific type of agreement as: informal personal communication, letters of agreement, written contract.
5. To determine which concerns should be considered for inclusion in a written agreement and which concerns are wisely excluded.
6. To select the most suitable form for preparing materials on written agreements to share with colleagues in the allied health professions– prospectus, guidelines, model(s).
7. To determine the mechanisms for drafting a suitable agreement.
8. To discuss trends and possible future requirements for agreements between universities and clinical facilities or agencies involved in clinical education.

LIST OF FACULTY AND STAFF

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Clinical Scientist, Child Development Institute; Instructor in Physical Therapy, and Staff Physical Therapist (On Vacation)

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Appendix B

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