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HEARING

BEFORE THE

COMMITTEE ON
...OR AND PUBLIC WELFARE
UNITED STATES SENATE

NINETY-FIRST CONGRESS

FIRST SESSION

ON

DR. JESSE LEONARD STEINFELD, OF CALIFORNIA, TO BE MEDICAL DIRECTOR IN THE REGULAR CORPS OF THE PUBLIC HEALTH SERVICE, AND TO BE SURGEON GENERAL OF THE PUBLIC HEALTH SERVICE

DECEMBER 18, 1969

Printed for the use of the Committee on Labor and Public Welfare

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THURSDAY, DECEMBER 18, 1969

U.S. SENATE,
COMMITTEE ON LABOR AND PUBLIC WELFARE,
Washington, D.C.

The committee met at 10:05 a.m., pursuant to call, in room S–207, the Capitol, Senator Ralph W. Yarborough (chairman of the committee) presiding.

Present: Senators Yarborough (presiding), Williams, Pell, Kennedy, Mondale, Hughes, Javits, Prouty, Dominick, Murphy, Schweiker, and Smith of Illinois.

The CHAIRMAN. The Committee on Labor and Public Welfare will come to order.

The first item on the agenda this morning is the nomination submitted by the President to the Senate for the confirmation of Dr. Jesse Leonard Steinfeld, of California, to be Surgeon General of the Public Health Service.

Senator Murphy.

Senator MURPHY. Mr. Chairman, I am greatly pleased by this opportunity to introduce to our committee, Dr. Jesse Steinfeld, a California resident who has been nominated to be Surgeon General of the Public Health Service.

I know that each member of the committee has before him a résumé of Dr. Steinfeld's past activities, which attests well to his qualifications for the important position to which he has been named.

I can assure you that he enjoys in his home area a reputation which more than backs up the qualifications revealed by the résumé.

He has a rare combination in his background of medical practice, educational achievement, and administrative activity which will be extremely useful in the challenging position of Surgeon General.

More than that, I would like to say that I know from past personal experience when Dr. Steinfeld cared for a friend of mine that he is the kind of doctor each of us would like to have available in time of real trouble.

I think that is extremely important, particularly in light of the testimony we listened to yesterday.

He has that rare ability to inspire confidence in his patients, and all concerned with the case, together with an evident competence in his field which bolsters that confidence.

It will be a great thing for the Public Health Service if Dr. Steinfeld, as its leader, can imbue in those who serve under him the same qualities which he has himself shown as a practicing physician.

Mr. Chairman, I am pleased to introduce Dr. Steinfeld and express my support for his nomination.

The Chairman. Thank you, Senator Murphy.

At this time I will order placed into the record the résumé of Dr. Steinfeld that each of you have in your folders. It is very, very impressive. He has had tremendous accomplishments.

I don't see how you did it all, Dr. Steinfeld, in 42 years.

I also order published with the hearings the list of publications by Dr. Steinfeld, all 37 of them.

(The material referred to follows:)

Curriculum Vitae

Jesse L. Steinfeld, M.D.

A. Personal information

1. Name, Jesse Leonard Steinfeld, Assistant Surgeon General, USPHS, Deputy Assistant Secretary for Health and Scientific Affairs.
2. Business address, Department of Health, Education, and Welfare, 330 Independence Avenue, SW., Washington, D.C. 20201.
3. Business Phone, Area Code 202, 962-2461.
4. Home Address, 9100 Rockville Pike, Bethesda, Md. 20014.
5. Date of Birth, January 6, 1927.
6. Place of Birth, West Aliquippa, Pennsylvania.
7. Citizenship, United States.
8. Sex, Male.
9. Marital Status, Married.
10. Wife's Maiden Name, Gen M. Stokes, married San Francisco, Calif., July 12, 1953.
11. Number of Children, Jacquelyn Mary Beth, July 30, 1954; Jody Katherine, October 31, 1955; Frances Susan, December 5, 1960.

B. Education

1. High school, Aliquippa High School, Aliquippa, Pa.; Graduated, January 1944.
2. College, University of Pittsburgh, Pittsburgh, Pa.: B.S., September 1945.
3. Medical School, Western Reserve, Cleveland, Ohio; M.D., June 1949.
4. Internship, Cedars of Lebanon Hospital, Los Angeles, Calif.; Internship, 1949-50
5. Residencies in Medicine:
   a. Veterans' Administration Hospital, Long Beach, Calif.
   b. University of California Hospital, San Francisco, Calif., "Laboratory of Experimental Oncology."
6. Fellowships, a. Atomic Energy Commission; Postdoctoral Fellowship in the Medical Sciences.
7. Awards and Honors, B.S. with highest honors, University of Pittsburgh, 1945. President-elect, American Society for Clinical Oncology, 1969.
8. Licensure, Ohio, California, District of Columbia, Maryland.
9. Board Certification, Internal Medicine, 1958.

C. Professional background

1. Academic appointments:
   a. Instructor in Medicine, University of California, San Francisco, Calif., 1952-54.
   b. Instructor in Medicine, George Washington University School of Medicine, 1954-58.
   c. Assistant Professor of Medicine, University of Southern California School of Medicine, 1959-63.
   d. Associate Professor of Medicine, University of Southern California School of Medicine, 1963-67. (1) Senior Attending Physician, Los Angeles County General Hospital, 1964-68.
   e. Professor of Medicine, University of Southern California School of Medicine, 1967-68.
   f. Associate Director for Program, National Cancer Institute, 1968-69.
   g. Deputy Director, National Cancer Institute, 1969.
   h. Deputy Assistant Secretary for Health and Scientific Affairs, Department of Health, Education, and Welfare, 1969.

2. Administrative responsibilities:
   a. Member of the Radioisotope Committee, D.C. General Hospital, Washington, D.C., 1954–58.
   b. Associate Editor, Journal of the National Cancer Institute, 1956–58, National Cancer Institute, Bethesda, Md.
   c. Director, Radioisotope Laboratory, National Cancer Institute, 1954–58.
   d. Director, Hospital for Blood Diseases, City of Hope Medical Center, 1959.
   e. Director, Cancer Chemotherapy Program, University of Southern California School of Medicine, 1960–68.
   f. Director, Clinical Cancer Traineeship Program, University of Southern California School of Medicine, 1960–68.
   g. Chairman, Radioisotope Committee, University of Southern California School of Medicine, 1960–66.
   h. Director, Radioisotope Unit, University of Southern California School of Medicine, 1960–66.
   i. Chairman, Interdepartmental Cancer Research Committee, University of Southern California, 1960–68.
   j. Member, Laboratory Safety Committee, University of Southern California School of Medicine, 1961–64.
   k. Coordinator, Phase I Activities of National Program in Cancer Chemotherapy for West Coast University Hospitals, 1963–68.
   l. Chairman, Western Cooperative Cancer Chemotherapy Group, 1963–68.
   m. Member, Editorial Board, Cancer Research, 1965–69.
   n. Member, Search Committee for Physiciology Department Chairman, USC, 1966.
   o. President, Attending Staff Association, John Wesley County Hospital, Los Angeles, Calif., 1964–66.
   p. Member, University of Southern California Academic Senate, 1965–66.
   q. Project Director for Cancer Hospital and Cancer Research Institute, University of Southern California Medical School, 1966–68.
3. Military service:
   a. U.S. Public Health Service, 1951–58.
   b. Inactive Reserve, U.S. Public Health Service, 1958–69.

D. Society memberships

1. Local:
   a. Los Angeles County Medical Society.
   b. President, Los Angeles Chapter, American Federation for Clinical Research, 1964–65.
   c. Executive Committee, USC Chapter, American Association of University Professors, 1964–66.
   d. Phi Delta Epsilon.
2. State:
   a. Member, Special Grants Committee, California Division American Cancer Society, 1963–68.
   b. Chairman, Special Grants Committee, California Division, American Cancer Society, 1965–68.
3. National:
   a. American College of Physicians (Fellow).
   b. American Medical Association.
   c. American Association for Cancer Research.
   d. Society of Nuclear Medicine.
   e. American Federation for Clinical Research.
   f. New York Adacemy of Sciences.
   g. American Society of Hematology.
   h. American Association for the Advancement of Science.
   i. Western Society for Clinical Research.
   j. Sigma Xi.
   k. Western Pharmacology Society.
   l. International Society of Hematology.
   m. American Society for Clinical Oncology.
   n. American College of Clinical Pharmacology (Fellow).

E. Consultantships

1. Local:
   a. Consultant in Medicine, Long Beach Veterans' Administration Hospital, Long Beach, Calif., 1961–68.

b. Member, Research and Education Committee, Long Beach Veterans' Administration Hospital, Long Beach, Calif., 1961–66.

c. Consultant to Blood Hospital, City of Hope Medical Center, Duarte, Calif., 1962–68.

d. Member, Tumor Board, Los Angeles County General Hospital, 1960–68.

2. State, a. California Cancer Advisory Council, Member 1960–68; Executive Committee 1965–68; Vice President 1966–67.

3. National:

a. Brookhaven National Laboratory, Research Collaborator 1961–62.

b. Krebiozen Review Committee, National Cancer Institute, 1963.

c. National Cancer Institute: Task Force on Chronic Leukemia, 1963–68.

d. Cancer Chemotherapy National Service Center: New Agents Committee, 1964–68.

e. Clinical Studies Panel, National Cancer Institute, 1964–65.

f. Member, Chemotherapy Advisory Committee, National Cancer Institute, 1967–68.

F. Research activities

1. Bibliography, See following pages.

2. Major Areas of Research Interests:

a. Cancer Chemotherapy.

b. Metabolic Effects of Neoplastic Diseases on the Host.

c. Hematology.

3. Grants for Research, a. U.S. Public Health Service:

(1) Cancer Research Training Grant.

(2) Cancer Chemotherapy Trials.

(3) Clinical Cancer Training—Cancer Coordinator.

(4) Planning Cancer Hospital and Cancer Research Institute Grant.

PUBLICATIONS

1. Steinfeld, J. L., White, L. P., Petrakis, N. L., and Shimkin, M. B.; Negative Effects of Some Metabolite Analogs in Human Neoplasms, Cancer Research 14: 315–318, May 1954.

2. Melcher, L. R., Steinfeld, J. L. and Reed, R.; Studies on I–131 Red Cell Antibodies, Proc. Soc. Exper. Biol. and Med., 88: 649–651, 1955.

3. Steinfeld, J. L., Paton, R. R., Flick, A. L., Milch, R. A., and Beach, F. E.; Distribution and Degradation of Human Serum Albumin Labeled with I–131, Monograph on Iodinated Proteins, N. Y. Acad. of Sci. 570: Art. 1: 109–121, 1957.

4. Chaplin, H. S., Jr., Schmidt, P. J. and Steinfeld, J. L.; Storage of Red Cells at Sub-Zero Temperatures; Further Studies Clinical Science 16: 651–661, November 1957.

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6. Fahey, J. L. and Steinfeld, J. L.; Chromatographic Differences Between Radioiodinated Albumin Preparations and Normal Human Serum Albumin, Proc. Soc. Exper. Biol. and Med. 97: 281–284, February 1958.

7. Steinfeld, J. L., Greene, F. E., Tabem, D. L., Paton, R. R. and Flick, A. L.; Degradation of Iodinated Human Serum Albumin Prepared by Various Procedures, J. Lab and Clin. Med. 51: 756–766, May 1958.

8. Flick, A. L. and Steinfeld, J. L.; Influence of Fever and ACTH Upon Degradation of I–131 Albumin in Man, Am. Jour. Med. Sci. 236: 65–79, 1958.

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11. Bierman, H.R., Kelly, K.H., Cordes, F.L., and Steinfeld, J.L.; The Influence of Heterospecific Type Whole Blood Upon the Circulating Leukocyte Level, Le Saag 31: 311–327, 1960.

12. Steinfeld, J.L.; Sections on "Aplastic Anemia" and "Anemia Due to Cancer" in Current Therapy, 1960 Ed.: H. Conn; W.B. Saunders Co.

13. Steinfeld, J.L., Davidson, J.D., Cordon, R.S., Jr., and Greene, F.E.; The Mechanism of Hypoproteinemia in Patients with Regional Enteritis and Ulcerative Colitis, Am. J. Med. 29: 405–415, 1960.

14. Steinfeld, J.L.; Differences in Daily Albumin Synthesis Between Normal Adult Males and Females as Measured with I–131 Albumin, J. Lab. and Clin. Med. 55: 904–911, 1960.

15. Steinfeld, J.L.; I–131 Albumin Degradation in Patients with Neoplastic Diseases, Cancer 13: 974–984, 1960.

16. Paton, R.R. and Steinfeld, J.L.; Methods of Simultaneous Measurement of Exchangeable Sodium and Potassium in Man, J. Lab and Clin. Med. 57: 306–313, February 1961.

17. Solomon, Joel, Alexander, M.J., and Steinfeld, J.L.; Cyclophosphamide: A Clinical Study, J A M A 183: 165–170, 1963.

18. Waldmann, T.A., Steinfeld, J.L., Dutcher, T.F., Davidson, J.D., and Gordon, R.S., Jr.; The Role of the Gastrointestinal System in "Idiopathic Hypoproteinemia" Gastroenterology 41: 197–207, 1961.

19. Bartter, F. C., Steinfeld, J. L., Waldmann, T. A. and Delea, C. A.; The Fate of Intravenously Administered Human Serum Albumin in the Hypoproteinemia of Gastrointestinal Protein Loss and in Analbuminemia, "Transactions of the American Association of Physicians," 74: 180–194, 1961.

20. Britten, J., Brecher, G., Steinfeld, J. L., and Shimkin, M. B.; Unusual End Stages of Untreated Acute Leukemia, Am. J. Path. 43: 93–106, 1963.

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22. Solomon, Joel and Steinfeld, J. L.; Pyroglobulinemia: Report of A Case with Protein Turnover Studies, Am J. Med., 38: 937–942, 1965.

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25. Steinfeld, J. L.; The Sites of Degradation of the Plasma Proteins, Ross Conference on Plasma Proteins, 1964.

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27. Steinfeld, J. L.; Degradation and Synthesis of Serum Albumin in Patients with Cancer, Proc. Fifth National Cancer Conference 1965.

28. Watkin, D. M., and Steinfeld, J. L.; Nutrient and Energy Metabolism in Patients with and without Cancer During Hyperalimentation with Fat Given Intravenously, American J. Clin. Nutrit. 16: 182–212, 1965.

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31. Stolinsky, D. C., Jacobs, E. M., Bateman, J. R., Hazen, J. G. Kuzma, J. W., Wood, D. A., Steinfeld, J. L.; Clinical Trial of Trimethylcolchicinic Acid Methyl Ether d-Tartrate (TMCA) (NSC–36354) In Patients with Advanced Cancer, Cancer Chemotherapy Reports, 51: 25–34, February 1967.

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34. Solomon, J., Steinfeld, J. L., and Bateman, J. R.; Chemotherapy of Germinal Tumors, Cancer 20: 747–50, May 1967.

35. Bateman, J. R., Peters, R. L., Hazen, J. G., and Steinfeld, J. L.; Methyl Methane Sulfonate (NSC–50256): A Phase I Study, Cancer Chemotherapy Reports 50: 675–682, December 1966.

36. Hyman, C. and Steinfeld, J. L.; Regulation of Plasma Volume, American Heart Journal, 74: 436–8, September 1967.

37. Steinfeld, J. L.; The Leukemias, Current Diagnosis, 2nd Edition, W. B. Saunders, 1968, pp. 341–346.

The CHAIRMAN. I will also order printed in the record at this point the position description of the Surgeon General-U.S. Public Health

Service, Department of Health, Education, and Welfare, and chapter 6A, sections 205 and 206, of title 42, United States Code annotated. (The material referred follows.)

Department of Health, Education, and Welfare

POSITION DESCRIPTION

(Surgeon General—U.S. Public Health Service)

The Surgeon General administers the Commissioned Corps of the Public Health Service. He is also the principal deputy to the Assistant Secretary for Health and Scientific Affairs in administering the health functions of the Department of Health, Education, and Welfare. During the absence of the Assistant Secretary or in the event of a vacancy in that Office, the Surgeon General serves as acting Assistant Secretary for Health and Scientific Affairs and is responsible for carrying on all activities of the Office.

The Surgeon General shares the Assistant Secretary's responsibilities in all program areas. This includes direct line authority for the health agencies of the Department. This also involves overall responsibility for health policy direction and coordination of other health programs, including Medicare and Medicaid.

[Excerpt From the United States Code Annotated]

Title 42.—The Public Health and Welfare, Sections 205 and 206

§ 205. Appointment and tenure of office of Surgeon General; reversion in rank

The Surgeon General shall be appointed from the Regular Corps for a four-year term by the President by and with the advice and consent of the Senate. Upon the expiration of such term the Surgeon General, unless reappointed, shall revert to the grade and number in the Regular Corps that he would have occupied had he not served as Surgeon General. July 1, 1944, c. 373, Title II, § 204, 58 Stat. 684.

NOTES OF DECISIONS

1. Prior law: Prior to the present designation of the Service, the President, in selecting a Surgeon General of the former Public Health and Marine Hospital Service, was not restricted by law to the list of commissioned officers in the Medical Corps of that service. 1911, 29 Op. Atty. Gen. 287.

§ 206. Assignment of officers as Deputy Surgeon General and Assistant Surgeons General; creation of temporary positions as Assistant Surgeons General

(a) The Surgeon General shall assign one commissioned officer from the Regular Corps to administer the Office of the Surgeon General, to act as Surgeon General during the absence or disability of the Surgeon General or in the event of a vacancy in that office, and to perform such other duties as the Surgeon General may prescribe, and while so assigned he shall have the title of Deputy Surgeon General.

(b) The Surgeon General shall assign six commissioned officers from the Regular Corps to be, respectively, the Director of the National Institutes of Health, the Chief of the Bureau of State Services, the Chief of the Bureau of Medical Services, the Chief Medical Officer of the United States Coast Guard, the Chief Dental Officer of the Service, and the Chief Sanitary Engineering Officer of the Service, and while so serving they shall each have the title of Assistant Surgeon General.

(c) The Surgeon General, with the approval of the Secretary, is authorized to create special temporary positions in the grade of Assistant Surgeons General when necessary for the proper staffing of the Service; but the number of such special temporary positions, when added to the eight positions created by section 205 of this title and subsections (a) and (b) of this section, shall not on any day exceed three-fourths of 1 per centum of the highest number, during the ninety days preceding such day, of officers of the Regular Corps on active duty and officers of the Reserve Corps on active duty for more than thirty days. The Surgeon General may assign officers of either the Regular Corps or the Reserve Corps to any such special temporary positions, and while so serving they shall each have the title of Assistant Surgeon General.

The CHAIRMAN. Dr. Steinfeld, you have submitted to me, and to Senator Javits a statement of your financial worth. We have discussed that and there are no holdings, in my opinion, would have any conflict with the position of Surgeon General.

This information is available to any member of the committee if they desire to see it. Neither Senator Javits nor I have any reservations concerning this matter.

Are there any questions of Dr. Steinfeld by any member of the committee?

Senator HUGHES. Yes, Mr. Chairman. Not relative to confirmation of his appointment, but while I have the opportunity, I would like to ask a couple of questions relative to narcotics.

You do have a tremendously impressive background. I notice you have been and are a professor of medicine on a number of faculties in the area.

Some of my concerns, and our concerns are in the new and increasingly growing problem areas of narcotics addiction, drug abuse, and alcoholism.

I think Senator Dominick has a piece of legislation requesting the Surgeon General to prepare a report on marijuana.

Is that right, Senator Dominick?

Senator DOMINICK. That is correct.

Senator HUGHES. And the chemical ingredients in marijuana to bring it up to date.

From my experience, in my own subcommittee in this field, I have found only two medical schools in America that have any basic instruction in the field of drug addiction and alcoholism.

Would you give me your views on that subject area?

Dr. STEINFELD. Yes. I think this is a major area about which we are not doing enough, and about which this Administration plans to do more.

I think a significant number of the admissions at the Los Angeles County General Hospital were associated with or due to alcoholism specifically, and a number of drug intoxications, particularly barbiturate.

We have in preparation plans for a major effort in this area, and I think we will undertake this within the very near future.

Senator HUGHES. Your colleague from California, Dr. Egeberg, has a special interest in these fields, also. I feel a great deal of assurance concerning your appointment, particularly in this area.

Our concern, and I think I probably speak for all of us here—I don't think we have any disagreement on this subject area—is that it is a tremendously growing problem.

Do you know of any medical schools that have any basic instruction in these fields that are satisfactory?

Dr. STEINFELD. I am not aware of any. I think we will have some, because I think with a major emphasis on this area, and with the physicians, faculty members, and the citizens aroused, I am certain that this will come forth.

This has happened, certainly, with the National Institutes of Health. The Congress, I think, was ahead of the medical profession and the scientists in deciding which were the important problems. The faculties, scientists, and physicians have responded.

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Senator HUGHES. Do you want to ask about that annual report?

Senator DOMINICK. If you will yield, Senator Hughes?

Senator HUGHES. I will yield.

Senator DOMINICK. I have a proposal that is very simple and involves no expenditure of funds particularly. We have been spending over the past 4 or 5 years about $9.5 million on research on marijuana. It is scattered all over like so many poppyseeds, to coin a bad phrase.

We found in our drug-abuse hearings by Senator Hughes that there seems to be a general public feeling that marijuana isn't very important or isn't very dangerous.

We have also had considerable testimony on different types of personalities. It seemed to me that we ought to do something along the nature that we did in the tobacco report.

I have a proposal which would ask for a preliminary report toward the end of March next year and an annual report thereafter.

Do you see any real roadblocks in this type of approach to at least getting information so that we can use it for public education purposes?

Dr. STEINFELD. I not only don't see a roadblock, I think it is excellent. I think the annual reports on smoking and health have proved extremely useful and I would hope that a report on marijuana would be most useful in bringing information to the public and forming a broad foundation from which we can teach and launch new research.

Senator HUGHES. Senator Murphy, I will be glad to yield to you.

Senator MURPHY. I had an experience within the last 2 weeks concerning a television show which has a wide coverage. The one thing I came away with was there is a feeling that smoking marijuana in a nice social atmosphere was a very good thing to do. I am not sure that that is right.

For instance, yesterday morning while driving in to work I was listening to the radio and they reported a death from an overdose of heroin, a child 12 years old who had been taking heroin into the veins, mainlining I think was the expression.

I think there is a tremendous need for education. I think it is time we cut away a lot of this nonsense and confusion that has been spread around. Some experts, really, or alleged experts, should know better.

I would hope that we can find out the facts and the truth and have a good education program get started. I am sure, knowing the good doctor, that this will be part of the program that he has in mind.

Dr. STEINFELD. It certainly would be.

Senator HUGHES. I intend to support Senator Dominick's bill on this annual report on marijuana. But I noticed the day before yesterday, I believe it was, in the New York Times—a very good article on the front page about one of the aftereffects of the President's conference with the Governors on local, community-based programs in the area of drugs and narcotics. Many inexperienced and uninformed people are beginning educational programs in this field right now on a massive scale.

I realize that NIH is putting out practically tons of literature in almost every way that they can. But I think this field of education is one that, if it is badly done or wrongly done by poorly informed people, we are going to be in more trouble than we have been in up to this point.

I just say this as a matter of concern in the hope that you will have your staff review this as rapidly as you can, and perhaps through public statements and other ways you can somehow direct these local concerns.

They are certainly based soundly but they can be wrongly carried out unless we are very careful.

Mr. Chairman, I am happy to yield. I am very pleased with the background, competence, and capabilities of Dr. Steinfeld.

I can only wish you well in your new position.

Dr. STEINFELD. Thank you.

Senator DOMINICK. I have just one more question, Doctor.

We had a discussion yesterday on migrant health problems, and particularly a visit which the subcommittee took to Texas. We found that one of the Public Health doctors down there had never even been in a migrant camp. It was a very interesting situation. That was even though he was supposed to be in charge of the program.

My question is perhaps not subject to your immediate interpretation, but just to get your viewpoint on this, are the Public Health officers in fact chosen by the various counties in the States, or are they part of the Public Health Service responsible to you as the Surgeon General, or who are they?

What controls does anybody have over them?

Dr. STEINFELD. There are different kinds of Public Health officers. States have them; territories have them; local communities have them. But the U.S. Public Health Service is a Federal establishment and our officers are responsible through channels to the Surgeon General.

I would be appalled if a person responsible for a migrant health program had never been in a migrant area. Certainly, if I am confirmed, I have a series of plans to visit Public Health Service hospitals which we now have in Fort Worth and Lexington, Indian hospitals, a number of migrant health areas, and see firsthand and do something about the health problems which the country has.

Senator DOMINICK. Thank you.

The CHAIRMAN. Dr. Steinfeld, concerning the position description of the Surgeon General in the Department of Health, Education, and Welfare, have you had an opportunity to read the description of duties?

Has it been submitted to you?

Dr. STEINFELD. Yes.

The CHAIRMAN. This position has been open for some considerable time, and in the brief year that I have been Chairman of the Health Subcommittee, and Chairman also of the Appropriations Subcommittee that deals with the Bureau of the Budget, I have been trying to dig into what has happened to the Public Health Service.

There has been, in my opinion, a steady erosion of its powers and influence over the past 20 years, not due to the personalities of the different Surgeons General, but, so far as I have yet been able to ascertain, due to the Bureau of the Budget, which constantly whittles away at the Public Health Service hospitals.

We had 23 hospitals 20 years ago, and there are only eight left now. Two of those have been ordered closed, one at Detroit, the only one left on the entire Great Lakes to serve the seamen. Of course, as you

know, there are broad capabilities for research in these hospitals that you do not have in a proprietary hospital.

I want to request that you use your great talents and abilities, shown by your past accomplishments in life, to recapture the influence, the drive and spirit of the Surgeon General to protect the Public Health Service hospitals of the United States.

Other efforts were made this year under pressure from the Bureau of the Budget—which seems to operate above the administration and the Congress—to close the only two narcotic treatment and research hospitals in the United States. They were set up in 1935 at Lexington, Ky., for States east of the Mississippi, and in 1938 at Fort Worth, Tex., for States west of the Mississippi. They take care of citizens from all the States.

I think you will have problems with the Bureau of the Budget which will call upon all the capabilities that you have. I wish you success in that. I will be on your side.

Also, the Migrant Health Service started years ago from this Labor and Public Welfare Committee, under a subcommittee chaired by Senator Harrision Williams of New Jersey.

We found that under previous health service laws created under statutes emanating from this committee, there has been a whittling away of this service. In a report we will file today on our hearings on extension of migratory services, this has been our finding. Notwithstanding the many reasons for continuing and expanding a migrant health program, the Public Health Service instituted a reorganization plan—I am not blaming that on the present administration; it started in 1968—that appears to destroy the operations of the migrant health program and obliterate the separate central and regional office staffs of the migratory health unit.

We found out that if you lump the migrant programs in with others, they come out on the bottom of the totem pole; the hearings before our committee show that among the migrant laborers in the United States, tuberculosis is 17 times more prevalent than among the general public, venereal disease 18 times more prevalent, and the general communicable diseases, I believe, 18 or 20 times more prevalent than other parts of the population.

We owe good health to our migrant workers who harvest the vegetables of the Nation. Pure, selfish interest would dictate we do something about their health.

I would like to request that you see to it that we extend this service. We are putting more money into it. This committee was unanimous in its report. We cut the extension from 5 to 3 years to see how it would work to assist these people with an opportunity in life. In 1968 there were 22 positions in the Migrant Health Service in Washington. That has been cut to two. So you will have problems down there being Surgeon General.

You will have the title but you will have forces trying to whittle that office away. I want to warn you of what is coming and say I am glad to see a man with your qualifications appointed. We are on your side to see that that is a real office.

Dr. STEINFELD. I would like to make one general comment. I think there has been a tendency toward comprehensive health programs with the idea that comprehensive is good and categorical is bad.

I think in the long run perhaps this is so. But we can't lose sight of the fact that there are special groups or special diseases, as you pointed out, in which we are not ready for comprehensive programs we therefore do need categorical programs and identified funds, people and positions in order to do—during the short run, the intermediate run—right by these people.

The CHAIRMAN. We have found that comprehensive means practically nothing to a migrant worker. He starts out from south Texas, generally, and heads for the beet fields or cherry orchards of Michigan, and until he gets there he can get no medical care. He is turned away from hospitals. He is a migrant and he can't get in.

If he is sick, that is just too bad until he gets up to those States.

Then they give him some help. But he is only going to be there about 6 weeks and he can't get hospitalization. Migrants get sympathy from the people they are working for. But they know they will be there today and gone tomorrow.

I am convinced if you don't have this categorical help for the migrant workers, they will be just left out. They are not at the bottom of health care. They are outside of it.

Gentlemen, I am forced to attend a conference between the House and Senate on the Economic Opportunity Amendments of 1969. I would like for Senator Kennedy to chair the hearing during my absence.

Senator KENNEDY (presiding pro tempore). Dr. Steinfeld, I would like to welcome you to the committee this morning. I have just a few questions.

As I understand it, the medicaid task force has expanded its mandate to include a study of national health insurance. Is that correct?

Dr. STEINFELD. I think the Secretary asked the medicaid task force to consider the possibilities downstream of national health insurance and to indicate what types of studies we should get underway in order to alert us to the problems, the possibilities, the types of activities that we would need, what kind of administrative programs, what kinds of personnel and so forth.

This is a planning or almost a preplanning activity to get ready for something which appears to be coming.

Senator KENNEDY. I understood that the task force was to make some recommendations on this issue, not simply to make recommendations as to how the issue should be studied further. Can you tell us whether the task force is actually studying the issue itself, or is it studying how to proceed to discuss the issue?

Dr. STEINFELD. I can't give you a specific answer, Senator, but I think they will probably study the issue, itself, and then try to give us guidelines as to what should be done in the event that we are going to go in that direction.

It is apparent, because of the multisystems of health care which we have in this country right now, that we do need to do a lot of planning.

We may have to revise our system of health care delivery. We may have to have full new groups of health professionals to make the physician more efficient so we are not wasteful of the physician's time and highly expensive talent.

So I think their mandate is a broad one. I think they are going to look at the issue and then look at how we might get there on the assumption that at some time in the future we will go in that direction.

Senator KENNEDY. The American Medical Association has a health insurance proposal which relies on tax credits. There are a number of other proposals as well. One that is quite far along is the proposal of Walter Reuther's Committee for National Health Insurance.

Is it your understanding that the task force report will consider the proposals in their study as well?

Dr. STEINFELD. I think there are no limits on what the task force will consider. From my attendance at their meetings, they consider really everthing that comes within their purview.

Senator KENNEDY. Do you attend those meetings?

Dr. STEINFELD. I have attended some of the meetings, but I have not been present at all of them. The task force started before I became a member of the department downtown.

Senator KENNEDY. Can you give us any idea as to when the task force will issue its report?

Dr. STEINFELD. I think the task force as it is now constituted is shooting for a report in another 6 months. I would say June or at most, July of next year.

Senator KENNEDY. The AMA's proposal for national health insurance—"Medi-Credit"—is financed by tax credits. The Reuther committee's proposals rely primarily on the Social Security System for financing the program.

I gather from your remarks that the task force will study both of these proposals.

Dr. STEINFELD. I think there is no limit on what they will study, Senator Kennedy. I think they will study these and probably others. They may come out with unique proposals or alternative proposals. But they were not restricted in any way in their approach to the problem.

Senator KENNEDY. As I understand it, then, the whole area of national health insurance is an area of inquiry by the task force.

Dr. STEINFELD. By the task force and by the department.

Senator KENNEDY. On another subject, can you give us any information as to whether the department is going to support the increased appropriations for health programs recommended by the Senate-House conferees in the HEW appropriations bill?

Dr. STEINFELD. I don't think I can do that because I don't know what the final position will be or what the final appropriations will be.

I can tell you personally I am interested in health programs, in health services and in health research. I will do everything I can to see that we improve the programs we have and get appropriate new programs.

Senator KENNEDY. I think the administration recommended reductions in those areas. It placed a low priority in the areas like health research and manpower.

I don't want to put you in a difficult position, since the administration and the department seem to have taken a position already. I wonder, though, what kind of personal reaction you have as to the importance of vigorous health research and manpower programs?

Dr. STEINFELD. Since I spent 17 years of my life doing clinical cancer research with patients, I certainly think it extremely important.

I think that our long-range answers must come from research into the health problems we have today. But I think we must balance the research which we are doing in order to combat problems or avoid them, prevent them in the future, and taking care of the people who have them today.

I think this is the balance we must have, between service, improving service, improving our systems of service, training more people and research for the future.

This is the problem of priorities. I think they are both extremely important.

Senator KENNEDY. Aren't there serious dangers in reductions in the funds for medical research? For example, if there is a significant reduction in funds, isn't there likely to be a disintegration of medical research teams? When overhead and costs increase, and available funds decrease, isn't it likely that major medical research teams will break up or be disbanded?

Dr. STEINFELD. I don't think too many teams have been broken up at this point. I think the problem might be looked at in another context. That is when we recruited young physicians and young scientists into training programs, the idea was when they finished with their training they would go out, do research, and set up their own programs.

The problem now is with a stable research base, people coming through are worried that this may not be an appropriate career, because they see that their professors, their teachers, are having trouble keeping the programs going.

I think we have kept the programs going that we have. I don't really know of any big or significant teams which have broken up. But our problem is for the future.

We have been expanding our research activities and I think we should continue. I hope that within a very short time we will continue.

I think the administration is sympathetic toward this and wants to do it.

In the balancing of priorities, shortly it will be able to undertake all of these activities.

Senator KENNEDY. Are you familiar with the administration's decision to close the Framingham Heart Study in Massachusetts?

Dr. STEINFELD. Yes, I am.

Senator KENNEDY. Are you familiar with the details of the decision?

Dr. STEINFELD. Not in great detail. I know Dr. Ted Cooper, the Director of the Heart Institute. He is a neighbor of ours. He has assured me that this is not a budgetary decision, but a decision which was made on a programmatic basis.

Senator KENNEDY. Hasn't the Framingham study been producing useful new information in heart research? Hasn't it been developing new approaches to other diseases, like stroke? Why isn't the project worth continuing?

Dr. STEINFELD. I am not familiar with it exactly, but I would say this, in terms of another program, and I think it may be applicable, Senator Kennedy. All of the research programs, as you know, are reviewed by study sections, and study sections are composed of scientists from around the country.

I think almost by law they have one Federal employee on a study section, so they represent widely university people, professors, and people who work in various research institutes.

The study sections tend to give high marks to the kinds of work which they, themselves, have done.

This means that in the field of cancer chemotherapy, if a particular program were to go to a study section that was oriented for its biochemistry, it might not get funded.

I think the problem here is that this is an epidemiologic study, and I am not certain it went to a group of epidemiologists. It may have gone to another group.

But the decision was not, as Dr. Cooper has explained to me, a budgetary decision. I think that we are familiar with the Framingham studies and with what it has done, and its potential for the future.

We are looking to keep a nucleus intact so that those important areas can be continued.

Senator KENNEDY. As I understand it, Dr. Cooper initially recommended that the Framingham study be continued, but that NIH overruled him. I also understand that your study section had recommended that it be continued. So the two groups that initially had the most direct responsibility for evaluating the Framingham study—the study section and the National Heart Institute—both recommended that the study should be continued. Yet, they were both overruled by the NIH. This is why I suggest that the reasons for closing the study may not be programmatic.

Dr. STEINFELD. I will talk to Dr. Cooper again. As I say, when I talked with him, this was not what he told me.

Senator KENNEDY. Let me also ask you about your ideas on developing new paraprofessionals in health fields.

Dr. STEINFELD. We are working on that. We have no specific suggestions at this point.

As you know, there are major problems because States regulate licenses for paraprofessionals. An individual who may get a license trained in one State may not be able to go to other States.

We have a group looking at State licensing laws. We have groups looking at the needs and possibilities for increasing the efficiency of physicians and so forth. I can't give you an exact time, but I hope that relatively soon we can come up with a realistic program which will meet some of the needs we have now.

Senator KENNEDY. Are you familiar with what is being done in the State of Washington in terms of retraining medical corpsmen coming back from Vietnam? This program has been quite successful, hasn't it?

Dr. STEINFELD. There is a good program at the University of Washington and also at Duke. It would be my intention to visit both of those and see what applicability these might have on a broader basis.

Senator KENNEDY. What liaison do you see in the future between OEO and HEW in the area of neighborhood health centers?

Is there a close working relationship between these two agencies in their attempts to provide comprehensive health care to both rural and urban disadvantaged areas?

Dr. STEINFELD. I think Dr. English, now the head of the Health Services Mental Health Administration had been in OEO and is familiar with the programs.

Senator KENNEDY. He was one of the originators of the idea.

Dr. STEINFELD. Right. But I am certain that, as in all of these programs, we could improve our cooperation. I can't give you the

exact status of how often people meet and how they review grants together and so forth.

Senator KENNEDY. Thank you very much, Dr. Steinfeld. I certainly congratulate you on your nomination, and I look forward to working with you in the future. Senator Williams?

Senator WILLIAMS. Doctor, it is proving out every day that there is a mounting congressional concern about diseases related to occupations. We hope finally, today, that Congress will deal with a disease which has plagued coal miners since the beginning of coal mining, a respiratory disease, pneumoconiosis.

Notwithstanding the fact that men have been offering up their lives for hundreds of years in coal mines, the disease was only recently related to their occupation.

It seems impossible, but this is the fact. Medicine had not established this as the miner's health problem, pneumoconiosis.

Now it has been established. This is, I am afraid, too typical of many other areas of occupation-related disease. We now have legislation that goes across the board for all occupations—the occupational health and safety bill. Whenever we have hearings on this, more information comes to us of the lack of information in the medical community on diseases arising from jobs.

Byssinosis is now one that we hear is related to the inhalation of cotton dust in textile mills.

I conclude that by relying on private medical research centers, the answers will be arrived at in a hit-or-miss fashion. Relying on corporate medical research for probably obvious reasons will cause a noticeable lag in the relation of the disease to the occupation.

It seems to me that one place where we can get the national focus for research, on diseases related to occupations, would be your office.

It seems to me that you are in a position to come to us and tell us where you see the problems so we can cooperate with you.

Is the Surgeon General's Office now equipped with the talent to take off into some exotic areas, for example, toxic materials that are causing diseases?

We count on you to come to us. We don't want to have to discover this on a hit-or-miss basis and go to you. I think the Surgeon General should tell the Congress, "Here is what I need to get to an understanding of the disease-related areas."

Dr. STEINFELD. We have two groups working on this. We have an Environmental Health Administration. We will come to you with a review of the problem and a proposal for its future.

I think this is an important matter and one that one can do something about.

Senator WILLIAMS. We certainly hope so. Do you find it incredible that medicine has taken so long to establish what now seems so obvious a relationship in an occupation like coal mining and pneumoconiosis?

Dr. STEINFELD. I am not sure I would say incredible. I would say that one of the amazing things is that myocardiac infarction was called acute indigestion. Here it is now the leading cause of death in the United States.

It wasn't recognized as being a problem of the heart and circulatory system but rather was thought to be gastro-intestinal. As complex as

medicine is, and as much as we try to teach medical students, we have a great deal to learn. We know just a tiny bit about the human body. That is what makes it so exciting.

Senator WILLIAMS. In a lot of these areas and occupations you have to break through barriers of resistance, you know.

There are economic barriers you have to get through. You get very little cooperation. We know it is going to cost some money to right the wrongs that can be righted.

Dr. STEINFELD. So far, Dr. Cotin, head of the National Institute of Environmental Health Sciences, has a very good rapport with industry industrial leaders and people in the plants.

I think we can look to him as well as C. C. Johnson to enlarge and improve these programs.

Senator WILLIAMS. Senator Mondale is finding this out in pesticides. There is a resistance.

Senator MONDALE. We have had quite a dispute in this committee. Part of the reason is that the facts are so hard to obtain. I think that is true, in part, because the official public agencies have not tried, or at least they have found other things to be deserving of a higher priority than this.

The Federal Government has a very haphazard system of collecting evidence on how many have been injured or poisoned by pesticide, how they died from pesticide poisons, what kinds of poisons they were.

One of the witnesses before us was from a data collecting agency, a Federal agency, in Atlanta, and estimated that about 800 deaths and 80,000 injuries result from pesticides each year.

Yet a doctor sitting next to him didn't think that was right. This is, I think, symptomatic of what I regard to be a very profound bias in American medicine by which it deals almost exclusively with the problems of those who can afford to pay a doctor, and only secondarily, sort of as an afterthought, with the vast problems of health of those who cannot afford the doctors.

That is all I had. I have no questions. I am willing to rest with my profound statement.

Senator MURPHY. May I make one statement, Mr. Chairman? I would like to say that in the 5 years I have been here—and I may be biased—I have known Dr. Steinfeld, and I found him to be the most responsive and obviously has the most comprehensive capability in his field of any witness.

I congratulate you, Doctor. You have even surprised me and I have been an admirer of yours for some time.

I think with the questions today, which have been wide-ranging, I feel better already. I think the people who need the attention will get better attention from what I have heard.

I think this committee, who can and want to be helpful in these areas, will get much greater cooperation from you and your office now than it has been my experience to receive in the past. I know that working together we will get a lot of these problems solved.

Senator KENNEDY. Senator Pell.

Senator PELL. Thank you, Mr. Chairman.

Mr. Chairman, I ask unanimous consent to present to Dr. Steinfeld a list of questions directed to him.

As soon as possible, I would like for him to respond to the questions in as complete detail as he wishes.

Upon receipt of the answers, I ask unanimous consent that both the questions and answers be placed into the record at this point.

Senator KENNEDY. Without objection, it is so ordered.

(The questions submitted by Senator Pell and answers received from Dr. Steinfeld follow:)

QUESTIONS SUBMITTED BY SENATOR PELL AND RESPONSES OF SURGEON GENERAL JESSE L. STEINFELD, U.S. PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Question 1: Do you agree that the United States should implement a national health insurance plan in the early 1970's?

Answer: The Federal Government has moved more and more into health research, health education, and provision of health services through financing mechanisms. In the latter situation, the Federal Government in partnership with those citizens over 65 in the instance of medicare and in partnership with the States in terms of medicaid is actively in the field of financing the provision of health services. Unfortunately, medicaid is not a resounding success since it is primarily a purchaser of services. The problem in this country is to improve both the quality and quantity of health care and to make it available for all who need health care. What I believe we must do immediately is to undertake a number of experiments and pilot projects involving the use of para-professional personnel as well as professional personnel with emphasis on preventive care or preventive medicine and use of ambulatory care facilities in lieu of institutional or hospital type facilities wherever possible. It seems to me, speaking as an individual, that we are moving toward a national health insurance program and it is our duty to be ready for it in terms of not only the capacity to provide the services but in terms of the administrative mechanisms to have an efficient program. I feel, therefore, that it is imperative for us to begin both such experiments and pilot programs as soon as possible.

Question 2: Since the poor have been shown by government statistics to be least able to pay for the health care that they need, do you agree that the Federal Government should pay the premium for the poor as part of a national health insurance plan?

Answer: There are two aspects to this question, Senator, as I interpret it. First and foremost, the goal really should be to eliminate poverty, to eliminate the ghetto, and in that situation then all our citizens will be able to afford either health care or the premium for health care or their share of the premiums for health care depending upon the type of program that the Congress and the people choose. However, that is a long-range solution. For the short-range, it is clear that the Government must help provide medical care for the poor through whatever mechanism is most efficient and most appropriate to get the job done in a fair or equitable way.

Question 3: Would you favor a national health insurance plan based on a plan similar to Social Security or a plan similar to the one Governor Rockefeller suggested where third party vendors, such as Blue Cross, would be paid through employer-employee work place contributions?

Answer: Here again, Senator, I think we must do pilot studies in different parts of the country such as urban areas, rural areas, suburban low, middle or upper income areas, and in what has been called the American ghetto, and have our decisions then be based upon our experience as to which of these programs fits our needs. It may well be that in different States or in different areas we will have modifications of a health insurance program rather than a single national plan.

Question 4: Do you agree that all the government's 23 health programs should be organized under one federal official?

Answer: Here I believe that there could and should be far more coordination and cooperation among these several programs and coordination and cooperation with States, local government, and the large number of private organizations and groups involved in health programs. As a step in this direction for the Federal programs alone it might be desirable to set up a coordinating mechanism with a single agency as the lead agency, one again, to learn from this what the problems are, what can be accomplished, and whether our overall effort would be helped or hindered if we were to move in such a direction.

Question 5: What types of incentives could be utilized to encourage physicians and hospitals to lower costs?

Answer: Regarding hospital costs, it must be remembered that hospitals are a recent institutional development in the sense that we utilize them for delivery of

children, for intensive care, myocardiac infarctions, operations on diseases as appendicitis, all of which result hopefully in cure of the patient. Not too long ago hospitals were places where people went to spend their last remaining days and it was not usual for the patient to return home able to function in society. In that not too distant past hospitals were charitable institutions run by religious organizations and staffed by dedicated individuals who were paid little or nothing beyond room and board. Accordingly, hospital wage scales have been appallingly low. As the hospital is looked upon more and more as any other business enterprise, wage scales, which make up the great bulk of hospital costs, have risen.

Another important feature and there are many others I won't mention, but another important feature is the increasing complexity and expense of instrumentation, as for example the monitoring equipment in a coronary intensive care unit.

To lower hospital costs might mean having different types of rates for patients who required different levels of complexity of hospital care. We might, as an incentive, provide higher fees for diagnostic medical work done on an outpatient rather than an inpatient basis. Some of our programs which provide payment only when the patient is hospitalized encourage the physician to hospitalize the patient for diagnostic work which could be accomplished with the patient in a non-hospitalized status.

Another form of experimentation would be prepayment of fees for an entire group of patients paid to a group of physicians who have access to and the use of a hospital as well as outpatient facilities. This might encourage more preventive medicine or preventive care. Such prepayment plans have not been utilized in any of this country's governmental health programs. At this point I am not proposing that this be done on a national basis but I do feel that here, too, experimental or pilot programs should be undertaken promptly to see if we can lower costs while maintaining or even improving the present quality of care.

Question 6: Do you agree that no federal money should be spent in any region unless that money is spent in conformance with a comprehensive regional health plan?

Answer: For health research and health education—no. For health services, this may be desirable if it is truly a comprehensive regional health plan but, as you indicated earlier when you mentioned that the government has at least 23 health programs, it may be difficult to enforce such a ruling directed presumably at the civilian population if other governmental facilities as DoD or VA facilities are present in a particular region.

Question 7: What steps should be taken to encourage a greater emphasis on preventive care services, such as neighborhood health centers, in the United States?

Answer: All of our programs should emphasize preventive care much more than we now do. This will involve education not only of our school age population but in industrial concerns, in all work situations, and hopefully of housewives as well. It may require the addition of new courses in medical school curricula, and in many or all paramedical educational institutions. We may even need a new type of professional but it seems to me that not only should our professionals be stimulated in this regard but our financing devices such as medicare and medicaid should be remoulded so as to emphasize and to reward those who can utilize preventive medicine rather than the much more expensive hospitalization approach.

Senator KENNEDY. Are there any further questions of Dr. Steinfeld? If not, thank you very much, Doctor, for coming before the committee.

Dr. STEINFELD. Thank you, Senator Kennedy.

Senator KENNEDY. That will conclude the public session of the committee and we will now proceed to executive session.

(Whereupon, at 10:45 a.m. the committee proceeded into executive session.)

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