FAMILY PRACTICE OF MEDICINE

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON
BOR AND PUBLIC WELFARE
UNITED STATES SENATE

NINETY-FIRST CONGRESS

SECOND SESSION

ON

S. 3418

TO AMEND THE PUBLIC HEALTH SERVICE ACT TO PROVIDE FOR THE MAKING OF GRANTS TO MEDICAL SCHOOLS AND HOSPITALS TO ASSIST THEM IN ESTABLISHING SPECIAL DEPARTMENTS AND PROGRAMS IN THE FIELD OF FAMILY PRACTICE, AND OTHERWISE TO ENCOURAGE AND PROMOTE THE TRAINING OF MEDICAL AND PARAMEDICAL PERSONNEL IN THE FIELD OF FAMILY MEDICINE

JULY 8 AND 9, 1970

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

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FAMILY PRACTICE OF MEDICINE

WEDNESDAY, JULY 8, 1970

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE
COMMITTEE ON LABOR AND PUBLIC WELFARE,
Washington, D.C.

The subcommittee met at 10.30 a.m., pursuant to call, in room 4232, New Senate Office Building, Senator Ralph W. Yarborough (chairman of the committee) presiding.

Present: Senators Yarborough (presiding), Kennedy, and Schweiker.

Committee staff members present: Robert O. Harris, staff director; John S. Forsythe, general counsel; and Jay B. Cutler, minority counsel to the subcommittee.

The CHAIRMAN. The Health Subcommittee of the Senate Labor and Public Welfare Committee will come to order.

This morning we open hearings on S. 3418 to amend the Public Health Service Act—it is cosponsored by 32 other Senators with me, a third of the Senate—to encourage and promote the training of medical and paramedical personnel in the field of family practice.

(The text of the bill, along with departmental reports follow:)

91ST CONGRESS
2D SESSION

S. 3418

IN THE SENATE OF THE UNITED STATES

FEBRUARY 9, 1970

Mr. YARBOROUGH (for himself, Mr. RANDOLPH, Mr. WILLIAMS of New Jersey, Mr. PELL, Mr. KENNEDY, Mr. NELSON, Mr. MONDALE, Mr. EAGLETON, Mr. CRANSTON, Mr. JAVITS, Mr. PROUTY, Mr. SCHWEIKER, Mr. ALLEN, Mr. BAYH, Mr. BROOKE, Mr. BURDICK, Mr. EASTLAND, Mr. ERVIN, Mr. FULBRIGHT, Mr. GOODELL, Mr. HART, Mr. HARTKE, Mr. INOUYE, Mr. JORDAN of North Carolina, Mr. MCCARTHY, Mr. MCGOVERN, Mr. METCALF, Mr. MONTOYA, Mr. PASTORE, Mr. PERCY, Mr. RIBICOFF, Mr. SCOTT, and Mr. SPONG) introduced the following bill; which was read twice and referred to the Committee on Labor and Public Welfare

A BILL

To amend the Public Health Service Act to provide for the making of grants to medical schools and hospitals to assist them in establishing special departments and programs in the field of family practice, and otherwise to encourage and promote the training of medical and paramedical personnel in the field of family medicine.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That part D of title VII of the Public Health Service Act is amended to read as follows:

★(Star Print)

"PART D—GRANTS TO PROVIDE PROFESSIONAL AND TECHNICAL TRAINING IN THE FIELD OF FAMILY MEDICINE

"DECLARATION OF PURPOSE

"SEC. 761. It is the purpose of this part to provide for the making of grants to assist—

"(a) public and private nonprofit medical schools—

"(1) to operate, as an integral part of their medical education program, separate and distinct departments devoted to providing teaching and instruction in all phases of family practice;

"(2) to construct such facilities as may be appropriate to carry out a program of training in the field of family medicine whether as a part of a medical school or as separate outpatient or similar facility;

"(3) to operate, or participate in, special training programs for paramedical personnel in the field of family medicine; and

"(4) to operate, or participate in, special training programs to teach and train medical personnel to head departments of family practice or otherwise teach family practice in medical schools.

"(b) public and private nonprofit hospitals which provide training programs for medical students, interns, or residents—

"(1) to operate, as an integral part of their medical training programs, special professional training programs in the field of family medicine for medical students, interns, or residents;

"(2) to construct such facilities as may be appropriate to carry out a program of training in the field of family medicine whether as a part of a hospital or as a separate outpatient or similar facility;

"(3) to provide financial assistance (in the form of scholarships, fellowships, or stipends) to interns, residents, or other medical personnel who are in need thereof, who are participants in a program of such hospital which provides special training (accredited by a recognized body or bodies approved for such purpose by the Commissioner of Education) in the field of family medicine, and who plan to specialize or work in the practice of family medicine; and

"(4) to operate, or participate in, special training programs for paramedical personnel in the field of family medicine.

"AUTHORIZATION OF APPROPRIATIONS

"SEC. 762. (a) For the purpose of making grants to carry out the purposes of this part, there are authorized to be appropriated $50,000,000 or the fiscal year ending June 30,

1971, $75,000,000 for the fiscal year ending June 30, 1972, and $100,000,000 for the fiscal year ending June 30, 1973, and for each of the next two succeeding fiscal years.

"(b) Sums appropriated pursuant to subsection (a) for any fiscal year shall remain available for the purpose for which appropriated until the close of the fiscal year which immediately follows such year.

"GRANTS BY SECRETARY

"SEC. 763. (a) From the sums appropriated pursuant to section 762, the Secretary is authorized to make grants, in accordance with the provisions of this part, to carry out the purposes of section 761.

"(b) No grant shall be made under this part unless an application therefor has been submitted to, and approved by, the Secretary. Such application shall be in such form, submitted in such manner, and contain such information, as the Secretary shall have prescribed by regulations which have been promulgated by him and published in the Federal Register not later than six months after the date of enactment of this part.

"(c) Grants under this part shall be in such amounts and subject to such limitations and conditions as the Secretary may determine to be proper to carry out the purposes of this part.

"(d) In the case of any application for a grant any part

of which is to be used for major construction or remodeling of any facility, the Secretary shall not approve the part of the grant which is to be so used unless the recipient of such grants enters into appropriate arrangements with the Secretary which will equitably protect the financial interests of the United States in the event such facility ceases to be used for the purpose for which such grant or part thereof was made prior to the expiration of the ten-year period which commences on the date such construction or remodeling is completed.

"(e) Grants made under this part shall be used only for the purpose for which made and may be paid in advance or by way of reimbursement, and in such installments as the Secretary may determine.

"ELIGIBILITY FOR GRANTS

"SEC. 764. (a) In order for any medical school to be eligible for a grant under this part, such school—

"(1) must be a public or other nonprofit school of medicine; and

"(2) must be accredited as a school of medicine by a recognized body or bodies approved for such purpose by the Commissioner of Education, except that the requirement of this clause (2) shall be deemed to be satisfied if, (A) in the case of a school of medicine which by reason of no, or an insufficient, period of

operation is not, at the time of application for a grant under this part, eligible for such accreditation, the Commissioner finds, after consultation with the appropriate accreditation body or bodies, that there is reasonable assurance that the school will meet the accreditation standards of such body or bodies prior to the beginning of the academic year following the normal graduation date of students who are in their first year of instruction at such school during the fiscal year in which the Secretary makes a final determination as to approval of the application.

"(b) In order for any hospital to be eligible for a grant under this part, such hospital—

"(1) must be a public or private nonprofit hospital; and

"(2) must conduct or be prepared to conduct in connection with its other activities (whether or not as an affiliate of a school of medicine) one or more programs of medical training for medical students, interns, or residents, which is accredited by a recognized body or bodies, approved for such purpose by the Commissioner of Education.

"APPROVAL OF GRANTS

"SEC. 765. (a) A grant under this part may be made only if the application thereof is recommended for approval

by the Advisory Council on Family Medicine and is approved by the Secretary upon his determination that—

"(1) the applicant meets the eligibility requirements set forth in section 764;

"(2) the applicant has complied with the requirements of section 763;

"(3) the grant is to be used for one or more of the purposes set forth in section 761;

"(4) it contains such information as the Secretary may require to make the determinations required of him under this section and such assurances as he may find necessary to carry out the purposes of this part;

"(5) it provides for such fiscal control and accounting procedures and reports, and access to the records of the applicant, as the Secretary may require (pursuant to regulations which shall have been promulgated by him and published in the Federal Register) to assure proper disbursement of and accounting for all Federal funds paid to the applicant under this part; and

"(6) the application contains or is supported by adequate assurance that any laborer or mechanic employed by any contractor or subcontractor in the performance of work on the construction of the facility will be paid wages at rates not less than those prevailing on similar construction in the locality as determined

by the Secretary of Labor in accordance with the Davis-Bacon Act, as amended (40 U.S.C. 276a–276a5). The Secretary of Labor shall have, with respect to the labor standards specified in this paragraph, the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 F.R. 3176; 65 Stat. 1267), and section 2 of the Act of June 13, 1934, as amended (40 U.S.C. 276c).

"(b) The Secretary shall not approve any grant to—

"(1) a school of medicine to establish or operate a separate department devoted to the teaching of family medicine unless the Secretary is satisfied that—

"(A) such department is (or will be, when established) of equal standing with the other departments within such school which are devoted to the teaching of other medical specialty disciplines;

"(B) such department will, in terms of the subjects offered and the type and quality of instruction provided, be designed to prepare students thereof to meet the standards established for specialists in the specialty of family practice by a recognized body approved by the Commissioner of Education; or

"(2) a hospital to establish or operate a special program for medical students, interns, or residents in the field of family medicine unless the Secretary is satisfied

that such program will, in terms of the type of training provided, be designed to prepare participants therein to meet the standards established for specialists in the field of family medicine by a recognized body approved by the Commissioner of Education.

"(c) The Secretary shall not approve any grant under this part unless the applicant therefor provides assurances satisfactory to the Secretary that funds made available through such grant will be so used as to supplement and, to the extent practical, increase the level of non-Federal funds which would, in the absence of such grant, be made available for the purpose for which such grant is requested.

"PLANNING GRANTS

"SEC. 766. (a) For the purpose of assisting medical schools and hospitals (referred to in section 761) to plan projects for the purpose of carrying out one or more of the purposes set forth in such section, the Secretary is authorized for any fiscal year (prior to the fiscal year which ends June 30, 1975) to make planning grants in such amounts and subject to such conditions as the Secretary may determine to be proper to carry out the purposes of this section.

"(b) From the amounts appropriated for any fiscal year (prior to the fiscal year ending June 30, 1975) pursuant to section 762 (a), the Secretary may utilize such amounts as

he deems necessary (but not in excess of $5,000,000 for any fiscal year) to make the planning grants authorized by subsection (a).

"ADVISORY COUNCIL ON FAMILY MEDICINE

"SEC. 767. (a) The Secretary shall appoint an Advisory Council on Family Medicine (hereinafter in this section referred to as the 'Council'). The Council shall consist of twelve members, four of whom shall be physicians engaged in the practice of family medicine, four of whom shall be physicians engaged in the teaching of family medicine, and four of whom shall be representatives of the general public. Members of the Council shall be individuals who are not otherwise in the regular full-time employ of the United States.

"(b) Each member of the Council shall hold office for a term of four years, except that any member appointed to fill a vacancy prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term, and except that the terms of office of the members first taking office shall expire, as designated by the Secretary at the time of appointment, three at the end of the first year, three at the end of the second year, three at the end of the third year, and three at the end of the fourth year, after the date of appointment. A member shall not be eligible to serve continuously for more than two terms.

"(c) Members of the Council shall be appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive service. Members of the Council, while attending meetings or conferences thereof or otherwise serving on business of the Council, shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding $100 per day, including traveltime, and while so serving away from their homes or regular places of business they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in Government service employed intermittently.

"(d) The Council shall advise and assist the Secretary in the preparation of regulations for, and as to policy matters arising with respect to, the administration of this title. The Council shall consider all applications for grants under this part and shall make recommendations to the Secretary with respect to approval of applications for grants under this part.

"DEFINITIONS

"SEC. 768. For purposes of this part—

"(1) the term 'nonprofit' as applied to any hospital or school of medicine, means a school of medicine or hospital which is owned and operated by one or more nonprofit corporations or associations, no part of the

net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual;

"(2) the term 'family medicine' means those certain principles and techniques and that certain body of medical, scientific, administrative, and other knowledge and training, which especially equip and prepare a physician to engage in the practice of family medicine;

"(3) the term 'practice of family medicine' and the term 'practice', when used in connection with the term 'family medicine', mean the practice of medicine by a physician (licensed to practice medicine and surgery by the State in which he practices his profession) who specializes in providing to families (and members thereof) comprehensive, continuing, professional care and treatment of the type necessary or appropriate for their general health maintenance; and

"(4) the term 'construction' includes construction of new buildings, acquisition, expansion, remodeling, and alteration of existing buildings, and initial equipment of any such buildings, including architects' fees, but excluding the cost of acquisition of land or offsite improvements."

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
OFFICE OF THE SECRETARY,
Washington, D.C. July 7, 1970.

Hon. RALPH YARBOROUGH,
Chairman, Committee on Labor and Public Welfare,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: This letter is in response to your request of February 12, 1970, for a report on S. 3418, a bill to amend the Public Health Service Act to provide for the making of grants to medical schools and hospitals to assist them in establishing special departments and programs in the field of family practice, and otherwise to encourage and promote the training of medical and paramedical personnel in the field of family medicine.

The bill would authorize a new five-year program of grants to medical schools:

(1) To operate separate departments devoted to teaching and instruction in all phases of family practice;

(2) To construct facilities appropriate to carry out family practice training programs whether as a part of a medical school or as a separate outpatient or similar facility;

(3) To operate or participate in special training programs for paramedical personnel in the field of family medicine; and

(4) To operate or participate in special training programs for medical personnel to head departments of family practice or otherwise teach family practice in medical schools.

The bill would also authorize grants to public or private nonprofit hospitals which train medical students, interns, or residents:

(1) To operate special professional training programs in family medicine for medical students, interns, or residents;

(2) To construct facilities appropriate to carry out these programs whether as part of a hospital or as a separate outpatient or similar facility;

(3) To provide scholarships, fellowships, or stipends to interns, residents, or other medical personnel in need of such assistance, who are participants in accredited training programs in the field of family medicine and who plan to specialize or work in the practice of family medicine; and

(4) To operate or participate in special programs for training paramedical personnel in the field of family medicine.

For the purpose of making the grants to medical schools and to hospitals, the bill would authorize appropriations of $50 million for fiscal year 1971, $75 million for fiscal year 1972, and $100 million each for fiscal years 1973, 1974, and 1975.

We are in full accord with the objective of encouraging and promoting the training of physicians and paramedical personnel to help to meet the needs of each patient for personalized and unfragmented care for all of his health needs as an individual in a particular family in a given community at a particular time. At a time of increasing specialization and with a variety of types of personnel and facilities often contributing to the care of a single patient, educational programs for health manpower at all levels must emphasize this aspect of training.

Methods of achieving the goal of personalized and unfragmented care for each individual—including not only diagnosis and treatment of illness but also preventive and rehabilitative services—are in a state of experimentation and change. A variety of terms is used to describe the kind of care or practice, or the type of practitioner, that is wanted: family practice, general practice, personal medicine, primary care, first-contact physician, generalist, comprehensive medical care.

A number of schools of medicine and osteopathy and their teaching hospitals have used, or have indicated their intention to use, at least a portion of their formula grants or their special project grants under the Health Professions Educational Assistance Program to support the teaching of continuity, primary, or family-oriented care through a variety of means. Some schools are gearing their entire educational program to the production of family physicians; some are establishing separate departments of family practice or family medicine; others are developing family practice or "primary care" programs on an interdepartmental basis.

Among the medical schools that have been awarded special project grants for expansion of enrollment (including Physician Augmentation projects) under the Health Professions Educational Assistance Program, a number will give additional emphasis to the teaching of family medicine in the course of achieving the goal of increased output.

The Health Professions Educational Assistance Program has aided in the construction of facilities for all teaching purposes in medical schools including their affiliated hospitals. We are trying to remove artificial barriers to sound planning and construction of the institution as a whole, rather than create them through categorical construction aid.

Several other legislative authorities already exist under which activities related to the field of family medicine as contemplated under S. 3418 may be aided. Authority for Federal support of training of physician assistants and other new types of paramedical personnel exists under the Allied Health Professions Personnel Training authority for developmental grants (section 794, Public Health Service Act) and under the new Health Professions Educational Assistance special project grant authority which went into effect July 1, 1969.

A number of projects involving the preparation of nurses to play a role in the provision of family-oriented medical care have been conducted under nurse training and public health training authorities. These have included, among others, projects to plan and evaluate experimental training programs for such clinical nursing specialists as pediatric nurse practitioners.

The Hill–Burton medical facilities construction program provide support for the construction and modernization of private, nonprofit medical facilities, including ambulatory care facilities of the type required for family medicine teaching programs.

At the level of internship and residency training, concern for the need for more training in the provision of personalized or family-oriented continuing medical care is reflected in the recent creation of family practice as a new medical specialty. There is pressure also for increased emphasis on training in continuous, comprehensive patient care in other specialty training programs such as internal medicine, pediatrics, and obstetrics. The costs of interns' and residents' salaries (and to a somewhat lesser extent, teaching costs for these training programs) now are met largely out of payments for services, including reimbursements for care under medicare and medicaid.

In view of the evolving character of the concept of family medicine, there are advantages to aiding activities in thi field under broad, flexible legislative authorities such as those contained in the Health Professions Educational Assistance Act. This type of authority permits the support of alternative approaches to training in the provision of comprehensive and continuing care to individuals and families, pending further evaluation of the various mechanisms for educating personnel and organizing medical services in this field. It also allows aid for training in family medicine to be provided in conjunction with aid directed toward another purpose such as expansion of enrollment of medical schools.

The Health Professions Educational Assistance authority is due to expire on June 30, 1971. Because of the close relationship between the family medicine activities proposed in the instant bill and the Health Professions Educational Assistance Programs, we recommend that action on that bill be deferred until the recommendations on the Health Professions Educational Assistance Act have been completed. In any event, however, we would strongly oppose the enactment of another categorical grant authority, such as that embodied in the bill, which would duplicate authorities or mechanisms already existing to achieve the purpose of this legislation.

We are advised by the Office of Management and Budget that there is no objection to the presentation of this report from the standpoint of the Administration's program.

Sincerely,

ELLIOT L. RICHARDSON, *Secretary.*

EXECUTIVE OFFICE OF THE PRESIDENT,
OFFICE OF MANAGEMENT AND BUDGET,
Washington, D.C., July 9, 1970.

HON. RALPH YARBOROUGH,
Chairman, Committee on Labor and Public Welfare,
U.S. Senate,
Washington, D.C.

DEAR MR. CHAIRMAN: This is in response to to your request for the views of the Office of Management and Budget on S. 3418, a bill "To amend the Public Health Service Act to provide for the making of grants to medical schools and

hospitals to assist them in establishing special departments and programs in the field of family practice, and otherwise to encourage and promote the training of medical and paramedical personnel in the field of family medicine."

In a report being furnished to your Committee, the Department of Health, Education, and Welfare states its reasons for recommending against the enactment of S. 3418.

We concur in the views of the Department of Health, Education, and Welfare, and, accordingly, recommend that your Committee not give favorable consideration to S. 3418.

Sincerely,

WILFRED H. ROMMEL,
Assistant Director for Legislative Reference.

The CHAIRMAN. Today the Health Subcommittee of the Senate Labor and Public Welfare Committee begins 2 days of intensive hearings on that bill. In that regard we will be receiving testimony from a wide variety of interested individuals and associations, including, of course, the administration.

If enacted, the bill would provide for making grants to medical schools and hospitals to assist them in establishing, special departments and programs in the field of family practice, including the training of family practitioners and related supporting staff.

Most Americans, laymen, and health professionals alike, are increasingly aware of this Nation's health care crisis. Last year the President, Mr. Nixon, highlighted this very real problem in a Presidential statement. In point of fact, while great strides have been made in uncovering new biomedical knowledge, little has been done to translate that knowledge into improved patient care for most Americans. Health care costs have continued to escalate at an alarming rate, which is almost double that of price increases generally. There is a shortage of physicians and allied health manpower, as well as growing specialization and subspecialization of medical education.

To document this trend of increased specialization in medical education and a concomitant reduction of physicians engaged in family practice, I am going to make a part of the hearing record and article published in June 1970, issue of Public Health Reports by Mrs. Mary Overpeck, entitled, "Physicians in Family Practice 1931–67." Mrs. Overpeck's study documents the growing need for and support of a specialty in family practice.

(The document referred to follows:)

[From PUBLIC HEALTH REPORTS, June 1970, Vol. 85, No. 6, U.S. Dept. of HEW, PHS]

Physicians in Family Practice 1931-67

MARY D. OVERPECK, M.P.H.

A SPECIALTY in family practice was established in 1969 in response to growing concern about the need for increasing the availability of comprehensive and continuous patient care. The great consideration given to the breadth and depth of residency training by those establishing this new specialty reflects the intention to improve the scope of responsibility and the quality of care provided by the traditional family physician.

Another major consideration in establishing the residency program for the specialty was to make the new "family practice" more attractive to the student whose major exposure in medical school had been to specialties rather than to general practice. An approved residency in general practice with no recognized specialty board has existed for a number of years. Only a small number of physicians have been taking advantage of this residency.

Although many educators and planners have felt that specialists in internal medicine, pediatrics, obstetrics, and gynecology would serve the functions of the family practitioners, these specialists have not replaced the losses occurring in the field of general practice, either in numbers or geographic distribution. This article documents the national numerical trends in those fields of practice of most physicians engaged in family practice in the last few decades.

In 1959 the Surgeon General's Consultant Group on Medical Education reported the trend toward specialization as it had affected the gross potential of family physicians (*1*). They stated that the 1957 count of physicians (doctors of medicine and doctors of osteopathy) showed that less than half of the physicians in private practice limited themselves to specialty practice (table 1) compared with one in four in 1940 and one in six in 1931. For the 1931–57 time period, detailed information available for doctors of medicine only was used in the report to obtain physician-population ratios. Specialists in private practice per 100,000 population increased from 17.9 in 1931 to 25.5 in 1940, 36.8 in 1949, and 43.5 in 1957.

For purposes of estimating the potential number of physicians performing the functions of the family practitioner, the report (*1*) combined specialists who limited their practice to internal medicine and pediatrics and physicians who were in general practice or part-time specialties. Information available only for doctors of medicine in private practice from 1931 to 1957 showed that 75 percent were part of this pool of potential family physicians in 1931 compared with 67 percent in 1940, 55 percent in 1949, and 45 percent in 1957. Specialty information for the doctors of osteopathy during this period was not available. The family physician potential, based on the number in private practice per 100,000 civilian population, dropped from 94 in 1931 to 89 in 1940, 75 in 1949, and 60 in 1957 (fig. 1 and table 2).

Since the Surgeon General's report was published, a number of changes have been made in counting methods and classification systems

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for physicians (*2, 3*). Although the information improved, the changes affected the comparability of data published for the periods before and after 1963. Estimates and adjustments were made for several major categories in the earlier period, but comparisons between these periods for the specialties and private practice classification are difficult (*2*).

Interest in this grouping of physicians is still pertinent, particularly since the new specialty in family practice was formed. The data used to compare time periods from December 31, 1963, to December 31, 1967, were taken from detailed tabulations (*4–7*) published by the American Medical Association (AMA) and the American Osteopathic Association (AOA). The report of the Surgeon General (*1*) and later Public Health Service publications used similar tabulations.

The data for my article are presented in the usual Public Health Service format, with minor modifications and with definitions inherent to the tabulations used. The category of general practitioner includes those physicians who did not specify a specialty (about two-thirds of whom are in internship programs) and those specifying a part-time specialty. This grouping is consistent with the earlier general practice category in which all active physicians who did not specify a full-time specialty were assumed to be general practitioners.

In the AMA tabulations, physicians specifying a specialty practice were not necessarily trained or certified in that specialty. The American Medical Association formally recognized the family practice specialty on January 1, 1970. When the data are tabulated for 1970, it will be interesting to see how many general practitioners, pediatricians, and internists have designated family practice as their specialty.

The difficulties of trying to describe numerically the changes in the pool of physicians serving the public have been discussed frequently. Changes in the methods of applying our rapidly expanding knowledge and the productivity of physicians, as well as quality changes, cannot be measured easily. Changes in population composition and demand also are not reflected. The increasing proportions of persons in the old and very young age ranges affect the incidence of certain types of diseases that must be treated. Changing expectations for health care created by economics, education, and mobility magnify the effects of the age factor on the services sought by the public. The physician-population ratio, although an insensitive index, is still the primary means of relating the number of physicians to the population served.

The number of total active physicians increased about 12 percent from 1963 to 1967, while the gross potential of family physicians, adjusted for activity, increased only about 4

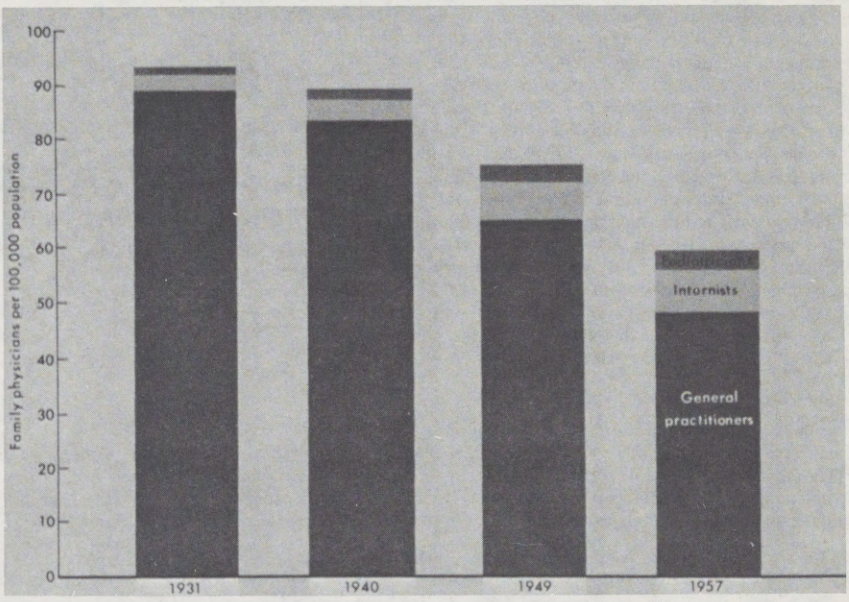
Table 1. Physicians (M.D.'s and D.O.'s) in the United States, by type of practice, midyear 1957

Type of practice	Doctors of medicine		Doctors of osteopathy	
	Number	Rate per 100,000 population	Number	Rate per 100,000 population
Total	226, 625	132. 4	13, 692	8. 0
Private practice	155, 827	91. 1	9, 501	5. 6
General practice and part-time specialty	81, 443	47. 6	8, 656	5. 1
Full-time specialty	74, 384	43. 5	845	. 5
Not in private practice	60, 137	35. 1	1, 205	. 7
Hospital service except Federal	36, 371	21. 2	872	. 5
Teaching, research, public health, other	7, 168	4. 2	321	. 2
Federal Government	16, 598	9. 7	12	[1]
Retired, not in practice	10, 661	6. 2	[2] 2, 986	1. 7

[1] Less than 0.05.
[2] Includes 2,006 D.O.'s who did not report type of practice.

SOURCE: Reference 1.

Figure 1. Family physician (M.D.) potential per 100,000 population, midyear 1931–57



SOURCE: Reference 1.

percent (table 3). Although the ratio of total active physicians to population continued to increase in the 1963–67 period, from 140 to 150 per 100,000 population, the ratio of the gross potential for family physicians (all active in family practice specialties) remained about the same.

Gross Potential of Family Physicians

The gross potential numbers of family physicians among total active physicians, without considering the possible activities, increased from 142,901 in 1963 to 149,426 in 1967 (table 3). Despite the increased numbers, the gross potential percentage of family physicians among total active physicians dropped from 52.4 to 48.9 in the 5-year period. Most of the decrease occurred in the general practice and unspecified physician category, from 34.4 to 29.2 percent. The proportion of specialists limited to pediatrics increased slightly from 5.2 to 5.8 percent, while the proportion in internal medicine increased from 12.8 to 13.9 percent.

The ratio of the gross potential of family physicians per 100,000 population stayed about the same for 5 years: 73.6 in 1963 and 73.4 in 1967. Specialists in internal medicine, whose ratio increased from 18.0 to 20.9 per 100,000 population, maintained the balance. (This balance does not hold for only those physicians in patient care, as explained in the next section.) The proportion of specialists in pediatrics also increased from 7.3 to 8.7 per 100,000 population. The increases in these specialties offset the decrease in the general practitioner and unspecified category from 48.3 to 43.8 per 100,000 population. The gross potential of family physicians

does not tell the whole story of access by the civilian population or of physicians' activities.

Comparisons of total active physicians are inadequate for these purposes. The figures include non-Federal physicians (M.D.'s and D.O.'s) in the United States, Puerto Rico, American Samoa, the Canal Zone, Guam, Pacific Islands, and Virgin Islands; those with addresses temporarily unknown to the American Medical Association; and Federal physicians in the United States and abroad. The corresponding population data include resident civilian and military personnel in the United States, Puerto Rico, and the outlying areas, military personnel and their dependents abroad, and civilians abroad employed by the U.S. Government (*8*, *9*). Categories that make the data more definitive are discussed in the next section.

Type of Practice and Activity

The old AMA classifications accorded to private practice are no longer used or available. The American Medical Association changed the classification system (see following list) to reflect patient care activities.

Old classification

Private practice
Training programs:
  Interns
  Residents and fellows
Full-time hospital staff
Preventive medicine
Research
Medical school faculty
Administration
Laboratory medicine
Inactive, address unknown

New classification

Patient care:
  Solo, partnership, group, or other practice
  Hospital-based practice:
    Interns
    Residents and fellows
    Full-time physician staff
Other professional activity:
  Medical school faculty
  Administration
  Research
Inactive, address unknown

The categories of preventive medicine and laboratory medicine were eliminated. Physicians in these two categories were reclassified according to principal employer. Physicians in the spe-

Table 2. Family physician (M.D.) potential and ratios to population, United States, midyear 1931–57

Type of practice	1931	1940	1949	1957
	Number of physicians			
Total physicians	156, 406	175, 163	201, 277	226, 625
Family physician potential [1]	117, 079	117, 386	110, 236	101, 973
Pediatrics [2]	1, 396	2, 222	3, 787	5, 876
Internal medicine [2]	3, 567	5, 892	10, 923	14, 654
General practice and part-time specialty	112, 116	109, 272	95, 526	81, 443
All others	39, 327	57, 777	91, 041	124, 652
	Physicians per 100,000 civilian population			
Family physician potential	94	89	75	60
Pediatrics	1	2	3	3
Internal medicine	3	4	7	9
General practice and part-time specialty	90	83	65	48
	Percent of total physicians			
Family physician potential	75	67	55	45
Pediatrics	1	1	2	3
Internal medicine	2	3	5	6
General practice and part-time specialty	72	63	48	36

[1] Includes only physicians in private practice.
[2] Estimated from total number of physicians limited to a specialty.

SOURCE: Reference 1.

Table 3. Gross family physician potential, United States, Puerto Rico, and outlying areas, December 31, 1963 and 1967

Specialty category	All physicians		Doctors of medicine		Doctors of osteopathy	
	1963	1967	1963	1967	1963	1967
	Number					
Total active physicians [1]	272, 500	305, 453	261, 728	294, 072	10, 772	11, 381
Gross family physician potential	142, 901	149, 426	133, 001	139, 131	9, 900	10, 295
General practice and unspecified	93, 705	89, 157	84, 052	79, 192	9, 653	9, 965
Pediatrics [2]	14, 253	17, 678	14, 207	17, 614	[3] 46	[3] 64
Internal medicine	34, 943	42, 591	34, 742	42, 325	[3] 201	[3] 266
	Percent [4]					
Total active physicians	100. 0	100. 0	100. 0	100. 0	100. 0	100. 0
Gross family physician potential	52. 4	48. 9	50. 8	47. 3	91. 9	90. 4
General practice and unspecified	34. 4	29. 2	32. 1	26. 9	89. 6	87. 6
Pediatrics [2]	5. 2	5. 8	5. 3	6. 0	. 4	. 6
Internal medicine	12. 8	13. 9	13. 3	14. 4	1. 9	2. 3
	Physicians per 100,000 population [4]					
Total population (1,000's) [5]	194, 169	203, 708	194, 169	203, 708	194, 169	203, 708
Total active physicians	140. 3	149. 9	134. 8	144. 4	5. 5	5. 6
Gross family physician potential	73. 6	73. 4	68. 5	68. 3	5. 1	5. 0
General practice and unspecified	48. 3	43. 8	43. 3	38. 9	5. 0	4. 9
Pediatrics	7. 3	8. 7	7. 3	8. 6	([3] [6])	([3] [6])
Internal medicine	18. 0	20. 9	17. 9	20. 8	. 1	. 1

[1] Includes non-Federal physicians in the 50 States, District of Columbia, Puerto Rico, American Samoa, Canal Zone, Guam, Pacific Islands, and Virgin Islands; those with addresses temporarily unknown to the AMA; and Federal physicians in the United States and abroad.

[2] Includes pediatrics, pediatric allergy, and pediatric cardiology.

[3] Private practice only.

[4] Totals of percents and ratios may not add because of rounding.

[5] Includes civilians in the United States, Puerto Rico, and outlying areas; the Armed Forces in the United States and abroad; dependents of the Armed Forces abroad; and U.S. civilians working for the U.S. Government abroad.

[6] Less than 0.05 per 100,000 population.

SOURCE: References 4, 5, and 6.

cialty of administrative medicine were reclassified according to their secondary specialty, and those who did not report a secondary specialty were reclassified as "not recognized."

In the new classification system, physicians providing patient care are grouped by hospital and nonhospital-based practices. Hospital-based patient care is delivered by interns, residents, and fellows, and a full-time physician staff. Nonhospital-based patient care includes only non-Federal physicians in the category of solo, partnership, group, or other practice.

Nonhospital-based patient care is somewhat similar to the old private practice group but is larger and includes all physicians in patient care not otherwise classified. Besides physicians providing patient care in office settings, this category includes physicians in clinical laboratories or institutional settings other than hospitals, those providing patient care in industrial plants and as State and local health officers, and those in other settings. Many physicians in "other" settings are in administration or research and are not included in patient care; therefore, they are not included in the category of patient care. Descriptions of this sort are not clean-cut.

The American Osteopathic Association still uses a private practice classification. Adjustments in the AOA data have been made wherever possible to make the two systems comparable.

During the 5-year period 1963–67, the activity categories showed great change (table 4). The total number of physicians, active and inactive, increased from 289,188 to 322,045, or 11 percent;

those active in solo, partnership, group, or other practice increased from 189,267 to 200,146, or 6 percent. Of the physicians in solo, partnership, group, or other practice, those limiting themselves to a specialty practice increased from 59 to 64 percent. The number of hospital-based physicians increased from 68,341 to 85,239, or 25 percent. While the number of all physicians in patient care increased from 257,608 to 285,385 (11 percent), the number of physicians in nonpatient care increased from 14,892 to 20,068 (35 percent); therefore, the fastest growth was in nonpatient care activities. The number of physicians in hospital-based patient care also increased at a fast rate.

The ratio of physicians per 100,000 population increased as follows: total physicians from 148.9 to 158.1, physicians in patient care from 132.7 to 140.1, and those in solo, partnership, group, or other practice from 97.5 to 98.3. The large increase in hospital-based physicians, from 35.2 to 41.8 per 100,000 population, should be viewed with some reservation, since more than half of these physicians were in the Federal service. Although a large increase occurred in the non-Federal segment, part of the increase may have reflected a temporary buildup in the Federal service for the Vietnam conflict.

In 1967, the doctors of osteopathy represented about 4 percent of all active physicians, 7 percent of those in the gross family physician potential, 11 percent of those in general practice (table 3), 4 percent of all physicians in patient care, and 5 percent of those in solo, partnership, group, or other practice—actually private practice for the doctors of osteopathy. Within the category of solo, partnership, group, or other practice, they comprised 11 percent of general practitioners (table 4).

Family Practice for Civilians

The civilian population had most access to the group of family practice physicians in solo, partnership, group, or other practice (table 5).

Table 4. Physicians (M.D.'s and D.O's) by type of practice, United States, Puerto Rico, and outlying areas, December 31, 1963 and 1967

Type of practice	All physicians		Doctors of medicine		Doctors of osteopathy	
	1963	1967	1963	1967	1963	1967
	Number					
Total physicians	289,188	322,045	276,475	308,630	12,713	13,415
Patient care	257,608	285,385	246,951	274,190	10,657	11,195
Solo, partnership, group, or other practice [1]	189,267	200,146	179,449	190,079	9,818	10,067
General practice and unspecified	77,427	71,495	68,728	62,844	8,699	8,651
Limited to specialty practice	111,840	128,651	110,721	127,235	1,119	1,416
Hospital-based physicians [2]	68,341	85,239	67,502	84,111	839	1,128
Not in patient care [3]	14,892	20,068	14,777	19,882	115	186
Inactive, address unknown	16,688	16,592	14,747	14,558	1,941	2,034
	Physicians per 100,000 population [4]					
Total population (1,000's) [3]	194,169	203,708	194,169	203,708	194,169	203,708
Total physicians	148.9	158.1	142.4	151.5	6.5	6.6
Patient care	132.7	140.1	127.2	134.6	5.5	5.5
Solo, partnership, group, or other practice [1]	97.5	98.3	92.4	93.3	5.1	4.9
General practice and unspecified	39.9	35.1	35.4	30.8	4.5	4.2
Limited to a specialty practice	57.6	63.2	57.0	62.5	.6	.7
Hospital-based physicians [2]	35.2	41.8	34.8	41.3	.4	.5
Not in patient care [3]	7.7	9.9	7.6	9.8	.1	.1
Inactive, address unknown	8.6	8.1	7.6	7.1	1.0	1.0

[1] D.O.'s in private practice only.
[2] Includes interns, residents, fellows, and full-time physician staff.
[3] Includes medical and osteopathic school faculties and those in administration and research. Also includes 7 D.O.'s in 1963 and 34 in 1967 in miscellaneous categories that were not private practice, hospital staff, osteopathic school faculty, administration, or research.
[4] Totals may not add because of rounding.

SOURCE: References 4, 5, and 6.

Table 5. Physicians in solo, partnership, group, or other practice, United States, Puerto Rico, and outlying areas, December 31, 1963 and 1967

Specialty category	All physicians		Doctors of medicine		Doctors of osteopathy [1]	
	1963	1967	1963	1967	1963	1967
	Number					
Physicians in solo, partnership, group, or other practice	189, 267	200, 146	179, 449	190, 079	9, 818	10, 067
Family physician potential	108, 324	106, 243	99, 378	97, 262	8, 946	8, 981
General practice and unspecified	77, 427	71, 495	68, 728	62, 844	8, 699	8, 651
Pediatrics [2]	9, 458	10, 530	9, 412	10, 466	46	64
Internal medicine	21, 439	24, 218	21, 238	23, 952	201	266
	Percent [3]					
Physicians in solo, partnership, group, or other practice	100. 0	100. 0	100. 0	100. 0	100. 0	100. 0
Family physician potential	57. 2	53. 1	55. 4	51. 2	91. 1	89. 2
General practice and unspecified	40. 9	35. 7	38. 3	33. 1	88. 6	85. 9
Pediatrics [2]	5. 0	5. 3	5. 2	5. 5	. 5	. 6
Internal medicine	11. 3	12. 1	11. 8	12. 6	2. 0	2. 6
	Physicians per 100,000 civilian resident population [3]					
Civilian resident population (1,000's)	190, 892	199, 783	190, 892	199, 783	190, 892	199, 783
Physicians in solo, partnership, group, or other practice	99. 2	100. 2	94. 0	95. 1	5. 1	5. 0
Family physician potential	56. 8	53. 2	52. 1	48. 7	4. 7	4. 5
General practice and unspecified	40. 6	35. 8	36. 0	31. 4	4. 6	4. 3
Pediatrics [2]	5. 0	5. 3	4. 9	5. 2	(4)	(4)
Internal medicine	11. 2	12. 1	11. 1	12. 0	. 1	. 1

[1] D.O.'s in private practice only.
[2] Includes pediatrics, pediatric allergy, and pediatric cardiology.
[3] Totals may not add because of rounding.
[4] Less than 0.05 per 100,000 population.

SOURCE: References 4, 5, and 6.

Other physicians providing patient care were the hospital-based interns, residents, and fellows, and full-time hospital staff. The hospital staff generally are not considered to be available as family physicians.

Nonhospital-based physicians in solo, partnership, group, or other practice increased from 189,267 in 1963 to 200,146 in 1967, slightly increasing the physician-population ratio from 99.2 to 100.2 per 100,000 civilian resident population. The physician potential in family practice, however, declined. The total number decreased from 108,324 in 1963 to 106,243 in 1967, and the physician-population ratio, from 56.8 to 53.2 per 100,000 civilian resident population. This decrease reinforces current discussions concerning national shortages of family or primary physicians although it does not reflect the many variations in numbers and characteristics of physicians in geographic areas.

The component changes demonstrate that the increase in the number of specialists in pediatrics and internal medicine was not enough to balance the decrease in the general practitioner and unspecified category. (The number of physicians in unspecified activities was only about 100 each year. The following references to general practice include the unspecified although they may not be mentioned.) The decrease of 5,932 general practitioners (77,427 to 71,495) for the 5-year period was not offset by the increase of 1,072 limited-specialty pediatricians and 2,779 limited-specialty internists. In ratios of physicians per 100,000 civilian residents, general practitioners decreased from 40.6 to 35.8, pediatricians increased from 5.0 to 5.3, and internists increased from 11.2 to 12.1 (fig. 2).

Osteopathic physicians represented such a small segment of the national total of physicians that their main effect was only as general practitioners. About 12 percent of general practi-

tioners in nonhospital-based patient care were doctors of osteopathy; the percentage varied significantly in certain States and counties. Within the osteopathic profession, the proportion of specialists in pediatrics increased from 0.5 to 0.6 percent of all doctors of osteopathy in private practice, and the proportion of internists increased from 2.0 to 2.6 percent.

Obstetrics and Gynecology

Although general practitioners historically have functioned as all-round family physicians, many of the more technical and sophisticated applications of our vast medical knowledge have been referred to specialists as they have become available. Many pediatricians and internists provide the more comprehensive functions of the family physician, according to the age of the patient. Sample surveying by the Health Information Foundation and the National Opinion Research Foundation in 1963 indicated the primary specialty of doctors of medicine used as regular sources of care. Fifty-six percent of the sampled population obtained care from general practitioners, 12 percent from general surgeons, 10 percent from internists, 8 percent from pediatricians, 7 percent from obstetrician-gynecologists, and 7 percent from other specialists (*10*).

A great, continuing need exists for obstetrician-gynecologist care, particularly; the limited numbers of specialists in this field have not been able to meet the demand for these specialized services. General practitioners and some internists still treat a number of such patients in order to cover the shortage.

Despite comparability difficulties, the data indicate that both the number and percentage of specialists limited to obstetrics and gynecology in the total of all active physicians have increased steadily in the last few decades. These increases, from less than 1 percent of total active doctors of medicine in 1931 to almost 6 percent of all active physicians in 1967, show the growing contribution to one segment of family practice.

The Surgeon General's report (*1*) did not include obstetrician-gynecologists in the discussion of family practice. Midyear data concerning all active doctors of medicine who limited their practice to a specialty (*11*), 1931 through 1962, showed less than 1 percent in 1931 and almost 5 percent in 1962: there were 1,418 in 1931, 2,551 in 1940, 5,074 in 1949, 8,147 in 1957, and 11,680 in 1962. Obstetrician-gynecologists represented about 6 percent of all doctors of medicine who limited their practice to a specialty in 1931, and about 9 percent in 1962. This increase indicates that the growth of the specialty more than matched the growth of all specialties during the 30-year period.

During 1963–67, the number of specialists limited to obstetrics and gynecology increased from 15,789 to 18,044, increasing the physician-population ratio from 8.1 to 8.8 per 100,000 population (table 6). The number of physicians serving the civilian resident population in solo, partnership, group, or other practice, increased from 11,874 to 13,205 and their ratio from 6.2 to 6.6. With a decrease in potential family practice

Figure 2. Family physician (M.D. and D.O.) potential per 100,000 population, 1963 and 1967 (based on table 5)

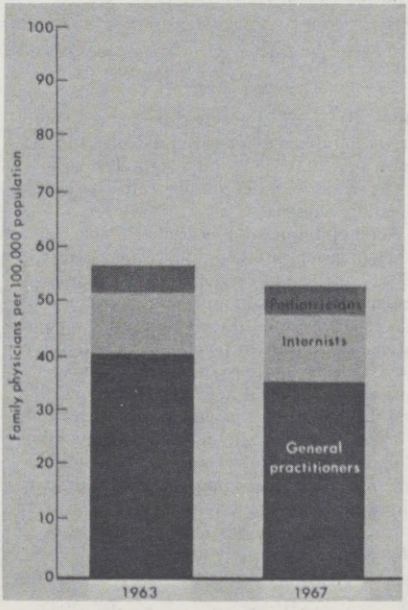


Table 6. Specialists in obstetrics and gynecology, United States, Puerto Rico, and outlying areas, December 31, 1963 and 1967

Specialty category	Total active physicians		Physicians in solo, partnership, group, or other practice	
	1963	1967	1963	1967
	Number			
Total active physicians	272, 500	305, 453	189, 267	200, 146
Obstetrics-gynecology specialists [1]	15, 789	18, 044	11, 874	13, 205
M.D.'s	15, 720	17, 964	11, 805	13, 125
D.O.'s [2]	69	80	69	80
	Percent [3]			
Total active physicians	100. 0	100. 0	100. 0	100. 0
Obstetrics-gynecology specialists	5. 8	5. 9	6. 3	6. 6
M.D.'s	5. 8	5. 9	6. 2	6. 6
D.O.'s [2]	(4)	(4)	(4)	(4)
	Physicians per 100,000 population [3]			
Population (1,000's) [5]	194, 169	203, 708	190, 892	199, 783
Obstetrics-gynecology specialists	8. 1	8. 8	6. 2	6. 6
M.D.'s	8. 1	8. 8	6. 2	6. 6
D.O.'s [2]	(4)	(4)	(4)	(4)

[1] Physicians limiting their practice to a specialty.
[2] D.O.'s in private practice only.
[3] Totals may not add because of rounding.
[4] Less than 0.05.
[5] Ratios based on total population for total active physicians, civilian resident population for physicians in obstetrics and gynecology in solo, partnership, group, or other practice.

SOURCE: References 4, 5, and 6.

in solo, partnership, group, or other practice from 56.8 to 53.2 per 100,000 civilian resident population, the slight increase in the ratio of obstetrician-gynecologists did not have much impact on family practice.

Summary

A continuing increase in the total number of physicians in the United States has resulted in a rising physician-population ratio in the last few decades. Physician potential in family practice, on the other hand, consistently has shown a reverse trend, both in numbers and in relation to population. The pool of potential family physicians, defined as general practitioners, internists, and pediatricians, in solo, partnership, group, or other practice, decreased from 56.8 in 1963 to 53.2 in 1967 per 100,000 civilian resident population. Increases in the internal medicine and pediatrics categories were not enough to make up for the decrease in the general practice category. The slight increases in the number of obstetrician-gynecologists did not have much impact on the decreasing trend in family practice.

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Tearsheet Requests

Information Office, Division of Physician Manpower, National Institutes of Health, Bethesda, Md. 20014

The CHAIRMAN. If adequately supported both by national public policy and appropriate actions on the part of health professionals and institutions, a specialty in family practice would measurably contribute to an amelioration of the health care crisis. It would do so by bringing into being highly competent health professionals who would treat the patients in the context of their family and surroundings. Such a professional would place great emphasis on preventive care, with the expectation that such care could forestall more serious and more expensive illnesses.

The importance of family practice is further underscored when one realizes that the poor and disadvantaged of our society are those who have suffered the most from the steady and systematic decline in the number of general practitioners. Such a trend and situation is at variance with an open society, which is affluent and which purports to equalize opportunity for all of its citizens.

Now some 30-odd years ago the majority of the medical doctors were engaged in family practice. Now only one out of each five is engaged in family practice. As each of us knows, a society which depends on the consent of the governed cannot reasonably expect that consent if substantial segments of the society live in poverty and ill health where medical care is beyond their reach or beyond their power to obtain.

My statement, gentlemen, is not based merely upon reports I have heard or read in magazines. It is based upon personal knowledge. I have been into the "colonias" in south Texas where the Mexican-Americans live. We have a medical service down there for migrant workers. We found on going there a doctor, a retired Army doctor, who had first gone out there with Pershing. They saw a nurse only about every 2 months. There is no one to give an examination.

Colonias are the areas where they live, back from the highways, where the rattan brush goes up and cane bamboo, where nobody sees them. They have been there for generations, since the revolution in 1910. You can drive the highways of the lower Rio Grande Valley and see citrus groves. Unless you go on the dirt roads and drive through there, you will never see these people. Since I have been with this committee one of the medical schools went back there and found leprosy, pellagra, all the diseases of poverty. For some reason or another, their report has not been released to the public.

I am old enough to have grown up at a time when living as a boy in a country town we had two doctors. If one moved away or died, another moved in. There were always enough doctors around to have competition. The doctor did not have his practice by himself. I was told one time after World War II we had 26 counties in Texas without a single doctor. We build hospitals under Hill-Burton as an inducement to try to get a doctor to move into the county.

At this point in the hearing record, I order printed the statements of Hon. Joseph M. Montoya, a U.S. Senator from the State of New Mexico, and Hon. Fred B. Rooney, a U.S. Representative in Congress from the State of Pennsylvania.

(The statements referred to follow:)

STATEMENT OF HON. JOSEPH M. MONTOYA, A U.S. SENATOR FROM THE STATE OF NEW MEXICO

Mr. Chairman, I am pleased and honored to cosponsor S. 3418. This bill would authorize the appropriation of $50 million, $75 million, and $100 million for fiscal years 1971, 1972, and 1973–75, respectively, for the purpose of making grants to medical schools and hospitals to create departments and programs in the field of family practice.

The need for more doctors specializing in family medicine is great. In 1931, 75 percent of all physicians in private practice were general practitioners. Today, as the demand for specialists (along with the doctors' own preference to specialize) has increased, the number of general practitioners has dropped to 20 percent.

Since 1963, surgical specialists have increased by 15 percent and medical specialists have increased by 18.6 percent. At present 80 percent of our medical school graduates go on for training in a specialty other than general practice. The increasing need for physicians to develop "breath of knowledge" to coordinate the expansion of this specialized medical care seems self-evident.

The family practice doctor would be similar to the general practitioner, but with one great improvement. He would be highly schooled in physical and behavioral sciences so that the physician can effectively handle the doctor-patient relationship. He would be the patient's first defense against disease, and, if unable to help, he could then direct the patient to the proper specialist.

Unfortunately, order, uniformity, and equity of access to medical service do not presently exist. Nor is there order, uniformity, and efficiency in the workings of the health care system. The current medical crisis does not remain hidden from the public. The miracles of modern medicine are common knowledge. The people are aware that millions of dollars are being spent on very specialized research. They know—and wonder why—medical needs are unmet in terms of both care and quality.

The public wonders about the following facts which contrast so much with our great advances in medicine:

In infant mortality, the United States ranks 15th among the nations of the world;

In life expectancy for males, the United States is 22d;

Nearly half of the American women giving birth in public hospitals this year will receive absolutely no prenatal care;

That 22 percent of all children born to these women will be premature births;

That 5 percent of all children born in the United States this year will be born mentally retarded, and of these children, 75 percent will come from rural and urban poverty areas.

Mr. Chairman, while the situation is certainly more acute in the ghetto and rural poverty pockets, this health care crisis is not confined to the poor. The crisis is national. It is felt by rich and poor, city dweller, suburbanite, and rural resident. Former Secretary of Health, Education, and Welfare Robert Finch, reported on July 10, 1969, "This Nation is faced with a breakdown in the delivery of health care unless immediate and concerted action is taken by government and the private sector."

Therefore, the specialty of "Family Medicine" was created in February, 1969, to help alleviate this problem. At least 40 medical schools and hospitals have family practice specialty programs. The grants made available by this proposal would allow more hospitals and medical schools to establish residency programs in this new field of medical study. A major consideration in creating this new residency program for the specialty is to attract the medical student whose major exposure in medical school is removed from general practice and directed toward specialization.

Regional medical programs can be bettered by helping plan comprehensive programs for the delivery of health services to the urban community. Physicians can take on paramedics (assistants trained in medical procedure) who would not diagnose or make any health decisions. In this way, doctors could be freed from details which presently prevent them from seeing a larger number of patients.

As we re-examine health care in the United States, we must restore primary family health care. Primary care is the entry way into the health system. The family must not feel lost when it requires medical attention. The confidence built when patient and doctor know each other well establishes a relationship which motivates the patient to see his physician regularly, not simply at those times when ill health forces him. In this way, family practice can strengthen medical help by expanding preventive health care. I urge all members of this committee to support this bill so that the health needs of our people can be met more effectively.

STATEMENT OF HON. FRED B. ROONEY, U.S. REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA

As the original House sponsor of S. 3418 (H.R. 16359), which will provide for the training of medical and paramedical personnel in the field of family medicine, I would like to urge the committee to act favorably on the bill.

Since 1968, when the subject was first brought closely to my attention, I have become increasingly more aware of the vital need for such legislation. I sponsored the bill originally in the House in April of 1969, and have introduced several revised versions of the legislation since then, the most recent in March of this year with 46 cosponsors.

It is a well-known fact that the number and percentage of physicians in general practice is steadily declining. Between 1931 and 1960 the percentage of general practitioners declined from 84 to 45, and by 1965 was down to 37. As a significant number of these doctors were over 65, and only 15 percent of recent medical school graduates have entered the field, the percentage will undoubtedly decline further.

Family practice, without a doubt, is a strongly needed commodity. Yet we live in a medically sophisticated society which asks its populace to self-diagnose, locate its own referral, and subject itself to a multitude of medical information without any medical direction. Patients often follow their own ideas as to what constitutes proper treatment, or take their problems to the hospital emergency room which is always open, and provides good medical care and facilities.

This solution, however, is certainly less than satisfactory to either the patient or the hospital staff, and presents a definite lack of continuity of treatment.

If health services are to be delivered effectively and efficiently there must be a central coordinating agent, which can only be the general practitioner. He presents a skill which encompasses all phases of medicine and requires an in-depth knowledge of the potential of paramedical personnel where they are available. Such technical skills, knowledge, and insight can be gained only by the medical student, and subsequently by the family practice resident, under the direction of a knowledgeable and experienced faculty in the specialty.

Mr. Chairman, I urge that the committee act favorably on the bill, not only for the benefit of the physicians who wish to enter the field, but for the benefit of all Americans in terms of a more excellent and more encompassing delivery of health care. I will certainly do all I can to see that the legislation receives prompt and favorable consideration in the House.

The CHAIRMAN. The first witnesses this morning are from the administration, Dr. John Zapp, Acting Deputy Assistant Secretary for Health Manpower, Department of Health, Education, and Welfare, and, Dr. Zapp, I will let you introduce those accompanying you, with the titles. You might have substituted since we have had this list.

STATEMENT OF DR. JOHN ZAPP, ACTING DEPUTY ASSISTANT SECRETARY FOR HEALTH MANPOWER, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY DR. KENNETH ENDICOTT, DIRECTOR, BUREAU OF HEALTH PROFESSIONS EDUCATION AND MANPOWER TRAINING, NATIONAL INSTITUTES OF HEALTH; AND DR. ROBERT BUCHER, DEPUTY DIRECTOR, BUREAU OF HEALTH PROFESSIONS EDUCATION AND MANPOWER TRAINING, NATIONAL INSTITUTES OF HEALTH

Dr. ZAPP. Thank you, Mr. Chairman. We appreciate the opportunity to come before your committee and testify on this bill.

Accompanying me this morning are Dr. Kenneth Endicott, Director of the Bureau of Health Professions Education and Manpower Training of the National Institutes of Health and his Deputy Director, Dr. Robert Bucher.

I would like to read a prepared statement, Mr. Chairman.

It is a pleasure to be here today to testify on S. 3418, a bill to amend the Public Health Service Act to provide for the making of grants to medical schools and hospitals to assist them in establishing special departments and programs in the field of family practice, and otherwise to encourage and promote the training of medical and paramedical personnel in the field of family medicine.

The bill would authorize a new 5-year program of grants to medical schools:

(1) to operate separate departments devoted to teaching and instruction in all phases of family practice;

(2) to construct facilities appropriate to carry out family practice training programs whether as a part of a medical school or as a separate outpatient or similar facility;

(3) to operate or participate in special training programs for paramedical personnel in the field of family medicine; and

(4) to operate or participate in special training programs for medical personnel to head departments of family practice or otherwise teach family practice in medical schools.

The bill would also authorize grants to public or private nonprofit hospitals which train medical students, interns, or residents:

(1) to operate special professional training programs in family medicine for medical students, interns, or residents;

(2) to construct facilities appropriate to carry out these programs whether as part of a hospital or as a separate outpatient or similar facility;

(3) to provide scholarships, fellowships, or stipends to interns, residents, or other medical personnel who are in need of such assistance to participate in accredited training programs in the field of family medicine and who plan to specialize or work in the practice of family medicine; and

(4) to operate or participate in special programs for training paramedical personnel in the field of family medicine.

For the purpose of making the grants to medical schools and to hospitals, the bill would authorize appropriations of $50 million for fiscal year 1971, $75 million for fiscal year 1972, and $100 million each for fiscal years 1973, 1974, and 1975.

We are in full accord with the objective of encouraging and promoting the training of physicians and paramedical personnel to help to meet the needs of each patient for personalized and unfragmented care for all of his health needs. At a time of increasing specialization and with a variety of types of personnel and facilities often contributing to the care of a single patient, educational programs for health manpower at all levels must emphasize this aspect of training.

Comprehensive health care includes preventive, diagnostic, therapeutic, rehabilitative and health-maintenance services, and requires appropriate referral of patients for selected specialized and supporting services. This implies and requires effective coordination among physicians within the various specialties and with personnel in the nursing and allied health fields. It also requires adequate interpretation to the patient and his family of the nature and progress of the patient's illness and the services being recommended and provided in the context of the patient's expectations.

Continuity of care may be provided by several physicians working together in formal or informal association, with each member having access to the patient's records. Continuity may also be facilitated by the appropriate use of nurses and other allied health personnel under proper supervision, in situations where continuing attention by the same physician may not be possible.

Methods of achieving the goal of comprehensive, personalized, and unfragmented care for each individual are in a state of experimentation and change. A variety of terms are used to describe the kind of care or practice, or the type of practitioner, that is wanted: Family practice, general practice, personal medicine, primary care, first-contact physician, generalist, comprehensive medical care are some of them. Many physicians are, of course, providing this kind of care right along. You are familiar with the manner in which general practitioners, internists, and pediatricians perform these roles.

In addition, a new medical specialty of family practice has just come into being. The specialty has its own examining board, the American Board of Family Practice. The specialty requires a 3-year post-M.D. program of training consisting of 1-year of internship and 2 of residency. Like the specialties of pediatrics and general practice, it is patient- and family-oriented rather than disease- or system-oriented.

The emergence of the new specialty of family practice provides one more evidence of the response to the need for personalized and comprehensive health care and for encouraging concepts of personalized service and continuity of care across the board in medical training.

Increasing numbers of medical schools are teaching aspects of family care. In the last few years or so, substantial numbers of schools have recognized the need to develop a more concerted effort to give students, interns, and residents the opportunity to learn first-hand more about the medical care of the patient as an individual, and as a member of the family, and about community resources that are available to augment the physician's efforts to provide effective care to all members of families.

We are very much interested in the devolpment of programs that provide medical students with experience in comprehensive health care and in family practice.

Under the Health Professions Educational Assistance Act both formula and special project grants are authorized to assist schools in the strengthening and improvement of their educational programs and for the modification of their curriculums. We are assisting schools of medicine and osteopathy, and their teaching hospitals, to support the teaching of continuity, primary, or family-oriented care. Some of these grants have been used to establish or strengthen departments of family medicine; others, to support family practice or continuity care teaching programs on an interdepartmental basis; and still others, across-the-board exposure of students to family care.

Among the medical schools that have been awarded grants to expand their enrollments under the recently inaugurated physician augmentation program a number are also giving additional emphasis to the teaching of family medicine.

I should particularly like to address myself for a moment to the provision of the bill (sect. 761(a)(1)) which would authorize grants to medical schools to operate separate and distinct departments devoted to the teaching and instruction in all phases of family practice. There is an implication in this provision that the only way for a medical school to emphasize family practice is to establish and operate a separate department of family practice. We question that implication. Our experience has shown that some schools are concentrating their educational program on the production of family physicians; other schools are developing family practice or continuity care programs on an interdepartmental basis, so that the concepts of family practice become an integral part of the teaching program of many departments. We feel that such efforts also have great potential and are making major contributions to both concepts and practice of family medicine. These contributions should also be recognized.

Under the health professions educational assistance construction program we are assisting in the construction of medical schools and their

teaching hospitals. Space for family practice activities (both the teaching and clinical practicum) is being constructed as an integral part of the teaching facility. This committee is aware that we also administer authorities for construction of nurse training facilities and for allied health training centers. The Hill-Burton medical facilities construction program provides support for the construction and modernization of private, nonprofit medical facilities, including ambulatory care facilities of the type required for family medicine teaching programs. In addition, one of the priorities provided under the new Hill-Burton legislation is for projects for the construction of facilities which will provide training in health or allied health professions. In view of these authorities, the construction authorities proposed in this bill are unnecessarily duplicative and overlapping. We feel strongly that, particularly in the case of construction aid, it is more reasonable, feasible, and economical to provide general rather than categorical construction assistance.

With respect to the provisions of the bill for grants for special training programs for paramedical personnel in the field of family medicine, several other legislative authorities already exist under which such activities may be aided. Authority for Federal support of training of physician assistants and other new types of paramedical personnel is provided under the allied health professions personnel training authority for developmental grants (sec. 794 of the Public Health Service Act). As you know, bills for the extension of this authority are presently before the Congress. This authority has real potential for the preparation of new types of personnel to assist in providing the type of care toward which this bill is directed.

The allied health legislation would also provide authority for grants to a variety of agencies, institutions, and organizations for planning, developing, and establishing new programs of training paramedical personnel or effecting significant improvements in curriculums. We feel that this legislative authority is sufficiently broad to cover the purposes of this bill and is the more appropriate vehicle for their accomplishment.

A number of projects involving the preparation of nurses to play a role in the provision of family-oriented medical care have been conducted under nurse training and public health training authorities. These have included, among others, projects to plan and evaluate experimental training programs for such clinical nursing specialists as pediatric nurse practitioners.

Mr. Chairman, with respect to internship and residency training, we must remember that the costs of salaries of interns and residents (and to somewhat less extent, costs for these training programs) are now met largely out of payments for patient services, including reimbursements for care rendered by such interns and residents under medicare, medicaid, and other third-party payment plans.

In view of the evolving character of the concept of family medicine, there are advantages to aiding activities in this field under broad, flexible legislative authorities such as those contained in the Health Professions Educational Assistance Act. This type of authority permits the support of alternative approaches to training in the provisions of comprehensive and continuing care to individuals and families, pending further evaluation of the various mechanisms for educating

personnel and organizing medical services in this field. It also allows aid for training in family medicine to be provided in conjunction with aid directed toward another purpose such as expansion of enrollment of medical schools.

The health professions educational assistance authority is due to expire June 30, 1971. The Department is in the process of developing its legislative recommendations for modification and extension of that act and other health manpower legislation. Because of the close relationship between the family medicine activities proposed in S. 3418 and the health professions educational assistance programs, we recommend against enactment at this time.

In any event, the administration strongly opposes the enactment of educational categorical grant authorities such as those embodied in this bill which would duplicate authorities or mechanisms which already exist and under which the purposes of this legislation could be achieved.

We therefore recommend against enactment of S. 3418 at this time.

Thank you, Mr. Chairman.

The CHAIRMAN. I note, Dr. Zapp, that one reason you give as a basis for the opposition to the enactment of the bill is the recent passage of the extension of the Hill-Burton Act for greater hospital facilities. I note the administration vetoed that act so as to prevent the extension of the Hill-Burton facilities. So I am relieved and congratulate you on the administration now saying it is a good thing and it will help.

We all realized that in overriding the veto so strongly in Congress. We are glad to see the executive department is beginning to catch up.

Now I am one of the committee of 100 for health insurance for the American people. I noted that after that plan was unveiled for the public yesterday Dr. Egeberg made a statement—I can't quote exactly, because I wasn't in town—to the effect that we didn't have the medical facilities to carry out that act, it would be impossible to implement. That is true.

The purpose of these bills is to start catching up on medical care in America. Do you gentlemen know of a country in Western Europe that does not have better health care for their whole population, if you average it out, than we have? I don't think so. We do spend a lot on health care in this country, some $40 to $60 billion, public and private together. But we are not bringing health care to tens of millions of the American people. I think this is one way to start helping to do it.

In 1964 the winning candidate for the Presidency promised not to send Americans to fight in Southeast Asia. In 1968, the winning candidate for the Presidency promised to end that war in Southeast Asia. Now we have poured over a hundred billion dollars into it in the last 10 years. We seem to be more concerned with killing people in Southeast Asia than curing them in America.

I intend to press forward with this legislation. I think it is more important that the world judge us by what we do at home than by what we destroy overseas.

I want to direct your attention to page 6 of your statement. I want to direct your attention to the second sentence on this page, where you say, "This committee is aware that we also administer authorities for

construction of nurses' training facilities and allied health training facilities." Now how much money has the administration requested in the present budget for the construction of allied health training centers?

Dr. ZAPP. I would defer to Dr. Bucher.

The CHAIRMAN. How much money did the administration request?

Dr. BUCHER. None, sir.

The CHAIRMAN. You have mentioned throughout your statement the training that is going on and that some schools now have programs for the training of general practitioners in family medicine. How many grants has HEW made for that purpose for the medical schools for training of general practitioners or family doctors?

Dr. BUCHER There are 17 programs in family medicine receiving assistance at the current time.

The CHAIRMAN. At the present time?

Dr. BUCHER. That is correct, sir.

The CHAIRMAN. Under what program?

Dr. BUCHER. This is under the special project mechanism. This does not include support that may be used from the institutional formula grant for family medicine programs. We do not have information on the specific programs for which the schools use these funds. But there are 17 programs of which we are aware where funds from the special project mechanism are being used specifically for family medicine programs in undergraduate medical education.

The CHAIRMAN. How much money do you have in those grants?

Dr. BUCHER. Approximately $1½ million, sir.

The CHAIRMAN. For the total of 17?

Dr. BUCHER. That is correct.

The CHAIRMAN. That is the fiscal year just ended or the coming fiscal year?

Dr. BUCHER. The fiscal year just ended, sir.

The CHAIRMAN. Those are grants to medical schools?

Dr. BUCHER. Schools of medicine and osteopathy.

The CHAIRMAN. Do you have data on how many medical doctors or doctors of osteopathy would be produced if you continue grants in the ensuing year?

Dr. BUCHER. In most instances there are commitments, subject to availability of funds, for continuing these projects.

The CHAIRMAN. Is that the first year you have had those grants?

Dr. BUCHER. No, sir.

The CHAIRMAN. How long has that program been in effect?

Dr. BUCHER. Actually, there were a few that could be identified as early as fiscal year 1968.

The CHAIRMAN. Sixty-eight?

Dr. BUCHER. Yes.

The CHAIRMAN. So, you have not had time yet to begin to see the end product of doctors going out into practice in family medicine?

Dr. BUCHER. We do not, sir. Unfortunately, there are no quantitative figures. These grants assist [are support for] programs that presumably benefit all of the students in the school.

The CHAIRMAN. Block grants?

Dr. BUCHER. Yes, sir.

The CHAIRMAN. To give all the students some knowledge of this rather than training the specialists?

Dr. BUCHER. That is correct. These are undergraduate training grants.

The CHAIRMAN. In your statement you say, "Some of these grants have been used to establish or strengthen departments of family medicine; others, to support family practice or continuity care teaching programs on an interdepartmental basis; and still others, across-the-board exposure of students to family care."

How many of these 17 were to establish or strengthen departments of family medicine? Let me ask first, there are some medical schools that have departments of family medicine?

Dr. BUCHER. Yes, sir.

The CHAIRMAN. Do you have data on how many of the 100-odd medical schools in the United States have departments of family medicine?

Dr. BUCHER. Yes, sir. According to our information there are at the present time nine full departments and 14 divisions of family practice in the medical schools.

The CHAIRMAN. That would be 23 medical schools that have some special recognition of family medicine?

Dr. BUCHER. That is correct.

The CHAIRMAN. How many of the grants to the 17 were to either establish or strengthen departments of family medicine?

Dr. BUCHER. We have made grants to support departments in seven instances, and divisions or sections in five instances. In other words, in 12 cases special project moneys are being utilized specifically to support departments or divisions.

The CHAIRMAN. Twelve out of the 17 grants? Your million and a half to 17 grants would be less than a hundred thousand dollars a grant average. Now these 12 that you mentioned, would that be the entire grant, or would that be part grant and part for across-the-board exposure to family practice?

Dr. BUCHER. This is very difficult to answer; the best we can do is to identify that component, of what may be a much larger grant, which is directly related to the family practice portion of the curriculum.

The CHAIRMAN. Dr. Zapp, in your testimony you say, "Under the health professions educational assistance construction program, we are assisting in the construction of medical schools and their teaching hospitals. Space for family practice activities (both the teaching and clinical practicum) is being constructed as an integral part of the teaching facility."

Is that specified, or is that general as a teaching facility? Is there any specific allocation of moneys or does that grow generally from the fact that the money is being put up for these medical schools and teaching hospitals?

Dr. ZAPP. It would be general. It would be under the general category. In most schools space for family practice is included as a general part of the teaching facilities. However, in some, the school does specify particular space for that activity. No specific alloation of money is made for any area of a facility since we participate in all that is essential to the educational program.

The CHAIRMAN. You just give a general grant to construct a medical school or teaching hospital. Do you specify also family practice, or do you have any categorical requirement that a certain amount or any amount would be a part of it, or do you just know that flows from it—the fact that you are building medical schools or teaching hospitals?

Dr. ZAPP. Each application submitted to obtain Federal assistance in the construction of teaching facilities contains a detailed description of the current and proposed educational program. Also, it contains a description of the space that is proposed for the educational program. If family practice is a part of the curriculum, space would be provided just as for anatomy, medicine, or any other. In a high percentage of new schools we find community medicine and family practice included in some way in the curriculum.

But we have yet to find a clear line that shows the medical schools taking a stand as to whether they want a separate department or if this is to be handled on an interdepartmental basis.

Dr. ENDICOTT. I might add that the only limitation that we have is a limitation on research space and library space. As you know, the authority was broadened in the last enactment to provide multipurpose grants for the construction of a total facility, but with limitations with regard to research space and library space. Otherwise, the distribution of the money by type of facility is at the discretion of the school.

The CHAIRMAN. I have a number of detailed questions about this. I will address a letter to you about that so that you can answer it. It would take too much time this morning to go into each specific item of expenditure.

Senator Kennedy a cosponsor of this family medical practice act has joined us.

Senator Kennedy, the witnesses for the administration have just testified, and their final conclusion was opposition to the measure. Do you have any questions?

Senator KENNEDY. Thank you very much, Mr. Chairman.

I want to extend a word of welcome to you and apologize that I was unable to be here for your testimony and the questions of the chairman. If you could cover at least some of the questions I have, I would very much appreciate it.

Can you provide statistics on the number of persons qualified under the American Board of Family Practice established in 1969?

Dr. ZAPP. Our understanding at this time is that there are 1,600 members that have been grandfathered in. The residency programs are new and residents have yet to graduate and take the examination for certification.

Senator KENNEDY. When will these 1,600 graduate?

Dr. ENDICOTT. These 1,600 already have received board certification, sir.

Dr. ZAPP. These are practicing physicians who took an exam.

Senator KENNEDY. How many medical schools actually have departments of family medicine?

Dr. ZAPP. The departments and divisions of family medicine or community medicine were 12.

Senator KENNEDY. What can you say about the prospective change in the curriculum over the next couple of years. Do some of the medical schools that do not have departments of family medicine plan to have them in the next year or two?

Dr. ZAPP. I would like to correct my last answer. There are 13—nine full departments and 14 divisions.

Dr. BUCHER. We understand that 34 medical schools are actively considering or developing either departments or divisions of family practice.

Senator KENNEDY. Can you give us a list of the medical schools that now have departments of family medicine?

Dr. BUCHER. Yes, sir.

(The information subsequently supplied follows:)

MEDICAL SCHOOLS WITH DEPARTMENTS OF FAMILY MEDICINE

As of July 9, 1970, 9 full departments and 14 divisions of family practice have been established in medical schools.

Full departments are located in the following medical schools:

University of Minnesota.
University of Nebraska.
University of Oregon.
Pennsylvania State University.
University of North Carolina (Chapel Hill).
Upstate University of New York at Syracuse.
Medical College of South Carolina.
University of Texas Medical Branch at Galveston.
Medical College of Virginia.

Divisions of family practice are located at the following medical schools:

University of Arkansas.
University of California at Irvine.
University of California at Los Angeles.
University of Colorado.
Howard University.
Louisiana State University.
University of Maryland.
Harvard University.
University of Missouri.
Creighton University, Omaha, Nebraska.
University of Rochester.
University of North Carolina (Moses H. Cone Hosp., Greensboro).
University of Oklahoma.
University of Miami.

Source: Division of Education, American Academy of General Practice.

Senator KENNEDY. Can you give us at least those that are planning to establish such departments over the next couple of years? Would you let us know if there are other medical schools that are planning such programs?

Dr. BUCHER. We will be delighted to submit that information.

(The information subsequently supplied follows:)

It is virtually impossible to ascertain whether the respective medical schools planning programs of "Family Practice" will establish it as an independent department or a division under another department.

The following medical schools have programs of Family Practice in the developmental stages (recruitment of faculty, development of curriculum, etc.):

1. Medical College of Alabama.
2. University of California School of Medicine (Davis)—department level.
3. University of Indiana, School of Medicine.
4. University of Iowa, College of Medicine.
5. University of Kansas, School of Medicine.

6. University of Mississippi, School of Medicine.
7. Dartmouth Medical School.
8. University of New Mexico, School of Medicine.
9. Hahnemann Medical College, Philadelphia, Pennsylvania.
10. University of Utah, College of Medicine.
11. University of Washington, School of Medicine.
12. University of West Virginia, School of Medicine.
13. University of Wisconsin, Medical School.
14. Marquette University, School of Medicine.
15. University of Virginia, School of Medicine—division level.

The following schools of medicine are in the early stages of planning programs in Family Practice (varies from initial committees to consider the need and feasibility of a program to formal planning procedures as a result of State legislation) :

1. University of Arizona, College of Medicine.
2. Loma Linda University, School of Medicine.
3. Stanford University School of Medicine.
4. University of California at San Diego School of Medicine.
5. University of Florida, College of Medicine.
6. Chicago Medical School.
7. Loyola University, Stritch School of Medicine.
8. University of Louisville, School of Medicine—department level.
9. University of Kentucky, College of Medicine—department level.
10. Michigan State University, College of Human Medicine.
11. University of Michigan, Medical School.
12. Wayne State University, School of Medicine.
13. State University of New York at Buffalo, School of Medicine.
14. State University of New York, Downstate Medical Center.
15. Wake Forest University, Bowman Gray School of Medicine.
16. Temple University School of Medicine.
17. University of Tennessee, College of Medicine.
18. Vanderbilt University, School of Medicine.
19. University of Texas, Medical College at San Antonio.

Source: Division of Education, American Academy of General Practice.

Senator KENNEDY. These departments, as I understand, are accredited, are they not?

Dr. BUCHER. No, the departments are not accredited. In the case of the medical schools, the accreditation is of the institution as a whole. We are distinguishing here between a department in the school and a graduate training program which is approved as a specific program.

Senator KENNEDY. Can you tell us how accreditation is obtained for a graduate training program?

Dr. BUCHER. This is conducted— and I believe you will have several witnesses who can describe this better than I—under the auspices of the American Board of Family Practice and the AMA Residency Approval mechanisms, and with special requirements for approval of the residency programs.

(Information subsequently supplied follows:)

ESSENTIALS OF APPROVED RESIDENCIES

[Source: "Essentials of Approved Residencies," Directory of Approved Internships and Residencies—1969–1970, American Medical Association, pp. 318–319.]

4. SPECIAL REQUIREMENTS FOR RESIDENCY TRAINING IN FAMILY PRACTICE

Residencies in family practice should be specifically designed to meet the needs of graduates intending to become family physicians. The family physician is defined as one who: 1) serves as the physician of first contact with the patient and provides a means of entry into the health care system; 2) evaluates the patient's total health needs, provides personal medical care within one or more fields of medicine, and refers the patient when indicated to appropriate sources of care

while preserving the continuity of his care; 3) develops a responsibility for the patient's comprehensive and continuous health care and when needed acts as a coordinator of the patient's health services; and 4) accepts responsibility for the patient's total health care, including the use of consultants, within the context of his environment, including the community and the family or comparable social unit. In short, family physicains must be prepared to fill a unique and specific functional role in the delivery of modern comprehensive health services.

Duration of training

The duration of the program should usually be a total of three years following graduation from medical school.

Family practice residency programs should provide for experience and responsibility for each resident in those areas of medicine which will be of importance to him in his future practice.

As stated in the general requirements, it is not essential, or even desirable, that all hospital residencies adopt exactly the same program, nor that they offer a rigidly uniform sequence of experience. It is essential, however, that all programs for graduate training in family practice be able to need the fundamental requirements for an approved program and the hospitals involved must individually or collaboratively attain comparable quality results in the training.

It is necessary that the family practice resident retain his identity as such throughout his graduate training period. He will need to learn appropriate skills, techniques and procedures of certain other specialties, as well as those of family practice. Such instruction should be under the supervision of qualified specialists in those fields. The resident's program should be planned so that he can discharge his continuing responsibilities to a selected group of patients under the supervision of experienced family physicians.

If the resident plans to practice another speciality in depth in addition to family practice, he should obtain appropriate additional training beyond that provided in the family practice residency.

The spectrum of knowledge and skills involved in the field of family practice will, as in other disciplines, usually exceed in scope those possessed by any individual physician.

Content

The following covers the general content of family practice, and, as such, should be available to the resident although certain portions may be optional, depending upon the knowledge and skill obtained by the resident in medical school, his interests, and the character of his anticipated practice.

Family Medicine.—The family practice unit should consist of a clinical service, the content of which is determined by the needs of representative population of patients rather than the particular skills of the physician. The patient composition of the family practice service should be such that continuity of care is a reasonable probability for most patients and continuity of experience by the resident will result.

This service should include not only patients of all income levels in the acute general hospital but also ambulatory patients, patients at home, and patients in institutions such as nursing homes. This should also include emergency care of patients. Residents assigned to the family practice service may spend a period of time outside the family medicine facility as necessary to meet the needs of his patients. Furthermore, when deemed desirable by the program director the resident may be assigned to other institutions or settings to acquire additional types of experience. This approach should help to focus attention upon the ambulatory patient, the diseases of high prevalence, patients with long-term illness and those with problems of adjustment, anxiety, depression and other emotional stresses. It should also facilitate emphasis upon preventive medicine, health maintenance, rehabilitation counseling and the use of all relevant community resources.

Internal Medicine.—Internal Medicine by nature of its integrative functions is recognized as a major foundation for programs in family practice. The resident should receive regular instruction and gain experience that will permit him to develop judgment in assessing the condition of the patient, in the use and interpretation of laboratory procedures and in applying the principles of differential diagnosis, as well as proper therapeutic management of the patient. Emphasis should be placed upon the history and cause of disease and should provide the resident an opportunity to become familiar with the major causes of disease and the principles of rational therapy.

Pediatrics.—There is much overlap and reinforcement between internal medicine and pediatrics, but the special contributions of pediatrics relate to the problems of the newborn, to congenital malformation, to growth and development through adolescence, to nutrition, mental retardation and the behavioral and emotional problems of children and their management. Modern pediatrics includes a large component of preventive medicine and emphasizes care of the ambulatory patient and the patient at home. Pediatrics should offer opportunity for learning the diagnosis and care of infectious diseases. It should also provide study of the position of the child in the social systems of family, school and community.

Psychiatry.—This discipline is one of the necessary bases for a family practice program. The resident should learn how to diagnose and manage most psychosomatic and emotional problems. He should become competent to deal with the common tensions, anxieties and depressions that initiate or complicate a substantial proportion of the problems with which the family physician will be faced. The resident should learn to recognize the neuroses and psychoses and to provide for the aftercare which many patients require following discharge from a mental institution.

In the family practice unit, most of the pertinent knowledge and skill can best be acquired through a program in which psychiatry is integrated with medicine, pediatrics, and other disciplines. In addition, experience on a specialized psychiatry service with responsibility for the care of serious illness under supervision may be desirable. This will enable the resident to recognize major psychoses and to deal with the psychiatric emergencies which constitute a major problem for family physicians.

Obstetrics and Gynecology.—The resident should be provided the instruction necessary to understand the biological and psychological impact of pregnancy, delivery and care of the newborn, upon a woman and her family. He should acquire skill in the provision of antepartum and postpartum care and the normal delivery process. He should also have an understanding of the complications of pregnancy and their management. He should become adept at managing the problems of medical and office gynecology. Marriage counseling and sex education are important areas of responsibility for the family physician and the training program should afford an opportunity for the development of skills in these areas.

Surgery.—The resident should acquire competence in recognizing surgical emergencies and when appropriate referring them for necessary specialized care, an ability to evaluate conditions that require elective surgical management, an understanding of the kinds of surgical treatment that right be employed and the problems that may result from surgical procedures and their management. He should have sufficient knowledge of these procedures to give proper advice, explanation, and emotional support to his patients. He should be trained in basic surgical principles by recognized surgical specialists and require from them the technical proficiency required to manage those limited surgical procedures a first contact (family) physician may be called upon to perform. If he expects to include major surgery as a part of his regular practice, he should obtain additional training.

Community Medicine.—Community medicine is one of the unique components of family practice. Through proper instruction, the resident should be provided with an understanding of the principles of epidemiology and environmental health, familiarity with the health resources of a community and community organization for health. He should appreciate the roles and the interrelationships of persons in the various professional and technical disciplines which provide health services.

Community medicine should provide the resident with an approach to the evaluation of the health problems and needs of a community and to the improvement of resources to meet community needs more adequately. The experience should assist the resident to understand the role of private enterprise, voluntary organizations and government in modern health care. The social and behavioral sciences should be used to provide the resident with an understanding of the research tools and methodologies which will be of use to the family physician in discharging his integrative functions.

Electives.—It is desirable that a training program in family practice provide the resident with experience in other specialties such as anesthesiology, radiology, dermatology, ENT, opthalmology, urology, othopedics, et cetera. This may be acquired through proper utilization of consultations.

Research.—The participation of the resident in an active research program should be encouraged. Generally this should be concurrent with other assignments, provided the responsibilities of the resident are adjusted during such as-

signments to permit reasonable time for research activity. Investigative work is permissible as an integral part of the three-year program, provided the research topic relates to problems involving the delivery of health care or is otherwise of special relevance to family practice. Assignments to other types of research activities, if they are desired by the resident, should be in addition to, rather than in lieu of, clinical instruction.

Categories of programs

There is a wide variety of circumstances under which the family physician will function, both geographically and in his associations with other physicians. His educational program is to be designed in conformity with the general principles set forth in the following basic program. Flexibility is necessary and the program may be adjusted according to his predicted needs and should be carried out under the guidance and control of his program director.

Though it need not be followed in a rigid or restricted manner, the suggested basic program will normally consist of two parts:

A. The resident's base of practice will be a model family practice unit, where he will usually spend a portion of each day. Over the three-year period a major portion of his training will be devoted to this aspect of the field.

B. In addition, education and supervised training in the following disciplines should be available during the three-year period: medicine, pediatrics, surgery, obstetrics-gynecology, psychiatry, community medicine, and electives; examples of these programs might be:

	Percent
Program I:	
Medicine	33
Pediatrics	16
Surgery	16
Obstetrics-Gynecology	16
Psychiatry	8
Community Medicine and Electives	11
Program II:	
Medicine	50
Pediatrics	16
Psychiatry	16
Community Medicine and Electives	18
Program III:	
Medicine	33
Pediatrics	16
Psychiatry	16
Community Medicine and administrative services, including health service administration and electives	35

These are only examples both as to content and percentages. Many other variations are possible and will be given consideration for approval by the Residency Review Committee, provided they comply with the intent and concept of Paragraphs A and B above. It is intended that all the disciplines mentioned in Paragraph B should be covered either in the family practice model or in the various specialty departments listed in that paragraph.

Since a residency program in family practice requires cooperation and assistance from other specially services, the program director will need to work out in advance the assignments and responsibilities of the various services.

For those residents desirous of additional skills in one or more particular fields, the hospital is encouraged to provide advanced training beyond the third year.

The provisions of the General Requirements (Section 1 to 10) must also be met for approval.

Residents who plan to seek certification by an American Board should communicate with the secretary of the appropriate board, as listed in Section IV, to be certain regarding the full requirements for certification.

Senator KENNEDY. I was at a press conference yesterday when the committee of 100 announced its program for National Health Insurance. There were several questions there dealing with the number of general practitioners and specialists in the United States.

Can you give us statistics on the number of general practitioners and specialists in the United States for, say, the representative years of 1950, 1960, and 1970, so that we can get an idea of the trend and changes?

Dr. BUCHER. I can give you an approximate figure at this time.

There are at the current moment approximately 20 percent of the physicians in the country who are general practitioners.

Senator KENNEDY. I am especially interested in the trend in recent decades. Are we moving rapidly from general practitioners to specialists?

Dr. BUCHER. There has been definitely a trend toward a diminution of the number of general practitioners. On the other hand, if one asks the question of how many are providing personal care or the type of care that might be included within a family practice definition in its broader sense, then it is a little difficult to obtain an extremely accurate figure. But including the internists, pediatricians, and others who do provide such care, it has been estimated I believe that somewhere between 35 and 40 percent of the physicians are providing such care.

Senator KENNEDY. If you would give us at a later time the statistics for, say, the years 1950, 1960, and 1970, and whatever further interpretation you wish to place on it, it would be welcome. I would also be interested in the geographic distribution of our physicians. And, as I indicated, I would be interested in your interpretation whether we have an oversupply of certain specialists and and undersupply of other specialists and general practitioners.

Dr. BUCHER. In response to the question of oversupply, I do not believe I would be able to provide such information, sir. That is rather judgmental. We certainly will provide the other material you have requested.

Senator KENNEDY. I would be interested in seeing whatever material you are able to make available.

(The information subsequently supplied follows:)

ACTIVE PHYSICIANS BY TYPE OF PRACTICE: 1949, 1960, 1967

Type of practice	1949	1960	1967
Number of physicians: Total active	191,577	230,762	294,072
Private practice:			
Total	150,417	165,844	[1] 190,079
General practice	95,526	74,553	62,757
Specialty practice	54,891	91,291	127,322
Nonprivate practice [2]	41,160	64,918	103,993
Percent of physicians:			
Total in private practice	100	100	100
General practice	64	45	33
Specialty practice	36	55	67

[1] Private practice not available for 1967. Figures shown are for solo, partnership, group, and other practice.
[2] Includes for 1949 and 1960: hospital service (including interns and residents), medical school faculty, administration research, and Federal service.

Source: Health Manpower Source Book, secs. 14 and 20. Public Health Service Publication No. 263.

DISTRIBUTION BY GEOGRAPHIC DIVISION OF PHYSICIANS IN GENERAL PRACTICE: 1967

Geographic division	Number of pyysicians in general practice[1]	Rate per 100,000 resident population
United States	62,757	31.8
New England	3,729	33.0
Middle Atlantic	12,931	35.2
South Atlantic	7,397	25.3
East South Central	3,417	26.6
West South Central	5,507	29.1
East North Central	12,101	31.1
West North Central	5,162	32.2
Mountain	2,414	30.3
Pacific	9,607	38.0
Possession	493	

[1] Includes physicians in solo, partnership, group, and other practice.

Source: Computed from: Haug, J. N. and Roback, G. H., Distribution of Physicians, Hospitals, and Hospital Beds in the United States, 1967. Chicago, American Medical Association, 1968.

AMERICAN BOARD CERTIFICATES OF PHYSICIANS

	Active certificates as of Dec. 30, 1967	Certificates awarded July 1, 1968 through June 30, 1969
Total boards	[1] 101,638	6,296
Anesthesiology	4,221	273
Colon and rectal surgery	216	12
Dermatology	2,332	99
Family practice	([2])	([2])
Internal medicine	17,056	874
Neurological surgery	1,131	82
Obstetrics and gynecology	9,027	736
Ophthalmology	5,338	146
Orthopaedic surgery	5,058	433
Otolaryngology	3,659	161
Pathology	5,990	563
Pediatrics	10,754	649
Physical medicine and rehabilitation	576	61
Plastic surgery	560	53
Preventive medicine	1,831	96
Psychiatry and nuerology	8,075	552
Radiology	7,840	486
Surgery	14,803	720
Thoracic surgery	81	144
Urology	3,090	156

[1] For physicians certified by more than 1 board, certifications indicated under specialty which physician has designated as his primary specialty. (From American Medical Association Director of Approved Internships and Residences 1969–70.)
[2] Board approved February 1969. Number certified to date, approximately 1,600. (From American Academy of General Practice.)

Senator KENNEDY. I have the general impression that manpower is probably the most serious aspect of the health crisis today. All of us are interested in the priority the administration places on increasing the supply of health manpower. What priority do you place on it, and what steps are being taken to alleviate that crisis?

Dr. ZAPP. We certainly consider this to be one of the high priorities in the Department. As I am sure you are aware, one of the main vehicles we have for assisting the training of physicians, the Health Professional Educational Assistance Act, expires June 30 of next year, also the Nurse Training Act expires June 30 of next year. Of course, the allied health training——

Senator KENNEDY. Nursing schools is one of the examples I had in mind. In testifying before the Seenate Appropriations Committee a few weeks ago, I think the request is about $9.6 million in terms of

nursing schools, training. This was one of the greatest additions in terms of request by the administration in relationship to authorization.

I wonder what the administration really feels in terms of nursing training. What sense of urgency do you have about that?

Dr. ZAPP. We have an extremely high urgency. If I might go back to the original question to give you a capsulation as we see the health manpower situation. We consider health manpower to be a high priority. This includes increasing the numbers of both professionals and subprofessionals; trying to find or develop methods of better utilization of these people so that they are operating at their highest skills a greater percentage of the time they are working with patients; and, finally solving the distribution problem, which perhaps is one of the most acute.

Regarding increasing the numbers of physicians and dentists and supporting personnel, we do plan on bringing our health professions and nurse training legislative proposals to you. In them we hope to reflect what we feel will be an improved balance or method of developing the needed numbers. We are at the same time addressing ourselves to some of the other major problems. We have been pleased by many of the innovations, the curriculum innovations, and so forth, that many of these medical and dental schools have brought about themselves, such as shortening their curriculum, taking a more comprehensive viewpoint in the training of their personnel, looking at their overall course, perhaps on a post-high school basis, to see how we get him educated comprehensively and trained to deliver health care to individuals.

There are many traditional patterns that have to be examined and we are taking a look at them as we prepare our legislation for next year.

Senator KENNEDY. Can you give us a list of the various health manpower programs and the administration's budget request? I would like to have it included in these hearings. Also would you be kind enough to let us know how these programs have grown, in terms of both authorization and appropriation, over the period of the last 7 years?

Dr. ZAPP. We will be pleased to provide that for you.

(The information subsequently supplied follows:)

The information for health manpower programs administered by the Bureau of Health Professions Education and Manpower Training of the National Institutes of Health follows: (Comparable information for other Administration health manpower programs was not available at the time this transcript was required for the Committee. It will be submitted to the Committee at a later date.)

AUTHORIZATIONS AND APPROPRIATIONS FOR HEALTH MANPOWER PROGRAMS ADMINISTERED BY THE BUREAU OF HEALTH PROFESSIONS EDUCATION AND MANPOWER TRAINING, NIH 1964–1971

[In thousands of dollars]

	1964	1965	1966	1967	1968	1969	1970	1971 estimate
HEALTH PROFESSIONS EDUCATIONAL ASSISTANCE								
1. Construction grants:								
Authorization [1]	25,000	75,000	75,000	135,000	175,000	170,000	170,000	225,000
Appropriation		100,000	75,000	135,000	175,000	75,000	118,100	118,100
Available funds		100,000	75,000	135,000	116,700	[2] 133,300	118,100	118,100
2. Educational improvement:								
Authorization			20,000	40,000	60,000	80,000	117,000	168,000
Appropriation			10,482	30,000	52,500	66,000	105,000	113,650
Available funds			10,482	30,000	42,292	66,000	101,400	113,650
3. Scholarships:								
Authorization			([3])	([3])	([3])	([3])	([3])	([3])
Appropriation			200	4,030	7,200	11,219	15,541	15,000
Available funds			200	4,030	7,088	11,219	15,541	15,000
4. Student loans:								
Authorization	5,100	10,200	15,400	25,825	26,000	26,500	35,000	35,000
Appropriation		10,200	15,400	25,325	15,000	15,000	23,781	12,000
Available funds		10,200	15,400	25,325	15,000	15,000	15,000	12,000
NURSING								
1. Construction:								
Authorization		([4])	15,000	25,000	25,000	25,000	25,000	35,000
Appropriation [4]		([4])	15,000	25,000	25,000	8,000	8,000	8,000
Available funds			15,000	25,000	16,700	[6] 16,300	8,000	8,000
2. Institutional grants—Payments to diploma schools: (Replaced in 1970)								
Authorization		4,000	7,000	10,000	10,000	10,000	(35,000)	(40,000)
Appropriation		4,000	2,500	6,000	3,000	3,000		
Available funds		4,000	2,500	6,000	3,000	3,000		
3. Institutional grants—Project grants for improvement of nurse training:								
Authorization		2,000	3,000	4,000	4,000	4,000	[7] 35,000	[7] 40,000
Appropriation		2,000	3,000	4,000	4,000	4,000	8,400	11,000
Available funds		2,000	3,000	4,000	4,000	4,000	7,000	11,000
4. Advanced traineeships:								
Authorization	([8])	8,000	9,000	10,000	11,000	12,000	15,000	19,000
Appropriation	7,325	8,000	9,000	10,000	10,000	10,470	10,470	10,470
Available funds	7,325	8,000	9,000	10,000	9,898	10,470	10,470	10,470
5. Nursing educational opportunity grants: (Scholarships in 1970)								
Authorization				3,000	5,000	7,000	([3])	([3])
Appropriation				500	5,000	6,500	7,178	17,000
Available funds				500	4,750	[9] 5,750	[10] 8,178	17,000
6. Student loans:								
Authorization		3,100	8,900	16,900	25,300	30,900	20,000	21,000
Appropriation		3,100	8,900	16,900	16,000	9,610	16,360	9,610
Available funds		3,100	8,900	16,900	16,000	9,610	9,610	9,610

ALLIED HEALTH

1. Construction:								
Authorization				3,000	9,000	13,500	10,000	[13]
Appropriation [11]					3,000	1,800		
Available funds					2,000	[12] 2,800		
2. Educational Improvement:								
Authorization				9,000	13,000	17,000	20,000	
Appropriation				3,285	9,750	9,750	9,750	9,750
Available funds				3,285	9,750	9,750	9,750	9,750
3. Advanced traineeships:								
Authorization				1,500	2,500	3,500	5,000	[13]
Appropriation				250	1,500	1,550	1,550	3,750
Available funds				250	1,184	1,550	1,550	3,750
4. New Methods:								
Authorization				750	2,250	3,000	4,500	[13]
Appropriation				200	1,000	1,225	1,837	4,495
Available funds				200	800	1,225	1,238	4,495

PUBLIC HEALTH

1. Public health traineeships:								
Authorization	[14]	4,500	7,000	8,000	10,000	10,000	10,000	14,000
Appropriation	4,195	4,500	7,000	8,000	8,000	8,000	8,000	7,400
Available funds	4,195	4,500	7,000	8,000	7,880	8,000	8,000	7,400
2. Public health project grants:								
Authorization	2,000	2,500	4,000	5,000	7,000	9,000	8,500	14,000
Appropriation	2,000	2,500	4,000	5,000	4,500	4,917	4,917	4,517
Available funds	2,000	2,500	4,000	5,000	4,500	4,917	4,917	4,517
3. Schools of Public Health:								
Authorization	2,500	2,500	5,000	5,000	5,000	6,000	7,000	9,000
Appropriation	1,900	2,500	3,500	3,750	4,000	4,554	5,154	4,554
Available funds	1,900	2,500	3,500	3,750	4,000	4,554	4,554	4,554

DENTAL TRAINING GRANTS

1. Dental auxiliary utilization:								
Authorization	[15]	[15]	[15]	[15]	[15]	[15]	[15]	[15]
Appropriation	2,161	2,269	2,399	2,649	3,000	3,200	4,680	3,651
Available funds	2,161	2,269	2,399	2,649	3,000	3,200	3,651	3,651
2. Continuing education:								
Authorization				[15]	[15]	[15]	[15]	[15]
Appropriation				100	200	200	200	200
Available funds				100	200	200	200	200

[1] Funds appropriated are available until expended. Authorizations recorded are based on aggregate appropriation authorization of $175,000,000 for 1964–66 and an aggregate of $480,000,000 for 1967–68.
[2] Includes: +$58,300,000 reserved from 1968.
[3] Formula.
[4] Funds appropriated are available until expended.
[5] Under HPEA.
[6] Includes: +$8,300,000 reserved from 1968.
[7] $35,000,000 authorized for both formula and project grants with stipulation that $15,000,000 of funds appropriated shall be available for project grants.
[8] Indefinitely.
[9] Includes: +$250,000 reserved from 1968 —$1,000,000, reserved until 1970.
[10] Includes: +$1,000,000 reserved from 1969.
[11] Funds appropriated are available until expended.
[12] Includes: +$1,000 reserved from 1968.
[13] Extension of legislation pending.
[14] None.
[15] Indefinite.

Senator KENNEDY. Would you describe the difference between family practice of medicine and general practice? Is there a substantial difference?

Dr. ENDICOTT. General practitioners engage in family practice, but the new specialty of family practice defines a degree of training which many of the men in general practice do not actually have, so that their patient clientele would be the same, but the degree of training would probably in general be different.

Many general practitioners have entered practice immediately after internship. The new specialty requires 3 years of training, 2 after the internship, and has in addition a set of specified requirements that must be provided in the training.

Senator KENNEDY. In terms of the kinds of care provided, how does the specialty of family practice really differ, other than in a longer period of training? How would you describe it in terms of the care provided?

Dr. ENDICOTT. It is essentially the same.

Senator KENNEDY. It is essentially the same?

Dr. ENDICOTT. Yes, sir.

Senator KENNEDY. In both general practice and family practice.

Dr. ENDICOTT. Yes, sir.

Senator KENNEDY. I have just one final question, Mr. Chairman. This is the financial situation in the medical schools. I think all of us have been concerned by the recent reports of the dire financial conditions of many of the medical schools around the country.

Can you give us any information on the degree of financial crisis of medical schools? How many schools are in danger of bankruptcy? Are we going to have a Penn-Central crisis in our medical schools? Can we rely at least on the contributions of the schools which are in existence over the period of the next year? What is the situation?

Dr. ZAPP. There are some general comments I should like to make, and then I would like to defer to Dr. Bucher. As we realize, to plan and construct a new school and graduate new students takes anywhere from 8 to 10 years. So we don't want to see any schools closed. The problem of financial distress is not as simple as may appear on the surface. The schools might have financial distress because of the educational program, because of their research program, or because of certain service commitments they may have made with a hospital in the area, or they may have it just as a result of mismanagement. There are a variety of causes and they are very difficult to identify.

We have under the health professions educational assistance legislation been assisting financially distressed schools. We hope under our new legislation to be able to work with the schools and develop mechanisms to solve their management problems, if that happens to be the reason for their financial distress. But financial distress of the schools is something that is of immediate concern to us, because we know that we need more physicians. We know it is costly and time consuming to construct new schools. By the time students would be graduated from them we would be into the next decade.

On the other hand, we know if the financial problem comes from multiple sources that we have to somehow work with the institutions and isolate and identify the source of that financial distress, and work with them to correct it.

Senator KENNEDY. Would you describe the HEW program to help financially distressed medical schools?

Dr. ZAPP. Yes. Under the Special Projects Grants of the Health Professional Educational Assistance authority, we are assisting medical schools in financial distress. These grants are used for educational purposes.

Senator KENNEDY. Recent reports have suggested that there is something like 61 medical schools now in financial distress. Are there sufficient resources within that HEW program to help such schools?

Dr. ZAPP. I think we have to go back to the identification, really, of what financial distress is. For some of these schools, obviously, there may be a question whether they would continue operation or not. With others, financial distress may mean that some of the ongoing programs that they have had, or ones that they would like to have, they won't be able to have unless they have new assistance.

What we would hope is that in giving assistance to the schools for financial distress we will be able to also bring about some other objectives that the Department, and we are sure the committee, is interested in—that is, more physicians, more graduates.

Senator KENNEDY. Can you give us an assurance that no medical schools will close next year because of financial reasons?

Dr. ZAPP. I can only say, Senator, that I would hope not, and the Department would do everything in its behalf to see that they wouldn't.

Senator KENNEDY. On the basis of the knowledge you have now and the studies you have made of the financial needs of these colleges, and aware as you are of the resources which are available to HEW to provide emergency kind of help and assistance, would you say now that there won't be any closings next year, or would you say there might be two or three closings next year?

Dr. ENDICOTT. Senator Kennedy, we are not aware of any school that is planning to close this next year. But the applications are submitted in the fall, around the first of October. So, it will be several months yet before we will actually know what the financial picture really is.

Senator KENNEDY. Of course, you must make surveys on your own, rather than just wait until these applications come in, do you not? You must make at least some kind of determination as to what the financial needs are going to be, without waiting for applications to come in——

Dr. ENDICOTT. We keep in constant touch with the schools.

Senator KENNEDY. Can you give us any assurance no medical schools will actually close this year because of financial distress? I gather that you don't want to predict that one or two might go under, but is this the dimension of the problem, or is it possible there with be a larger number of closings?

Dr. ENDICOTT. There are some schools that are running enough of a deficit—these are private schools, not public schools—so that their endowments and other resources may be completely liquidated, let us say, over a period of 3 or 4 years. Some of them might elect at most any time to stop taking new classes, with the expectation of phasing out. We are aware of several such private schools.

Senator KENNEDY. How many schools are in that category?

Dr. ENDICOTT. I would say about six.

Senator KENNEDY. Are you prepared to provide the kind of resources which would make up the difference between their endowment funds and their operating costs? Do you think it is sufficiently important to keep those medical schools operating that you would request those funds from Congress?

Dr. ENDICOTT. Yes, sir. The problem, as Dr. Zapp has pointed out, is the extent to which we want to subsidize through this mechanism activities either tangentially related or unrelated to the educational process.

Senator KENNEDY. If they just had the basic medical curriculum would you be prepared to move into these situations to insure that their doors would not be closed to medical students?

Dr. ENDICOTT. Yes, sir. The tough decision, though, would be, for instance, in a school in a large metropolitan area that has undertaken a contract to operate the municipal hospital and is encountering a major deficit as a result of that. There is some question in my mind as to whether this mechanism of financial support should be used to solve that problem.

Senator KENNEDY. Now that is a terribly interesting point, because that happens to be the case in Boston, at Boston City Hospital, and in the District of Columbia and many other communities. If the hospitals did not have this kind of input from the medical schools, it would be a catastrophe.

What are you prepared to do about these situations? Do you think, if we move into a national health insurance program with prepaid programs, we might not need the municipal hospitals?

There are those who feel that way.

Dr. ENDICOTT. If that happened, we might have a different problem. But the question now is illustrated by the following example: There are medical schools in New York City with, let us say, 400 students who have control over 4,000 beds. Obviously they do not need that many beds for that many students. The real question, I think, the policy question, is should we try to solve the problem of the municipal hospital through subsidy to the school or should we tackle the municipal hospital problem directly?

Senator KENNEDY. If you make a decision to withhold your resources from these hospitals, you will adversely affect the municipal hospitals, which are already in tremendous difficulty.

In St. Louis the city hospital recently lost its accreditation. Boston City Hospital lost its accreditation. There was a reasonable chance that Cook County General Hospital in Chicago might do so. I certainly hope that the administration will come up with some kind of alternative to help these municipal hospitals. Even with the help of the new Hill-Burton Act, I think it is going to be extremely difficult for Boston City Hospital or any other municipal hospital to raise the resources that are necessary.

If you are going to withhold funds from these schools and colleges, what sort of program are you going to seek from Congress to help the municipal hospitals?

Dr. ENDICOTT. I defer to Dr. Zapp on that point.

Dr. ZAPP. I was not sure I was following part of your and Dr. Endicott's dialog as far as it related to the withholding of funds or changing priorities. I think what we are identifying is the fact that

the authority of HPEA to assist medical centers is basically assistance to the medical school in its educational activities. Sometimes the financial distress of the medical center is being caused, or worsened, by these other factors such as hospital deficits. I think that you raise an extremely important point in that this relates to the school, although it may be a separate facility on the other side of town or something. In the review of our health manpower legislation we are going to have to look maybe more across the board at the supporting mechanisms for the municipal and county hospitals, because of these recent contracts they have developed with the teaching universities.

Senator KENNEDY. Thank you very much.

The CHAIRMAN. Senator Schweiker, do you have any questions?

Senator SCHWEIKER. No questions.

The CHAIRMAN. Dr. Zapp, your statement identified a number of programs that you said would help in this family practice. I am going to request that you file a report this week with the committee—I am not going to take time now, we are far behind on the hearing this morning—identifying each program mentioned in your statement as a possible area of support for family medicine and specify how much money has been requested for each program in this year's budget, and how many doctors can be produced by each of these programs under the amount of money requested in the budget this year.

Dr. ZAPP. Fine.

The CHAIRMAN. Will you file that with the committee this week, please?

(The information subsequently supplied follows:)

PROGRAMS MENTIONED AS POSSIBLE AREAS OF SUPPORT FOR FAMILY MEDICINE:

FISCAL YEAR 1971 APPROPRIATION REQUEST

	Millions
Health professions educational assistance act:	
Basic support grants [1]	$44.1
(Medicine and Osteopathy, estimates)	(22.5)
Special educational improvement grants [1]	69.5
(Medicine and Osteopathy ,estimates)	(53.9)
Construction of teaching facilities	118.1
(Medicine and Osteopathy, estimates)	(88.0)
Allied health professions personnel training act:	
New methods grants	4.5
Construction grants	0.0
Nurse training act:	
Special project grants	11.0
Nurse traineeships	10.5
Construction	8.0
Public health:	
Project grants for graduate public health training	4.5
Public health traineeships	7.4
Medical facilities construction (Hill-Burton)	89.3
Medicare and Medicaid	([2])

[1] Under authority of the Health Professions Educational Assistance Act, the Department awards institutional and special project grants to assist schools of medicine and osteopathy to plan, develop, establish, maintain or modify programs in various fields—including family practice. These funds assist institutions training approximately 41,000 medical students to give basic preparation to their students which qualifies them for the basic M.D. degree. The number of graduates of schools of medicine and osteopathy will total approximately 9,250 in the 1970–71 school year.

[2] Costs of salaries of interns and residents and teaching costs for their training programs are met largely out of payments for patient services including reimbursements under medicare and medicaid.

The CHAIRMAN. I call your attention to the fact this bill, cosponsored by 33 Senators, was introduced on the ninth day of February. The Department report on this bill that you brought up today is dated July 7 and it says in response to my request, as chairman of this committee, of February 12, 1970.

Now, many times since February 12 the staff director or the general counsel phoned HEW and asked for this report. HEW is following the practice developed by this Administration of bringing up the report on the bill the day you are to testify on it. We called Secretary Finch's attention to this when he was Secretary and pointed out what we think is a bad practice—of dragging, trying to kill, don't give a report, turn down all requests for your stand on the bill. We finally force the issue by holding hearings after many requests for a report, and then you bring the report up the day you testify.

I realize you are not the determining factor in HEW, but since Secretary Richardson has had executive experience in this Government and in the Executive Department before his appointment as Secretary of HEW, I request that you go tell him—I will write him a letter, if you would prefer—to spur these decisions in getting their reports to this Committee. I think that is very necessary for smooth functioning, if we really want to do something about improving the status of the Government for the people of this country, particularly in the field of health and education, which I think are the two most important fields in the country.

If we are going to strengthen the people in the country, we must strengthen their health and education. Morals may be more important than that, but we will leave that to the religious sector, which is a private sector of society.

Any further questions?

Senator KENNEDY. Mr. Chairman, may I amend my previous request, for the number of general practitioners and specialists, and ask that comparable figures also be provided on West European countries, including Great Britain? Also, I would like to see whether comparisons are available in terms of statistics on infant mortality, longevity, any of the other traditional indicators of the quality of medical care. I think that we will find an enormous number of surgeons in our country and a shortage of general practitioners and certain specialists in other areas, as compared to other industrialized societies.

I think it would be useful for us to have these figures along with those in my previous request.

The CHAIRMAN. Surely. It might be of interest to mention that the week before last, in England, I had a conference set up by our Embassy with Dr. Yellinghist, the deputy chief medical officer of the Ministry of Health of the British Government. At least he held that office when I spoke with him. They just had an election, so he may have changed since then. Dr. Yellinghist administers the health care assistance of England, which is what we would call socialized medicine as distinguished from the health insurance plan that was unveiled yesterday. As I mentioned earlier, I am one of the Committee of One Hundred sponsoring that plan.

Dr. Yellinghist and I discussed the British system very extensively. He stated that under their system, doctors have three choices as to how

they may practice: (1) They may come entirely under the government plan and treat only under the plan; (2) they may have a combined plan, devoting part of their time to the Government plan and part to private practice; or (3) they may devote all of their time to private practice. This third category has fewer doctors than either of the first two, and they are primarily surgeons, who get the higher fees.

One area of complaint has arisen concerning the dual practice category. There is a back-up of patients wanting operations under the Government plan, and if the doctor had both private practice and Government practice, there is a temptation to not push anybody forward but wait and let him pay a big fee on the side to get an immediate operation out in the private sector. Dr. Yellinghist states now that 70 percent of all the British are strongly in favor of the Government plan at the present time. Some have strong opposition, and some don't like it but don't have strong opposition.

The British system is different from the insurance health plan that the distinguished Senator from Massachusetts and I are cosponsoring, along with many others. I understand that the medical plans of the Scandinavian countries are insured health plans rather than socialized medicine, as we call the English plan. Is that correct? Are you familiar with the Scandinavian plans? I hope to visit there before the year is over and personally look into those as I have in the British plan to some extent.

Are there any further questions?

We appreciate your contributions and hope, gentlemen, that working all together we can push this health care for the American people. We have to produce the personnel and the facilities with which to do it.

Dr. ZAPP. I am sure we agree.

The CHAIRMAN. Dr. Egberg's criticism of the health insurance plan was that we did not have the doctors, facilities, or medical personnel. I agree with him, we are short on those. That is why we are pushing diligently. I know that those who succeed me will push it as diligently as I am and probably more so. They won't be diverted by a campaign next year.

I hope that the new Secretary can use his good offices and Secretary Finch down at the White House to see that the health of the American people gets a fair share of the budget dollar.

That is the big problem in America as I see it.

Thank you very much.

Dr. ZAPP. Thank you, Mr. Chairman.

The CHAIRMAN. The next witness is Dr. Kowalewski, and the data sheets says in addition to being president of the Academy of General Practice, he is from Akron, Pa.

We have a distinguished Senator from Pennsylvania who is a member of this committee. I am going to yield to him for the introduction.

Senator SCHWEIKER. Thank you very much, Mr. Chairman.

I would like to welcome Dr. Kowalewski. I want to say that with Dr. Kowalewski as my constitutent, I have known and met the doctor before. He is well regarded in his home community. He is respected for his dedication to humanitarian causes as well as for his specialty and skill in family practice.

I am very pleased to see the doctor take time from his busy schedule to come and enlighten this Health Subcommittee, of which I am not a member although I am a member of the full Labor and Public Welfare Committee, about the problems that this committee is so vitally interested in.

The CHAIRMAN. Doctor, you are accompanied by Dr. Price. Is that right?

Dr. KOWALEWSKI. Thank you, Mr. Chairman and Senator Schweiker.

STATEMENT OF DR. EDWARD KOWALEWSKI, PRESIDENT, ACADEMY OF GENERAL PRACTICE, AKRON, PA.; ACCOMPANIED BY DR. JAMES PRICE, SPEAKER, HOUSE OF DELEGATES, ACADEMY OF GENERAL PRACTICE, BRUSH, COLO.; AND MIKE MILLER, HEADQUARTERS, ACADEMY OF GENERAL PRACTICE

Dr. KOWALEWSKI. That is right.

The CHAIRMAN. He is speaker of the house of delegates of the Academy of General Practice, from Brush, Colo.

All right, Doctor, you proceed in your own way.

Dr. KOWALEWSKI. Thank you, Mr. Chairman and Senator Schweiker.

I am Dr. Edward Kowalewski, a practicing physician of 22 years' experience, and fortunate enough to have 18 years' experience to view medicine as it is practiced and as it is needed in every nook and cranny in this country.

I practice in an urban area of Pennsylvania, in the farm district of Akron. I was a former member of the Expert Review Panel of HEW, the Regional Medical Programs Review Committee, and a consultant to the U.S. Public Health Service as a member of its Family Health Care Service Committee.

I am appearing here today as president of the American Academy of General Practice, and in an effort to relate to you the need of the grassroots people of this country with whom we bump hands with and work with every day.

The academy is the Nation's second largest medical association, with a current membership of over 31,000 physicians residing in all 50 States, Washington, D.C., Puerto Rico, and the Virgin Islands.

As academy president, it is with a great deal of pleasure that I appear before you today to testify in support of Senate bill 3418. Seated with me are Dr. James G. Price, a family physician from Brush, Colo., and current speaker of the academy's congress of delegates, and Mr. Mike Miller of the headquarters office.

Gentlemen, in recent years there has been a startling decline in the percentage of the total physician population which is engaged in the practice of family medicine. This is, in my opinion, a trend which must be reversed if we are to establish the best possible health care delivery system. The ultimate beneficiary of this reversal will not be the Federal Government or the American Academy of General Practice or the individual physician, but the Nation's people.

In the year 1931, three out of every four physicians in the United States were general practitioners. That is to say, three out of every four doctors were engaged in providing health care primarily outside the hospital. The number of physicians engaged in limited spe-

cialty practice in 1931 comprised roughly 15 percent of the total physician population.

By the year 1949, the trend had become obvious. Only 50 percent of the total physician population was engaged in private practice as general practitioners. On the other hand, the number engaged in private practice as specialists represented nearly 29 percent of the total physician population.

As of 1967, the most recent year for which figures are available, the general practitioner in private practice represented only 21.3 percent of the total physician population, or approximately one out of every five doctors, as compared to three out of every four doctors in 1931.

If I may express these figures in different terms, in 1931 there were 1,097 people for every general practitioner in private practice, and 5,551 people for every limited specialist in private practice. In 1967, there were 3,171 people for every general practitioner in private practice, and 1,564 people for every limited specialist in private practice.

I cite these figures not as proof of the need for more family physicians, but as a proof of the emphasis on specialization. I think there are very valid reasons, which I shall presently discuss, why this emphasis is undesirable, and must be reversed.

I should state at this point, there are several reasons why there has been a de-emphasis on training family physicians. Advances in medical science have opened new medical horizons and made feasible the practice of medicine in many specialized areas. At the same time, medical schools have focused much of their attention on research aimed at discovering new horizons.

The medical school curriculum has been geared to accommodate research, with the result that few, if any, of the medical school faculty have been general practitioners with a primary interest in training family doctors.

It is only natural that faculty surgeons would tend to support programs which would improve the training of surgeons, just as faculty internists would tend to support programs to improve the training of internists. Once the emphasis switched to research, the trend toward limited specialization became self-perpetuating.

Allow me now to suggest some of my reasons for previously stating that the de-eemphasis of general practice is undesirable and must be corrected.

Based upon past figures, it can reasonably be estimated that today only 15 percent of the medical school graduates will enter private practice as general practitioners. When this is viewed in light of the fact that the family practitioner is capable of treating 85 percent of the illnesses which beset mankind, it becomes alarming.

Certainly no one would disagree with the statement that there is an immediate need to increase the number of physicians providing patient care. Can anyone possibly disagree with the statement that this need should first be met by increasing the number of physicians capable of providing 85 percent of this care?

The role of the family physician in the overall health care picture is more vital today than ever before. He can treat the vast majority of illnesses which confront him. In those instances when it is necessary to refer his patient, the family doctor assumes the role of team quarterback, the advocate.

From his vantage point, he can see the whole person as that person relates to his total environment. With that perspective, the family physician is in the best position to determine the patient's next step in the health care system.

In this vein, and basic to the system of residencies being considered under this bill, is the heir to classic general practice—the new broad-scale specialty of family practice.

This new primary specialty became a fact in February 1969, when the council on medical education of the American Medical Association and the independent advisory board for medical specialties approved creation of a certifying board in family practice.

Where classic general practice was, like all of medicine, crisis-oriented, family practice will emphasize keeping people healthy as well as providing comprehensive, continuing medical service. This is a subtle but highly important difference. It is concerned with preventive health care, the scientific application of the old adage about an "ounce of prevention."

More than ever before, because they now will be taught, family doctors in this new specialty will treat the patient within the context of his environment—his family relationships, his job, his economic situation—not only when he is sick, but before he gets sick.

He will be able to do this because family practice residency training will orient him in psychology, anthropology, family economics, and the interrelationship and availability of community service. This family doctor specialist truly will be a new doctor for a new day.

This specialty board now has had its first examination and has certificated its first diplomates, some 1,600 of them. These men are all practicing family doctors—99 percent are members of the Academy of General Practice—and are the vanguard of this new kind of physician.

The important ones, however, as St. John said, are those that will come. These will be trained in the residency training programs supported by this legislation. These doctors are the primary physicians of the future who will bring medical care back to the American people.

The new specialty will give doctors-to-be the incentive to enter primary care in large numbers. The family practice residency system—supported by this legislation—will train them in how to render primary, preventive health care.

Another reason I believe current deemphasis on family practice must be corrected is the increased cost of health care. There are obvious reasons why the decrease in family doctors has contributed to increased costs, and there are more subtle reasons.

Hospitalization costs have risen rapidly in recent years. This is, in some part, due to the law of supply and demand. With the unavailability of adequate numbers of physicians to treat patients outside the hospital, the only alternative is to admit the patient to the hospital, where he can be properly cared for. This puts a premium on hospital space and increases costs.

Health care costs are further increased when, due to the lack of sufficient numbers of office-based family practitioners, people's illnesses reach the point at which they must be treated in the hospital.

I submit the proposition that if there were an adequate supply of family physicians, many illnesses which eventually require hospitalization could be effectively treated in the office, and, therefore, make hospitalization unnecessary.

The increasing number of malpractice suits, with a resulting increase in the cost of malpractice insurance, has been a major contributing factor in the increase in heatlh care costs. The decline in the number of family physicians has had a subtle but very real impact in this area.

On November 20, 1969, the Subcommittee on Executive Reorganization of the Senate Committee on Government Operations issued a voluminous report entitled "Medical Malpractice: The Patient Versus the Physician." The report points out the fact that due to the depersonalization of medicine, individuals are much more likely to instigate malpractice suits in the present day than they were in the past. On page 9 of the report, it is noted:

> . . . Perhaps the most overlooked factor in the rise of these claims has been the slow but constant change in the organization of health care services. Care by the old family physician has generally diminished. Much of our care is now in the hands of superspecialists and supersurgeons whom we may see only once or twice in our lives and in whose hands we entrust our very lives.

And on page 6, the subcommittee states:

> The breakdown in the physician-patient rapport results, in part, from the growing specialization in medicine. Doctors, whose specific professional interest is a certain medical problem that poses the scientific challenge they have been trained to deal with, may show—or appear to show—less concern for a patient's emotional needs that does the general practitioner or family physician.

Perhaps one of the most immediate reasons why steps must be taken to produce more family physicians is because many communities don't have a doctor, or are faced with the possibility of not having a doctor at some future time. And I have before me the communities in Pennsylvania without physicians.

It is a fact of life that smaller communities cannot support a limited specialist. Since the demand for family doctors is greater than the supply, it follows that some communities must be without an adequate physician popultaion now, and it will get worse.

The CHAIRMAN. Doctor, that document you just exhibited, how many pages is it?

Dr. KOWALEWSKI. These are letters. I would guess there are 50 letters.

The CHAIRMAN. Do you desire to file those?

Dr. KOWALEWSKI. Yes, sir.

I have other statistics.

The CHAIRMAN. The material will be made a part of the hearing record.

(The material referred to follows:)

COMMUNITIES LISTED WITH THE PHYSICIAN PLACEMENT SERVICE

SEEKING SPECIALISTS

(Revised March 3, 1970)

Town and specialty	
Aliquippa	Emergency department chief
Altoona	Internists, orthopedic surgeons
Berwick	Internists
Bethlehem	Orthopedists
Bradford	Obstetrician-gynecologists
Carlisle	Internists
Chambersburg	Anesthesiologists
Columbia	Internists, obstetrician-gynecologists
Connellsville	EENT, obstetrician-gynecologists, pediatricians, ophthalmologists, otolarynologists, surgeons, resident physicians
Danville	Anesthesiologists, psychiatrists, orthopedists, ophthalmologists, dermatologists, physical therapists, internists, neurologists, pediatricians, pathologists
DuBois	Radiologists
Erie	Physician in physical medicine, pediatrician
Franklin	EENT, internists, pediatricians
Greenville	Anesthesiologists, internists, pathologists
Hamburg	Pediatricians
Huntingdon	Internists
Indiana	Surgeons
Lancaster	Obstetrician-gynecologists
Lansdale	Internists, obstetrician-gynecologists
Lewistown	Pediatricians
McAlisterville	Internists
McKeesport	Pediatricians
Meadville	EENT, orthopedic surgeons, obstetrician-gynecologists, urologists, pediatricians, internists, psychiatrists, surgeons, ophthalmologists
New Castle	Obstetrician-gynecologists
Pittsburgh	Internists, urologists.
Quakertown	Pediatricians.
Reading	Internists, surgeons, urologists.
Ridgway	EENT, internists, radiologists, urologists.
Sharon	Obstetrician-gynecologists, pediatricians, surgeons.
St. Marys	Anesthesiologists, obstetrician-gynecologists, surgeons.
Sunbury	Obstetrician-gynecologists.
Telford	Pediatricians.
Titusville	Anesthesiologists, internists, obstetrician-gynecologists, surgeons.
Union City	Obstetrician-gynecologists, pediatricians, surgeons.
Warren	Internists, urologists.
Waynesburg	Surgeons.
West Point	Internists.
Drums	Industrial physician.
Ellwood City	Cardiologists.

SEEKING GENERAL PRACTITIONERS

(Revised Mar. 3, 1970)

Town and county

Albion (1), Erie
Aliquippa (1), Beaver
Avonmore (1), Westmoreland
Barrett Township (1), Monroe
Bedford-Everett-Schellsburg Area (1), Bedford
Biglerville (1), Adams
Blossburg (1), Tioga
Bolivar-Robinson Area (1), Westmoreland
Brooklyn-Harford-Kingsley Area (2), Susquehanna
Catawissa (1), Columbia
Chambersburg (1), Franklin
Columbia (1), Lancaster
Conway (1), Beaver
Corry (1), Erie
Dawson (2), Fayette
Drums (1), Luzerne
Dry Run (1), Franklin
Elkland (1), Tioga
Ellwood City (1), Beaver and Lawrence
Emporium (1), Cameron
Franklin (1), Venango
Freeport (1), Armstrong
Greencastle (1), Franklin
Hawley (1), Wayne
Huntingdon (1), Huntingdon
Hyndman (1), Bedford
Indiana (1), Indiana
Irwin-Jeannette Area (1), Westmoreland
Kane (1), McKean
Knoxville (1), Tioga
Landisville (1), Lancaster
Lemasters (1), Franklin
Leraysville (1), Bradford
Lewistown (1), Mifflin
Liberty (1), Tioga
Littlestown (1), Adams
Long Branch Boro (Roscoe, Allenport, Elco, Dunlevy) (2), Washington.
Marion (1), Franklin
Martinsburg (1), Blair
Masontown (2), Fayette
McConnellsburg (1), Fulton
Meadville (1), Crawford
Mercer (1), Mercer
Mercersburg (1), Franklin
Millheim (1), Centre
Moscow (1), Lackawanna
Mount Holly Springs (1), Cumberland
Mt. Jewett (1), McKean
Myerstown (1), Lebanon
New Albany (2), Bradford
New Berlin (2), Union
New Bethlehem (1), Clarion
Nuremberg (1), Luzerne and Schuylkill
Perryopolis (2), Fayette
Philipsburg (1), Centre
Port Allegany (1), McKean
Punxsutawney (1), Jefferson
Ralston Area (2), Lycoming
Richfield, (1), Juniata
Ridgway (2), Elk
Riegelsville (1), Bucks
Roaring Creek Valley (1), Columbia
Rockwood (1), Somerset
Roulette (2), Potter
Sagamore-Beyer (Indiana County) (2), Armstrong
Saltsburg (1), Indiana
Sarver—S.E. Butler County (1), Butler
Sharon (1), Mercer
Smethport (1), McKean
Somerset (1), Somerset
Thompson (1), Susquehanna
Towanda (1), Bradford
Tower City (1), Schuylkill
Tremont (1), Schuylkill
Tunkhannock (1), Wyoming
Tyrone (1), Blair
Union City (1), Erie
Waynesburg (1), Greene
Weatherly (1), Carbon
West Sunbury (2), Butler
Youngsville (1), Warren
Zelienople (1), Butler

PHYSICIANS LISTED WITH THE PHYSICIAN PLACEMENT SERVICE

1. Number of General Practitioners listed with the Physician Placement Service to date—32.

2. Number of Specialists listed with the Physician Placement Service to date—96.

47-743—70——5

CORRY MEMORIAL HOSPITAL,
Corry, Pa., January 21, 1966.

MR. BENJAMIN A. BRONSTEIN,
Staff Assistant, Physician Placement Service,
Pennsylvania State Medical Society,
Harrisburg, Pa.

DEAR MR. BRONSTEIN: As is true of many communities, ours is in need of additional physicians. The Corry area has a population of approximately 26,000 people. It is served by only eight General Practitioners, two of whom are limiting their practices very much, and one orthopod, on our active staff.

Our Medical Staff is interested in having more general practitioners come into the area. However many townspeople and our Board of Trustees are interested in having a few specialists, possibly one in OB–Gyn; Pediatrics, and Surgery.

We have a well equipped 53 bed hospital and are planning a thirty-five bed geriatric addition and changes in ancillary facilities. We have a forward looking Board of Trustees which is quite anxious to provide the best health facilities for the city.

I sincerely think the best aspects of our hospital are really four fold; we have excellent nursing service and dietary departments, both of which are highly praised by the patients; up to date equipment and building facilities; and a good medical staff which is being overworked. We recently received a three year accreditation from the Joint Commission.

The people of Corry are congenial. There is practically no juvenile delinquency which of course makes it an excellent locality for a family. Also, it is a community which has a number of industries and very little unemployment.

If you have inquiries from energetic doctors looking for a good location to practice, will you please have them write to me. Or, if you have any suggestions, I would welcome them. Recently, I sent the enclosed bulletin to a number of hospitals with residency programs. There has not been sufficient time to expect a response to the posters.

You may be interested to learn Dr. Dean A. Clark told me Mrs. Mabel Baron suggested I write to you.

Thank you for any help you can give.

Very truly yours,

SAMUEL E. ANTRIM,
Administrator.

—

CRESSONA LIONS CLUB,
Cressona, Pa., September 26, 1967.

THE PENNSYLVANIA MEDICAL ASSOCIATION,
Lemoyne, Pa.

GENTLEMEN: At a recent meeting of the Cressona Lions Club the need for additional medical doctors was disscussed. Cressona, (population 2000) Schuylkill County, and the rural area traditionally served by doctors of Cressona (embracing another 2–3000 people) was once served by three active general practitioners. Today this community is served by one active doctor.

The Cressona Lions desire to investigate the circumstances and conditions that induce doctors to locate in a given area. We will appreciate receiving any aid or advice your association may extend.

Sincerely,

JAMES A. ROMBERGER,
President.

—

CHAMBERSBURG, PA., *July 21, 1967.*

PENNSYLVANIA MEDICAL SOCIETY,
Lemoyne, Pa.

GENTLEMEN: I am chairman of a committee to obtain general practitioners for our area. Could you furnish us a list of the physicians who are being discharged from the armed forces this year. Also could you furnish us with a list of the current interns in the hospitals surrounding our area. Any other suggestions for obtaining prospective names would be appreciated.

Yours truly,

DAVID M. RAHAUSER, M.D.

CONYNGHAM, PA., *July 25, 1969.*

Mr. ROBERT H. CRAIG,
Pennsylvania Medical Society,
Lemoyne, Pa.

DEAR MR. CRAIG: I am writing as a follow-up of our phone conversation of late Tuesday afternoon. I was in Harrisburg at the time and Herb Packer of the Pennsylvania Home Builders Association had suggested that I call you.

In our rapidly growing community of Conyngham Valley (near Hazleton) we have the services of only one Medical Doctor (Dr. Richard J. Wise) who is rapidly approaching the age of retirement. We also have an Osteopath who has succeeded extremely well in the four years since he moved here.

Our problem is an obvious one. Because of Dr. Wise's age, we are faced with the very real possibility of being without the services of a Medical Doctor at any time. Dr Wise has been dedicated to our people far beyond the demands of his professional duty for more than 30 years; but the growth of our community requires the services of another Medical Doctor now.

Furthermore, there is presently available office space on ground floor (with no steps at all) with adequate parking which would be an ideal location for a Medical Doctor to establish a new practice.

I am certain that a Medical Doctor would be very successful with his practice in Conyngham Valley and would enjoy the bonus of living in a delightful suburban community in one of the most beautiful valleys in the Commonwealth.

I will be in Harrisburg on Thursday, August 7th, for our Pennsylvania Home Builders Assn. Legislative Committee meeting and I would like to stop over to Lemoyne to discuss this situation further with you. I could see you at 9:00 a.m. or later in the afternoon about 4:00 p.m. In fact, I could stay over to see you Friday morning if that would be more convenient to you.

I am forwarding under separate cover a brochure of the Greater Hazleton area and I have indicated in red the scenes and descriptions which pertain to Conyngham Valley.

Very truly yours,

HAROLD B. BENJAMIN.

PITTSBURGH TESTING LABORATORY,
Cabot, Pa., May 17, 1963.

PENNSYLVANIA STATE MEDICAL SOCIETY,
Commission on Rural Practice,
Harrisburgh, Pa.

DEAR SIR: Our community is in need of a physician.

We are located in S.E. Butler County 30 miles N.E. of Pittsburgh.

The following Towns do not have a physician, Cabot, West Winfield, Marwood, Denny Mills, Sarrer, and Slatelick.

Our community will help to get a good residence for a physician.

Do you have a physician looking for a place to practice?

We have modern schools and churches, etc. A prompt reply will be greatly appreciated.

Sincerely yours,

PAUL G. ROENIGK.

GRATZ, PA., *December 22, 1969.*

DEAR SIR: I am still asking for a Dr. for Gratz, Pa. We ought to have one so bad don't it have any yet it is a nice little town and one would make good I am sure.

Yours truly,

MRS. ALLEN DANIEL.

BOROUGH OF FREEPORT, PA., *August 8, 1966.*

PENNSYLVANIA MEDICAL SOCIETY,
Harrisburg, Pa.

GENTLEMEN: It is our profound opinion that the Borough of Freeport is in dire need of at least two General Practitioners.

The Borough and surrounding area is now served by only one Doctor, and it is virtually impossible for him to take care of all the medical needs of this community that we now have. It is with his blessings and hopes, as well as the local citizens, that we present our request for additional medical services.

We feel that our town can and will be able to support two more General Practitioners and hope that you can help us in our goal.

Gratefully yours,

JAMES H. NOLF, *Mayor.*
ALFRED A. ATKINSON, *Council President.*
ALAN A. SCHROTH, *Borough Secretary.*

—

MEMORIAL HOSPITAL OF BEDFORD COUNTY,
Everette, Route 1, March 21, 1969.

PHYSICIAN PLACEMENT SERVICE,
Pennsylvania Medical Society,
Lemoyne, Pa.

DEAR SIR: A Physician Search Committee consisting of members of the Medical Staff, Board of Trustees, and community leaders is attempting to attract physicians to the Bedford County area. Our efforts are being made because of the retirement and pending retirement of some of the physicians in the area and with the increased workloads being placed on the remainder of our physicians.

The population is approximately 47,000 in Bedford County. Ours is a progressive county, one which has recently attracted a popular ski resort and four new industries in the last four years. We're a growing community, but we wish to retain our small town way of life. No traffic problems, no racial undercurrent, but plenty of golf and other recreation.

Our area is known as a year-round recreational area. In addition to excellent skiing and hunting, we have a number of hotels and motels which cater to the vacationer, providing the best in food and enterteainment. We have two 18 and one 9 hole golf courses in the area, so there's no waiting in line to play golf. Beautiful Shawnee State Park is located nearby, so there is plenty of boating, swimming and fishing in our backyard. We also have an excellent school system in Bedford County. There is a very well programmed and supervised summer recreation program for youngsters.

Memorial Hospital of Bedford County is a 17 year old facility and contains 82 beds and 16 bassinets. We are currently working on an expansion and improvement program which would expand our hospital to a 115 bed facility. Ours is an open medical staff of approximately 15 active physicians. The strategic position of the hospital with reference to the Turnpike, U.S. Route 30, Interstate Route 70, etc., affords a great deal of traumatic work besides the routine service to the community.

Pittsburgh is 100 miles to the west, while Philadelphia and New York are 200 and 260 miles to the east. Many of our Staff members and their wives spend weekends shopping and relaxing in these cities.

Last year we had approximately 3300 admissions, not including nearly 500 newborn. Our operating suite contains two well-equipped major rooms and a postoperative recovery room. Anesthesia service is provided by three excellent registered nurse anesthetists, and we are fully accredited by the Joint Commission on Accreditation of Hospitals.

We believe our situation presents an ideal opportunity for physicians who wish to practice in a stimulating environment. Our committee would be pleased to receive correspondence from interested individuals. Correspondence should be directed to:

M.D. Search Committee c/o Administrator,
Memorial Hospital of Bedford County,
R.D. #1, Everett, Pa. 15537

I would appreciate your referring the letter through the appropriate channels were it would do the most good. Thanking you in advance, I remain

Very truly yours,

NED BROWN,
Chairman, MD Search Committee.

—

EVANS CITY ROTARY CLUB,
Evans City, Pa., April 4, 1968.

DR. JOHN H. HARRIS, SR.,
Taylor By-Pass and Erford Road,
Lemoyne, Pa.

DEAR DR. HARRIS: At the suggestion of Mr. Norman H. Davis, of the Sears-Roebuck Foundation, I am taking this opportunity to acquaint you and the Dean

of our nearest medical school with our need in the Evans City-Zelienople-Mars area for another physician. Dr. R. C. Allsopp is our only physician in Evans City following the recent deaths of Dr. H. W. Nicklas, O.D., Dr. H. W. Wilson, M.D. and Dr. Dombart, M.D. Neighboring Mars and Zelienople have also recently lost physicians, so this area only 25 miles north of Pittsburgh is acutely in need of additional physicians.

Now if you have any advice or suggestions, we would certainly appreciate them. We can assist a new man in setting up a practise, but feel we should wait until the man is on the scene before launching into any full scale physical facility development. We patiently wait, but feel some action is necessary. Your assistance would be appreciated.

Sincerely yours,

W. JULIAN CARTER, Jr.

EMPORIUM-CAMERON COUNTY CHAMBER OF COMMERCE,
Emporium, Pa., September 12, 1967.

PENNSYLVANIA MEDICAL SOCIETY,
Taylor Bypass and Erford Road,
Lemoyne, Pa.

GENTLEMEN: This area is bady in need of at least one more doctor. There have been three general practitioners in Emporium and they have been very busy and very prosperous. However, one is retiring from a very large active practice and moving west, and another has reached the age where he is forced to limit his practice.

The town and county are very prosperous and blessed with full employment in diversified industries, the largest of which is Sylvania Electric Products Corporation.

The population of this county is just under 8,000 and most of this is concentrated in and around Emporium.

We are in the middle of wonderful hunting and fishing country, near winter sports, and the people are very friendly. A modern country club with a sporting nine hole course is well established.

There is enclosed a brochure of Emporium and Cameron County as well as a color brochure of the Bucktail State Park area.

We believe there is an excellent opportunity for a general practitioner to quickly establish a very lucrative practice.

Modern hospital facilities are available.

There are two office spaces available and a new doctor will be given full cooperation by the other doctors.

If further information is desired communicate with this office or with Dr. Joseph M. Blackburn, Fourth St., Emporium, Pa. 15834.

We would appreciate it if this information is made available to your members.

Yours very truly,

ROBERT S. KRAUSE, *Office Manager.*

ARMSTRONG CO.,
Leechburg, Pa., October 22, 1968.

GENTLEMAN: The doctor of Elderton, Pa. (Dr. Heilman) has retired and the citizens are anixous to have a doctor locate in the Community.

We have been advised to contact your office for any names you may have of Doctors wishing to set up a practice in a new location.

Dr. Heilman is very willing to be of any assistance that may be needed and the citizens are anxious to learn what may be expected of them. There is several large industries and many mines in operation. The nearest hospitals are about twenty miles from Elderton. I will send you any other information you may need.

Sincerely Yours,

Mrs. I. M. AVERY,
Out Reach Worker, Community Action Program.

SWAB WAGON COMPANY, INC.,
Elizabethville, Pa., July 17, 1969.

PENNSYLVANIA MEDICAL SOCIETY,
Taylor Bypass and Ereford Road,
Lemoyne, Pa.

GENTLEMEN: I am writing to you at this time to request an appointment to discuss a serious medical condition which exists in our area—the Northern part of Dauphin County.

We have no medical facilities of any kind, except the local physicians' offices; and, with a distance of an average of 35 miles to the nearest hospital (Polyclinic, Harrisburg) we cannot receive the proper immediate medical attention so often required in accident, coronary, or emergency cases.

With a population of approximately 24,000 persons being served by only 6 doctors—most of whom are at or approaching "retirement" age—you can understand our concern.

Because of the existing inadequate facilities and conditions, we are looking into the idea of establishing a Clinic whereby immediate emergency assistance can be rendered, then transporting the patient to a general hospital. It is our thought to create a Clinic, or Emergency Hospital, to be staffed full time—either by a resident physician or by a cooperative program of local doctors.

It will be greatly appreciated if you could give me an appointment to discuss these problems, and to enlighten us as to how other areas have met the problem. We need help and suggestions to get started, and will appreciate any assistance you can give to us.

Thank you very much for your consideration and reply.

Sincerely yours,

WM. P. LEHMAN.

DRY RUN, PA., *September 3, 1968.*

GOV. RAYMOND SHAFER,
Main Capitol Building,
Harrisburg, Pa.

GOV. RAYMOND SHAFER: What I am writing to you for is, in this little Path Vally, we are in bad need of a Dr. What can we do to fine a Dr. Wont you *try help us out to fine a Dr, wont you* (*Please*) look into this at once, and I want to be hearing from you soon.

As ever,

ETHEL COONS.

THE UNITED METHODIST CHURCH,
Johnsonburg, Pa., August 14, 1969.

MR. GEORGE E. FARRAR,
President, Pennsylvania Medical Society,
Taylor Bypass and Erford Road,
Lemoyne, Pa.

DEAR MR. FARRAR: I am writing to you as the medical representative of the Johnsonburg Chamber of Commerce.

Our community of Johnsonburg has a need, and opening, and an opportunity, for the services of a "General Practitioner."

Can you, Sir, provide me with a listing of individuals with whom I might make contact concerning our need? Or, can you provide me with a listing of persons who are interested in beginning a practice in a new community?

In short, we are looking for a doctor. Can you give me any assistance?

I will appreciate hearing from you at your earliest convenience.

Most cordially yours,

REV. MEARL E. HENLEY,
Johnsonburg Chamber of Commerce, Medical Committee.

HAZLETON, PA.,
March 12, 1968.

GEORGE A. ROWLAND, M.D.,
Pennsylvania Medical Society Placement Offices,
Taylor Bypass and Erford Road,
Lemoyne, Pa.

DEAR DR. ROWLAND: The Hazleton Branch of the Luzerne County Medical Society has recently become interested in the possibility of getting additional Physicians to come to our area to practice medicine; we have need of Specialties as well as General Practitioners. We decided that we in the Medical Society had best try to work at this problem among ourselves.

I sent for and received a kit of information from the American Medical Association, and noted your name as a discussor in one of the brochures presented, and thought that I would write to you directly about any further information that may be available to us. We are, I suppose, a rural area; the city of Hazleton itself has a population of about 35,000 and serves an area of perhaps 100,000 people. We have had some help from the Sears foundation in the past 2 years in attempting to obtain a General Practitioner for what is truly a local rural area in Nuremberg; two physicians have come, and both have left. This, however, is only part of our problem.

At any rate, what I am really most interested in is information that the Pennsylvania Medical Society can provide to help us; and perhaps even more, the possibility of discussing with you or someone with similar qualifications, directly among a committee of our Medical Society, what measures we may take to begin to present the attractions which our area offers to Physicians in general, and certain Physicians in particular to bring them here.

Certainly, we who practice here now, are almost unanimous in our conclusion that our choice was wise; there should be some way we can transmit this feeling to new young Physicians.

Yours very truly,

H. L. AUERBACH, M.D.

—

THE FIRST PRESBYTERIAN CHURCH,
Hawley, Pa., February 19, 1969.

PENNSYLVANIA MEDICAL SOCIETY,
Le Moyne, Pa.

To Whom It May Concern:

I am writing on behalf of the Rotary Club of Hawley, Wayne Co., Pa. We are deeply concerned about our lack of adequate medical care in our area. We have two Medical Doctors, both in poor health and unable to carry on a normal full time practice.

All the way from Honesdale, Pa. through Hawley and up to Newfoundland there are just these two Doctors.

What is the proper procedure for our seeking additional Doctors for our area? We are in a summer resort area considered a very attractive place to live.

We have heard of the Sears Foundation, but would like to know some of the first steps we should be taking before our situation becomes even more critical.

The Rotary Club would act as a sponsor for a new Doctor, and we would be interested in getting a small medical arts building constructed for the use of one or more Doctors.

Sincerely yours,

ROBERT W. L. MARK,
Rotary Past President.

—

HAMLIN, PA., *April 14, 1967.*

PENNSYLVANIA MEDICAL SOCIETY,
Placement Committee,
Taylor By Pass,
Erford Road,
Le Moyne, Pa.

GENTLEMEN: We are a community located in Wayne County, Pennsylvania, Salem Township in the Pocono Mountain range. At our recent Chamber of Commerce meeting it was strongly suggested that we try and have a physician locate in our town. In answer to a letter to Dr. Robert M. Bucher, Dean of Medicine, Temple University, he has suggested we contact your office for further help.

We are primarily a dairy and farm community, and are growing larger each year in population. The closest physician to our town of Hamlin is four (4) miles away at Lake Ariel, nine (9) miles at Newfoundland, or seventeen (17) miles in Scranton. We have our own school, all denominations of churches, and businesses. A physician who establishes a practice here would be kept quite busy.

What we are looking for is how to go about having a practicing physician settle in our town. Any advice or recommendations you might have regarding this request will be appreciated by all of our towns people.

It has also been suggested to us to contact the Rural Practice Commission of the Pennsylvania State Medical Society, however, we cannot seem to locate their offices.

Everyone here is in anticipation of some news regarding our situation in getting a physician, so anything you could possibly do for us will be greatly appreciated.

Thanking you for your attention, and waiting to hear from you with anticipation, I remain.

Yours truly,

EDWIN R. JAGIELSKI.

—

LE RAYSVILLE, PA.

To Whom It May Concern:

We have a need for a doctor in our area. Le Raysville is located in the northeast section of Bradford County, Pennsylvania. We are approximately sixty miles north of Scranton and Wilkes-Barre, seventy miles northeast of Williamsport, and forty miles south of Binghamton, New York.

Because of a previous commitment, our present doctor, Dr. Henry P. Brown, will leave to go into practice with his brother in New Hampshire on December 1, 1959. Dr. Brown has practiced in this area since 1953 and has established a very fine practice.

Le Raysville is a community with a population of 350 people. It is surrounded by the following towns: Rome, Potterville, Warren Center, Neath, Herrickville, Stevensville, North Orwell, Rush, Windham and the surrounding area which our doctor serves. This area is basically a dairy farming area. However, many of the inhabitants are employed by the local schools, Sylvania in Towanda, I.B.M. in Endicott and Owego, and by Bendix in Montrose, and other factories located nearby.

The closest doctors may be found in an approximated radius of eighteen miles around Le Raysville. There are doctors in Montrose, Laceyville, Wyalusing, Towanda, Sayre, Athens, and Nichols, New York. There are a number of hospitals to which a doctor in our area may send patients. (1) Robert Packer Hospital in Sayre, (2) Tyler Memorial Hospital in Meshoppen, (3) Tioga General Hospital in Waverly, N.Y. and (4) the new Memorial Hospital in Towanda, Pennsylvania.

In 1955 the people built a Medical Center in Le Raysville. This building consists of a waiting room, two examining rooms, a small laboratory, a supply room, two lavatories, (one in the waiting room and one inside the offices). In the back of the building are three rooms for a dentist, for which we also have a vacancy. This building has automatic hot water heat, oil fired boiler and is adequately wired for 110–220 volts. This building cost approximately $12,000 and has been paid for. We are now able to offer this building rent free for a year and not to exceed $30 a month thereafter. There is also a spacious basement that can be used for storage.

We have many good homes in which a single man could board or there are a number of homes available for a married man. We have a new high school of 400 students and there are four elementary schools in the district. The doctor also has the option on school physicals.

If you are or know of anyone who would be interested in this position, please contact William S. Davis, Jr., President of the Northeast Medical Center, Le Raysville, Pennsylvania.

LANDISVILLE, PA., *May 16, 1969.*

PHYSICIANS PLACEMENT SERVICE,
Pennsylvania Medical Society,
Taylor By-Pass and Erford Road,
Lemoyne, Pa.

GENTLEMEN: The town of Landisville, Penna. needs another general practitioner to properly continue our high standard of medical care. We would like to ask for your assistance by placing our town on your physician placement list which we understand is readily available to physicians planning to practice in Pennsylvania.

Thank you very much for your help in this matter.

Sincerely,

GERALD S. ALBRIGHT, M.D.

KNOXVILLE, PA.

ALLEN W. COWLEY, M.D.,
Secretary, Pennsylvania Medical Society,
North Front Street,
Harrisburg, Pa.

DEAR DR. COWLEY: The Women's Society of the First Baptist Church of Knoxville has instructed me to write to you for information concerning the correct procedure in obtaining the services of a physician. Our community of approximately 700 persons has been without a doctor since the illness and death of Dr. D. E. Lewis.

Sincerely,

ANNE P. LUGG
MRS. ROBERT S. LUGG.

THE COMMUNITY HOSPITAL,
Kane, Pa., March 6, 1967.

MR. DAVID H. SMALL,
Staff Assistant, Pennsylvania Medical Society, Physician Placement Service, State Street, Harrisburg, Pa.

DEAR MR. SMALL: The Community Hospital of Kane, Pennsylvania, is again in desperate need of a GENERAL PRACTITIONER. We have only four physicians at this hospital doing general practice and as of April 15, 1967, one will be leaving us to go to Kenya, Africa, to become a medical missionary.

Will you please send me a list of physicians who may be interested in our town and would you also place the name of our hospital on a list you may be sending out to physicians?

You have always been very gracious to us in helping our community obtain physicians and for that we are most grateful.

Again, thank you for any assistance you may give to us at this time.

Sincerely yours,

Mrs. Irene Carlson,
IRENE CARLSON,
Administrator.

NEWFOUNDLAND, PA.,
July 31, 1967

PHYSICIANS PLACEMENT SERVICE,
Lemoyne, Pa.

GENTLEMEN: As president of our local Women's Club, I am requesting that our community be placed on your list of communities needing a doctor.

We need one desperately. We are located in the heart of the Pocono Mountain Resort area; a very lovely spot, with many summer visitors. While we are rural, a doctor here serves much surrounding country.

If there is anyone interested, or wants more information, kindly contact: Mrs. Robert Robacher, Nefoundland, Pa., Pres. Greene-Dmeker, Woman's Club Crt., or Mr. Arthur Frey, Pres. Tobyhanna Lions Club, South Sterling, Pa.

We will greatly appreciate anything you can do for us.

Sincerely,

MRS. ROBERT ROBACHER.

INTERNATIONAL LIONS CLUB,
New Berlin, Pa., November 22, 1967.

THE PENNSYLVANIA STATE MEDICAL ASSOCIATION,
State Street,
Harrisburg, Pa.

DEAR SIRS: The Lions Club of New Berlin is endeavoring to obtain the community, have initiated a project to obtain a doctor for the area.

We had such a doctor in the person of Phillip Lankford, M.D., who served our community faithfully and well until Thanksgiving 1966, when he lost his life in a tragic airplane accident.

Recently the Lions Club, acting upon numerous appeals from persons in the community, have initiated a project to obtain a doctor for the area.

New Berlin has recently been selected as the site for the new SUN Vocational High School. A school which will serve the counties of Snyder, Union and Northumberland. We believe that this will become and added inducement for a general medical practitioner to locate in our area.

Would your office please supply us, as you did on another occasion, with the names of doctors who would like to locate or relocate in our area.

We would be very grateful to you for any assistance that you would be able to give us in this very worth-while project.

DONALD L. WETZELL, *Secretary.*

NEMACOLIN, PA., *February 12, 1968.*

PHYSICIAN PROCUREMENT,
PENNSYLVANIA STATE MEDICAL SOCIETY,
Erford Road, Harrisburg, Pa.

GENTLEMEN: It was suggested to us that we write to your society hoping that you can help us.

Our community of Nemacolin and The Buckeye Coal Company are desperately in need of a doctor as the former doctor, who had been here approximately twenty years, left this area the latter part of November 1967. There are two doctors in private practice in nearby Carmichaels, but the load is too great for them to absorb all the patients of our former doctor. As a result, sometimes it is necessary for one to travel approximately 25 miles, and then it is even difficult to get an appointment.

The Buckeye Coal Company owns a building (which in years gone by was a well equipped hospital) that has been used by the doctors who have been in this community ever since the hospital was closed down many years ago. There is a waiting room plus five other rooms and a bath that are for the use of the doctor. It is in good condition, and any repairs or painting is done by the company.

In order that a doctor could be available, the company is willing to lease these office rooms for the small monthly sum of $28, and this will include oil heat, water and garbage collection. There are also parking facilities near the office.

In addition to taking care of the accident cases at the Nemacolin Mine, the former doctor also served the Duquesne Light Company at Greensboro a few miles south of us. No doubt a new doctor could do likewise if he wished.

Good schools are in the area, and there are two churches in Nemacolin, one Protestant and one Roman Catholic.

We certainly will appreciate any help you can give us, and if there is any more information you might need, please feel free to contact us at once.

Yours very truly,

Howard Gevicy, President, Nemacolin, Inc.; Rudolph E. Gusich, President, Local 6290, Nemacolin, The Buckeye Coal Co.; Kenneth A. Forsyth, Timekeeper, The Buckeye Coal Co.; Alexander Scott, Safety Engineer, The Buckeye Coal Co.; Robert Ryland, Chief Engineer, The Buckeye Coal Co.; Joseph J. Klimek, Preparation Engineer, The Buckeye Coal Co.; Frank Orlosky, President Nemacolin Community Club; H. A. Gabeletto, President Nemacolin Fire Department; Mrs. Glennal M. Jones, Resident of Nemacolin.

Any information that you may have for us, please address it to Robert R. Ryland, Chief Engineer of The Buckeye Coal Company, Nemacolin, Pa. 15351. Anything you can do will most certainly be appreciated by the people who live in Nemacolin, as well as by the company.

I E INDUSTRIES,
Minster, Ohio, August 29, 1969.

Pennsylvania State Medical Association,
Harrisburg, Pa.

GENTLEMEN: I have accepted the Chairmanship of a local committee to secure physicians for our community. We are about to construct a clinic for this purpose, however, we are attempting to make contacts at this time.

I was informed that your department has a list of names which are anticipating taking their boards or have just taken them. In other words, physicians who are anticipating a move in or out of the state.

I would certainly appreciate anything you might have that would be an aid to us.

May we hear from you?

Very truly yours,

JAMES A. EITING, *President.*

CENTRE, HALL, PA., *August 16, 1969.*

PENNSYLVANIA MEDICAL SOCIETY,
Taylor By-Pass and Erford Road,
Lemoyne, Pa.

DEAR SIR: The Penns Valley Area Health and Welfare Association would appreciate your cooperation in locating a physician(s) to practice in the Penns Valley Area. A facility to house a physician is being considered at present. Such a facility will be fitted to suit the individual needs of the physician with certain limitations.

Penns Valley, a peaceful rural area with a population of 8,750 persons, is located midway between two universities, The Pennsylvania State University at State College, Pa., and Bucknell University at Lewisburg, Pa.

The Centre County Hospital has been located in Bellefonte, Pa., for many years. Ground has been broken for a new unit of the hospital near State College to be operational in the near future.

The personnal committee of the Penns Valley Area Health and Welfare Association would be happy to provide additional information. To obtain this information please contact the secretary of this organization:

Mrs. George Marcum,
Coburn, Pa. 16932

Very truly yours,

MRS. PHILIP H. BLAZER,
Personal Committee, Penns Valley Area Health and Welfare Association.

THE FULTON COUNTY MEDICAL CENTER,
McConnellsburg, Pa., December 12, 1969.

PENNSYLVANIA MEDICAL SOCIETY,
Physicians Placement Service,
Camp Hill, Pa.

GENTLEMEN: Our area is like every other community—we need physicians, we have three trying to serve about 16,000 people.

I am requesting you to place my name on your mailing list—

Thank you.

Sincerely yours,

BROOKS F. SMITH, *Vice President.*

STEWART'S REXALL DRUG STORE,
Punxsutawney, Pa., September 16, 1963.

PENNSYLVANIA MEDICAL SOCIETY,
State Street, Harrisburg, Pa.

GENTLEMEN: Residents of this area, consisting of some 25,000 persons, have a shortage of doctors, especially general practitioners. There are no doctors in the surrounding communities and those in Punxsutawney are badly overworked. For this reason, we are writing to you for help in interesting someone in coming here.

Punxsutawney is a very nice residential town, there are some very good homes available and excellent office rooms, also very good schools and a college, all

of which present a fine setup for families and young people. We believe that we have not only an urgent need but an excellent opportunity for physicians.

Something must be done to relieve our present medical situation, and any aid you may render will be appreciated by our local physicians and the community at large. Possibly you could talk with some of your men or give us the names of those who may be interested so that we may contact them.

May we hear from you?

Respectfully,

CHARLES J. RUMFOLA.

PENNRIDGE CHAMBER OF COMMERCE, INC.,
Perkasie, Pa., February 23, 1967.

PENNSYLVANIA MEDICAL SOCIETY,
Lamoyne, Pa.

To Whom It May Concern:

Are you interested in establishing a general practice of medicine in a rural community?

Do you wish to have the opportunity to live in a small borough, far enough to escape the disadvantages of city living, yet close enough to remain in contact with urban life?

Would you like to educate your children in an accredited public school system with completely new physical facilities?

All of these advantages and opportunities and even more, are available to you in Perkasie Borough, located in the northern portion of Bucks County. Since December 1, 1966, one general practitioner moved from the community to enter private industry and another general practitioner has died, leaving an urgent need for compentent medical doctors. The community needs you, and in turn, the community is also able to provide you with a most comfortable livelihood. Perkasie is a prosperous and growing town.

Perkasie is a rural borough having a population of approximately 5,000 people. It is immediately adjacent to U.S. Highway Route 309, twenty-five miles from Allentown. The vacation resorts of the Pocono Mountains and the Atlantic shore are easily accessible. We also have the local distinction of being in the historic and scenic section of Upper Bucks County.

Immediately adjacent to Perkasie is the rural Borough of Sellersville with a population of approximately 3,000 people. Serving this area and located just outside Sellersville Borough is the Grand View Hospital, an open staff community hospital which is about to embark on a program to increase its present facilities.

We are proud of our community and we would be both proud and happy to have you join us. If you are interested will you please contact the undersigned and we shall be glad to furnish additional details.

Very truly yours,

R. LLOYD WEISEL, *Secretary.*

COAL OPERATORS CASUALTY CO.,
Rockwood, Pa., October 28, 1968.

PENNSYLVANIA MEDICAL SOCIETY,
Taylor Bypass, Eford Road,
Lemoyne, Pa.

GENTLEMEN: I am Chairman of a Committee of the Laurel Hill Lions Club, which is commissioned to secure the service of a physician for our immediate area. This area is located in Somerset County, Pennsylvania, and is serviced by the Somerset Community Hospital.

I have been told that your organization can help us in locating a physician for our area. We would appreciate any aid or suggestions you might have along these lines. We would appreciate your comments.

Very truly yours,

W. A. THOMAS, *President.*

THE NUMIDIA CHARGE OF THE UNITED CHURCH OF CHRIST,
Catawissa, Pa., September 23, 1968.

PENNSYLVANIA MEDICAL ASSOCIATION,
Harrisburg, Pa.

DEAR SIR: I live in an isolated community in central Pennsylvania by the name of Roaring Creek Valley, Columbia County. In the 64.3 square miles we

have 2,291 residents who have for the last fifteen years found it increasingly difficult to secure medical help in times of need.

We are approximately ten miles from the nearest doctor which is in the community of Catawissa. It is necessary to cross a mountain range in order to reach help and in extreme weather, that natural barrier presents some real problems.

The physicians in the area seem hesitant to take on house calls when they are needed in our area and over weekends, it's extremely difficult to find a doctor at all. Most of our people have given up in their attempt to secure medical attention at certain times and rush their children or heart patients directly to Geisinger Medical Center which is a long 28 miles away.

In light of our problem, as I am sure there are many others in the state that have been brought to your attention, we are seeking advice from your association. The Planning Commission of R.C.V. has as one of its concerns, the health and welfare of the citizens and our major problem, next to poor sewage disposal, is medical facilities.

We would like to seek your advice as to how a community such as ours might proceed to hopefully lure a doctor to take up residence here. I understand there is a foundation which would assist us in a drive to establish a clinic facility but hearing of the problem encountered by Nuremberg, Pa., we are somewhat hesitant until we have further information. What advice would you have to offer us and what procedures have you found to be most attractive to doctors looking for a change?

Any help you might be able to suggest would be greatly appreciated.

Sincerely yours,

Rev. Henry C. Meiss.

Lycoming Valley Chamber of Commerce,
Trout Run, Pa.

Mr. Lester H. Perry,
Executive Director, Pennsylvania Medical Society,
Harrisburg, Pa.

We as the Lycoming Valley here are in great need of a general practitioner and I had written to the Department of Health, Education and Welfare, who referred me to you.

In the last year 2 general practitioners retired and nobody to replace them. Personally, I thought maybe we can request a Cuban refuge through Washington but I was referred to you.

As our Chamber of Commerce we would like to present our case and would be happy to come to Harrisburg to talk about this. If at all possible not on a Friday, but any other day is fine with us.

Will you please let us know?

Thank you.

Wiebe Jelsma.

Smethport Rotary Club,
Smethport, Pa., January 21, 1970.

The Pennsylvania Medical Society,
Lemoyne, Pa.

Attention Mr. L. Reigel Haas.

Gentlemen: Our medical coverage needs in the Smethport Area still require another medical doctor.

Our community is without a hospital and only one medical doctor to cover Smethport proper, the out-lying farm districts and the Sena-Kean Manor (A home for the Aged). The importance and urgency of another doctor is one of our uppermost needs.

Your continued effort in trying to find us a medical doctor will be most appreciated.

Thanking you, we remain

Very truly yours,

Edw. E. Carlson, *President.*

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C., October 21, 1969.

Dr. G. E. FARRAR,
President, Pennsylvania Medical Society,
Lemoyne, Pa.

DEAR DOCTOR FARRAR: In your capacity as President of the Pennsylvania Medical Society, I believe the contents of a letter sent to me may be of interest to you and the Members of PMS, and, hopefully, the combined efforts of all may be helpful in alleviating the condition as explained.

Although Mr. Bruno and the area of Renovo is no longer in my Congressional District, I feel the seriousness of the stated condition existing there warrants any assistance we can give. Mr. Louis R. Bruno is Chairman of the Hospital Committee in Renovo, Pennsylvania and he resides at: 436 Pennsylvania Avenue. His letter follows, in essence:

> This letter is an earnest and prayerful plea to you to use the influence of your office to alleviate a deplorable situation existing in our little community.
>
> We are in desperate need of immediate professional medical service. At present, there are only two part-time doctors in the entire western part of Clinton County. Neither of these are able to work as a doctor should because of their own physical limitations. Only one of these two has been willing to service the local hospital and recently he has voiced his intentions of retiring the first of October.
>
> We have, for the size of our community, a very fine hospital but it is of no value because we have no professional help (doctors) to service it.
>
> We have a new industry coming into our community, the Berwick Car Works. They expect to hire at least 200 men in the near future. This, I understand, is heavy duty work and we are concerned how the management will feel when they realize the absence of doctors.
>
> We (the Renovo area) comprise a total population, including other areas of Western Clinton County, of some 7,000 people. The nearest source of medical help (including doctors and hospital) is 28 miles away (Lock Haven). Should any emergency develop we would be practically helpless.
>
> Is there any possibility that, with the reduction of armed forces personnel, some of the doctors now serving military installations might be interested in coming to Renovo either on a temporary duty basis or willing to engage in a private practice in our area? If at all possible we would like to have at least three doctors.
>
> Attached is a clipping that was taken from the Renovo paper this evening. From this you can realize the critical stage we are facing. This is the only one of the instances that has happened in recent days.
>
> If a personal interview is necessary a committee from Renovo would be only too glad to meet with you.

It is altogether possible that you and other Members of your Society are aware of this situation in this mid-state area of Pennsylvania and perhaps have been turning your efforts toward some resolution of the problem, but I thought if anyone could give some advice and/or assistance in the matter, you and PMS would be the logical ones.

I will appreciate your consideration of this problem and will look forward to hearing from you at your convenience.

Thank you for whatever help or encouragement you may lend to this area of our State.

Sincerely,

HERMAN T. SCHNEEBELI.

KISKIMINETAS SPRINGS SCHOOL,
Saltsburg, Pa., January 31, 1968.

SECRETARY GEORGES,
Welfare Department,
Harrisburg, Pa.

DEAR MR. SECRETARY: I am writing at the suggestion of Mr. John A. Pidgeon, Headmaster of this private boys boarding school, to request your advice and counsel on a matter of the utmost importance to the local community in which this school is located.

The town of Saltsburg, Pennsylvania can claim a population of approximately 1,200 persons. It has been served by two devoted Doctors for a number of years. Recently one of these men suffered severe injuries in an automobile accident

which necessitated a long hospital stay and subsequently closed his practice of medicine. The other man, severely overburdened and approaching retirement, can not long be expected to cope with this situation.

Community leaders have met (including Mr. Pidgeon) and have made some attempts to attract young men to this area. Guaranteed income plans have been forwarded . . . but they just aren't attractive enough to entice a young man to start practice here. The group's thinking is now running toward the establishment of a medical center (on a small scale) for the community, in which a doctor could have at his disposal those staff members (perhaps volunteer and professional) and equipment designed to make his job a great deal less burdensome.

We are hopeful that you can (1) counsel us on the advisability of this plan of action, and (2) suggest any alternate plan that might better suit our particular situation. We are hopeful that you are in possession of more information on situations that are similar to ours, possibly situations which have been solved, and can therefore advise us as to the best possible plan to action.

We will look forward to hearing from you at your earliest possible convenience.

Sincerely,

C. Jackson Blair.

The Lemasters Charge,
The Evangelical United Brethern Church,
St. Thomas, Pa., November 27, 1966.

The Pennsylvania Medical Association,
Harrisburg, Pa.

Dear Sir: Our community has lost Dr. Ellis to the Letterkenny Army Deport. We are hoping to purchase his office for a replacement when we can find one.

Can you give us any suggestions of men who would like to serve a rural community as a general practitioner? Do you have any?

I have written this letter at the request of the citizens of St. Thomas.

Thank you so very much for your time and consideration.

Respectfully yours,

John W. Schildt, *Pastor.*

Zelienople Area Jaycees,
Zelienople, Pa., May 24, 1968.

Pennsylvania Medical Society,
Taylor Bypass, LeMoyne, Pa.

Re: Physician Placement Service.

Gentlemen: I note with interest an article in the April '68 issue of *Pennsylvania Medicine* that you have a Physician Placement Service for assisting communities that are in need of additional general practitioners.

Our area is faced with the critical situation of having only two doctors for a total population of 10,000 people. Could you please inform me as to what information you need from us in order that you may begin to try to help us with finding several doctors?

Thank you for your cooperation.

Sincerely,

Thomas R. Murray, Jr.

Youngsville, Pa., *August 28, 1969.*

Pennsylvania Medical Society,
Rural Placement Bureau, Harrisburg, Pa.

Dear Sirs: The members of Brokenstraw Grange #407 of Youngsville, Pennsylvania are interested in securing an additional Doctor to serve the people of our area.

We are interested in a general practioner and prefer one who would be willing to make house call when necessary.

Youngsville is located on route 6 in the center of Warren County and ten miles west of the city of Warren where the Warren General Hospital is located. The population of the boro of Youngsville is 2,200, and the surrounding rural area adds another 3,000.

At the present time there are two Doctors in our town they tell us there is a great need for another. They are willing to cooperate to the fullest extent with a new doctor if we are able to secure one.

Respectfully yours,

Robert K. Jameson, *Master.*

WILLIAMSBURG, PA., *September 27, 1967.*

TEMPLE COLLEGE,
Philadelphia, Pa.

To Whom It May Concern:

As chairman of the Community Action Group of Williamsburg, Pa. (Blair Co.) I am writing for information concerning where to write for information for a Doctor, Dentist and Pharmacist that would be interested in coming to a small industrial and rural community of 2200 residents.

Thank you Sincerely,
Your truly,

MRS. KENNETH R. SHOWALTER.

OCTOBER 5, 1968.

DEAR SIR. I seen your ad in the Pennsylvania Farmer about the book sent free if we need a doctor. Yes we need a doctor very bad, we had one for our community, but politics step in and gave him a better one then he quit our community. Dr. Cabla was a good doctor, every body loved him as far as I know, he did not bleed the poor people, like other ones do that I know, he was loved by all now we need another doctor. Can you help us, I am only a poor man, we are living on starving social security, but that doesn't stop us from having a doctor. Please send your information to Ralph Taylor, Market and First Street, Trevorton, Pa.

We love our Lord and Savior.

MR. LUTHER DERK.

—

PORTER-TOWER LIONS CLUB,
Tower City, Pa., August 4, 1963.

MR. DAVID SMALL
Pennsylvania Medical Society
Harrisburg, Pa.

DEAR MR. SMALL: We are in the process of trying to locate a doctor for our community. We have one doctor who is serving the entire community of approximately 5000 people.

I am advised by Mr. George E. Kauffman, Sec'y-Treas. of Pennsylvania State Council of Lions Club that you are in charge of the Physicians Placement Service of the Pennsylvania Medical Society.

Would it be possible to give us some information or advice as to the obtaining a doctor who would like to serve our community; any information you can give us will be appreciated.

Sincerely,

HARRY FISHER,
Lions International Counsellor,
Chairman of Civic Improvement Committee.

—

TELFORD, PA., *October 13, 1968.*

PENNSYLVANIA MEDICAL SOCIETY,
Taylor Bypass and Erford Road,
Lemoyne, Pa.

DEAR SIR: How does a rural community in need of a doctor go about finding one?

May I request booklet by the American Medical Society prepared to provide background information and offer suggestions.

Kindly write to the above address, or telephone me at Code Area 215–723–9532.

Sincerely yours,

ELIZABETH DETWILER.

—

ARMAGH, PA., *January 22, 1970.*

PENNSYLVANIA MEDICAL SOCIETY,
Lemoyne, Pa.

DEAR SIR: The people of the Bolivar and Robinson Area, which is located in the Southern part of Indiana County, Pa. 50 miles east of Pittsburgh, have been trying to bring a doctor to their medical center, located in Bolivar. The building is fairly new and semi-equipped. The problem is that, of the three doctors, all have left, for a better position and work conditions. It seems that when a doctor becomes settled here, he becomes overworked, because of the demand of the medical care of the people.

I am a VISTA Volunteer working in this area. The people brought this problem to me and ask me to help them with it. From contacting the American Medical Association, I received you as a reference. If you can help us acquire a doctor for this center, please let me know. My address is: Lee C. Schweitzer, Box 109, Armagh, Pa., 15920.

Sincerely,

LEE C. SCHWEITZER.

CRESCO, PA., *July 25, 1969.*

Hon. HUGH SCOTT,
U.S. Senate,
Washington, D.C.

DEAR SENATOR SCOTT: I am writing you on behalf of our neighborhood—specifically, Barrett Township of Monroe County—in the hope that somehow you might be able to put us in touch with some young physician who evidences competence and who might be attracted to an assured practice here in the Poconos.

Granted, this hope sounds a bit preposterous, but you are respected, and influential, and you know and love the Poconos. For example, through your personal contacts and those of your staff, you might find someone in one of the three Military Services who could locate a young doctor who is completing his tour of duty and who would welcome a future with us.

Our predicament stems from a recent turn of events. We had two good general practitioners here: Dr. Harold Tattersall and Dr. Carl Broock Weiss. Dr. Tattersall has all the patients he has the strength to endure, and so did Dr. Weiss until the results from two independent physicals indicated that he could no longer continue his long hours. He tried to find an assistant, but couldn't. So, reluctantly, he has closed his office—and we of the area are very concerned about the situation.

No one could expect Dr. Tattersall to take on any more patients—nor can Dr. Headrick over at Mt. Pocono. Dr. Horn, at Tannersville, has given up his practice, too. Which means that about the only thing left for a lot of us, when we get ill, we must drive down to the Monroe General Hospital in East Stroudsburg and wait our turn in the Emergency Room until a young intern who knows nothing of our case histories can have a look at us.

Mr. John Horsman, President and General Manager of the Buck Hill Falls Company, of course, is leaving no stone unturned. It's not a happy situation for the guests at all of our resorts to be without the services of a doctor in the area. But to date, we haven't succeeded in finding a candidate. We could use two or three men.

In this day and age, one almost despairs of finding a general practitioner. But if we could locate a competent internist and a pediatrician to start with, we could build from there. The resorts, The Service Clubs, the Township Supervisors—all the residents of the Township—are concerned. And certainly there are enough people here with better than average incomes who are ready to assure the physical facilities necessary for the doctors.

For the nonce, we're pleading for one good doctor. We ask for your support, and counsel.

Cordially,

ROBERT A. IDE.

Senator KENNEDY. Can you give us an estimate of how many communities don't have general practitioners in the country?

Dr. KOWALEWSKI. I could not say. I am coming to some statistics that may relate to that.

In 1968, the AMA's Physician Placement Service received 208 requests from family doctors seeking job opportunities, while 1,060 opportunities were offered. In the same year, the Placement Service received 448 requests from surgeons seeking opportunities, while 170 opportunities were offered, and 224 requests from obstetrician-gynecologists, while 158 opportunities were offered.

I would like to make one additional point before discussing the reasons I believe, and the American Academy of General Practice believes, that Senate bill 3418 is a necessary first step in increasing the number of physicians providing patient care as family physicians.

The American public has continued to rely heavily on the family physician, and has made this reliance known by ever-increasing patient demands on the family physician. According to statistics published in the January 5, 1970, issue of Medical Economics, a survey conducted in June of 1969 indicated that general practitioners averaged 179 patient visits per week, whereas general surgeons averaged 116 patient visits per week, ob-gyn specialists averaged 122 visits per week, and pediatricians averaged 155 visits per week.

Further proof of the public's demand for family doctors may be seen in recent actions taken by State legislatures in New York, New Jersey, Illinois, Kentucky, and North Carolina. In these five States, laws have been enacted requiring State supported medical schools to establish departments of family practice. In the two States most recently enacting this type of law, Kentucky and Illinois, the proposed bills passed the houses unanimously, and the senates with one dissenting vote in each State.

This, in itself, can't be seen as the solution to the problem, in view of the fact that funds still must be provided to establish and maintain these departments. This can be viewed as a positive indication that the public is beginning to demand appropriate action by Government to insure the training of additional family physicians.

To this point, I have attempted to explain the situation as it exists, and the reasons the present situation is undesirable. I would now like to make a few comments regarding the potential impact of Senate bill 3418 on this undesirable situation.

It is imperative that funds be made available on a categorical basis for training family physicians.

I have already spoken of the medical school trend toward research, with a resulting emphasis on limited specialization, which has become self-perpetuating. By simply increasing the amount of Federal funds avialable to medical schools, one has no reason to expect that medical schools will establish departments of family practice. Rather, the supposition would be that medical schools would tend to strengthen those departments and programs already in existence.

On the other hand, if funds are specifically earmarked for establishing family practice programs, that is the purpose for which they will be used.

If the supply of family doctors is going to be increased, it must be done at the level of the medical school and teaching hospital.

S. 3418 provides the mechanism for insuring that more physicians will receive residency training in family practice at either the university medical center or the AMA-approved teaching hospital, and also for insuring that medical students will have adequate exposure to family practice at the undergraduate level.

This exposure at the undergraduate level is vitally important if we are to expect medical students to enter the field of family medicine. I have stated that in the past, few, if any, medical school faculty have had experience as general practitioners. Students tend to identify with their instructors. Consequently, it is understandable that the number entering family practice training programs after 4 years of medical school is very low.

S. 3418 makes it possible for medical schools not only to provide residency training programs in family practice, but to set up depart-

ments of family practice with which medical students at the undergraduate level may identify.

We have had much experience to support this. It is of vital importance. Through exposure to these departments during the first 4 years of medical school, it can reasonably be predicted that increased numbers of students will enter hospital or medical school residency programs in family practice.

The legislation which you are considering here today provides for the training of paramedical personnel in family medicine. This is desirable in that there is a definite need for paramedical personnel trained specifically to assist family physicians.

For the same reasons that departments of family practice must be established through categorical grants, the training of paramedical personnel must be done through categorical grants.

I have included in the written testimony which you have before you figures indicating the number of programs which could be established under the sums authorized by this legislation.

For the sake of time, I will summarize this part of my statement.

It should be noted in arriving at final figures, no amounts were allotted to planning grants or for the training of personnel to head departments of family practice.

Based upon estimated costs of $300,000 for establishing a program, and $250,000 for maintaining a program, 6 years after the funds authorized by this bill are made available, 4,840 physicians will have graduated from family practice residencies, 310 hospital residency programs, and 85 medical school programs would be producing 1,600 family practice residents per year.

This is not an overabundant program, when you consider, for example, the fact that there are 416 residency programs in internal medicine, and 393 residency programs in general surgery.

Gentlemen, I have attempted today to give you some idea of the feeling of the American Academy of General Practice, the practicing physicians, and people of the grassroots of this country as to the future practice of medicine in this country.

I firmly believe that the enactment of S. 3418 will prove invaluable in providing additional doctors whose primary function is to take care of people.

I would now like to touch upon the amount of funds which would be authorized by S. 3418. I should preface my remarks with the statement that the figures which I will be using are estimates which are subject to many variables in different situations.

Based upon an approximate cost of $300,000 for establishing a department of family practice in a medical school or teaching hospital, 40 medical schools and 130 hospitals could establish programs during the first year for which funds are authorized. This would cost $51 million.

The cost of maintaining these programs would drop to $250,000 after the first year. Although construction costs will not exist after the first year, additional residents would be added to the programs, thereby making the net decrease in funds only $50,000. To maintain the original 170 programs during the second year would cost $42½ million. Twenty new medical school programs and 80 new hospital

programs could be established during the second year at a cost of $30 million. Total costs for the second year would be $72½ million.

During the third year, it would cost $67½ million to maintain the 270 existing programs. Fifteen new medical school programs and 90 new hospital programs could be added the third year at a cost of $31½ million. Total costs for the year would be $99 million.

During the fourth year, it would cost $93¾ million to maintain the 375 programs in existence. Ten new medical school programs and 10 new hospital programs could be added at a total cost of $6 million. Total expenditures for the year would be $99¾ million.

During the fifth year, it would cost $98¾ million to maintain the 310 hospital programs and 85 medical school programs in operation. It is not anticipated that there would be any necessity for establishing new programs during the fifth year.

Based upon a family practice residency program with four residents, 680 physicians will have received residency training after 3 years; an additional 1,080 will have received their training after 4 years; an additional 1,500 after the fifth year; and, an additional 1,580 after the sixth year. Since no new residency programs were added during the fifth year, the figure of 1,580 per year would remain constant after the sixth year.

Six years after the funds authorized by S. 3418 have been made available, 4,840 physicians will have graduated from family practice residencies—310 hospital residency programs and 85 medical school programs will be producing 1,580 family practice residents per year. This is not an overabundant number of programs when you consider, for example, the fact that there are 416 residency programs in internal medicine and 393 residency programs in general surgery.

I would like to reemphasize my earlier statement that the figures of $300,000 for starting a program and $250,000 for maintaining a program are estimates, subject to several variables. In arriving at these figures, no amounts were alloted to planning grants or for the training of personnel to head departments of family practice.

I should further point out that, after 3 years, hospital residency programs will generate income of their own which may reduce the amount of outside funding necessary. It is hoped, however, that after 3 years, the hospital residency programs will be expanded to graduate more than four residents per year. If this happens, much of the self-generated income will be used to expand the hospital programs.

I have attempted today to give you gentlemen some idea of the feelings of the American Academy of General Practice regarding the future of family practice in this country. I firmly believe that the enactment of S. 3418 will prove invaluable in providing additional doctors whose primary function is the care of people.

Thank you for giving me the time to appear here in behalf of the academy. If you have any questions, I will be happy to answer them at this time.

The CHAIRMAN. Thank you for your very comprehensive statement. I have a few questions.

Senator Kennedy, do you have any questions?

Senator KENNEDY. No, sir.

Senator SCHWEIKER. Yes.

The CHAIRMAN. Go ahead.

Senator SCHWEIKER. Thank you, Mr. Chairman.

Doctor, in your statement, you say 85 percent of the illnesses can be treated by the family practitioner. What do you base this on? How is this arrived at?

Dr. KOWALEWSKI. I think this is a very good question.

We have had a constant study of this for the past 20 years We have had reviews within the academy, and we have based the new concept of family medicine on what we call the core content of family medicine. This clearly delineates all the activities of the family physician.

As you know, sir, basically we are a specialty of breadth. We need specialists in depth. However, to serve the needs of the people, we must be well trained in the five basic areas of medicine: internal medicine, obstetrics and gynocology, pediatrics, surgery, and psychiarty.

Now, we fully recognize, sir, that the needs of medicine, and the needs of our people all over this country are very, very different, and in some areas a resident in family medicine would not need a lot of surgery, but I tell you gentlemen that there are parts of this country where if the family physician did not do surgery, doing it well, and qualified to do it, the people in his area would have a lack.

Senator SCHWEIKER. For the specialty of family practice or family medicine, how long is the length of residency, and how does this compare to the other specialties?

Dr. KOWALEWSKI. Mr. Schweiker, the length of the residency at present is 3 years.

We are not certain, sir, in all honesty, that this is the proper period of time, but I call to your attention that as one of the mechanisms of establishing a specialty in this country, you have to comply with the status quo of what others have been doing.

We hope, sir, that after some observation we would be able to reduce this period of time, but in this stage of development, especially if you recall it is only 15 months that we have been a recognized specialty, there are many innovations that we would like to make as we develop, but at this stage of the game, we could not do that.

Senator SCHWEIKER. Are the other specialties a comparable period, 3 years?

Dr. KOWALEWSKI. Yes, sir. Most are comparable.

The trend now is—and it will take a little time, the AMA is on record, and all those interested in residency training are interested—there will be no internship per se. All post-M.D. education will fit into the 3-year residency program.

Senator SCHWEIKER. What is the view of the American Academy now on the house call? Where does the house call fit into family practice, in your judgment?

Dr. KOWALEWSKI. With your permission, I am going to allow Dr. Price to take a shot at that.

Dr. PRICE. Senator Schweiker, the house call does play an important role. Without any question, the increased demands on our time have given us less available time to do this than we might have had 20 years ago, plus the increase in more sophisticated diagnostic techniques that we now have may not be applicable to use in the home.

However, having made a half dozen house calls in the last week myself, house calls are here to stay, as far as we are concerned, for certain

sorts of ailments, certain patients, certain conditions. We do have to be selective.

Senator SCHWEIKER. I gather the family practitioners probably are the only ones that do made house calls today. Is that an accurate statement?

Dr. PRICE. Primarily, sir. I know that many other specialists do, but not perhaps to the same extent or number that we do.

Senator SCHWEIKER. What is that?

Dr. PRICE. Men in other specialties do—pediatricians, internists—but not to the same extent. I heard a lady this morning speak of a dermatologist making a house call. Other specialists do.

Senator SCHWEIKER. I have one last question.

Will the shortage you pointed out of family practitioners force the house call to decline further, for the reasons you just mentioned? In other words, with the more efficient use of the physician's time, with more and more patients to serve, it is obvious he can see a lot more people in his office as opposed to traveling.

Will this further restrict house calls, just by the necessity of serving more people on a narrow base of family practitioners?

Dr. PRICE. Yes, sir, it will. By that time, if there are not family physicians available, there will be no house calls.

Senator SCHWEIKER. In your thinking, how can we be certain that we do get some relationship, after training these men, to the need of a community? In other words, the question was asked before, how many communities don't have family practitioners. Once we set up a training program, what mechanism or what can the bill do in terms of assuring, if it is feasible, that these people will go where they are needed?

Dr. KOWALEWSKI. That is a very good question in depth.

To date, young physicians have not been adequately prepared to go into a community where are problems. I say that because I believe it is an evolutional thing, but we have come to the point now in the new area of family medicine where we are not only going to teach the science of medicine, but we are going to teach individuals to learn about the behavior of people. They are going to be exposed to people as patients from the very first day of the medical school.

They are going to be given responsibility. They are going to live with people. They are going to have preceptorships in small communities. We are, sir, going to build a man of strength.

This has been our problem in medical education. We have not had individuals who felt comfortable with people. I pointed out to you, sir, that the complexity of the family requires special education. We are determined to do that.

We are firm in the belief that America must have one class medical care for all, and we believe that with the provision of a strong primary—care physician, who is the first person to see the patient, we will be able to guarantee that that person has rapid care, economic care, and eventually the best care possible.

Senator SCHWEIKER. Thank you very much, Mr. Chairman.

The CHAIRMAN. Doctor, has there not really been a tendency in the past years in the medical profession to treat the surgeon as the man with special competence, and the general practitioner as a man with less competence? Has that not lead to the decline of the general practitioner?

Dr. KOWALEWSKI. I think so, sir. But in all fairness, on the other side of the coin, we need this specialist in depth.

The CHAIRMAN. I agree with you.

Dr. KOWALEWSKI. We need him, and we need him to support us. But we family doctors also need recognition, especially in the case of the young man—and I should like to say here that we are not concerned about ourselves. We are fixed—but we know, and are in daily contact with medical schools and with medical students, and to them this is important. That is one of the reasons why we made the strong effort to obtain a board of family practice.

If this man is specially educated in the area of family medicine, then let him be recognized, let him be given equal recognition.

The CHAIRMAN. Talking to my own family doctor and other doctors, it seems to me that the family doctor requires aptitudes that a specialist may not have to have in dealing with people. Sometimes a family doctor, if he goes to a home on a call, comes to a divided family, divided on whether they want medical care or not. They may have religious beliefs. Some of the families are against medical care, and some are not. If a doctor comes into a house where there is an ill person, there is a bitter dispute whether they want him in the house, because of this.

There are other doctors who get calls, and they may arrive to find that there is a narcotic addict who wants to get him out there and try to get narcotics from him.

It seems to me a general practitioner who receives a call from a person they do not know is very hesitant to go there because of situations that can develop.

The family doctor has to be more of an all-around person in understanding people practically than anybody else in the profession, excepting maybe a psychiatrist.

Dr. KOWALEWSKI. Senator, one of the things we must provide for our people is an easy entry into the medical care system. This can be done by having a sufficient number of family physicians all over this country, and especially in the areas of need, such as the rural, the urban, the ghetto. We must make it easy for that person to identify with the family doctor. This is extremely important.

I would like to make one correction of an answer that Dr. Zapp gave, probably inadvertently, that 1,600 people were grandfathered into the American Board of Family Practice. This is not so. These men were board certified by special examination. And in that same vein, we are the first specialty in this country to guarantee quality to the American people; we require recertification within 6 years. This, we feel, is an expression of responsibility to the American people.

The CHAIRMAN. That is the reason I asked those questions.

I don't think that the general practitioner is any less of a qualified person, if he is really qualified, than your surgeon. He must have a great aptitude for dealing with people and I think the problem of dealing with people is one of the more difficult of all problems in general.

In your statement you talk about the rise in hospital costs, and the law of supply and demand. Doesn't insurance have a lot to do with that, too? People buy insurance policies to take care of the health costs, and insurance is generally written that it is payable only if a person enters a hospital.

I doubt that most people can pay a hospital bill without having insurance. Some people say the doctors told them in the hospital they don't need it, but from my observations these doctors are charitably inclined, they may stretch a point to help their patient get care that they can't otherwise get, because of the way the policy is written.

I think we need an examination into this whole question of insurance for medical care. The doctor is faced with a dilemma. This person is not able to pay for medical care without being hospitalized. Shall we put him in the hospital before he needs it, or shall we wait until his condition deteriorates and he gets sick enough so that any doctor will say he has to go to the hospital, and he runs up a bigger bill? I think the doctor is in a dilemma because of the way the insurance policy is written. The doctor thinks, "I am not going to let him deteriorate here, whether it is TB or diabetes, until he has to go to the hospital." I think we need to reexamine the way the hospital policies are written under the health care program in this country.

Doctor, what do you think is the most essential thing needed to provide for the health care of our people today?

Dr. KOWALEWSKI. Today we have got to recognize a very important factor, and I would like to quote something that Dr. Stewart, the present chancellor of the Medical School Center of Louisiana State University and former Surgeon General of the United States, said:

> The main reason we are in a state of crisis in health care service in this country is that we have failed to give adequate consideration to the basic health care service needed by the patient and his community.

He further stated that:

> None of the presently considered possible solutions will solve our problem unless we have a redistribution of our medical resources toward these basic health care needs of our people.
>
> And I say that we have gone overboard on institutionally based medical care. We have been obsessed with the rare and the dramatic. We have grafted, and we have transplanted for the few at the expense of the many.
>
> We have passed the necessary plateau in the development of medical care in this country, which rightfully concerned itself with the dramatic, lifesaving, crisis-oriented, special disease-entity phase, and balanced effort, of course, will have to be continued in this area. But now we have come to realize that if we are going to further improve medical care for more people, we will have to devote increasing efforts to the improvement of the quality of life, and this could best be done through the family practice concept of medical care.
>
> This is the highly important, undramatic, unglorified, day-by-day activity which has to do with close patient-doctor relationship with the comprehensive and the holistic approach, where the family physician as a human being uses himself to help other human beings with the art and attitude of medicine, and the preventive care aspect of medical care.
>
> I say that the measure of the eventual quality, effectiveness, and cost and rate of care is directly proportional and dependent on the high quality and availability of the first medical professional to see the patient. Therefore, more properly-trained, high-quality primary physicians, decentralized, practicing in effective groups where the patient is, is the answer.

The CHAIRMAN. Thank you.

How many departments of family practice are in existence today?

Dr. KOWALEWSKI. We have in the neighborhood of seven fully established departments that are operational and approximately that many more under consideration. We have a total of about 40 medical schools who are in some way or other involved in preparing for this area.

But I must say without any hesitation here, having been involved very closely at the medical school levels all over the country, and with the medical students that I have not seen these moneys which were alluded to by the previous witness.

The CHAIRMAN. You don't see that money coming into those medical schools?

Dr. KOWALEWSKI. It is not there. The schools and the students are begging us, as you will have testimony tomorrow, to get the money somehow, because there is the student interest, and there is the medical school interest, but they don't have the money.

The CHAIRMAN. I have asked Dr. Zapp and Dr. Endicott and Dr. Bucher here to file a report with us this week showing exactly where it is.

I had another question, and I believe you have already answered it in your primary testimony, as to why you think there is a need for separate and coequal departments of family medicine in medical schools, if we are going to produce these family physicians. It is to give prestige that the surgeons and the other specialists now have?

Dr. KOWALEWSKI. Sir, it is more than that.

We in the general practice area have gone down the blind alley of trying to produce family doctors in a nonspecialty department. We have had much experience showing that it does not work, because the department is set out in a corner in the medical school. It does not work.

But we do have experience in the last 15 months with schools setting up primary areas of family practice. The student interest is tremendous. The interest on behalf of new teachers of family medicine is tremendous.

In other words, sir, we want departments, distinct departments, because we have had much experience dictating that this be done. We have been down the blind alley once. It doesn't work.

The CHAIRMAN. I grew up in a simple society where there were three main groups of educated people on whom the people relied in different communities. One was the preacher, or priest. Another was the family doctor. The third was the schoolteacher.

Now we have had all kinds of reports that schools are inefficient if they don't have, say, in a high school, about 1,500 people, so the schools are consolidated, and the children are carried away from the community. The preacher or priest is still there, but the family doctor is gone.

I think that is one reason for the deterioration of family ties and relationships in America, and many of the other things which strengthen the family.

I want to commend you for this move to bring back the family doctor. I think it strengthens the whole family, not merely medicine, and helps alleviate this great need for health care. But I think it also strengthens the family, the family relationship, and the community.

Dr. Price, do you want to comment on the need for this department? Do you have any additional remarks? You are the speaker for the house of delegates.

Dr. PRICE. Yes, Senator, I do.

As Dr. Kowalewski has said, in the past we have had general practice residencies, which to a large extent covered much of the area that we are now covering with the family practice residency. However, the students in these residencies became second-class citizens. They would go on service, perhaps a surgical service, and the head of the department was more interested in teaching his surgical residents than the general practice resident who at that time happened to be on surgery.

This same thing was repeated through every service, and this second-class citizen lost his zeal for this endeavor, and the residencies by and large became defunct.

We do not want to go down that same track. Whether or not we get departments may well determine our ability to keep from going down this old track.

The CHAIRMAN. What is your opinion on the necessity for training programs for physician assistants to be included in the bill? What about physician assistants? Does the family doctor need those as much as the specialist in the hospital, where he is coming in as a great surgeon?

Dr. PRICE. Yes, sir. Dr. Kowalewski's testimony points out the number of patient calls per physician. Here it is given as 179, I believe, for the general practitioner, and something like 120 for the limited specialist.

He needs them. The place where this should be done, where these people should be trained, is that same place where we are training the family physician, so that the physician's assistant will know what is expected of him, know how best he can help the family physician. The same facilities would be in use, and by and large the same instructors could be used, so I think they should be trained at the same place at the same time.

The CHAIRMAN. Thank you.

I have one other question. What is the situation as relates to the availability of health care in your State of Colorado, where you live?

Dr. PRICE. I was born in the town of Brush, where I have practiced the last 18 years.

The CHAIRMAN. Where is it located?

Dr. PRICE. Brush is in the northeastern corner of the State, and on the plains. It is flat. We are in the midst of a lush irrigated valley.

When I first moved there, and for the first few years we were there, there were five physicians, all general practitioners. Now there are two, my partner and myself. The population has not changed that much.

The county, that had 16 doctors when I first got there 18 years ago, now has 10, again all general practitioners.

Statistically, we can be fooled, because Colorado enjoys, along with four or five other States, the reputation of having more doctors per capita than other States in the Union. This is misleading, because these physicians are located along the foothills, in the metropolitan areas. We have the large medical centers, which have many doctors, that don't see patients, but still show up on our statistics.

Our rural areas are badly in need of physicians, of general practitioners, also. Fortunately, the people there, if they can't find a family doctor, usually can find somebody else, but in the rural areas they can't.

In the last 3 years, our community has twice been isolated by floods for periods of 36 hours. Any medical care given within the community had to be given by general practitioners. Without us, no care would be given.

The need is great.

The CHAIRMAN. A few months ago I visited Eagle Pass, a city in Texas on the border of Mexico on the Rio Grande River, 15,000 people, where they dedicated a new hospital. There were four doctors there. There had formerly been many more. It is a county seat in an area of ranches and small towns where there are no medical doctors.

There were formerly a number of Anglo doctors. The one Anglo doctor left is over 80 years of age, still practicing. He went there as an Army doctor with an infantry regiment, when Pershing was on the border in 1916. We liked the town and stayed.

The other three doctors are all Mexican-Americans, all graduates of medical schools in Mexico who came over and were licensed in Texas.

We are not turning out doctors to treat our own people. These three young doctors who have come in are from Mexico. Otherwise there would be only one doctor in a city of 15,000 people.

Are there any further questions?

Senator SCHWEIKER. I would like to ask Dr. Kowalewski whether he has any suggestions, or the academy does, as to how we might recruit more minority doctors in terms of our blacks and Puerto Ricans and Mexican neighborhoods in terms of the family practice concept.

Do you have any suggestions or ideas or anything you can recommend to us that your academy feels is essential to solve this problem?

Dr. KOWALEWSKI. Yes, Senator Schweiker, this is a very important area.

I would make a few suggestions. First of all, we have to be very certain in our recruitment of all medical students—no matter what race or what area of social concern—that we will have a place for them in medical school. We have even at the present time up to six good, qualified applicants for every one place. So we have to address ourselves to this.

Senator SCHWEIKER. Nationally, 6 to 1?

Dr. KOWALEWSKI. This is about where we are.

Senator SCHWEIKER. You mean six applicants that could pass the standards of the school?

Dr. KOWALEWSKI. Qualified applicants.

Senator SCHWEIKER. Only one of which can get in?

Dr. KOWALEWSKI. Only about one can get it.

Now, we recognize the difficulties the medical schools have had. But what hurts me—and it hurts me every year many times because of my position in organized medicine—is that young men who have devoted their high school and college preparation to go into medicine, who want to help humanity, and who are fully qualified, get to this point, and then cannot get into medical school.

At the very same time, from the other side of the mountain, we are saying we need more physicians.

Now, the Student American Medical Association, with our assistance and the assistance of the American Medical Association, is going to make a great effort to go out and encourage young people, in high

school and in college, to get themselves prepared, to assist them in every way possible.

We in the American academy are willing to go down this line all the way, to find these people who need assistance, but we have to start far down.

At the very same time, I do not want to bring any youngster up, of any color, of any creed, having prepared himself, bring him to this point, and then let him dangle. We can't do that. We must not do that.

The CHAIRMAN. Doctor, in my own State, in the fall of 1968, the medical societies certified 1,300 young men as qualified to enter medical school. They had the requisite high grades, good moral character, recommendations from their own medical society that thought they had the attributes and characteristics that a doctor ought to have, and the stability.

Of that 1,300, 400 were admitted to the four medical schools in Texas. I think this dramatically illustrates what you are talking about.

Now, that same year, the entering medical class of the University of Guadalajara, in Mexico, included 600 from the United States, a good many from my State.

Many who grdauate will be glad to license themselves in the United States. Even though we consider their education inferior to ours, we will be glad to license them, because over 20 percent of all our interns in the hospitals are graduates of foreign medical schools, and over 30 percent of the residents.

I have talked to the people in medical schools in Texas. They talk about, "we are going to admit 10 percent more." Where we had been admitting a hundred to an entering class, they say this is great, we are going to admit 110.

Why, I think that is chickenfeed. They ought to admit 150, at least. They are not stretching themselves to admit 10 more.

I think the people running the medical associations and medical schools are playing tiddley winks with health care. When I was to the Parliamentary Union at New Delhi, we were told in Tashkent, at the university they founded there in 1920, they have 15,000 students. They have 7,500 of them in the medical school.

Of course, that includes subjects that we have in separate schools such as dentistry, pharmacology, and so forth, but it comes under medicine. That requires college degrees.

They export medical care to the underdeveloped nations of the world, while we are not producing enough for our own needs.

I personally think that the society that furnishes medical care to the people of the world is apt to make more progress in influencing the people of the world than the society that drops the most bombs on them.

I think we need a reorientation of priorities in this country to put more money in medical education.

Dr. KOWALEWSKI. Senator, I have a more detailed answer for you, and if you will permit me, I will include it as part of my testimony.

(The information referred to follows:)

HOW TO FULFILL THE URGENT NEED FOR MORE DOCTORS, NOW

The most important single factor in solving any of our health care problems today, *is the shortage of medical manpower*, especially physicians. To date we have made only token inroads to alleviating this problem. I believe that *today without*

the necessity of having to lay one new brick we can produce more doctors if we do the following:

1. All of us must be aware of the *great numbers of highly qualified dedicated young people who want to be physicians,* but yet are denied entry into medical schools every year.

2. We must have every one of our *medical schools reaffirm the fact* that their *main purpose for being is to educate physicians.*

3. *Necessary changes,* based on high quality and broader participation in the methods used *by medical school admission committees are long overdue.* Antiquated admission methods have proven to be stumbling blocks to more meaningful student selection.

4. To more adequately utilize all of the facilities and teachers in our medical schools today—*We can have two concomitant classes running staggered.* By this one step alone, and without the addition of one new brick, we could double our output of physicians. Efforts to establish new medical schools, and for additions and replacement of old schools should be pursued at the same time.

5. We should recognize that there are basically *two types of medical school candidates and interests.* One is oriented basically to the *care area of Medicine*", the other toward the "*Research or Academic* areas". Both are fine and necessary interests and must be pursued. But the research academic interest does not need as much of the clinical materials and clinical facilities which could be more efficiently used in the care area, and the degrees offered in the research academic pursuit area need not be an M.D. degree.

6. *Time spent by the student in school is a most essential consideration.* Therefore, why not permit the student to progress at his own rate and capability. Let him fulfill the established requirements and graduate sooner, rather than have him adhere to a fixed, time honored period which is unrealistic because we all do not learn at the same rate.

7. *All of organized medicine,* especially the strong important voice of the practicing physicians, *must openly come out to work for the financial support of our medical schools,* so that medical schools do not have to rely on "*research funds*" for support—thereby sidetracking their main purpose for being, namely education.

8. *Medical schools,* to justify any request for funds from society *Must put their financial structures in order.* At present many of them could not support such requests because of this deficiency.

9. In the final analysis—health care, which includes the production of medical manpower, and most importantly physicians, can be improved only to the extent that society—*The American Public as a whole—places a high priority on achieving first-class health care* for all of its citizens, in a spirit of reason and without the emotion charged, often politically motivated backdrop of the recent past.

EDWARD J. KOWALEWSKI, M.D.,
President, American Academy of General Practice.

1931–67 DISTRIBUTION OF PHYSICIANS BY MAJOR PROFESSIONAL ACTIVITY AND SPECIALTY

Total physicians [1] (100 percent)	Total non–Federal	Total non–Federal patient care	Total private practice	Private practice general practitioners	Private practice specialists	Hospital service	Administration, research medical school faculty	Federal service
1931:								
150,425	146,874	143,974	134,274	112,116	22,158	9,700	2,900	3,551
Percent	97.6	95.7	89.2	74.5	14.7	6.4	1.9	2.4
1940:								
165,290	160,497	157,148	142,939	109,272	33,667	14,209	3,349	4,793
Percent	97.1	95.1	86.5	66.1	20.4	8.6	2	2.9
1949:								
191,577	179,041	175,304	150,417	95,526	54,891	24,887	3,737	12,536
Percent	93.5	91.5	78.5	49.9	28.7	13	2	6.5
1959:								
225,772	208,253	200,322	160,592	81,957	78,635	39,730	7,931	17,519
Percent	92.2	88.7	71.1	36.3	34.8	17.6	3.5	7.8
1967:								
294,072	266,520	249,273	190,079	62,757	127,222	59,194	17,247	27,552
Percent	90.6	84.8	64.6	21.3	43.3	20.1	5.9	9.4

[1] Total physician figures exclude those inactive and address unknown; tabulation of M.D.'s only.

Source: 1931 through 1959 figures from Health Manpower Source Book, section 14, PHS Publication No 263, pub. 1960. 1967 figures from Distribution of Physicians, Hospitals, and Hospital beds in the United States—1967, published by Department of Survey Research, American Medical Association in 1968.

The number of physicians increased by 95 percent from 1931 to 1967, the number in private practice increased by 73 percent. During the same period the number of general practitioners in private practice declined by 44 percent and the number of specialists increased by 469 percent.

From 1949 to 1967, while total physicians increased by 53½ percent, nonfederal physicians in patient care increased by 42 percent, physicians in private practice increased by 26 percent, general practitioners in private practice declined by 34 percent, specialists in private practice increased by 132 percent, physicians in hospital based practice increased by 138 percent, physicians in administration, research and medical school faculty increased by 362 percent and physicians in Federal service increased by 120 percent.

RATIO OF M.D.'s TO POPULATION IN THE UNITED STATES (1931–67)

	Total M.D.'s per 100,000 population				
	1931	1940	1949	1959	1967
Total physicians	122.3	125.2	127.1	126.3	147.8
Total in patient care	117.1	119.1	116.3	112.1	125.3
Total in private practice	109.2	108.3	99.8	89.9	95.5
General practitioners in private practice	91.2	82.8	63.4	45.9	31.5
Specialists in private practice	18.0	25.5	36.4	44.0	63.9

	Number of persons per M.D.				
	1931	1940	1949	1959	1967
Total physicians	818	799	787	792	677
Total in patient care	854	840	860	892	797
Total in private practice	916	923	1,002	1,113	1,04
General practitioners in private practice	1,097	1,208	1,578	2,181	3,171
Specialists in private practice	5,551	3,921	2,746	2,278	1,564

Note: Physician figures from Health Manpower Source Book, sec. 14, PHS publication No. 263, for the years 1931 through 1959. Physician figures for 1967 from Distribution of Physicians in the United States, by the Department of Survey Research, American Medical Association. (Inactive and address unknown are not included.) Population data from Population Estimates, P–25, No. 413, January 1969, for the years 1949, 1959, and 1967. Population data for the years 1931 and 1940 from Statistical Abstracts of the United States, 87th edition, Bureau of Census, U.S. Department of Commerce.

The CHAIRMAN. Thank you very much, Doctor. Thank you all for your great contribution here, for your very able paper, and for your leadership in forming this academy.

I congratulate you on the first 1,600 diplomats who are now practicing family doctors. I have computed if my State gets its percentage on the basis of population, that will be about 40 in my State. I hope they can spread their influence around.

I think our oldest medical school, at the University of Galveston, has a department. They are very much interested in pushing this program.

Senator SCHWEIKER. If I may interrupt, Senator Murphy has requested that we ask a question of Dr. Kowalewski.

One survey of why doctors locate in certain areas found that 25 percent said they were practicing in the area in which they were reared. Also, once a physician establishes a practice, he is unlikely to move.

With these facts in mind, Senator Murphy plans to offer an amendment that would provide a family physician scholarship program, with the recepient of such grant being required to serve in a physician-shortage area.

I wonder if you have any comments on that approach, or any other suggestions on Senator Murphy's approach.

Dr. KOWALEWSKI. Yes. I commend the Senator for looking in a forward manner toward this problem.

I would suggest, however, that there have been some experiences in this country already where the, shall we say, the mandatory clause of practice does not seem to work. As a matter of fact, in some States it was proved illegal.

However, I think the responsibility of the entire country is involved as to where a young man settles today.

For a moment, sir, if I can elaborate on this.

The most important reason why a young family selects a community today is that now the wife, the young wife who has an average of two and a half to three children before she and her husband leave medical school, has a great deal of influence as to where they settle.

So, in the view of the family, there are two things on an equal basis that really determine where the family will settle. First, is this an area where my professional needs can be satisfied, professional needs, those involving a good hospital, et cetera? But just as important today is the consideration: is this a community where I am raise my family like I always wanted?

Way down on the list, you have to believe me, way down on the list is: is this a community where there are going to be enough patients and enough money?

That was my first priority in my day, but it is not the priority of the young man today. His wife is involved, his family is involved. They want a community where they can raise their children.

They mean by this, for example, good schools, safety in walking down the streets. What is the social concern of the community? Does that community make me feel necessary there? These are the aspects that are very important.

So, in organized medicine, we have the responsibility of preparing from an educational point of view, to the best of our ability, every young doctor.

But society today also has a responsibility in this area. It directs itself specifically to what I mentioned: Is this a community where I can raise my family?

The CHAIRMAN. Thank you.

We have two more very important witnesses to be heard. I have other engagements at 12 and one at 12:30. I cannot remain any longer.

I will recess the hearing until 2 o'clock. Hopefully the other witnesses can be heard at 2 o'clock.

How about Dr. Willard and Miss Costa? Can you come at 2 o'clock?

Miss COSTA. Yes.

The CHAIRMAN. Dr. Willard?

Dr. WILLARD. Yes, sir.

The CHAIRMAN. The hearing is recessed until 2 o'clock.

I want to thank those who testified. It is a great contribution.

(Whereupon, at 12:30 p.m., the subcommittee recessed, to reconvene at 2 p.m., the same day.)

AFTERNOON SESSION

The CHAIRMAN. The Subcommittee on Health will come to order. We will resume hearings on S. 3418, the family practice bill.

The first witness this afternoon is Dr. William R. Willard. Dr. Willard is from the University of Kentucky Medical Center, Lexington, Ky., and a member of the AMA Council on Medical Education.

We welcome you here. We appreciate the fact you stayed over. It was impossible to reach you before noon.

Do you have people accompanying you? Will you introduce them for the record?

STATEMENT OF DR. WILLIAM R. WILLARD, VICE PRESIDENT, MEDICAL CENTER, UNIVERSITY OF KENTUCKY, AND IMMEDIATE PAST CHAIRMAN OF THE COUNCIL ON MEDICAL EDUCATION OF THE AMERICAN MEDICAL ASSOCIATION; ACCOMPANIED BY DR. C. H. WILLIAM RUHE, DIRECTOR OF THE ASSOCIATION'S DIVISION OF MEDICAL EDUCATION; AND BERNARD P. HARRISON, DIRECTOR OF AMA'S LEGISLATIVE DEPARTMENT

Dr. WILLARD. Yes, Mr. Chairman.

I am Dr. William R. Willard, vice president for the medical center of the University of Kentucky, and immediate past chairman of the Council on Medical Education of the American Medical Association.

Accompanying me today are Dr. C. H. William Ruhe, director of the association's division of medical education, and Mr. Bernard P. Harrison, director of AMA's legislative department.

The CHAIRMAN. We welcome them here with you.

How old is your medical school there, Doctor, at the University of Kentucky at Lexington?

Dr. WILLARD. We started planning from the ground up in 1956.

The CHAIRMAN. How old is the medical school at Louisville?

Dr. WILLARD. That is over a century.

The CHAIRMAN. Pardon this personal digression.

When I was a small boy, before we had as many medical schools as we have now in Texas, we had a good many graduates from the University of Louisville Medical School in Texas. That was a favorite place for the Texas students to go, in those days. This is some years ago.

We welcome you here as representative of not only the AMA but of that medical center.

You have one of the newer ones there?

Dr. WILLARD. That is right, we are one of the newer ones.

The CHAIRMAN. Proceed in your own way.

Dr. WILLARD. I will point out that we have a few modifications in the prepared testimony. These are mostly clarifications and elaborations of general points made. I will point them out as we go along.

The CHAIRMAN. If you care to file your whole statement, we will file it, and you can condense it if you wish, but it will be fully considered as if every bit were read.

Dr. WILLARD. Mr. Chairman, we appreciate this opportunity provided to the American Medical Association to present its views on S. 3418, which establishes a 5-year program of assistance to public and private nonprofit medical schools and hospitals to expand existing programs, or to establish new programs, of training in the field of family practice.

The bill also gives the Secretary of Health, Education, and Welfare the authority to appoint a 12-member advisory council on family medicine.

We are pleased to recommend that this bill be supported and enacted into law, with certain modifications that I will point out.

The CHAIRMAN. We welcome your support, needed particularly since the administration, we think ill advisedly, recommended against the bill.

Proceed.

Dr. WILLARD. There can be no doubt remaining in the minds of the Members of Congress, and there is certainly no doubt within the medical profession, that one of the most pressing and vexing problems facing this country is the provision of comprehensive and high-level medical care to every American.

In spite of all that has been done by Congress and other groups, there remain important problems in the delivery of health care. S. 3418 addresses itself to one of these problems which has not previously been considered by Congress, insofar as I know.

We are in an age of specialization which has been the basis for many of the major breakthroughs in modern medical science and improvements in patient care. However, if the patient is to receive maximum benefits from medical science, his total health care must be evaluated and managed efficiently.

This cannot be done satisfactorily if the patient must first diagnose his own ailments to determine the specialists he should see. This is expensive, time consuming, inefficient, often impersonal, and not very satisfying to the patient. What is needed is a generalist who is the patient's first contact physician.

In earlier days, the general practitioner filled this need, and most physicians were general practitioners. It was an easier role to fill then than now, because knowledge was limited and specialization was not well developed.

The need today is for a new type of generalist who is prepared to function as a family physician. Unfortunately most medical schools and hospitals do not at present offer this kind of training.

The new type of generalist we need must be trained to evaluate the patient's problems in their totality, to provide by himself or with assistants a high proportion of the care needed by most patients, and to coordinate the care provided by others when necessary.

He must be concerned as much with prevention, health maintenance, and rehabilitation as with diagnosis and treatment, must care for ambulatory and out-of-hospital patients throughout their illness, and in times of good health as well as sickness, and must deal with the environmental and emotional problems of the patient and his family. He must make his services available as well as accessible.

This is what we mean by comprehensive, family-centered, patient care, and this is the kind of care the modern family physician should give.

The American Medical Association has been concerned for a long time about the decline in the number of physicians in family practice, and the lack of educational programs designed specifically to prepare physicians for careers in family medicine.

This concern led in 1964 to the appointment by the AMA of the Ad Hoc Committee on Education for Family Practice "to examine the problem of the declining numbers of family practitioners and to support solutions which might increase the supply."

I was privileged to chair that committee, and Dr. Ruhe provided staff services for it. The ad hoc committee studied the problem for 2½ years, and in 1966 submitted a report entitled "Meeting the Challenge of Family Practice."

The recommendations of the report were approved by the AMA House of Delegates, the Council on Medical Education was charged with responsibility for implementing the recommendations. The

entire report is relevant to S. 3418, and we have provided the committee with copies for its information.

I will point out parenthetically this report does deal with a number of problems that were asked about this morning, some relating to trends on physicians in family practice, related training programs, and the like. Not all these questions are easily and dogmatically answered.

The CHAIRMAN. Your staff here includes representatives of the Council on Medical Education, Medical Academy of General Practice, AMA Section on General Practice, Association of American Medical Colleges?

Dr. WILLARD. Yes, sir.

The CHAIRMAN. Doctor, frankly, I am astonished you have such an able committee without a single Texan on it.

You may proceed.

Dr. WILLARD. The most glaring problem identified by the report was the lack of effective and attractive educational and training programs for family practice in our medical schools and teaching hospitals.

The reasons for this lack are many, and there is not time to dwell upon them now. Perhaps it is enough to say that the need for a new approach has become both clear and compelling only recently, and the resources and incentives for developing such programs have been lacking.

As a result, we find the following conditions to be generally prevalent in our teaching institutions, although there are some exceptions:

1. Most medical schools and teaching hospitals do not have departments or organizational units for teaching family medicine, and do not offer in their patient care programs, where medical students, interns, and residents are taught, a model or example of family-oriented, comprehensive patient care.

2. There are few family physicians teaching on the clinical faculties of medical schools—outstanding men with whom students can identify and whom they can emulate. There are few career opportunities for such physicians in academic medicine. Even more serious for the future, there are few who are qualified for academic appointments, although happily there are many young physicians with potential interest in this field if attractive career opportunities and training opportunities for them can be developed.

If teaching by example is more effective than teaching by exhortation, and I have no doubt that this is true, it is no wonder that the field of family practice now attracts few recruits among medical students.

I do not personally blame medical schools for this. We have been in a period which has emphasized medical research and specialization, and the schools have adapted to the prevailing values and patterns for the delivery of health care and to sources of available financial support. Their programs have been effective and socially beneficial, but they have been incomplete and out of balance with the needs of today.

Another problem identified by the AMA ad hoc committee report was the lack of status and recognition for the young physician considering family practice as a career. Family practice was not a recognized specialty, and the traditional specialist dominated the scene.

Hospital privileges for family or general practitioners were sometimes unnecessarily restricted. Third parties who paid for physicians' services, including the U.S. Government, paid the specialist more than the general practitioner for identical services.

The prestige, status, and influence of the specialist were greater. Why should a student take additional training after medical school to become a family or general practitioner, when with little additional time, effort, and expense he could become a specialist?

Much has happened since the report of the ad hoc committee was released in 1966, but we are just at the beginning of what must be a long-term, sustained effort to solve the family practice problem:

1. As a result of leadership by the American Academy of General Practice and the American Medical Association, family practice is now a recognized specialty, with an approved specialty board, and the status problem for physicians in this field should begin to improve.

2. Some medical schools and hospitals have developed training programs for family practice. Many others are considering the development of new programs.

3. Interest in the field has grown substantially, and the climate for constructive work is much better than it has ever been.

At the recent meeting of the AMA in Chicago, the House of Delegates strongly reaffirmed its support of measures for increasing the numbers of family physicians.

However, the family practice movement faces some serious problems, the most serious of which is financial. The ad hoc committee report recognized this problem and states:

> Substantial additional funds will be needed if medical schools and teaching institutions are to develop satisfactory training programs and appropriate models of practice.

Support will be required for faculty and other staff, and for operating expenses similar to other major clinical departments. Suitable facilities for training programs are generally lacking, and to provide them will necessitate some construction. Funds for training faculty and stipends for trainees will be needed.

The committee report recognized that most medical schools and teaching institutions were already fully committeed in this use of their resources. In fact, many face grave problems just to maintain their present operations, without adding new and major programs such as family practice.

It is true that family practice programs in a few institutions have obtained support from institutional funds, or from service contracts with Federal agencies such as the Office of Economic Opportunity. Relative to need, this support has been only a drop in the bucket, and the problems involved in financing an educational program from a service contract may seriously distort the educational program, and sometimes the service program as well.

If the family practice movement is to succeed in helping to solve a major problem in the delivery of health services, it must be supported adequately. It must command a national commitment analogous to research in the post-World War II period, not necessarily in the amount of money, but in the assurances of gradually increasing funds, stable in nature, and flexible in their use. Nothing will assure success more than this.

A new program, not yet engrafted firmly into the medical educational system, needs earmarked funds, not funds that might or might not become available to it from institutional grants.

Without such funds, the family practice movements will develop much more slowly than it should if it is to meet pressing national needs. S. 3418 is designed for the type of program that is required.

The proposal before you authorizes the Secretary of Health, Education, and Welfare to make grants to public and private nonprofit, medical schools to establish and operate educational departments devoted to teaching all phases of family practice. Grants would also be available to assist in the cost of construction of any additional facilities as may be required, and funds could be used to defray the costs of training needed teaching personnel.

This is a laudatory program and should be supported.

We are somewhat concerned, however, over the specification in section 761(a)(1) that there must be "separate and distinct departments" established for those purposes. While new administrative units would be desirable, the requirement of "separate and distinct departments" established for these purposes. While new administrative units otherwise worthy programs of family practice.

The ad hoc committee report dealt with the organizational issue as follows. I quote from page 48:

> There are various ways in which this need—that is, for an administrative unit—might be satisfied: An academic department of family medicine is one way; another is the creation of addition of family medicine within a major department such as medicine or community medicine; a third way might be the creation of an interdepartmental unit; and there might be other approaches which would serve satisfactorily in a given setting.

In the light of this, surely it would be inadvisable to legislate the organizational structure for teaching family medicine, especially since some medical schools are successfully developing programs without separate departments.

I would like to elaborate a little further on some other points.

I would suggest further that section 765(b)(1)(A) and (B) be deleted. It states that departments of family medicine should be of "equal standing" with other clinical departments. It is not clear what is meant by this. The various clinical departments of medical schools are not equal now in terms of budget, numbers of faculty, patient load, curriculum, or other measurable criteria.

What we want are departments adequate to conduct the final programs as specified in application and approved by the advisory council.

The CHAIRMAN. I am referring your recommendations to the general counsel and staff counsel of the committee and my own personal counsel for my office for a careful study of these recommendations.

Dr. WILLARD. Section 765(b)(1)(B) specifies that the programs should meet the standards established for the specialty of family medicine.

The bill provides elsewhere that grantee institutions and their programs must be accredited or have reasonable assurance of accreditation. This accomplishes the objectives in assuring that standards are met and avoids the implication in this section of legislative dictation of curriculum content and quality, which are the proper responsibilities of the faculty.

Hence, I would suggest that the committee consider deletion of this section.

The grant program for hospitals is valuable and should provide the needed impetus to the development of family medicine training programs in the post-medical school, hospital environment. The scholarships, fellowships, and stipends to interns and residents will enable the program to compete better with the other medical specialities in attracting aspiring physicians to the practice of family medicine.

We would like to recommend to this committee that it give serious consideration to amending this legislation by the deletion of the provisions relating to the training of paramedical personnel in the field of family practice.

While the training of such individuals is desirable and should be undertaken, its inclusion in this proposed program can only dilute and encumber the primary purpose of the legislation—that is, the training of physicians to practice in the field of family medicine.

We would urge that the training of paramedical personnel be the subject of separate legislation, and that S. 3418 be directed solely to the training of physicians.

I have here a modification relative to the advisory council. We would suggest a modification of the composition of the advisory council on family medicine to be appointed by the Secretary of Health, Education, and Welfare.

Because family medicine draws from all disciplines of medical practice, we would suggest that some of the members include medical educators in other fields. This would broaden and strengthen the deliberations of the council.

If a membership of 12 is desired, three could be practitioners of family medicine, three could be teachers of family medicine, and three could be medical educators from other fields, and three could be public representatives.

We would suggest further that the Secretary of HEW make his appointments of physicians in consultation with the organized medical profession, soliciting for his consideration a panel of names of physicians who would be qualified to serve.

In conclusion, then, let me reiterate our support of this important bill. We recommend its enactment as modified to delete the restrictions identified above, and some modification in the composition of the council. We believe that this legislation will make a meaningful contribution to present efforts to increase the number of physicians practicing in the field of family medicine.

We will now be happy to attempt to answer any questions which the committee may wish to ask.

The CHAIRMAN. Thank you very much for your presentation, Doctor.

I have some questions in mind. If I submit them, they will be in writing.

I request counsel for the majority and minority, if they have questions, that they prepare them in writing, because we are past 2:30, and a committee of which I am a member, the Appropriations Committee, is marking up a bill. I have to be over there.

So we will have to forego questions and hear the next witness on the list.

Dr. RUHE. Mr. Chairman, there was in the previous testimony a statement made which I think ought to be corrected for the record.

That was to the effect that there are six qualified applicants, well qualified applicants, for every place in the medical school.

The statement was made that there are six well qualified applicants for every position in medical school. I believe that this was a misunderstanding based on the fact that virtually every individual medical school has that approximate ratio, or even greater, of applicants to first-year positions.

However, when you take into consideration the fact that many applicants apply to many medical schools, and you total for the entire country the number of applicants and the number of first-year positions, the ratio is really quite different.

The ratio of total applicants to first-year positions is approximately 2.2 to 1, at the present time, and not all of those are qualified applicants.

The CHAIRMAN. How many qualified applicants, would you say?

Dr. RUHE. It is hard to say, exactly, because the definition of qualified varies from school to school.

The CHAIRMAN. If we say those who have had the requisite training and grades, approved by their local medical societies, would you consider that qualified?

Dr. RUHE. Yes. We would estimate the ratio would be 1.4 to 1.

The CHAIRMAN. In my State, it was 3.2 to 1, 400 out of 1,300.

I don't have time to question that further. I would like to go into that.

If it is 1.4 to 1, we need that 1.4 now.

Dr. RUHE. We could not agree more.

The CHAIRMAN. The American people are not going to be satisfied with the inadequate health care that they have had in the past. I think you are moving wisely in pushing family medicine here.

The people of this country have come to the realization that health care and medical care is not a privilege of the rich any more. It is something they ought to be entitled to, and they are not going to wait 25 years. Medicare is coming like the tide.

I think you ought to open these medical schools and let these qualified students in, instead of holding the schools as a monopoly and holding it down. With coming medical care, you should do what you can to encourage them, or you will not be able to turn out enough doctors.

Dr. RUHE. We would not agree that there has been a monopoly or deliberate effort to restrict the enrollments in medical schools. As a matter of fact, we have been trying very hard to increase enrollments. We are on record as supporting a place in medical school for every qualified applicant.

The number of first-year students has been increasing substantially over the past years, and will continue to increase. It has been increasing about 10 percent per year, and will over the next few years.

The CHAIRMAN. We have a vote on the floor.

I would like to discuss this. I would like to encourage you to continue to admit all the qualified people. Until we admit all the qualified people, we don't have to stop and talk about whether our qualifications are too high. We are just not admitting the people who are highly qualified.

Dr. RUHE. We agree with you.

The CHAIRMAN. Will you come up, please, Miss Costa?

STATEMENT OF MARJORIE A. COSTA, AMPH, ASSISTANT DIRECTOR, CONTINUATION EDUCATION, PUBLIC HEALTH, COLUMBIA UNIVERSITY SCHOOL OF PUBLIC HEALTH, ADMINISTRATIVE MEDICINE, NEW YORK, N.Y.; ACCOMPANIED BY DR. AMOS JOHNSON

Miss COSTA. I realize how busy you are. I will give you the briefest presentation of the day.

The CHAIRMAN. I am advised you come here from New York at your own personal expense.

We will be glad to hear you. If you will introduce the gentleman accompanying you.

Miss COSTA. This is Dr. Amos Johnson, a family physician from North Carolina accompanying me this afternoon.

The CHAIRMAN. Yes. We know Dr. Johnson. He has been very active on this.

Will you proceed, please.

Miss COSTA. Thank you.

I am Marjorie A. Costa, a public health educator with a master of public health degree from Columbia University School of Public Health and Administrative Medicine.

I have lived in the Bedford-Stuyvesant area of Brooklyn for more than 40 years. The Bedford-Stuyvesant area is primarily a black ghetto with a population of approximately 450,000 in 2,582 acres.

For many years, my concern for comprehensive health services has kept me involved on a voluntary basis as well as on a paid professional basis.

In my capacity as staff consultant for the program of continuation education in public health at Columbia University, I have gone into similar areas as Bedford, for example East Harlem, Central Harlem, and the South Bronx.

In a voluntary capacity, I have been serving as chairman of the board of directors of the OEO-funded Neighborhood Health Center of the Provident Clinical Society, Inc.; chairman of the board of directors of the Bedford Mental Health Clinic; secretary to the board of directors of the Brooklyn Psychiatric Centers; and appointed member to the mayor's advisory board to the New York City Department of Mental Health and Mental Retardation Services.

It is with this background that I testify this morning on behalf of Senator Ralph Yarborough's bill, S. 3418, relating to the need for more practitioners of family medicine.

Due to the increased emphasis on medical specialization, the general practitioner or family doctor has been gradually phased out of our society, leaving little or no personalized medical attention.

Disadvantaged individuals have been forced to substitute the emergency room of hospitals for the family doctor. Consequently, utilization of ambulatory care facilities in areas heavily populated with minorities is on the increase.

In any given area with a heavy concentration of poor immigrant residents, emergency room visits have increased 50 percent over the previous year. The "emergencies" in the eyes of the patients were real, but an analysis of the cases indicated that the number of "hospital emergencies" were minimal, and supports the substitution of the emergency room for the family doctor.

As a result of this practice, the health care institutions are being forced to expand staff and facilities for a component for which they are neither financially nor professionally prepared. Ofttimes, in these emergency rooms, nurses carry out many of the functions of physicians, which is not a desirable practice, since it is of an "unofficial" nature. Very seldom, if ever, do you see a chief of staff in an emergency room or outpatient clinic situation.

Priorities in the medical education programs are concentrated on the inpatient aspect, to give broad exposure on the ward with the patient that can be followed and studied.

Emergency room or clinic rotation of the intern or resident is less desirable and comprises only a minute portion of the total schedule, since there are no regular assignments, but a sharing with other services on a limited and undisciplined basis.

In order to remove some of the distaste regarding the family approach to medicine, and create this new specialty, the medical schools and hospitals must be able to envision some financial support in the development and implementation of programs for this objective. Their current operating costs are excessive and spiraling.

Preventive medicine is one of the major objectives of the family physician. It is imperative that we move ahead seriously and rapidly to achieve a family-oriented health delivery system with broadly trained family physicians.

The availability of Federal funds with matching State funds for the education of family physicians is extremely desirable and necessary.

I submit that these funds be made available to disadvantaged high school graduates immediately upon graduation from high school, if they so desire, and should carry them through premedical and medical school. Upon completion of their formal education with a specialty in family medicine, they should serve in a fully equipped family-oriented health center in the area from which they came, or a similar area, for a period of at least 5 years.

At the end of the 5-year period, they should be given the health center which they helped build as a further incentive to remain, if they choose to remain in the service of that community.

This solution is certainly not in place of the allocation of funds for the training of paramedical staff to assist and become members of the health team, but in addition thereto.

Nor is this statement to minimize the importance of specialists. On the contrary, it is because of these specialists and the advances in our technology that we know how to render superior medical care.

We are about 10 years behind in the application of our medical knowledge, due to the shortage of physicians, et al., to apply it. Hence, fragmentation.

I further submit that these recommendations will not only improve the health lot of the disadvantaged, but of the advantaged, as well.

The CHAIRMAN. Thank you very much for this contribution, Miss Costa.

I agree with you that we must have more medical education, and more people qualified.

I have read with great interest your suggestion about the education of family physicians and the plan you outline that will result in education of more people from disadvantaged families who should like-

wise have an opportunity, if they have the incentive and capability to get this training.

I want to mention one avenue now where that training might be open. That is the cold war GI bill. Of course, that is limited to servicemen only, but we have the best GI bill in the history of this Nation.

I was able to pass that bill after 8 long, bitter years of fighting against three Presidents, two in my own party, the VA, and the Bureau of the Budget, and the Defense Department in the background, of course.

Now, we do have the best in our history now, because if an exserviceman has not finished grade school, this permits him to get a certificate of competency for the required reading level, then he can go through high school without using up any of his eligibility, and be paid all the way by the Federal Government.

In the past, if he had 3 years of eligibility, and he needed 3 years of high school, he used it up. Now, we pay for him to go through the high school, and then he has 4 years in college.

Under the old bills, if he reenlisted, he lost the right. Now, he can reenlist for 20 years, he can be an officer, a West Ponit graduate when he comes out, and he can take this training. If he is a young veteran killed in service, and he leaves a widow, she can get the training. Never before have we had that.

Before, with some of the ethnic minority groups, if they had five or six children, they could not afford it. For the first time, we pay an allowance for every child. A serviceman cannot afford not to take his training, unless he has his Ph. D. That is the only man who can afford not to go to school and get the training under the GI bill.

I worked with Senator Lister Hill in sponsoring a bill creating 12 new medical schools. All are not open yet. It should have had the united support of the medical profession in pushing through the medical schools.

I have some questions, Miss Costa, to you as a public health educator. I am going to submit them in writing. And request that you provide the committee with your written answers.

(Miss Costa's response to Senator Yarborough's questions follows:)

THE RESPONSE OF MISS COSTA TO QUESTIONS OF SENATOR YARBOROUGH

Question 1. Miss Costa, do you have a personal family physician?

Answer. Not anymore. In order that I may have a physical examination I have to see four or five physicians (specialists) and then not have a complete examination. Just last year I was in the West Indies and inherited an infected mosquito bite on my leg. I was bitten in June and the infection was finally controlled in September by the 12th physician I attended. He is a Dermatologist and personal friend and came to my home to prescribe the necessary antibiotic dosage to control the infection. Not one of the 12 physicians (all specialists) even took a blood test or a culture of the infection.

Question 2. What is your personal experience at present with the now prevalent health care system?

Answer. In the Bedford-Stuyvesant area, as in many similar areas, there is: no municipal hospital; no family physician or general practitioners; inadequate and expensive transportation; long waiting hours in the emergency room; and depersonalized treatment in the emergency room which includes, among other things, unkindness and downright rudeness.

Health care is not only totally inadequate and prohibitively expensive to the disadvantaged but to everyone except the extremely wealthy. The professional physicians, dentists, etc.; because of their professions have access to superior

specialized services and priorities and appointments for specialists services. However, they too have the same difficulties as their neighbors when faced with typical health problems.

Question 3. Do you think that the technique of pouring more money into the purchase of health care services as is advocated today by national compulsory health insurance, can be the answer to the unavailability of medical care presently?

Answer. No. Health care is not available at any price today. I am not opposed to a National Health Insurance plan, if it insures comprehensive quality health services for all. A dual standard system of health care: one for the poor and one for the rich: is totally unacceptable and inadvisable. Along with a National Health Insurance Plan there must be a comprehensive health Insurance Plan, there must be a comprehensive health care system without insuring that it is acceptable, accessible, Available and continuous will not improve the present system at all. There are some health systems in the U.S. which combine problems with reasonable interaction between professional and community groups and their interests. One example is a good system of Puget Sound, Seattle. This might be considered for expansion to the whole city as an example. Today the U.S. is alone among the major countries of this world in failing to ensure that medical services are freely unavailable to everybody.

Question 4. Would you elaborate further on your concept for the financing of scholarships for bright, young students from underprivileged and impoverished areas.

Answer. As previously proposed, the availability of Federal Funds with matching state funds for the education of family physicians is extremely desirable and necessary. Upon completion of their formal education with a specialty in family medicine, they should serve in a fully equipped family-oriented health center in the area from which they came or a similar area, for a period of not less than 5 years. By this time their roots and loyalties should be so firmly entrenched as to preclude any desire to move on their party. The gift of the health center, to one or a group, who helped build the center should be a further incentive for family physicians to remain in the service of communities which need them the most.

The CHAIRMAN. If you will excuse me. I regret, with the vote on the floor, unless I hurry, I will miss my duties over there.

Thank you very much for your presence.

Thank you, Dr. Johnson, for your great contribution to this bill.

The hearing is recessed until 10 in the morning.

(Whereupon, at 2:50 p.m., the subcommittee recessed, to reconvene at 10 a.m., Thursday, July 9, 1970.)

FAMILY PRACTICE OF MEDICINE

THURSDAY, JULY 9, 1970

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE
COMMITTEE ON LABOR AND PUBLIC WELFARE,
Washington, D.C.

The subcommittee met at 10:40 a.m., pursuant to recess, in room 4232, New Senate Office Building, Senator Ralph W. Yarborough (chairman of the committee) presiding.

Present: Senator Yarborough.

Committee staff members present: Robert O. Harris, staff director; John S. Forsythe, general counsel; and Jay B. Culler, minority counsel to the Health Subcommittee.

The CHAIRMAN. The Subcommittee on Public Health will come to order and hearings will be resumed on the family medical practice bill, S. 3418.

The first witness on the list this morning is Dr. Gerald Bassett, associate professor of the University of Washington Medical School, Spokane, Wash.

Is Dr. Bassett here?

Is Dr. Johnson here?

Dr. JOHNSON. Senator Yarborough, Dr. Bassett was to come in last evening. He was looking forward to being here at your hearings but he is in Spokane in the hospital with pneumonia. We did get his testimony phoned in to us yesterday afternoon and he asked me to present it for him.

The CHAIRMAN. I regret to hear that. I hope that we can through the cancer study group we have set up, find something for cancer similar to what penicillin does for pneumonia.

Dr. Johnson, we welcome you back. You are one of the foremost advocates of this bill; you have been a stanch worker for it. We will be glad if you will make this statement on behalf of Dr. Bassett.

When you wire him, express our deep regrets and our best wishes for a speedy recovery.

STATEMENT OF DR. GERALD BASSETT, ASSISTANT PROFESSOR, SCHOOL OF MEDICINE, UNIVERSITY OF WASHINGTON, SPOKANE, WASH., PRESENTED BY DR. AMOS JOHNSON, GARLAND, N.C.

Dr. JOHNSON. Mr. Chairman and members of the subcommittee, my name is Gerald Bassett. I am a staff physician for the MEDEX Program in the State of Washington.

Let me stop one minute and explain to you what MEDEX is. That is the training program which is in operation at the University of Washington at Spokane to train the physicians assistants, the paramedical personnel that will work with the family physician. Their name for it is MEDEX. It extends the arm of medicine.

The CHAIRMAN. I am glad to hear this. As you know, there is some objection to this in the medical profession. I look forward to this statement.

Dr. JOHNSON. As deputy director of MEDEX, one of my primary responsibilities is curriculum development and teaching of Medex trainees during the university phase of the program. Since the MEDEX Program has as its objective the extension of physicians practicing family medicine, I appreciate the opportunity to comment on S. 3418 and to add support for this much needed legislation.

We hardly need authoritative commissions to point out what many people already experience in seeking medical care: Difficulties in obtaining appointments for routine health care; long periods in waiting rooms; seemingly hurried examinations and explanations; impersoal emergency room care on nights and weekends. Clearly our supply of sufficiently qualified physicians is not sufficient alone to meet the increasing health expectations and future demands of an expanding population.

The State of Washington shares in this national problem. In the rural heart of the State physician numbers are declining as doctors migrate to cities or towns to specialty practices rural areas cannot support. Rural doctors are not being replaced and the age of the few pracitioners left behind is steadily rising. Both large and small communities without medical practitioners constantly advertise for help in professional journals. Today, there are more than 80 towns and cities in the State of Washington looking for family practitioners—some of these communities asking for more than one practitioner.

Truly, then, one of the more serious problems facing our Nation in the health field is the manpower shortage. The shortage cuts across the entire range of health occupations but is perhaps most acutely felt by patients seeking the help of physicians for themselves and their families. There is a critical need for family physicians.

There are, in the main, three ways to tackle this relative lack of family physicians:

(1) We must strive to increase enrollment and graduates of medical schools;

(2) We must attempt new allocational patterns that will utilize more efficiently the services provided by existing family physicians; and

(3) We must help develop new professionals whose job will be to extend the family physicians' capacity to provide medical services.

I am pleased to note that S. 3418 helps solve some problems in each of these areas.

In the first instance, medical schools are already in the process of opening their doors to more students. This action is well and good, but will not answer the problems of students specializing in areas other than family practice. S. 3418 is a farsighted proposal that will

work within the overall goal of increasing total physician manpower, at the same time helping solve the distributional problem caused by specialization. By actively recognizing and financing support programs in family medicine, students will now have a choice of and chance to enter a field of practice not readily available to them in the recent past.

In case there is any question of the interest of medical students in the field of family medicine, I can tell you for example that 42 junior medical students at the University of Washington have applied for summer fellowships in family medicine, sponsored by the Washington Academy of General Practice. From my personal conversations with students I have the distinct impression that many of them have assessed and understood the importance of the family practitioner—or, in other words, they know where the action is.

The second and third instances are, however, the areas of most interest to me as a worker in the field of training paramedical personnel. For example, we find that our Medex—and I am speaking of Medex only because I know best who they have been and what they are now doing—we find that our Medex and their family physician preceptors are putting together new organizational patterns for covering the medical service needs in their rural communities. Several preceptors and Medex teams are working together to cover locales which, by force of circumstances, were formerly left with pretty much episodic and near-emergency-only care. Most clearly, S. 3418 would aid in the development of new professionals whose job will be to help physicians meet increasing demands for medical services. In addition, I see an especially strong commitment of the bill being the provision for training paramedical personnel specifically in the field of family medicine. To me this provision would have two very important results:

(1) It is training for the greatest need, and

(2) It makes explicit in a teaching-learning situation the connection between medical and paramedical team members.

The opportunity will now exist for future coworkers to jointly learn and develop professionally. I suggest a triple benefit from this kind of potential for team learning:

(1) For the patient; he will have more skilled people to help him;

(2) For the student physicians; he will learn not only what family practice can be, but also that it can be a way of life shared with others instead of a "one-man slave to the practice" situation; and

(3) For a whole cadre of interested, dedicated individuals; they who will have an opportunity to find satisfying employment in a career not readily available to them in the past.

My closing remarks are brief. Both my State medical association and the medical school are deeply committed to the idea of family practice and the training of paramedical personnel to assist family physicians. Evidence of this commitment is the offering of a "family pathway practice" recently instituted at the medical school, and joint sponsorship of the MEDEX Program by both the Washington State Medical Association and the University of Washington School of Medicine.

As deputy director of the MEDEX Program, and as an individual physician, I enthusiastically support and recommend S. 3418 as a positive step that will help meet the Nation's health manpower shortage.

The CHAIRMAN. Thank you, Dr. Johnson.

I think Dr. Bassett had a very fine statement. It will be very helpful to us during our consideration of this bill.

May I ask you a question? Someone told me you had experience working with physician assistants in your practice. Is that correct?

Dr. JOHNSON. Senator, 31 years ago I hired a man the week after he graduated from high school and I trained this man on the job in my office. He is the original, so far as I know, physician's assistant.

The program to train these people at Duke University was stimulated by the knowledge and access to the activities of this man and his productivity, and I would say that this person in my everyday practice enables me to see at least 35 to 50 percent more patients effectively and efficiently than I could do without his services.

The CHAIRMAN. Could you tell us what he can do to take time off your hands and let you do the medicine part?

Dr. JOHNSON. Senator, he works under my supervision and I assume responsibility for those things that he does. He is astute at doing routine dressings for wounds and infections, et cetera. He can put a cast on a fracture of an arm or leg better than I can. It looks much better when he is through with it than it does when I put it on. He is an excellent plastic surgeon.

When a patient comes into my office with lacerations, after I have made an evaluation to see that the deep tissues and vital tissues are not injured, I back off and let him perform the job of closing the skin. All my patients are tickled to death to have him do this. When the children in the community have to have immunization injections, they will not permit me or my nurse to give them. He can hypnotize them, sit them on his lap and give the injections to them; and they don't cry. When I have an emergency call to see someone whom I know, and I know my patients quite well, in the middle of a busy morning, I can send this man and have him evaluate the patient and see if I need to go at that particular moment or if I can go at a later time or if indeed I need to go at all.

I have patients in homes that have in-dwelling catheters or other prosthetics and things that have to be looked at occasionally and this man can go and change a catheter or look after other dressings, and things in the home, just as effectively as I can.

He is a very vital part of my team, and the community accepts him as such.

The CHAIRMAN. But, of course you make all the vital decisions on diagnosis, and so forth?

Dr. JOHNSON. Yes.

The CHAIRMAN. All the work he does is sometimes what the registered nurses do?

Dr. JOHNSON. Yes, sir; but he goes even beyond that capability in many instances. This man is bright, he has a very high IQ, he learns quickly.

Another thing he does for me when I am seeing patients, particularly new ones, he will check the patient, a male patient, and will

present the patient to me much as an intern or resident does to the physician in ward rounds in the hospital. He is of immense benefit.

The CHAIRMAN. It sounds like the way I remember the medical students. Instead of universities, one way they could get a medical license in my State was to go around and take training with a medical doctor. That was in the horse and buggy days. As part of his job he was assigned to a doctor in the rural town and if a long-distance call came in with a desperate case he had to hitch up the horse, get the buggy ready and do all the things for the doctor. Of course that day is gone. This was part of the doctor's training. If they had a medical student it saved the doctor from looking at his equipment. He kept his kit filled and bottles filled with medicine. The medical student had to learn those things first before the doctor went on the road.

Dr. JOHNSON. I almost go back that far, myself. I remember what you are talking about.

The CHAIRMAN. Of course that was when I was quite young. That ended in my State before World War I. I was a small boy then. The talk of the town was not of the doctor but the doctor's assistant.

Now, is it really important that the family physician and the physician's assistant be trained together?

Dr. JOHNSON. I think it is very important that these two people be trained together to a degree. Of course the medical assistant does not have to have the 4 years of training that is commonly given to medical students. But this could be worked out very effectively in the 3-year residency programs that are now being offered for medical students, young doctors who are taking training to become certified family physicians. I think it is most important that these people learn to work with each other and learn what can be done, and I think in many instances we will see in the not too distant future these people emerging from the training program together and going for their first day to a community and working together from the first day. I think it is of considerable importance; yes, sir.

The CHAIRMAN. How long should that joint training period last?

Dr. JOHNSON. The program at Duke, in my opinion, is a little too sophisticated. Their program for training this person is 2 years in a medical school and affiliated medical hospital training program. The one at the University of Washington is 3 months in medical school and medical affiliated hospital and training program and then a preceptorship of 9 months, making a 1-year training program, of which the last 9 months would be with the doctor with whom he is going to work. That could go on in the last year of residency, the third year of residency of training of a family physician.

The CHAIRMAN. Do you have an estimate of the number of people who might be needed nationally? Has that been worked up?

Dr. JOHNSON. There has been a good bit of thought given to that. Not every physician who is out practicing now would be willing to take on one of these people because they do not know first hand, nor can they believe it when they are told, how much aid these people can be to them.

I would say that there would probably be room for 50,000 of them now in group practices in rural community hospitals, in the solo practices of physicians here and there. But I can envision as we train more family physicians that the number will probably increase. I

would say that maybe it would rise from around 25 or 30 thousand to maybe eventually 75 or 80 thousand of them.

The CHAIRMAN. This type of medical assistance—the physician's assistant—is more apt to be needed in a rural area than, of course, by a surgeon. They would be of more aid to a doctor trying to cope with a good bit of geographical territory.

Dr. JOHNSON. That is where their prime importance rests. But they can also be used with family physician practices in the middle of the most urban area.

The CHAIRMAN. When family practitioners have to make house calls, they would be valuable.

Dr. JOHNSON. Yes. A family physician as busy as I am can only make so many house calls in one 24-hour period. That is not sufficient to take care of the needs of some of the elderly people who can't be transported to your office. But much of that can be done by a competent assistant.

The CHAIRMAN. Thank you very much. This is a very valuable contribution to our knowledge and information here, Dr. Johnson.

Dr. JOHNSON. Thank you, Mr. Chairman.

The CHAIRMAN. The next witness is Dr. Jack Hall, president of the Association for Hospital Medical Education, Methodist Hospital, Indianapolis, Ind.

Dr. Hall, you have someone accompanying you?

STATEMENT OF DR. JACK HALL, PRESIDENT OF THE ASSOCIATION FOR HOSPITAL MEDICAL EDUCATION; ACCOMPANIED BY TED KUMMER, EXECUTIVE DIRECTOR

Dr. HALL. Yes; I have with me Ted Kummer, the executive director for the Association for Hospital Medical Education.

On behalf of the membership of the association, I would like to say we appreciate very much this opportunity to comment today on the need for family practitioners and programs to train them.

Through its membership, the Association for Hospital Medical Education represents the medical educational programs in approximately 500 community hospitals. The hospitals are fairly large, averaging about 450 beds.

These hospitals have in their graduate education programs—intern and resident education—approximately 40 percent of the intern and resident education positions. Over 125,000 practicing physicians in the United States belong to or relate to the medical staffs of these hospitals—community hospitals with approved graduate education programs.

There are now 46 approved family practice residency training programs—27 in community hospitals, and 19 in medical schools. Twenty-three of the community hospitals and two of the medical schools are represented by members in the Association for Hospital Medical Education.

Why is it that family practice residency programs have developed in community teaching hospitals? Development of these programs in community hospitals has been rapid and natural because it is in community hospitals that the majority of practicing physicians are represented and there is less dissipation of effort when teaching occurs where the physician teachers work and practice. Further, a signifi-

cant portion of the practice of family medicine is carried out in hospitals and a majority of hospital health care is delivered through community hospitals that have provided a milieu for care and education in family practice. In other words, the community hospital is the front line of health care delivery. What better learning environment could there be?

The major factor inhibiting establishment of family practice training programs in hospitals is the financial crisis faced by most institutions. Many simply do not have funds available to implement new programs or to reimburse faculty, either on a part-time or full-time basis.

Inauguration of a graduate program in family practice is difficult and costly. In other areas of medicine physicians have had experience in teaching their specialty during the years of residency education. Since established family practice residency programs are relatively new, and of short duration (3 to 4 years), the pool of available experienced teachers of family medicine is comparatively small. Furthermore, family paysicians are often overwhelmed by patient care demands which leaves them little time to learn to teach, and to teach.

Funds made available through Senate bill 3418 will contribute significantly to development of additional family practice residency programs, both in community hospitals and medical schools. These funds will stimulate development of faculty education programs, they will provide reimbursement to part-time faculty and stimulate development of full-time physicians interested in family practice education, and they will enable institutions to construct model ambulatory patient care centers.

Gentlemen, we are confronted by a crisis in health care delivery in this country, partially as a result of manpower shortage, partially as a result of inadequate distribution of available physician manpower, and partly as a result of manpower specialty. Over 30 million Americans do not have access to primary medical care, not through any fault of their own, but simply because there are not enough qualified practitioners to provide primary care. Present programs in graduate education seem to be yielding physicians doing more and more for fewer and fewer. By the very nature of family practice, techniques of preventive health care and management and control of practice become perfected and serve as models for efficient delivery of health care for larger numbers of people.

The community hospital and the community delivery of care is the home base of family physicians, and educational experience gained in this environment is most realistic. The funds provided by grants authorized by this legislation will stimulate development of community hospital-based family practice training programs. The support of the family practice movement has been a major position of the Association for Hospital Medical Education over the past decade and we look upon enactment of Senate bill 3418 as vital to improved health care for all our citizens.

Mr. Chairman, we thank you for this opportunity to comment, and we would appreciate questions.

The CHAIRMAN. Thank you, Dr. Hall.

I believe you say now and I think the witnesses for the administration said there were 17 to 19 medical schools having family practice residency training programs. You say 27 in community hospitals and

19 in medical schools. Do you have a list of those medical schools that provide family physicians?

Dr. HALL. I guess we do.

The CHAIRMAN. I would like to put in the record a list of the community hospitals and the medical schools that provide this kind of training.

Dr. HALL. If you would like, I can read it or we can present it to you and enter it in the record.

The CHAIRMAN. I believe it will suffice to just print it in the hearing record.

(The material referred to follows:)

APPROVED GRADUATE TRAINING PROGRAMS IN FAMILY PRACTICE

[approved by the Council on Medical Education of the American Medical Association under the new "Essentials of Approved Residencies in Family Practice."] Cont,—

	Program	Program director or person in charge
HOSPITALS		
Good Samaritan Hospital, 1033 East McDowell Rd., Phoneix, Ariz.	Family practice residency	Donald F. Schaller, M.D., director.
San Bernardino County General Hospital, 780 East Gilbert St., San Bernardino, Calif.	do	J. P. Loge, M.D., director.
Santa Monica Hospital & Medical Center, 1250 16th St., Santa Monica, Calif.	Residency in Family	Thomas L. Stern, M.D., director.
Community Hospital of Sonoma County, 3225 Chanate Rd., Santa Rosa, Calif.	Family practice residency	John Geyman, M.D., director.
General Hospital, Ventura County, 3291 Loma Vista, Ventura, Calif.	do	J. Austin Daly, M.D., director.
Hospital of St. Raphael, 1450 Chapel St., New Haven, Conn.	do	Joseph Mignone, M.D., director.
MacNeal Memorial Hospital, 3249 South Oak Park Ave., Berwyn, Ill.	Family practice training	Kenneth F. Kessel, M.D., director, Department of Family Medicine, 1133 Cleveland Ave., La Grange Park, Ill.
West Suburban Hospital, 518 North Austin Blvd., Oak Park, Ill.	Family practice residency	A. L. Burdick, Jr., M.D., director.
Methodist Hospital of Indianapolis, Inc., 1604 North Capital Ave., Indianapolis, Ind.	do	Jack H. Hall, M.D., director of medical education.
St. Vincent's Hospital, 120 West Fall Creek Parkway, Indianapolis, Ind.	do	Steven R. Stouder, M.D., director.
Ball Memorial Hospital, 2401 University Ave., Muncie, Ind.	do	Ross L. Egger, M.D., director.
Memorial Hospital of South Bend, 615 North Michigan St., South Bend, Ind.	do	L. L. Frank, M.D., and Ben Biasini, M.D., directors.
St. Joseph Hospital, 3400 Grand Ave., Wichita, Kans	do	Robert K. Purvis, M.D., director. Wichita, Kans.
Wesley Medical Center, 550 North Hillside, Wichita, Kans.	do	G. Gayle Stephens, M.D., director.
Edward W. Sparrow Hospital, 1215 East Michigan Ave., Lansing, Mich.	do	Harold E. Crow, M.D., director.
Midland Hospital, 4005 Orchard Dr., Midland, Mich.	do	Robert E. Bowsher, M.D. director of medical education.
Saginaw Affiliated Hospitals, Inc., 705 Cooper St., Saginaw, Mich.	Family medicine residency	Roy J. Gerard, M.D., director of family medicine.
Hennepin County General Hospital, Portland and 5th Sts., South Minneapolis, Minn.	Family practice residency	Eldon Berglund, M.D., director.
Research Hospital and Medical Center, 2316 East Meyer Blvd., Kansas City, Mo.	do	Paul Young, M.D., director.
West Jersey Hospital, Mount Ephraim and Atlantic Aves. Camden, N.J.	do	John H. Olsler, III, M.D., director of medical education.
Hunterdon Medical Center, Rural Route 69, Flemington, N.J.	do	Dwight J. Hotchkiss, M.D., director.
Lutheran Medical Center, 4520 4th Ave., Brooklyn, N.Y.	do	Eugene Fanta, M.D., director, Department of Family Practice.
Deaconess Hospital 1001 Humboldt Parkway, Buffalo, N.Y.	do	Ernest Haynes, M.D., director, Department of Family Practice.
Flower Hospital, 3350 Collingwood, Toledo, Ohio	do	Franz B. Ruwe, M.D., director.
Conemaugh Valley Memorial Hospital, 1086 Franklin St., Johnstown, Pa.	do	Thomas Dugan, M.D., director.
Lancaster General Hospital, 525 North Duke St., Lancaster, Pa.	do	Nikitas J. Zervanos, M.D., director of community medical services.
York Hospital, 1001 South George, York, Pa	do	Thomas M. Hart, M.D., director.
Spartanburg General Hospital, 101 East Wood St., Box 4186, Spartansburg, S.C.	do	Robert H. Taylor, M.D., director.
McLennan County Medical Society, Post Office Box 5110, Waco, Tex.	do	Jackson K. Walker, M.D., director of medical education, Providence Hospital, 1725 Colcord Ave., Waco, Tex.

APPROVED GRADUATE TRAINING PROGRAMS IN FAMILY PRACTICE

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	Program	Program director or person in charge
UNIVERSITIES		
University of Arkansas, School of Medicine, 4301 West Markham, Little Rock, Ark.	----do----	John Tudor, M.D., director, St. Vincent Infirmary, Markham at University, Little Rock, Ark.
University of California, College of Medicine at Irvine, Irvine, Calif.	----do----	Robert E. Rakel, M.D., director, 301 Newport Blvd., Newport Beach, Calif.
University of California, Los Angeles School of Medicine, Los Angeles, Calif.	Family medicine residency	Carl D. Strouse, M.D., Los Angeles County Harbor Hospital, 1000 West Carson, Torrance, Calif.
University of Colorado, School of Medicine, 4200 East 9th Ave., Denver, Colo.	Family practice residency	Herbetr Brettell, M.D., director, General Rose Memorial Hospital, 1050 Clermont St., Denver, Colo.
Howard University College of Medicine, 520 West St. NW., Washington, D.C.	----do----	William E. Matory, M.D., director, Freedman's Hospital, 6th and Bryant Sts. NW., Washington, D.C.
University of Miami School of Medicine, Miami, Fla., Post Office Box 875, Biscayne Annex, Miami Fla.	Division of family medicine (Jacskon Memorial Hospital).	Lynn P. Carmichael, M.D., director.
University of Maryland School of Medicine, 522 West Lombard St., Baltimore, Md.	Division of family medicine (University of Maryland Hosptial).	William L. Stewart, M.D., director.
Harvard Medical School, 83 Francis St., Boston, Mass.	Family health care	Joel J. Alpert, M.D., director.
University of Minnesota School of Medicine, Minneapolis, Minn.	Department of family practice and community health.	Benjamin F. Fuller, M.D., chairman.
Creighton University School of Medicine, 25th and California Sts., Omaha, Nebr.	Family practice residency	Michael Haller, M.D., director.
University of Nebraska College of Medicine, 42d and Dewey Ave., Omaha, Nebr.	----do----	Francis L. Land, M.D., director, division of family practice.
University of Rochester School of Medicine, 335 Mount Vernon St., Rochester, N.Y	Family medicine program (Highland Hospital).	Eugene S. Farley, Jr., M.D., director of family medicine, Highlan Hospital, South Avenue at Bellevue.
State University of New York, Upstate Medical Center, Syracuse, N.Y.	Family practice residency	Francis Caliva, M.D., director of medical education, St. Joseph's Hospital, 301 Prospect Ave.
University of North Carolina School of Medicine, Chapel Hill, N.C.	Family practice residency (Moses H. Cone Memorial Hospital, Greensboro, N.C.	William Heering, M.D., associate professor of medicine, Moses H. Cone Memorial Hospital, 1200 North Elm St., Greensboro, N.C.
University of Oklahoma School of Medicine, Oklahoma City, Okla.	Division of family medicine	Roger I. Lienke, M.D., director.
Group Health Cooperative of Puget Sound, 200 15th East, Seattle, Wash.	Residency training program for family practice.	John Quinn, M.D., chief of medicine.
University of Wisconsin School of Medicine, 333 North Randall Ave., Madison, Wis.	Family practice residency	John L. Renner, M.D., director.

The CHAIRMAN. In your experience as a doctor and in your broader experience as president of the Association for Hospital and Medical Education, and your experience with the Methodist Hospital in Indianapolis, Ind., do you find that young men graduating from medical school desire family practice or do they prefer to become specialists in cities, specialists of different types? What is the real desire of the medical graduate today or is that molded by his experience in the university?

Dr. HALL. It is molded in great part by his experience in the university. I think this is a critical factor that we need to emphasize and create some changes in the milieu there. I don't want to say in spite of this but there is a considerable interest of bright young men in the field of family practice. In my experience last year in the family practice program that we provided, we had 12 positions open and we had 12 positions filled, nine of these positions were filled by men who were No. 1, 2, or 3 in the medical school class in four different universities, outstanding young men. I think this shows a trend of intelligent

medical studies wishing to get to people and deliver primary care. These men provide good leadership in the development of our program.

The CHAIRMAN. What about this paramedical or medical assistant provision of the bill? Do you think we need those to assist the family physician, like the MEDEX Program in the University of Washington that has just been described?

Dr. HALL. My definition of a physician is an individual who assumes responsibility for decisions relating to health care that is more effective than any other like individual, and then he is best qualified to provide health care. He has to assume that responsibility. I do not think the doctor can get away from the assumption of the responsibility for the delivery of health care and decisions relating to it, but I don't think that he has to do everything in the delivery of health care, and certainly Dr. Johnson just related many, many things that people can do that a few years ago were considered the exclusive province of highly trained specialists in medicine.

But if the proper decisions are made when there is an adequate amount of information on that individual and they are made by people most qualified, who feel a sense of responsibility for patient care, then tasks can be delegated and people can be trained to do this.

I do not feel that we are going to be successful in training an individual to work for all doctors across the board. I do not think that we can have a paramedical training program that will train a man that could be a surgeon's assistant one day and an intern cardiologist's assistant the next day and family practice assistant the next day. I think we will be most effective in our paramedical training program when we train them specifically in the areas in which they wish to work and have them in association with those people in the learning program. I am strongly in favor of paramedical people for family practice to be trained in this area.

I might say the precedent for this has been set by the National Institutes of Health and schools of medicine as they have asked the National Institutes of Health to support technician training programs in their finite specialties of nephrology, cardiology, and so forth. I do not think we ought to deprive family practice of the same opportunity to generate the important technical support of these paramedical personnel.

The CHAIRMAN. It seems to me that a great deal of a doctor's time is wasted by the need to fill out voluminous insurance forms. So much of health care today comes under insurance policies. So many people carry insurance to pay part or all of the medical cost for illnesses, particularly where hospitalization is required. In my practice of the law I had some cases for injuries that involved conferences with doctors, and they often complained to me about the time they had to spend filling out these forms. I have seen very busy doctors struggling with these insurance forms because the nurse did not know how to fill them out. I wonder if the paramedical personnel could not be of great assistance in saving the doctor's time if they had training how to fill out the detailed forms of the insurance companies which must be completed in order for the doctor to collect his fees for services or operations. It seems to me that would be one field where a doctor's time could well be saved by having someone else fill out these questionnaires. Sometimes these lengthy forms are required merely for an examination

for an insurance policy. For the modest fee charged for an examination for an insurance policy a doctor often has to fill out a lengthy questionnaire.

Dr. HALL. It is paradoxical—I am associated with a relatively large hospital—we delegate this responsibility to paramedical trained personnel to fill out these forms in detail for the hospital reimbursement program. But yet this has been relatively condemned in the practice of medicine.

The CHAIRMAN. Condemned if you turn it over to paramedical personnel?

Dr. HALL. Yes. No one in hospital administration really reviews the synopsis of the record as turned out by the insurance clerk. It is a delegated responsibility. I believe the physicians will increasingly do this. There are many of them, the forward-looking physicians, that are doing it now.

The CHAIRMAN. Of course if the physican reads it over he could correct possible errors. Having the form filled out by paramedical personnel would certainly save a lot of time that the doctor would otherwise have to spend digging out answers to the questions.

Dr. HALL. As the physicians get better organized, they will be able to tell the insurance company, "We will only accept certain kinds of forms," as the hospital does. Right now, every insurance company has its own peculiarity in forms they slip the doctor. The hospitals refuse to accept them.

The CHAIRMAN. And very voluminous forms, too.

Dr. HALL. Yes. There is no question that this can be a delegated task.

The CHAIRMAN. It seems to me that the insurance company forms are wasting a lot of the doctor's time, from some I have seen. The questions should be condensed. There is an inordinate amount of time consumed in the filling out of forms to collect fees for the treatment that has been given people.

Dr. HALL. We have two community health centers which are manned by members of our family practice community at the hospital. We have found that we can develop paramedical personnel in these areas which collect information for the physicians. When the physician sees the patient he can talk to the patient about what the patient must talk about. All of us who practice medicine know that the frequent complaints of the patient is, "I went in to see the doctor but I never got to tell him what I wanted to tell him. We talked about grandmother's gout or Aunt Matilda's rheumatism."

We have the paramedical personnel getting the information. It is displayed to the doctor. He can talk to the patient about what he wants to talk about and make decisions relative to the health care that he wants carried out. We train these people in the milieu with the family physician.

The CHAIRMAN. Your organization represents 500 community hospitals, which you say average 450 beds each?

Dr. HALL. That is correct.

The CHAIRMAN. You would have some 225,000 beds represented.

Dr. HALL. That is correct.

The CHAIRMAN. Has there been money from the National Institutes of Health and other Federal sources operationally available to community hospitals?

Dr. HALL. Not as a rule, Senator Yarborough. Basically, the National Institutes of Health have been organized to generate new scientific information in medicine. They have encouraged the gathering of this knowledge, they have encouraged the development of the finite specialty which has been for the advancement of medicine.

The CHAIRMAN. What about the regional medical program?

Dr. HALL. I do not believe that there has been a significant input of financial resources in the community hospitals as a result of regional medical programs. I think a lot of this relates back to the review committees that review the grants. By and large, the National Institutes of Health have put upon their review committees the specialists who are likewise requesting the grant, and the same has been true in regional medical programs. These kinds of people have been put back on the review committees.

It is natural that you see the fellow most like you as being the best.

The CHAIRMAN. Is that a factor in the overemphasis of specialists if they are overemphasized? We hear the specialists have been overemphasized and they care for few patients and there has been neglect of the primary physician who takes care of many patients. What do you think are the main factors for the overemphasis on specialists and neglect of primary physician care?

Dr. HALL. I am a specialist, I am a cardiologist, myself, and do a finite piece of cardiology, really. I spend most of my time in education, but when I do practice this is what I do. I think there has been a great emphasis on specialty. It has been for the advancement of the science in medicine. It has not been felts important as it should be in the practice of medicine. I think that the categorical grants of the National Institutes of Health have led to the development of the science of medicine. I believe it is time now to make possible by categorical grants—and I read the report of the administration yesterday which opposed categorical grants—I think it is time now that we make it possible by a categorical grant to give equal emphasis to those who are practicing medicine and make it possible for them to deliver this new scientific knowledge.

The CHAIRMAN. We have found in the Senate that if we do not write in the law categorical grants, when it gets down to the budget many of these necessary programs are wiped out.

Last year for the first time I became chairman of the Appropriations Subcommittee that passes on the budget for the Bureau of the Budget. They have 178 hearing examiners. They modestly admit they have the best educated people in the Government. They average more degrees per person than any other branch. They pass on the education budget and the health budget. They recommend nothing for many things we passed after days of hearings here. They admitted there wasn't a single trained health professional, nor a single educational professional in that whole Bureau of the Budget. So, my respect for what they pick out and want to kill and what they pick out and want to keep is just about nil. They haven't had the training.

It is hard enough to write these things to get money for categorical grants. If we don't write these things for categorical grants somebody who has not had health training and has not heard the witnesses we have heard here writes off the programs.

Dr. HALL. You are pointing out something that takes a few years to learn. It is a reality that sitting close to the treasury is a great asset. I think the community hospitals have felt that they have not had an opportunity to sit close to the treasury.

The CHAIRMAN. The Bureau of the Budget thinks it is something up next to God. They do not have the knowledge of the needs of this country. We are suffering, health is suffering and education is suffering by what has happened down there. The bill picked out to be vetoed was on the advice of the Budget. The total last year of all these bills was $200 billion in appropriations. The only thing vetoed was health and education. This year the President picked out a bill for hospital construction and modernization and he vetoed it.

The statement by a representative of Dr. Egeberg the other day regarding the criticism of the President's veto of the hospital bill pointed out that more Government money was being spent on health, 10 percent of the budget, than ever before in our history. But most of this was Medicare and Medicaid. The article stated we are doing more than ever before when really we are going to cut down on research and training. I think it is idiotic to cut down on education and research and training of people who deliver health care.

Dr. HALL. I have very strong feelings on this. With Medicare and Medicaid, we created a credibility gap by making promises that we didn't have the trained and educated personnel geared to provide.

The CHAIRMAN. In the very article it says this cost is going up. It says we are going to reduce this training. This is in the papers in the last 72 hours. Did you see that?

Dr HALL. Yes, the most elementary economics will tell them it will continue to go up until they create a balance.

The CHAIRMAN. It was the most uninformed statement I have ever read by somebody who is supposed to be a spokesman for somebody.

Thank you very much, Doctor.

Dr. HALL. Thank you, Mr. Chairman.

The CHAIRMAN. The next witness is Dr. Heyssel, associate dean for health care programs, Johns Hopkins University School of Medicine, Baltimore, Md.

Doctor, you have someone with you?

STATEMENT OF DR. ROBERT M. HEYSSEL, ASSOCIATE DEAN FOR HEALTH CARE PROGRAMS, JOHNS HOPKINS UNIVERSITY SCHOOL OF MEDICINE, BALTIMORE, MD.; ACCOMPANIED BY DR. JOHN A. D. COOPER, PRESIDENT, ASSOCIATION OF AMERICAN MEDICAL COLLEGES, WASHINGTON, D.C.

Dr. HEYSSEL. I have Dr. John Cooper, president of the Association of American Medical Colleges.

The CHAIRMAN. What medical colleges are you associated with, Dr. Cooper?

Dr. COOPER. Senator Yarborough, I am now a full-time president of the association here.

Dr. HEYSSEL. The Association of American Medical Colleges appreciates this opportunity to offer comments on S. 3418, the bill introduced by Mr. Yarborough to authorize grants to support training of physicians and other health personnel in the field of family practice.

I would like to digress a moment from the prepared statement and identify my own institution's involvement in this field a little better.

I am director of the office of health care programs at Johns Hopkins which has the responsibility for the development and operation of a new comprehensive family centered health care program in the new city of Columbia, Md., which has been in operation since October of this last year which now assumes the care for some 4,000 people in Maryland on a voluntary basis through a prepaid group practice arrangement which is a training ground for students, for house staff, to introduce them to the concept of family practice through group practice methods and to introduce them to the use of paramedical personnel.

This organization is intended to grow to care for about 25,000 to 50,000 people in the city of Columbia, Md., and will be a major training ground for both medical students and residents in future years.

Already we have medical students there, and house staff. At the same time, we have a similar program which has now been funded in East Baltimore, the area in which Johns Hopkins is located, which is an inner city urban ghetto. This program will serve as a model training ground in family practice for students and house staff.

Allied with these two ventures is the Health Services Research Center where we evaluate the efforts to serve as a trainer of new kinds of medical personnel.

The Association of American Medical Colleges is comprised of all of the 107 medical schools in the United States and 390 of the major teaching hospitals. This community of institutions encompasses most of the processes of medical education in this country as well as providing training for large numbers of related health professions and occupations, and contributing in a considerable and influential way to the improvement of the medical care scene through innovation, demonstration, and providing medical and health services. Thus the association and its membership have a direct and deep involvement in the problem and activities with which the bill being considered by this subcommittee deals.

I should say that at least 10 of these medical schools are now involved in programs such as Johns Hopkins has mounted in the inner city and in the new city of Columbia; that is, developing comprehensive family centered practices to serve as new models for their student bodies.

At the outset, it is important to emphasize that the association fully supports and is broadly committed to the basic objectives being sought through S. 3418. The association commends Senator Yarborough for his continuing interest in improving the health care of the American people and the support provided by the many distinguished cosponsors of the bill.

The advance of medical science and technology, the necessary expansion of specialization in medicine to assure effective clinical application of these advances, rising public expectation that their health needs will be more adequately met, and the growing inaccessibility of health services has made it abundantly clear that there are major deficiencies in the Nation's present arrangements for the provision of medical care. This set of circumstances has emphasized for some time that a more direct confrontation with the problems of meeting society's health needs constitutes perhaps the central challenge before medical educa-

tion today, and is really the reason that Johns Hopkins has entered into these new programs as well as Harvard, UCLA, and a variety of other medical schools.

The perception of this challenge has generated widespread and diverse response on the part of American medical schools and teaching hospitals. In brief and in summary, these responses involve:

Major effort to expand medical school enrollments and thus the production of physicians;

The development of departments of community medicine and family practice;

Curriculum modification which has brought to medical students a greater awareness and understanding of the social, behavioral, and environmental factors in disease and health;

Expanded research and development activity in the area of medical care and health services; and

Extensive involvement in the community health scene and the development of innovative approaches to the delivery of health services.

Out of this considerable activity has emerged a set of generalizations which are pertinent to the committee's action on S. 3418.

In general, it seems clear that a major national need is for the better provisions of primary, personal, and comprehensive medical care. Various terms are utilized to describe this need—family practice, general practice, personal medicine, primary physician, generalist, and so forth.

Because of this confusion in terminology, it is more useful to think of the functions which should be performed in the optimum provision of primary health care to patients:

1. Assessment of their total needs before they are categorized by specialty.
2. Elaboration of a plan for meeting those needs in the order of their importance.
3. Determination of who shall meet the defined needs—physicians, general or specialist, nonphysician members of the health team or social agencies.
4. Followup to see that needs are met.
5. All must be done in a continuous, coordinated, and comprehensive manner.
6. Attention at each step must be given to the personal, social, and family dimensions of the patient's problem.
7. Health maintenance and prevention which has been lacking in the past, are as important as cure and rehabilitation.

The achievement of a pattern of medical care which provides for the full and competent performance of these functions is dependent upon changes in not only the content and scope of the educational experience of the M.D. but also upon considerable change in the structure and process of delivery of health services.

The broad efforts now going on in medical schools and teaching hospitals to extend both the educational experience of physicians in this respect and the involvement of academic medical centers in these problems have already been briefly summarized. What is important to keep in mind is the diversity of approaches being taken.

This diversity of efforts is of the utmost value because, as noted by one student of this problem, Dr. Kerr White of Johns Hopkins:

To date, no clear pattern for the future of medical practice has emerged, and the nature of American society makes it probable, indeed desirable, that there be diversity of medical care arrangements, opportunity for experiments, and acceptance of the need for critical evaluation of new approaches to the provision of health services.

Thus, the concentration of support only on developing departments and programs in family practice such as proposed in S. 3418 would, in the view of the association, not provide the broadest opportunities to achieve the overall objectives being sought. For example, studies have shown that the function of providing primary care is by no means confined to general practitioners. A study by Dr. Kerr White of Johns Hopkins reported in the April 1964 issue of the Journal of Medical Education indicates that substantial amounts of primary care are given by internists (77 percent of patients seen), obstetricians (85 percent of patients seen), and pediatricians (88 percent of patients seen). In Columbia and East Baltimore our plans are to have group practice family-oriented medical care done by internists, pediatricians, obstetricians, working closely with psychiatrists in a team approach. Under such a system, incidentally, one could use very effectively nurse practitioners to give pediatrics care, to give care for mental health, and in other areas.

It seems evident, therefore, that the education of internists, obstetricians, and pediatricians as well as general practitioners and other specialists should have sustained exposure in their educational experience to the needs, functions, and practices involved in providing family medicine.

The urgent and fundamental need is for broad flexible support of the whole process of innovation and new developments in medical education aimed at increasing its relevance to the problems, conditions, and needs of developing a system of medical care services characterized by comprehensiveness, continuity, competence, humaneness, and family orientation.

The association would view with great concern approaches which would have the effect of determining departmental organization and the nature of the curriculum in medical schools by statutory action. We join with the American Medical Association in this reservation concerning the specific language of S. 3418. Medical schools are actively changing their educational programs to meet new challenges. Support for specific programs rather than general support will limit the speed, flexibility, and effectiveness of this process of innovation.

The objectives sought through S. 3418 could be well achieved if the bill was modified to provide broad support for all programs that will increase the number of physicians qualified to participate in the delivery of primary health care. One way of doing this would be by appropriate amendment of part E of title VII of the Public Health Service Act to provide for the following:

1. A modification in the language of section 772—Special Project Grants, to emphasize the use of these grants for educational innovation and development relating to the needs for physicians capable of providing primary, comprehensive, and personal medical care.

2. Enlarge the institutions eligible for special project awards to include hospitals and public and private nonprofit agencies involved in education and training in health.

3. Increase the appropriation authorizations in section 770 to assure that adequate funds can be budgeted for special project grants in this area.

S. 3418 amended to provide for the changes noted above in existing legislative authority would, we believe, be fully adequate to achieve the essential objectives being sought. It goes, almost without saying, however, that the most effective legislative action, to assure that medical education and the institutions involved can make their maximum contribution to the public needs and objectives in health, is the appropriation of funds adequate to the dimensions and urgency of the tasks involved.

The CHAIRMAN. I am studying here your proposed change in the language of S. 3418. I am instructing the staff to give that the closest attention and we will consider this in executive session. I assure you.

I am impressed by your statement that what we need is a broad general education rather than family medicine, surgeons, and so forth. Of course in the past we did not get the family practitioners out there. The education has not been so broad as to cause the students to think of family practice as something desirable along with a specialty. It has been thought by those urging this bill that it is going to take categorical assistance on family practitioners, not to deemphasize surgical.

I would like to say to Dr. Hall, I would not want to eliminate the number of cardiologists in this country from what I know of the men who happen to be much younger than I who have suffered heart attacks.

There are many very provocative statements in your paper, Doctor. I do not mean provocative in the sense of controversial, but thought provoking.

There is one about "curriculum modification which has brought to medical students a greater awareness and understanding of the social, behavioral, and environmental factors in disease and health."

Did you see the report of the geographical survey of health that has been released in England and was reported in the press last week?

Dr. HEYSSEL. No, sir.

The CHAIRMAN. In certain areas of England the average person lives a good many more years than in other areas because of geographical factors. They have made a geographical survey of England and a chart of health according to geography. I don't know if they put in there the reason why in some areas they average many more years than in others.

The week before last in England I was talking with a prominent electrical engineer, who told me of his home in Yorkshire where his family had lived for many centuries. After having spent many years away from Yorkshire he had a desire to go back and see the other families in the countryside. He went back to this area, where there are a great many coal mines, and found that all the people were coughing. The coal is now treated at the mining area so that it does not produce smoke and soot at the time of burning and as a result the smoke and soot now settles over the countryside there in Yorkshire. This treatment of the coal at the mines has benefited London, as you know from newspaper accounts concerning the diminution of the famous London fogs, but now the soot has settled over the countryside. He is not a medical doctor but he had his suspicions as to what was happening to the health of

the people. Although London is not having the fogs they had in the past, all the smoke and soot is settling near the mines.

In the study of cancer has there been research into whether or not stress triggers growth that causes cancer? Are people undergoing great emotional stress for long periods of time more susceptible to cancer? I don't know if there is a cancer research person in the room or not.

Dr. HEYSSEL. There have been studies in this regard. As you know, there is a variation in geographic incidence of different kinds of cancers. There has been clusters of leukemia.

The CHAIRMAN. Is there any consensus of medical opinion as to whether prolonged period of stress does or does not cause cancer?

Dr. HEYSSEL. I don't think there is a consensus. There have been studies in this area.

I would like to comment that we have introduced into the curriculum at Johns Hopkins, as have other places, studies in behavioral science and the geographic incidence of disease. We have made available to our students the opportunities to involve themselves in health planning, to involve themselves as patient advocates for people in the innner city as well as in Columbia, Md. We now have students working in programs that we have not dealt with in the past, such as alcoholism and drug abuse. So I think we are moving to an awareness of the fact of social and other forces in health rather than simply concentrating on illnesses that are found in an acute general hospital which has been the pattern of medical education pretty much in the last years.

I think the development of these programs in medical schools will in themselves interest students in family practice. I think that there are a variety of ways of delivering primary care in group practice around primary care specialists suc as internists, pediatricians, obstetricians is one method of doing so and one way of exposing the student to this experience.

The CHAIRMAN. In your statement, on page 5, point 1, you suggest special project grants to be specifically earmarked for educational innovation and development.

Dr. HEYSSEL. Yes, sir. I would like to give an example, if I could, again looking at the program in Columbia. This is a program which has been totally underwritten by a major life insurance company in the United States. This is totally underwritten, obviously, to give medical care to people, not to support educational developments, not to support the training of new kinds of health personnel, not to support faculty effort in teaching and demonstrating to students the care of families and the comprehensive care of patients.

It would be greatly helpful to the institutions to have funds specifically earmarked for education within such programs. They are supported now basically only by service dollars or dollars devoted to the care of patients.

What is needed is the addition of funds for the educational program. I think from the medical schools' viewpoints, also, I would point out that the creation of these new kinds of programs involving the commitment to the care of 25,000 or 50,000 people, which is the size populations needed for the best kind of experience, is a very expensive undertaking. I think that we can estimate with some

accuracy at Johns Hopkins that institutional funds of at least a quarter of a million dollars have been devoted to this.

In addition to funds derived from foundations, grants from the Federal Government, and in addition to funds which were essentially startup costs underwritten by the Connecticul General Life Insurance Co. to get the insurance program going, I think there is an investment of at least a half million dollars involved in developing these kinds of programs and probably greater, and it is these kinds of funds which are totally lacking now in order to develop the educational programs which will have an impact on students and change in pattern.

The CHAIRMAN. In other words, not put them in the pattern per se but give them a broad view of the whole field of medicine.

Dr. HEYSSEL. Yes, sir.

The CHAIRMAN. On page 6 you say:

> Increase the appropriation authorizations in section 770 to assure that adequate funds can be budgeted for special project grants in this area.

What increase in the authorization would you recommend? What additional amount of money do you think would be required?

Remember, we put the authorization in the bill. We have the harder job of getting the Appropriations Committee to appropriate.

Dr. COOPER. Senator Yarborough, maybe I can answer that. Actually, as you know, the special project grants and the money which has been appropriated for them have been very heavily involved in rescuing those schools that are in severe financial difficulties and permitting schools not only to innovate in this particular area but in other areas of the curriculum. Certainly the kinds of authorizations which you propose in S. 3418, if added to the existing 772 would furnish the same level of support which you and the sponsors of this bill are considering for the development of programs related to better training of medical students for the care of families, comprehensive family practice.

The CHAIRMAN. We will work on this. You did not say what amount definitely. Do you have a recommendation in mind?

Dr. COOPER. Certainly, the authorization which you have in this bill, if added to the existing authorization for special project grants, would provide an adequate level of support for the objectives of S. 3418.

The CHAIRMAN. Thank you. I will very favorably consider your recommendation and see what I can do before the subcommittee.

Dr. COOPER. You made the comparison of England. If I might be permitted, I just returned from an exchange mission to Russia. This was headed by Dr. Steinfeld, the Surgeon General. Dr. Marston was on the exchange mission as was Dr. Russell Roth, speaker of the house of delegates of the American Medical Association. We had quite an interesting 3 weeks there. I think it is important to note that there have been recent changes in the approach of the Russians to the education of their physicians.

In the first place, they are going to substantially increase the number of M.D.'s trained. They now have about 630,000 physicians, which gives them over twice as many per population as we now have.

They are going to increase this to about 340 to 360 physicians per hundred thousand. At the present time in the United States we have about 160 physicians per 100,000. So this will be over twice the number of physicians per population that now exists in the United States.

More interestingly, they are changing the nature of the program as well. First they have lengthened it. Their program as in many other countries of the world takes students out of secondary school directly into the professional education which involves preparation in physics, biology, mathematics and general studies and continues through the basic medical sciences into clinical medicine. The program which used to be 6 years is now 7 years in most of the institutes that are training medical students, and by 1973 this new program will have been instituted in all of the medical schools in Russia.

The last 2 years of this program are specialty training. They will not turn out generalists any more in the medical schools. The students specialize in one of four areas, therapeutics, which is equivalent to our internal medicine, pediatrics, obstetrics, gynecology and surgery.

During the 6th year of their curriculum they have general clinical training in one of the four areas and in the 7th year it becomes more specialized. They will use in their primary care clinics, which are called Uchastok clinics, three of these groups as those delivering the primary care to the population. They will use the therapeutist, which is the internist, the pediatrician, and obstetrician along with the other health professionals which will form the team in these clinics. The more highly specialized specialists, I call these generalist specialists, the more highly trained specialized specialists such as the thoracic surgeons or cardiologists and so on are back in either the Rayon Hospital or the Oblast Hospital. I think it is quite interesting that they now are developing a kind of medical education which is approaching much more nearly the kind which has been given in this country in the past.

It is also interesting that 30 percent of the medical students in Russia are now doing research during their medical school career, not only those ultimately interested in a career in academic medicine, but also those who are interested in practice.

Both the Ministry of Health and the Medical schools wish to increase the opportunities for students to participate in research because they feel that to deliver the kind of care which they feel the people deserve, the students should have a much broader and more fundamental basis in scientific medicine than they have been able to give in the past.

I thought that might be an interesting comparison.

The CHAIRMAN. Very interesting.

Did you have an opportunity to visit any of their medical schools?

Dr. COOPER. Yes, sir; I visited four medical schools.

The CHAIRMAN. You saw the classes in operation?

Dr. COOPER. Yes, sir; I attended lectures.

The CHAIRMAN. What percentage of the classes you saw were men and what percentage were women?

Dr. COOPER. At the present time the entering classes in the medical schools in Russia are about 40 percent women and 60 percent men. They have a plan to reduce this to 30 percent women and 70 percent men. At the present time, in practice in Russia, there are about 75 percent women.

To explain this one has to look back to the terrible consequences of World War II for that country. They had a terrible loss of life, much of it male, and many of the jobs and professional responsibilities

which ordinarily are taken by men in other countries were assumed by women because of the really severe shortage of manpower. However, they are in the process of changing this ratio. Ultimately, they think that the 30–70 percent ratio is about the proper one for medical education and for the practice of medicine.

The CHAIRMAN. The reason I asked that, the week before last I attended the 54th Meeting of the International Labor Organization in Geneva. The Russians for years had taunted the West that, "You don't give your women an equal chance. Look, in Russia 75 percent of our doctors are women. You have very few women doctors, you deny opportunity to women doctors." The last year or two the percentage of men doctors have been increasing in Russia so the Russians no longer say this.

The Russians have quit talking about the increasing percentage of women each year in medicine. We know that the terrible loss of life they suffered in World War II is the cause of this vast percentage of women doctors, as well as the large numbers of women who work everywhere. We saw women carrying heavy stones on the street. We don't have men doing that in this country. We put machines to doing it. During the war Russia was virtually stripped of able-bodied men, furnishing forces against Germany, and as a result the number of women in the professions increased.

Thank you very much for your fine contribution here. This will be very helpful to us.

Dr. HEYSSEL. Thank you, Mr. Chairman.

The CHAIRMAN. The next witness is Mr. Peter Andrus, chairman of the Standing Committee on Health Affairs of the Student American Medical Association, Hunterdon Medical Center, Flemington, N.J.

STATEMENT OF PETER ANDRUS, CHAIRMAN, STANDING COMMITTEE ON HEALTH AFFAIRS, STUDENT AMERICAN MEDICAL ASSOCIATION, HUNTERDON MEDICAL CENTER, FLEMINGTON, N.J.

Mr. ANDRUS. Mr. Chairman and members of the subcommittee:

I am Peter L. Andrus, a senior student at the University of Pennsylvania School of Medicine. I am appearing before you today in my capacity as chairman of the Standing Committee on Health Affairs of the Student American Medical Association. SAMA is an autonomous organization representing over 20,000 active medical student members and over 60,000 affiliate intern and resident members.

Mr. Chairman, our Nation today faces a crisis in health of steadily mounting portions. The severity of this crisis becomes clearer to more and more people with each passing day. We are faced by severe contraints in each of the operative parameters which determine the extent to which high quality health care is available to all of our country's people.

First, the manpower shortage in practically all categories of health professionals is worsening appreciably with each passing week. This shortage of qualified manpower is perhaps our most pressing and immediate constraint on the delivery of health care, since, in the final analysis, health care is people-people trained and available to serve other people who are sick.

Second, and of great importance as well, is our lack of suitable facilities in which to deliver health care.

I might mention in passing that I think it is largely due to the efforts of this committee and the Congress as a whole that H.R. 11102, which provides for a number of progressive programs in terms of health facilities, was recently passed over the veto of the President.

Both consumers and providers of health care alike are becoming increasingly aware that our existing institutional structure of health facilities is not maximizing the time of scarce health professionals engaged in the delivery of services nor are they conducive to optimal utilization of the limited funds available to finance health costs. Thus, we must expect in the coming months and years to find a great deal of innovation exerted in developing new facilities for aiding in the delivery of fast, effective, comprehensive, economic health services.

Third, we find ourselves in the midst of a devastating upward spiral of health care costs brought on by a host of factors including: A rise in the consumer expectations in the health care system; attempts at new funding mechanisms for health care, such as Medicare and Medicaid; and a rapid inflation in the economy as a whole. Thus, health costs have skyrocketed. I need hardly elaborate on this point except to say that adequate documentation of this phenomenon is readily available elsewhere.

Within the context of this most distressing picture, I wish to state the strong support of the Student American Medical Association for S. 3418, a bill which we feel will make a significant contribution in remedying the problems to which I have previously alluded and in improving the quality of health care of all Americans.

In testimony presented yesterday before the subcommittee, the American Academy of General Practice strongly emphasized the shift away from generalization toward specialization that has occurred in American medicine in the past 40 years. A rise of specialty-oriented practice, based firmly in scientific and technologic knowledge and advances is a very significant, and for the most part positive, feature in the growth of medicine. Historically, this movement was strongly aided by the development of the National Institutes of Health in the late 1940's and their subsequent growth as a source of funds for research and training of manpower in the several specialties of medical practice.

Looking at the contemporary scene, however, we see a health care system that has in part grown away from the fundamental reason for its existence; the good health of our Nation's people. While I strongly support the rise of scientific, specialized medicine, I also wish to suggest that at present we are in the process of reexamining our objectives and reformulating our goals so as to reemphasize health services as the end toward which the means of health research and education are directed.

I think that as a basic conclusion we are reaching in this sweeping reappraisal is that the primary care, or family, physician must play a central role in the delivery of health services in the years ahead. Family practice, as Dr. Vernon E. Wilson, recently appointed head of the Health Services and Mental Health Administration, points out "is the first specialty whose specialization arose from the need of the community rather than the need of the discipline." The family physi-

cian specializes in generalization and adaptability. His training equips him to deal with a broad range and the vast majority of the illnesses which afflict mankind and to deal with them in a competent effective and economical manner. This training further equips him to recognize and delineate those problems of a highly complicated nature which require a specialist, and further to coordinate the various health services in a community to the overall need of his patient.

Yet, as has been pointed out by Dr. Kowalewski of the AAGP in his earlier testimony, the numbers of family physicians as a proportion of all practicing physicians has been steadily dropping for the past 40 years, and the ratio of health consumers to family physicians has risen steadily during this same period. Even more frightening are the current estimates which indicate that only between 10 to 15 percent of the graduates in recent medical school classes are going into general or family medicine.

I think the data which was presented earlier would suggest that the large numbers of internists, obstetricians and pediatricians providing family general practice medicine are merely further documentation of the fact that there is a very pressing need for more family physicians in this Nation.

Within the past 18 months, the development of the American Board of Family Practice and the rapid increase of family medicine residency programs from a mere handful to 38 (as of June 1970), and I now learn 46—has begun to provide a sound base for certification and strong training in this legitimate patient-oriented medical specialty. Yet the efforts to provide adequate numbers of well-qualified family physicians have to date been pitifully small.

An important factor in the prospect for future success of such programs is, of course, the attitude of today's medical students toward family medicine. I can state with conviction that the activism and commitment that mark today's students in their efforts to face and solve many of today's health problems will provide a strong stimulus to devote their professional lives to the practice of high quality, patient-oriented family medicine.

It is for the reasons I have stated that the Student American Medical Association strongly supports S. 3418. We believe this bill focuses at each of the important levels required to develop a strong program of training in family medicine. By its provisions for funding departments of family medicine within the medical schools, a significant positive exposure and influence by family medicine can be provided for medical students at a crucial time in their career decisionmaking process. By providing funds for the development of family medicine residency training programs there will be a strong impetus placed on capitalizing upon the increased interest in and need for the practice of family medicine. Finally, by providing funds for the training of allied health personnel in this area the bill takes the very progressive step of encouraging innovation in developing new patterns of delivering health care in a more effective and economic manner.

In conclusion, let me say that we believe this bill, S. 3418, to be most timely, and its sponsor and cosponsors are to be heartily congratulated for its inception. Just as the provision of Federal funds since the late 1940's for the National Institutes of Health has provided this country with tremendous advances in biomedical knowledge and

specialty practice, so, too, the initiation of the program proposed in S. 3418 will make a dramatic contribution toward the goal of better quality health care for all Americans that we are all seeking in the 1970's. The Student American Medical Association strongly supports that goal and this effort to achieve it.

Thank you for the opportunity to present our views here today. I shall be glad to answer any questions you may have at this time.

The CHAIRMAN. We have about six questions we would like to submit, Mr. Andrus, but I think I will submit them to you in writing and ask you to answer them in writing since it is 12 and I must go to another engagement.

Mr. ANDRUS. Very well, sir.

The CHAIRMAN. Your paper is very helpful. I have been following it closely and we do have these questions and we do want the answers in the record from the students' standpoint.

If we had the percentage of physicians that Dr. Cooper indicated that Russia had we probably would not need these family specialists as much because we would have enough doctors. I don't know how they would distribute those in Russia but I assume they would have outpatient clinics with experts in all categories.

What did Dr. Cooper say—360 physicians per hundred thousand population where we have 160 for a hundred thousand? Is that the figure?

Mr. ANDRUS. Something of that order.

The CHAIRMAN. We have 160 per hundred thousand. We have a great shortage. We must have family physicians to get out over this country and give medical help to the people of this country. After Red China came into power, General Wedemeyer was appointed head of the American mission to find out why China fell to the Communists. It was not military superiority. We furnished Chiang Kai-shek with arms and equipment. We hear a lot of stories in the press often that America was sold down the river by people in the State Department who gave China to the Red Communists.

You ought to read the Wedemeyer report. The Wedemeyer report reports that the average Chinese, if he is arrested, might languish in jail for years before any charge was filed or anybody could find out what charge there was against him because he did not have the means to hire an attorney to file a habeas corpus proceeding and get him out of jail. If his tooth ached he got a neighbor to pull it, there was no dentist for him. If he got sick he might die, there was no doctor for him to go to. This is one of the great weaknesses in the structure of the Chinese society. The failure to have professional men to render personal service to people: a lawyer to help him in his monetary quarrels for his personal liberty, doctors and dentists and others to help him with his health problems. This was absent in the Chinese society for the average Chinese. The rich Chinese had that, yes, but for most of the people it was unavailable.

So they just said, "What difference does it makes? This government means nothing." One war lord after another came along to levy taxes, so government meant nothing to them.

I think a medical health care should be available in America not only for the affluent and middleclass society but for all our people.

We can't have health care without the people trained to deliver it. This whole problem in health care is to train more doctors, paramedical personnel, nurses, all across the board, and get the facilities in which they can treat people once they are trained. This is what this committee is trying to do.

Thank you very much.

Mr. ANDRUS. Thank you.

The CHAIRMAN. Now I have been given the information that the figure by Dr. Cooper for 280 physicians per hundred thousand does not include the Russian feldfher physician assistants.

The hearing is adjourned. We will leave the record open to submit these questions. We have other questions that we have submitted to the administration. We will leave the record open until next Monday. Anybody who has any additional written statement or information they desire to file with the committee, we will be glad to have it.

(The material referred to above follows:)

STUDENT AMERICAN MEDICAL ASSOCIATION,
Philadelphia Pa., July 12, 1970.

Hon. RALPH W. YARBOROUGH,
Chairman, Committee on Labor and Public Welfare,
U.S. Senate, New Senate Office Building, Washington, D.C.

DEAR SENATOR YARBOROUGH: I am writing in response to your request that I answer several questions relating to my testimony on July 9, 1970, for the Student American Medical Association on S. 3418, a bill to fund programs to encourage the training of health manpower in family medicine. Let me initially thank you for the opportunity to present SAMA's testimony on this important bill. I will attempt to answer your several questions briefly and clearly.

Q. "Would increasing the number of medical schools *per se* be the best approach toward increasing the numbers of physicians being graduated?"

I would think not. The initial expenses incurred in the development of an entire new plant and the recruitment of a full staff of new faculty members, makes the creation of more than a very few new medical schools a short run impossibility. Instead, I believe we must concentrate our effort in increasing the output of the existing medical schools: this implies support for construction of new facilities where needed, increased institutional support (for faculty salaries, operating expenses, etc.) and increased support for students through scholarships and loans. There are significant economies of scale to be gained from increasing the efficiency of our usage of present teaching facilities and faculties, which I will not elaborate upon at present, that would seem to make this the best approach to follow.

Q. "How can more practicing physicians be utilized in the process of medical education?"

This relates directly to the matter of efficiency noted above: if community hospitals, with well-trained practicing physicians involved in their own continuing education through university ties, were actively involved in a significant portion of the basic science and clinical education of medical students, our capacity to provide high grade educational experiences, especially in clinical medicine as practiced in the communities of our Nation would be significantly enhanced. This potentially could provide for great increases in the number of students being trained in medicine each year, and would encourage a stronger community orientation among today's medical students.

Q. "How might this influence continuing medical education?"

The above would provide a major stimulus for practicing physicians to maintain active continuing educational programs on a formal basis with their university affilations, and through the informal give and take of teaching students, interns and residents.

Q. "What are the implications of periodic recertification of physicians—such as practiced by the AAGP?"

Clearly, the emphasis is on each individual practictioner's maintaining his currency with new methods or prevention and treatment of disease. The American Board of Family Practice is, to the best of my knowledge, the first specialty board to require periodic recertification through an examination procedure. The

practice should prove a most helpful one in terms of ensuring continuing high quality medical care, and should be emulated by other Boards. It should provide a further incentive to active continuing medical education in addition to the other incentives noted above.

Q. "What efforts have medical students made to expose themselves to community- and patient-oriented-medical practice?"

I cannot adequately answer this question in any reasonable amount of space. Let me briefly cite the following activities of the Student American Medical Association in the area of community health and have forwarded to you comprehensive information on each of these endeavors:

1. The SAMA Appalachia Student Health Project-funded by the Appalachia Regional Commission, 100 medical and 20 nursing students spent the summer of 1969 in ten states of Appalachia in a variety of rural health care settings. This summer, the number of students is increased and includes dental and pharmacy students as well.

2. The SAMA Job Corps Project- in both 1969 and 1970, twenty medical students (approximately) spent the summer working in various job corps training centers throughout the country aiding in providing health services to trainees and studying the health problems which these people have faced.

3. The SAMA Indian Health Project-funded for the first time in 1970, approximately thirty medical students are spending the summer participating in health activities among the Indians throughout the Western United States.

4. The SAMA-Sears Community Health Grants Programs- provides seed money of $1000–1500 to local medical student groups involved in organizing local community health clinics and other public health activities.

These are but a few of the Student American Medical Association's activities in this area, but should provide some insight into the active efforts students are making in familiarizing themselves with today's pressing health problems throughout the country.

Q. "What has been your personal experience with family medicine?"

During the past two months I have been serving as a junior intern during my senior year on the medical service of the Hunterdon Medical Center in Flemington, N.J. This medical center is unique in its organizational make-up. All twenty-five family physicians in Hunterdon County, N.J. (population 60,000) are members of the admitting staff of the medical center. In addition, there is a hospital based staff of specialists in the various areas of medicine, pediatrics, OB-Gyn, surgery and psychiatry who see patients of the family physicians only by referral and who also, of course, have admitting privileges at the medical center. In this manner the role of the family physician as primary or first contact physician is retained, as it should be, and the specialist staff acts as a referral staff when required and appropriate. There is a Family Medicine Residency Program at the medical center which is outstanding, in my opinion, and in addition there is a teaching program for medical students (such as myself) who affiliate here during portions of their four years of medical undergraduate education. I enclose further information on the medical center for your information. I can say, without qualification, that my experience at the Hunterdon Medical Center, has been one of the most rewarding educational and personal experiences of my entire medical education to date.

Q. "What is your reaction to the establishment of an Advisory Council on Family Medicine?"

I believe that it is most appropriate that a council of this sort, composed of teachers, practitioners and consumers of family medicine be available to assist the Secretary of Health, Education and Welfare in awarding grants under the provisions of S. 3418. However, I would recommend that at least one or two of the positions on such an advisory body be specifically for students or residents in training in family medicine. Since theirs is an especial perspective, and their future career choices are committed to family medicine, it seems both wise and appropriate that the counsel of young physicians in training for family medicine be provided for in this fashion. This would also set a significant precedent, to the best of my knowledge.

In closing, I would like to offer one or two brief further comments. First, some of the witnesses who testified before the Committee expressed concern that the language of the bill was too restrictive with respect to dictating institutional administrative arrangements for the teaching of family medicine. I do not find this to be so in study of S. 3418. Rather, the bill requires that there be "separate and distinct departments devoted to providing teaching and instruc-

tion in all phases of family practice." The bill does not stipulate that this be the sole purpose of such a department: thus, in some schools, where the institutional arrangements are such that a Department of Community Medicine, for example, fulfilled such functions, such a department would logically be eligible for receipt of grants under this program, so long as they fulfilled all legally and administratively set standards for doing so.

Second, there are those, including the Administration, who apparently object to the bill because of its categorical nature. Nevertheless, the categorical approach is the only realistic one to follow in order to place the special sort of emphasis on the current pressing need of more family physicians that is required in order to deal with this need. As was pointed out in our testimony before the subcommittee, just as the categorical provision of funds for the NIH has provided enormous impetus and progress in the areas of bio-medical research, so too, it is equally appropriate in this day of increased need for more and better health services that we should turn to mechanisms such as the proposed family medicine bill to provide for these needs.

Many thanks again for the opportunity to testify on this important bill, and to answer your questions in some depth. With best wishes I remain

Sincerely yours,

PETER L. ANDRUS,
Chairman, Standing Committee on Health Affairs.

FAMILY PRACTICE TRAINING PROGRAM

HUNTERDON MEDICAL CENTER, FLEMINGTON, N.J.

The training of the Family Physician has been the primary post-graduate training endeavor of the Hunterdon Medical Center since its inception in 1953, initially with a one-year family practice residency, and since 1962 with a family practice internship and residency which, now, has been expanded to a three-year program fully approved by the AMA Council on Medical Education. The enclosed brochure was written in 1967 following five years of experience in planning and developing a successful two-year Family Practice Training Program. During the past three-year period the program each year has filled its intern quota of four. With the approval by the AMA of a Board in Family Medicine, the teaching program at the Hunterdon Medical Center has been modified and expanded to meet the requirements for Board eligibility. This supplement to the enclosed brochure will outline in some detail the current program offered.

As you read the brochure you will note that the philosophy behind the teaching program is comparable to the concepts for family practice teaching as outlined by the Ad Hoc Committee on Education for Family Practice of the AMA Council on Medical Education, and the report of the Citizens Commission on Graduate Medical Education, both published in 1966. The teaching program incorporates the "Core Content of Family Medicine" as published by the American Academy of General Practice Committee on Requirements for Certification, also in 1966.

The brochure records in some detail the unique medical structure in Hunterdon County, which is family practice oriented. The teaching program therefore is family practice oriented. It is an unusual situation that the Hunterdon Medical Center and the entire medical community serve as a "family practice model." Although the house staff, in addition to the Family Practice Trainees includes one first year medical resident from the University of Pennsylvania on a two-month rotation, and a first year Ob-Gyn. resident from Lenox Hill Hospital in New York City on the surgery service for a six-month rotation, the emphasis of teaching on all services and in didactic conference is upon a family and community approach to medicine. The house staff and teaching programs are further strengthened by the presence of three medical students from the University of Pennsylvania and three medical students from the Jefferson Medical College on the medical service on rotation, and one medical student from the University of Pennsylvania on a pediatric rotation.

The present three-year rotation is as follows:

1. First year (internship):
   Medicine—6 months
   Pediatrics—3 months
   Ob-Gyn.—2 months
   Surgery and Orthopaedics—1 month

2. Second year (residency) :
   Medicine—5 months
   Pediatrics—3 months
   Diagnostic and Out-Patient Surgery and Subspecialties—2 months
   Ob-Gyn.—1 month
   Elective period—1 month
3. Third year (residency) :
   Practice experience—6 months
   Psychiatry—3 months
   Elective period—3 months

The purpose of the first two years of the training program is to teach in as much depth as possible the knowledge and techniques of each discipline in medicine which will be required for the individual in family practice. A description of the teaching program given by the Department of Medicine, Department of Pediatrics, Department of Obstetrics & Gynecology, and Department of Surgery, are outlined in the brochure. Teaching is conducted by both full-time specialty staff and family practice staff. Since the Family Practice Training Program is the only specialty program offered by the Hunterdon Medical Center, the emphasis in teaching in all disciplines is upon family medicine.

The brochure describes the emergency room experience which continues throughout the first two-year period of the program. This is considered a most valuable experience due to the wide variety of problems encountered. Adequate supervision and consultation are available at all times from the senior residents, the family practice staff, and the specialty staff, any one or more of whom might be called.

The family practice perceptorship, which has now been in operation for a three-year period, is described in the brochure. A certain number of families are followed by each second year resident who is assigned to the office of a family physician one afternoon each week.

Throughout the second year of the program, there is a weekly conference in physchiatry, largely informal, with discussion of numerous behavioral problems, generally centered about one or more patients. Further physchiatric experience will be gained during the third year of the program when at least three months will be devoted to both in-patient and out-patient physchiatric problems. A mental health facility is presently under construction at the Medical Center and should be completed within the next year. It will include both in-patient beds and a day center which will be used for active teaching.

During the second year of the program the residents attend the weekly Home Care meetings and are assigned a certain number of patients whom they have known in the hospital which they follow weekly in their home or nursing home. The Home Care meeting is attended by a physician, a social worker, a visiting nurse, a physchiatric social worker, and, usually, the family physicians responsible for the patients presented. During this experience the trainee develops an understanding of community resources available to him, as well as the social and emotional problems which accompany a protracted illness. Since this program has been in effect it has been found by the residents to be most profitable.

In addition to the informal teaching rounds and conferences a daily didactic conference designed primarily for the family practice trainee is given by various members of the house staff and attending staff. As noted in the brochure this conference rotates among the various medical disciplines. The first four to six weeks of conferences are directed primarily to the first year trainee and include largely emergency medicine and surgery. Beginning in September of 1969, there will be regular family practice conefrences which will include topics which will be of particular benefit to the budding family physician. Included will be conferences and discussions concerning the behavioral sciences. the humanities, community resources, government in medicine, religion in medicine, the office aspects of medical practice, and public health. For this conference we will draw not only from local physicians and local administrative personnel, but will also include the county public health officer, and invited faculty members from the affiliated medical schools.

The third year of the program is designed primarily to permit the family practice resident to apply the basic knowledge and techniques which he has acquired during the rather intensive training offered during the first two years of the program. It is at this time that he will be offered an expanded practice experience under the guidance and tutelage of a practicing family physician. A peripheral community health clinic is being designed for Lambertville, N.J., a

small community in Hunterdon County approximately 12 miles from the Medical Center. It is contemplated that this unit will be staffed by two full-time family physicians and will be the main unit for supervised practice experience during the third year of the training program. This experience may also be obtained in the office of one of the practicing family physicians in the county. During at least six months of this year the resident will serve as a family physician practicing as a partner of the family physician who will also serve as his tutor. The experience will be largely an out-patient office experience. He will, however, serve as primary physician for his patients admitted to the Medical Center. He will make rounds on his patients on a daily basis and will avail himself of the consultation services available, if required. The resident during the third year will also attend the daily didactic conference and will be available several hours each week during the first three months of the year to teach the first year interns in the emergency room.

There is a three-month elective during the third year which may be spent in any of the medical disciplines in which the individual desires more training. He may wish to extend his practice experience or he may spend a further period of time with the Department of Psychiatry. Additional time may be spent with the departments of Medicine, Pediatrics, Obstetrics & Gynecology, or Surgery.

The third year of the program, by design, is flexible. This is for several reasons.

1. The first two years of the program have evolved over an eight-year period and provide the basic training in depth required for the practice of family medicine. This two-year training period has been highly successful. Throughout the years it has been evaluated and criticized not only by the interns and residents in training, but also by graduates of the program. Many phases of the program have been developed following suggestions from former residents.

2. The flexibility of the current third year will permit individualized training, depending upon the resident's past medical experiences and future medical needs. It is to be emphasized that material peculiar to the new specialty of family medicine in incorporated in this program throughout the entire three-year period. Teaching on all services is directed towards family medicine. There is a large out-patient experience particularly in pediatrics, psychiatry, gynecology, and surgical subspecialties including ENT, ophthalmology, urology, and orthopaedics, and also dermatology. The introduction to office practice during the preceptorship experience of the second year expands during the third year to a sizable, supervised office practice experience.

Community and preventive medicine is emphasized throughout the teaching program. This is particularly true in the teaching given by the Department of Pediatrics where there is considerable emphasis upon epidemiology, immunizations, normal and abnormal growth and development, environmental health, and community relations. The regular family practice conference is designed to cover many aspects of community, preventive and family medicine.

With the three-year program a more active participation by the interns and residents in clinical studies and case reports is encouraged.

The family practice trainee salaries are currently as follows:

First year—$4800.00 plus full maintenance.
Second year—$5400.00 plus full maintenance.
Third year—$6000.00 plus full maintenance.

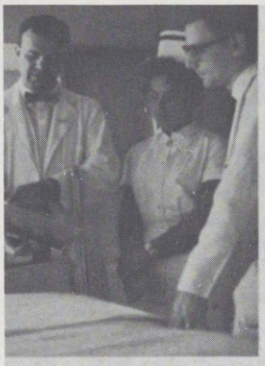
As you will note in the brochure, completely furnished apartments are available on the hospital grounds. Other fringe benefits including food, uniforms, laundry, and hospitalization insurance are also recorded. It has been estimated that the cost of full maintenance plus fringe benefits is approximately $3100.00 per intern or resident. Thus, in actuality, salaries are as follows:

First year—$7900.00.
Second year—$8500.00.
Third year—$9100.00.

Appointments to the program are made by participation in the National Intern Matching Program. A personal interview is strongly urged for applicants to the program. For further information, application forms, and arrangements for a personal interview, please write Dwight J. Hotchkiss, Jr., M.D., Director, House Staff Education, Hunterdon Medical Center, Flemington, N.J. 08822.

FAMILY PRACTICE TRAINING PROGRAM

AN UNUSUAL OPPORTUNITY in AN UNUSUAL ENVIRONMENT



FAMILY PRACTICE TRAINING PROGRAM

HUNTERDON MEDICAL CENTER • FLEMINGTON, NEW JERSEY

In medicine today, there is a growing opportunity, and a growing need, in the field of Family Medicine. This is an area of continual challenge and stimulation, because the family physician is usually the first person to see a broad range of medical problems. It is a field where relationships with patients and families are deep and meaningful.

In Family Medicine, the physician has an opportunity to fully utilize a broad knowledge of medicine and of human development, to gain insight into the emotional aspects of illness, and to participate in preventive care.

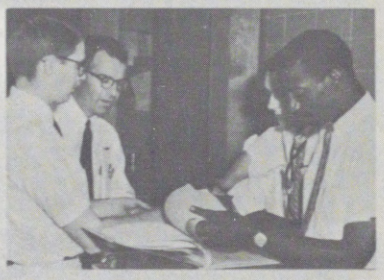
Many medical educators today recognize that a new kind of family physician is required to integrate medical knowledge and individual patient and family care. "For the moment a group of specialists working as a clinic sometimes serves as a composite personal doctor, but it seems possible that a major new specialty, that of integrated or personal or comprehensive medicine, is going to evolve."*

The Family Practice Training Program at Hunterdon Medical Center offers an unusual opportunity and an unusual program, designed to train and develop the comprehensive family physician.

Established in 1962 under the auspices of the Council on Medical Education of the American Medical Association, this program offers two years of training following graduation from medical school. The first year is an accredited year of internship, and the second year is comparable to a year of residency training.

* From Magraw, R.M., and Magraw, D.B.: Ferment in Medicine, W.B. Saunders Company, Philadelphia, 1966.

At Hunterdon Medical Center, all of the 24 specialists and 21 family physicians on the staff participate in the educational program. In addition to daily formal rounds and conferences, much of the daily training derives from the direct relationship of the trainee with the attending physician in the care of patients. This constitutes a refined preceptorship in which the trainee assists the physician in the care of patients, and learns through repetitive practice, example, and discussion, the knowledge and skills appropriate to patient care.



These opportunities are presented in the in-patient and out-patient services of Medicine, Surgery, Obstetrics and Gynecology, Pediatrics, and Psychiatry by the specialist staff and the family physicians. In one phase of the program the trainee develops the concept of continued family care for selected families by participating in the office practice of a family physician over an extended period. Emergency Room experience is not isolated to short periods, but rather continues over the entire training period on a regular basis. Responsibility for patient care increases as the individual's

training and capabilities increase and is sharpened by his responsibility to participate in the teaching of medical students and junior trainees.

Hunterdon Medical Center is located in Flemington, New Jersey, the county seat of Hunterdon County. The county is 440 square miles in area, has a population of 65,000, and is equidistant from New York and Philadelphia. The Medical Center has 150 beds and 22 bassinets. A six-floor out-patient building has recently been completed and contains physicians' offices, the library, research laboratories, a speech and hearing unit, and an enlarged physical therapy unit. Laboratory and x-ray facilities include many of the most recent techniques and procedures. The Emergency Room has been enlarged, and is adjoined by a minor surgery room. An intensive care unit, including a coronary care unit, also has been completed.

Hunterdon Medical Center is affiliated with the New York University School of Medicine, and has a full time specialist staff of 24 board-qualified or certified physicians, representing the major specialties.

Each full time specialist is a member of the faculty of the New York University School of Medicine, and maintains regular teaching and research responsibilities there. These physicians direct the operations and teaching of the various services at the Hunterdon Medical Center, and serve as a faculty in situ. In addition, all sub-specialties of medicine and surgery are available on a part-time or consultant basis.

All family physicians in Hunterdon County are on the staff of the Medical Center and share in all activities. A broad diversity of patient material is seen at the Medical Center and all become part of the teaching program and are the responsibility of house staff members as well as of the attending physician.

Hunterdon Medical Center is "one of the most unusual projects in the chronicles of medical care in this country." It offers a new formula for medical service in a rural community in which a hospital represents the medium by which the patients remain under the care of the family physicians. They, in turn, have the complete cooperation as well as guidance of a full-time specialist staff. "In this type of organization the full-time staff supplements the family physician, but does not supplant or compete with him. The environment is that of a university-type medical center in which education and training, as well as investigation, play such important roles in medical care."*

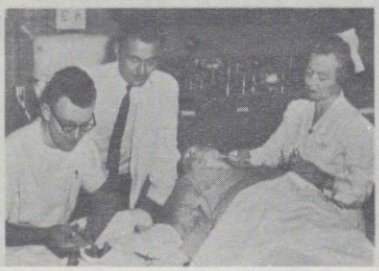
* C.E. de la Chapelle: Introduction to Trussell, R.E.: Hunterdon Medical Center, Harvard University Press, Cambridge, Mass., 1956.

The teaching programs at Hunterdon Medical Center are well established. They include full-time teaching of senior medical students on rotation from the University of Pennsylvania School of Medicine, Jefferson Medical College, and the New Jersey College of Medicine and Dentistry. In addition, Lenox Hill Hospital and the Hospital of the University of Pennsylvania send, on a rotation basis, a surgical and medical resident respectively to the Medical Center for facets of their training. The Family Practice Trainee participates in the teaching of the medical students, and during his second year shares equally with the surgical or medical resident the responsibilities of patient care. One of the second year Family Practice Trainees is chosen as the Chief Resident.

Highlights of the Training Program:

The Family Practice Training Program is scheduled as follows:

First Year Traineeship – (Internship)	Medicine – 6 months Pediatrics – 3 months Obstetrics & Gynecology – 2 months Surgery & Orthopedics – 1 month



Second year Traineeship – (Residency)	Medicine – 5 months Pediatrics – 3 months Diagnostic & Out-Patient Surgery – 2 months Obstetrics & Gynecology – 2 months

A brief description of the program in the various disciplines is as follows:

On the *Medical Service* the Family Practice Trainee is given responsibility for complete patient care commensurate with his growing experience, under the supervision of the members of the Department of Internal Medicine and the family physicians. Teaching rounds with other members of the house staff are made daily with a staff member of the department. In addition, a late afternoon conference of house staff and all department members affords an opportunity for discussion of the more critical patients and for presentation of new admissions.

The first year Family Practice Trainee (intern) is responsible for the evaluation and care of the patients assigned to him and performs and assists the senior medical students will all procedures, including spinal taps, thoracenteses, paracenteses, pelvic examinations, and other techniques. During the second year the Family Practice Trainee (resident) shares the responsibility of the Medical Service with the medical resident. He also assists the students and junior trainees with procedures, and is himself trained in the performance of sigmoidoscopies, electrocardiographic interpretation, and the performance and interpretation of bone marrow biopsies.

As he matures in judgement and experience, the trainee assumes increasing responsibilities in patient care and in the teaching of medical students. He learns to integrate laboratory and x-ray studies, as well as community resources into total patient care and learns to seek specialist consultation when needed. He plays an active role in the Home Care and Nursing Home Care programs of the Medical Center, following a selected number of patients in the home or nursing home.

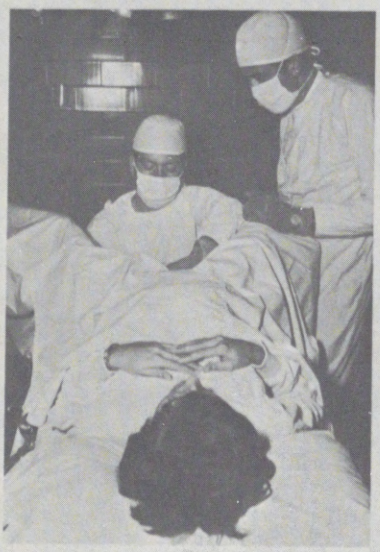
On the *Pediatric Service* the Family Practice Trainee has the responsibility and authority to provide comprehensive pediatric care of medical and surgical inpatients under the individual supervision of the family physicians and the members of the full-time Pediatric staff. The closeness of supervision and the amount of assigned responsibility are individually and progressively varied according to the ability of the trainee. Generally, three phases are noted:

a) Learning procedures, techniques, and skills of total patient care, including knowledge of human development in infants and children.
b) Learning to use these skills in a variety of clinical problems, acute and chronic.
c) Acquiring broader perspective – fitting patient care into family situations and learning how to use community resources. An appreciation of preventive care is gained.

Simultaneously, teaching the medical students is a daily routine. Daily teaching rounds in the newborn and premature nurseries and the Pediatric Medical and Pediatric Surgical floors are made. Specialists from all of the services are utilized for clinical teaching when indicated. Ambulant patients are also seen and managed.

On the *Obstetrical and Gynecological Service* the Family Practice Trainee learns the techniques needed for normal delivery, including anesthesia and the use of low forceps when required, under the supervision and guidance of the obstetricians and family physicians. Many of these

deliveries are performed on patients from the Clinton Farms State Prison (New Jersey's only female prison), for whom he also performs complete pre-natal and post-natal care, under supervision. Principles of pre-natal and post-natal care, as well as the techniques of delivery are taught. The trainee learns to recognize and treat the complications which occur in obstetrical care, and when to obtain obstetrical consultation.



The trainee is responsible for all gynecological admissions. Since out-patient gynecology becomes a large part of Family Medicine, gynecologic training is also provided by members of the department by participation in their active out-patient service. Here he learns the principles of diagnosis and treatment of such problems as tumors, disorders of the menstrual cycle, infections, and problems in infertility and menopause.

On the *Diagnostic and Out-Patient Surgical Service* the second year Family Practice Trainee (resident) is taught minor surgery techniques, trauma, and the essentials of out-patient urology, orthopedics, ear, nose and throat, ophthalmology, and dermatology which will be of benefit to him in his office practice of Family Medicine. Here the specialized history taking and physical examination and studies pertinent to these specialties are integrated into the educational program.

Formal teaching rounds are made on the General Surgical Service once weekly. Surgical patients, however, are seen daily by the trainee with the attending surgeon with emphasis upon pre- and post-operative care. One morning is spent in the Operating Room, primarily to learn minor surgical techniques. The remaining mornings are spent in the Out-Patient Department with concentration upon the various surgical sub-specialties. The responsibility for patients on the Surgical Service is shared equally with the surgical resident. The trainee is also responsible for the senior medical students assigned to his portion of the Surgical Service.

At the beginning of the first year, the Family Practice Trainee (intern) spends one month divided between the General Surgery and Orthopedic Services. During this month he will learn basic techniques which will be of value to him during his Emergency Room experience, such as proper suturing techniques, recognition of acute surgical and orthopedic problems, and methods of simple casting.

Throughout the two year period the Family Practice Trainee participates in the *Emergency Room* on a rotation basis. The trainee obtains the necessary history and physical examination required for an accurate diagnosis, and either institutes the proper treatment or seeks further assistance. Supervision is rendered by the family physicians in the county who, on a rotation basis, make themselves available during assigned morning and afternoon hours to review all cases seen in the Emergency Room with the trainee during the previous 24-hour period. In addition, the entire full-time specialist staff of the Medical Center is available for consultation. A varied experience in trauma, and in medical, surgical, pediatric, and psychiatric emergencies is provided. This is considered one of the most valuable experiences since the Emergency Room closely simulates the types of problems seen in the practice of Family Medicine.

During the second year, one afternoon per week is spent in a *Family Practice Preceptorship* in the office of a family physician in the county. This provides an opportunity to observe a family physician "at work", and to learn the aspects of office management and methods of utilization of personnel and equipment. More important, however, is the opportunity to follow a certain number of families under the guidance of the family physician with

the trainee as the "Family Doctor". Families are seen in the office and, as much as practicable, on emergency and house calls. This gives the trainee a continuity of patient and family care. It also gives him the opportunity to see the patient in his environment and to learn of the community resources available to assist in the total care of the patient.

The training program in *Psychiatry* extends throughout the entire second year of the Traineeship. Patients with emotional disturbances are followed by the trainee under the guidance and supervision of the staff psychiatrist. The trainee will learn to recognize and treat the various behavioral problems which may be associated with organic symptoms. He will also attempt to gain insight into family interrelationships and into the doctor-patient-family interactions and relationships.

A *Daily Conference* is designed primarily for the Family Practice Trainee, but is also attended by the senior medical students and others. This luncheon conference rotates among the various medical disciplines, including Medicine, Surgery, Pediatrics, Orthopedics, Ob-Gyn, Urology, Ophthalmology, ENT, Dermatology, Radiology, Social Service, Psychiatry, and Epidemiology. There is a monthly Chief Resident's Conference which concerns problems which the trainees have faced in the Emergency Room, Medical, pediatric, and surgical autopsy reviews are periodically presented in the conferences of the respective departments. A weekly Medical Staff Conference is held primarily for the family physicians in the county for which they receive AAGP credit, during which formal lectures are given by members of the full-time specialist staff and also by outside speakers. Once each month this conference is replaced by a clinico-pathologic conference.

The Family Practice Trainee salaries are as follows:

First year – $275.00 per month
Second year – $300.00 per month

Completely furnished apartments on the hospital grounds are available. Married trainees receive an apartment, or if none is available, an additional $100.00 per month living allowance. All trainees receive uniforms, rooms, meals, and laundry services at no cost. Blue Cross and Blue Shield benefits are provided for the trainee and his family. Malpractice insurance coverage is also provided by the Medical Center. Social and recreational facilities are abundant and readily available to the trainee and his family.

Appointments to the program are made by participation in the National Intern Matching Program. Four openings are available each year. A personal interview is strongly urged for applicants to this program. For further information, application forms, and arrangements for a personal interview, please write Robert R. Henderson, M.D., Medical Director, Hunterdon Medical Center, Flemington, New Jersey.

AMERICAN OSTEOPATHIC ASSOCIATION,
Washington, D.C., July 8, 1970.

The Honorable RALPH W. YARBOROUGH,
Chairman, Senate Committee on Labor and Public Welfare,
New Senate Office Building, Washington, D.C.

DEAR MR. CHAIRMAN: The American Osteopathic Association appreciates this opportunity to note, for the record, its support for Senate Bill 3418.

The American Osteopathic Association is the national professional organization of osteopathic physicians and surgeons. There are in excess of 13,454 osteopathic physicians and surgeons in the United States. Some 252 hospitals with a bed capacity in excess of 22,117 are staffed by doctors of osteopathy. There are six colleges of osteopathy all approved by the A.O.A. and there are 79 intern training and the 68 residency training hospitals likewise approved by the Association, which is the recognized accrediting agency by the Division of Education of the Department of HEW, and the National Commission on Accrediting.

The objective of the A.O.A. is to promote the public health, to encourage scientific research, and to maintain and improve high standards of medical education in osteopathic colleges.

For the past twenty years, as this distinguished Committee is well aware, this country have been moving unswervingly in the direction of a crisis in health manpower resources. Our population growth has far out-paced our ability to increase the number of qualified physicians. At the same time, we have been faced with an explosion of technological advances in medicine, which by their nature have occasioned increased specialization in health manpower. As a result, we are now faced with a grave shortage of family physicians.

Historically, our profession has been and continues to be a major supplier of family phyisicians. A significantly larger percentage of osteopathic physicians practice family medicine than do medical doctors. Of our 13,454 osteopathic physicians, approximately 65% or about 8,750 are engaged solely in the delivery of comprehensive health care as primary physicians.

The fact that the majority of our physicians devote their entire practice to family medicine (or the delivery of primary health care) is no accident, but rather a manifestation of our basic philosophy which emphasizes the treatment of human ailments within the context of treating "the whole man".

Given the acute shortage of family practitioners and consonant with our profession's philosophy, it is with pleasure that we offer our endorsement of Senate Bill 3418.

It is assumed that the language of the Bill, as presently drafted, envisages the participation of osteopathic medical schools in the grant programs, and representation from our profession on the Advisory Council on Family Medicine. However, because our inclusion is not now explicit and because of our interest in the area of family medicine and the expertise, we believe our institutions and members can and do contribute to that field, we would respectfully request that the legislative history of this Bill reflect the Congressional intent that our profession be included.

Very truly yours,

J. O. WATSON, D.O.

THE UNIVERSITY OF TEXAS MEDICAL BRANCH,
GALVESTON, TEX., *July 13, 1970.*

Senator RALPH W. YARBOROUGH,
U.S. Senate,
Chairman, Subcommittee on Health,
Washington D.C.

DEAR SENATOR YARBOROUGH: Thanks for an opportunity to submit an opinion on S.B. 3418 which you have introduced.

This bill satisfies an urgent need if we are to produce more practitioners of family medicine. In the total health care system of our country this is an area where the greatest shortage exists. There are vast numbers of our citizens who are unable to secure the services of a primary physician. In most cases this is due simply to the fact that there are not enough physicians at the point where medical care is delivered. Since the supply is low, the cost is prohibitive.

I shall not repeat statistics nor enter into any arguments for the necessity for family practitioners within our total medical care system. These are well known.

My only observation would be that one only has to ask the rank and file of our citizens if they can get adequate medical care at a cost they can afford. I believe the answer would be an overwhelming, "No!".

S.B. 3418 is a step in the right direction to put more well trained physicians on the firing line where they are needed.

Thanks for the opportunity to submit this statement.

Sincerely Yours,

M. LAMAR ROSS, M.D.,
Director, Division of Family Practice.

AMERICAN HOSPITAL ASSOCIATION,
Washington, D.C., July 10, 1970.

Senator RALPH YARBOROUGH,
Chairman, Committee on Labor and Public Welfare,
U.S. Senate,
Washington, D.C.

DEAR MR. CHAIRMAN: This letter is written to place before you and the members of your committee the views of the American Hospital Association with regard to S. 3418 which would authorize grants to medical schools and hospitals that have training programs for medical students, interns or residents to help them provide professional and technical training in the field of family medicine.

One of the most noticeable changes in the practice of medicine in our country in recent years has been the great increase in specialization. Whereas eighty percent of the physicians in private practice declared themselves to be general practitioners forty years ago, recent information from medical school graduates indicates that at this time only about fifteen percent are planning to enter general practice. The decrease in the number of physicians providing health care as general practitioners or family physicians has, we believe, been one of the major causes of the increasing difficulties encountered in trying to obtain the services of a physician when medical help is needed. This lack of accessibility to physician services is not limited to the poor, although, it is especially apparent in urban and rural poverty areas.

In addition to the importance of the family physician as a means of entry into the health care system, his role includes evaluating the total health needs of the patient; providing preventive, curative, and rehabilitative health care; referring the patient, when appropriate, to other sources of care; preserving the continuity of care; and coordinating health services for the patient.

The new field of family practice has emerged in recent years in recognition of the family physician's key role in and responsibility for the total health care of patients. Some medical schools are beginning to develop curriculum and offer courses in family practice. However, much more needs to be done along these lines by medical schools and by hospitals engaged in training medical and paramedical personnel.

The American Hospital Association is pleased to support S. 3418 in view of the great need for both medical and paramedical personnel trained in the field of family medicine.

We shall not comment on all of the provisions of the bill. We would, however, note with approval that the bill specifically provides that public and private nonprofit hospitals shall be eligible for grants to operate special professional training programs in the field of family medicine for medical students, interns or residents; to operate or participate in special training programs for paramedical personnel in the field of family medicine; to provide financial assistance in the form of scholarships, fellowships or stipends to needy interns, residents, or other medical personnel receiving training in the hospital's program in the field of family medicine; and to construct, acquire, expand, remodel or alter facilities appropriate to carrying out a program of training in the field of family medicine.

The provisions permitting the Secretary of Health, Education, and Welfare to make planning grants (Sec. 766) are certainly desirable inasmuch as medical schools and teaching hospitals are already hard pressed to maintain their present programs and for the most part simply do not have available the funds that are necessary to plan and develop new programs in family medicine.

In order to assure that proper consideration is accorded the problems and needs of teaching hospitals engaged in training in the field of family medicine, we

urge that Section 767 of the bill be amended to provide for representation of such hospitals on the Advisory Council on Family Medicine. This could be accomplished without increasing the size of the proposed twelve member council by having the council consist of twelve members, three of whom are physicians engaged in the practice of family medicine, three of whom are physicians engaged in the teaching of family medicine in medical schools, three of whom are engaged in the teaching of family medicine in hospitals, and three of whom are representatives of the general public.

We appreciate the opportunity to present the Association's views on S. 3418 and request that this letter be made a part of your committee's hearings on the bill.

Sincerely,

KENNETH WILLIAMSON,

Deputy Director.

[Western Union Telegram]

AUSTIN, TEX., *July 7, 1970.*

SENATOR RALPH W. YARBOROUGH,
Subcommittee on Health, Senate Labor and Public Welfare Committee, U.S. Senate, Washington, D.C.:

We note with interest that the Senate subcommittee on Health is holding public hearings on S. 3418, which establishes an assistance program in the field of family practice. As you are aware, many physicians are needed to provide medical care to the people of this State. The greatest need is for more general practitioners and for those who desire to practice family medicine. It has been estimated that this State could readily absorb as many as 600 physicians. The majority of the locations are in the smaller communities and in rural areas. Nevertheless, the metropolitan areas and the suburbs provide good opportunities in family practice. The Texas Medical Association is lending its full support in providing more family physicians to serve the people of this State.

JOE T. NELSON, M.D.,
Chairman, Council on Medical Jurisprudence,
Texas Medical Association.

THE UNIVERSITY OF NEBRASKA MEDICAL CENTER,
DIVISION OF FAMILY PRACTICE,
Omaha, Neb., July 17, 1970.

HON. RALPH YARBOROUGH,
U.S. Senate, New Senate Office Building, Washington, D.C.

DEAR SENATOR YARBOROUGH: I have recently read the testimony concerning your bill S. 3418 and feel called upon to make some comments concerning the testimony that was given before your committee.

First, let me identify myself as the Director of the Division of Family Practice, University of Nebraska College of Medicine, and a senior member of the Council on Medical Education of the American Medical Association, having been a member for seven years. I also serve as a member of the Family Practice Committee of the AMA Council on Medical Education. I was a practicing family physician in Fort Wayne, Indiana, for 15 years.

Dr. Willard, the past chairman of the Council on Medical Education, recommended the deletion of the requirement for a sepate department of equal standing in Family Practice. I am certain this is not the opinion of the entire Council. In particular, as a working Director of a Division, I feel that in order for the family practice program to be viable in a medical school, it is absolutely essential that there be a separate *entity* of equal standing in family practice with the Chairman or Director reporting directly to the Dean. I state this because only in this fashion can the director of the program become a member of the Executive Faculty and engage in decision making concerning the entire medical school curriculum, including both undergraduate and graduate. This to me is a very essential element in the development of this movement to provide more clinicians, primary physicians, for this nation. I reiterate that I am fully qualified to express my opinion since I am engaged in this endeavor and, as a matter of fact, would not accept a position as director of a program unless this type of administrative arrangement were present.

A quote from page 30, the penultimate paragraph, of the Report of the Ad Hoc Committee on Education for Family Practice, chaired by Dr. Willard, I think gives further credulence to the concept of the separate entity. "Furthermore the faculty should have the same recognition in terms of rank and prerogatives as afforded the faculty in other major clinical areas. To insure the quality of patient care, the family practice service, both in and out of the major teaching hospital, should be subject to the same kind of surveillance and audit by the faculty of the institution to which other disciplines and services are subject."

With regard to the testimony by HEW's team of Dr. John Zapp, Dr. Kenneth Endicott and Dr. Robert Butcher, I hope that you were able to pose a question to them as to what programs are already in existence that are sufficient to accomplish the aims of the legislation. I know of absolutely none. Our program is financed entirely by State of Nebraska funds because there are no federal funds available at the present time such as you have requested in your bill. I do not know what the Administration people had in mind, but I can assure you that a thorough search of the records of NIH Bureau of Health Professions Education Manpower Training will show that no grants have been given for this primary purpose.

I also do not understand, as a member of the Liaison Committee on Medical Education of the AMA and the Association of American Medical Colleges, that the AAMC would object to some portions of this bill. I would like to quote some parts of the Ad Hoc Committee report, which I think would be helpful for your committee members. This committee, as you are probably well aware, consisted of four members of the Council on Medical Education, two representatives of the American Academy of General Practice, one representative of the AMA Section on General Practice and three representatives of the Association of American Medical Colleges. I particularly call your attention to the statement agreed to by representatives from the AAMC that "The need for family physicians in the United States is viewed by the Ad Hoc Committee to be a major national need which should claim a high priority—comparable to that for research and research training. The realization of more family physicians will require an infusion of substantial and growing sums of money for medical schools and training programs for family practice." (page 46)

The present generation of medical students have a high degree of interest in participating in this program and are most hopeful your bill will be enacted.

Sincerely yours,

FRANCIS L. LAND, M.D.,
Professor of Family Practice.

THE UNIVERSITY OF WISCONSIN MEDICAL CENTER,
MADISON, WIS., *June 17, 1970.*

SENATOR GAYLORD A. NELSON,
Senate Office Building,
Washington, D.C.

DEAR SENATOR NELSON: As a member of the faculty and administration of the medical school, I would like to share with you my frustration in working toward larger class size and improved educational programs at Wisconsin. The Program in Primary Care, which is described briefly in the accompanying document, is now five years old. It is dedicated to producing more physicians educated to be capable of, and interested in, practicing in those areas of the state most in need of personal or primary physicians. We have been able to secure *no* federal support whatsoever. Most recently an educational grant was approved, but was unable to be funded. The support given the Health Manpower Division of the NIH (and health education in general) is pitifully inadequate.

Except for the fact that we (the faculty of the Program in Primary Care and the Wisconsin Academy of General Practice were able to lobby a special appropriation through the 1969–70 Wisconsin State Legislature (unanimously) in a year in which the University was *not* popular) our program would be completely unable to grow and meet its expanding objectives to train Family Physicians, Pediatricians and Internists.

I believe that active congressional support is needed to insure passage of medical education appropriations in the next year. There must be enough money to go around, or else previously strong medical schools (such as Wisconsin) will be converted to weak ones as weak ones are kept alive by the small funds available. Of particular importance is the *Rooney Bill* appropriating money to

develop educational programs in Family Medicine. I hope you all recognize its importance for Wisconsin.

Medical Schools are in very difficult circumstances. They have many inadequacies but are all we have to educate physicians, they must not be allowed to flounder and become weaker.

I would be more than happy to provide any assistance you might need in defining the issues, particularly as they apply to Wisconsin. We are really counting on your informed support to rescue the medical schools from very restrictive limits placed upon our ability to do a job, which society is continually demanding be bigger and more difficult.

With best regards.

Sincerely,

M. F. HANSEN, M.D.
Assistant Dean.

THE TEXAS ASSOCIATION OF
OSTEOPATHIC PHYSICIANS AND SURGEONS,
Austin, Tex., July 8, 1970.

Hon. RALPH W. YARBOROUGH,
Old Senate Office Building,
Washington, D.C.

DEAR SENATOR: I called your office today regarding S. 3418. We feel this is an excellent measure toward improving health care. Our main concern is to be sure that our School of Medicine will be completely included in this measure.

On page 5, line 20, it refers to "School of Medicine". If it could be placed into the record that this would relate to either M.D. or D.O. degree, this would make the intent clear.

On page 10, line 4, naturally we would like to have a D.O. on the Advisory Council.

Your consideration will be very much appreciated and I want to especially express my deep appreciation in your effective efforts not only on the health field, but in all of the excellent work you have rendered the people of Texas.

I hope we can get together soon.

Sincerely,

ELMER C. BAUM.

THE UNIVERSITY OF WISCONSIN MEDICAL CENTER,
Madison, Wis., June 16, 1970.

Mr. JOHN R. WESTCOTT,
Chief, Health Manpower Grants Branch,
Department of Health, Education, and Welfare,
Bethesda, Md.

DEAR MR. WESTCOTT: I am of course greatly disappointed that our approved Health Professions Special Project Grant was not able to be funded. I understand the problems which you are facing in competing for funds within a seriously unbalance national priority policy. Until the crisis in health care and health education is recognized, and the cost of setting it right is understood, medical schools will be obliged to slowly deteriorate, rather than to improve their programs in response to national need.

I admit to great frustration, which you must share, in looking at the really substantial work which goes into grant preparation and review. Even with the approved grant, pending funds being available, there is no carry over, and if we are to share any federal funds we must now start the process all over again. I do not believe that this is a very efficient use of medical educator manpower. Teachers of medicine are in just as short supply and just as overworked as are practicing clinicians (and, I suppose, people in government).

Since the major problem seems to be a failure to assign health *education* a very high national priority, I am taking the liberty to send this letter, and the introduction of our grant proposal to Wisconsin's congressmen and senators. I know that many of them are intensely concerned over the physician shortage in Wisconsin. They can most constructively work to improve the situation by working together to assure adequate health education funding to be directed to the division of health manpower.

Thank you for your continued efforts on our behalf. I trust that by informing our representatives and leaders we can accomplish the task we must accomplish if the health care system is to be improved.

Sincerely,

M. F. HANSEN, M.D.
Assistant Dean.

YALE UNIVERSITY,
SCHOOL OF MEDICINE,
DEPARTMENT OF INTERNAL MEDICINE,
New Haven, Conn., February 17, 1970.

Hon. RALPH YARBOROUGH,
Senate Office Building,
Washington, D.C.

DEAR SENATOR YARBOROUGH: I am writing to extend my enthusiastic support of your proposed amendment to Part D of Title 7 of the Public Health Service Act. Its passage should have an exceptionally favorable impact on the health problems facing the medical profession and the nation. In my opinion, formal assistance of family health care programs is long overdue, and the lack of such assistance has led to misdirection and resultant misuse of our most important medical manpower commodity—the physician. Your bill strikes at the heart of a dire situation, and outlines a pertinent and far-reaching strategy for alleviating the storage and increasing maldistribution of medical manpower.

My personal interest in this bill is particularly great because of the absence of a family health care department at my alma mater (University of Cincinnati College of Medicine), as well as at the Yale School of Medicine where I now serve on the faculty. Indeed, most medical schools and teaching hospitals have been derelict in meeting what should be their preeminent responsibility—the provision of adequate training and service facilities for family health care. A singularly appealing feature of your proposal, in this respect, lies in the provision which would promote the establishment of family health care as a major specialty department, although perhaps this is impossible within our present system of outpatient care in university medical centers.

The overwhelming emphasis in our medical schools has been on basic, disease-oriented research and training, while applied clinical research and training oriented toward comprehensive and continuing personal health care has been almost totally neglected. Most "clinic" care is so fragmented that it has often led to serious omissions or to expensive duplications of clinical procedures. Ambulatory services are on the bottom rung of the academic ladder and are usually so inefficient that unnecessary financial burdens are perpetrated on the patients, as well as on the taxpayers who often have to pay the bill. With priorities so deranged, it is no wonder that physicians-intraining visualize family health care as a particularly unattractive career.

The tired arguments that physicians will instinctively seek careers in family health care and will learn how to practice family medicine through intuition and experience have lost their credibility in the face of our present manpower problems. May I suggest that a department such as you propose should take advantage of the predilection of many trainees in internal medicine and pediatrics to become primary physician specialists if training opportunities were available. This inclination toward primary care could be supplemented by experience in delivering personalized family health care in an organized setting—with emphasis on continuity, coordination and comprehensiveness of care—within a department dedicated to these principles.

Multispecialty group practice with a strong core of primary physician specialists has demonstrated repeatedly an ability to overcome most of the existing deficiencies in the area of service and manpower, while providing significant cost benefits. I believe that the principles of family care can best be learned in the setting of a medical-school-sponsored multispecialty group practice—which may turn out to be the only feasible framework for training next-generation physicians in the practice and delivery of comprehensive medical care.

I should be most happy to support, in any way I can, your efforts to obtain passage of this bill. Please feel free to call upon me for personal or further written testimony on behalf of your proposed legislation to establish special departments in the field of family medicine.

With high regard for your concern with the health of the nation, I am

Sincerely yours,

GORDON K. MACLEOD, M.D.,
Associate Clinical Professor of Medicine and Public Health.

TARRANT COUNTY MEDICAL SOCIETY,
Fort Worth, Tex., March 3, 1970.

Hon. RALPH YARBOROUGH,
Senate Office Building,
Washington, D.C.

DEAR SENATOR YARBOROUGH: It is with a great deal of interest that we physicians in Tarrant County regard your Senate Bill to help finance Family Practice Departments in hospitals and medical schools.

The shortage of physicians doing family practice has become acute throughout Texas and we hope your bill will stimulate medical schools to orientate medical students to enter the field of family practice.

Best wishes,
Sincerely,

JAMES D. MURPHY, M.D.,
Immediate Past President.

TEXAS ACADEMY OF GENERAL PRACTICE,
Fort Stockton, Tex. March 5, 1970.

Hon. RALPH YARBOROUGH,
Senate Office Building,
Washington, D.C.

DEAR SENATOR YARBOROUGH: We shall follow the progress of your Senate Bill to help finance the Family Practice Departments in the hospitals and medical schools with much interest.

It is gratifying to know that some of our Legislators are aware of the acuteness for family practitioners throughout our nation and more particularly I speak in the interest of Texas. What we need is more "people doctors" who can handle up to 90% of the medical problems of the general public. We would hope that your bill will stimulate medical schools to orient their medical curriculum to produce family practitioners.

I remain,
Sincerely yours,

JOHN C. HUNDLEY, M.D.,
President, Texas Academy of General Practice.

TEXAS ACADEMY OF GENERAL PRACTICE,
Beaumont, Tex., March 10, 1970.

Hon. RALPH YARBOROUGH,
Senate Office Building,
Washington, D.C.

DEAR SENATOR YARBOROUGH: We physicians of Jefferson County have a great deal of interest in regards to your Senate Bill to help finance Family Practice Dept. in hospitals and medical schools.

There is a tremendous shortage of physicians doing family practice in Texas and we hope your bill will stimulate medical schools to encourage more of their students to enter the field of family practice.

Best wishes,
Sincerely,

B. B. WESTBROOK, Jr., M.D.,
President-Elect.

BRECKENRIDGE, TEX., *March 14, 1970.*

Hon. RALPH YARBOROUGH,
Senate Office Building,
Washington, D.C.

DEAR SENATOR YARBOROUGH: Your Senate bill to help finance family practice departments in hospitals and medical schools is a worthwhile one and appreciated by physicians like me in general practice.

Texas, including our town of Breckenridge, needs more family physicians and I hope your bill will stimulate medical students to enter the field of family practice in the future.

Sincerely,

EDWIN GOODALL, M.D.

FLORESVILLE, TEX., *March 11, 1970.*

Senator RALPH YARBOROUGH,
Senate Office Building,
Washington, D.C.

DEAR SENATOR YARBOROUGH: It has come to my attention that you have recently introduced a bill in the Senate which is similar to, but enlarges upon, the Rooney Bill in the House. These bills propose to furnish funds to increase and improve the number of family practice departments in medical schools and hospitals.

You are well aware of the need for more physicians in this state, as well as the nation, and I certainly hope that your efforts in this matter will encourage others, particularly medical educators, to increase the output of those who will serve as family physicians, both in urban and rural situations.

Sincerely,

SAM A. NIXON, M.D.

FAMILY MEDICAL AND SURGICAL CLINIC,
Dallas, Tex., March 17, 1970.

Senator RALPH YARBOROUGH,
U.S. Senate,
Washington, D.C.

DEAR SENATOR YARBOROUGH: I was delighted to see the newspaper reporting of your efforts to encourage the education of family doctors. I have tenaciously continued in the practice of what I consider to be the most vital area of medicine, general pratcice, since 1954. There are times when I feel that it might be more advisable to take up a specialty, give up my practice and make things easier on myself and my family. This attitude is common place among doctors in general who are over worked, and I think under-appreciated.

The AMA newspaper carried the telegram from the President of the Massachusetts Medical Society to Senator Kennedy. If you have not read this I would appreciate your doing so.

The shortage of physicians in this country is now very real as I am sure you are aware. I do not find our foreign colleagues measuring up to our standards and yet many of our people are forced to accept their care which in many instances, though certainly not always, is inadequate and substandard. I am most interested in being brought up to date on the legislation proposed in the House regarding the expansion of medical education facilities and the encouragement of more doctors entering into the general practice of medicine and surgery as family doctors.

Thank you for your consideration and interest on behalf of the family doctors of the country.

Sincerely,

P. E. WHITTLESEY, M.D.

BIG LAKE, TEX., *March 17, 1970.*

Hon. RALPH YARBOROUGH,
Senate Office Building,
Washington, D.C.

DEAR SENATOR YARBOROUGH: I am writing with regard to your Senate Bill which is designed to help finance Family Practice Departments in hospitals and medical schools. As President of a Medical Society composed of physicians practicing 100% Family Practice in West Texas, and having been in private practice in West Texas for over 23 years, I am acutely aware of the need for legislation which will stimulate medical schools to encourage medical students to enter the field of private practice.

Best regards.

Sincerely,

JOHN L. WRIGHT, M.D.,
President, Crane, Upton, Reagan Medical Society.

LOMA LINDA UNIVERSITY,
SCHOOL OF PUBLIC HEALTH,
DEPARTMENT OF EPIDEMIOLOGY,
Loma Linda, Calif., March 30, 1970.

Sen. RALPH YARBOROUGH,
Senate Office Building,
Washington, D.C.

DEAR SENATOR YARBOROUGH: This brief communication is to applaud you for efforts to boost the practice of family medicine in the United States. I believe with you that the situation is getting desperate and will become catastrophic if measures are not taken soon to correct it. The New York State Legislature is to be commended for the measures they have recently passed. I wish instant success for your bill designed to help medical schools develop from the practice departments.

Sincerely yours,

RAYMOND O. WEST, M.D.,
Chairman.

MEDICAL UNIVERSITY OF SOUTH CAROLINA,
Charleston, S.C., March 5, 1970.

Hon. RALPH YARBOROUGH,
U.S. Senate,
Washington, D.C.

DEAR SENATOR YARBOROUGH: I wish to compliment you and representative Fred Rooney for your foresight and your efforts to make a very significant contribution in medical care to the American people. The bill which you are sponsoring will encourage medical schools to add programs which will produce family doctors. As new medical schools are developed and old ones increase their enrollment, I hope the expansion will be in the direction of family practice. The production of specialists and continuation of research is essential but does not need to expand until the critical shortage of family doctors has been corrected.

On February 4, 1970 the Medical University of South Carolina made a historic decision that I believe will help our family physician shortage. A new Department of Family Practice was established and I was given the responsibility to organize and develop a program to attract medical students into family practice and to provide the opportunity for them to be thoroughly trained in this field. Having been a family physician before I became an internist and neurologist I am pleased with the opportunity of this exciting challenge.

I shall appreciate receiving a copy of the bill you have introduced in order that I may use it's provisions for the development of this new Department of Family Practice.

Sincerely and Respectfully yours,

HIRAM B. CURRY, M.D.,
Professor and Chairman, Department of Family Practice.

THE MISSOURI ACADEMY OF GENERAL PRACTICE,
Springfield, Mo., April 21, 1970.

Re Senate bill S. 3418.

Sen. STUART SYMINGTON,
Senate Office Building,
Washington, D.C.

DEAR SIR: Please cast your vote in favor of the above bill when it comes for vote. It would be a great help to medicine and the people of this country if you will even help get these bills out of committee this year. It would probably be a greater benefit to the bill if you would add your name as a co-sponsor.

I sincerely regret it, but in my opinion this bill will not do what it is fully intended to do. All it does is actually provide funding and physical facilities for family practice departments in medical schools.

In my opinion, this will only partially solve the problem of supplying more family doctors to the medical pool of this country. The biggest problem of the aspiring young family physician is one which never hits the surface and one of which I am sure you are unaware. The aspiring young family physician's biggest problem is a matter closely akin to unionism. Upon finishing medical school and training he then goes to a community to practice medicine and finds

that he is "locked-in" to a system whereby his advancing privileges are subject to the strongest of restrictions, despite his own aptitude and abilities. This is one of the "benefits" of specialization in the practice of medicine. The result of this practice has been that unless one actually declares himself a specialist and gets specialty training; he is forbidden the right to provide certain services which are within the domain of certain of the specialities, despite his ability. This results in the young family physician entering practice and being beset with road blocks every time he attempts to improve his services or increase the number of procedures which he is competent of doing.

This unfortunate defect of American medicine is one for which only the hierarchy of the American Medical Association and the American College of Surgeons can be held responsible.

Followed to its logical conclusion then, this results in fewer and fewer young general practioners, family physicians, desiring to enter this particular branch of medicine and thus the country is suffering from acute over-specialization. In turn, this situtation has resulted in the reversal of the ratio of general physicians to specialists that has occurred in our country in the past 25 years. The funding provided in the above bill may help somewhat in reversing the ratio of 65 per cent specialists and 35 per cent generalists, but I am sincere in stating that I don't think this is the real answer to the problem. It may be a step in the right direction and deserves your help.

Respectfully,

JOHN T. CROWE, M.D.,
President, Missouri Academy of General Practice.

[Western Union Telegram]

SPOKANE, WASH., *July 9, 1970.*

SENATOR YARBOROUGH,
Senate Office Building,
Washington, D.C.

The family doctors in the State of Washington have been following your bill 3418 and your handling of the hearings on the bill this week. We think you are great. Please keep pushing. We need this bill.

RICHARD H. GANZ, M.D.
Immediate Past President,
Washington Academy General Practice.

PREPARED STATEMENT OF WILLIAM O. ROBERTSON, M.D., ASSOCIATE DEAN, SCHOOL OF MEDICINE, UNIVERSITY OF WASHINGTON, ON S. 3418

Gentlemen, both the public and the professions in the state of Washington have a great interest in supporting Senate Bill 3418. Our citizens have noted the decline in family physicians over the past generation; our professional groups have initiated joint ventures between the training component and the practice component to evolve a new group of paramedical personnel—"MEDEX"—to begin to fill this void; to date, we feel this step has proved unexpectedly successful. But—in itself—it provides no total solution. Our state supported medical school has responded to professional, public, and legislative encouragement in beginning to develop a family medicine program and to build such a program into their new curriculum. In concert with clinic groups and hospitals throughout the region, they are attempting to establish graduate training programs. Senate Bill 3418 would provide much needed encouragement and fiscal resources to culminate such activities. As an example of interest amongst our students, 41 out of 80 third-year students have applied for opportunities to work with general practitioners throughout the Pacific Northwest during their elective quarters; interestingly, this program has received some financial backing from the professional groups involved—a temporizing short term solution, but no long term one. The current program is grossly inadequate to permit all students so interested to participate.

As a consequence of obvious interest in this problem and some existent approaches towards solution, I feel certain that the public and the professions in the Pacific Northwest would benefit immeasurably were this Bill favorably acted upon.

WASHINGTON/ALASKA REGIONAL MEDICAL PROGRAM,
Seattle, Wash., March 19, 1970.

ABRAHAM B. BERGMAN, M.D.,
Director of Outpatient Services, Associate Professor of Pediatrics and Preventive Medicine, Children's Orthopedic Hospital, Seattle, Wash.

DEAR ABE: I appreciate the opportunity of reviewing S. 3418, Senator Yarborough's Bill to provide assistance in the training of more practitioners of family medicine.

Among the current problems in health care in the United States, none seems more pressing than the critical shortage and maldistribution of physicians, particularly family physicians who are available to deal with primary health care needs. Evidence of this deficiency of family physicians, particularly in the rural and remote areas of Washington and Alaska has been striking and distressing to us in the Washington/Alaska Regional Medical Program as we have surveyed health needs in our region.

While many medical schools are keenly aware of this problem and are taking steps to reverse the declining numbers of family physicians, these measures do not seem drastic enough or to be occurring in sufficient numbers to meet the need. Senator Yarborough's bill would provide important encouragement and support to medical schools in this regard, and I approve it with enthusiasm.

If I can be of any other assistance in support of this legislation, please let me know.

Yours truly,

DONAL R. SPARKMAN, M.D.
Director.

COOPERATIVE OF PUGET SOUND,
Seattle, Wash., March 20, 1970.

ABRAHAM B. BERGMAN, M.D.,
Seattle, Wash.

DEAR ABE: Thank you for your letter of March 16, 1970 which was quite timely since I was thinking of writing Senator Magnuson regarding my support of Senator Yarborough's Bill S 3418.

As you probably know, we have a three year family practice residency program at Group Health. The program started July 1, 1969. So far we have been successful in filling all residency openings, both for the year 1969–70 and the year 1970–71.

We feel the need for well-trained family practice physicians is very great. As I am sure you know, the number of physicians engaged in the general practice of medicine is declining at an alarming rate. However, in order to be an adequate family physician today you need more training than a degree from a medical school and a one year rotating internship provides. Thus, the reason for our three year program. We feel that family physicians make a real contribution to the group practice of medicine—they fill a very vital role in personal care that cannot be filled by a specialist in internal medicine or surgically oriented physician.

I feel the Bill would benefit from a little clearer statement regarding the type of institutions that could participate. I understand it includes non-profit organizations such as our own if there is some affiliation with a grade A medical school.

I would appreciate your passing my thoughts on to Senator Magnuson. Best personal regards.

Sincerely,

HAROLD F. NEWMAN, M.D.,
Director.

UNIVERSITY OF WASHINGTON,
Seattle, Wash., March 23,1970.

ABRAHAM B. BERGMAN, M.D.,
Seattle, Wash.

DEAR ABE: My advice would be for Senator Magnuson to support Yarborough's legislation concerning establishment of programs in family practice.

Warm personal regards,

ROBERT G. PETERSDORF, M.D.,
Professor and Chairman.

(Whereupon, at 12:08 p.m., the subcommittee recessed, subject to call of the Chair.)

○